State of New Jersey

Annual Progress and Services Report

2015

Allison Blake, Ph.D., L.S.W.
Commissioner

June 30, 2015

State of New Jersey
DEPARTMENT OF CHILDREN AND FAMILIES
P.O. BOX 729
TRENTON, NJ 08625-079

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Governor

KIM GUADAGNO
Lt. Governor

ALLISON BLAKE, PH.D., L.S.W.
Commissioner

June 25, 2015

Alfonso Nicholas, Regional Program Administrator
Administration for Children and Families
U.S. Department of Health and Human Services
26 Federal Plaza, Room 4114
New York, NY 10278

Dear Mr. Nicholas,

On behalf of the State of New Jersey, I am pleased to submit a CD-Rom containing the New Jersey 2015 Annual Progress and Services Report (APSR) with the attached targeted plans, fiscal documents CFS 101-Parts I, II and III, CFS 101 Addendum as well as the Annual Reporting of ETV Awards.

This submission contains detailed progress reports and plans for services covered under the Child and Family Services Plan, including Title IV-B subparts 1 and 2, the Chafee Foster Care Independence Program, the Child Abuse Prevention and Treatment Act, the Children's Justice Act Program and other related state child welfare initiatives.

As agreed upon we have re-submitted the three Citizen Review Panel reports that were published last year.

We trust that this report satisfactorily addresses all federal requirements and we look forward to your response to this document. As always, we thank you for your continuing support of our efforts to improve outcomes for children and families of New Jersey.

Sincerely,

Allison Blake AR

Allison Blake, Ph.D., L.S.W.
Commissioner

c: Evelyn Torres-Ortega
Aubrey C. Powers
Dawn M. Leff

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Annual Progress and Services Report 2015

Introduction

As the New Jersey Department of Children and Families (DCF) moves into its 10th year as a State Department, it continues to focus on integrating best case practice throughout its service structure in order to improve outcomes and to sustain the progress already made on behalf of the state's most vulnerable children and families. DCF has remained focused on safety, permanency, and well-being while continuing to strengthen families and ensure a better today and even a greater tomorrow for every individual we serve.

NJ Child Welfare System Structure

Legislation was signed on July 11, 2006, establishing the New Jersey Department of Children and Families (DCF) as New Jersey's first cabinet-level department with responsibility for child welfare, child behavioral health, child abuse prevention, and community support programs for children and their families. The legislation transferred the administrative arms responsible for these programs from the Department of Human Services (DHS) to DCF. In June of 2012, legislation was signed that reorganized DCF into a single point of entry for all families with children with developmental disabilities and renamed the four divisions within DCF. The former Division of Youth and Family Services is now known as the Division of Child Protection and Permanency (DCP&P); the Division of Prevention and Community Partnerships is now the Division of Family and Community Partnerships (DFCP); and the Division of Child Behavioral Health Services is now the Children's System of Care (CSOC). Additionally, the Division on Women has been transferred to DCF from the Department of Community Affairs. The programs and services administered by each Departmental component are outlined below.

Division of Child Protection and Permanency (DCP&P)

DCP&P is New Jersey's lead child welfare and protection agency. Its mission is to ensure the safety, permanency and well-being of children and to support families.

- **Investigation and Assessment:** DCP&P operates a State Centralized Registry which is a 24 hour, seven day a week, centralized call center to receive all reports of child abuse, neglect, and referrals for child welfare assessments. CP&P investigates these allegations and assessments through a network of 46 Local Offices. In addition there are 9 Area Offices to support the production and operations of the local offices.
- **Placement:** Children in DCP&P protective custody may require temporary placement in out-of-home settings in order to preserve their safety. CP&P promotes the concept of family placement settings and will seek
- **Family Support Service:** Includes services provided to strengthen families and children in their own homes as well as foster and adoptive families and those in out-of-home placement.

- **Permanency:** Services are designed to achieve and maintain permanency - a sustained, stable family who will care for and nurture the child - through reunification, adoption, or Kinship Legal Guardianship. Permanency also includes supporting youth in making a successful transition to independent adulthood

Division of Family and Community Partnership (DFCP)

DFCP administers a continuum of community-based child abuse prevention and intervention programs that are culturally competent, strengths-based, and family-centered with a strong emphasis on child abuse prevention.

Early Childhood: Services focus on children under 6 years of age, including:

- Home Visitation
- Nurse Family Partnership
- Healthy Families
- Parents as Teachers
- Strengthening Families Initiative (NJSFI)
- Evidence-Based School Linked
- Children's Trust Fund

School-linked Services: Program services include:

- School Based Youth Services
- Family Empowerment Program
- Family Friendly Centers
- Adolescent Pregnancy Prevention Initiative
- Parent Linking Program
- NJ Child Assault Prevention Project
- School Based Medical Centers

Family Support: Resources are focused on meeting the unique needs of families before child maltreatment becomes an issue.

- Family Success Centers

Domestic Violence

- 24-hour hotline, emergency shelter, and related support services are available in each county.
- Peace: A Learned Solution (PALS) offers intensive therapeutic interventions for children exposed to domestic violence.

Service Integration within and across counties: DFCP works with local entities and organizations, such as the Task Force on Child Abuse & Neglect Prevention Subcommittee; Child Welfare Agencies and Human Service Advisory Councils to create a network for planning, prioritizing, and implementing effective prevention efforts that are county-focused and county-driven.

Children's System of Care (CSOC)

CSOC serves children and adolescents with emotional and behavioral health challenges and their families; and children with developmental and intellectual disabilities. Services are based on the

needs of the child and family and are provided in a family-centered, community-based manner. Perform Care is the point of entry into the CSOC system.

- **Mobile Response and Stabilization Services (MRSS):** Services are available 24/7 to help children/youth experiencing emotional/behavioral crises. Services are designed to defuse an immediate crisis, keep children and their families' safe, and maintain children in their own homes or current living situation.
- **Residential Services:** CSOC continues to provide residential services. As more and more community alternatives are made available, the overall percentage of children receiving residential care has decreased.
- **Family Support Organizations (FSO's)**: FSO's are family-run, county-based organizations that provide direct family-to-family peer support, education, advocacy, youth partnership, and other services and support to families of children with emotional and behavioral problems.
- **In-Community Behavioral Assistance:** CSOC supports 46 community-based outpatient and partial care providers across the state and authorizes the enrollment with Medicaid of more than 300 intensive in-community providers and approximately 400 Behavioral Assistants statewide.
- **Care Management Organizations (CMO's):** Care management organizations (CMO's) are agencies that provide a full range of treatment and support services to children with the most complex needs. They work with child-family teams to develop individualized service plans. The CMO's goals are to keep children in their homes, their schools and their communities.
- **Eligibility Determination for Children with Developmental Disabilities:** As of January 1, 2013, CSOC assumed responsibility for determining eligibility for developmental disability services of children under age 18. This eligibility process for children, which was formerly completed by the Division of Developmental Disabilities, is required under New Jersey law in order to access publicly available developmental disability services.
- **Traumatic Loss & Suicide Prevention (TL&SP)**: TL&SP is responsible for reporting on the State's suicide prevention related activities. TL&SP also oversees the division's constituent relations and external inquiries. In addition, TL&SP serves as the division's liaison to the Judiciary. TL&SP also represents CSOC on several interagency committees including the Children in Court Improvement Committee and the Child Abuse and Neglect Task Force's Staffing and Oversight Review Subcommittee. TL&SP also serves as DCF's liaison to the State's County Inter-Agency Coordinating Councils (CIACCs).

Division of Women

The New Jersey Division on Women (DOW) is a pioneering state agency that advances public discussion of issues critical to the women of New Jersey and provides leadership in the formulation of public policy in the development, coordination and evaluation of programs and services for women. DOW evaluates the effectiveness of program implementation and plans for the development of new programs and services.

The Division is also charged with establishing a liaison with state departments and other public and private agencies involved with laws, regulations and program development affecting women

in joint efforts to expand opportunities for women. In this capacity, DOW collaborates with other state departments to understand and address the changing needs and concerns of women. DOW oversees Sexual Assault Direct Services, Sexual Assault Prevention Services and Displaced Homemaker Services.

- Funds, monitors and evaluates programs for the advancement of women;
- Develops new programs to serve women;
- Develops and analyzes policies that affect women;
- Educates and trains the public;
- Refers women to direct service providers;
- Provides information on women's issue to the general public;
- Provides technical assistance to agencies representing women;
- Represents women on boards, commissions, councils, committees and task forces

Department Units and Central Operations

DCF administers a number of functional offices and units that directly impact the department's broad delivery of protective and supportive services to children and families

- **Office of Performance Management and Accountability:** Manages the Qualitative Review Process, as well as the CFSR and the APSR, including the Program Improvement Plan development and monitoring. In addition, the office oversees Research, Evaluation and reporting (RER), the Child Fatality and Near Fatality Review Boards, Domestic Violence Fatality Near Fatality Review Board as well as the Executive Directed Case Review Process.
- **Office of Adolescent Services:** The Office of Adolescent Services (OAS) supports adolescents in the transition to adulthood to achieve economic self-sufficiency, independence, and engage in healthy life-styles by:

1. Ensuring that services provided through the Department of Children and Families are coordinated, effective, meet best practice standards, are youth driven, and adapt to the needs of families and communities,
2. Developing linkages with other service providers in order to create a more equitable and seamless service system, and
3. Providing leadership and policy development in the field of adolescent services.

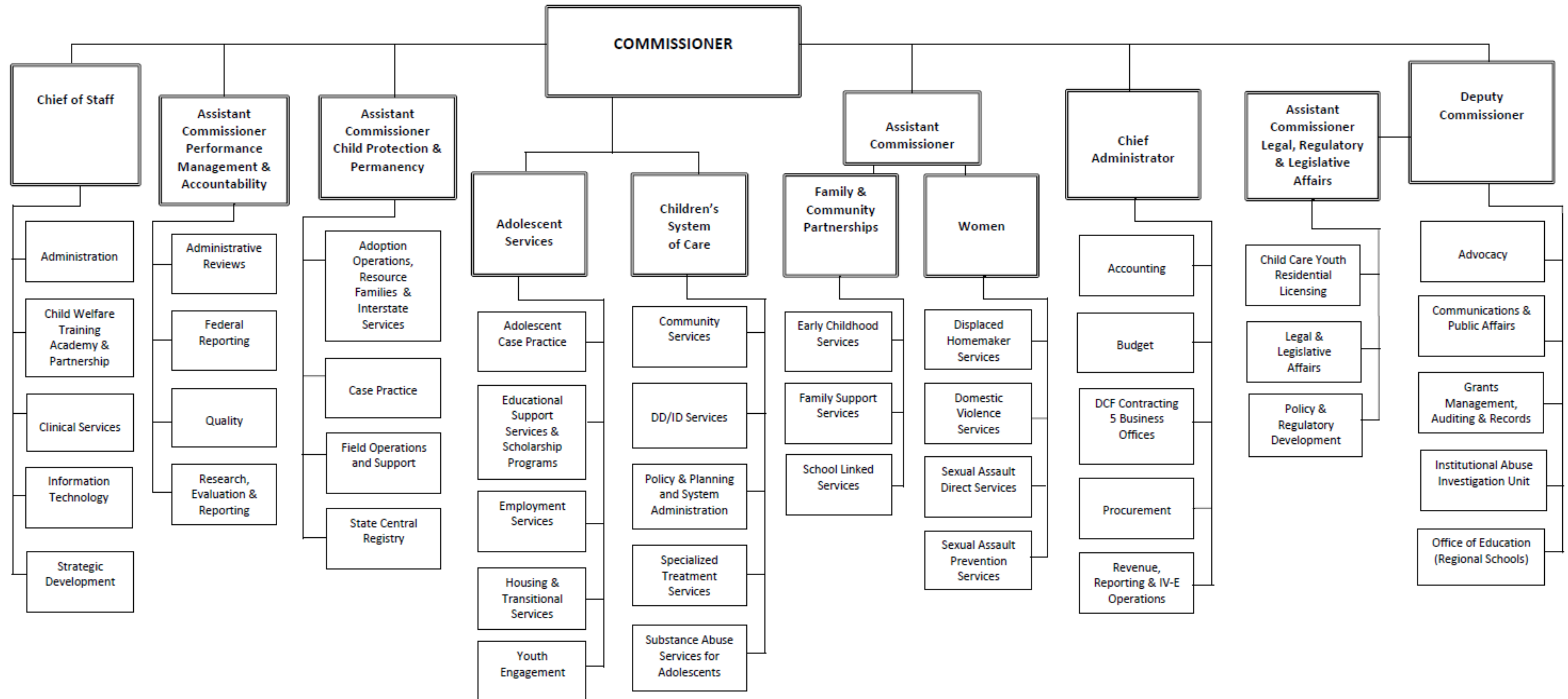
- **Office of Child and Family Health & Clinical Serves:** The Office of Clinical Services is charged with providing support, guidance and leadership across DCF on child and family health related matters.
- **Office of Strategic Development:** The Office of Strategic Development was created in April 2014 as part of DCF's long term strategic planning process and, among other roles, will be focused on working with the Department's divisions, offices and service providers to help DCF become a trauma-informed system of care and transition toward more evidence-based services. The Office of Strategic Development will focus on performance-based contracting and on ensuring DCF's service array is responsive to the changing needs of the women, children, youth, and families we serve.
- **Child Welfare Training and Professional Development & Partnership:** The Office of Child Welfare Training and Professional Development and the New Jersey Child Welfare Training Partnership are charged with the development of curriculum and delivery of educational training that enhance case practice and planning for the support of

the protection, permanency and well-being of children and families for more than 5,000 child welfare professionals across the state.

- **Office of Education:** The Office of Education provides intensive 12 month educational services to children and young adults ages 3 through 21. The severity or uniqueness of their needs requires removal from the public school setting for a period of time.
- **Information Technology (IT):** Manages the NJ Spirit Application (SACWIS) and provides over 100 reports on DCF performance.
- **Office of Licensing:** The Office of Licensing (OOL) is the licensing and regulatory authority of the Department of Children and Families. OOL licenses and regulates child care centers, youth and residential programs, resource family homes and adoption agencies.
- **Institutional Abuse Investigation Unit (IAIU):** IAIU investigates allegations of child abuse and neglect in out-of-home settings such as foster homes, residential centers, schools, detention centers, and child care centers.
- **Office of Advocacy:** The Office of Advocacy supports families by providing information, referral and advocacy services.
- **Oversight Boards:** DCF is responsible for coordinating boards and taskforces including:

  NJ Child Fatality & Near Fatality Review Board
  Staffing Oversight and Review Committee
  NJ Task Force on Child Abuse and Neglect and Management of Children's Justice Act funding
  NJ Children's Trust Fund
  NJ Domestic Violence Fatality Near Fatality Review Board

http://nj.gov/dcf/about/TO.pdf



New Program Requirements: Preventing Sex Trafficking & Strengthening Families

DCF began its efforts by promoting awareness and education on trafficking to our staff, stakeholders, and service providers. Funding has been provided for prevention services for at-risk youth. DCF has linked street-outreach providers with law enforcement. Additionally, we are partnering with the Department of Health and other health care providers to combat trafficking in New Jersey. Our work also helped bring the Safe Shelter Collaborative project to New Jersey, which is assisting domestic violence programs in our State to assist adult survivors of both labor and sex trafficking.

DCF received over 150 reports of potential trafficking of minors in New Jersey between July 2013 and June 2014 with the majority of cases involving girls, and that the youth (boys, girls, and transgender) primarily are residing with a parent or relative at the time of the report. Consistent with national findings, many of the youth have had adverse childhood experiences along with past involvement with the child welfare system. These youth come from throughout our State, and most are domestic minors.

In efforts to better capture and report on relevant Human Trafficking data, the Division of Child Protection and Permanency Case Management System (NJ Spirit) was enhanced to incorporate added values within the Intake and Investigation windows. With these refined data and reporting capabilities, DCF is now better equipped to provide more focused allocation of resources/services to these families in need.

DCF understands that youth exiting care will require necessary documentation to identify and transition into adulthood. Current policy incorporates this process by requiring that all children exiting care be given their birth certificate and social security card. Policy revisions are under way to extend the addition of medical records, health insurance information as well as State issued ID or driver's license.

Family Team Meetings are at the core of the case practice model for case plan development. DCF policy is currently underway with including development and consultation with youth 14 and over with the inclusion of at least two other members identified by the youth. DCF is also in the process of adjusting policy to extend beyond the current Educational Bill of Rights to include other categories of Health, Visitation, Court Participation and Safety. Policy for credit reporting for youth will also be expanded from the current 16 and over youth to include youth 14 and over.

DCF has initiated Permanency Roundtables to assist in addressing and limiting the use of Another Planned Permanent Living Arrangement (APPLA) in preparation of the enactment of the Act under Section 112. Documentation requirements are already met for all children in placement.

DCF has policy, practice, resources, and initiatives in place to ensure that youth have opportunities to engage in developmentally-appropriate activities, please see section 12 for the Chafee Foster Care Independence Program update.

Collaboration

DCF endorses the practice of involving a wide variety of state and local partners in all aspects of its work to ensure the safety, permanency and well-being of children. Programs and services identified and assessed reflect a rich array of information and ideas that were developed with system partners and stakeholders through a variety of routine and specific collaborative efforts.

As part of the collaborative efforts, DCF embarked on a developing a comprehensive strategic plan over the past several years. This comprehensive process included the input and recommendations of many stakeholders to include community partners, child welfare system partners, service providers, Citizen Review Panels, parents, resource parents and youth to help guide and steer the course for DCF. Through formalized engagement opportunities and informal consultations, this ambitious process took over a year to complete and helped spawn the 2014-2016 DCF Strategic Plan. It was a natural progression that the DCF Strategic Plan influenced the 2014-2019 Child and Family Services Plan. The CFSP contains core strategies that are aligned with the DCF strategic plan and mimic the goals and objectives necessary to carry out the principles of the Mission, Vision and Priorities of DCF.

Since that time, DCF continues ongoing engagement in meetings with these system partners to elicit feedback as it relates to the progress of the implementation of the CFSP. Although under a Modified Settlement Agreement, DCF views the Federal Monitor as a partner in guiding DCF practice performance. The Monitor Reports are a collaborative reporting vehicle that highlights the strengths as well as areas of focus of DCF performance. The Federal Monitor seeks the input of several external stakeholders to include contracted service providers, youth, relatives, birth parents, advocacy organizations and judicial officers.

Through collaborative reviews such as the DCF Qualitative Review (QR) process, system partners are interviewed to gain insight and feedback into DCF performance and are key stakeholders in the production of county Performance Improvement Plans (PIPs). This feedback provides guidance into the action plans identified in the DCF Assessment of Performance. During calendar year 2014, stakeholders participated in 15 QRs which included over 1700 interviews. In addition to DCF, interviewees included:

- Child, if age and developmentally appropriate;
- Biological mothers and fathers;
- Current caregivers or resource parents;
- Extended family supports;
- School personnel including teachers, guidance counselors or principals;
- Court Appointed Special Advocates (CASA), and
- Community providers

DCF Child Stat is a case conferencing collaborative assessment tool that can help identify critical decision making elements and themes both locally and statewide. DCF local staff co-present an identified individual case with internal DCF staff and external partners. These partners identify how they helped with decision making and how they perceive the measured change in the family. They provide additional information that was not presented by the office on the family with an analysis from their own professional perspective. These partners share strategies integrated into

assisting the family and lessons learned that can be tied back to the family presentation. In addition, individual case strengths and challenges/barriers as well as county level strengths and challenges/barriers are assessed. During calendar year 2014, both internal and external stakeholders participated in 16 Child Stat presentations. More information regarding the DCF Child Stat process can be reviewed at: http://nj.gov/dcf/about/divisions/opma/

The New Jersey Task Force on Abuse and Neglect engaged with DCF leadership as well as services providers, community advocates, parents and others to develop a strategic guide for preventing child abuse and neglect. This collaborative provides an overview of child maltreatment as a public health concern and opportunities for improving prevention efforts. Most important, as a living document, it provides a shared vision, strategic goals and strategic objectives to guide prevention efforts in New Jersey, 2014 through 2017. For more information on this living report please see:
http://nj.gov/dcf/news/reportsnewsletters/taskforce/SupportingStrongFamiliesandCommunitiesinNew%20Jersey.pdf

To ensure that every child in out of home placement receives the necessary nutritional meals afforded to them while attending school programs, NJ DCF Research, Evaluation and Reporting worked in collaboration with the NJ Department of Agriculture to boost the number of children receiving free or reduced lunches.

At the local, county and Area level CP&P maintains ongoing collaborative efforts to elicit feedback from community stakeholders. Each CP&P local office supports a Resource Development Specialist who conduct outreach collaborative efforts to develop and maintain local community supports. Local offices also hold resource fairs as well as invite community stakeholders to staff meetings to engage in partnerships to enhance performance and outcomes for the families served within the local community. CP&P Area offices support County Service Specialists who regularly host presentations and trainings as well as review of CP&P policy, performance and outcomes as well as introduction of new initiatives relevant to that community.

The Office of Adoption Operations, Resource Families and Interstate Services has transitioned all local Resource Family Recruiters under their office to assist in the efficiency of recruitment efforts. Resource Family Recruiters work with a host of community partners to expand the pool of resource homes available to children in need of out of home placements. Resource Retention Taskforce is in the infancy stage of formation whose framework will be to identify strengths, needs, policies and services for resource families. This taskforce will be a collaboration of DCF, resource parents, Foster and Adoptive Family Services and other community stakeholders.

The DCF Office of Performance Management and Accountability has partnered with the Division of Child Protection and Permanency to host monthly Data Quality and Compliance meetings to review performance and outcome measures. These meetings allow for internal collaborative discussion and review of system strengths and areas needing improvement. Some highlighted lessons identified from this internal collaboration include:

- Some counties have a high population of adolescents going into shelters partly due to policy and practice that makes it easy for parents to drop place their children in shelters.

- When it came to reunification some offices reported children were sent to non-offending parents soon after the placement. For example when placements were done late at night workers could not contact biological fathers. Soon after the placement a father would come forward and that child was returned to him. In a case like that it may look like the child was reunified from a placement very quickly.
- There were big variances in judges. Even within the same county, different judges had different rules.
- Some offices reported they were more likely to do a placement via emergency "Dodd" placement and some offices reported they would ask the court for custody before placing.
- Some offices reported that after high profile cases, their office was more likely to substantiate investigations and remove children.
- Many counties reported an increase in drug use in the community.
- There was also a reported need for treatment of people with co-occurring substance abuse and mental health issues.
- Offices reported that workers had difficulty determining when to re-place a child in cases where they had been reunified and their parent relapsed with drug use.
- Some offices reported large undocumented populations. There were more challenges with these families for example finding Spanish speaking services.

These internal meetings highlight and identify areas where further collaborative partnerships can be strengthened.

Thoughts for future meetings:

- Focus more at the local office level
- Bring in some real case examples
- When local offices within a county or area vary significantly, dig in to see why that may be.

Additional DCF collaborative partnerships can be seen throughout the APSR such as those identified in the Services to Populations at Greatest Risk of Maltreatment: Outreach and Collaborative Efforts to Populations at Greatest Risk, efforts identified under the Chafee Services for NJ adolescent population and on-going partnerships with educational institutions identified in Attachment D- Training Plan to inform organizational development. Guidance and feedback is also gleaned from naturally occurring partnership meetings to include the Citizen Review Panels, the Administrative Office of the Courts, County Human Service Directors, NJ Association of Mental Health and Addiction Agencies (NJAMHAA), NJ Alliance for Children Youth and Families as well as statewide Youth Advisory Board meetings, County Inter-agency Coordinating Councils, County Councils for Youth Children

In addition to the above mentioned collaborative efforts, DCF has strategically positioned itself as a leader in both preventing and responding to the trafficking of minors in New Jersey. Our efforts have included strong collaboration with the Office of the Attorney General and other federal, state, and local law enforcement entities to help ensure traffickers are convicted, while survivors receive the critical services they need.

For additional information on new collaborative partnership initiatives to broaden and strengthen DCF's stakeholder relationships view the Partnerships section of the 2013-2014 DCF Today at: http://www.state.nj.us/dcf/childdata/continuous/ .

SECTION A:

UPDATE ON ASSESSMENT OF PERFORMANCE

Update on Assessment of Progress and Performance Preparing for the CFSR Round 3

New Jersey successfully completed its CFSR Round 2 Program Improvement Plan (PIP) on March 31, 2012. DCF just completed the Primary Title IV-E review in February 2015 and while official notification has not been received, preliminary findings and feedback indicate that DCF will be once again in substantial compliance. This will be the second substantial compliance review since FY 2012. In preparing for the Round 3 CFSR scheduled for 2017, NJ DCF has begun to review progress of performance using the guidance of the CFSR Statewide Assessment. The following is a preliminary snapshot of performance on the CFSR Outcomes and Systemic Factors.

Ongoing assessment of performance and progress was completed by gathering available information from SACWIS data (NJSPIRIT or NJS) represented in Figures unless otherwise noted, data profiles, Modified Settlement Agreement (MSA) measures (see monitoring reports at http://nj.gov/dcf/about/welfare/federal/) and Qualitative Review (QR) case review processes (for full description of indicators and outcomes see 2014 QR annual report at http://nj.gov/dcf/about/divisions/opma/) which include monitoring and feedback from a variety of System and Community Partners.

Outcomes – Safety

Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect

- **CFSR R3 National Standard Safety Data Indicator 1**: Maltreatment in Foster Care: National Standard = 8.50 or lower victimizations per 100,000 days in foster care.
    - NJ performance as of July 10, 2014 is 4.8 = standard is met

- **CFSR R3 National Standard Safety Data Indicator 2**: Recurrence of maltreatment: National Standard = 9.1% or lower
    - NJ performance as of July 10, 2014 is 7.3% = standard is met

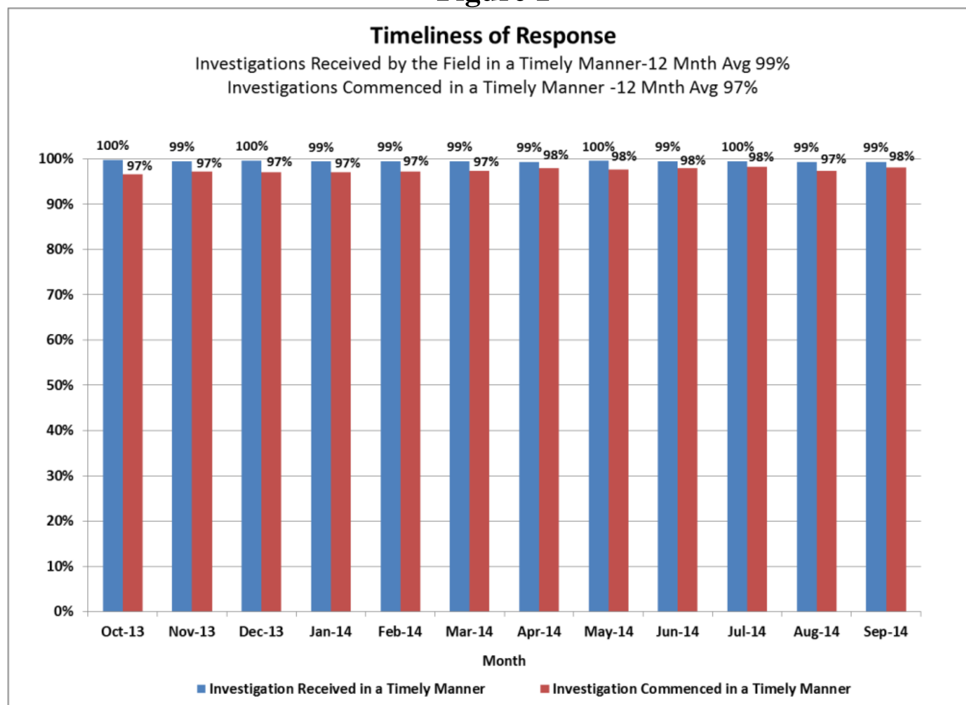
- **Item 1- Timeliness of initiating accepted reports of child maltreatment and face to face contacts**

New Jersey Child Protection and Permanency (CP&P) Policy as well as New Jersey Administrative Code N.J.A.C. 10:129-2.3 outlines the response criteria for accepted Child Protective Services (CPS) reports received through the statewide centralized screening operations of State Central Registry (SCR). Once a CPS report is accepted it is assigned one of two response timeframes to initiate an investigation. An immediate response requires that an investigator shall make in-person contact with the identified child victim(s) by the end of the work day in which SCR assigned the report to the field office for response. The second response timeframe requires that an investigator make in-person contact with the identified child victim(s) within 24 hours of the assignment of the report from SCR to the field office. Good faith effort attempts are also outlined in policy and code when investigators are unable to make in-person

contacts with child victim(s). Face to Face response to CPS reports to include good faith effort attempts, collateral contacts, Structured Decision Making (SDM) tools such as safety and risk assessments as well as formal investigation documentation are captured and documented into NJS.

In addition to policy and Administrative Code, standards set under the MSA identify two case practice performance measures relevant to Item 1. The final overall benchmark for investigations received by the field in a timely manner and investigations commenced within the required response time frame (to include face to face contact) is 98%. Data in Figure 1 is gleaned from NJS and demonstrates NJ performance for these benchmarks is meeting this target, thus making Item 1 a strength for NJ.

Figure 1



Safety Outcome 2: Children are safely maintained in their homes whenever possible and appropriate

- **Item 2- Concerted efforts to prevent entry into foster care or re-entry after reunification**

New Jersey continues to make concerted efforts in maintaining children in their home environment whenever possible and appropriate. Figure 2 shows data from NJS that is reflective of the total number of active families receiving services. As of September 30, 2014 there were 24,783 active families receiving CP&P services, similar to the number of families in 2013 however the trend pattern appears to be decreasing. The total number of children receiving

services to include children 18-21 years of age was 49,576 of which 7,543 were in out of home placement as seen in Figure 3.

This downward trend is also seen in the initial placement rate of children over the past two years as well with a rate of 1.9 per 1,000 children as of September 30, 2014 (see Figure 4) as well as the comparative analysis of children entering and exiting out of home care.

Figure 2

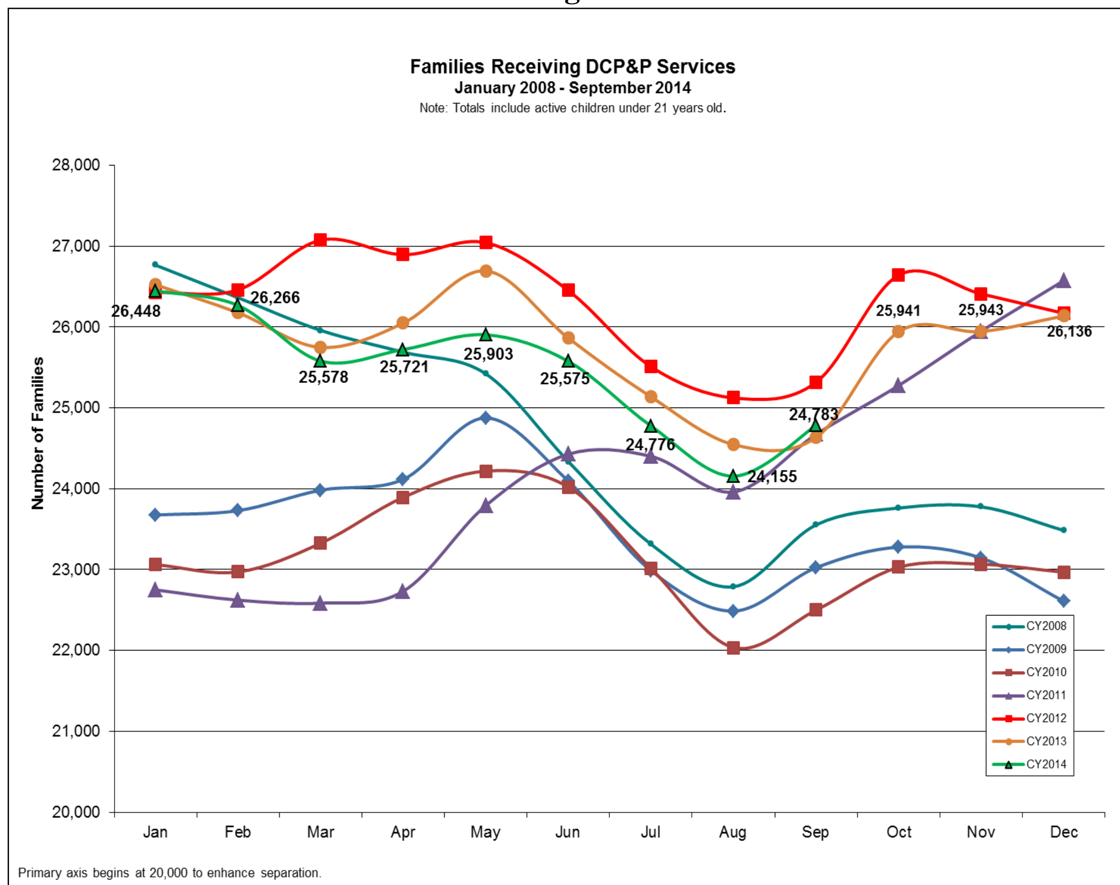


Figure 3

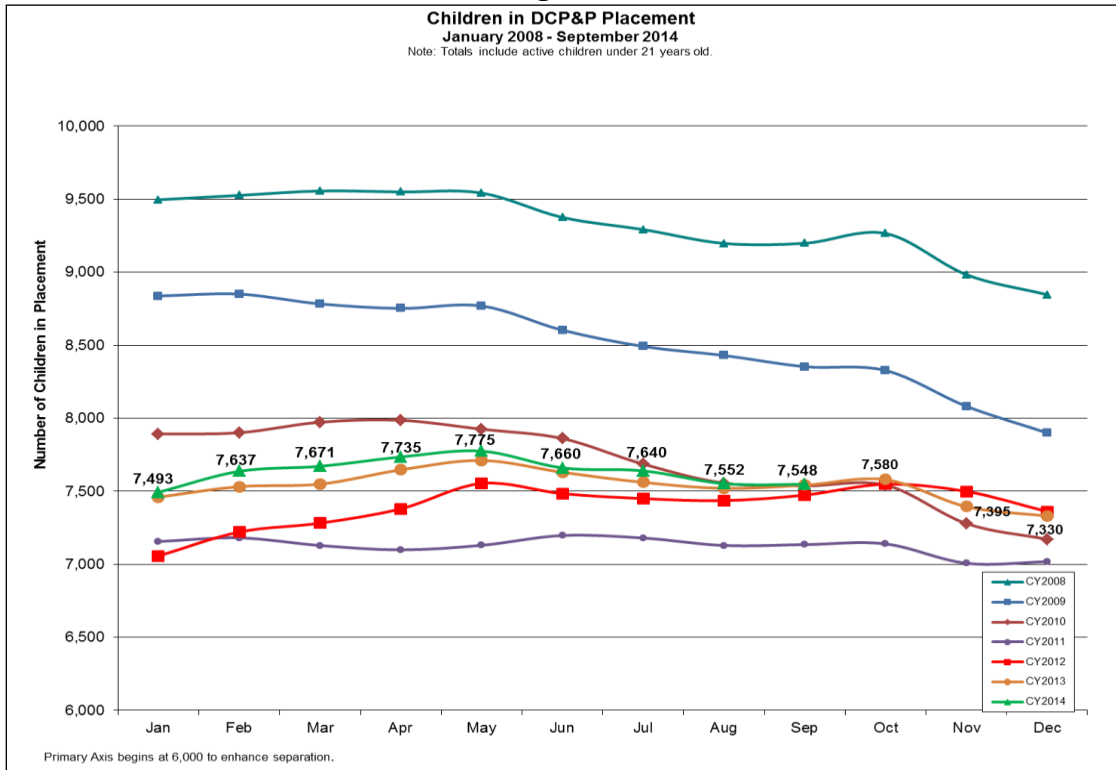
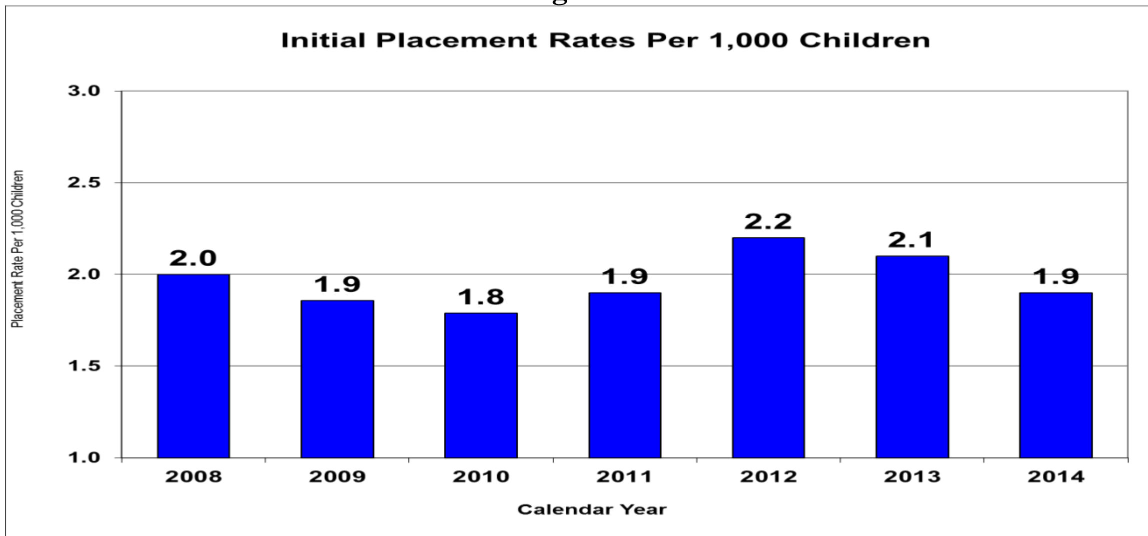
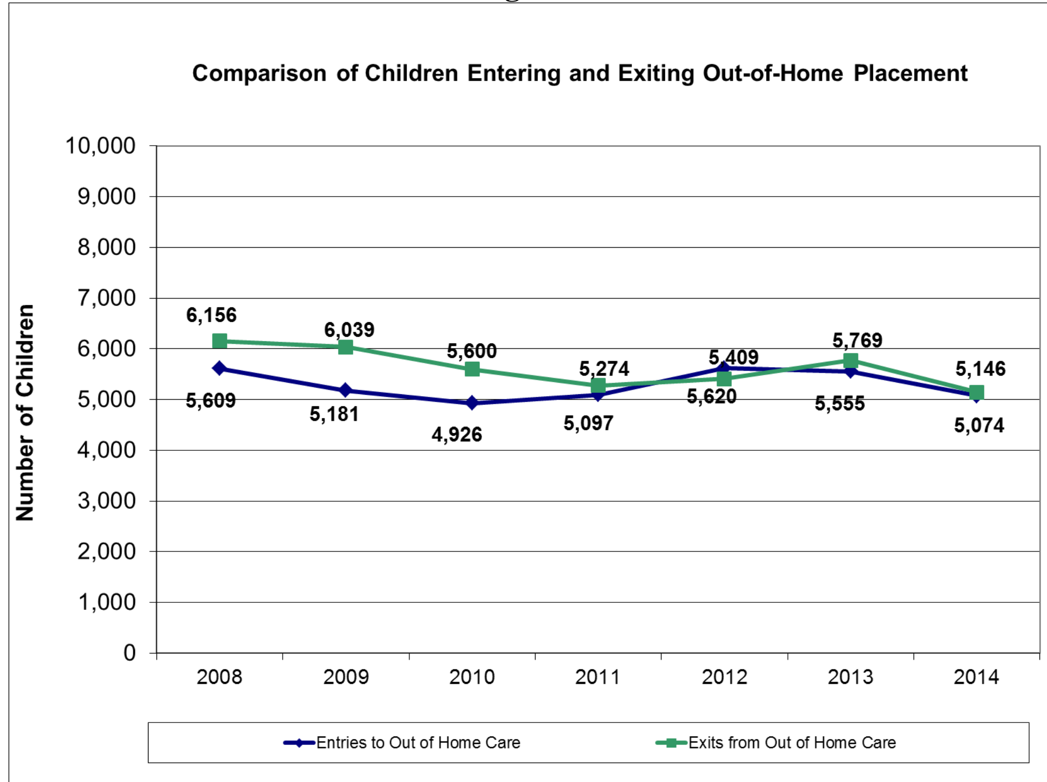


Figure 4



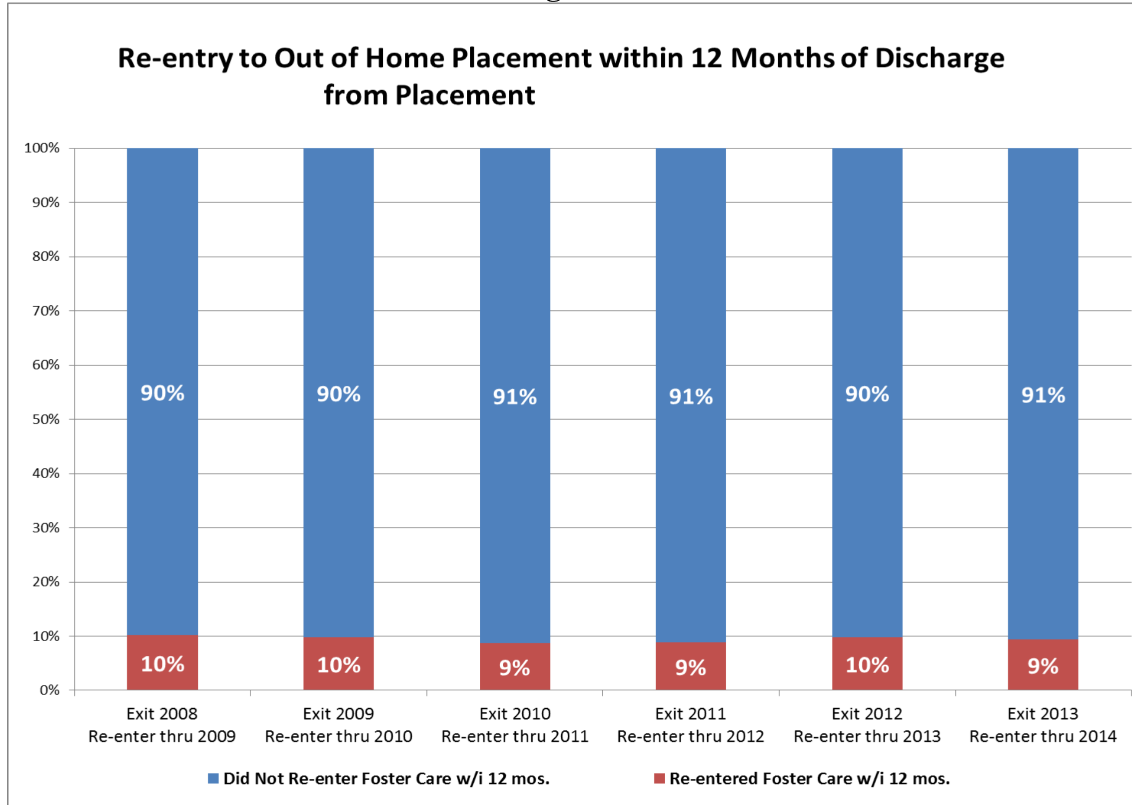
NJ continues to have more children exit from out of home care than enter care. In CY 2013 there were 5,769 children exit out of home placement as compared to 5,555 enter care while comparatively there was a decline in both areas in CY 2014 with 5,146 children exit out of home placement as compared to 5,076 children enter care as shown in Figure 5.

Figure 5



Formal and informal supportive services are key components to the success of families as they move through the child welfare system. Matching the right services to the needs of families and children, especially when children are placed in out of home care, lead to better permanency outcomes. When a child enters out of home placement, NJ strives to reunify children with their families safely and swiftly. Once reunification occurs, NJ monitors the family and their on-going support system to ensure they have the necessary resources to sustain their family functioning and successfully separate away from the child welfare system. NJ maintains a low rate of out of home placement re-entry with 12 months of discharge from placement. Figure 6 shows that 91% of children who exited care in 2013 did not return in 2014.

Figure 6



- **Item 3- Assessing Safety and Risk**

Structured Decision Making (SDM™) is a uniform process for decision-making regarding critical aspects of the agency intervention with a child and family. Structured Decision-Making assessment tools are research and evidence-based, designed to assist field staff to make important decisions, based on the facts of a case, rather than relying solely on individual judgment. SDM tools, completed in NJS, assure that case characteristics, safety factors, risk factors, and domains of child and family functioning are assessed for every family, every time. Safety Assessments, both for in-home and out of home, as well as Safety Protection Plans, Risk Assessments, Risk Re-Assessments (for in-home permanency service cases) and Risk Reunification Assessments (out of home cases) are the primary SDM tools used to assess safety and risk. Guidance on how and when to use these tools are outlined in policy which can be viewed at: http://www.state.nj.us/dcf/policy_manuals/CPP-III-B-6-600_issuance.shtml.

Practice standards for Safety and Risk assessments are identified in the MSA for NJ and target benchmarks require that:

a) 98% of investigations will have a completed safety assessment
b) 98% of investigations will have a completed risk assessment

As shown in Figure 7, these benchmarks continue to remain at 100% compliance rate for safety and risk assessments on CPS reports.

The NJ QR process also looks at two safety indicators when reviewing cases:

1. Safety at home indicator is used to access the living environment of children who are living at home with their parents as well as those residing in out of home placement in a family setting.
2. Safety in other settings indicator is used to assess other environments in which they spend time such as their neighborhood, community and/or educational setting.

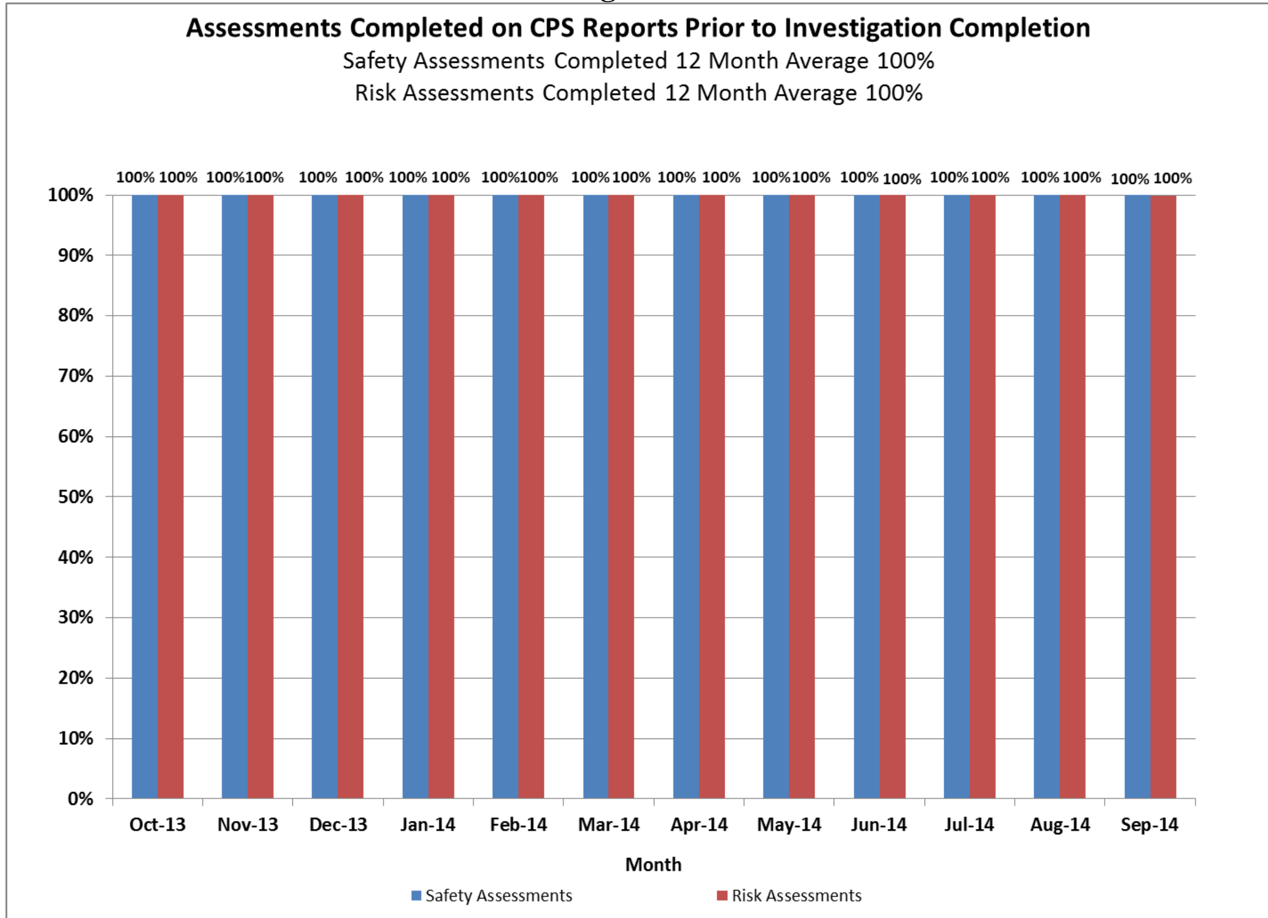
In order for any indicator to be considered a "Strength", 70% or more of cases must receive an acceptable rating. In CY 2014 a sample of 180 children/youth in total were reviewed in 15 out of 21 counties.

When assessing the Safety at Home indicator, reviewers incorporate questions about high risk behaviors of the caregivers, the child, domestic violence and/or addictive behaviors, other safety or risk identifiers listed on the SDM tools as well as disciplinary measures used in the home. Cases receive an overall rating using a six-point scale ranging from optimal (6) to unacceptable (1). For CY 2014 the statewide average performance for the Safety at Home indicator was 99% received an acceptable rating with 13 out of 15 counties achieving 100% rating.

The same standards are used by reviewers when assessing the Safety in Other Settings indicator to include the child's placement environment, educational environment and the neighborhood/community in which they live. For CY 2014 the statewide average performance for the Safety in Other Settings was 97% acceptable rating with 10 out of 15 counties achieving 100% rating.

When reviewing these areas of assessment, it is evident that continuous effort is employed by NJ to ensure that children, whether in their own homes or in out of home placement are safe and that any risk factors remain low or are safely managed.

Figure 7



Outcomes - Permanency

Permanency Outcome 1: Children have permanency and stability in their living situations

- **CFSR R3 National Standard Permanency Data Indicator 1:** Permanency in 12 months for children entering foster care:
  National Standard = 40.5% or higher
    - NJ performance as of July 10, 2014 is 40.6% = standard is met

- **CFSR R3 National Standard Permanency Data Indicator 2:** Permanency in 12 months for children in foster care between 12 and 23 months
  National Standard = 43.6% or higher
    - NJ performance as of July 10, 2014 is 42.5% = standard is not met and will require a PIP. NJ was required to have an additional 39 exits to meet this standard and will require a percentage of 44.7%.

- **CFSR R3 National Standard Permanency Data Indicator 3:** Permanency in 12 months for children in foster care for 24 months or more:
  National Standard = 30.3% of higher
    - NJ is at 40.3%- standard is met

- **CFSR R3 National Standard Permanency Data Indicator 4:** Re-entry to foster care in 12 months:
  National Standard = 8.3% or lower
    - NJ is at 10.8% = standard is not met and will require a PIP. NJ was required to have an additional 65 fewer re-entries to meet this standard and will require a percentage of 7.2.

- **CFSR R3 National Standard Permanency Data Indicator 5:** Placement Stability:
  National Standard = 4.12 moves per 1,000 days in foster care or fewer.
    - NJ is at 4.05 moves per 1,000 days in foster care- standard is met

- **Item 4- Stability of foster care placement**

When placing a child in out of home care, concurrent planning to include a first placement best placement practice model is employed to reduce the relationship disruptions a child experiences. If a child cannot remain with their birth family, every effort is made to place a child with a kinship caregiver to maintain the familial relationship. Placement with kinship caregivers reduces the negative impact that separation and loss can have on a child. It can help promote engagement with birth families with case planning decisions, visitation, placement disruption as well as permanency planning. NJ continues to see an increase in the number of children placed with kinship caregivers as their first placement as evidenced in Figure 8. As more children are placed with kinship caregivers, more children become stable in their placement settings as observed from NJS data in Figure 9 which shows that children who were removed in 2013 had two or fewer placements in a 12 month period into 2014.

The NJ QR Process also looks at two stability indicators:

1. Stability at Home indicator assesses how a child has positive and enduring relationships with parents and/or caregivers to ensure consistency of settings and routines to promote optimal social development.
2. Stability at School indicator assesses a child's educational setting to include changes or disruptions for reasons other than academic promotion.

Using the same six point scale with the same sample, in CY 2014 Stability at Home and Stability at School were both rated as acceptable. Stability at Home was rated as strength statewide with an average of 78% of cases and Stability at School was rated as a strength statewide with an average of 88%.

As reported above, NJ continues to meet the CFSR R3 National Permanency Standard for placement stability, making item 4 a strength for NJ.

Figure 8

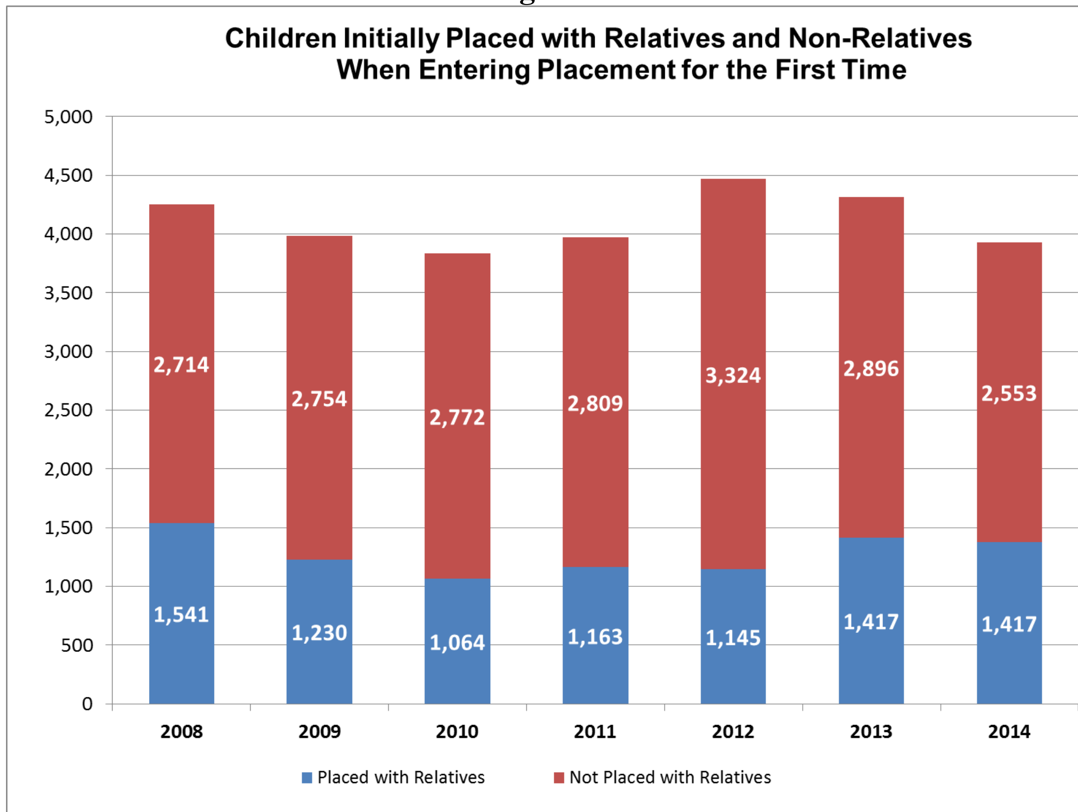
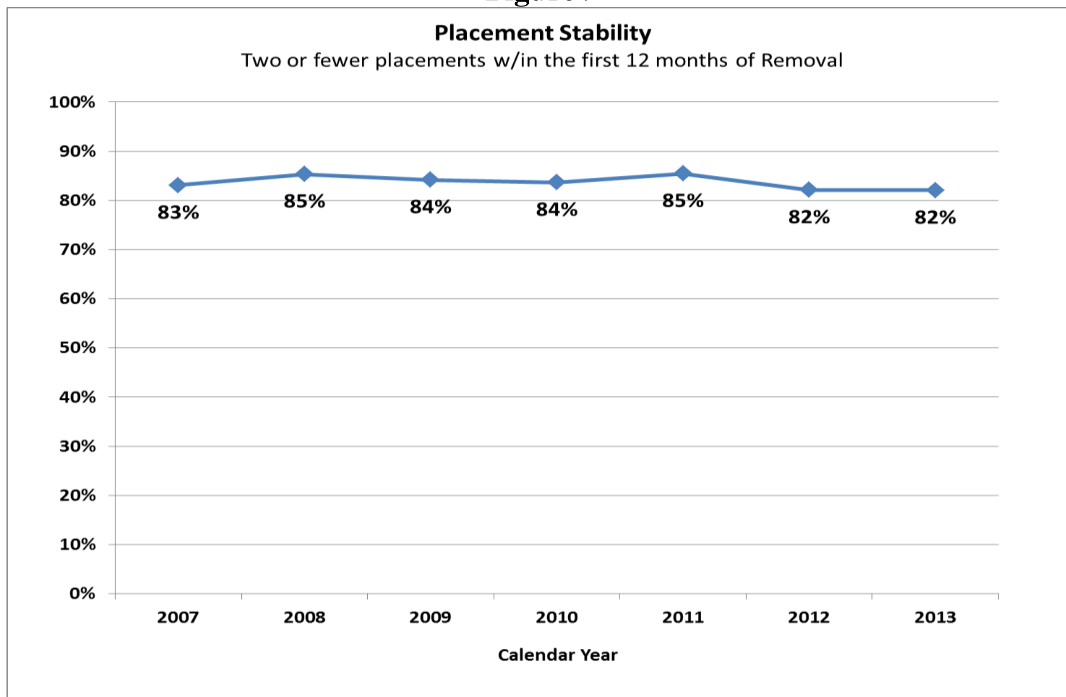


Figure 9



- **Item 5- Permanency Goal for Child**

Every child receiving services through CP&P in NJ are entitled to permanency and stability in their living environment whether they remain stable with their birth families or are residing in out of home placement with concurrent planning. Establishment of permanency goals should occur timely and policy identifies that for every child who enters, or re-enters, out of home placement case planning to include the identification of primary and secondary concurrent goals are established within 30 calendar days of entering out of home placement in the initial case plan and every six months thereafter for on-going(see CP&P policy: http://www.state.nj.us/dcf/policy_manuals/CPP-III-B-1-100_issuance.shtml)

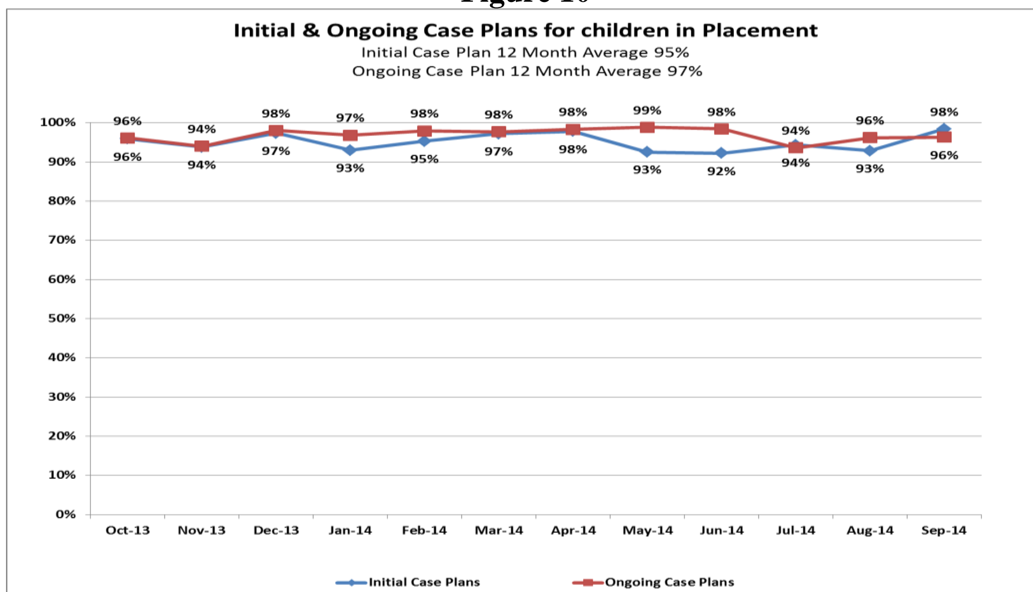
Case plans with goals are documented in NJS after discussion and consideration with the family has occurred and they are subsequently electronically approved by supervisory staff. Case plans cannot achieve approval in NJS without casework staff identifying both the primary and secondary concurrent permanency goals. Casework as well as their supervisory staff receives tickler notification in NJS when a case plan and the concurrent goals are not complete within policy timeframes.

Practice standards for initial and ongoing case plans are identified in the MSA for NJ and target benchmarks require that:

a. 95% of required initial case plans will be completed
b. 95% of required on-going case plans will be completed

Figure 10 shows NJ performance in meeting case plan timeframes, thus also establishing permanency goals in a timely manner. On average as of September 30, 2014, NJ met the benchmark requirement for the establishment of initial case plans (to include concurrent case goals) 95% of all required cases. Performance for on-going assessments of plans and goals exceeded for an average of 97% of all required cases thus making item 5 a strength for NJ.

Figure 10



- **Item 6- Achievement of reunification, guardianship, adoption or other planned permanent living arrangement**

As documented earlier, NJ is meeting two out of three CFSR R3 National Standard Permanency Indicators. NJ continues to meet standards to achieve permanency in 12 months for children entering foster care as well as for children in care for 24 months or longer. As reported for item 5, Policy requires that concurrent planning begins at the point of the removal of a child and that case plans require a primary and concurrent secondary goal. We glean from data represented in figure 5 that more children are exiting care, either to reunification or other permanent living arrangement such as guardianship, adoption, etc… than entering care. NJS captures ASFA requirements as it relates to filing timely TRP petitions as well as TPR exceptions. Figure 11 shows a point in time snapshot that 86% of children in a removal episode 15 out of 22 months have a TPR petition filed/granted/legally free or have a TPR exception granted. Case plans also document efforts in achieving identified case concurrent goals.

There are also several practice standards under the MSA that ensure that efforts to promote permanency are done. For instance adoptions finalized within 9 months of placement into adoptive home standards are looked at with a final target of 80%. As represented in Figure 12 the third quarter data of CY 2014 shows that NJ was at an average of 91.2% exceeding the final benchmark target established in the MSA.

Figure 11

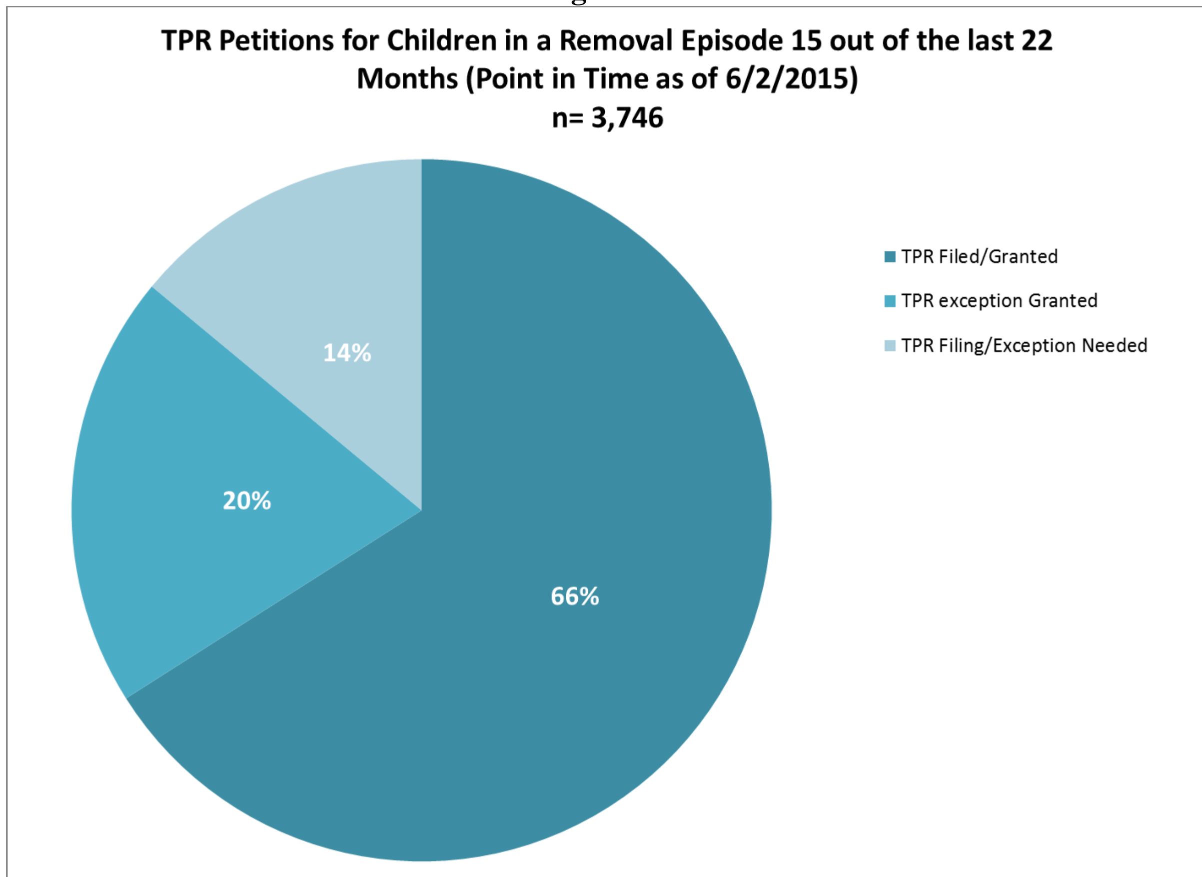


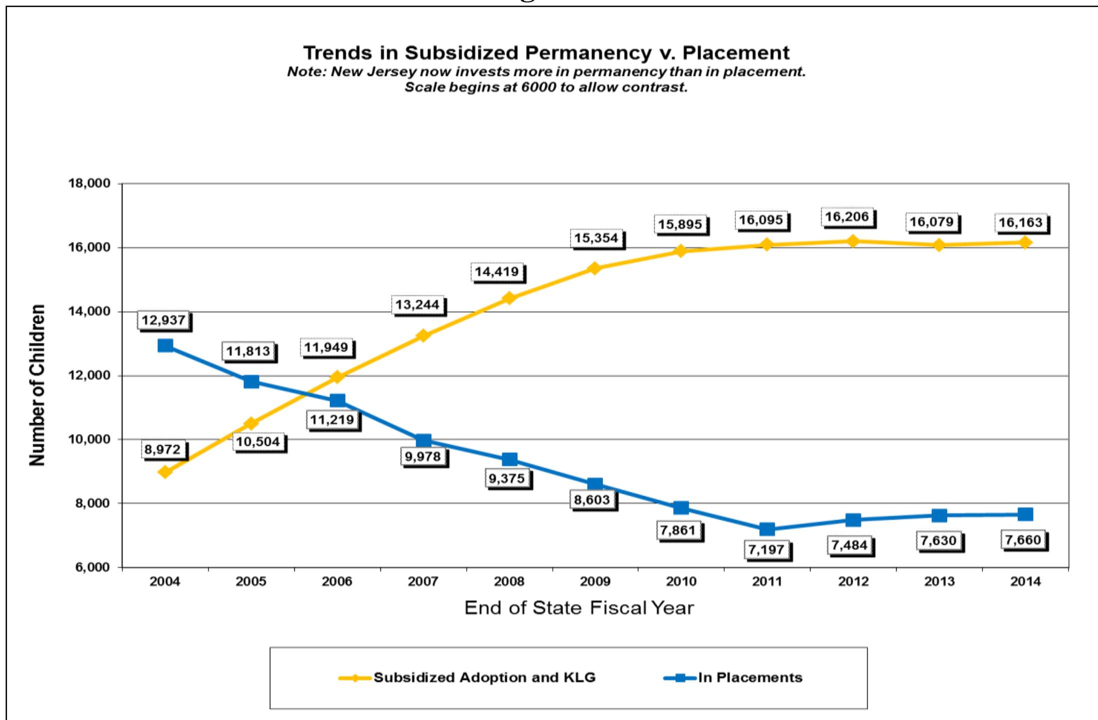
Figure 12

Measure # 38 Adoptions Finalized within 9 Months of Placement SafeMeasures Screen "Adoption Finalization Timeliness" Quarter 3 2014								
	Jul-14		Aug-14		Sep-14		Total	%
	#	%	#	%	#	%	#	%
Finalized w/in 9 months	68	90.7%	81	89.0%	78	94.0%	227	91.2%
Not Finalized w/in 9 months	0	0.0%	0	0.0%	2	2.4%	2	0.8%
Missing Data	7	9.3%	10	11.0%	3	3.6%	20	8.0%
Total	75	100%	91	100%	83	100%	249	100%

Source: SafeMeasures; Extract date:11/30/2014

NJ continues to invest more in permanency than in placement, with the number of children in permanency under subsidized kinship legal guardianship or adoption steadily rose from 15,351 in CY2009 to 16,163 in CY2014, while the number of children in placement has declined from 8,603 in CY 2009 to 7,660 in CY2014 over the same time.

Figure 13



NJ continues to see an increase in the number of children with a permanency goal of reunification, an upward trend that has continued over time:

- FFY2009: 40.9% (Data Profile of 8/26/11)

- FFY2010: 44.2% (Data Profile of 5/28/13)
- FFY2011ab: 46.7% (Data Profile of 3/21/14)
- FFY2012ab: 51.9% (Data Profile of 3/21/14)
- FFY2013ab: 52.6% (Data Profile of 3/21/14)

This data profile from FFY2013ab also shows that the majority of children discharged from placement are achieving reunification as a goal; 3,451 out of 5,009 children and that the median time children are discharged from care to reunification is 4.9 months. This representation demonstrates that a majority of children in care achieve timely permanency- see Figure 14.

Figure 14

POINT-IN-TIME PERMANENCY PROFILE	**Federal FY 2011ab**		**Federal FY 2012ab**		**Federal FY 2013ab**	
VIII. Length of Time to Achieve Perm. Goal	**# of Children Discharged**	**Median Months to Discharge**	**# of Children Discharged**	**Median Months to Discharge**	**# of Children Discharged**	**Median Months to Discharge**
Reunification	2,806	6.2	2,985	4.4	3,451	4.9
Adoption	1,063	31.2	1,016	31.0	910	32.3
Guardianship	195	22.8	194	23.6	185	23.8
Other	569	22.5	486	22.3	463	18.8
Missing Discharge Reason (footnote 3, page 16)	0	--	0	--	0	--
Total discharges (excluding those w/ problematic dates)	4,633	13.1	4,681	10.0	5,009	9.6

NJ acknowledges the need to continue to assess permanency for children in placement between 12 and 23 months. NJ is reviewing both quantitative and qualitative data to assist in this evaluation. The NJ QR process identifies progress towards permanency as an area needing improvement with 69% of cases reviewed statewide. Some issues identified include lengthy court or service delays. These issues vary across the state and individual county Program Improvement Plans (PIP) using the SMART model is initiated to strategically assist in addressing these issues. Input from local, county and state stakeholders assist in the identification of areas needing improvement, the development of PIP's as well as the PIP implementation in each county.

Permanency Outcome 2: The continuity of family relationships and connections is preserved for children

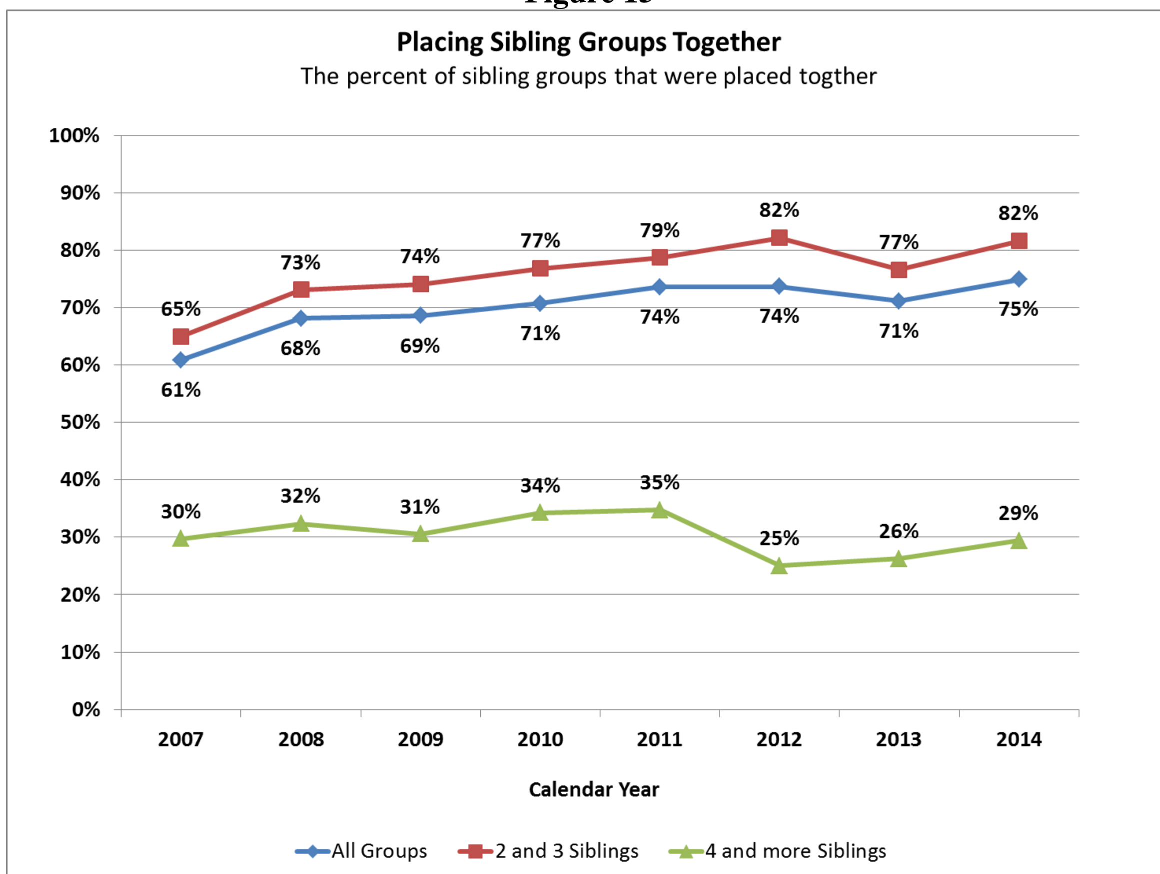
- **Item 7- Placement with siblings**

NJ CP&P policy manual identifies and guides casework staff to promote sibling relationships by placing siblings together, reuniting siblings when they cannot be placed together as well as the identification of exceptions to placing siblings together (http://www.state.nj.us/dcf/policy_manuals/CPP-IV-B-2-200_issuance.shtml)

NJS captures placement information for every child in out of home placement to include date of placement, location, type as well as whether the child is part of a sibling group. Figure 15 represents the percentage of sibling groups placed together as documented in NJS for CY 2014. NJ identifies two main categories of sibling groups, 2-3 siblings and 4 or more. Across both groups, NJ is able to place siblings together 75% of the time with an increase in sibling placements for those groups of 2 or 3. NJ identifies that placing sibling groups of 4 or more continues to be a struggle. Strategic recruitment efforts have been initiated through the use of Market Segmentation and other recruitment plans guided by Training and Technical Assistance opportunities to target recruitment of resource homes for large sibling groups. Licensing requirements for resource homes also play a role on the ability to place large sibling groups together. Capacity limitations can be viewed at http://www.state.nj.us/dcf/policy_manuals/NJAC-10-122C-1.4_issuance.shtml.

Population limitation waivers can be requested and approved after careful consideration is documented to include appropriate safety assessments and written assessment of the resource parents' ability, willingness and capacity is evaluated. It should be noted that although most sibling groups range from 2-5, there have been a small percentage of sibling groups of 10 or more. These are part of the 29% represented in the 4 and more sibling group placement identified in Figure 15.

Figure 15



- **Item 8- Visits with parents and siblings in foster care**

NJ acknowledges that frequent visitation with parents and siblings promote continuity of familial relationships, reduce stress and separation trauma and can promote positive permanency outcomes.

The frequency and duration of visits is dependent on the purpose of the visits, the case goal and case plan and practical considerations of all parties. Visits which are frequent and of long duration are strongly recommended as they benefit children in placement and facilitate movement toward achieving the case goal of return home. Gradual reunification is promoted through flexible scheduling that allows for visitation on evenings and weekends. This will give families time to adjust to living back together.

The visitation plan is developed in cooperation with all affected parties. The frequency and duration specified in each child's visitation schedule is a professional social work decision which shall be made by the Division with full input from all those affected by the visitation plan. A Family Team Meeting is an ideal place to develop the visitation schedule. Visitation plans and face to face visits between children, parents and siblings are recorded into NJS.

NJ Administrative Code as well as CP&P policy outlines the comprehensive visitation requirements for children with parents and siblings which include the development of a visitation

plan with the family identifying the participants, frequency, duration as well as identified areas of concerns such as safety or visitation limitations: http://www.state.nj.us/dcf/policy_manuals/CPP-IV-A-5-100_issuance.shtml

There are several MSA performance measures that monitor visitation between children, parents and siblings. NJ is required to meet the final target benchmark of 60% of children shall have weekly visits with their parents and 85% shall have visits every other week. Figure 16 identifies the 12 month performance average in meeting these targets for visitation between parents and children with a primary goal of reunification. NJ saw an increase in performance in weekly visitation between children and parents over the past FFY to include exceeding the target in the last 7 months. Although bi-weekly visitation performance has not been fully achieved, there continues to be an upward trend.

Visitation between siblings is another measure required by the MSA with a final target performance of 85% of children in placement shall have monthly visits with siblings who are placed apart. As shown in Figure 17, NJ continues to see an upward trend performance progress in meeting this benchmark as data is reviewed. Data entry in capturing all eligible sibling visitation contacts in NJS was looked at to determine data issues. Tip guidelines as well as training opportunities were presented to casework staff to assist them with correct data entry in order to capture the work they were performing with families and siblings.

Figure 16

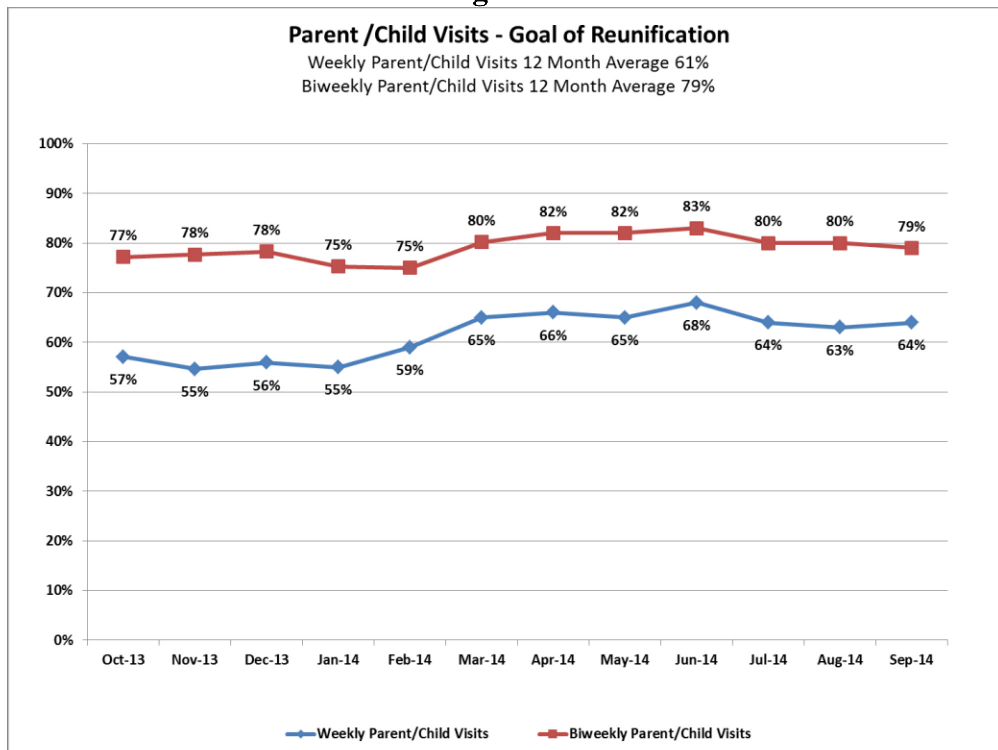
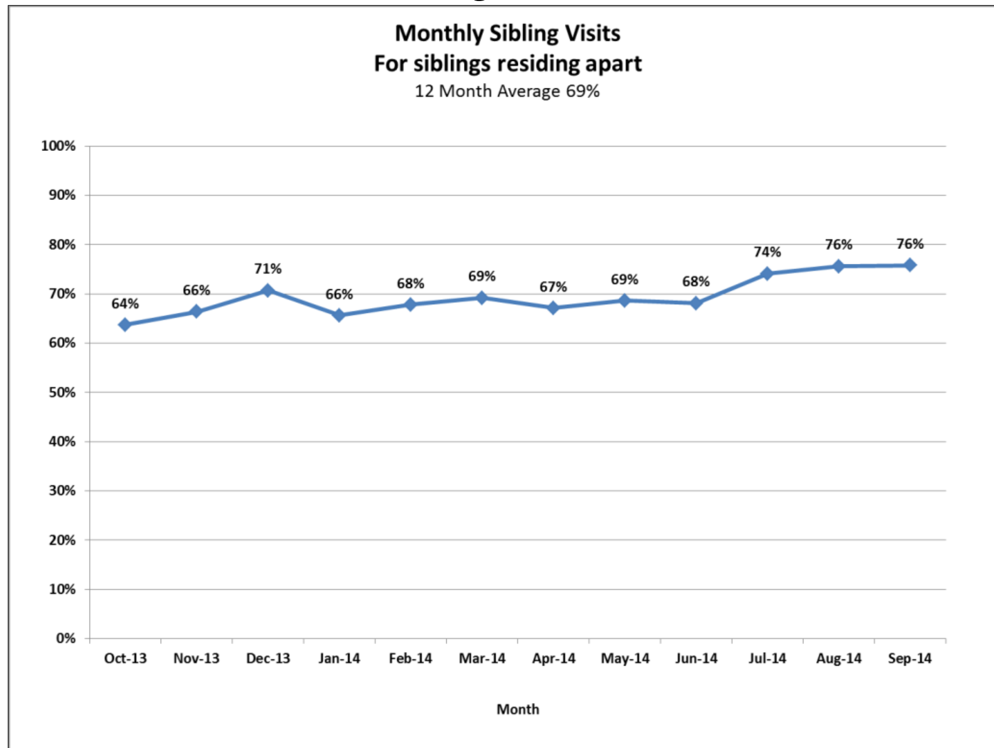


Figure 17



- **Item 9- Preserving Connections**

In addition to visitation, maintaining connections between a child and his/her neighborhood, community, extended relatives, school and friends while a child is in out of home care helps the child transition into their placement setting with less trauma. NJ makes every effort to place children with relatives and within or as close to their home community as possible. As documented under item 4 and figure 8, NJ is seeing an increase in the number of children placed with kinship caregivers upon initial out of home placement. Placing children with kinship caregivers enhances a child's connections to their community and extended relatives.

Educational stability statutes and polices as issued and referenced at http://www.state.nj.us/dcf/policy_manuals/CPP-VII-A-1-100_issuance.shtml ensure that children who are removed from their home of origin can maintain their school connections when appropriate. An educational best interest determination must be made for every eligible child who enters out of home placement within five business days. These determinations are recorded in NJS and identified Educational Stability Liaisons in every county assist staff in ensuring educational connections is maintained (see information on educational stability at http://nj.gov/dcf/families/educational/stability/). Data shows that approximately 82% of eligible children placed through CY 2013 remained in their school of origin (see report issued July 2014 http://nj.gov/dcf/childdata/continuous/2012-2013%20Ed%20Stability%20Report.pdf).

Through the use of geocoding, we can see in Figure 18 that 75% of children are placed within 10 miles of their removal home.

Figure 18

Children Entering Placement and Placed Within 10 Miles of Their Home First Entrants					
Entry Year	First Entrants	Geocoded Records		Placed Within 10 Miles	
		Number	% of First Entrants	Number	% Within 10 Miles
2007	4,392	2,225	51%	1,513	**68%**
2008	4,252	2,132	50%	1,438	**67%**
2009	3,982	2,017	51%	1,365	**68%**
2010	3,842	1,951	51%	1,325	**68%**
2011	3,972	2,083	52%	1,513	**73%**
2012	4,469	2,187	49%	1,547	**71%**
2013	4,314	3,640	84%	2,755	**76%**
2014	3,930	3,484	89%	2,628	**75%**
Data from 2007-2014 reflect the percent of first entrants placed within 10 miles of home for whom home and placement addresses were successfully geocoded, excluding contract provider addresses.					

Data is based on analytic files derived from DCF NJ SPIRIT data through December 2014.
Data from 2007-2011 was analyzed by Chapin Hall.
Data from 2012-2014 was analyzed by Hornby Zeller Associates.

2014 first entrants are based on children in a removal episode type 1, which is consistent with the federal reporting of AFCARS.

The NJ QR process also looks at indicators addressing the preservation of connections for children. The Living Arrangement Indicator looks at whether the child's placement is most appropriate and enables that child to continue their connections to their home, extended relatives, school, religion, neighborhood and culture. In CY 2014 this indicator was identified as a strength both statewide with a performance of 96% of cases rating as acceptable as well as a strength in all counties reviewed. This informs NJ that when children are placed in out of home settings, their connections to their communities, families, schools and peers are being preserved.

Other QR indicators that review the preservation of connections are:

1. Family and Community Connections Overall: this indicator assess the strategies used to maintain family bonds and the rating is determined in consideration of the ratings on the remaining three Family and Community Connections indicators. Inclusive in this as well as the other ratings is how the agency engaged with the community to preserve these connections
2. Family and Community Connections- Mother: this indicator assesses the strategies used to maintain maternal bonds with children in care

3. Family and Community Connections- Father: this indicator assesses the strategies used to maintain paternal relationship with children in care
4. Family and Community Connections- Sibling: this indicator assesses the strategies used to maintain sibling bonds when they reside apart from one another

In CY 2014 Family and Community Connections Overall was identified as a strength statewide with 12 out of 15 counties rating the in acceptable range. Three counties were rated in the area needing improvement range.

Family and Community Connections- Mother indicator was also rated as a strength statewide with 12 out of 15 counties rating in the acceptable range. Three counties were rated in the area needing improvement range. One out of the three counties was also identified in the overall rating.

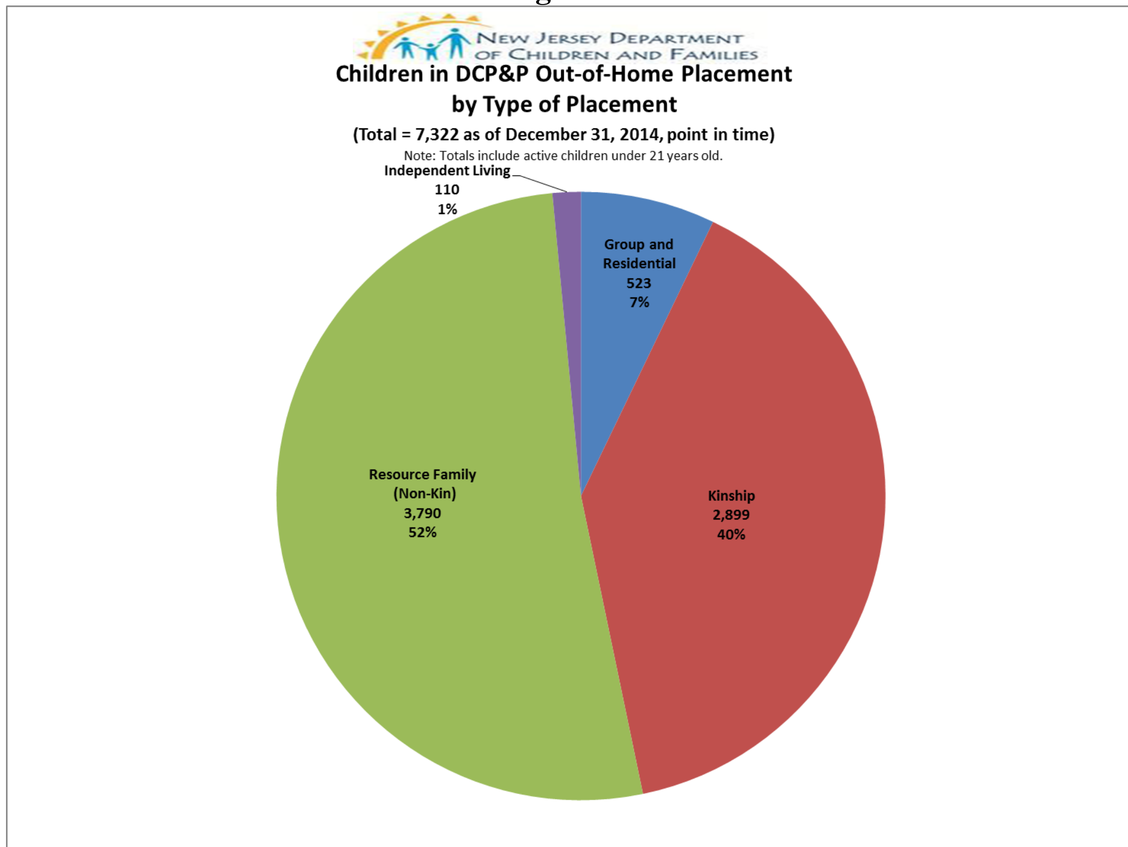
Family and Community Connections-Father indicator was identified as an area needing improvement statewide with only three counties in the acceptable range.

Family and Community Connections- Siblings indicator was rated as a strength statewide with 10 out of 14 counties rating in the acceptable range (one county was excluded as none of the cases reviewed involved siblings).
Those areas in which these indicators were rated as an area needing improvement have the opportunity, along with input and collaboration with key stakeholder and community partners; to implement strategies in their PIP's to improve outcomes.

- **Item 10- Placement with Relatives**

As indicated in Figure 4, NJ makes every effort to place children with relatives upon their initial out of home placement. When children must be placed in an unrelated resource home, efforts are made to search for, engage and assess any potential relatives that can provide a nurturing and sustainable safe loving environment. Diligent effort notifications occur within 30 days of a child's placement (see CP&P policy http://www.state.nj.us/dcf/policy_manuals/CPP-X-A-1-5.58_issuance.shtml) Identified relatives are evaluated using resource home licensing standards and when approved, children are then transitioned into relative home placement. Relatives that have been assessed and identified as ineligible to provide care must be notified within one week of agency decision (see CP&P policy http://www.nj.gov/dcf/policy_manuals/CPP-X-A-1-5.52_issuance.shtml). If children cannot be placed with relatives, NJ makes every effort to ensure that children are placed in a family setting. Figure 18 shows that 40% of children in out of home placement at the end of CY 2014 were in kinship placement and 52% were in resource family (non-kin) placement for a total of 92% of all children placed in a family type setting.

Figure 19



- **Item 11- Efforts to promote positive relationships between children in care and parents**

NJ understands that promoting and maintaining positive relationships between children in care and their siblings and parents does not stop with visitation. Encouraging parents to participate in all aspects of planning for their children while in care provides a sense of partnership while allowing them to retain their sense of parenting. Through CP&P policy as well as NJ Administrative Code, casework staff must engage in reasonable efforts with parents to reinforce the family structure and assist parents in remedying the reasons for intervention and placement of their child(ren). Case management activities related to reasonable efforts include but not limited to engaging and involving the family and resource parents in the family engagement process, case planning, arrangement of services for the parents and child as needed and identified in the case plan, arrangement of transportation, informing and encouraging parental participation of their child's progress in school, medical, dental and mental health/behavioral health needs or activities as well as other efforts as outlined in CP&P policy: http://www.state.nj.us/dcf/policy_manuals/CPP-III-B-2-200_issuance.shtml.

When parents cannot visit with their children frequently due to circumstances such as incarceration or distance, other means of contact are encouraged to include phone calls, letters or social media outlets such as Facebook to provide another avenue for parents and children to continue to build their relationship. Resource parents are encouraged to promote and maintain

contacts between children and parents in these and other creative ways that will provide a safe way to maintain the parental relationship for the child.

Outcomes – Well-Being

Child and Family Well Being Outcome 1: Families have enhanced capacity to provide for their children's needs

- **Item 12- Assessment of needs and services of children, parents and foster parents**

Assessment and understanding of the needs of children, parents and resource parents is a critical step in the well-being of families to promote positive permanency outcomes. As indicated earlier securing the right resources for children and families will assist in their success in achieving their goals and identified outcomes. NJ begins to assess children and families through the use of SDM tools to include Strength and Needs Assessment as outline in CP&P policy: http://www.state.nj.us/dcf/policy_manuals/CPP-III-B-6-600_issuance.shtml.

These tools are recorded in NJS and are completed to identify critical strengths and needs of parents, caregivers and children. Strengths and needs are incorporated into the family case plan and are used as a platform for the identification of service intervention.

Assessment and services can be measured by the NJ QR process through several system practice indicators.

1. Engagement indicators assess the development of a collaborative and working relationship that supports on-going assessment, understanding and service planning. This indicator has four components:
    - Engagement Overall- rating is determined in consideration of the other three
    - Engagement of child/youth
    - Engagement of Parents
    - Engagement of Resource Caregivers

In CY 2014 Engagement Overall indicator statewide was identified as an area needing improvement with an overall rating of 66%. Six counties received an acceptable rating while the remaining nine counties had percentage range of cases rated as acceptable between 33%-67%.

Engagement of Child/Youth indicator was rated as a strength statewide with 12 out of 15 counties rated as acceptable.

Engagement of Parents indicator combines engagement of both individual parents if applicable into one rating. If engagement efforts were optimal with one parent but were unacceptable with the other parent a case cannot score higher than a marginal rating of 3 identifying this case into the refinement/unacceptable zone. Statewide this indicator was rated as an area needing improvement overall as well as in 14 out of 15 counties.

Engagement or Resource Caregivers indicator was identified as a strength statewide with 13 out of 15 counties rated as acceptable.

Several individual county PIP's have identified engagement as an area that will require strategic planning around to improve case practice outcomes. Since engagement is the cornerstone of the NJ Case Practice Model, strengthening the case practice model was identified as a core strategy in the NJ 2015-2019 Child and Family Services Plan (CFSP).

2. Assessment and Understanding indicators evaluate how well the agency gathered information, both formal and informal assessments, to understand the strengths, underlying needs, behavioral expressions as well as risk factors for children, parents and resource caregivers. This indicator has four components:
   - Overall Assessment- rating is determined in consideration of the other three
   - Child/Youth Assessment
   - Parent Assessment
   - Resource Caregiver Assessment

Overall Assessment indicator in the QR process for CY 2014 was identified as a strength statewide with 9 out of 15 counties rated in the acceptable range.

Child/Youth Assessment indicator was also identified as a strength statewide with 14 out of 15 counties reviewed in the acceptable range.

Parent Assessment indicator statewide was identified as an area needing improvement with 4 out of 15 counties rated in the acceptable range.

In contrast the Resource Caregiver Assessment indicator was identified as a strength statewide with all 15 counties rated in the acceptable range.

Similar to engagement, several counties identified Assessment of Parents as an area to improve upon in their PIP.

3. Resource Availability indicator measures the array and quality of resources both formal and informal and whether they were individualized, implemented sufficiently and timely as well as whether they were culturally appropriate and sufficient in intensity and duration to support the implementation of the case plan.

In CY 2014 the Resource Availability indicator was identified as a strength statewide with 14 out of 15 counties rated in the acceptable range. This indicator helps to inform NJ that not only is the array of resources available throughout the state but that the quality and sufficiency of those resources are supporting the families in meeting their goals and outcomes.

4. Family Supports Indicator assesses the efforts of the service system to include providers in assisting the family to acquire or adapt the skills, resources, guidance and connections to supports necessary to mitigate the safety and risk factors as well as meet the identified needs of the children in order to achieve the goals and outcomes identified in the case plan. This indicator has three components:
   - Family Supports Overall- rating is determined in consideration of the other two
   - Family Supports of Parents

- Family Supports of Resource Caregivers

For CY 2014, the Family Supports Overall indicator was identified as a strength statewide with 13 out of 15 counties rated in the acceptable range.

It is interesting to note that for Family Supports of Parents, this indicator was identified as an area needing improvement statewide with 6 out of 15 counties falling into the acceptable rating range.

In contrast, Family Supports of Resource Caregivers indicator was identified as a strength statewide with all 15 counties rated as acceptable.

Areas to improve upon identified for Family Supports of Parents include lack of sustainable long term supports for basic needs to stabilize families at home such as housing and public assistance. Further assessment for these supports is targeted through the Needs Assessment process- see Item 29 for more information.

- **Item 13- Child and Family involvement in case planning**

Case planning is crucial in working with children and families and a key component of the NJ Case Practice Model. Case plans should always include the family voice and is based on the strengths and needs of the participants of the plan. Plans should be individualized, comprehensive and should provide direction on the goals, strategies, activities and resources required to achieve positive outcomes. Furthermore, plans should be implemented timely and adjusted accordingly to the changing needs of the family. NJ Statute, Administrative Code and CP&P policy guides casework staff on the case plan requirements (http://www.state.nj.us/dcf/policy_manuals/CPP-III-B-1-100_issuance.shtml).

Case plans are documented in NJS and on-going discussions regarding case plan activities are captured through case note documentation in NJS as well. These areas of documentation require supervisory review and approval to ensure that case planning activities are done timely and of good quality.

There are several performance measures that can track and monitor how NJ performs as it relates to case planning with families.

Two performance measurements fall with the standards identified by the MSA. The MSA requires that 95% of initial case plans are completed within 30 days and then 95% are reviewed and/or modified every six months thereafter. As indicated in Figure 10, NJ continues to meet and/or exceed these case plan benchmarks.

Several performance measurements within the QR process also address case planning activities.

1. Case Planning Process indicator assesses how well case plans were individualized to include the family voice and input in addressing the identified needs to achieve the specified goals. Evaluation also includes whether identified supports, services and interventions were relevant to the family's needs.

2. Case Plan Implementation indicator evaluates how the identified resources, services and interventions were implemented by examining the timeliness, appropriateness, availability and quality of the service providers to meet the individual needs of the family.

In CY 2014, the QR Case Planning Process indicator was rated as an area needing improvement statewide with 5 out of 15 counties receiving a case review strength rating.

Similarly the Case Plan Implementation indicator was also rated as an area needing improvement statewide with 5 out of 15 counties receiving a strength rating (one out of the five counties in this indicator differs from the five counties in the case planning process).

Quality of case planning is measured for the MSA by combining the Case Plan Process indicator with another QR indicator:

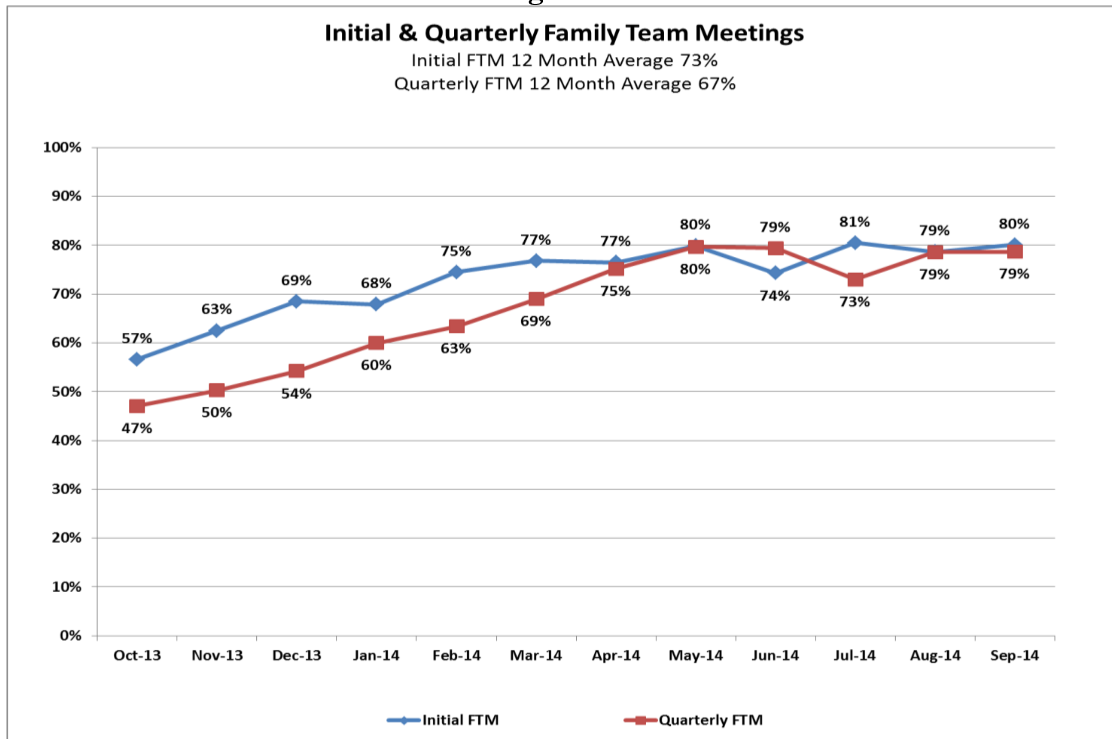
- Tracking and Adjusting indicator assesses how the progress of the case plan is viewed and evaluated by the family team and how case plan activities are routinely evaluated and modified in response to changing or emerging needs.

Other QR indicators include:

3. Family Teamwork Formation indicator evaluates whether all appropriate formal and informal supports are identified to work together as a team to meet, talk and plan for the activities necessary to successfully achieve the goals and outcomes for the family.
4. Family Teamwork Functioning indicator evaluates how all of the members of the team then plan evaluate and function collaboratively.

Both indicators were identified as areas needing improvement statewide with similar outcomes. Teaming is also a MSA performance measure which looks at target benchmarks for initial quarterly compliance of Family Team Meetings (FTM). Initial and quarterly FTM benchmarks are set at 90% compliance. Although these benchmarks have not been achieved, NJ continues to see an upward trend as evidenced in Figure 20. Since teaming is an essential part of the Case Practice Model, strategies to strengthen this performance have been incorporated into the core goals of the NJ 2015-2019 CFSP.

Figure 20



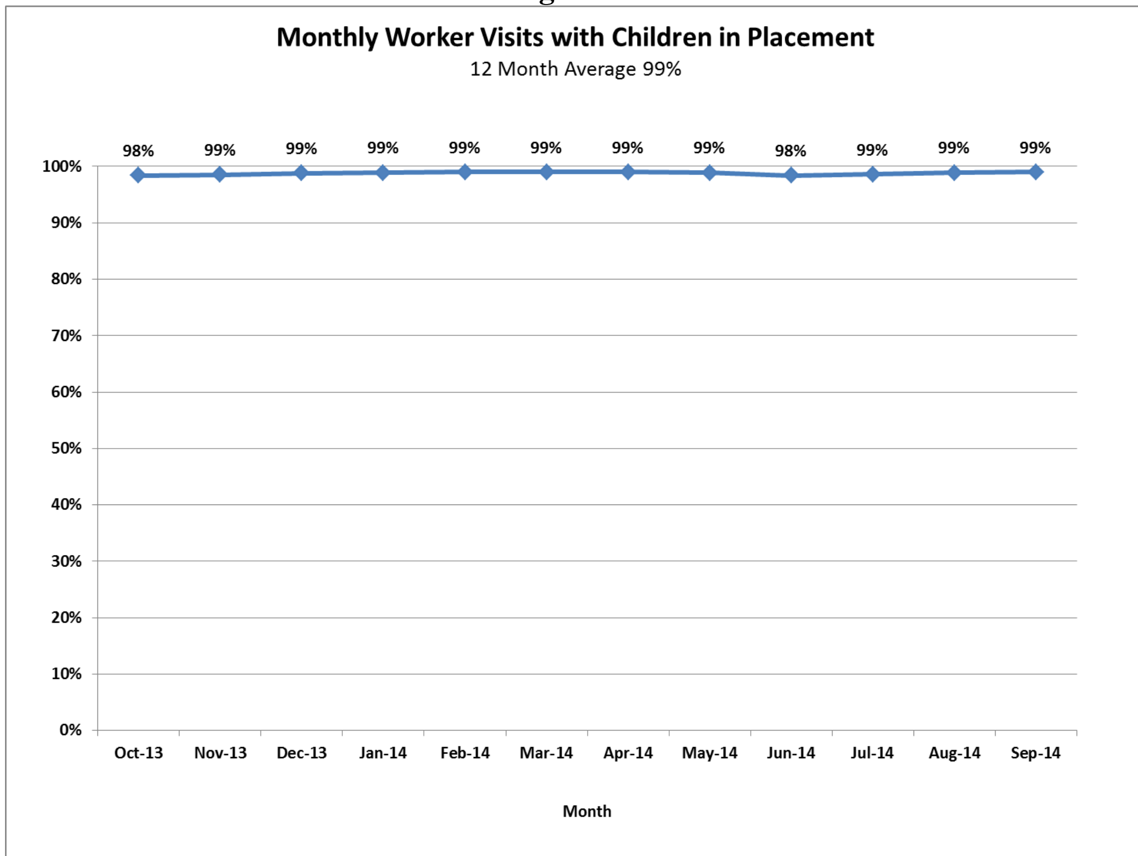
- **Item 14- Caseworker visits with child**

NJ understands that in order for families to successfully achieve the positive outcomes, casework staff needs to meet regularly with children in order to ensure that they are safe and that the objectives of the case plan are being met. Frequent face to face contacts with children is desirable but at a minimum should be monthly. The Monthly Visitation Requirement (MVR) for case work staff to meet with children is established by the identified risk value assessed for the case. The risk value will determine how often casework staff should be visiting with children as outlined in State statute, Administrative Code and CP&P policy (http://www.state.nj.us/dcf/policy_manuals/CPP-III-C-3-100_issuance.shtml). Caseworks then record their contacts with children in NJS.

NJ continues to exceed with this Federal requirement. Figure 21 represents data analysis from NJS that shows on-going substantial conformity in meeting or exceeding the Federal Standard putting NJ in line with meeting the new standard of 95% as of FY 2015 of monthly caseworker visits with children. The monthly average performance between 10/1/13 and 9/30/14 was 99%.

NJ also continues to exceed the federal standard of 50% for monthly caseworker visits to children that occurred in the child's residence. Data from NJS shows that NJ standard performance is 96%.

Figure 21



- **Item 15- Caseworker visits with parents**

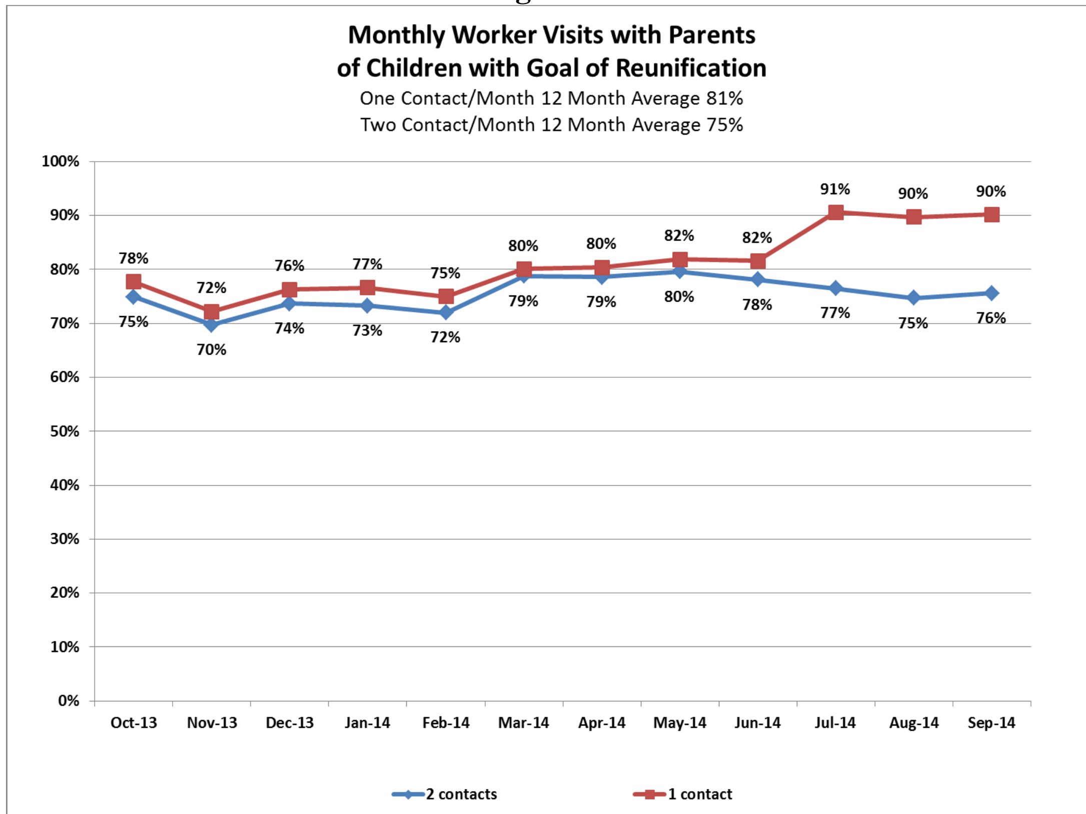
Parallel to caseworker visits with children, in order for families to successfully achieve the outcomes outlined in their family case plans, caseworks need to meet regularly with parents to review and discuss their progress, services needs and areas concerning their children. Frequent face to face contacts with parents is desirable but at a minimum should be monthly. The Monthly Visitation Requirement (MVR) for case work staff to meet with parents is established by the identified risk value assessed for the case. The risk value will determine how often casework staff should be visiting with parents as outlined in State statute, Administrative Code and CP&P policy (http://www.state.nj.us/dcf/policy_manuals/CPP-III-C-3-100_issuance.shtml). Caseworkers then record their contacts with parents in NJS.

Data shown in Figure 22 is from NJS and it which shows the two performance measures in regards to caseworker visits with parents:

1. Monthly worker visits with parents
2. Bi-monthly worker visits with parents

Between 10/1/13 and 9/30/14, one monthly worker visit with parents occurred on average in 81% of cases, with an upward trend in the last three months. Performance for bi-monthly worker visit with parents is lower with an average of 75%.

Figure 22



This is an area needing improvement as seen through the MSA performance measures of caseworker visits with parents/family members that require the following benchmarks:

a) Caseworker visits with parents/family members- at least one face to face visit per month- 85%
b) Caseworker visits with parents/family members- two face to face visits per month- 95%

Child and Family Well Being Outcome 2: Children receive appropriate services to meet their educational needs.

- **Item 16- Educational needs of children**

The educational needs of children within the NJ child welfare system are evaluated and monitored to safeguard that children are receiving all the necessary and appropriate educational services. Child Protective Service reports that identify criteria outlined in CP&P policy for

educational neglect are investigated to the fullest extent and any recommended services are crafted in a case plan with the family and the school district.

For CPS reports that do not identify any educational issues, collateral contact is made with the applicable school to determine if the children is receiving the necessary educational services. If concerns are identified through collateral contacts, caseworkers will partner with families and schools to address the concerns.

For children in placement, Educational Stability statute and policy guide caseworkers to ensure that the educational needs of all children in placement are addressed. As part of the case plan, the child's educational information is documented in NJS to include requirements for best interest determination- see Item 9 for policy link.

The Child and Family Status Indicator of Learning and Development through the QR process measures whether key milestones for educational needs as well as developmental needs are met for children under five as well as children over five. For CY 2014 the overall statewide rating for learning and development for children under five was 89% and for children age five and older was 91% statewide.

Child and Family Well Being Outcome 3: Children receive adequate services to meet their physical and mental health needs.

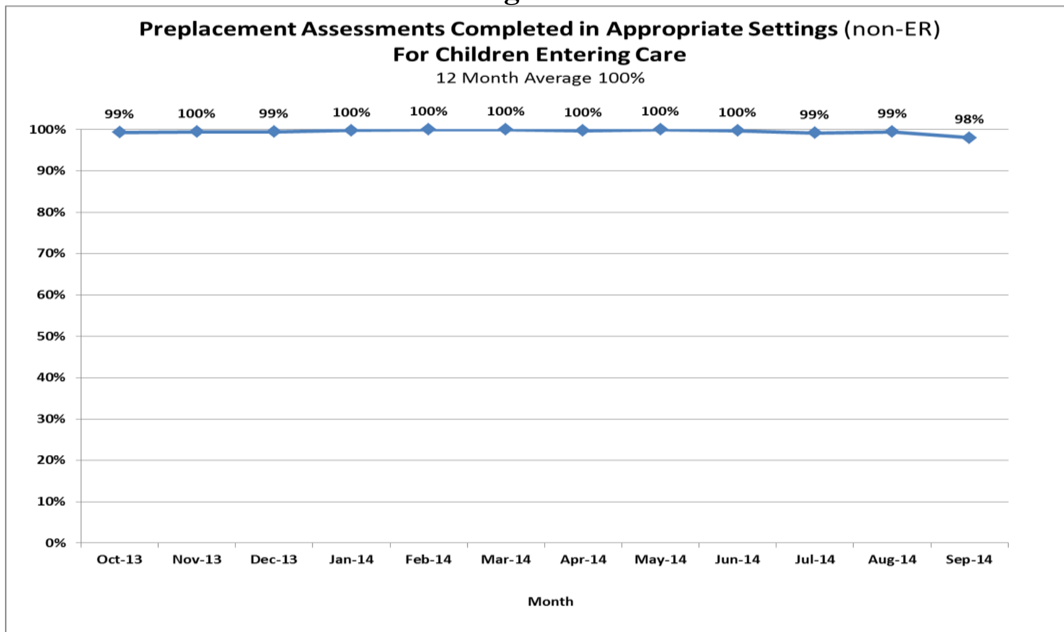
- **Item 17- Physical health of the child**

Timely, preventive medical care is important for maintaining good health. All children receiving services from CP&P receive preventive medical care and treatment in addition to medical care and treatment required by a present health condition. NJ statute, administrative code as well as comprehensive CP&P Health Services policy outlines the efforts casework staff must do in order to address the physical health and dental needs of children up to age 21, to include coordinating with other federally mandated programs.
(http://www.state.nj.us/dcf/policy_manuals/Child%20Protection%20&%20Permanency_113B34A2-A559-4F81-8379-E7070B788D27_V%20-%20Health_A%20-%20Health%20Services.shtml)

There are several performance measures through the QR process as well as MSA benchmarks that identify NJ compliance with meeting the medical and dental needs of the children of NJ.

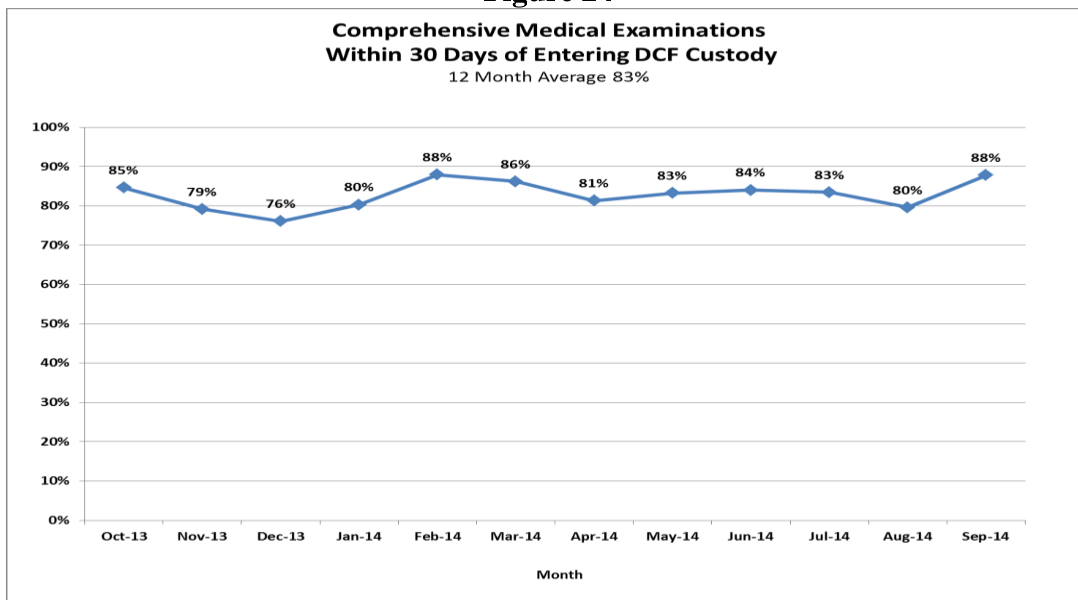
MSA performance benchmarks for pre-placement medical assessments require that 98% of children will receive an assessment either in a non-emergency room setting or in an ER setting if the child needed emergency medical attention. Figure 23 represents data from NJS which demonstrates NJ exceeded this measure with an average of 100%.

Figure 23



Another MSA performance measure is initial Comprehensive Medical Examination (CME) which requires that 85% of children shall receive a CME within 30 days of entering out of home placement. CME is an examination, conducted by an appropriate health care professional, occurring within 30 days of a child's entry into out-of-home placement, which complies with EPSDT standards and also includes a mental health screening. Data in figure 24 illustrates the upward trend in meeting this benchmark with a 12 month average of 83%. Although this benchmark is not consistently reached for completion of CME's within 30 days, almost 100% are completed within 60 days.

Figure 24



EPSDT screenings for children 12-24 months as well as for children over 2 are also performance measures under the MSA. The final benchmarks for these performance measures are:

1. EPSDT 12-24 months: 98%
2. EPDST over 2: 98%

Data from NJS in Figures 25 and 26 demonstrates the 12 month average percent in meeting these benchmarks:

Figure 25

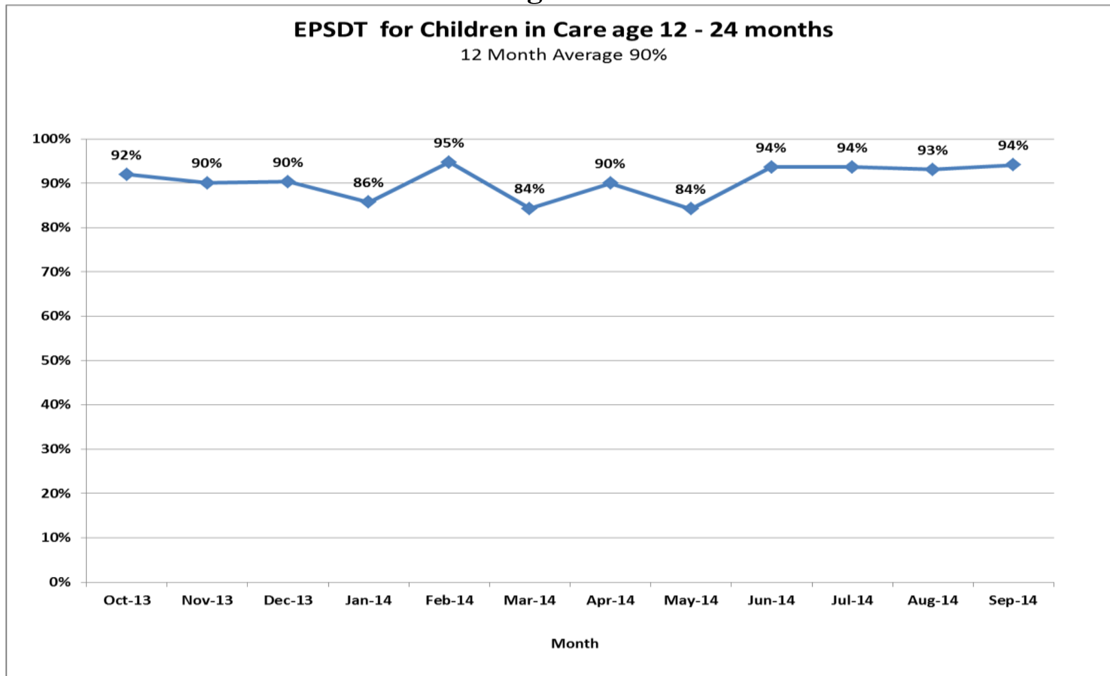
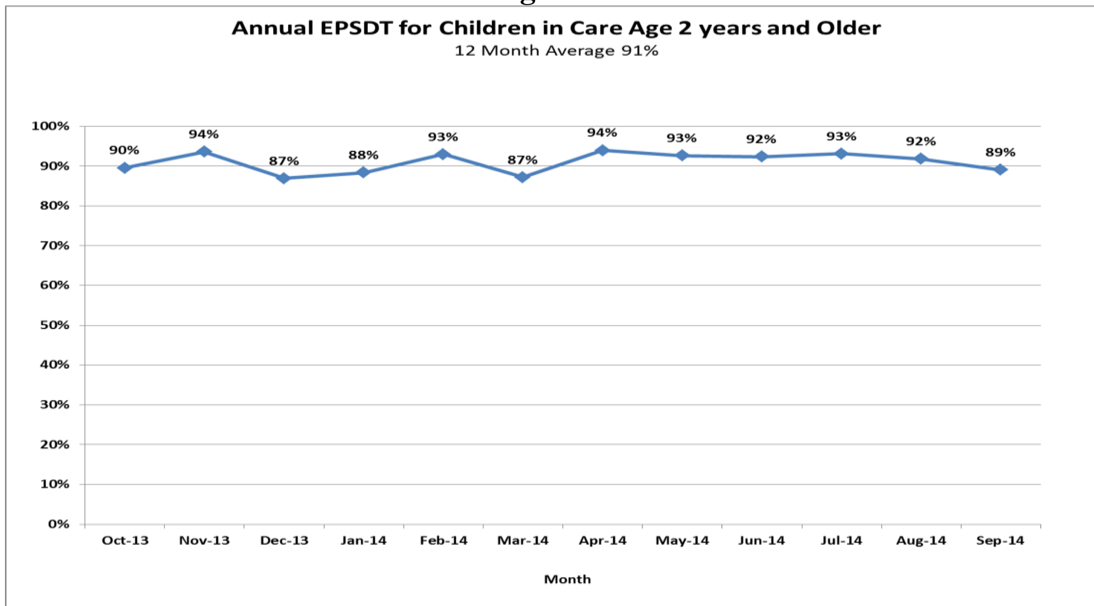
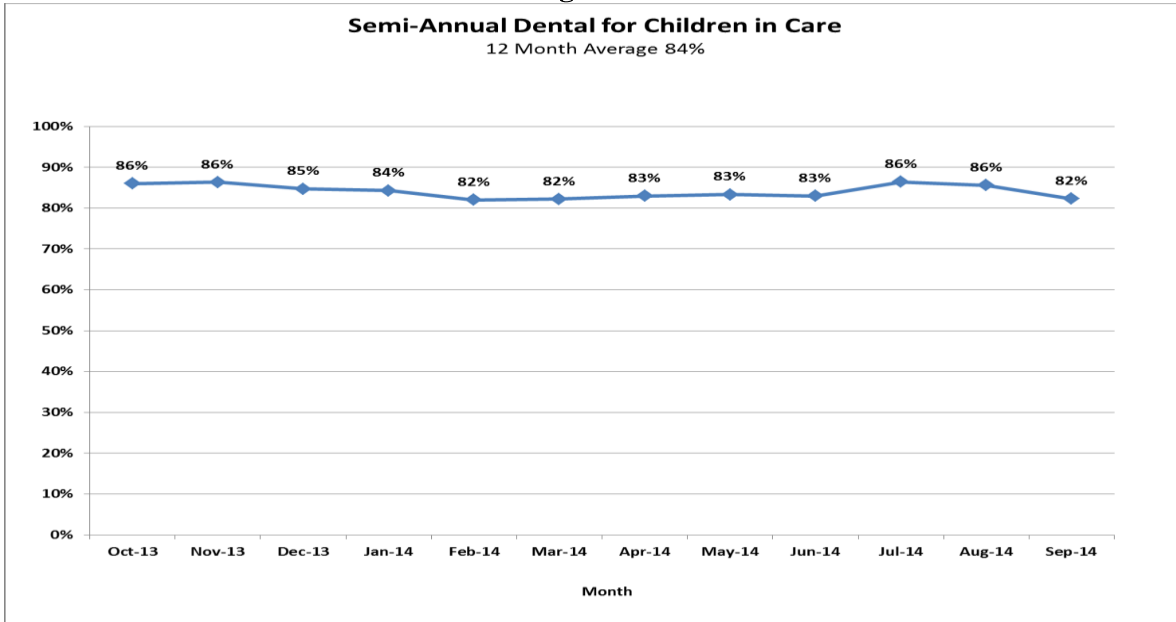


Figure 26



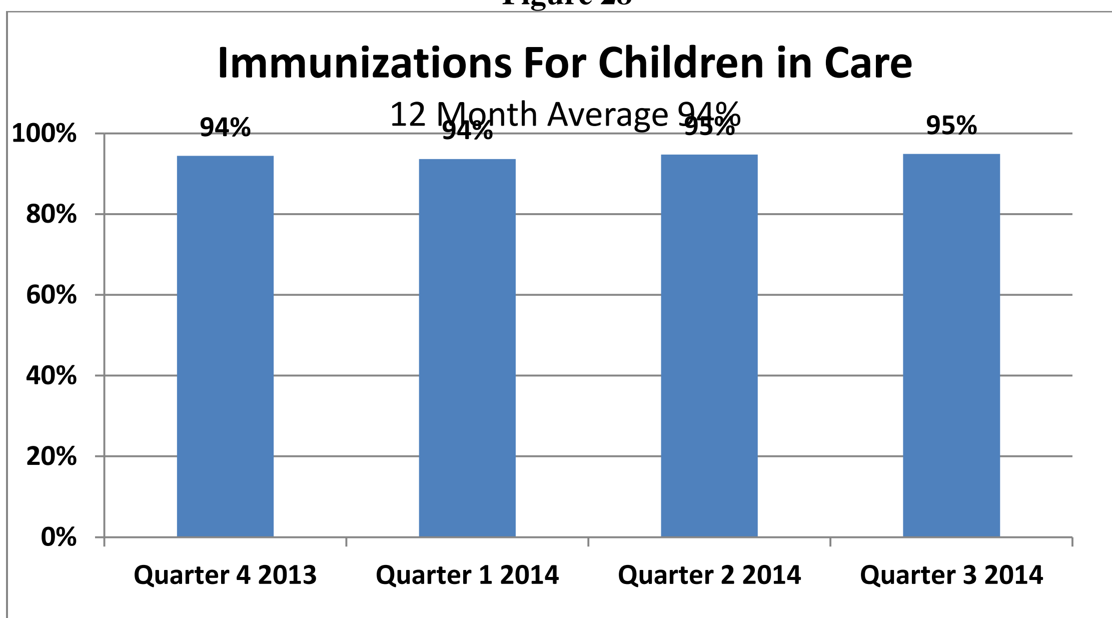
Semi-annual dental examinations for children three and older are also measured by the MSA. Final target performance measurement for semi-annual dental examinations is 90%. Figure 27 represents data analysis over a 12 month average is 84% compliance.

Figure 27



The MSA also measures performance on ensuring children in custody receives current immunizations. The final target benchmark is 98% of children will be current with immunizations. Data from NJS is represented in figure 28 shows that although this benchmark has not been fully achieved, NJ continues to ensure that the majority of children in care are receiving their immunizations to help promote their health and wellbeing.

Figure 28



There are also several performance indicators through the QR process that evaluates physical and dental health care of children.

Physical health care of the child as well as provision of health care services is two indicators measured through the QR process.

1. Physical health of the child examines the child's current health and the system's ability to effectively identify health needs to include reviewing medical/dental care, nutrition, hygiene, exercise, diagnosis and prognosis as well as medication monitoring.
2. Provision of Health Care Services examines the degree to which a child/youth received timely and effective health care services required to achieve his or her best attainable health

In CY 2014, the Physical Health of the Child indicator was rated as a strength statewide achieving 96% of cases rated in the acceptable range. All 15 counties were rated as a strength with this indicator.

Likewise the Provision of Health Care Services was also rated as a strength statewide achieving an impressive 98% of all cases rated in the acceptable range. All 15 counties were again rated as a strength with this indicator as well.

These substantial performance ratings continue to illustrate that NJ is committed to the physical and dental health of children.

- **Item 18- Mental Health/Behavioral health of the child**

When a child receives a CME, if there are indicators that a child has mental health and/or behavioral health concerns that have not previously been addressed will receive a treatment plan identified by a medical professional. Children coming into care with an identified need will have their treatment team participate in the service planning for that child. Children in their own homes receive mental health/behavioral health care through the Children's System of Care array of services (http://nj.gov/dcf/about/divisions/dcsc/).

Besides the MSA measures reported in Item 17 which also carry mental health/behavioral components, the previously mentioned QR indicators in Item 17 also evaluate mental health/behavioral health of a child(ren).

NJ continues to fulfill the requirement to support the provision of in-home and community based mental health services for children and their families. This requirement has been substantially maintained and is monitored on an on-going basis.

Additional updates to the physical/dental health as well mental/behavioral health of children can be reviewed under the Health Care Oversight and Coordination Plan Update Attachment A.

Systemic Factors

Statewide Information System

- **Item 19**

The New Jersey SPIRIT application readily supports the documenting and reporting of children's case status, demographic characteristics, locations, and goals. This information is gathered for all case participants including those children in foster care.

NJ SPIRIT allows workers to document their case involvement throughout the life of the case. At different stages of a case, workers will use relevant modules/screens to capture essential information to help manage the children and families they serve (i.e. investigative, case planning, litigation, adoption, etc.). The compilation of this information builds the electronic case file for the family and children involved.

As is the nature of child welfare and protective cases, information pertaining to each child evolves and frequently changes over the life of a case. NJ SPIRIT is able to supports this type of flow by the data fields which make up the specific modules. These fields allow for multiple areas of data entry, depending on the stage of the case, but retain data integrity by the dynamic interaction between these screens. In addition, NJ SPIRIT contains overview or summary screens that pull related participant data together and presents it in a clear and concise display. For example all participant demographic information is housed and displayed in the "Person Management window" and the "Maintain Participant Information window" is a screen that allows for a worker to quickly view the summary of a participants legal status, education information, medical data, and service/placement history. These are just a few illustrations.

In addition to these on demand screens within the application itself, the NJ SPIRIT data also drives routine reports that are available to a range of staff throughout the Department. These reports are designed to provide workers and management with the outcome data they need to help manage their families and support the development of best case practice. NJ SPIRIT also produces routine reports required by the Federal Government concerning the children and families we serve (AFCARS & NCANDS).

Overview of NJ SPIRIT during October 1, 2013 – September 30, 2014

- DCF focused on the process of correcting those General requirements and Foster Care/Adoption data elements identified in the AFACRS Assessment Review. Development and Implementation continued on system fixes needed to meet full compliance on all requirements.
- The continued implementation of system fixes to mitigate the SARR findings and support our corrective action plan designed to achieve SACWIS compliance.
- Implementation of the NJ SPIRIT Direct Deposit/ Debit Card enhanced functionality, allowing for the shift away from paper checks for all resource providers, adoptive families, and kinship families.
- Completion of a successful week long Disaster Recovery exercise on the newly upgraded NJ SPIRIT environment.

- Implementation of new worker search functionality, which gives supervisors easier access to their staff's work; and allows them to reroute work from one convenient location.
- Continued maintenance, support and expansion of the NJ SPIRIT mobile solution used to support SPRU investigators, adolescent workers, and workers responsible for supervising and documenting parent child visits.
- Upgrades to the DCF network hardware and software that supports the NJ SPIRIT application were completed.

Adoption and Foster Care Analysis and Reporting System (AFCARS) Review

New Jersey implemented four system enhancements (incidents) designed to alleviate specific AFCARS findings during the current reporting period.

- Incident 21285 – Add subsidy amount to the subsidy agreement window and map to AFCARS adoption # 36.
- Incident 20805 - Foster Care element # 49 - 54, allow to properly report on foster family structure.
- Incident 20870 – Change mapping for element # 64 and # 65 to account for trust account enhancements.
- Incident 20855 – Modifications to the medical mental health window to comply with appropriate report of diagnoses.

To date New Jersey will have completed 20 enhancements designed to alleviate specific AFCARS findings.

SACWIS Assessment Review Report (SARR) Corrective Action Update

In November 2010, DCF received the results of the March 2010 site visit in the SACWIS Assessment Review Report (SARR). The report indicated that of the 90 requirements, 56 requirements were in conformity with the standards, 18 were in conditional conformity, and 16 were not in conformity.

DCF worked closely with ACF in completing and submitted the corrective action plan to address the findings and received final approval from ACF on March 1, 2013.

Out of the 34 requirements that were found either not conforming (16) or only conditionally conforming (18), twenty one resulted in a corrective action that required a system enhancement. These enhancements are logged as incidents for tracking and development purposes.

Eight requirements were completed during this reporting period.

1. Requirement # 1 "*Record contact/referral*" – (*finding*) As part of the States incorrect intake process some duplicate data entry issue were identified.

   One incident was created to mitigate this finding.

   - Incident 22212 enhanced the current way the application addressed "incorrect" intakes. The system now allows for an intake override process. This only happens after an intake is completed (frozen) prior to identifying that it is "incorrect". Once this occurs a very limited number of users within the system have the appropriate security to override the original intake. The intake then becomes editable again,

while maintaining the original information. The user will then have the ability to add to the intake necessary information to allow for proper assignment and subsequent resolution. This was implemented in January 2015.

2. Requirement # 15 "*Collect and Report Special Needs/Problems*" - *(finding)* The State is required to review the process for capturing and documenting this information and consider using a single screen updated by nurses and/or case workers to capture detailed information as it will provide more reliable medical/mental health history to staff.
   Two incidents were created to mitigate this finding.

   - Incident 19786 (completed in November 2011) enhanced the existing Medical Mental Health screens to support more comprehensive and reliable medical/mental health history documentation. A summary of the enhancements are as follows:
     - The Medical Mental Health window - Medical Profile tab was updated to include changes as a result of new Health Passport and Placement Assessment form.
     - The Provider tab was added to the Medical Mental Health window to record client's health care provider information and history.
     - The Medication tab was added to the Medical Mental Health window to record client's prescribed medications.
     - The Health Plan tab was added to the Medical Mental Health window to record acuity level determination, medical testing information and history, and other information contained in a client's health plan.
   - Incident 20855 is the second component of the plan to fully address Requirement #15. This enhancement to the Medical Mental Health screen built upon the improvements achieved through incident 19786 (above) by streamlining and capturing diagnosis information in a manner that supports both SACWIS and AFCARS requirements. This occurred in January 2015.
3. Requirement # 21 “Determine IV-E eligibility” (*finding*) The title IV-E eligibility process is not sufficiently automated. Reviewers noted a number of areas where additional automation would make the determination process more efficient, reducing duplicate data entry and improving the quality of the data in the system. They include:

   - Basic information, such as the manner of removal and whether or not there is a voluntary placement agreement in place, does not pre-fill from information entered into NJ SPIRIT by the case worker.
   - The eligibility worker must also complete a manual AFDC eligibility worksheet* that is printed out and filled out in hard copy format.

   *The AFDC eligibility worksheet was automated prior to the SARGe report even being generated.

   One incident was created to completely mitigate the remainder of this finding.

   - Incident 20840 addressed the need to further automate the NJ SPIRIT Eligibility Screens. The new design now prefills roughly 19 additional data elements within the Eligibility screens. This went into production in January 2015.
4. Requirement # 26 “Generate documents related to eligibility determinations” –
   - (*Finding A*) New Jersey utilizes a printed form (10-5) to document the title IV-E eligibility determination. The review team noted a number of discrepancies between the way the system documents the determination and the way the form documents the determination:

    - The form requires a supervisory approval, but the system does not and has no way of indicating such approval.
    - If the client is found ineligible, there is no reason listed when the form is printed and it must be hand written on the form.
    - If a determination was voided in the system that status clearly displays on the audit trail, but does not indicate “Void” on the printed form.
  - *(Finding B)* There are a number of criteria that the State may use to find a child eligible for title IV-E adoption assistance. While those criteria are noted on the subsidy agreement form, they are not documented in full on the eligibility screen.

Three incidents were created to mitigate these findings.

  - Incident 20856 disabled the print option for a determination that was voided. This occurred in October 2013.
  - Incident 20875 modified the determination window to allow a worker to select a reason when a child has been deemed ineligible (then prefills 10-5fc form). This occurred in January 2015.
  - Incident 20868 modified the adoption assistance screen so that the same criteria found on the subsidy forms is reflected on the subsidy and eligibility screens. This occurred in January 2015.

5. Requirement # 33 “Match client to placement alternatives, if needed” - (*finding*) While the functionality to support matching clients to placement options is in NJ SPIRIT, it is not widely used. The review team identified two issues impeding widespread use of the matching function:
  - The matching program functions by matching client characteristics and search criteria input by the worker with the provider‘s record indicating which characteristics they will accept. At this time there is not widespread use of the characteristics screens either by provider workers or by caseworkers. Additional training and reinforcement of programmatic requirements may be in order.
  - The review team also noted that placement facilitators use ancillary systems to track resources available and which of their resources are best able to work with clients with certain characteristics. They are also often using spreadsheets to track available beds.

Prior to the March 2010 ACF site visit, resource staff requested enhancements to improve the resource search capability and better support their daily operations. These enhancements were in development at the time of the ACF site visit. In June 2010 the new search functionality was released into production. Users are now able to search by service type, availability, and license status. Additional trainings were offered by the DCF Training Academy to help users become familiar with the newly enhanced search features as well as continue to stress best practice in searching for resources.

As for the general caseworker population and their need to enter more comprehensive characteristic data, the plan was twofold.

First an incident was required to help mitigate this finding:

  - Incident 20855 enhanced the system’s ability to prefill child diagnoses determined in the Medical Mental Health windows into the correlation value in the child's characteristics. This ensures that this critical diagnosis data is captured in areas that will help facilitate appropriate placement settings. This was implemented in January 2015.

The second facet of this plan addresses the informational or communication issues concerning the importance of this functionality.

- The May 2011 NJ SPIRIT newsletter alerted staff of the importance of entering and updating this characteristic data. The State reinforced this with Local Office Managers and asked them to go over this with their own individual offices. The IT Director attends monthly CP&P Area Directors meetings, which allows for continual communications between local field and application staff. The State also provides a NJ SPIRIT Help Desk to answer further questions and identify office training needs.

6. <u>Requirement # 34</u> "Generate documents as needed" – (finding) The State should provide an update that more clearly outlines the role of the facilitator in the placement process, including details on how system automation supports the business process.
   In addition to a more detailed description of a facilitator, the State created an incident to help mitigate this finding.

   - Incident 20812 developed an automated alert in the form of an email to notify the primary case worker that a child on his/her caseload was placed in an out of home placement. This alert also notifies the primary worker when the child moves from placement to placement (i.e. foster home to foster home). The email contains identifying information concerning the child including the current location. This alert is only sent if the actual placement line was entered in NJ SPIRIT by someone other than the primary case worker. This alert ensures that the primary worker on the case is alerted if a child on his or her caseload was place in their absence (i.e. by SPRU worker or while out on vacation). This went into production in January 2015.
7. Requirement # 52 "Maintain Directory" - (*finding*) The review team found numerous examples of local offices maintaining lists of placement resources in ancillary systems and not in NJ SPIRIT.
   Prior to the March 2010 ACF site visit resource staff requested enhancements to improve the resource search capability and better support their daily operations. These enhancements were in development at the time of the ACF site visit. In June 2010 the new search functionality was released into production. Users are now able to search by service type, availability, and license status. Additional trainings were offered by the DCF Training Academy to help users become familiar with the newly enhanced search features as well as continue to stress best practice in searching for resources.

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Managers and asked them to go over this with their own individual offices. The IT Director attends monthly CP&P Area Directors meetings, which allow for continual communications between local field and application staff. The State also provides a NJ SPIRIT Help Desk to answer further questions and identify office training needs.

8. Requirement # 64 "Provider Claims Processing" – (*finding*) There are some payment related processes that are performed outside NJ SPIRIT.
    - If a user receives an inquiry and wishes to verify that a check was cashed and the date it was cashed, they may consult the Treasury system directly; the information is not in NJ SPIRIT.
    - Requests to place a stop order or void a check can be made to Treasury, but that status update does not automatically come back into NJ SPIRIT once the action is taken.
    - Requests for replacement checks are made directly to Treasury via a manual process and must be noted in NJ SPIRIT manually.

    To efficiently address Provider payment inquiries regarding check cashing verification (bullet 1 under ACF Findings above), the State Treasury Department offers an online site to allow any provider to search for pending payments via their FEIN number. For those Providers without computer access, DCF will continue to facilitate the inquiry process to Treasury.

    Regarding Provider requests to place a stop order, void a check or requests for replacement checks (bullets 2 and 3 under ACF Findings above), the state created the following incident to mitigate this aspect of the finding.

    - Incident 20833 resolved these identified issues by changing how we process these specific payments. DCF moved away from paper checks for all resource providers, adoptive families, and kinship families. These families are given the choice of having their monthly board payments directly deposited into their bank account or provided a debit card. This enhancement was designed to provide a more immediate and convenient payment process for those resources that provide such a vital service to our children and families. This solution was implemented in July 2014.

One requirement was partially completed during this reporting period.

1. Requirement # 83 "Title IV-A (TANF)" – (*finding*) NJ SPIRIT does have some limited exchange of information with the FAMIS and OMEGA systems containing title IV-A program data, but the mandatory bi-directional interface is not yet complete. For example:
    - No demographic information is exchanged/updated.
    - New Jersey does not use the interface to obtain AFCARS data on clients receiving a TANF payment (AFCARS foster care element #61), resulting in inaccurate reporting for this data element.

    Two incidents were created to mitigate this finding.

    - Incident 20704 remapped the AFCARS logic to grab element # 61 data from the correct Medicaid certification table as opposed to where it was incorrectly mapped at the time of the review. This went into production in July 2014. In addition, a separate incident was developed (20429) to address the storing of historical TANF records. This will aid in future AFCARS resubmissions.
    - Incident 20869 will require demographic information from the IV-A incoming interfaces. The schedule date for this enhancement is reliant on the consolidation of current DHS interfaces, CASS project. This project is currently under review by DHS.

Two requirements remain partially completed from last reporting period.

1. Requirement #12 *"Generate documents as needed in response to investigation" – (findings)* The State still has a number of templates related to various functions and does not adequately automate/support the investigation business flow.
   Three incidents were created to mitigate these findings.

   - Incident 20874 removed the investigative checklist from NJ SPIRIT. It was a tool no longer used by staff in the field. This was changed in production in November 2012.
   - Incident 20756 will incorporate the Institutional Abuse Investigative Unit (IAIU) form 'Memo to Area Directors' (concerning an investigation finding to a provider in their Area) into NJ SPIRIT. This form was identified by Operational Staff as a key component to meet the business need of this particular unit. This is scheduled for June 2015.
   - Incident 20775 incorporated key investigative forms into NJ SPIRIT. These forms were identified by Operational Staff as key components to meet the business needs of this particular unit. This occurred in January 2015.
2. Requirement #29 *"Prepare and document service/case plan" – (findings)* The system does not support the State's case management requirements for independent living program and ICPC. In addition the Case Plan did not meet the current business needs of the agency.
   Three incidents were created to mitigate these findings.

   - Incident 20876 redesigned the case plan to better support current case practice initiatives. This went into production in April 2012.
   - Incident 20094 enhanced the system to capture information currently being documented in the Transitional Living Plan, which is a form that provides a plan for adolescents who are placed out of home. The new Transitional Living Plan template will then prefill with this data entered directly into NJ SPIRIT. This occurred in January 2015

   - Incident 19912 will create new functionality within NJ SPIRIT that captures the specific day to day work being done by the Interstate Service Unit. This requires modifications to NJ SPIRIT to allow us to incorporate forms that are currently being used outside of the system. The addition of this added functionality will allow for Interstate Service staff to document work directly into NJ SPIRIT, it will also provide automated alerts to ensure that the necessary work is completed in the required time frames. Once the data is housed within NJ SPIRIT it will also allow for reports to be generated for quality control purposes and for use as daily management tools. This is scheduled for January 2016.

Summary of SARR progress to date

Out of the original 22 SARGe requirements that required incidents (application enhancements) to mitigate ACF findings, only 5 remain incomplete.

Direct Deposit / Debit Card enhancement

With the advent of electronic banking, DCF has taking steps to become more environmentally conscious while improving the fiscal reimbursement experience for those providing out of home placement for our children.

DCF moved away from paper checks for all resource providers, adoptive families, and kinship families during the summer 2014. These families are now given the choice of having their monthly board payments directly deposited into their bank account or provided a debit card. This enhancement was designed to provide a more immediate and convenient payment process for those resources that provide such a vital service to our children and families. Starting in the spring of 2014, DCF engaged in an outreach to inform and prepare families for summer 2014 implementation.

NJ SPIRIT Disaster Recovery Exercise

Introduction

On Tuesday, April 8, 2014 the Department of Children and Families conducted a disaster recovery exercise on the software application New Jersey SPIRIT. The exercise began on April 8, 2014 at 5 AM and concluded the following Tuesday, April 15 at 5 AM.

New Jersey SPIRIT is the case management system used by the Division of Child Protection and Permanency. This is a mission critical application used 24 hours a day, 7 days a week.

NJ SPIRIT is physically located at the HUB Data Center (West Trenton, NJ), run by the Office of Information Technology (OIT). OIT is also responsible for the storage and backup of NJ SPIRIT. Administration of the application is the responsibility of the Department of Human Services' (DHS) various departments. Networking falls under the purview of both OIT and DHS.

There are other aspects of New Jersey SPIRIT that interface with outside agencies, partners, etc.

Statement of the Problem

The purpose of the exercise was to test the functionality of the core application to run at the disaster recovery site in Hamilton, New Jersey. The testing met audit guidelines as well as provided assurance to the State that in the case of a real disaster, DCF could run the mission critical components of NJ SPIRIT.

Exercise Summary

The goal or objective of the exercise was to run NJ SPIRITS' critical components at an alternate location for a specified period of time (in this case, one week). The timeframe was selected as a result of taking into consideration business practices, hardware improvements over the past two years and adding additional components that were not tested in the last exercise (interfaces, batch, mobile and extension users).

As part of pre-exercise activities, a checklist was created that detailed the necessary steps that would need to be completed for the exercise to run smoothly. Teams that needed to be involved were identified from all agencies. Communication consisting of email, conference calls and in-person meetings were conducted to advise every one of their tasks and monitoring to ensure that responsibilities were being completed on time.

Exercise templates and support were provided by the disaster recovery team at OIT. This ensured that documentation of the exercise was properly recorded.

As mentioned above, Departments and units from three state agencies were included in the exercise (DCF, OIT and DHS). DCF had technical and managerial staff from their IT department. OIT had staff from their storage, disaster recovery, security and networking teams. DHS' members included their Enterprise Business Systems Unit, Networking, Firewall and Application Development Support Unit.

Accomplishments and Shortfalls

The disaster exercise ran through to completion with great success. There were minimal interruptions to parties involved in the use of the application. Performance by DCF end-users was not a factor as the NJ SPIRIT Help Desk did not receive any calls regarding performance. Issues that impacted parties outside of DCF were quickly identified and solution plans were put into place.

The previous disaster recovery exercise did not test the batch, interfaces, and mobile or extension capabilities. This exercise tested all of those components. Whereas some lessons were learned, specifically with DHS' interfaces, the other areas functioned properly.

A separate area identified as a lesson learned was the export file to OIT to update the data warehouse that is used by the DCF reporting unit. After the exercise completed it was discovered that there may have been some update data lost. This is still being researched and is identified as a lesson's learned for the next exercise.

Based on our successful Disaster Recovery exercise DCF is confident that our disaster recovery environment and plan combined with the dedicated support staff (from DCF, OIT and DHS) are more than adequate to sustain full-scale business operations in the event of a true disaster.

Specialized Worker Search & Improved work flow functionality

In efforts to better support the day to day job responsibilities of supervising front line staff, the following enhancements were developed. NJ SPIRIT now provides supervisors easier access to their staff's pending work; and allows them to reroute work from one convenient location. Additionally, improvements were made to the auto-recall functionality in NJ Spirit, which better assists Supervisors in moving work through the approval process without delay.

This was accomplished by:

- NEW – NJ SPIRIT Specialized Worker Search - A new Specialized Worker Search was added to NJ SPIRIT, which gives supervisors the ability to search for and access an individual staff member's pending work.

- IMPROVED - Re-route Work Functionality -The "re-route work" functionality in NJ SPIRIT was enhanced to give supervisors the ability to reroute pieces of work from one worker to another. In addition, the worker selection dropdown was limited to only active workers.

- IMPROVED – NJ SPIRIT Auto-Recall Functionality - The "auto-recall" functionality was enhanced to prohibit the recall of work to an inactive worker. Supervisors now receive a message indicating if a worker is inactive and directs them to reroute the piece of work to an active worker. Workers receiving this message are required to reroute the pending work to a supervisor, who in turn may reroute to the appropriate worker.

Mobilization of NJ SPIRIT

The initial phase of this initiative, dating back to 2011, used multiple federal grant/funding streams to enable remote access to the NJ SPIRIT application. This access was used to support several grant specific case practice functions.

- The Caseworker Visitation Grant originally provided DCF the opportunity to purchase 376 smart phones (and accessories) for case aides to utilize while in the field to enter supervised

parent/child visit activities directly through their phones. This is done via the NJ SPIRIT extension which allows NJ SPIRIT access over the internet. The extension utilizes a combined web and application server protected by its own firewall. Through the extension, this information is entered directly into the NJ SPIRIT Production application data base and into the child's case record. Parent/child visit activities are then immediately available for review by the caseworker. DCF successfully worked with NJ OIT to implement this solution. Although network security and Mobile Management software issues proved challenges, DCF completed implementation of this portion of the Mobile solution by the beginning of calendar year 2014.

The original Caseworker Visitation Grant also provided DCF the opportunity to purchase 200 iPad 2s (accessories & licenses) to further support casework staff in documenting parent/child visits in a timely manner. Workers use the "Go to my PC" software to access their desktop computer and enter information directly into NJ SPIRIT.

DCF successfully implemented the training and roll out of all 200 iPads to identified staff across the state in multiple offices and regions within 2012. In what can be considered phase two of the initiative, DCF received a subsequent Caseworker Visitation Grant in FY 2012. DCF purchase an additional 330 iPads 2s (accessories & licenses). This phase was fully implemented by summer 2013.

DCF receive phase three funding from the same Caseworker Visitation Grant during the FY 2014. This allowed for further expansion of the original mobile solution in addition to offsetting some of the recurring costs of prior year's mobile purchases (i.e. software maintenance renewals). DCF purchased 270 more iPads and deployed them by spring 2014.

- The State also originally received a Children's Justice Act Grant which provided an opportunity for a mobile solution for SPRU workers. Many of the SPRU investigators' tasks are completed in the field with families and away from the secure DCF network. This presents a delay in workers accessibility to information within NJ Spirit as well as a barrier to immediate documentation of investigative work completed while in the field.
  The initial Children's Justice Act Grant enabled DCF to purchase 163 iPad 2s (and accessories & licenses) for our Special Response Unit (SPRU) investigators, which respond to abuse and neglect referrals made after hours. Using the "Go to my PC" software, these investigators have immediate direct access to critical information available in NJ Spirit. It also allows for prompt entry of the investigation documentation and findings into NJ Spirit avoiding duplicate data entry.

  DCF successfully implemented the training and roll out of all 163 iPads to identified staff across the state in multiple offices and regions within 2012.

  The State decided to again deploy a portion of Children's Justice Act Grant towards a mobile solution during this most recent reporting period. It was determined that the Institutional Abuse Investigation Unit (IAIU) would benefit from remote NJ SPIRIT access from the field. These IAIU workers are charged with investigating allegations of abuse of children by staff within schools, facilities, foster homes, etc.

  DCF chose to use this opportunity to test an alternate mobile solution, not previously available in years prior. DCF settled on a 'windows' based tablet (Dell Venue), which had mobile broad band capabilities. The workers connect directly to NJ SPIRIT via the State's Virtual Private Network (VPN).

In addition, these Venues will also fill the role of desktop machines for the investigators while in the office. They will have their own docking stations and desktop monitors. The windows operating system allows for this interchangeable and seamless computing solution.

- The State also originally received Chafee Grant funding which provided an opportunity for a mobile solution for work with adolescents. With this funding DCF was able to purchase 67 iPad 2s and "Go to my PC" software to provide casework staff with mobile access to the internet so they may work directly with youth and caregivers to complete the independent living assessment during home visits. This also allows for the completion of the outcomes survey required by the National Youth in Transition Database (NYTD) via iPad.
  DCF successfully implemented the training and roll out of all 67 iPads to identified staff across the state in multiple offices and regions within 2012.

The NJ SPIRIT help desk has taken over as the gateway to accessing support for these devices. Local Office field support staff now provides on-site technical support and re-provisioning services.

Once all phases of this solution are implemented this year, DCF will have 760 iPads and 376 smart phones and 78 Venues (nearly 1,200 mobile devices) operational and in the hands of front line staff. Routine surveys are sent out to users to gauge the progress of the initiative and allow for appropriate distribution of equipment.

Systems Maintenance – Enhancements

Releases are more structured and routine as NJ SPIRIT has moved to a more systematic release schedule. The priority of releases has gone from a reactive mode (i.e. fixing bugs and "putting out fires") to a proactive mode (i.e. developing functionality to meet our changing business practice and federal requirements).

Highlighted achievements of individual releases are identified below. These do not represent a comprehensive listing of all the work comprised in each release.

System Enhancements

Release 5.0 (October 2013)

The State made numerous modifications and enhancements within Release 5.0. The major objectives are detailed below:

A New disclaimer message was added to the NJ SPIRIT Login screen. Users now are required to acknowledge they have read and understand the confidentiality disclaimer before being granted access to NJ SPIRIT.

Improved Resource Services Selection Options were made available. A new Inactive Services expando was added to the search results display. This new feature allows workers to view and select an inactive service with the condition the service was in an active status when it was provided. The following fields were also added to the results display:

- Service Date Start
- Service Date End
- Service Rate
- Service Payment Method

Improved CWS Assessment/Contact Activity notes were made available. Contact Activity Notes generated from within a CWS Assessment in NJ SPIRIT now automatically associate with the correct CWS Assessment regardless of how many CWS Assessments are in pending.

In an effort to improve the search functionality in NJ Spirit, NEW features were added to the Case and Resource Non-Restrictive Search window:

- My Cases / My Resources Option - Displays all cases or Resources currently checked out by the user.
- Select All - Selects all Cases and/or Resources displayed under the My Cases or My Resources view.
- Unselect All - Deselects all Cases and/or Resources displayed under the My Cases or My Resources view.
- Ability to select individual or multiple Cases/Resources for check-in.

Person Merge was made easier. Local Office merge liaisons complete a Person Merge for duplicate person records in NJ SPIRIT. NJ SPIRIT was enhanced to allow the merge to proceed, even if the merged person is on an investigation; granted the investigation is fully approved.

A NEW Medical/Mental Health Type category of Psychiatric Activity was added to the Medical History window. In addition, values for Psychiatric Evaluation, Medication Monitoring and Other are now also available in the Activity drop down for selection.

The Placement and Service Ending window in NJ SPIRIT was enhanced to give supervisors the ability to override a Birthday Batch placement end reason when appropriate.

Various fields on the Allegation tab of the Investigation window in NJ SPIRIT have been expanded to display more text.

The LOBA check limit was increased from $500 to $600 to accommodate the recent increase in Independent Living Rent allowance.

Upon investigation approval, staff now receives a reminder to complete an Early Intervention System Services referral for children under the age of three years old involved in a Substantiated or an Established investigation. In addition, staff is required to document the referral information on the Medical History Tab of the Medical Mental Health Window in NJ Spirit.

The Auto-recall functionality was enhanced to prohibit the recall of work to an inactive worker. Supervisors now have the ability to reroute the pending work to an active worker, while workers are able to reroute the pending work to a supervisor, who in turn may reroute to the appropriate worker.

Enhancements made to address:

- To ensure the accuracy of address information, NJ Spirit no longer automatically updates resource members address when a change is made to a Resource Primary/Physical Address. Address information for individual members, with the exception of Primary Caregiver, may be updated by staff when appropriate.
- Staff now receive message asking them to accept the USPS standardized address when creating/editing a person or resource mailing address in NJ Spirit. Accepting the U.S.

Postal Service standardized address will help to ensure the accurate and timely delivery of mail.

Release 5.1 (November 2013)

The State made numerous modifications and enhancements within Release 5.1. The major objectives are detailed below:

NJ Spirit has been enhanced to accept either a completed Family Risk Assessment or a Family Risk Re-assessment to satisfy the requirement that one be completed within 30 days before closing an in-home case.

Changes were made to Institutional Abuse Investigative Units online summary and forms to better support case practice.

Human Trafficking values were added to Intakes for CPS and CWS.

Release 5.2 (January 2014)

The State's main focus for this release dealt with modifications and enhancements surrounding the Affordable Care Act.

NJ SPIRIT now allows for the extension of Medicaid coverage for qualifying young adults between the age of 18 and 26. Qualified candidates with existing DCF Medicaid in NJ SPIRIT will automatically be transferred to the new Federal Medicaid program in their 18th or 21st birthday month. NJ SPIRIT will automatically terminate this Medicaid at the end of the young adult's 26th birthday month. Enrollment and termination of new Medicaid will be administered through the DCF Office of Child and Family Health.

Release 5.3 (July 2014)

The State made numerous modifications and enhancements within Release 5.3. The major objectives are detailed below:
Redesign the current or previous agency involvement section of the 'Intake Window' and the 'Other Intake Narrative' section on the screening Summary Report to be more user friendly.

To better assist supervisors in managing their staff's pending work, a new 'Worker Search' has now been added to the Non- Restrictive Search window in NJS. This new search feature will give supervisors the ability to view all pending approvals for a particular worker.

Functionality has been added to NJS which allows Local Office Adoption Staff to attach scanned documents to the adoption planning window.

Add the subsidy amount to the subsidy agreement window and related batches.

An alert was added to the out of home placement process. An email will now be sent to the primary worker when a child on their caseload has been placed/replaced. This will only occur when the placement line was created by someone other than the primary worker. This is designed to ensure that proper notification exists especially for when placements occur after hours by emergency staff.

Correct investigative Extension screen approval process to allow for appropriate approval by assigned supervisors.

Upgrade to the latest version of Internet Explorer from version.

Twenty five incidents were dedicated to the implementation and improvement of our Trust Account functionality. These incidents were spread over multiple areas of the application:

- Online
- Reports
- Interfaces
- Database

Three incidents were AFCARS PIP related:

- The addition of the subsidy amount to the subsidy agreement window and mapping to AFCARS adoption element #36
- AFCARS element #49 (foster home structure) was correctly mapped to also pick up contract agency roles (#57 & #58) to report the primary and secondary caregivers marital status.
- Enhancement to the current element #64 (SSI) mapping to adjust for the improvements to the trust account functionality.

Correct the General Search screen to allow the wildcard search to work properly on the respective address and town fields.

Ongoing Support

The Help Desk team continues to provide end-user and application support for NJ Spirit. The responsibilities are highlighted below:

- Responds to inquiries regarding system functionality, systemic problems, proposed enhancements, and/or other IT reported issues.

- Performs System and User Acceptance Testing (UAT) for NJ Spirit new system development, enhancements, change requests, and/or incidents, and provide implementation and on-going maintenance support for NJ Spirit production and related extension and mobile applications.

- Performs NJ Spirit systems needs analysis for NJ Spirit enhancements and redesign initiatives. Develops and maintains functional and technical design specifications for existing and new functionality. Coordinates and leads Joint Application Design (JAD) meetings as required.

- Develops database modification scripts for the purpose of data analysis, and/or data corrections.

- Conducts training in new applications and/or new system releases/modules.

Help Desk Newsletters

The Help Desk continued to produce monthly newsletters to provide caseworkers with tips and to introduce new or improved functionality.

Current Activities

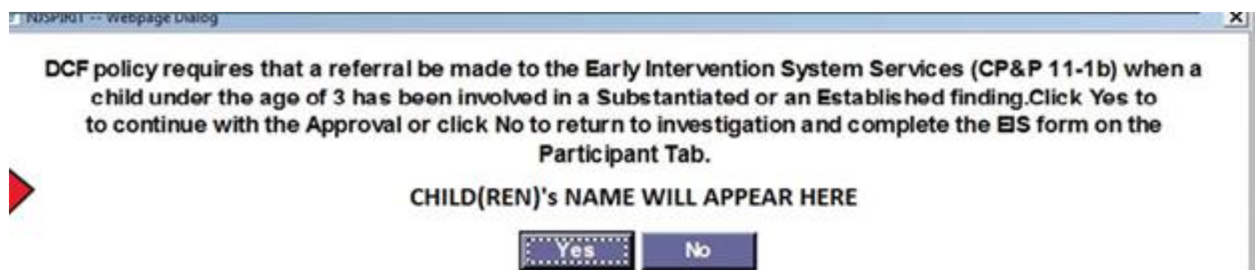
Early Intervention System Service

Child Abuse Prevention and Treatment Act (CAPTA) - an amendment to the Federal law, 42 U.S.C.§5106a, effective June 25, 2004, requires CP&P to refer a child under the age of three years to early intervention services, when child abuse/neglect is found.

In accordance with the Department's four-tier finding determination policy, CP&P refers each child under the age of three (3) years, who is involved in a substantiated or an Established case of child abuse/neglect, to early intervention services (EIS).

The Early Intervention System Services (EIS) referral form (CP&P 11-1b) is now available on the Participant tab of the Investigation window in NJS. A Create hyperlink displays for each child under the age of 3 with a Substantiated or Established finding. The form is launched by clicking on the Create hyperlink under the EIS referral.

Staff will continue to receive the below reminder message in NJS until the EIS form is fully completed and saved.



The new EIS form is designed to reduce data entry, as it pre-fills much of the form information from other areas of NJS. In addition, upon final approval of the investigation the EIS referral information will automatically be transferred onto the Medical Window.

Adolescent Module

This NEW Adolescents Module gives staff the ability to create/print Transitional Plans in NJ SPIRIT. This federally required form assists youths who are placed out-of-home to create a plan to identify goals and the steps needed to achieve those goals.

The objective is for a coordinated Transitional Plan to be in place for all agencies or providers involved with the youth. The Worker takes the lead by bringing individual service providers together in the planning and development process.

Not only is this form now available within NJ SPIRIT it also pre-populates with related existing information and supports the standard NJ SPIRIT approval process. This enhancement successful incorporates Adolescent case practice that was previously captured outside of NJ SPIRIT.

Eligibility window

The Foster Care and Adoption Eligibility window has been enhanced to prefill more data and to also allow reviewers to update person management information directly from the window.

The CP&P 10-5fc Initial IV-E Foster Care Eligibility Initial Determination form in NJ SPIRIT is entirely prefilled from the NJS Eligibility window > Initial tab.

Investigation Client Risk Factor

A NEW Investigation Client Risk Factors window is being added to the Disability or Risk Factors hyperlink within the Investigation window. This window allows users to enter risk factors based on information collected at the time of the investigation. The Diagnosis history will also display on this window in addition to other areas of NJ SPIRIT such as, the Placement Request and Adoption Planning windows.

Other Related Activities

Central Office Cold Room Refresh

DCF Central Office began the process of replacing mission critical hardware that was end of life and/or out of warranty in our data center. As part of this refresh project DCF developed a plan to convert the data center into a virtual environment. DCF has determined that this virtualization will:

- Lower hardware, power and space requirements.
- Quickly and easily provision new servers into the environment.
- Reallocate resources with no downtime.
- Ensure applications stay up in a highly available architecture.
- Prioritize the most important applications to ensure they receive the resources required to meet business needs.
- Simplify systems management and operations.
- Simplify and improve the disaster recovery process.

Continued Implementation of new IT Service Management solution

DCF transitioned from outdated and unsupported software used by the NJ SPIRIT helpdesk to track service tickets during the last reporting period. DCF implemented Alloy Navigator 6.0 as there IT Service Management solution. This provides a powerful business process automation engine that equips DCF with the tools to streamline and improve the efficiency of IT operations, including incident and problem management, service level management, IT asset management, and more. It offers an intuitive, comprehensive, easy-to-use approach to managing the Service Desk, IT assets (inventory), task assignments and other routine activities in throughout our department.

DCF continued to implement the multiple facets of this solution during this reporting period.

Data Sharing with Department of Agriculture and Department of Education

In the summer of 2013, a Memorandum of Understanding (MOU) was reached between DCF and Department of Agriculture (DOA). This MOU established the procedures and methods by which DCF would provide the Data to DOA for matching purposes so that Local Education Agencies could directly certify foster children eligible for free meals. Additionally, this MOU was intended to protect the confidentiality of the Data disclosed by DCF to DOA and ensure that it would be used by DOA and Local Education Agencies approved users as specified in this MOU and as authorized under the National School Lunch Act.

The Department of Agriculture will use NJ SPIRIT data on children in foster care to better identify the population deserving of the free lunch benefits. Along with household income, one eligibly component is whether child is in foster care. By sharing this data between departments it will help ensure the greatest program efficiency and effectiveness.

In sharing data with the Department of Education (DOE) a greater understanding can be gained concerning the educational needs of our children in foster care and those in families we serve. This more comprehensive look at these children's education status will help both the DOE and DCF better serve and meet the needs of these children and families.

DCF began this data share with the DOA and the DOE for the 2014-2015 school year. This was achieved through the creation of a Data Mart in which reports and outcomes can be produced and used by all parties to improve the 'free lunch program' effectiveness in serving children in foster care. As well as gain a greater insight to educational data/measures to help focus resources to the appropriate services and populations.

Manage by Data Initiative

The Manage by Data Initiative was designed to be an innovative approach to change the culture of the agency to one that uses the data that is already being collected to improve decision-making. DCF's Manage by Data Fellows Project is now its fourth year of training that began in September 2014 and will run through June 2015, training 40 Fellows. The umbrella topic for the new class of Fellows is stability. The Fellows are studying all children who entered CP&P out-of-home placement in 2012 to better understand their experience related to stability – in home stability, placement stability, post-reunification stability, and educational stability. The DCF Fellows will work to understand the factors associated with stability. They will learn how stable these children are, areas of providing stability where DCF excels, areas where challenges exist, and opportunities to improve stability. This provides an opportunity for continuous learning that encourages cross-teamed learning and sharing of findings and resources with the end result of sharing these findings with leadership so that informed decisions can be made.

Office of Licensing (OOL) Eform Project Transformation

DCF Office of Information Technology and DCF Office of Licensing (OOL) originally partnered with NJ OIT to develop the current Inspection/Violation Report as an e-form back in 2012. The vision was to enable inspectors to complete the report on a tablet on-site at the time of the inspection, print it through a mobile printer, and provide the inspection results promptly to the center administrator.

A data base was also to be developed to collect the data from the e-form. This would allow for general reporting and would meet the ultimate project goal, which was to publish the child care center inspection results on the web for public access.

An increase in the funding stream (Race the Top grant) has allowed OOL to revisit the original scope of this project. The decision was made to move away from the initial more narrow vision and plans were made to grow and integrate this solution with other IT needs within OOL.

DCF is currently exploring enhancing the existing licensing information system (LIS) or possibly developing/purchasing a new piece of software to meet the comprehensive growing IT needs of OOL, not just solely a mobile solution. Because this could be a lengthy process, we had requested and received permission to have until 12/31/2016 to allocate this new funding.

Separately, DCF has implemented a searchable database on the DCF – OOL website which allows users to search for childcare centers by name, address, capacity, etc. The next step is to post the violations, which is currently being discussed.

Systemic Factor-Case Review System

This Systemic Factor will be a focus priority as NJ prepares for the Round 3 CFSR. Training and Technical support from the Region 2 Children's Bureau staff have been instrumental in identifying areas of strength and areas needing additional concentration. Several internal workgroups have been formed in response to this support to enhance these areas.

- **Item 20- Written Case Plan**

Since the inception of the case practice model, NJ has strived to enhance partnerships with parents and caregivers by teaming with them to jointly plan for their family. Individualized case plans assist a family in identifying their strengths as well as actionable items to improve upon to ensure their children safe and maximize their family's potential. The family and child who are the subject of the plan should be the primary authors of the plan. In order to establish an effective case plan, it is necessary to engage the family and their support network in a strength based, solution oriented, consensus building process.

The case plan is based on mutual understanding and acceptance of what the problems are and what changes need to take place. Family involvement in the case planning process will increase the rate of successful goal achievement and result in reduction of risk of future maltreatment.

The plan specifies the services or actions needed to:

- Address the issues/needs related to the safety, permanency, and well-being of the child.
- Resolve the problems which caused the Division to become involved with the family.
- Achieve the case goal.

The case plan provides:

- A written working agreement which states the problems that need to be resolved and the proposed solutions;

- A record to help the participants remember what each person promised to do for the child and family;
- A yardstick to mark progress (or lack of progress) throughout the life of a case;
- A useful monitoring and accountability tool for the family, the Worker, Supervisors, Managers, the courts, and others involved in providing services to the family.

The case plan is written in a "family friendly" format, allowing family strengths, needs, concerns, goals and tasks to be in the family's own words. The goal is for a single, coordinated case plan to be in place for all agencies or providers involved with the family. The CP&P Worker takes the lead by bringing individual service providers together in the planning and development process. For full description of Case Plan policy see: http://www.state.nj.us/dcf/policy_manuals/CPP-III-B-1-100_issuance.shtml

As indicated in Item 5 there are several performance areas that address case plans. See figure 10 for performance of initial and on-going case plan requirements.

Additional Case Planning Process performance can be gleaned by the relevant information, policy and data presented in Item 13 to include Figure 20.

The current case plan can be viewed at: http://www.state.nj.us/dcf/policy_manuals/26-81a.pdf and addresses the required provisions for:

- Placement in the least restrictive, most family-like setting appropriate to the needs of the child and in close proximity to the parents' home where such placement is in the child's best interest
- Visits with a child placed out of state by a caseworker at least every 12 months
- Documentation of the steps taken to make and finalize a permanent placement when the child cannot return home

The current placement information section of the case plan requires casework staff to document the pertinent placement information for each child in out of home placement to include reasoning and explanation as to whether the placement meets the required provision outlined in the first bullet for least restrictive setting.

The in-person visitation schedule section in the case plan requires casework staff to document the Minimum Visitation Requirement (MVR) as determined by identified Risk Assessment value necessary between the caseworker and the child in placement as well as the parents and caregiver. Policy outlining MVR requirements with children in placement are specified under the Procedures section: C) Procedures for Worker Visits with the Child and the Placement Provider When the Child is Placed Out-of-Home. This specific policy can be viewed at: http://www.state.nj.us/dcf/policy_manuals/CPP-III-C-3-100_issuance.shtml

For children placed out of state but within 50 miles of a NJ border, the required caseworker visits with children are two face to face visits per month for the first two months of placement and then one face to face visit per month. For children placed out of state beyond 50 miles of a NJ border, the required caseworker or other State CPS agency representative visit is once every 3 months.

The case plan has several areas that can address the steps necessary to make and finalize an adoptive or other permanent placement when a child cannot return home with the most critical identified in Section 6 under the Family Summary which specifically requires caseworker staff to document those steps.

The family agreement section of the case plan as well as the CP&P form 26-87- Desired Family Outcomes and Specific Activities (see form policy: http://www.state.nj.us/dcf/policy_manuals/CPP-X-A-1-26.87_issuance.shtml) enable the family to have a voice in their case plan.

There is currently an active CP&P Case Plan workgroup reviewing the case plan in its entirety to include all sections and attachments so that it can be more user friendly for staff.

- **Item 21- Case review system of periodic review of the status of each child, no less frequently than once every 6 months, either by a court or by administrative review.**

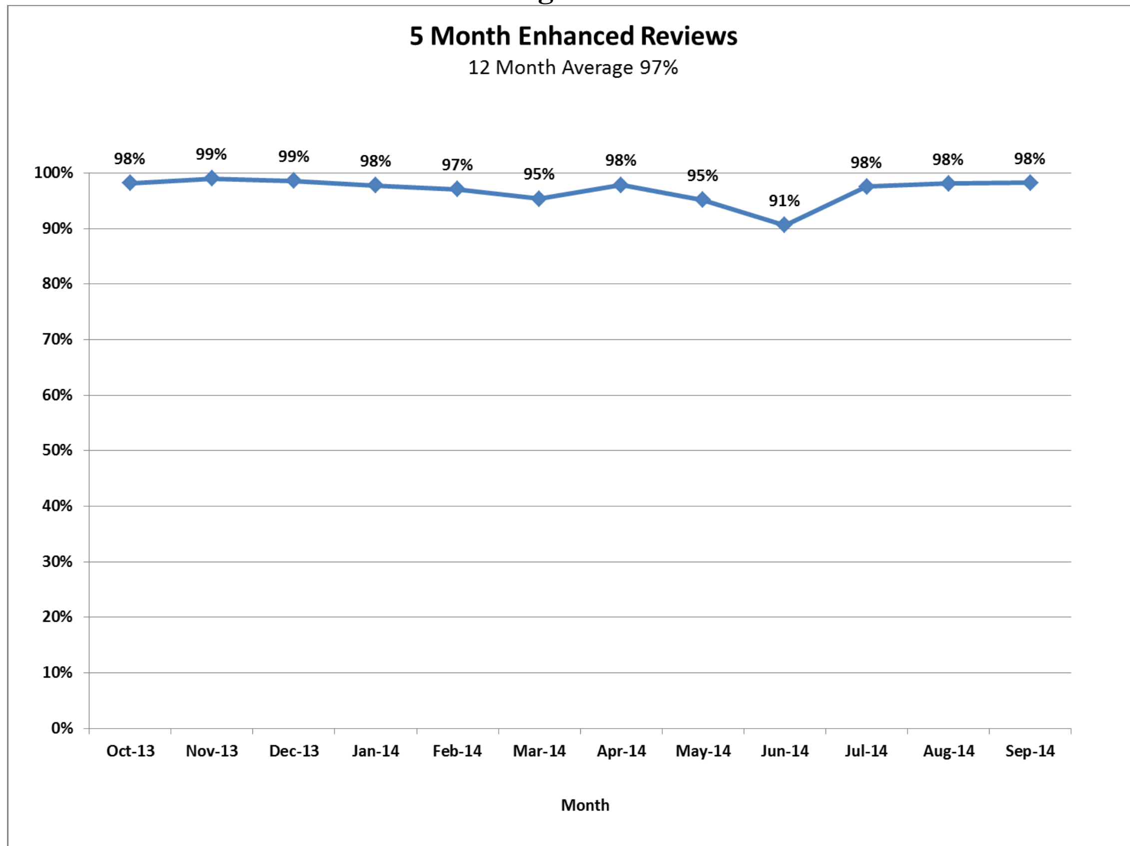
As part of the enhanced review process, NJ CP&P conducts reviews at the initial five months of placement of a child, known as the five month enhanced review or regional review. Other reviews both internally as well as through the Child Placement Review Boards and the Court System occur throughout the life of a litigated case. These include the pre-placement conference which is held with parents/caregivers and other interested parties within the first 72 hours of a child's placement into out of home care. This begins the engagement process as well as provides an opportunity for full disclosure. Discussion of ASFA timeframes as well as permanency planning begins. Interval 30 day and 90 day staffing reviews are held with case management staff to review case plan goals, family assessments and other tasks identified.
The 5 month enhanced regional review is conducted by the Regional Reviewer. This is a formal Administrative Review Process which includes case management staff, parents/caregivers, the child if age appropriate and any other interested parties and is facilitated by an impartial 3rd party CP&P representative. The focus of this review process includes but not limited to:

- The welfare and safety of the child
- Discussion of the need and continuing need for placement
- Review compliance with case plan and progress made to alleviate or remove the causes necessitating placement.
- Review of visitation schedule/plan
- Review of the date by which return home might be expected or other appropriate permanency planning

Comprehensive Administrative Placement Review policy guidelines can be found at: http://www.state.nj.us/dcf/policy_manuals/CPP-IV-A-3-250_issuance.shtml

Once the review is complete, it is documented by the regional reviewer in NJS and approved through electronic supervisory review and approval. It is from NJS that we glean our performance progress as indicated in figure 29 which illustrates that for a 12 month average, 97% of 5 month enhanced regional reviews were completed.

Figure 29



- **Item 22- Case review process that ensures that for each child, a permanency hearing in a qualified court or administrative body occurs no later than 12 months from the date the child entered foster care and no less frequently that every 12 months thereafter.**

NJ CP&P as well as the Court system understand the need for timely permanency for children in out of home placement. One area to ensure that permanency outcomes are being achieved within ASFA timeframes is the 12 month permanency hearing. Data reports from NJ Judiciary Court Management April 2015 shows a caseload profile timeline of permanency hearing compliance from July 2013 to June 2014. During this time frame there were 8,329 total pending cases of which 100% were in the accepted normative case-processing time frame of 12 month permanency hearing. There 35 backlog cases were identified that did not meet the permanency hearing timeframe; however this is -5% of the total and therefore is not statistically significant. This data shows that NJ child protective services as well as NJ courts continue to make

permanency planning a priority for children. For the data report please review: http://www.judiciary.state.nj.us/quant/

- **Item 23- The state provides a process for termination of parental rights proceedings in accordance with the provisions of the Adoption and Safe Families Act.**

NJ does have a process for termination of parental rights proceedings. Timely action on the provisions of ASFA is a shared priority both for DCF as well as the NJ court system. The NJ CFSR data profile over the last five FFY under Measure C2-4, Children in care 17+ months achieving legal freedom within 6 months highlights this priority as NJ has exceeded both the national median of 8.8% as well as the 75th Percentile of 10.9% each year:

- FFY2009: 11.8% (Data Profile of 8/26/11)
- FFY2010: 17.0% (Data Profile of 5/28/13)
- FFY2011ab: 14.1% (Data Profile of 3/21/14)
- FFY2012ab: 18.4% (Data Profile of 3/21/14)
- FFY2013ab: 16.3% (Data Profile of 3/21/14)

This data is mirrored under Item 6 Figure 11.

- **Item 24- Case review process to ensure that foster parents, pre-adoptive parents and relative caregivers of children in foster care are notified of, and have a right to be heard in any review or hearing held with respect to the child.**

As reported in item 21, within CP&P the Administrative Regional Review is a process in which foster parents, pre-adoptive parents and relative caregivers are notified with respect to the child in their care. In preparation for the internal 5th month regional review, the regional reviewer will have notices sent out two weeks in advance to all pertinent parties to include all resource caregivers.

Once a child enters out of home care, the CP&P Child Placement Review (CPR) coordinator notifies the court and Child Placement Review Board (CPRB) of the child's placement information and the judiciary database will generate notifications of CPRB as well as other judiciary hearings/reviews to include resource caregivers. As reported in the State Court Improvement Program 2014 Annual Self-Assessment Report, FACTS reengineering enhancement is underway which will include the capability to notice all parties electronically to include email transmission notification to all participants.

Quality Assurance System

- **Item 25- The state has developed and implemented standards to ensure that children in foster care are provided quality services that protect the safety and health of the children.**

In 2014 DCF began the implementation of a multi-year needs assessment that focuses on identifying the strengths and needs for children and youth in out of home placement through the Division of Child Protection and Permanency (DCP&P) as well as for children at risk of entering out of home placement. The focus of the DCF Needs Assessment is narrow in scope in order to have the ability to delve deeply into areas identified through a mixed-methods approach to gathering and assessing information from a variety of sources. This needs assessment will not only provide the data for DCF to understand the needs of children, youth, and families, but will prioritize needs for implementing actionable change to enhance the current service array. Using data to drive the focus of the needs assessment will ensure that the results and recommendations are germane to the geographic area and subpopulations subject to the needs assessment.

DCF will collaborate with stakeholders including youth in care, families, external providers (i.e. court system, service providers, etc.), other key community informants, and internal staff members to create a responsive approach that focuses on the safety, permanency, and well-being of children and youth in out-of-home care and families with children at risk of placement. The goals of this needs assessment are to:

- Identify and prioritize the placement and service needs (as identified by the family-serving professionals) and the service demands (as identified by families themselves) of the target population;
- Identify and evaluate the current service array within DCP&P through contracted and community based resources focusing on the availability, accessibility, utilization, and quality of services;
- Identify gaps in services and placement resources needed to support children in out-of-home placement and their families;
- Partner with external stakeholders to develop targeted, prioritized recommendations based on the findings of the needs assessment;
- Provide recommendations to DCF leadership to enhance and/or develop services to improve the permanency, safety, and well-being of children and youth in out of home placement or at risk of placement and their families.

While professional assessments for services are needed to account for underlying needs and the presenting behavior, DCF recognizes the importance of the family voice in determining their needs and acknowledges that there may be differences between that family voice and the assessment of family needs from the professionals working with the family.

An internal DCF workgroup is responsible to carry out the DCF Needs Assessment planning, implementation, recommendation, and follow-up. This internal workgroup is comprised of leadership from across the Department with authority to ensure discussions are productive and decisions are made timely. In an effort to better collaborate and receive feedback from stakeholders, the creation of an external stakeholder board is imperative. This group will be comprised of a broad range of individuals representing community based agencies, the court system, families, youth, and other key participants from all three regions. This board will be charged with reviewing, interpreting, and validating findings from the DCF Needs Assessment and working with DCF's internal workgroup to formulate recommendations for action. Recommendations will then be incorporated into a final report and utilized by DCF's internal workgroup to strategically plan regional or local service improvements and, when appropriate, statewide enhancements.

While the external stakeholders function as an intermediary that ensures community feedback is incorporated, it is the internal workgroup that is accountable to ensure appropriate and meaningful steps are taken to strengthen the overall system.

Since the DCF Needs Assessment is designed to identify the placement and service needs for children and youth in out of home settings, as well as service demands of at risk families, the process must be positioned to identify local variation among needs. In order to address the array of service needs across the state, DCF has divided the state into three regions (North, Central, and South) focusing on one region each year over a three-year period to ensure each region is assessed every three years.

The DCF needs assessment takes a systematic and comprehensive approach based on the framework outlined by McKenzie, Neiger, and Thackeray (2012) in Planning, Implementing, and Evaluating Health Promotion Programs. DCF's needs assessment includes four phases including I) gather, analyze and summarize existing data available across a variety of quantitative and qualitative data sources; II) collect and analyze new data from stakeholders to identify and prioritize needs across specific subpopulations; III) identify and evaluate current services; and IV) validate needs identified and make recommendations. By utilizing this robust, mixed-methods approach, DCF can expand its reach and understanding of current service needs, existing services, and gaps.

The first phase of the needs assessment has been implemented and included activities such as:

- **Review of DCF Reports and Assessments**: Evaluative reports and assessments completed by DCF from 2008-2014 were subjected to a content analysis to identify common elements of child and family need encountered across the service domains of DCF. Interviews with stakeholders, case file reviews, and secondary data included in the review of reports and assessments converged around the finding that community adversity is a major impediment to achieving permanency and a major factor in determining if a family will become involved with the child welfare system. Specifically, families were reported as having difficulty with acquiring safe, stable housing; accessing consistent, affordable transportation; locating employment and vocational opportunities; and affording food. Additionally, the availability of social services was listed as a need for families, including mental health care, substance abuse treatment and child care. Other major themes highlighted in the materials focused on the need for stronger engagement and teaming with families and identification of the broader array of available supports; greater communication regarding policy and practice changes with resource parents, as well as training and support for parenting challenging youth and more comprehensive transition planning for all older youth.

- **Identification of Existing Data Sources**: Existing sources of data were identified to begin the process of defining the needs that families have when they present to DCF and New Jersey's service array for vulnerable children and families. These data sources include:
    1. New Jersey's Statewide Automated Child Welfare Information System (NJ SPIRIT);
    2. Children's System of Care (CSOC) behavioral health care data;
    3. Division of Family and Community Partnerships' Community Program Directory;
    4. DCF County Needs Assessment Service Inventories;
    5. NJ Department of Mental Health and Addiction Services' Directory of Mental Health Services;

6. DMHAS Addiction Services Treatment Directory; and
7. United States Census.

The United States Census' American Community Survey was used to establish the geographic distribution of the major socioeconomic and community risk factors identified in the review of existing DCF reports and assessments. This information will be paired with data from NJ SPIRIT and the service array to identify gaps and/or overlaps in the services that address the needs of children and families.

- **Formation of Internal and External Workgroups**: The Internal and External Workgroups will provide critical guidance as the Needs Assessment process goes forward. The Internal Workgroup met in early December 2014 to detail the mission of the group and establish a meeting schedule for 2015.A sub-group of the Internal Workgroup has been meeting weekly since August 2014 to guide the initial NJ SPIRIT data extract to be used in the Needs Assessment and identify the sources of existing data discussed above. This group will continue to meet weekly as the Needs Assessment unfolds and is responsible for carrying out the tasks necessary to produce analysis and deliverables for the project. Lastly, the External Workgroup first met in January 2015 and is comprised of individuals from around New Jersey, including representatives from community-based agencies, the court system, families, youth, and other key stakeholders. These individuals will provide feedback on needs and service priorities. DCF has begun to solicit participation from stakeholders and the Internal Workgroup will monitor and facilitate the formation of the External Workgroup.

For a comprehensive review of the DCF Needs Assessment as well as the Interim Report please see: http://nj.gov/dcf/childdata/continuous/index.html

Staff and Provider Training

- **Item 26- Initial training is provided to all staff who deliver services pursuant to the CFSP that includes the basic skills and knowledge required for their positions.**

Through the Office of Training and Professional Workforce Development (OTPWD), DCF provides a comprehensive initial training program for staff that promotes best practices of child welfare and better outcomes for children and families.

Pre-Service training is 180 hours of training that includes training on intake, assessments, community resources, Genograms, child passenger restraint and the critical components of the case practice model. All workers are enrolled within two weeks of their start date. Competency exams are completed by all new case-carrying workers. The Pre-Service training curriculum is centered on the new case practice model that includes family and community engagement. The Pre-Service training consists of 31 classroom days and 24 field days dispersed throughout the curriculum. The Pre-Service training also includes simulation exercises that provide trainees with a realistic setting to conduct interviews with parents, medical staff, and other child welfare professionals.

Additional training for new staff includes:

Concurrent Planning: Through the School of Social Work at Rutgers University, DCP&P staff are trained in concurrent planning methods, which optimize caseworkers' skills and ability to simultaneously work toward family reunification while also ensuring timely adoption, if the courts so move. The 18 hours of training are offered in a classroom setting.

Supervisory Practices in Child Welfare: Supervisory Practices in Child Welfare was developed to train newly promoted employees. It offers 14 days of combined classroom and field Supervisory training followed by competency assessments. The training is divided into 3 modules which are Self-Management, People Management and Casework Management.

Immediately following their pre-service training, 26 days of training for newly hired CP&P employees are offered within their first year of service which includes the following in-service foundation courses:

- *Case Practice Module 1: Engaging Families and Building Trust-Based Relationships* (3 Day Course)
  This introduction to the guiding principles of DCF Case Practice focuses on engagement skills as the initial step in this strengths-based, family-centered model of practice. Concepts and strategies promoting respect, genuineness, empathy, and trustworthiness will be presented and further discussed. Skills that foster trust-based relationships with children, families, and communities will be highlighted and practiced. In addition, tools and techniques to identify the needs and strengths of the family will be illustrated through case studies.

- *Case Practice Module 2: Making Visits Matter—Home Visiting to Improve Safety, Well-Being, Stability, and Permanence for Children and Families* (3 Day Course)
  Today's changing child welfare practices focus strongly on the relationships with the child, family, or substitute caregiver(s) as well as the family's informal and formal supports. Skills needed to make the visit effective for information gathering and decision making will be presented so that participants will be better able to define the family's needs, the potential of all team members, and the support of all involved systems. Learning how to use the principles of the practice model in getting to know each family will be a central point in this workshop. Methods to achieve the four outcomes (safety, permanency, well-being, and stability) will be further explored. Ways to connect/join with children, families, and their informal and formal support networks will be emphasized.

- *Child Sexual Abuse Training for Child Welfare Professionals: Module 1* (4 Day Course)
  This training prepares the child welfare professional for working with families in which children have been sexually abused. Module 1 offers days 1-2 (Course 31) and days 3-4 (Course 32) of this course to examine how participants' values, beliefs, and emotional responses can impact case practice; identify the facts and myths about child sexual abuse that are prevalent in our society; and discuss the historical context of child sexual abuse and its influence on present day beliefs. Participants will also be able to identify the many systems involved in child sexual abuse cases and differentiate between the specific roles and resources they offer, discuss the indicators of child sexual abuse within the context of

normal and problematic sexual behaviors, discuss the effects of child sexual abuse and recognize the need for specialized treatment, examine personal feelings and beliefs about the non-offending parent/adults in the family, and discuss the crisis of the disclosure and the impact on the family.

- *Child Sexual Abuse Training for Child Welfare Professionals: Module 2* Course # (4 Day Course)
  Module 2 offers days 1-2 (Course 33) and 3-4 (Course 34) of the child sexual abuse curriculum to guide the child welfare professional in exploring how personal values, culture, and gender impact issues surrounding child sexual abuse; recognizing implications within the context of domestic violence, language barriers, and immigration status; reviewing the immediate and long-term impact of sexual abuse on children; identifying effective treatment options and remediating treatment barriers; exploring the impact of sexual abuse on the non-offending parent and family members; helping workers recognize common characteristics and types of offenders; and exploring Meghan's Law and other components of the legal system. Participants will discuss specific investigative processes and interview procedures to utilize with children and family members while also learning about effects of vicarious trauma.

- *Concurrent Permanency Planning* is a three-day course that lays out the concepts and practice of permanency, beginning with an historical perspective of relevant legislation, the modified settlement agreement, and exploration of children's developmental needs. The specific permanency practice of concurrent permanency planning is then explored, including the concepts of prognostic assessment, diligent search, and full disclosure; and the emerging practices of birth parent/resource parent relationships and post-permanency communication. The training culminates with a module concentrating on permanency for youth beyond concurrent planning timelines.

- *Domestic Violence* (2 Day Course)
  Current information on domestic violence and applicable NJ laws to provide a framework for the basic assessment of risk and protective factors in families will be the focus of this workshop. Participants will learn about prevalence, correlates, dynamics, and common manifestations of domestic violence. The cycle of violence and the typical progression of an abusive relationship will be illustrated. Highlights of the workshop also include a discussion of the impact of culture on the experience of domestic violence, including culturally accepted behaviors and community responses. Techniques for assessing and responding to domestic violence will be explored, and laws of NJ that pertain to domestic violence will be clarified.

- *Domestic Violence Policy and the DCP&P Case Practice Protocol* (1 Day Course)
  This workshop is taught by a trainer and a domestic violence liaison. Supervisors will explore and discuss the Domestic Violence Protocol that guides DCP&P staff when responding to DV situations in families where child abuse/neglect is present. Assessment and management of DV cases will be the central focus of this workshop. The emphasis will be on promoting the use of available DV tools, remedies, and resources so DCP&P workers can effectively address DV issues in their caseloads. To conclude, methods will

be presented that supervisors can use to assess and develop the domestic violence skills of staff

- *Mental Health Screening Tool* (1 Day Course)
  This workshop is for non-clinical staff to learn to use the Mental Health Screening Tool for children with mental health concerns. Presentations will address the tool in the context of the effects of trauma on children's mental and physical development. The impact of trauma on the brains of children in foster care and the long-term effects of trauma will be examined. Participants will have an opportunity to practice using the Mental Health Screening Tool on case examples

- *Mental Health* (1 Day Course)
  A basic overview of a variety of serious mental illnesses will start this workshop. Participants will learn to recognize "red flags" that may indicate an adult may not be able to safely and effectively care for a child because of a mental illness. Resources in the mental health system and how to use them to create a safety net will be highlighted. Participants will develop skills in helping the adult who is suffering from a mental illness to care for the child (ren) in a safer and more effective manner.

- *Substance Abuse 1: Understanding Substance Abuse and Child Welfare* (Day 1)
  The goal of this first module is to provide child welfare professionals with a contextual knowledge of the effects of substance use and/or abuse that may be experienced by parents involved in the child welfare system. This module discusses the importance of using a family-centered approach to identify and respond to the variety of needs experienced by the entire family. This module will also discuss the prevalence of substance use (alcohol and other drugs), mental health disorders, and many other issues that may coexist for child welfare-involved families. The prevalence of mental health and substance abuse in New Jersey and the differential impact of these issues from a gender and race/ethnicity perspective will be highlighted.

- *Substance Abuse 2: Substance Abuse Disorders, Treatment, and Recovery* (Day 2)
  The goals of this second module are to inform child welfare professionals about the substance use disorder, treatment, and recovery needs of child welfare-involved families that can be used in the context of home visitation and case management. This module provides an explanation of the treatment and recovery processes, and it discusses the specifics on how substance use disorders can affect the interpersonal relationships and family dynamics of the family involved with the child welfare system in the context of safety, permanency, and well-being of children

- *Substance Abuse 3: Mental Illness* (Day 3)
  This third module aims to increase the child welfare worker's recognition of the differences between mental health disorders and substance use disorders in adults; explain symptoms that warrant comprehensive screening and assessments; define the different models of treatment for co-occurring disorders; and identify how these disorders affect interpersonal relationships and family dynamics of the family involved with the child welfare system in the context of safety, permanency, and well-being of children.

- *Substance Abuse 4: Case Planning* (Day 4)
  The purpose of this fourth module is to make child welfare workers aware of the various ways in which children are impacted by their parents' substance use and/or mental disorders, including co-occurring disorders, from prenatal exposure through childhood and adolescent development. This module discusses the importance of screening and assessment for a child's own alcohol, drug, and mental disorders that may or may not be a result of their parents' personal issues. The importance of delivering culturally competent services and collaborating with other service providers in developing and monitoring case plan progress will also be emphasized. Participants will also be provided with techniques for gathering and incorporating information about an individual's or family's substance use, mental health, or co-occurring disorders and treatment into the case plan.

- *First Responders in Child Welfare (Child Protective Services Intake):*
  The First Responders in Child Welfare training has been developed and incorporated into the Pre-Service program. The First Responders in Child Welfare training is also offered as a stand-alone training to existing intake case carrying staff. During 2012, this course was expanded to 3 modules or six days or 36 hours. First Responders in Child Welfare is a training program designed to enhance investigator's required skills in the areas of family engagement; communication/interviewing; assessment; documentation and investigation.

- *SDM/Safety and Critical Thinking:*
  This is a 2 day in-service program focusing on safety assessments using structured decision-making, and the creation of safety plans. Training includes instruction on how to recognize and respond to safety issues, and procedures to follow to ensure the safety of the child(ren). A competency exam is administered at the end of the course.

- *Documentation for Child Welfare Professionals:*
  This two-day in-service program covers the fundamentals of grammar rules typically involved in documentation narratives, and instruction and practice in summary recording. The program teaches how to determine relevant content for case narratives, and how to capture it in writing with clarity, accuracy and conciseness.
- *Cultural Competency:*
  This two-day in-service program discusses the influences of culture, assumptions and biases on case practice, and what it means to be culturally competent. Instruction on the importance of cultural competence when working with the LGBTQI community is also provided.

- *SPRU Worker Training:*
  This three-day program provides instruction to Special Response Unit (SPRU) workers on policy and practice in responding to child protective services referrals during evenings, weekends and holidays. Instruction includes the use of internal agency policies on after-hours response..

- *NJ Spirit:*
  The New Jersey Child Welfare Training Academy trains new and seasoned workers on the automated case management tool that supports case carrying workers' child protection, foster care, and adoption practice work. Training includes instruction on how to navigate the computer system and how to develop and maintain automated records management, case planning, service planning and data tracking. Since January, 2009, more than 3,000 staff (3,294) received NJ Spirit training.

- *Adoption Subsidy Training:*
  This is a 3 hour workshop offered to all adoption staff to explore in detail at what is involved in meeting the requirements of the Adoption Subsidy Program. Presentation is focused on Adoption subsidy policy/procedures and skills related to pre-finalization approval through post-finalization case completion.

- *Working With and Supporting Families:*
  This 3-day training focuses on introducing Assistant Family Service Worker staff (a.k.a. case aides) to the skills and concepts needed to effectively work with and support families involved with DCP&P.

- *DCP&P Case Practice and the Domestic Violence Protocol:*
  This course will provide a brief review of domestic violence dynamics, as well as information on the Domestic Violence Protocol adopted by the agency in 2009. Instruction includes how to respond to families experiencing domestic violence, statutory requirements, DCF guiding principles and goals, the application of DV Protocol standards within the DCP&P Case Practice Model.

- *Case Planning for Case Planning With Youth, Children and their Families*
  This interactive mandatory class has two components: an online class and two day classroom training. The online course informs caseworkers about the NJ Spirit enhancements to the Case Plan. In addition, everyone is to complete the online before attending the two classroom training.
  The purpose of the two day classroom training is to help staff continue to functionalize the skills learned during the Case Practice Model trainings. The revised Case Plan document was created to reflect ongoing efforts to relate to families, to address their underlying needs, and to share decision-making authority with them.

  The classroom training will address the process that caseworkers, families, and youth follow in developing a Case Plan that captures the family's Case Goal and the incremental steps made during the life of the case.

  In-class demonstrations will model how monthly visits and Family Team Meetings can be used as opportunities to create and update a family agreement. Participants will think about and prepare for each section of the Case Plan such as the Case Goal, Family Summary, Strengths and Needs, Family Agreement (new tab), Visitation, and Educational Stability.

- *Immigration Training Day 1*
  The goal of this day one of a three day training (each day is an independent module) is to increase child welfare workers understanding of the importance of working together with indigenous family and community structures when serving refugee and immigrant children. Module 1 will offer an overview of Immigration and Child Welfare, which will include knowledge about the various statuses of immigrant families in this country and knowledge about national laws and state policy regarding immigrant and refugee families, their rights and applicable services.

- **Item 27- The State provides for ongoing training for staff that addresses the skills and knowledge base needed to carry out their duties with regard to the services included in the CFSP.**

After the first year and annually thereafter, staff are required to complete 40 hours of in-service training per calendar year. In partnership with Rutgers University, Montclair State University and the Richard Stockton College, the OTPWD offers over 167 training courses on a variety of relevant topics for all staff levels.

In addition, the OTPWD continues to sponsor the Baccalaureate in Child Welfare Program (BCWEP) that provides a two-year post-graduation employment opportunity for graduates with DCF; MSW program that allows for staff to continue full time employment while pursuing an advanced degree as well as a Child Advocacy Certificate Program to enhance child advocacy knowledge and skills of staff.

For a comprehensive list of Staff Development training please see Attachment D: Updates to the Training Plan

- **Item 28- Training for current or prospective foster parents, adoptive parents, and staff of State licensed or approved facilities that care for children receiving foster care or adoption assistance under title IV-E that addresses the skills and knowledge base needed to carry out their duties with regard to foster and adopted children.**

All resource parents whether prospective or current are afforded a plethora of training that addresses and enhances the skills and knowledge necessary to carry out their duties regarding the children entrusted in their care.

All potential Resource Families complete PRIDE Pre-Service training. This training program is designed to strengthen the quality of resource and adoption services by providing a standardized, consistent, structured framework for the competency-based recruitment, preparation, and selection of foster and adoptive parents. This program offers a competency-based, integrated approach to recruitment, family assessment, and pre-service training. Through a series of at-home consultations and competency-based training sessions, prospective families have an opportunity to learn and practice the knowledge and skills they will need as new foster and adoptive parents. The readiness of families to foster or adopt is assessed in the context of their ability and willingness to meet the essential competencies. This training is facilitated by trainers

in the Resource Family Support Units and is usually co-facilitated by a seasoned resource parent. This pre-service training course consists of 27 training hours and 9 modules.

For perspective kinship resource parents, the option if available is an 18 hour standardized training geared specifically for the needs of relatives. The Traditions of Caring training can be completed in lieu of PRIDE, however the successful completion of one training program is required prior to the issuance of a license by the Office of Licensing as part of the completion of the home study process.

In collaboration with the NJ Foster and Adoptive Family Services (NJFAFS), resource parents are afforded many training opportunities and supportive services to ensure they meet and maintain the licensing standards. Upon licensing approval, all primary resource parents must complete 7 training hours annually or 21 hours over a 3 year licensing cycle. Secondary resource parents must complete 5 training hours annually or 15 hours over a 3 year licensing cycle. All training opportunities, whether they are county based workshops, home correspondence courses, online training or webinars are free for all New Jersey licensed resource families. The multitude of training topics are designed to assist resource parents in meeting the special needs of the children placed in their care.

For a comprehensive list of training opportunities please see Attachment A- Updates to the Foster and Adoptive Parent Diligent Recruitment Plan

Training for staff of State licensed or approved facilities that care for children receiving assistance under Title IV-E are outlined within the Licensing Regulations Manuals for the specific population served.

Service Array and Development

- **Item 29- The State has in place an array of services that assess the strengths and needs of children and families and determine other service needs, address the needs of families in addition to individual children in order to create a safe home environment, enable children to remain safely with their parents when reasonable, and help children in foster and adoptive placements achieve permanency. The services in item 35 are accessible to families and children in all political jurisdictions covered in the State's CFSP.**

NJ continues to expand on its existing comprehensive array of services to address the needs of children and families. This includes services that are delivered both publically and privately. NJ DCF organizes the service array under several divisions or offices depending on the identified service need while acknowledging that families may require a multitude of services.

The Division of Child Protection and Permanency provides services that focuses on four prongs: 1. Investigation and Assessment of child abuse and neglect or welfare services; 2. Out of home placement services when necessary; 3. Family support services for both intact families as well as for those whose children have been separated and finally 4. Permanency services to include

reunification, adoption, Kinship Legal Guardianship as well as transition to independence services for adolescents.

The Division of Family and Community Partnerships (DFCP) administers community-based child abuse prevention and intervention programs that are culturally competent, strengths-based, and family-centered with a strong emphasis on child abuse prevention. These services include Early Childhood Services which focus on children under 6 years of age. Some of the services under Early Childhood Services include but are not limited to home visitation, healthy families, NJ Strengthing Families Initiative and the Children's Trust Fund. School-linked services also fall within DFCP which include programs such as school based youth services, Family Empowerment Programs, Adolescent Pregnancy Prevention Initiative and NJ Child Assault Prevention Project to name a few. Other services include family support services and Domestic Violence services as well.

There continues to be service integration within as well as across counties statewide and DFCP works with local entities and organizations, such as the Task Force on Child Abuse & Neglect Prevention Subcommittee; Child Welfare Agencies and Human Service Advisory Councils to create a network for planning, prioritizing, and implementing effective prevention efforts that are county-focused and county-driven. All DCFP services can be found on the directory at:
http://nj.gov/dcf/families/dfcp/DFCPDirectory.pdf

The Children's System of Care (CSOC) provides comprehensive mental health, behavioral health services to children and adolescents experiencing challenges in those domains. CSOC also services children with developmental and intellectual disabilities. All services are family centered and community based with one central statewide point of entry through Perform Care. Services include but are not limited to Mobile Response and Stabilization Services; Residential Services; Family Support Organizations; In-Community Behavioral Assistance; Care Management Organizations and Youth Case Management. Comprehensive service description can be found at:
http://nj.gov/dcf/families/csc/index.html

The Division of Women (DOW) funds, monitors and evaluates programs for the advancement of women in the state of NJ. DOW oversees services to include the Sexual Assault Direct Services, Sexual Assault Prevention Services and Displaced Homemaker services. In addition, DOW develops and analyzes policies that affect women as well as advance new programs to better serve this population. DOW is a lead agency to advance public awareness and promote discussions surrounding critical issues to the women of New Jersey while collaborating with other state departments to address these issues and concerns. More comprehensive information and services under DOW can be found at:
http://nj.gov/dcf/women/

The Office of Adolescent Services (OAS) is a robust service system that provides services and supports to NJ youth. Some of these services include but are not limited to safe and stable housing, transportation, job training and education, financial stability, life skills and other training to promote positive development, physical and mental health care, connections to caring

adults to assist with life decision and provide emotional support, engagement activities in programs and communities, and preparation for economic self-sufficiency, interdependence, and healthy life-styles. These services are available to youth up to 21 years of age. For a more comprehensive overview of the services and programs offered through OAS please go to: http://nj.gov/dcf/adolescent/

Other direct services can be seen in several sections throughout this submission. For instance, Section 4B comprises those services to populations at the greatest risk of maltreatment including primary, secondary and tertiary prevention services. Section 13 contains the CAPTA State Grant programs which include community based Child Abuse Prevention programs. Section 2E reports on the CAPTA Child Protection Substance Abuse Initiative Program services. Section 4A contains all of the services under Promoting Safe and Stable Families which include Family Preservation Services, Family Support Services, Time-limited Family Reunification Services and Adoption Promotion and Support Services. Section 12 describes services that are available to all NJ youth and young adult population up to age 21. These services include Chafee funded services, services to the LGBTQ population as well as Youth Advisory Boards.

NJ understands that services not only have to be of quality and relevance to the needs of children and families, they also have to be readily accessible. NJ has made tremendous strides in expanding the populous of service provision across the state to meet the ever growing needs of the families to which it serves. The expansion of accessible services includes the availability of Family Success Centers in all 21 counties in the state. These comprehensive centers provide services to between 3-4,000 children and families per month. Services previously under the Department of Human Services have been realigned under DCF to provide a seamless system of care for children and youth with developmental needs, behavioral health needs, addiction service needs as well as the provision of services where child abuse and domestic violence co-exist.

As an ever evolving organization, NJ DCF understands the need to continue to evaluate and monitor the services available and has begun the process of a statewide Needs Assessment. See Item 25 for additional information on the Needs Assessment.

- **Item 30- The services in item 29 can be individualized to meet the unique needs of children and families served by the agency.**

In order for services to be individualized to meet the unique needs of children and families, there needs to be an overall understanding and assessment of what those needs are as well as engagement with families to provide them an opportunity to identify what services will best suit their needs. Once these needs and services are identified, they should be memorialized in a family centered plan that is custom to each individual.

The NJ QR process examines the array of services and supports to ensure that they are not only sufficient, readily available and culturally appropriate but that they are also individualized. As reported in Item 12, for CY 2014 the Resource Availability indicator was rated as a strength with an average of 88% Strength Rating- this is a 6% increase as compared to CY2013. Out of 15 counties reviewed, 14 of them had a strength rating, emphasizing that NJ is on the right path in

matching children and families to accessible services and resources. In addition, as indicated in Item 12, the Overall Assessment Indicator as well as the Family Supports Overall Indicator was both identified as strengths statewide for CY 2014.

Agency Responsiveness to the Community

- **Item 31- Engagement in ongoing consultation with tribal representatives, consumers, service providers, foster care providers, the juvenile court, and other public and private child- and family-serving agencies and includes the major concerns of these representatives in the goals and objectives of the CFSP.**

NJ engages in ongoing consultation at many levels with pertinent stakeholders to assist, inform and guide the critical work of ensuring the safety, permanency and well-being of the children and families that are served. DCF embarked on a developing a comprehensive strategic plan over the past several years. This comprehensive process included the input and recommendations of many stakeholders to include community partners, child welfare system partners, service providers, Citizen Review Panels, parents, resource parents and youth to help guide and steer the course for DCF. Through formalized engagement opportunities and informal consultations, this ambitious process took over a year to complete and helped spawn the 2014-2016 DCF Strategic Plan. It is a natural progression that the DCF Strategic Plan influence the 2014-2019 Child and Family Services Plan. The CFSP contains core strategies that are aligned with the DCF strategic plan and mimic the goals and objectives necessary to carry out the principles of the Mission, Vision and Priorities of DCF.

Each year NJ DCF develops and produces an Annual Progress and Services Report pursuant to the CFSP in consultation with the system partners through formal and informal meetings. Meetings include but not limited to the Citizen Review Panels, the Administrative Office of the Courts, County Human Service Directors, NJ Association of Mental Health and Addiction Agencies (NJAMHAA), NJ Alliance for Children Youth and Families as well as statewide Youth Advisory Board meetings. These meetings are the host to illicit input on the progress and areas needing improvement to better promote better outcomes for children and families across the state.

The Children's Interagency Coordinating Council (CIACC) is a platform that fosters cross-system service planning for children with behavioral health problems.

CIACCs serve as the mechanism to develop and maintain a responsive, accessible and integrated system of care for children with special social and emotional needs and their families, through the involvement of parents, consumers, youth and child serving agencies as partners. CIACC reports are posted monthly and give an overview of the statewide as well as individual county activities. They can be viewed at: http://nj.gov/dcf/childdata/continuous/index.html

In recognizing the need for prevention partners to work together, many stakeholders, including parents, caregivers, community advocates, providers, and public and private partners, participated in the development of the Supporting Strong Families and Communities plan. This strategic plan provides an overview of child maltreatment as a public health concern and opportunities for improving prevention efforts. Most important, as a living document, it provides

a shared vision, strategic goals and strategic objectives to guide prevention efforts in New Jersey, 2014 through 2017. Stakeholders included:

- Seven-hundred and forty-seven (747) individuals who participated in interviews, focus groups and on-line surveys; 62% were parents and 30% were providers and community advocates
- Members of the Prevention Committee of the New Jersey Task Force on Child Abuse and Neglect and community leaders representing advocacy organizations, human services, education, health, behavioral health, substance abuse treatment, domestic violence, labor, agriculture, universities, and foundations
- Senior leadership from the New Jersey Department of Children and Families including the Commissioner and representatives from the Divisions of Family and Community Partnerships, Child Protection and Permanency, Children's System of Care, Office of Adolescent Services, Performance Management and Accountability, and Communications and Public Affairs

This plan is intended to be a high-level guide to be used as a vehicle for promoting community dialogue, problem-solving and planning at the statewide and local levels. This plan as well as other collaborative consultative reports can be reviewed at:
http://nj.gov/dcf/news/reportsnewsletters/taskforce/njtfca_reports.html

As an agency moving towards transparency, relevant information is available on the DCF Public site to include data as well as DCF policy and practice procedures which was made public in July 2014. All policy can be viewed at: http://www.nj.gov/dcf/policy_manuals/toc.shtml

- **Item 32- The State's services under the CFSP are coordinated with services or benefits of other Federal or federally assisted programs serving the same population.**

The identified Divisions and Offices under DCF encompass a vast array of services under one umbrella, promoting easier coordination and collaboration. Services that do not fall within the DCF family are coordinated at the Community Level through ongoing communication and collaboration. This can be in the form of formal or informal collaborative mechanisms such as meetings, educational opportunities and partnerships. NJ continues to increase the opportunities to engage in collaborative efforts with the many services at the individual case, interagency and community levels as well as other federally assisted programs. Many of those services and programs can be reviewed on the DCF Public Site at: http://nj.gov/dcf/ . The following is a sample of the coordinated benefits with other federally assisted programs.

In SFY14, with the use of state and TANF funding DCF was able to support 37,762 students through the School Based Youth Services Program (SBYSP). This program blends healthy youth development and counseling to engage students in an effort to support and strengthen their ability to successfully graduate healthy and drug free.

DCF was able to assist over 500 expectant and parenting teens (including strategic focus to young fathers) with funds from state, federal Temporary Aide to Needy Families (TANF) and

ChildCare Block Grant (CCBG) as well as grant assistance through Pregnancy Assistance Fund (PAF) grant from the United States Department of Health and Human Services.

DCF was able to assist 2024 students through the use of TANF funds to support the Adolescent Pregnancy Program (APPI). The goal of APPI is to reduce the birth risk of adolescent boys and girls that are most at risk of adolescent pregnancy.

DCF, in partnership with the Department of Human Services (DHS), worked to identify housing subsidies and service dollars to support a Keeping Families Together (KFT) pilot in Essex County, New Jersey over the course of FY 2015. The goal of KFT is to improve outcomes for children by providing a secure place for families to live in an affordable, caring, supportive setting. Families are provided with the necessary support and guidance to manage their lives and improve well-being. Children benefit from supportive and stable communities, positive adult role models, and stronger family units. In supportive housing, parents are able to enhance their capacity to provide a safe and stable home for their children.

In October 2013, DCF was one of 18 jurisdictions to receive a YARH Federal Planning Grant award. This project is led by DCF's Office of Adolescent Services (OAS), working in partnership with three national organizations: the Center for the Study of Social Policy (CSSP), Child Trends, and the Corporation for Supportive Housing (CSH). The YARH grant is being used to fund the development of strategies to reduce and prevent youth in foster care from becoming homeless and to promote education/employment, permanency, and well-being outcomes specifically for young people who have experience in the child welfare system. These strategies aim to make system and practice level improvements in four areas: stable housing, permanent connections, education/employment, and social-emotional well-being. In the Spring of 2015, DCF will apply for five year implementation funding in order to carry out these strategies and solutions to end homelessness for youth in foster care.

Foster and Adoptive Parent Licensing, Recruitment and Retention

- **Item 33- Statewide standards are applied to all licensed or approved foster family homes or child care institutions receiving title IV-E or IV-B funds.**

NJ continues to implement and maintain standards for resource family homes, regular, kinship as well as adoptive homes and child care institutions in accordance with recommended national standards. These standards are established through policy, regulations and statutes that govern the licensing, approval and maintenance of all resource, adoptive and child care institutions. The Office of Licensing which is the governing entity for DCF regulates and licenses all resource homes to include regular, kinship and adoptive homes as well as all child care institutions, residential and other youth placement programs and all adoption agencies.

Licensing standards are codified through NJ Administrative Codes as well as NJ State Statutes and can be reviewed at:

http://www.state.nj.us/dcf/providers/licensing/laws/

At a minimum, licensing regulations require all resource and adoptive homes, adoption agencies, child care institutions as well as residential and other youth placement programs to meet and successfully complete the following:

- Criminal Background History Investigation (CHRI) check for both state and federal
- Child Abuse and Registry Investigation (CARI) check
- Pre-service and annual training credit requirements
- In person on site life/safety inspection/evaluation of physical location
- Homes study for resource and adoptive homes

- **Item 34- The State complies with Federal requirements for criminal background clearances as related to licensing or approving foster care and adoptive placements and has in place a case planning process that includes provisions for addressing the safety of foster care and adoptive placements for children.**

DCF continues to meet and comply with state and federal requirements for criminal background clearance as related to licensing or approving foster care and adoptive placements and has in place a case planning process that includes provisions for addressing the safety of foster care and adoptive placements for children. Thorough criminal background checks for every applicant and every adult household member over the age of 18 are required prior to the licensing and approval of any resource or adoptive home. Criminal checks include:

- Local Police checks for every address listed in the previous 5 years
- Human Service Police checks to include Domestic Violence Registry
- Promis Gavel check which is an automated criminal case tracking system through the Administrative Office of the Courts
- State and federal fingerprinting

In addition to the home study and licensing process to ensure the safety and well-being of children in placement in resource and adoptive homes, there is case planning processes in place as well. Upon the initial placement of a child in an approved licensed resource or adoptive home a safety assessment is completed within 5 days of placement. If the child(ren) is placed in a kinship home on an emergent basis, criminal backgrounds checks as well as a safety assessment are completed immediately prior to the approval of the placement under presumptive eligibility. The kinship home must then complete all licensing requirements within the regulated time frame. Safety assessments are to be completed during every caseworker/child visit. For placements in congregate care settings, the congregate care safety questionnaire is completed within one month of placement and every 6 months thereafter. Safety as well as congregate care assessments is also completed during a child protection investigation by the Institutional Abuse Investigation Unit (IAIU), when following up with a Correction Action Plan after an IAIU investigation, during the annual re-evaluation and when a request is made for an exception to the population limitations of a home. Each resource and adoptive home is assigned a resource family support worker who inspects, evaluates, advocates and plans with the resource family. This includes the participation in the child(ren) case plan as well as family team meetings, participation in periodic administrative regional review process as well as the inclusion in the caregiver and child strength and needs assessments.

- **Item 35- Ensuring the diligent recruitment of potential foster and adoptive families who reflect the ethnic and racial diversity of children in the State for whom foster and adoptive homes are needed is occurring statewide.**

New Jersey remains committed to finding potential foster and adoptive families that reflect the cultural and ethnic diversity of the children in the State for whom out-of- home placements are needed, through our diligent recruitment efforts. We continue to be successful in our efforts to recruit foster and adoptive parents that not only reflect the ethnic and racial needs of children who require out-of-home placement but also meet the various needs and characteristics of our children. We are committed to maintaining our success through the implementation of innovative approaches along with retention efforts that will lead to positive outcomes for our children and families.

In FFY 2014, New Jersey continued its commitment to recruit potential families that are reflective of the racial and ethnic characteristics of children in out of home care. Our diligent recruitment efforts continue to be data driven, taking into account where families reside, where children in need of placement are coming from and where our current licensed families are located. This allows us to target our recruitment efforts in the neighborhoods and communities where children in need of out of home care reside.

Our successful efforts are reflected in the number of families licensed in CY'14 which was 1,424. This exceeded our 2014 target of 1,376 licensed families. This is a result of the diligent recruitment efforts that have been made statewide.

In FFY 2014, we implemented or continued the following statewide and local initiatives:

- Implemented a plan to bring recruitment staff under the direct supervision of the Central Office, Office of Resource Families
- Recruiters continue to use data driven methods to develop local targeted recruitment plans that determine geographic and subpopulations areas of need
- We continue to support and provide guidance to recruitment staff with the goal of continuously enhancing our recruitment efforts and developing effective strategies to reach the right types of families
- Continue the practice of bi-monthly Group Engagement orientations with inquiries in each County
- Continue the use of resource parent adjunct recruiters and youth recruiters for events and trainings to share their experiences as current resource parents and as a youth in care
- Continue to encourage current resource parents to help in recruitment by offering an honorarium program, travel reimbursement, and child care expenses to attend events and trainings
- In an effort to enhance the expertise of our recruitment staff, recruiters participated in workshops that addressed their ability to communicate more successfully, build coalitions and enhance their networking potential as well as strategies to break down communication barriers in the context of recruitment

- We also have worked to enhance their skills through exercises that improve their ability to engage, build relationships and team with others
- Accomplished the goal of phasing in the use of the market segmentation tool statewide
- Work diligently in our efforts to educate communities and develop partnerships with local organizations.
- NJ continues to emphasize and support local recruitment activities in the communities where children reside
- Continue working with the Human Rights Campaign's -All Children, All Families initiative
- Continued statewide development of partnerships with national and state organizations such as the RaiseAChildUS.org
- Actively make updates to the public website as policies, new initiatives and or practice changes
- Continue to support Child Specific Recruitment Activities for Adolescents and Waiting Children
- Continue to allocate funds for recruitment events, adjunct recruiters, and local advertisements from our statewide recruitment budget
- Continuously assessing and identifying needs of the local recruitment staff and implementing new tools to ensure their success in meeting local office objectives

In addition, we have continued our work with consultants at National Resource Center for Diligent Recruitment (NRCDR) at Adopt US Kids around Market Segmentation through onsite visits, teleconferences and via e-mail. With the assistance of the consultants at the NRCDR, We have been able to build our capacity to translate the data and use the information to better inform our recruitment efforts. As a result, our targeted recruitment efforts have become more strategic as we take into account lifestyle characteristics, population densities as well as the locations of where children in need of placement are coming from.

In FFY 2014, we implemented or continued the following statewide and local initiatives using Market Segmentation:

- We continue to use the lifestyle characteristics of our current successful families to drive our recruitment strategies in targeted communities
- Continue to update recruitment materials/publications that are customer centered and reflective of the lifestyle characteristics in our market segmentation tool
- Promotional Items will be purchased to reinforce the message that will be developed
- Use lifestyle characteristics to target advertising opportunities within local geographic areas
- Continue use of tracking tools for market segmentation outcomes and targeted geographic and subpopulation outcomes
- With the assistance of the NRCDR at Adopt US Kids, We are developing a method of analyzing data captured that is reflective of the impact of our recruitment efforts
- Recruiters continue to develop new partnerships with businesses/organizations as informed by the market segmentation lifestyle characteristics as well as maintain current relationships
- Participate in peer to peer calls with other States in an effort to learn from each other
- In collaboration with NRCDR at Adopt US Kids, we are developing a workshop for recruiters to more effectively translate Market Segmentation data using communication marketing techniques while out in the community

New Jersey has, for the past several years, focused and succeeded in building a robust pool of licensed families. Our success has allowed us to shift our focus on ensuring that we properly support and retain our current pool of licensed families while continuing to license the right types of families for our children in out-of-home care. Our goal being that it will lead to positive outcomes for both, our children and families. As a result, we requested and received assistance from the National Resource Center for Diligent Recruitment (NRCDR) at Adopt US Kids and have collaborated on developing our capacity to more effectively support all resource families. We have made progress in developing our plan.

In FFY 2014, we implemented or continued the following statewide and local retention initiatives:

- NJ developed a new methodology of identifying local needs that focuses on engagement and retention of current licensed families
- We continue to work with consultants from the National Resource Center for Diligent Recruitment at Adopt US Kids (NRCDR) on-site and through teleconferences
- NRCDR at Adopt US Kids conducted an on-site assessment that included facilitating discussions with staff in different areas of practice as well as licensed resource families
- NJ finalized a framework for retention based practices that will lead to a retention case practice plan and provide the structure to implement changes to policy and practice
- NJ Commissioned the Rutgers University School of Social Work to conduct a study on the perspectives of NJ resource families. The study focused on the experiences of resource parents to gain a better understanding of what are the causes of attrition from the foster care program
- We received the study conducted by the Rutgers University School of Social Work on resource families' perspectives which provided great insight into areas where we are enhancing our practice
- We are in the process of finalizing tools that will allow DCF to gauge family's perspectives regularly
- We are planning a kick off meeting with DCF leadership in the first quarter of 2015 to begin the process of exploring methods to develop a plan of action to implement changes that will strengthen our States ability to effectively retain our current pool of families
- We are developing a statewide taskforce that will include licensed resource families, youth and staff. This taskforce will drive the action steps that will ultimately lead to NJ's retention case practice plan

NJ is dedicated to developing effective strategies that can be implemented to recruit and retain foster and adoptive families that reflect the race and ethnicity of children entering care. We are also determined to continue implementing new and innovative ways of recruiting and retaining families that will result in positive outcomes for our children. We will continue to identify areas of need and work toward continually improving our performance.

- **Item 36- The State has in place a process for the effective use of cross-jurisdictional resources to facilitate timely adoptive or permanent placements for waiting children.**

Recruitment efforts through the use of the Interstate Compact Unit, the Adoption Resource Exchange as well as the Office of Adolescent Services and Office of Adoption Operations has successfully achieved permanency for all of the identified longest waiting teens. These recruitment efforts have been expanded and are utilized to facilitate timely adoptive and permanency placements for children who are currently legally free as well as those who are not yet legally free but who are in out of home placements that are not committed to providing a permanent home.

NJ continues to utilize the Adoption Resource Exchange to register legally free children so that families nationwide from other agencies can provide permanent homes. Children are registered through AdoptUSKIDS .org at:

http://www.adoptuskids.org/states/nj/index.aspx.

Recruitment efforts for permanency through AdoptUSKIDS.org include photo listing, profile production and media spots. These efforts allow for a wider audience of potential permanent candidates for the children of NJ.

NJ continues to be part of the Interstate Compact on Adoption and Medical Assistance (ICAMA) maintaining the delivery vital services for children and families who are relocated to another jurisdiction. Services include but are not limited to Medicaid and subsidy.

NJ also continues to be a member of the Association of Administrators of the ICPC (AAICPC) which affords NJ the opportunity to work with other states in a cooperative and collaborative manner to ensure that the children of NJ who move to another jurisdiction receive the necessary services to achieve permanency.

The Office of Interstate Services Unit within DCF oversees the activities necessary to place a child within another states jurisdiction and ensure that the receiving state establishes supervision and complies with all federal and fiscal mandates under the Interstate Compact on Placement of Children (ICPC). Data was manually obtained from the Interstate caseworkers' monthly reports for fiscal year 2014 (October 1, 2013-September 30, 2014). The numbers below is an approximate as this process is very time consuming and may not accurately reflect the real numbers. Homes that were upgraded to adoption, residential and private studies were removed from the total number.

Interstate electronic logs and manual count revealed the following about the 1,089 home study requests received:

- 121 were completed within 30 days or less.
- 325 were completed over 30 and up to 60 days
- 234 were completed in over 60 and up to 90 days
- 201 were completed in over 90 days

Although, it appears as though some progress has been made, the thematic issues that prompted the need for additional time continues to remain the same:

- Reluctance of the Resource to complete the process by failing to respond or withdrawing from the process.
- Administrative time delays in resolving issues, such as criminal history waivers.
- Prospective Resources not fully informed on pertinent elements of their potential role, e.g., financial or medical provisions.
- The assignment of cases sometimes involves staff at 2-3 levels before actually assigned.

New Jersey is taking the following action to address avoidable delays in processing home studies:

- Continue to address how we meet compliance with the requirements when the reason for the delay is beyond the control of the agency. However, since our Interstate Office has been scanning information to states that will allow it, the delay in response has been less than previous years.
- Initiated the process of incorporating Interstate data into NJ SPIRIT, including the assignment of cases.
- To eventually participate in the NIECE Project which was launched in November 2013. NIECE (National Electronic Interstate Compact Enterprise) is based on the electronic web-based Interstate Compact System (ICS) developed by the state of FL. The ICS system has significantly shortened processing times and reduced administrative costs for FL. Six states are currently participating in the pilot and the implementation continues through 2015. More states are scheduled to participate by 2016.

NJ DCF Priorities for 2015-2019

Year One Progress

Over the past several years DCF has developed and implemented a strategic plan that guides our work in the coming years. That process took over a year to complete and offered stakeholders, parents and staff an opportunity to help guide what the work of DCF will look like. The DCF Strategic Plan is an ambitious yet grounded plan for the on-going development of the department, its staff, its services and its partnerships with its providers, families, children and women.

The Child and Family Services Plan (CFSP) for 2014- 2019 leveraged and aligned with the work of the DCF Strategic Plan. Specifically, the DCF Strategic Plan guided the selection of the Core Strategies as well as the goals for the initial year of implementation of the CFSP. Additionally, the current CFSP builds on the accomplishments seen in the 2010-2014 CFSP which provided a solid foundation for continued development of the DCF system.

Hence, the frame of this plan according is the following core strategies:

- Strengthening the Case Practice Model
- Refinement of the Service Array
- Continuous Quality Improvement
- Organizational Development
- Enhancing Partnerships

Several key themes will continue to be evident in our work: 1) the continued commitment to the Case Practice Model, 2) the use of data to manage work, assess performance, and guide decision-making; and 3) the development of a strong organizational structure to sustain and institutionalize systems progress and changes.

Priority Strategic Goal 1: Strengthening the Case Practice Model

In 2007, DCF embarked on an ambitious plan to implement a new Case Practice Model (CPM) in order to standardize and strengthen the way staff from the Division of Child Protection and Permanency (CP&P) work with the children and families they serve. The foundation of the CPM is partnerships with families through engagement of formal and informal supports, joint planning and teaming for desired outcomes, as well as individualized services to address the specific and unique needs of families. Over the past seven years, DCF has provided initial training to all of its CP&P frontline, supervisory and leadership staff on the CPM and continues to weave through all of its training courses, the themes evident from the CPM.

As we move forward and as noted in the CFSP from 2009-2014, the initial work was in laying the groundwork of the CPM for staff and stakeholders and the future work lies with the organization’s ability to truly have the CPM evident in each interaction with its families, children, youth and stakeholders.

Priority Strategic Goal 2: Refinement of Service Array

DCF has taken a number of steps in recent years to ensure that children, youth and families have access to the services they need to both prevent entry into the child welfare system as well as to provide services once involved. DCF is pleased to have a vast number of services available across the state. However, as with any system, the service array must change to accommodate the new and emerging populations, new challenges for families and new trends in assessment and treatment.

Additionally, with the implementation of the CPM, came a focus not just on the presenting needs but also on the 'underlying' needs of the family or individual. This concept asked CP&P staff to engage in deeper assessment with the family about the history of the presenting issue which sometimes led to newly identified services. While many of the same services noted in the 2009-2014, were developed, the future work remains to both enhance and refine the services needed as well as to be responsive to emerging needs of those we serve.

As we move forward, development of a high quality, flexible and responsive service array promotes attainment of the key outcomes of safety, permanency, stability and well-being.

Priority Strategic Goal 3: Organizational Development

Through many initiatives and plans completed over the last several years, DCF has built a culture of learning across the entire department. DCF recognized the importance of providing a broad array of training opportunities, both in house and through leveraging the expertise in the provider and academic communities. DCF further recognizes that organizational development is larger than classroom training and certificate programs- it means investing in the staff for the future growth and sustainability of the agency.

Organizational development builds on the accomplishments made in training and development of its workforce; coupled with the increased availability of access to the tools necessary for staff to effectively and efficiently work with the children, youth and families we serve. This Priority Strategic Goal also includes steps to strengthen the technology available to staff to effectively and efficiently work with children, youth and families. The strengthening of the organization helps staff accomplish the broader positive outcomes for those it serves.

As we move forward, we will continually examine and prepare DCF structurally to be a learning organization that supports the mission, goals and values outlined in the strategic plan.

Priority Strategic Goal 4: Continuous Quality Improvement

DCF understands the value of the development of a robust and fully functioning system for Continuous Quality Improvement (CQI) that ensures the integrity and quality of the entire system of care. In fact, there are many parts of the CQI system that are in place and guide the

system's assessment of its performance across an array of benchmarks and measures. But CQI goes beyond what can be measured using quantitative metrics; rather it marries the quantitative and the qualitative to provide a fuller picture of performance.
The challenge ahead for DCF is the need to formalize the processes in place and offer a sense of uniformity through standard policies, training and infrastructure.

Included in this Priority Strategic Goal is further development of the five component parts of a fully functioning CQI system:

- Foundational Administrative Structure
- Quality Data Collection
- Case Record Review Data and Process
- Analysis and Dissemination of Quality Data
- Feedback to Stakeholders and Decision-makers and Adjustment of Programs and Process

As we move forward, DCF is committed to strengthening existing CQI processes and ensuring our activities are sustainable and integrated throughout the Department.

Priority Strategic Goal 5: Strengthening and Enhancing Partnerships

DCF is committed to the process of collaboration with stakeholders and community partners to improve outcomes for those we serve. Building on the successes in joining with our partners to implement the CPM, we plan to strengthen and enhance our partnerships through the development of strategic initiatives, the implementation of key projects to ensure safety, permanency and well-being.

DCF is moving to become more accountable and transparent with our stakeholders, partners as well as the families, youth and children we serve. This will be evident through our activities to engage families and use their input toward change as well as through our efforts at providing the public increased access to data and information that guides our decision-making.

As we move forward, DCF is committed to strengthening our partnerships with our families through engagement and teaming as well as enhancing our partnerships with our stakeholders and other community partners.

2015-2019 CFSP
First Year Action Plan Results

Core Strategy 1 – Strengthening the Case Practice Model

The Case Practice Model (CPM) is the foundation of the work at the Department and is envisioned to be infused in all interactions with children, youth and families. The core of the CPM is partnerships with families through engagement of formal and informal supports, joint planning and teaming for desired outcomes, as well as individualized services to address the specific and unique needs of families. Over the next five years, the Department will build on the implementation of the CPM model to pilot initiatives aimed as refocusing staff attention on CPM core strategies like teaming and case planning. Through these efforts, it is expected that families will experience thorough joint planning and teaming will aid in providing supports for the family after child welfare involvement has ended.

Line #	Date Added	5 Year Intent	Year 1 Action Plan 10/1/13-9/30/14	Measures	Results (date)
1-1	14-Jun	**Families will experience collaborative service planning through timely completion of case plans and greater quality of case plans.**	Assess Sustainability Plans for counties	Build on sustainable initiatives	In terms of sustainability, developed a master formula that details the number of facilitators, coaches and master coaches based on staffing allocations per each Local Office The formula involves having a master coach for each casework supervisor tier; a coach for each unit; and any one in the family service specialist title trained as a facilitator
			Initiate a county based pilot (Cumberland) to re-engaged staff in CPM	Increase of quality of case planning (NJS) by 5% in Cumberland	Back to Basics (B2B) pilot involves an in-depth case review of the family's history to gain a greater understanding of the families strengths and opportunities for growth.

			Assess and phase into other counties based on results	Determine baseline in quality of case planning (QR) by 5% in Cumberland	Knowing a family's history prepares the case worker to meet the family where they are as when caseworkers are informed, they are in a better position to help the family. Many county Program Improvement Plans (PIP) from the Qualitative Reviews are focused on strategies to improve engagement with the families. Baseline used for quality of case plans in Cumberland was the 2013 QR results for two case plan indicators: Case Planning process and Case Plan Implementation. Cumberland's 2013 QR results for these two indicators was 42% for each. Although outside of the year 1 time frame- Cumberland completed their next QR in February of 2015. Their results of each indicator yielded a significant increase of 75% and 83%. In August 2014, initiated B2B pilot in Local Offices in Salem and Cumberland counties- this concept was a re-introduction of getting back to the fundamentals of engagement strategies and building teams and trusting relationships with children and families consistent with DCF 2007 case practice model.
				Assess results and implement next steps	Although there appears to be an increase in the quality of case planning- an error was identified in the methodology that included incorrect measurable factors. There was a lack of measurability for supervision and overall assessment. CP&P will collaborate with RER to assist in using correct methodology.

1-2	14-Jun	**Teaming process will lead to positive permanency outcomes**			
			Focus on increasing family engagement in initial teaming in two pilot counties (Hudson and Bergen)	Increase frequency of initial teaming by 5% in pilot counties	The Hudson and Bergen FTM expansion pilot was successfully completed in both Hudson and Bergen Counties. This piloted started in December 2013 and concluded in March 2014. There was a 20-30% increase in initial FTMs and a significant decrease in family decline and unavailable category which means that the family was not available within the 30 day time frame to have the family team meeting.
				Expand pilot based on lessons learned	CP&P will expand pilot to the 4 Camden Local Offices in October 2014.
			Ensure adequate staff are trained on teaming	5% of increase in staff as FTM facilitators/ coaches in pilot counties	The results of Bergen and Hudson revealed a significant reduction in families declining the initial FTM when a master coach was used. There was an increase in the development of coaches, master coaches and facilitators. There was a 5% increase in coaches but only a slight increase in facilitators. The majority of family service specialists (IE casework staff) are already facilitators. This process

					was particularly helpful in bringing up staff who are in support positions. We have identified that there are 410 staff who serve in support positions and the goal is to bring them up as facilitators, coaches and master coaches. This will enable building capacity for teaming in the local offices. This process will continue into year 2.
1-3	14-Jun	**Families' needs and histories are understood and inform engagement strategies**	Strategic phase in of case conferencing model Focus on Supervision	Increase an additional 7 Local offices through the immersion process of the case conferencing model- Focus on Supervision.	The Focus on Supervision (FOS) process seeks to support the supervisory techniques CP&P supervisory staff through a partnership with community providers that is consistent with and builds upon the DCF Case Practice Model (CPM). The purpose of FOS is to expand upon the existing skill set of Casework Supervisors and Supervisors, who are responsible for facilitating supervision. The goal of FOS is to create a Case Conferencing model that supports the development of critically thinking staff that leverage the support and knowledge of subject matter experts, Local Offices consultants, and their peers and supervisors. Case conferences help create a team approach to working with families and in the assessment of and planning for safety, permanency, and well-being. Local Offices who have been immersed in FOS have developed sustainability plans which include keeping an account of the cases conferenced in this model to later determine any impact of the conference. During this fiscal year 9 additional Local offices have completed the immersion

					process.

Core Strategy 2 - Refinement of the Service Array

DCF will conduct a robust statewide assessment of the array of services available to children, youth and families. Services must be flexible and reflect current thinking on interventions as well as be nimble enough to respond to emerging needs for its service recipients. The statewide assessment process will result in better availability of services to address needs in the population; including prevention services and services to children in need of out of home placement.

Line #	Date Added	5 Year Intent	Year 1 Action Plan 10/1/13-9/30/14	Measures	Results (date)
2-1	14-Jun	**The needs of the children and families served by DCF are well understood and services are in alignment with identified needs**	Initiate a statewide needs assessment process beginning with analysis of existing information on needs through other assessment processes and quantitative data	Meta analysis of DCF Data such as NJS, CSOC, Census data, Data set identified	NJ developed and finalized the Needs Assessment Plan in 2013 and began implementation planning. DCF contracted with Rutgers University to complete the data analysis. Meetings were held to explore the data sets to be shared. In addition, we identified individuals to attend the weekly workgroup, and the internal and external stakeholder advisory boards. By September we

					began sharing secondary data sets with Rutgers for analysis The first interim report, on the activities of the needs assessment for the first phase, was issued December 2014: http://nj.gov/dcf/childdata/continuous NJ is in the first stage of a 3-year Needs Assessment process focused on identifying the strengths and needs of children and youth at risk of entering out of home placement and those already in out of home placement through the Division of Child Protection and Permanency (CP&P). The following data sets have been identified: 1. New Jersey's Statewide Automated Child Welfare Information System (SPIRIT) 2. Children's System of Care (CSOC) behavioral health care data 3. Division of Family and Community Partnerships' Community Program Directory 4. DCF County Needs Assessment Service Inventories 5. NJ Department of Mental Health and Addiction Services' Directory of Mental Health Services 6. DMHAS Addiction Services Treatment Directory 7. United States Census The OSLS worked with the most recent data related to the number of child abuse substantiations, violence reporting, total student population and poverty rating to develop a funding formula to determine the amount of child abuse prevention funds that the provider NJ Child Assault Prevention program (NJ-CAP) should allocate to each

					county.
2-2	14-Jun	**Families will have access to evidence supported services to address their needs**	Conduct Area-wide contracting meetings to refine local service array process	Increase understanding of the strengths and gaps in service array	The Office of Contract Administration (OCA) collaborated with its colleagues from CP&P, DCF's Offices of Strategic Development and Clinical Services to review contracts administered by each of DCF's four (4) Business Offices that serve CP&P Area and Local Offices. The meetings concluded in January 2015. For each Area, we identified services that are well-received by families and the Division and others that are challenging to work with for a variety of reasons. We also identified services that are incongruent with CP&P's case practice model or best practices; and areas of unmet need (i.e. geographic or language barriers). DCF is incorporating the information it gathered from this process to develop contracts for evidence based services. Below are examples of the information gathered from this process as well additional steps we have taken to work towards the refinement of our service array. The Department currently supports and has experience with successful implementation of a continuum of evidence (evidence-based (EB), evidence informed (EI), and promising practice (PP) services across the state. DCF's Division of Children's Systems of Care (CSOC) supports the implementation of several evidence-based models, including Functional Family Therapy and Multisystemic Therapy. Multiple Offices of DCF's Division of Family & Community Partnerships (FCP) partner with community

					providers to successfully implement evidence based /evidence informed programs and/or curriculum. In FCP's Office of Early Childhood (OEC) the NJ Home Visiting Initiative (NJHV) is an interdepartmental collaboration with NJ Department of Health and DCF's Division of Family & Community Partnerships. Three evidence-based home visiting models that meet the Department of Health and Human Services criteria for evidence of effectiveness are currently implemented in all 21 NJ counties, serving 5,000 families with young children (prenatal to 5) each year. Examples of EB/EI programming in FCP's Office of School Linked Services (OSLS) include: the NJ Child Assault Prevention Program (NJ CAP); the DHHS, Office of Adolescent Health supported Parent Linking Program; Traumatic Loss Coalition for Youth – Suicide Prevention; and School Based Youth. FCP's Office of Family Support Services (OFSS) has begun surveying the statewide network of Family Success Centers (FSCs) to determine which EB/EI programs are being utilized the parent education/parent child groups. Additional DCF's partners including our Regional Diagnostic and Treatment Centers and community providers have been pioneers in the adoption and implementation of evidence-based and evidence informed practices including Trauma-Focused Cognitive Behavioral Therapy, Combined Parent-Child Cognitive Behavioral Therapy, Eye Movement Desensitization and Reprocessing, Expressive Arts Therapy, and Parent-Child Interaction Therapy to name just a few.

					Though evidence-based and evidence informed practices are being incorporated by community partners, providers, and within our own system, we also identified services that are incongruent with CP&P's case practice model or best practices; and areas of unmet need (i.e. geographic or language barriers). We also identified nonspecific programming and treatment and legacy contracts which offer services that may have been appropriate and state of the art for the time, but have become less relevant to meeting the needs of today's families. We recognize the need to realigning our service dollars to purchase more programming that holds promise to achieve positive outcomes with some of our most vulnerable children and families versus The Traumatic Loss Coalitions for Youth (TLC) NJ Child Assault Prevention (CAP) School Based Youth Services Program (SBYSP) * as we are working to ensure each program are using an evidence based curriculum, a great number independently use evidence based curricula. The work of school based is evidence informed as an overwhelming amount of research indicates the effectiveness of supporting the social and emotional health of youth in the school. Parent Linking Program (PLP) OFSS has begun surveying the FSCs to determine which Evidence Based Programs are being utilized across the state.

2-3	14-Jun	**Children have family based settings that allows them to remain connected with their siblings in OOH placement**	Resource homes are available to serve larger sibling groups (SIBS homes). Siblings place apart have regular contact with one another.	Increase available homes for large sibling groups by 10% Children with 3 or more siblings able to be placed together is increased by 5% 60% of children visit regularly with their siblings	The number of large SIBS homes (accepting of 5 or more siblings) has remained constant with a total number of 24 homes statewide. Currently, the Office of Resource Families is developing a plan to expand the SIBS program to include sibling groups of 4 or more due to an increase in the number of this population entering placement in CY2013. The proposed program includes supportive services and additional resources. The Local Offices are currently engaging families to determine the number of families willing and able to take a larger sibling group. Recruitment events for large sibling groups continue to occur 2014 data indicates 25.2% of 4 or more sibling group placed together. This target was not met and will be a continue focus for action in the following year. Larger sibling groups appear to have a higher rate of replacements due to the lack of homes to accommodate them together. CP&P is developing special recruitment efforts to target existing resource families who will be explored to accommodate 4 or more siblings. The MSA target for sibling visits is 85%. As of June 2014- this measure has not been met however for all sibling groups- 68% were visiting.

Core Strategy 3 – Organizational Development

Organizational development builds on the accomplishments made in training and development of its workforce; coupled with the increased availability of access to the tools necessary for staff to effectively and efficiently work with the children, youth and families we serve. This Core Strategy also includes steps to strengthen the technology available to staff to effectively and efficiently work with children, youth and families. The strengthening of the organization helps staff accomplish the broader positive outcomes for those it serves.

Line #	Date Added	5 Year Intent	Year 1 Action Plan 10/1/13-9/30/14	Measurement/Evidence	Results
		Families benefit from well trained staff who are competent in their ability to engage and team with families.	Maintain support for certificate programs in specialty areas like domestic violence, managing by data, adolescent services	Percentage of staff completing the program (total completion/total enrolled) Percentage of staff completing the program (total completion/total enrolled	95% of all students enrolled completed the DV certificate program. 100% of all Data Fellows completed the program and 95% of those the adolescent advocacy program completed 42 students were enrolled in the DV program and 41 completed the program , 44 were enrolled in the Data Fellows Program and 44 completed the program, lastly and 40 were enrolled in the adolescent advocacy program and 38 completed the program. Since inception, in total, 124 people completed the Violence against Women Certificate course,

3-1	14-Jun		Use educational incentive programs to recruit and retain social workers into the agency (BCWEP, MCWEP)	Percentage of staff still employed 2 years post program (total retained/total graduated)	171 people completed the Managing by Data course and 223 completed the certificate program in Adolescent Advocacy. BCWEP- 95% of all those hired into the BCWEP program completed the program and were hired. In total 369 students graduated the program and from that 354 were hired. After two years 284 or 88% were still on the job. Overall the attrition rate of BCWEP is at 4.4% The DCF Data Fellows program teaches staff how data can improve outcomes for children and families. It is at the center of our department-wide commitment to operate as a learning organization. As of September 30, 2014, the Fellows program had 167 active Fellows, with an additional 40 candidates in the 2014-15 cohort which began September 10, 2014. • Round 1 (2011-12): 100 enrolled/93 completed; 96% retention • Round 2 (2012-13): 40 enrolled/35 completed; 100% retention • Round 3 (2013-14): 46 enrolled/44 completed MCWEP- This is a fairly new program This program is too new to have Percentage of staff still employed 2 years post program (total retained/total graduated) will look to incorporate into year 2

3-2	14-Jun	Align staff training to critical or emerging areas of practice	Conduct a trauma focused symposium to provide basic understanding of trauma to front line staff Conduct training on serving victims of human trafficking	Staff participating in training opportunities (total staff trained/total staff of agency)	320 people attended the first of 4 symposia planed on Trauma. 172 DCF staff participated or 3.7 % of DCF staff in the first of 4 trauma symposia. Remaining participants were external stakeholders who were afforded this collaborative training opportunity. 4,892 staff were training during the review period in Human Trafficking awareness- In total 6359 individuals have attended 1 or more "Human Trafficking" prior to 9/30/2014
3-3	14-Jun	**Provide enhancements to technology to improve workflow for staff and transparency to ensure staff are prepared**	Continue NJ SPIRIT releases as scheduled	Release schedule followed	DCF released 4 NJ Spirit modifications: Release 5.0 (October 2013) A New disclaimer message was added to the NJ SPIRIT Login screen. Users now are required to acknowledge they have read and understand the confidentiality disclaimer before being granted access to NJ SPIRIT. Improved Resource Services Selection Options were made available. A new Inactive Services expando was added to the search results display. This new feature allows workers to view and select an inactive service with the condition the service was in an active status when it was provided. Improved CWS Assessment/Contact Activity notes were made available. Contact Activity Notes generated from within a CWS Assessment in NJ SPIRIT now automatically associate with the correct CWS Assessment regardless of how many CWS Assessments are in pending. In an effort to improve the search functionality in NJ Spirit, NEW features were added to the Case and Resource Non-Restrictive Search window. Person Merge was made easier.

					Local Office merge liaisons complete a Person Merge for duplicate person records in NJ SPIRIT. NJ SPIRIT was enhanced to allow the merge to proceed, even if the merged person is on an investigation; granted the investigation is fully approved. A NEW Medical/Mental Health Type category of Psychiatric Activity was added to the Medical History window. In addition, values for Psychiatric Evaluation, Medication Monitoring and Other are now also available in the Activity drop down for selection. The Placement and Service Ending window in NJ SPIRIT was enhanced to give supervisors the ability to override a Birthday Batch placement end reason when appropriate. Various fields on the Allegation tab of the Investigation window in NJ SPIRIT have been expanded to display more text. The LOBA check limit was increased from $500 to $600 to accommodate the recent increase in Independent Living Rent allowance. Upon investigation approval, staff now receives a reminder to complete an Early Intervention System Services referral for children under the age of three years old involved in a Substantiated or an Established investigation. In addition, staff is required to document the referral information on the Medical History Tab of the Medical Mental Health Window in NJ Spirit. The Auto-recall functionality was enhanced to prohibit the recall of work to an inactive worker. Supervisors now have the ability to reroute the pending work to an active worker, while workers are able to reroute the pending work to a supervisor, who in turn may reroute to the appropriate worker. Staff now receive message asking them to accept the USPS standardized address when creating/editing a person or resource mailing address in NJ Spirit. Accepting the U.S. Postal

					Service standardized address will help to ensure the accurate and timely delivery of mail. Release 5.1 (November 2013) NJ Spirit has been enhanced to accept either a completed Family Risk Assessment or a Family Risk Re-assessment to satisfy the requirement that one be completed within 30 days before closing an in-home case. Changes were made to Institutional Abuse Investigative Units online summary and forms to better support case practice. Human Trafficking values were added to Intakes for CPS and CWS. Release 5.2 (January 2014) NJ SPIRIT now allows for the extension of Medicaid coverage for qualifying young adults between the age of 18 and 26. Qualified candidates with existing DCF Medicaid in NJ SPIRIT will automatically be transferred to the new Federal Medicaid program in their 18th or 21st birthday month. NJ SPIRIT will automatically terminate this Medicaid at the end of the young adult's 26th birthday month. Enrollment and termination of new Medicaid will be administered through the DCF Office of Child and Family Health. Release 5.3 (July 2014) Redesign the current or previous agency involvement section of the 'Intake Window' and the 'Other Intake Narrative' section on the screening Summary Report to be more user friendly. To better assist supervisors in managing their staff's pending work, a new 'Worker Search'

					has now been added to the Non- Restrictive Search window in NJS. This new search feature will give supervisors the ability to view all pending approvals for a particular worker. Functionality has been added to NJS which allows Local Office Adoption Staff to attach scanned documents to the adoption planning window. Add the subsidy amount to the subsidy agreement window and related batches. An alert was added to the out of home placement process. An email will now be sent to the primary worker when a child on their caseload has been placed/replaced. This will only occur when the placement line was created by someone other than the primary worker. This is designed to ensure that proper notification exists especially for when placements occur after hours by emergency staff. Correct investigative Extension screen approval process to allow for appropriate approval by assigned supervisors. Upgrade to the latest version of Internet Explorer from version. Twenty five incidents were dedicated to the implementation and improvement of our Trust Account functionality. These incidents were spread over multiple areas of the application: Online, Reports, Interfaces, and Database. Three incidents were AFCARS PIP related: • The addition of the subsidy amount to the subsidy agreement window and mapping to AFCARS adoption element #36 • AFCARS element #49 (foster home structure) was correctly mapped to also pick up contract agency roles (#57 & #58) to report the primary and secondary caregivers marital status. • Enhancement to the current element

					#64 (SSI) mapping to adjust for the improvements to the trust account functionality. Correct the General Search screen to allow the wildcard search to work properly on the respective address and town fields.
3-4	14-Jun		Provide access to tools to enhance knowledge and skill Post longitudinal data for internal use	CP&P policies are available on DCF internet page HZ Longitudinal data available on DCF intranet	In promoting a more collaborative and transparent agency all DCF policies are now available as of July 2014 on the DCF internet page for all stakeholders to review and elicit feedback on- see http://www.nj.gov/dcf/policy_manuals/toc.shtml The CPP Longitudinal Outcomes are now posted to DCF's intranet annually with data by State and County.
3-5	14-Jun		Update Safe Measures to version 5 Deploy new screens for tracking performance based on organizational need	Change over time during year 1 in the number of staff utilizing Safe Measures to regularly track and monitor workload and performance Screen shots of new screens	During this period, CLC workers viewed different screens in Safe Measures 442,262 times while supervisors viewed Safe Measures screens 1,041,743 times. SafeMeasures usage by staff remained steady during this period. Supervisors usage, however, increased by 5%. New screens continue to be developed to meet the needs of the users. Existing screens also continue to be enhanced. **<u>New Screens:</u>** • NYTD follow- up screen: tracks surveys completed by youth age 21 as per the NYTD federal requirement • Race/Ethnicity screen: tracks clients with missing race/ethnicity information • Missing Clients

3-6	14-Jun		Request technical assistance (TA) to further development of the information and data associated with the Systemic Factors	Request is planned and initiated Follow plan as needed	Ongoing T/TA is continuing for Retention and Recruitment through Market Segmentation. Additional support in enhancing reporting for the CFSR Systemic Factors began in February 2015 and will continue. NJ has completed the introductory call with the Capacity Building Centers and will be moving forward in the summer of 2015 with the State Capacity Assessment.

Core Strategy 4 – Continuous Quality Improvement

Continuous Quality Improvement (CQI) at the Department includes the development of a fully functioning and sustainable system that has the organizational structure to support high quality data collection including case record review processes, data analysis, with stakeholder feedback processes as well as ways for public dissemination of information. Many of the component parts are present and with some refinements will form the basis for the CQI system.

Line #	Date Added	5 Year Intent	Year 1 Action Plan 10/1/13-9/30/14	Measures	Results (date)
		Develop a robust and fully functioning CQI system			
4-1	14-Jun		Gather understanding about current status of CQI activities	Baseline accounting of CQI activities statewide	Developed and administered a statewide CQI survey to assess existing CQI effort in the state. Results of the survey then informed regional

			Initiate policy and process development to guide practice	Draft policies	Leadership CQI focus groups. In addition, a "CQI activities" session/conversation was held with the Local Office Managers; information was gathered about how: CQI activities are prioritized; tracked; analyzed; and inform ongoing decision making. Developed a CQI Grid to track existing Department CQI activities. The CQI Grid is updated as new CQI activities emerge. DCF's commitment to ongoing learning and quality improvement is keenly demonstrated with the NJ's Data Fellows program. A 4th cohort of Fellows began during this reporting period and continued the practice of reviewing Department data, prioritizing needs based on the data, developing hypothesizes, conducting reviewing reviews and making recommendations to the Department for improvements. DCF convened planning groups to review ChildStat processes to improve the presentations. 2014 launched the revised Child Stat overview on permanency with reunified families. In June 2014, an education day was held for statewide offices to introduce and review the new and improved ChildStat focus. Education day covered how to: better integrate data; utilize Strengthening Families Protective Factors; and engage in ongoing practice reflection. In addition, there was an increase in external stakeholders worked with local offices in co-presenting with local office staff the family and child's story. PMA continued to facilitate twice a month the Key Performance Indicators (KPI) calls with each leadership from DCP&P Area Offices. The calls provide an opportunity to look at practice compliance and data accuracy. Completed the draft of the DCF Statewide CQI Plan, the branding for the DCF CQI initiatives, and updated the DCF website with the new CQI

					narrative and logo. PMA drafted CQI policies, reviewed additional Department policies that are connected to CQI and/or Administrative Order, and developed a plan to finalize CQI policies.
4-2	14-Jun				
			Identify core components of CQI training	Draft CQI employee training	The State consulted with other Child Welfare systems and Child Welfare Organizations to learn about their process for adopting a CQI plan and its accompanying employee training. NJ drafted Employee Orientation on CQI.
4-3	14-Jun				
			Operate a quality data collection process Initiate process to build additional controls around data collection Complete AFCARS PIP	Pilot accountability/quality control after a targeted review and follow next steps PIP completion	To further work on NJ quality data collection we maintained regular (Weekly to bi-weekly) Data Quality & Compliance meetings between DCP&P and PMA. These meetings offer leadership an opportunity to have data inform its decision making while verifying if the data being used is accurately measuring what is needed. NJ continues to hold 16 Qualitative Reviews (QR) and various targeted case reviews all with quality assurance measure in place to ensure rater reliability. Enhancements to the SACWIS system have been ongoing to mitigate the AIP findings with quarterly reports submitted timely to ACF. There are additional enhancements to the SACWIS system still pending with anticipated completion

					dates of April 2016. Once ACF determines that the technical requirements and data quality requirements have been met and maintained, the AIP is considered complete. An estimated completion date for the AIP is 4/2017.
4-4	14-Jun				
			Operate a case record review process Continue implementation of the QR process and made modifications as needed	# QRs completed Annual summary report published	In 2014, PMA led QR reviews in 15 of the state's 21 counties, with a sample that included 1,770 interviews linked to 180 children/youth. The report is to be published on the DCF site in the coming months The Overall Child and Family Status Indicator was recognized as a strength, with 90% of cases reviewed being rated as acceptable. (Strength is indicated when 70% or more of all cases receive an "acceptable" rating). DCF has consistently maintained this positive trend, as the Overall Child and Family Status Indicator was also identified as a strength in the 2013 and 2012 QRs, with 91% and 90% of cases rated as acceptable, respectively. The Overall Practice Performance Indicator was identified as an area in need of improvement, with 66% of cases reviewed being rated as acceptable. However, it should be noted that 66% represents a significant (9%) increase from the previous year, when 57% of the cases were rated as acceptable in the Overall Practice Performance Indicator. NJ has been having internal conversation in preparation for the CFSR Round 3. Several key colleagues attend the Boston MA conference which discussed the changes in the round 3
			Begin discussions to understand implications of Round 3 case reviews		

					approach. We attend a peer network that has been exploring the cross walk of the QRs and CFSR tools. Key DCF team members have also been talking with fellow colleagues in other states who are preparing for the CFSR in 2015. In addition we have held an in person meeting and conference calls with ACF to discuss the CFSR. Ongoing Technical Assistance calls will be arranged with ACF as well as an internal DCF-CFSR workgroup. DCF has started discussions about the impact of the CFSR tool on the QR and possible training needs on the CFSR tool plus changes needed to the QR sample methodology.
4-5	14-Jun		Complete targeted reviews on the quality of investigations as well as the quality of services to older adolescents	Results of the reviews and recommendation follow up	During the time frame, PMA led several targeted review: Measure 16, (Jan. and August 2014), M54 (Nov. 2013), M55 (Feb 2013 and Aug. 2014) and Investigative Practices (September 2014). At this time the following reports are on the DCF web site: 2013 M54 report (still working on the 2014), 2013 M55, 2014 Investigation Report. See reports for recommendations.
4-6	14-Jun				
			Analyze and disseminate quality data Complete in-depth Data Quality and Compliance meetings to review outcomes with each CP&P Area that integrate data from AFCARS, the MSA, longitudinal measures	Lessons learned	DCF has completed in-depth reviews of quantitative and qualitative data across each county in the State with local teams. Through this process, strengths and challenges emerged for each area highlighting the regional differences in population, partners, performance and outcomes. See Collaboration section for more detail.

4-7	14-Jun		Provide data reports on key agency performance indicators to the public	# of reports posted publically	DCF now post the following reports on the DCF website: Monthly Commissioner's Dashboard, Monthly Screening and Investigation Report, Annual Child Abuse and Neglect Report, Annual Educational Stability Report
4-8	14-Jun				
			Integrate feedback from stakeholders into processes and systems	review of PIP participants and PIPs for statewide themes	Area and county based Program Improvement Plans (PIP) have been shared with Area Quality Coordinators in an effort to communicate strategies for practice enhancements across the state. The development of PIPs now incorporates input from stakeholders, staff at multiple levels of the system, and PMA Office of Quality QR team leads. PMA tracks trends in QR performance and quarterly PIP updates.
			Counties with QRs during period have completed Program Improvement Plans from a systems perspective with input from stakeholders		
4-9	14-Jun		Identify future opportunities to discuss CFSP goals with stakeholders	Calendar of meetings with CFSP as agenda items	The approved NJ 2015-2019 CFSP has been made public for all stakeholders to review and provide feedback on the progress and performance see Federal Reporting at http://www.state.nj.us/dcf/childdata/njfederal/
				Plan for feedback from stakeholders	On-going meetings with key stakeholders as outlined in the collaboration section cycle on a monthly basis with discussions that center around the improvement of outcomes as it relates to the goals and strategies of the CFSP. As a transparent agency, available data is made public and is monitored, tracked and adjusted through continuous stakeholder feedback.
				Update on strategic plan	Update on strategic plan: See DCF Today 2013-2014 at http://www.state.nj.us/dcf/childdata/continuous/

Core Strategy 5 – Strengthening and Enhancing Partnerships

DCF is committed to the process of collaboration with stakeholders and community partners to improve outcomes for those we serve. Accountability and transparency are two key components to enhancing partnerships. Additionally, partnership must reflect the voices and input of those served by the system. Formal systems of data collection and information gathering from stakeholders and partners must be in place and leveraged in decision-making and planning for true systems change.

Line #	Date Added	5 Year Intent	Year 1 Action Plan 10/1/13-9/30/14	Measures	Results (date)
5-1	14-Jun	**Partnerships are strengthened through transparency**			
5-2	14-Jun		Make data reports available to the public through the DCF webpage	CIACC reports and Data Dashboard are available monthly on the DCF website	DCF now post the following reports on the DCF website: Monthly Commissioner's Dashboard, Monthly Screening and Investigation Report, Annual Child Abuse and Neglect Report, Annual Educational Stability Report, CIACC reports
5-3	14-Jun		Partner with entities in the research committee to disseminate knowledge	# of research projects approved # of articles published	DCF's research review committee approved 6 research projects from 10/1/13 to 9/30/14. 5 of these projects are still ongoing. • Mother and Infant Childhood Home Visiting Program Evaluation (MIHOPE) • Home visitation enhancing linkages project (HELP): Enhancing evidence based home visitation to address

					substance abuse, mental health and DV • HomeStyles: Shaping Home Environments and Lifestyles Practices to Prevent Childhood Obesity • Youth Perspectives on the Youth Advisory Boards • Evaluation of the New Program for Domestically Trafficked Adolescents • The Assessment of Parent Linking Programs Project External researchers submitted 2 reports during this time period, but neither was published in a peer-reviewed journal. The Parent Linking Program expansion project Promoting Success for Expectant and Parenting Teens NJ was approved to be evaluated by John Hopkins University (JHU)
5-4	14-Jun	**Youth perspective is incorporated into the DCF system**			
5-5	14-Jun		The Youth Advisory Boards are restructured and systems recommendations to DCF are made	# of engaged youth in YABs DCF response to recommendations	A total of 836 unduplicated youth attended local YAB meetings A total of 196 youth attended 3 YAB Statewide Quarterly Networking meetings DCF made efforts to update policy and started to make changes and improvement to practice, policy, and resources through trainings, reminders to staff, and started to

					directly work on contract language and resource capacity regarding issues and needs presented. DCF also staff met with some YABs directly to address and explore specific concerns presented.
5-6	14-Jun	**Mechanisms are available to receive stakeholder feedback and feedback is used to inform the system**			
			Resource families are engaged have structured opportunities to provide input and feedback on the system	Final Report on Resource Family Assessment Next Steps are implemented	The first survey on resource family assessment was conducted and the response rate was not representative enough of a survey necessary to make any assumptions. As a result, the survey was modified and resent to 1000 resource families. Participants will have the option of either completing an online survey or completing the survey by mail. Once the survey results are received, the results will be analyzed and recommendations will be considered in the resource family retention framework.
5-7	14-Jun		Family surveys are completed by those engaged in the Teaming process	Quarterly reports on FTM survey	FTM surveys continue to be provided to FTM participants and quarterly reports are issued by PMA for CP&P leadership. In 2013 a time limited workgroup revised the FTM survey to better assess the impact of an FTM on case planning and incorporating the family's voice. The revised survey (in both English and Spanish) was shared with CP&P in April 2014.

2015-2019 CFSP
Second Year Action Plan

Core Strategy 1 – Strengthening the Case Practice Model

The Case Practice Model (CPM) is the foundation of the work at the Department and is envisioned to be infused in all interactions with children, youth and families. The core of the CPM is partnerships with families through engagement of formal and informal supports, joint planning and teaming for desired outcomes, as well as individualized services to address the specific and unique needs of families. Over the next five years, the Department will build on the implementation of the CPM model to pilot initiatives aimed as refocusing staff attention on CPM core strategies like teaming and case planning. Through these efforts, it is expected that families will experience thorough joint planning and teaming will aid in providing supports for the family after child welfare involvement has ended.

Line #	Date Added	5 Year Intent	Year 2 Action Plan 10/1/14-9/30/15	Measures	Results (date)
1-1	14-Jun	**Families will experience collaborative service planning through timely completion of case plans and greater quality of case plans.**	Provide opportunities for children and youth to understand their rights while in care, including what they can expect regarding their health, safety and court involvement. Update the existing transitional plan to make it more goal oriented and facilitate planning conversations with adolescents.	Creation of a bill of rights policy for children and youth. Publishing the updated transition plan form and policy to incorporate identification of goals, conversations and youth voice.	

			Assess Sustainability Plans for counties Assess and phase into other counties based on results	Build on sustainable initiatives Assess results and implement next steps	
1-2	14-Jun	**Teaming process will lead to positive permanency outcomes**			
			Focus on increasing family engagement in initial teaming into other pilot counties	Increase frequency of initial teaming by 5% in other pilot counties Continue to Expand pilot based on lessons learned	

			Ensure adequate staff are trained on teaming	5% of increase in staff as FTM facilitators/ coaches in pilot counties	
1-3	15-Jun	**Families' needs and histories are understood and inform engagement strategies**	Strategic phase in of case conferencing model Focus on Supervision PMA/CP&P to formulate methodology to measure FOS outcomes	Increase immersion of Local Offices by 5 additional offices Measureable tool is identified and initiated	

Core Strategy 2 - Refinement of the Service Array

DCF will conduct a robust statewide assessment of the array of services available to children, youth and families. Services must be flexible and reflect current thinking on interventions as well as be nimble enough to respond to emerging needs for its service recipients. The statewide assessment process will result in better availability of services to address needs in the population; including prevention services and services to children in need of out of home placement.

Line #	Date Added	5 Year Intent	Year 2 Action Plan 10/1/14-9/30/15	Measures	Results (date)

2-1	15-Jun	**The needs of the children and families served by DCF are well understood and services are in alignment with identified needs**	Through the support of the ACYF Federal Planning Grant conduct data analysis, a needs assessment, and refine an intervention framework in order to address ongoing service gaps related to the need for evidence-based, trauma-informed, protective factor focused and comprehensive life skills and other critical program for adolescent and young adults being served through CP&P. Initiate second phase of statewide needs assessment process	Create an intervention that works to prevent homelessness for youth in care, 14-21. Continue Meta analysis of DCF Data such as NJS, CSOC, Census data, additional Data set identified if needed focus groups interviews of key stake holders both internal and external	
2-2	15-Jun	**Families will have access to evidence supported services to address their needs**			
			Convene Evidence Based Advisory Group to include	Identify guidance strategies on the selection, adoption,	

			multidisciplinary internal and external stakeholders Convene Implementation Science Learning Group	implementation, evaluation and quality improvement practices for evidence-based/evidence informed programs. Identify evidence based methods to support quality implementation and scaling up of evidence based/evidence informed programs and the application to our existing efforts of integrating more EB/EI programs into our service array.	
2-3	14-Jun	**Children have family based settings that allows them to remain connected with their siblings in OOH placement**			
			Resource homes are available to serve larger sibling groups (SIBS homes). Siblings place apart have regular contact with one another.	Increase available homes for large sibling groups by 10% Children with 3 or more siblings able to be placed together is increased by 5% Increase sibling visitation by 5%	.

Core Strategy 3 – Organizational Development

Organizational development builds on the accomplishments made in training and development of its workforce; coupled with the increased availability of access to the tools necessary for staff to effectively and efficiently work with the children, youth and families we serve. This Core Strategy also includes steps to strengthen the technology available to staff to effectively and efficiently work with children, youth and families. The strengthening of the organization helps staff accomplish the broader positive outcomes for those it serves.

Line #	Date Added	5 Year Intent	Year 2 Action Plan 10/1/14-9/30/15	Measures	Results
		Families benefit from well trained staff who are competent in their ability to engage and team with families.			
3-1	14-Jun		Maintain support for certificate programs in specialty areas like domestic violence, managing by data, adolescent services Use educational incentive programs to recruit and retain social workers into the agency (BCWEP, MCWEP)	Percentage of staff completing the program (total completion/total enrolled) Increase MCWEP program to 4 cohorts/80 students Percentage of staff still employed 2 years post program (total retained/total graduated)	

3-2	15-Jun	Align staff training to critical or emerging areas of practice			
			Conduct a trauma focused symposium to provide basic understanding of trauma to front line staff	Provide 3 more trauma focused workshops	
			Complete Case Plan Transfer of Learning (TOL) training to expand to all CP&P Local Offices	All 46 Local offices will have completed TOL training	
			Technical improvements to training website to display test data	Supervisors will be able to readily view test performance of their workers.	
			"Boot camp" training to be provided to all training staff on NJ SPIRIT functions including safety assessment	Training staff will fully understand how to integrate the NJSPIRIT actions into regular classroom training so that training emulates the mixture of activities (meeting with families, conferencing with supervisors, writing up for NJSPIRIT) that occur.	
				CP&P staff and	

			Collaborate with external partners to create a Youth Thrive training for adolescent serving CP&P staff and contracted providers.	contracted providers serving adolescent population will be afforded the opportunity to participate in the new Youth Thrive training/number of participants trained	
3-3	14-Jun	**Provide enhancements to technology to improve workflow for staff and transparency to ensure staff are prepared**	Continue NJ SPIRIT releases as scheduled	Release schedule followed	
3-4	14-Jun		Provide access to tools to enhance knowledge and skill Post longitudinal data for internal use	CP&P policies are available on DCF internet page HZ Longitudinal data available on DCF intranet	
3-5	15-Jun		Continue to support the Use of Safe Measure Deploy new screens for tracking performance based on organizational need	Maintain or increase the number of staff using Safe Measures to monitor workload and performance Screen shots of new screens	

	15-Jun 15-Jun		Train CQI staff on access and use of longitudinal date Increase access to county and case level outcome data	Number of people trained, topics covered Number of people with access to local data	
3-6	14-Jun 15-Jun		Continue technical assistance (TA) to further development of the information and data associated with the Systemic Factors	Employ monthly phone calls with CB Regional Office support Monthly OPMA/CP&P Collaboration Meetings	

Core Strategy 4 – Continuous Quality Improvement

Continuous Quality Improvement (CQI) at the Department includes the development of a fully functioning and sustainable system that has the organizational structure to support high quality data collection including case record review processes, data analysis, with stakeholder feedback processes as well as ways for public dissemination of information. Many of the component parts are present and with some refinements will form the basis for the CQI system.

Line #	Date Added	5 Year Intent	Year 2 Action Plan 10/1/14-9/30/15	Measures	Results (date)
4-1	14-Jun	**Develop a robust and fully functioning CQI system**	Gather understanding about current status of CQI activities Review and approve Draft CQI policies	Update accounting of CQI activities statewide Publish CQI policies	
4-2	15-Jun		Initiate draft CQI training Initiate Implementation Science focus group to engage in the Active Implementation Hub's (http://implementation.fpg.unc.edu/?o=nirn) modules and lessons Identify core components of CQI Framework	Target training to DOW/FCP staff Increase knowledge and understanding of the Active Implementation Framework and provide recommendations Draft CQI Framework	
4-3	14-Jun				

			Operate a quality data collection process Initiate process to build additional controls around data collection Complete AFCARS PIP	Pilot accountability/quality control after a targeted review and follow next steps Continue work of AFCARS PIP-enhancements during year 2 period	
4-4	14-Jun				
			Operate a case record review process Continue implementation of the QR process and made modifications as needed	# QRs completed 2015 Annual summary report published	
4-5	14-Jun		Complete targeted reviews on the quality of investigations as well as the quality of services to older adolescents for 2015	Results of the reviews and recommendation follow up	.
4-6	14-Jun				
			Analyze and disseminate quality data Complete in-depth PMA/CP&P Collaboration meetings to review outcomes with each CP&P Area that integrate data from AFCARS, the MSA, longitudinal measures	Lessons learned	

4-7	14-Jun		Provide data reports on key agency performance indicators to the public	# of reports posted publically	
4-8	14-Jun				
			Integrate feedback from stakeholders into processes and systems Counties with QRs during period have completed Program Improvement Plans from a systems perspective with input from stakeholders	review of PIP participants and PIPs for statewide themes	
4-9	15-Jun		Provide Technical Assistance to Local offices on PIPs	PIP's will be updated as needed and that the improvement practices identified are attainable and measurable.	

Core Strategy 5 – Strengthening and Enhancing Partnerships

DCF is committed to the process of collaboration with stakeholders and community partners to improve outcomes for those we serve. Accountability and transparency are two key components to enhancing partnerships. Additionally, partnership must reflect the voices and input of those served by the system. Formal systems of data collection and information gathering from stakeholders and partners must be in place and leveraged in decision-making and planning for true systems change.

Line #	Date Added	5 Year Intent	Year 2 Action Plan 10/1/14-9/30/15	Measures	Results (date)
5-1	14-Jun	**Partnerships are strengthened through transparency**			
5-2	14-Jun		Make data reports available to the public through the DCF webpage	CIACC reports and Data Dashboard are available monthly on the DCF website	
5-3	14-Jun		Partner with entities in the research committee to disseminate knowledge	# of research projects approved # of articles published	
5-4		**Youth perspective is incorporated into the DCF system**			
5-5	15-Jun		Create a policy to provide and ensure a safe, healthy, and inclusive environment for all the youth and families we serve, including LGBTQI youth and families	LGBTQI Policy to be published as well as accessible in policy manuals for DCF staff and external stakeholders	

			NJ Statewide Youth Advisory Boards (YABs) present concerns and recommendations to DCF twice per year. DCF to update policy, practice, programming where appropriate in response to the YABs DCF presents updates and progress with Adolescent Service Providers.	DCF reports back to YABs on progress twice per year. Publish policy/practice change Hold quarterly Provider Meetings	
5-6	15-Jun	**Mechanisms are available to receive stakeholder feedback and feedback is used to inform the system**			
			DCF to engage stakeholders through the Youth At-Risk of Homelessness Federal Planning Grant	Focus groups, planning sessions and surveys are initiated Reports information to the public through emails, newsletters, and the public website	

			Resource families are engaged have structured opportunities to provide input and feedback on the system	Initiate Retention Taskforce	
5-7	14-Jun		Family surveys are completed by those engaged in the Teaming process	Quarterly reports on FTM survey	

Promoting Safe and Stable Families

The Promoting Safe and Stable Families (PSSF) Program is federally funded (Title IV-B, Subpart 2) grant program that focuses on helping families stay together, promotes family strength and stability, enhances parental functioning, and protects children. The federal government requires that at least 20% must be spent on programs in each of the following four funding categories: Family Preservation Services, Family Support Services, Time-Limited Family Reunification Services and Adoption Promotion and Support Services.

DCF maintains a comprehensive contract monitoring and execution process to ensure that:

- Purchased services meet the identified needs of the Department's Clients;
- Purchased services achieve identified performance objectives;
- Provider agencies and programs meet contracted levels of service;
- Programs comply with all applicable DCF contracting and all applicable program standards and policies;
- Agencies operate in a fiscally responsible manner and in compliance with agreed upon budgets;
- Agencies comply with applicable licensing requirements;
- DCF and provider agencies maintain open communication that encourages prompt problem identification and resolution; and
- Feedback regarding service needs from local DYFS staff, children and families, and other stakeholders is incorporated into negotiations for new contracts and renewals.

This monitoring process reviews all relevant program and service information, to include information contained within the PSSF update reports, during the monitoring process procedure which include:

- DCF Internal Check-in: DCF Contract Administrator meets with DCF Program Leads to review programmatic performance and contract compliance during the first contract quarter
- On-Site Monitoring Visit: DCF Monitoring Team consisting of Contract Administrator, Program Lead and DCF Business Office supervisory staff completes program on-site visit during the second and third contract quarters to review programmatic performance, contract compliance as well as address any concerns or issues raised during check-in meeting. This visit includes an Administrative interview, program service interviews, record reviews, exit conference and written report.
- Coordinated Contract Review Meetings (CCRMs): During the fourth contract quarter the DCF Business Office will conduct an internal meeting to review all relevant program information received during the monitoring process. The meeting is used for assessing if the provider agency is achieving contracted levels of service, meeting performance objectives, submitting required reports, and is in compliance with any applicable licensing standards. Its primary purpose is to support decision making concerning the contract renewal which will improve the services purchased through the contract. At the conclusion of the Coordinated Contract Review Meeting (CCRM), the Contract Administrator completes a Contract Monitoring Report which identifies the findings in all programmatic, administrative and fiscal areas, including any actions identified for follow-up. Recommendations to improve the contracts services, service availability and

accessibility, are included in the report, and are the basis for contract negotiations with the provider.

Family Preservation Services (FPS)	**Family Support Services (FSS)**	**Time-Limited Family Reunification Services (TLFRS)**	**Adoption Promotion and Support Services (APSS)**
Services are designed to help children and families who are at risk or in crisis including: services that are geared to: • Help children reunify with families • Help children be placed for adoption, or with legal guardian • Offer pre-placement preventive services • Provide post reunification follow-up • Offer respite care of children • Improve parenting skills • Infant Safe Haven programs	Community-based services are provided to promote the well-being of children and families by: • Increasing the strength and stability of families • Increasing competence in parenting abilities • Building a safe and stable environment • Strengthening parental relationships • Promoting healthy marriages • Enhancing child development	Services are provided to the parents or the primary caregiver and children in placement, in order to facilitate reunification. The services and activities include: • Counseling • Substance abuse treatment services • Mental health services • Assistance to address domestic violence • Temporary child care/ therapeutic services • Crisis nurseries • Transportation to or from services and activities • Visitation	Services and activities are designed to encourage more adoptions out of the foster care system, when adoptions promote the best interests of children. This includes: • Pre and post-adoption counseling • Summary writers • Visitation and treatment • Behavioral Supports • Information and referrals • Advocacy and support services
1,241,148	1,131,619	1,266,535	1,614,568
23.6%	21.5%	24.1%	30.7%

2015 PSSF Update Report

Section 1 – Identifying Information		
1a	**Provider**: SAFE in Hunterdon	**1b Program Name:** Community Outreach Advocacy Team (COAT) formerly known as Shelter without Walls (SWW)
1c	**Relevant PSSF Program**: ___FPS, ___ FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 47 E. Main Street Flemington, NJ 08822	
1e	**Objective**: Expand outreach services into the community due to rural geography and reduce barriers to service	
1f	**Outcome(s) Addressed**: ____Safety ____Permanency _X__Well-Being	
Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)		
2a	**Overview of Service**: In an effort to expand outreach services in Hunterdon County's rural geography by establishing 6 "SAFE sites" throughout the county that helps to reduce transportation barriers. The services were also designed as individualized support services to address various client needs (i.e. counseling, case management, advocacy, etc)	
2b	**Population Served**: Individuals and families impacted by domestic violence and/or sexual violence.	
2c	**Geographical Area of Services**: Hotline, SAFE in Hunterdon outreach services, social services agencies, community organizations, "SAFE sites" state and local providers	
2d	**Referral Sources**:	
Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)		
3a	**Provide a summary of program accomplishments on goals.** **Include data where available:** 6 "SAFE sites" were set up at various confidential locations throughout Hunterdon County. Partnerships were developed in the community as part of outreach services and client services were expanded.	

3b	**How did this improve outcomes for children and families?** This program improved outcomes for children and families by reaching families that may have been unable to access our main outreach services and offer varied services based on family needs.
3c	**Identify specific factors that contributed to this improvement:** Outreach efforts and additional service sites improved awareness of services, as well as, accessibility to services.
3d	**Identify significant barriers to goal accomplishment:** It was difficult to originally setup the services without payment for the "SAFE sites" but continued outreach efforts allowed for the sites to be secured.
3e	**Definition of Level of Service as per contract:** Individualized support sessions
3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14:** 288 contracted level of service for reported level of service – 4/1/14 – 9/30/14. Beginning was spent developing off-site program. Setting up program materials and 6 "SAFE sites".
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14:** 129 individualized support sessions provided. The program needed to be set up and "SAFE sites" developed in the community.
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals:** **# of unduplicated families:** 20
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** Satisfaction surveys were originally to be dispersed at the time of termination – n/a results – many forwarded surveys to be dispersed on quarterly basis.
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.** "SAFE sites" providers had mentioned that partnership between SAFE in Hunterdon and several "SAFE sites" created additional opportunities for clients and some staff of the "SAFE sites" completed their hours DV/SV training for volunteer.

4b	**Identify changes you will make that stem from stakeholder feedback.** The stakeholder feedback demonstrated how important providing off-site services can be to strengthen community partnerships.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** 584 individualized support sessions
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals**: **# of unduplicated families:** LOS – is set by target # of individualized support sessions as indicated above
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** Continue to grow level of service now that program is set up. Client satisfaction surveys will be dispersed on a quarterly basis, which will address any progress with improved knowledge of community resources, knowledge of safety, etc.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** Quarterly use of client satisfaction surveys and continued building of community partnership and exploring and providing SAFE services at other community agencies.
5c	**How do you collaborate with community partners?** We strongly collaborate with community partners by outreaching about the expanded services, as well as, also being able to provide some services at their site. We also increased awareness about all of SAFE in Hunterdon's services. We engaged individuals and groups in the community to be part of SAFE in Hunterdon's volunteer program and individuals also joined our community coalition, Partners Promoting Healthy Relationships.

2015 PSSF Update Report

<table>
<tr><th colspan="3">Section 1 – Identifying Information</th></tr>
<tr><td>1a</td><td>Provider: Center For Family Services, SERV Cumberland County</td><td>1b Date: June 1, 2015</td></tr>
<tr><td>1c</td><td colspan="2">Relevant PSSF Program: _X FPS, ___FSS, ___TLFRS, ___APSS</td></tr>
<tr><td>1d</td><td colspan="2">Program Address:
PO Box 1149
Vineland NJ 08360</td></tr>
<tr><td>1e</td><td colspan="2">Objective: To reduce/eliminate the psychological and emotional trauma of family violence experienced by child victims.</td></tr>
<tr><td>1f</td><td colspan="2">Outcome(s) Addressed: ___x_Safety ____Permanency ____Well-Being</td></tr>
<tr><th colspan="3">Section 2 – Service Description Basics FFY ’15 (10/1/13 – 9/30/14)</th></tr>
<tr><td>2a</td><td colspan="2">Overview of Service: SERV Child Advocacy program provides advocacy and support services for child victims of domestic violence. Advocacy includes basic needs assessments, education advocacy, and special needs advocacy. Support services include individual and group counseling, age-appropriate safety planning, and recreational activities. The children’s group meets weekly during the same time as the adult support group and their individual counseling sessions are scheduled at a convenient time for both the parent and the child.
SERV provides a holistic healing environment to help children feel safe and comfortable. As part of the counseling process, all participants are encouraged to explore and express their emotions that often accompany exposure to violence in the home. Role playing, art, music, games, toys, and stories are used by the children to help express their emotions. The child’s age, previous level of adjustment and coping ability, plus the current level of environmental support all shape the specific child’s response to stressful events. The appropriate counseling activities will be individualized and provided in accordance with the outcomes of the intake assessment and observations, with a heightened sensitivity to each child’s preferred method of engagement.
Recreational activities are coordinated through the child counselor and involve celebrations of holidays, birthdays, seasons, and community events. Some activities include trips to the library, movie night, decorating for the seasons, learning about another culture, and ideas from the children. The child’s parent is encouraged to get involved in the activities in hopes the parent will continue this special time with their child once they have left the program.</td></tr>
<tr><td>2b</td><td colspan="2">Population Served: Child victims of domestic violence</td></tr>
<tr><td>2c</td><td colspan="2">Geographical Area of Services: Cumberland County, New Jersey</td></tr>
<tr><td>2d</td><td colspan="2">Referral Sources: SERV clients, victims of domestic violence, outside agencies, and the community.</td></tr>
<tr><th colspan="3">Section 3 – The Year in Review FFY ’15 (10/1/13 – 9/30/14)</th></tr>
<tr><td>3a</td><td colspan="2">Provide a summary of program accomplishments on goals.
Include data where available: Over the past year, children have been seen in individual sessions as well as in groups. In group sessions, children learn skills to be able to cope with violence seen at home</td></tr>
</table>

	over the course of 10 weeks. Children are also able to receive individual sessions for more advanced needs and concerns. These services can occur concurrently or simultaneously. In this past year, 45 children received services. Of those, 31 received individual counseling services, 28 received group counseling services, and 2 received family counseling services.	
3b	**How did this improve outcomes for children and families?** Children who participated in the program began to heal from the effects of domestic violence; experienced an increased awareness and understanding of abusive behavior; and achieved higher levels of safety in the event of future violent incidents.	
3c	**Identify specific factors that contributed to this improvement:** Our success was accomplished through the use of various mediums in counseling including play. The consistency of the Child Counselor in using techniques and activities designed to address the individual needs of the children also contributed to the improvement.	
3d	**Identify significant barriers to goal accomplishment.** None at this time.	
3e	**Definition of Level of Service as per contract**: A unit of service equals 1 hour of counseling or related program activity.	
3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14:** N/A	
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14:** 128 units	
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.** **# of unduplicated individuals: 45 (children)** **# of unduplicated families: 28**	
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** Primary stakeholders are the parents of the children we serve. The majority of the parents report improvement in their children's behavior and overall satisfaction with the services provided.	
	Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program** At this time there are no intended changes to the program.	
4b	**Identify changes you will make that stem from stakeholder feedback.** At this time there are no intended changes to the program.	

4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** 175
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals: 50 children** **# of unduplicated families: 30 families**
	Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)
5a	**How will you measure progress?** SERV utilizes pre and post test with clients as well as victim assistance outcomes forms. Every client establishes short and long-term goals and is re-evaluated on a monthly basis. Follow-up is conducted with permission from the client to determine if their goals have been met, and whether any additional referrals/references are needed.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** Evaluation surveys are used in the first 30 days and then a 3-month and 6-month intervals and upon exit from the program to obtain consumer feedback and measure their progress.
5c	**How do you collaborate with community partners?** SERV participates in community events and meetings, the SERV Program Director is an active Board Member of the Vineland Prevention Policy Board and serves as Co-Chair of the Domestic Violence Workgroup. SERV participates in the Cumberland County Positive Youth Development Coalition. SERV collaborates and has an affiliation agreement with Casa PRAC, Inc., Center for Human Services (CHS), Seeds for Success, and the Police Chaplin program. SERV has a Memorandum Of Understanding with School Based Youth Services programs in Port Norris Middle School, Vineland Boys and Girls Club, Creative Achieve Academy, Impact Program, Cunningham School, RAFT programs. All of the schools participate in a prevention program focused on bystander intervention to prevent sexual and dating violence. SERV has provided prevention and awareness presentations to several community service providers throughout the county on services available and domestic violence. Within a short time period, SERV has become actively involved in the community through coalitions, events, and on the Cumberland County College campus. CCC and SERV have collaborated in awareness and prevention events on campus including a Take Back the Night, a Clothesline Project, and a Candlelight Vigil. For Domestic Violence Awareness Month, SERV collaborated with the Victim Witness Advocacy Unit at the Prosecutor's Office in a DV Walk. The walk turned out at least 70 participants and speakers from survivors to politicians. SERV is an active member of the New Jersey Coalition for Battered Women, New Jersey Coalition Against Sexual Assault, and routinely works in collaboration with DYFS, law enforcement, and superior courts to meet the needs of our clients.

2015 APSR PSSF Update Report

Section 1 – Identifying Information		
1a	**Provider**: Center for Family Services	**1b Program Name:** FPS Step-Down
1c	**Relevant PSSF Program**: _x_FPS, _x_FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 180 South White Horse Pike Clementon, New Jersey 08021	
1e	**Objective**: To provide an extended range of services to families that have completed a Family Preservation (FPS) intervention in order to further strengthen family functioning and address factors supporting permanency and improving child and family well-being.	
1f	**Outcome(s) Addressed**: ___x_Safety __x__Permanency __x__Well-Being	

Section 2 – Service Description Basics	
2a	**Overview of Service**: The Step-Down program provides a community based continuum of care to families that successfully complete an initial Family Preservation Services (FPS) intervention. Program participants receive a comprehensive range of supportive services that extend beyond the short term crisis intervention and stabilization provided by FPS programs. Step-Down services are based on an aftercare model and focus on more enduring issues that impact family functioning and child and family well-being. The overarching goal of the program is to empower and assist families in maintaining a safe and stable home environment. Consistent with the general FPS model, Step-Down programs seek to: ensure child safety by eliminating identified risk factors; prevent out of home placement; improve family functioning; and link families with appropriate community resources. Step-Down programs provide an array of social, health, educational, counseling, and case management support services either directly or through community-based resources. All services are coordinated, individualized, goal-oriented, and adapted to each family's changing needs and circumstances. Participating families receive three (3) to nine (9) months of services provided at differing levels of intensity according to their unique needs and rate of progression in achieving case goals.
2b	**Population Served**: The target population is children and families under DYFS supervision who have completed a 4-8 week FPS intervention program and who require continued support and supervision to further reduce or eliminate risk factors identified by the Division and/or FPS

2c	**Geographical Area of Services**: Camden and Gloucester Counties
2d	**Referral Sources**: Family Preservation Services Program
	Section 3 – The Year in Review FFY ’15 (10/1/13 – 9/30/14)
3a	**Provide a summary of program accomplishments on goals. Use data to support your comments.** • 7 families successfully completed the FPS/FSS Step Down program • Placement disposition of child(ren) at end of the intervention: 42 children remained with their families, 0 were placed by DCP&P • Program level of service is 10 unduplicated families per contract year. The program served 24 families • Step-Down served 1 family 25 months;2 families 11 months; 1family 9 months;3 families 8 months; 1 family 6 months; 4 families 5 months; 1 families 4 months; 1 family 2 months; 2 families 1 month. The average number of days open was 213 days approximately 7 months. Eight families are continuing to work with Step Down and is expected to successfully complete the program • Total number of hours (months): Average = 88.20 hours/family for a Total of 2117 hours
3b	**How did this help children and families experience better outcomes?** Children were able to remain in a safe and stable home environment.
3c	**Identify specific factors that contributed to the improvements/accomplishments.** Contributing factors include the provision of in-home therapeutic services in a strength-based, family-focused manner that empowers a family to move toward health and stability.
3d	**Identify significant barriers to goal accomplishment and how you addressed them.** • Family Preservation Services level of services was high this past contract year. The demand for Step-Down services continues to increase as evidenced by the 23 families served • There is only one staff member on FPS/FSS Step-Down. The demand for her services is great. There is never a down-time period between closing and opening cases • Communication with DCP&P: a strong partnership with DCP&P is essential to best serve the children and families in the program.
3e	**Define the Unit of Service, or Units if more than one** Definition of Unit(s) of Services: One family = one unit of service. Each FPS/FSS Step Down program has one worker who is supervised by the FPS Program Supervisor. At any one time, the maximum caseload is 8 families, depending upon the family’s progress and program phase. A family’s length of stay can extend up to 9 months.
3f	**Enter your <u>contracted</u> Level of Service (number of units expected) funded under**

	Title IV-B PSSF for the period of 10/1/13– 9/30/14 The contracted level of service is 10 unduplicated families.
3g	**Enter your <u>actual</u> Level of Service (number of units delivered) with that Title IV-B funding for the period of 10/1/13 – 9/30/14** The actual Level of Services was 24 unduplicated families
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals (children):87 (56 children)_** **# of unduplicated families: _24_**
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** The satisfaction survey is given to families when services are completed. The survey was given to 16 families. Fourteen families returned` the satisfaction survey. The feedback has been positive.
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section 2 and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program** No changes to the FPS/FSS Step Down program are anticipated.
4b	**Identify changes you will make that stem from stakeholder feedback.** As part of our ongoing commitment to providing the highest quality of services, the FPS/FSS Step Down program will adapt to meet client needs as appropriate based upon Case Record Review Report, NCFAS results and client satisfaction surveys. Upon review of these reports, no changes to the program are anticipated.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** At a minimum, 10 families will be served during FFY'15
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve for the period of 10/1/14 – 9/30/15.** **# of unduplicated individuals: __**60**___** **# of unduplicated families: ____**16**____**
Section 5 – Evaluating Progress FFY '16 (10/1/13 – 9/30/15)	

5a	**How will you measure progress?** • Information regarding placement outcomes and whether or not there were substantiated incidents of child abuse/neglect will be obtained 12 months after discharge • A family's successful completion of the program and improved levels of functioning as documented by the NCFAS standard assessment tool will be considered • Consumer satisfaction surveys will be used
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** Center for Family Services reviews chart for quality assurance in a yearly basis. Also, the Step-Down Supervisor conducts utilization reviews of the charts at the closing of each case. Center for Family services also conducts a client satisfaction survey once a year
5c	**How do you collaborate with community partners?** Ongoing communication with DCP&P in Camden and Gloucester Counties, the Boards of Social Services, the school systems, the mental health system, the legal system are an integral part of the program.

2015 PSSF Update Report

	Section 1 – Identifying Information	
1a	**Provider**: Ocean Mental Services, Inc	**1b Program Name:** FSS/FPS Step Down Program
1c	**Relevant PSSF Program**: ___FPS, _x_ FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 122 Lien St. Toms River, NJ. 08753	
1e	**Objective**: To provide an extended range of services to families that have completed a Family Preservation (FPS) intervention in order to further strengthen family functioning and address factors supporting permanency and improving child and family well-being.	
1f	**Outcome(s) Addressed**: _x_Safety _x_Permanency _x_Well-Being	

	Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)
2a	**Overview of Service**: The Step-Down program provides a community based continuum of care to families that successfully complete an initial Family Preservation Services (FPS) intervention. Program participants receive a comprehensive range of supportive services that extend beyond the short term crisis intervention and stabilization provided by FPS programs. Step-Down services are based on an aftercare model and focus on more enduring issues that impact family functioning and child and family well-being. The overarching goal of the program is to empower and assist families in maintaining a safe and stable home environment. Consistent with the general FPS model, Step-Down programs seek to: ensure child safety by eliminating identified risk factors; prevent out of home placement; improve family functioning; and link families with appropriate community resources. Step-Down programs provide an array of social, health, educational, counseling, and case management support services either directly or through community-based resources. All services are coordinated, individualized, goal-oriented, and adapted to each family's changing needs and circumstances. Participating families receive three to nine months of services provided at differing levels of intensity according to their unique needs and rate of progression in achieving case goals.
2b	**Population Served**: The target population is children and families under DCPP supervision who have completed a 4-8 week FPS intervention program and who require continued support and supervision to

	further reduce or eliminate risk factors identified by the Division and/or FPS.
2c	**Geographical Area of Services**: Ocean County
2d	**Referral Sources**: Family Preservation Services Program
Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)	
3a	**Provide a summary of program accomplishments on goals.** **Include data where available:** The Step-Down program exceeded its contracted level of service for the reporting period associated with this grant, as 10 families and 19 children received services. Of the 10 families receiving services, 7 families were discharged within this reporting period with 3 families carrying over into the next federal fiscal year. The following data reflects the 7 discharged families. The 7 families comprised of a total of 13 children that received an average intervention of 7 months. All 13 children served or 100% remained safely at home upon completing the program.
3b	**How did this improve outcomes for children and families?** Children were able to remain in a safe and stable home environment.
3c	**Identify specific factors that contributed to this improvement:** A key factor to the program's success is the provision of in-home supportive counseling services that are delivered in a strength based, family focused manner which empowers families to move toward health and stability.
3d	**Identify significant barriers to goal accomplishment:** Barriers to goal accomplishment include the unwillingness of some families to participate in services once the case has been opened, as participation is voluntary. Other barriers include issues related to staff turnover.
3e	**Definition of Level of Service as per contract:** One family equals one unit of service. Each FPS/FSS Step Down program has one worker who is supervised by the FPS Program Supervisor. At any one time, the maximum caseload is 8 families, depending upon the family's progress and the intensity of services being provided. A family's length of stay can extend up to 9 months.
3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14:** 8
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the**

	period of 10/1/13 – 9/30/14: 10
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals:** 19 **# of unduplicated families:** 10
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** Families are provided with a Participant Satisfaction Survey at the end of the intervention to complete and return. 8 surveys were returned with positive feedback on the service provided.
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.** No changes to the program are anticipated.
4b	**Identify changes you will make that stem from stakeholder feedback.** As part of its commitment to providing quality services, the FPS/FSS Step Down program adapts to meet the needs of its clients based on internal reviews, contract monitoring activities, and client satisfaction surveys. There are no changes anticipated at this time.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** 10 families
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals**: 20 **# of unduplicated families:** 10
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** Progress is measured through the following methods: *A family's successful completion of the program and improved levels of functioning as documented by the NCFAS standard assessment tool. *Individual supervision provided on a weekly and as needed basis. *Ongoing record reviews by the program supervisor *Follow-up information regarding subsequent incidents of child abuse/neglect and out-of-home

	placements 12 months after clients are discharged from the program.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** Quality assurance is monitored throughout the course of the contract term via aggregate NCFAS assessment results that indicate trends in services and family needs, feedback from the DCPP local office, DCF contract monitoring processes, and consumer satisfaction surveys.
5c	**How do you collaborate with community partners?** FPS/FSS Step Down program communicate on a regular basis with the Division of Child Protection and Permanency by sending written reports of a family's progress every 45 days and reaching out to consult with the family's DCPP case worker as needed. Additionally, the Step Down program works collaboratively with other collateral community services such as DCBH, Perform Care, Schools, Social Welfare Services, local domestic violence shelters, health care providers and others as dictated by the needs of the families with whom we are working. It is important to note that one of the hallmarks of the Step Down program is the empowerment of families to advocate for themselves with various community services. Much work is done to assist families in the navigation of the various service systems.

2015 PSSF Update Report

Section 1 – Identifying Information		
1a	**Provider**: Youth Consultation Services	**1b Program Name:** FPS Step-Down
1c	**Relevant PSSF Program**: ___FPS, _X_ FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 711 32 Street, 2nd Floor Union City, NJ 07087	
1e	**Objective**: To provide an extended range of services to families that have completed a Family Preservation (FPS) intervention in order to further strengthen family functioning and address factors supporting permanency and improving child and family well-being.	
1f	**Outcome(s) Addressed**: __X Safety _X_Permanency _X__Well-Being	
Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)		
2a	**Overview of Service**: The Step-Down program provides a community based continuum of care to families that successfully complete an initial Family Preservation Services (FPS) intervention. Program participants receive a comprehensive range of supportive services that extend beyond the short term crisis intervention and stabilization provided by FPS programs. Step-Down services are based on an aftercare model and focus on more enduring issues that impact family functioning and child and family well-being. The overarching goal of the program is to empower and assist families in maintaining a safe and stable home environment. Consistent with the general FPS model, Step-Down programs seek to: ensure child safety by eliminating identified risk factors; prevent out of home placement; improve family functioning; and link families with appropriate community resources. Step-Down programs provide an array of social, health, educational, counseling, and case management support services either directly or through community-based resources. All services are coordinated, individualized, goal-oriented, and adapted to each family's changing needs and circumstances. Participating families receive three (3) to nine (9) months of services provided at differing levels of intensity according to their unique needs and rate of progression in achieving case goals.	
2b	**Population Served**: The target population is children and families under DCP&P supervision who have completed a 4-8 week FPS intervention program and who require continued support and supervision to further reduce or eliminate risk factors identified by the Division and/or FPS.	
2c	**Geographical Area of Services**:	

	Hudson County
2d	**Referral Sources**: Family Preservation Services (only)
	Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)
3a	**Provide a summary of program accomplishments on goals.** **Include data where available:** • 9 families with 21 children received FPS Step Down services**.** • Placement disposition of child(ren) at end of the intervention: 20 children remained home upon completing the FPS/FSS Step Down program • Length of stay: On average, families participated in the program for 5 months, receiving an average of 40 hours of face-to-face sessions.
3b	**How did this improve outcomes for children and families?** Children were able to remain in a safe and stable home environment with the exception of one child who voluntarily relocated with her biological father.
3c	**Identify specific factors that contributed to this improvement:** One of the key factors contributing to the success of the program is the in-home therapeutic services and support services provided to the family focusing on empowering families to continue reaching their goals in a healthy and stable manner.
3d	**Identify significant barriers to goal accomplishment:** Family Preservation level of services, i.e. if the FPS program level of service is low, then the pool of cases to refer to the Step-Down program reduces.
3e	**Definition of Level of Service as per contract:** Definition of Unit(s) of Services: One family=one unit of service. Each FPS/FSS Step Down program has one worker who is supervised by the FPS Program Supervisor. At any one time, the maximum caseload is 8 families, depending upon the family's progress and program phase. A family's length of stay in the program may be extended up to 9 months.
3f	**Enter your contracted Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14:** A minimum of 10 families per year.
3g	**Enter your actual Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14:** 9 families
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals: 35** **# of unduplicated families: 9**
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** All Step Down families were provided with Satisfaction Surveys at the end of the intervention to complete and return. Each parent was given a survey, 11 parents in total and 12 children in total. The remaining 9 children were not provided with surveys due to their

	age, ranging from 1-8 year old. Responses and survey results are monitored by YCS research department, at this time the results are not available.
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.** No changes to the FPS/FSS Step Down program are anticipated.
4b	**Identify changes you will make that stem from stakeholder feedback.** FPS/FSS Step Down program has a commitment to provide quality services by adapting to meet the appropriate requirements of each client based upon the review of such reports from YCS client satisfaction surveys, DCP&P case record reviews, and NCFAS results. No changes are anticipated at this time.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** A minimum of 10 families will be served.
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals**: 38 **# of unduplicated families: 10**
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** • The family's successful completion of the program • Client satisfaction survey • NCFAS: North Carolina Family Client Assessment Scale • Follow-up information in regards to subsequent incidents of child abuse/neglect and out-of-home placements 12 months after the clients are discharged from the program. • Individual supervision on a bi-weekly or as needed basis.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** • Case Record Reviews conducted by YCS. • Client Satisfaction Surveys • Cumulative NCFAS assessment results that indicate trends in service provision and family level of need.
5c	**How do you collaborate with community partners?** FPS/FSS Step Down program communicates with DCP&P by sending written reports of the progress each family has every 45 days and through contact with the DCP&P case worker as needed to discuss matters concerning such families. Step Down program works in conjunction with collateral community services such as: local schools, Perform Care, shelters, social welfare services and health care providers or other services dictated by the needs of the families being serviced. Step Down program thrives on empowering each family to advocate for themselves and navigate various community services to ensure and maintain stabilization of the families.

2015 PSSF Update Report

Section 1 – Identifying Information		
1a	**Provider**: Catholic Charities, Diocese of Metuchen	**1b Program Name:** FPS Step Down
1c	**Relevant PSSF Program**: _X__FPS, ___FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 26 Safran Avenue Edison, NJ 08837	
1e	**Objective**: The target population is children and families under DCP&P supervision who have completed a 4-8 week FPS intervention and who require continued support and supervision to further reduce or eliminate risk factors identified by the Division and/or FPS.	
1f	**Outcome(s) Addressed**: __X__Safety _X___Permanency _X___Well-Being	

Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)	
2a	**Overview of Service**: The Step-Down program provides a community-based continuum of care to families that successfully complete an initial Family Preservation Services (FPS) intervention. Program participants receive a comprehensive range of supportive services that extend beyond the short-term crisis intervention and stabilization provided by FPS programs. Step-Down services are based on an aftercare model and focus on more enduring issues that impact family functioning and child and family well-being. The over-arching goal of the program is to empower and assist families in maintaining a safe and stable home environment. Consistent with the general FPS model, Step-Down programs seek to: ensure child safety by eliminating identified risk factors; prevent out of home placement; improve family functioning; and link families with appropriate community resources. Step-Down programs provide an array of social, health, educational, counseling, and case management support services either directly or through community-based resources. All services are coordinated, individualized, goal-oriented, and adapted to each family's changing needs and circumstances. Participating families receive three (3) to nine (9) months of services provided at differing levels of intensity according to their unique needs and rate of progression in achieving case goals.
2b	**Population Served**: Families under DCP&P supervision who have completed a 4-8 week FPS intervention and who require continued support and supervision to further reduce or eliminate risk factors identified by the Division and/or FPS.
2c	**Geographical Area of Services**: Middlesex County
2d	**Referral Sources**: Middlesex County Family Preservation Services Program

<table>
<tr><th colspan="2">Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)</th></tr>
<tr><td>3a</td><td>Provide a summary of program accomplishments on goals.
Include data where available.

➢ Goal 1: Child remains home in a safe and stable environment at 12 months post-termination. During FFY 2014, five families (13 clients) were contacted for follow-up purposes. Of those, all 13 were living in the home at 12 months post-termination.
➢ Goal 2: Program maintains fidelity to the established Step Down model. The program's most recent record review was conducted in October 2012 by staff from DCP&P; however the written results have not been received by Catholic Charities. Verbal feedback indicated clients were provided with quality services in accordance with the program model, and no concerns were identified.</td></tr>
<tr><td>3b</td><td>How did this improve outcomes for children and families?
Children were able to remain in a safe and stable home environment.</td></tr>
<tr><td>3c</td><td>Identify specific factors that contributed to this improvement:
Contributing factors include the provision of in-home therapeutic services in a strength-based, family-focused manner that empowers a family to move toward health and stability.</td></tr>
<tr><td>3d</td><td>Identify significant barriers to goal accomplishment:
No barriers.</td></tr>
<tr><td>3e</td><td>Definition of Level of Service as per contract:
One family = one unit of service</td></tr>
<tr><td>3f</td><td>Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14
Contracted LOS is 8 to 10 families</td></tr>
<tr><td>3g</td><td>Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14
During FFY 2014, eight families were served.</td></tr>
<tr><td>3h</td><td>How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.

# of unduplicated individuals: <u>16</u>
# of unduplicated families: <u>8</u></td></tr>
<tr><td>3i</td><td>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.
During this time period, the program distributed satisfaction surveys to five families, and four were returned. All families reported feeling that the service was helpful and that their situation was better than it was prior to the treatment. Additionally, all respondents reported being happy with their clinician and happy with the service.</td></tr>
</table>

Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.** No changes are anticipated.
4b	**Identify changes you will make that stem from stakeholder feedback.** As part of its commitment to providing the highest quality of services, the Step Down program adapts to meet each family's needs based on case record reviews, internal quality control measures, and client satisfaction surveys. At this time, no changes are anticipated.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** The program anticipates that 10-12 families will be served during FFY 2015.
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals: 20** **# of unduplicated families: 11**
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** ➢ Information regarding placement outcomes and subsequent incidents of child abuse/neglect will be obtained 12 months after discharge via telephone interviews with clients. ➢ A family's successful completion of the program and improved levels of functioning as documented by the NCFAS standard assessment tool will be considered. ➢ Consumer satisfaction surveys will be used.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** The Step-Down program will utilize the following methods as part of its on-going quality assurance and self-assessment process: ➢ Case record reviews conducted by DCP&P ➢ Utilization reviews conducted quarterly by the program supervisor ➢ Consumer satisfaction surveys distributed twice per year ➢ Aggregate NCFAS assessment results that indicate trends in service and family needs
5c	**How do you collaborate with community partners?** Ongoing communication with DCP&P and other collateral supports is an integral part of the program. As part of the program's case management responsibilities, Step Down staff is in frequent contact with other service providers and community-based agencies that are working with these families.

2015 PSSF Update Report

Section 1 – Identifying Information		
1a	**Provider**: Twin Oaks Community Services	**1b Program Name:** FPS Step Down
1c	**Relevant PSSF Program**: __x_FPS, __x_ FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 11 38 East Chestnut Avenue, Unit 3 – A Vineland, New Jersey 08360	
1e	**Objective**: To provide an extended range of services to families that have completed a Family Preservation (FPS) intervention in order to further strengthen family functioning and address factors that support permanency and improve child and family well – being.	
1f	**Outcome(s) Addressed**: _x___Safety _x___Permanency __x__Well-Being	

Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)	
2a	**Overview of Service**: The Step Down program provides a community based continuum of care to families that successfully complete an initial Family Preservation Services (FPS) intervention. Program participants receive a comprehensive range of supportive services that extend beyond the short term crisis intervention and stabilization provided by FPS programs. Step Down services are based on an aftercare model and focus on more enduring issues that impact family functioning and child and family well-being. The overarching goal of the program is to empower and assist families in maintaining a safe and stable home environment. Consistent with the general FPS model, Step Down programs seek to : ensure child safety by eliminating identified risk factors; prevent out of home placement; improve family functioning; and link families with appropriate community resources. Step Down Programs provide an array of social, health, educational, counseling, and case management support services either directly or through community- based resources. All services are coordinated, individualized, goal-oriented, and adapted to each family's changing needs and circumstances. Participating families receive three (3) to nine (9) months of services provided at differing levels of intensity according to their unique needs and rate of progression in achieving case goals.
2b	**Population Served**: The target population is children and families under DCP & P supervision who have completed a 4-8 week FPS intervention program and who require continued support and

	supervision to further reduce or eliminate risk factors identified by the Division and/or FPS.
2c	**Geographical Area of Services**: Cumberland County
2d	**Referral Sources**: Family Preservation Services
Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)	
3a	**Provide a summary of program accomplishments on goals.** **Include data where available:** **During this time period we serviced 11 families. Three families achieved /met all goals. Eight families achieved at least one of their goals.**
3b	**How did this improve outcomes for children and families?** **Of the two families that had a one year follow up , the children remain in the home. The other family, two of the children remain in the home and the other two children are living with a relative.**
3c	**Identify specific factors that contributed to this improvement:** **The provision of in-home therapeutic services in a strength based, family focused manner that empowers families to move toward health and stability are the primary factors that contribute to improved outcomes for children.**
3d	**Identify significant barriers to goal accomplishment:** **Of the eleven families serviced, there were four interrupted cases, meaning the families did not complete at least the minimum of three months. However, these same families were able to achieve at least one of their goals. Perhaps, if they had continued with the program, they could've achieved all of their goals.**
3e	**Definition of Level of Service as per contract:** **One family = one unit of service.**
3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14:** Twin Oaks is contracted to serve 20 families per year.
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14:** **11 units**
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals: 25**

	# of unduplicated families: 11
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** **11 families were serviced during this time period. 3 of the 11 families were interrupted, noting they did less than the minimum three months in program. Four Twin Oaks Feedback Surveys were returned. In the four surveys, consumers report overall satisfaction with services provided. One survey provided additional comments of " I'm really going to miss you all!!! We enjoyed every moment with you". There were seven Step Down Satisfaction Surveys returned. Seven of the surveys report a number 5 as far as satisfaction. Five being the highest score.**
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.** The FPS Step Down program service model is standard and will remain unchanged.
4b	**Identify changes you will make that stem from stakeholder feedback.** **As per our consumer satisfaction surveys, family stakeholders have reported that they enjoy the service and felt that it was beneficial for their family needs.**
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** 20 families
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals**: 40 **# of unduplicated families: 20**
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** • **Information regarding placement outcomes and whether or not they were substantiated incidents of child abuse/neglect will be obtained 12 months after discharge** • **A family's successful completion of the program and improved levels of functioning as documented by the NCFAS standard assessment tool will be considered** • **Consumer satisfaction feedback surveys will be used** • **Quality Assurance calls to the stakeholders during services**
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** **Quality assurance is monitored throughout the course of the contract term via** • **Feedback from the DCP&P local offices**

	• **DCF contract monitoring process** • **Consumer satisfaction surveys** • **Quality Assurance calls to the stakeholders during services**
5c	**How do you collaborate with community partners?** **Communication with the DCP&P and other collateral supports is an integral part of the program. As part of the program's case management responsibilities, Step Down staff is in frequent contact with other service providers and community-based agencies that are working with these families.**

2015 PSSF Update Report

<table>
<tr><th colspan="3">Section 1 – Identifying Information</th></tr>
<tr><td>1a</td><td>Provider: The Bridge</td><td>1b Program Name: FPS / FSS Step Down Program</td></tr>
<tr><td>1c</td><td colspan="2">Relevant PSSF Program: _X__FPS, _X__ FSS, ___TLFRS, ___APSS</td></tr>
<tr><td>1d</td><td colspan="2">Program Address:
589 Grove Street
Irvington, NJ 07111</td></tr>
<tr><td>1e</td><td colspan="2">Objective:
To provide an extended range of services to families that have completed a Family Preservation (FPS) intervention in order to further strengthen family functioning and address factors supporting permanency and improving child and family well-being.</td></tr>
<tr><td>1f</td><td colspan="2">Outcome(s) Addressed: __X__Safety __X__Permanency __X__Well-Being</td></tr>
<tr><th colspan="3">Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)</th></tr>
<tr><td>2a</td><td colspan="2">Overview of Service:
The Step-Down program provides a community based continuum of care to families that successfully complete an initial Family Preservation Services (FPS) intervention. Program participants receive a comprehensive range of supportive services that extend beyond the short term crisis intervention and stabilization provided by FPS programs. Step-Down services are based on an aftercare model and focus on more enduring issues that impact family functioning and child and family well-being.

The overarching goal of the program is to empower and assist families in maintaining a safe and stable home environment. Consistent with the general FPS model, Step-Down programs seek to: ensure child safety by eliminating identified risk factors; prevent out of home placement; improve family functioning; and link families with appropriate community resources.

Step-Down programs provide an array of social, health, educational, counseling, and case management support services either directly or through community-based resources. All services are coordinated, individualized, goal-oriented, and adapted to each family's changing needs and circumstances.

Participating families receive three (3) to nine (9) months of services provided at differing levels of intensity according to their unique needs and rate of progression in achieving case goals.</td></tr>
<tr><td>2b</td><td colspan="2">Population Served:
The target population is children and families under DCP&P supervision who have</td></tr>
</table>

	completed a 4-8 week FPS intervention program and who require continued support and supervision to further reduce or eliminate risk factors identified by the Division and/or FPS
2c	**Geographical Area of Services**: Essex and Union Counties
2d	**Referral Sources**: Family Preservation Services Program
Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)	
3a	**Provide a summary of program accomplishments on goals.** **Include data where available:** ***Cases Opened:*** **10** families and **24** children received Step-Down services during FFY '14. **0** out of the **10** families and **0** out of the **24** children were carried over from FFY '13. ***Cases Closed:*** **4** out of the **6** families completed Step-Down services during FFY '14 **10** out of the **16** children completed Step-Down services during FFY '14 Of this figure: • **14** out of the **16** children remained with their families at end of the intervention; indicating a **87.5** % placement prevention rate • On average, each family received **149** days of service or **5** months of service • On average, each family received **35** direct face-to-face hours of service • Aggregate data indicates that a total of **208.25** direct service hours with a range of direct service hours between **6.5** hours and **71.25** hours were provided, and **295** indirect service hours were provided during FFY 2014
3b	**How did this improve outcomes for children and families?** Children were able to remain in a safe and stable home environment.
3c	**Identify specific factors that contributed to this improvement:** The provision of in-home therapeutic services in a strength based, family focused manner that empowers a family to move toward health and stability.
3d	**Identify significant barriers to goal accomplishment:** A couple of barriers related to goal accomplishment included the following: Step Down is a voluntary program; some of the families did not make themselves completely available throughout the intervention which impacted the service time. We experienced staff turnover which had an impact on the receipt of cases. A Step Down counselor was hired and trained during this time period, which impacted the Level of Service.
3e	**Definition of Level of Service as per contract:** One family = one unit of service.

3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14:** 8 to 10 families per year
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14:** __6____ families received and completed Step Down services during FFY '14
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals:** _16 children__ **# of unduplicated families:** _6____________
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** Satisfaction Surveys are distributed to families at termination and either mailed back to the agency or submitted in a sealed envelope as a means of gathering confidential client feedback. __3____ surveys were provided (__2___ out of the __6___ families were not available for an exit interview); __2___ surveys were returned and __1___ survey was not returned. __1___ survey was not able to be provided due to the limited cognitive ability of the client. All clients responded positively and indicated their satisfaction with the services delivered by Step Down. One client commented, "*Step Down* taught me the "how to" of being a loving, but firm & consistent parent, which I am convinced, helped the four of us to go on our vacation together & helped the judge with the idea of reunification."
	Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.** No changes to the FPS/FSS Step Down program are anticipated.
4b	**Identify changes you will make that stem from stakeholder feedback.** As part of the program's ongoing commitment to providing quality services, the FPS/FSS Step Down program adapts to meet the needs of its clients as appropriate based upon the Case Record Review Report (DCP&P), NCFAS assessment results and client satisfaction surveys. Upon review of these reports, no changes to the program are anticipated.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** 8 to 10 families will be served during FFY 2015
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals**: _16 children__

	# of unduplicated families: _8_
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** • 12 month follow up information regarding placement outcomes will be obtained 12 months post discharge from the Step Down program • A family's successful completion of the program and improved levels of functioning as documented by the NCFAS standard assessment tool will be considered • Consumer satisfaction surveys will be used • Achievement of the contracted Level of Service
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** • The Bridge will conduct utilization reviews of all charts to ensure compliance with programmatic standards and customer satisfaction surveys will be obtained from families who complete the program. • The Step Down Supervisor will obtain feedback from DCP&P Case Managers. • The Step-Down Supervisor will conduct random quality assurance telephone calls to client families in order to obtain their feedback. Based upon responses that are received, the program will make any changes that are necessary to improve services.
5c	**How do you collaborate with community partners?** Ongoing communication with DCP&P and other collateral supports is an integral part of the program. The program's collaborative efforts include: providing Acceptance Letters to DCP&P, engaging in Bi-weekly Communication with DCP&P, submitting 45 Day Review Reports to DCP&P, inviting DCP&P workers to family sessions on an as needed basis, and initiating telephone contact with collateral services.

2015 PSSF Update Report

Section 1 – Identifying Information		
1a	**Provider**: The Bridge	**1b Program Name:** FPS Boarder Baby Program
1c	**Relevant PSSF Program**: _X__FPS, ___ FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 589 Grove Street Irvington, NJ 07111	
1e	**Objective**: The purpose of the FPS Boarder Baby Program is to work with the family with whom the infant/child has been placed and to provide intensive in-home counseling in order to stabilize the family and maintain the placement.	
1f	**Outcome(s) Addressed**: __X__Safety __X__Permanency __X__Well-Being	
Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)		
2a	**Overview of Service**: The Bridge provides Family Preservation Services in Essex and Union Counties, which consists of short-term intensive in-home counseling services. Services are designed to stabilize the family's crisis, facilitate child safety, reduce the risk of child abuse and neglect, & avoid the unnecessary out-of-home placement of a child or lengthy stay in hospital. Services are responsive (within 72 hours of referral), intensive (5 -20 hrs of direct time per week), accessible (24 hours/7 days a week), focused on family strengths, goal oriented (2 -4 goals developed with the family to address problems that led to the crisis), family centered, and focused on skill building and problem resolution.	
2b	**Population Served**: Newborn infants who are medically cleared for discharge but not released because they are identified as being at risk of abuse, neglect or abandonment.	
2c	**Geographical Area of Services**: Essex County and Union County	
2d	**Referral Sources**: The Division of Child Protection and Permanency	
Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)		
3a	**Provide a summary of program accomplishments on goals.** **Include data where available:** 1. _**4**__ Families and _**14**___Children received services from the FPS Boarder Baby program. The average length of service that families received was__**35**___days. The average direct	

	hours of service that families received were **_34.25__** hours. 2. Placement disposition of children at the end of FPS intervention was **_92.86** %. The placement prevention rate at six months post termination of FPS averaged **100 %** for the FFY 2014.
3b	**How did this improve outcomes for children and families?** Children were able to remain in a safe and stable home environment.
3c	**Identify specific factors that contributed to this improvement:** The provision of in-home therapeutic services in a strength based, family focused manner that empowers a family to move toward health and stability were factors that contributed towards the accomplishments.
3d	**Identify significant barriers to goal accomplishment:** No barriers to service were identified.
3e	**Definition of Level of Service as per contract:** One family equals one unit of service.
3f	**Enter your contracted Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14:** Up to 14 families as needed.
3g	**Enter your actual Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14:** 4 families received FPS Boarder Baby Services
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals:** 14 Children **# of unduplicated families:** 4 Families
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** Satisfaction surveys are distributed towards the end of the intervention. The family is provided with a self-addressed stamped envelope. __3___ surveys were submitted to the families. __3__ out of the _3__ surveys were returned by the families. The surveys indicated that the families were satisfied with the services rendered. Verbal feedback received from the referral source, DCP&P, indicates that they are happy and satisfied with the provision of services rendered to the families. One family commented, *"Having FPS in my life changed me as a person because I use to be so sad*

	before and now I feel so free and I believe in myself now."
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.** No changes to the FPS Boarder Baby program are anticipated.
4b	**Identify changes you will make that stem from stakeholder feedback.** As part of the program's ongoing commitment to providing quality services, the FPS Boarder Baby program adapts to meet the needs of its clients as appropriate based upon the Case Record Review Report (DCP&P) and client satisfaction surveys. Upon review of these reports, no changes to the program are anticipated.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** Up to 14 family units of service will be delivered depending on the specified need of DCP&P and the rate of referrals submitted to the program.
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals**: Up to 14 children will be served depending upon the rate of referrals received from DCP&P **# of unduplicated families:** Up to 14 families will be served depending upon the rate of referrals received from DCP&P
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** • Client Satisfaction Survey • Program Level of Service • Placement Outcomes • A family's successful completion of the program
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** Utilization Reviews will be conducted where all charts will be reviewed to ensure compliance with programmatic standards. Customer satisfaction surveys will be obtained from families who complete the program. Feedback will be received from DCP&P Case Managers. Random quality assurance telephone calls will be made to client families in order to obtain their feedback. Agency auditing of all programs will be conducted by an outside auditing agency.

5c	**How do you collaborate with community partners?** Ongoing communication with DCP&P and other collateral supports is an integral part of the program. The program's collaborative efforts include: Distribution of email notification to DCP&P RDS's to make known the available slots to receive referrals, submittal of Monthly & Quarterly Reports, FPS provision of In-Service sessions as needed or requested in order to promote the use of the program to current and new DCP&P workers. Upon receipt of the referral, DCP&P is invited out to the intake session; during the intervention, DCP&P is invited to the Mid-Case Conference and Termination Session.

2015 PSSF Update Report

	Section 1 – Identifying Information	
1a	**Provider**: Preferred Children's Services	**1b Program Name:** Family Visitation
1c	**Relevant PSSF Program**: _X__FPS, ___ FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 1200 River Avenue Suite 9D Lakewood, NJ 08701	
1e	**Objective**: Provide supervised and clinical services that will assist families in maintaining and increasing their understanding of childcare basic needs, familial bonds, communication, emotion recognition, anger management, organizational skills, age appropriate boundaries and limits, as well as provide an in-depth understanding of the DCP&P case and the permanency plan when appropriate.	
1f	**Outcome(s) Addressed**: _X___Safety _X___Permanency __X__Well-Being	

	Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)
2a	**Overview of Service**: Please note that Title IV-B funding accounts for less than 10 % of the program. The information contained within this report evaluates the program in its entirety as there is no way to isolate which 10% of consumers are funded by IV-B. Family Visitation provides an array of services; supervised visitation, therapeutic visitation, and in-home therapy. • Supervised visitation provides an avenue for the family to maintain regular, positive contact on a planned basis between children, parents, family members and significant others that will reinforce the plan of reunification, help children to maintain a sense of family identity or determine other permanent plans for the child. • Therapeutic visitation is similar to supervised visitation in that it is designed to maintain regular scheduled contact for families who have an open case with the Division of Child Protection and Permanency (DCP&P) and children in out of home placement. It does differ, however, in that a clinical approach is utilized to guide the family through the permanency process as it pertains to visitation, understanding reason for placement and moving toward reunification/permanency. The goal of the program is to enhance the safety and well-being of children during visitation, while supporting the plan for permanency. • In-home therapy provides home-based clinical interventions for families, whose children are at risk for out of home placement or transitioning back into the family home. The goal is to promote permanency of the family. This is accomplished through interventions that focus on physical and emotional safety and well-being of children.
2b	**Population Served**:

	Families with an open DCP&P case in which children are in placement, at risk of placement, or transitioning to reunification.
2c	**Geographical Area of Services**: Ocean County, New Jersey
2d	**Referral Sources**: Ocean North and South Local offices
	Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)
3a	**Provide a summary of program accomplishments on goals.** **Include data where available:** 100% of the clients who became invested in the program achieved regularly scheduled contact. 100% of the families that participated in therapeutic visitation were provided with trained LAC/LPC/LSW/LCSW level staff to guide communication as it related to the DCP&P case and permanency. 100%Families were provided with the necessary skills and techniques for setting age appropriate limits and boundaries. 100% of the children who participated in the program had their basic care needs met.
3b	**How did this improve outcomes for children and families?** The program achieved the desired results as seen in children's understanding of the DCP&P situation. This was evaluated through intakes, progress notes, and interim assessments. Children identified as having either no understanding or a broad concept for DCP&P involvement at time of intake gained insight into reasons for their placement outside of the family home, the action steps necessary for reunification and which family member was responsible for achievement. In addition, parents who openly participated in the program were able to identify how their choices and lifestyle factors (substance use, domestic violence, lack of/minimal parenting knowledge, etc) impacted the family unit and the child's mental/emotional health (also seen and measured through use of progress notes and the interim assessment).
3c	**Identify specific factors that contributed to this improvement:** • Families were available and arrived for scheduled appointments • Parents willingness to accept responsibility for their actions and discuss participation in court ordered or recommended services with their children • Family members participated in treatment, practiced and applied skills.
3d	**Identify significant barriers to goal accomplishment:** • One significant barrier lies within the parameters of the program when families do

	not schedule appointments or do not become invested in service and DCP&P or the Family Court request the slot be held for a period of time. This negates success for families that may remain on the wait list. • A second barrier is the available funding which determines the pay rate of professionals, this only allows for entry level clinicians and frequently results in staff turnover.
3e	**Definition of Level of Service as per contract:** Units of service is defined as the number of families that participated in the program.
3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14:** 504 total units, funding from Title IV-B is equivalent to less than 10%
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14:** 297 total units (10% funded by Title IV-B) There is a large difference between the contracted units due to vacant positions, multiple families utilizing various services (preventing additional units (family participation) at the request of DCP&P and Family Court.
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals:** **# of unduplicated families:** 52 (10% funded by IV-B) *(please note this number differs from that submitted with the quarterly report as that number counts each family once per month not per year)*
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** **Stakeholder feedback was primarily received through weekly or biweekly conferences between Program Director, Resource Development Specialists, DCP&P Supervisors, and DCP&P Casework Supervisors. Additional non-formal feedback was provided through caseworker and program direct staff and submitted for review at team meetings.**
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.** Currently there are no planned changes to the program.

4b	**Identify changes you will make that stem from stakeholder feedback.** Information will be uploaded into the NJ-SPIRIT system more frequently to allow DCP&P readily accessible documentation to meet their guidelines and to provide Discovery for litigation cases**.**
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** Contracted units of Service will remain the same; 504 total (less than 10 % funded by IV-B)
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals**: **# of unduplicated families:** 126 (estimate that each family will participate for a duration of 4 months currently DCP&P requests no duration be built into program)
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** The program will continue use of intakes, treatment plans, and interim assessments to measure the arc of improvement. In addition, outcome measures will continue to focus 6-12 month post discharge. Emphasis will be placed on measuring success as no new allegations of abuse/neglect or out of home placement.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** • Continue conferences with the Resource Development Specialists to determine areas of concern, needs, and focus of program services. • Consideration to re-implement the stakeholder surveys (historically these surveys were not completed) • Consumer surveys will continue to be sent at time of program discharge. • Staff will continue to allow flexibility outside appointments to meet with consumers to address program service delivery and goals • Program suggestion box will remain in the reception area
5c	**How do you collaborate with community partners?** Program staff provides intensive, efficient, family friendly case management. They not only assist the family in assessing their strengths and develop a plan, they engage in continuous communication with DCP&P to ensure results. Staff participates in Family Team Meetings when invited by consumers, obtains releases from family/DCP&P to discuss progress with other service providers, participates in clinical team meetings, and participates in scheduled & unscheduled case conferences. Preferred Children's Services operates several family support programs: TANF Initiative for Parents (TIP), Healthy Families, Mobile Response, Family Friendly Center, four School Based Programs, Family

	Support, and Post TANF services. Each of these programs has a strong case management component with a strong network of collaborators. Preferred not only accesses family support programs for consumers easily, it also utilizes existing relationships to accelerate engagement with other service providers and government entities.

2015 PSSF Update Report

<table>
<tr><th colspan="3">Section 1 – Identifying Information</th></tr>
<tr><td>1a</td><td>Provider: Twin Oaks Community Services</td><td>1b Program Name: FOCUS</td></tr>
<tr><td>1c</td><td colspan="2">Relevant PSSF Program: _X_FPS, ___ FSS, ___TLFRS, ___APSS</td></tr>
<tr><td>1d</td><td colspan="2">Program Address:
79 Chestnut Street
Lumberton, NJ 08048</td></tr>
<tr><td>1e</td><td colspan="2">Objective:
Prevention of hospitalization and/or placement in residential treatment in order to maintain children in their own homes and attain or improve child and family well-being.</td></tr>
<tr><td>1f</td><td colspan="2">Outcome(s) Addressed: ___Safety ___Permanency _X_Well-Being</td></tr>
<tr><th colspan="3">Section 2 – Service Description Basics FFY ’15 (10/1/13 – 9/30/14)</th></tr>
<tr><td>2a</td><td colspan="2">Overview of Service:
Intensive in-home family therapy for children and families involved in the children’s acute mental health system. Master’s level therapists work with families up to 3 hours per week for 6 months. The primary goals are prevention of hospitalization and residential treatment.</td></tr>
<tr><td>2b</td><td colspan="2">Population Served:
Children ages 5 to 21 and their families.</td></tr>
<tr><td>2c</td><td colspan="2">Geographical Area of Services:
Burlington, Atlantic, Camden, Cape May, Gloucester, Cumberland, and Salem counties.</td></tr>
<tr><td>2d</td><td colspan="2">Referral Sources:
Children’s Crisis Intervention Services units in the Southern Region, Mobile Response, DCP&P, and Psychiatric Community Residences in the Southern Region.</td></tr>
<tr><th colspan="3">Section 3 – The Year in Review FFY ’15 (10/1/13 – 9/30/14)</th></tr>
<tr><td>3a</td><td colspan="2">Provide a summary of program accomplishments on goals. Include data where available.
Program objectives were:
Prevent hospitalization for at least 75% of active consumers.
This objective was met 100% for both consumers while engaged in services. No hospitalizations were reported during service delivery. One consumer is still actively engaged in ongoing services.

Prevent residential placement of the identified child during the intervention for at least 75% or more of the families.
This objective was met 100% for both consumers while engaged in services. No residential</td></tr>
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	placements were reported during service delivery. **Prevent hospitalization for at least 75% of discharged consumers for up to 6 months post-discharge.** This objective was met 100% for one family. Outreach attempts for the other family serviced were not successful.
3b	**How did this improve outcomes for children and families?** By helping children and families increase their understanding, acquire or enhance their skills for managing illness, and improve overall family functioning, children are able to remain in their communities with their families.
3c	**Identify specific factors that contributed to this improvement:** Therapist use individualized interventions to address the presenting issues. Family involvement through service provision contributes to long-term success and skill building. Service planning incorporates linkage to community based resources for ongoing support, the identification of informal supports, and the teaching of self-advocacy to families.
3d	**Identify significant barriers to goal accomplishment:** Lack of understanding regarding a child's diagnosis and the absence of skills needed to cope. Throughout service provision, we provided psycho-education and skill building to assist families in better coping with the challenges presented by their child.
3e	**Definition of Level of Service as per contract:** One unit equals one family.
3f	**Enter your contracted Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14:** 2 Families
3g	**Enter your actual Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14:** 2 Families
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals:** 6 **# of unduplicated families:** 2
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** Satisfaction surveys indicate overall satisfaction with the service.
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.** No changes will be made.
4b	**Identify changes you will make that stem from stakeholder feedback.**

	No changes are indicated at this time.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** 2 Families.
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals**: N/A **# of unduplicated families:** 2 Families
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** Quarterly outcomes measures, satisfaction surveys and letters from consumer's families as well as feedback from other stakeholders will yield indications of progress.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** The program includes intense supervision of cases. Feedback from stakeholders and other treatment team members is solicited. Clinical records are reviewed by the supervisor and the agency's Quality Treatment Review Committee. Outcomes are measured quarterly while families are actively participating in the service and during the six month follow up period. Satisfaction surveys are twice a year.
5c	**How do you collaborate with community partners?** Collaboration is accomplished formally and informally. The Vice President serves on the Southern Region Children's Coordinating Committee, Burlington County CIACC, and the Human Services Advisory Council of Burlington County. Program Management attends CIACC meetings in Camden, Burlington, and Cumberland counties. Therapists collaborate on an individual basis with the entire treatment team providing services to their families. Community partners include: all levels of case/care management, DCF partners, child study teams, medical service providers, and human services (welfare, social security, etc.)

2015 PSSF Update Report

	Section 1 – Identifying Information	
1a	**Provider**: Care Plus NJ	**1b Program Name:** Healthy Families Hudson
1c	**Relevant PSSF Program**: ___FPS, _X__FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 600 Meadowlands Parkway Suite 142, P.O Box 11 Secaucus NJ 07094	
1e	**Objective**: Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.	
1f	**Outcome(s) Addressed**: _X_ Safety _X_ Permanency _X_ Well-Being	

	Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)
2a	**Overview of Service**: The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families' culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.
2b	**Population Served**: The Healthy Families-TIP target population is families who are screened through Metropolitan Health clinic and who reside in Hudson County and TANF recipients with a child 12 months and under. HF-TIP has Memorandum of Understanding with Metropolitan Family Health Network (MFHN). MFHN is a federally qualified health center in Hudson County. In addition, HF-TIP receives outside referrals from our host agency, Care Plus and Central Intake Hudson County.
2c	**Geographical Area of Services**: Hudson County
2d	**Referral Sources**: Metropolitan Health Clinic, Nurse Family Partnership, Welfare Office, WIC, and Central Intake Hudson County and many other agencies in the county of Hudson

Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)	
3a	**Provide a summary of program accomplishments on goals.** **Include data where available.** 1. 100% of children were enrolled in health insurance 2. 95% of participating infants/children were up-to-date on immunizations. 3. 93% of participants increased their interpregnancy interval (birth to conception) to 18 months 4. 100% of participating infants/children had a medical home 5. 94% of participating infants/children received developmental screening and appropriate referrals.
3b	**How did this improve outcomes for children and families?** Program accomplishments increased: • the number of children and parents linked to a primary health care provider • number of children receiving up to date immunizations • number of families use of community resources • appropriate identification and referral of infants and children for developmental delays
3c	**Identify specific factors that contributed to this improvement.** Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child's emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child's immunizations and well-child visits.
3d	**Identify significant barriers to goal accomplishment.** Some of the barriers HF-TIP faced during this time period were retention of the TANF families. TANF families dropped out of the program once their TANF case closes or if they are enrolled in a 35 hour weekly core activity. HF-TIP is outreaching more prenatal families referred by Central Intake and Metropolitan Health Clinic. HF is outreaching more TIP families who are not yet mandated to participate in a core activity to focus more on the home visit prior to them starting a core activity. HF-TIP continues to offer evenings and weekend home visits to accommodate these families.
3e	**Definition of Level of Service as per contract**: In Healthy Families, the level of service is measured by "case weight." Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program

	(weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.
3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14** 179
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14** 121.56
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals:** 164 **# of unduplicated families:** 82
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** In June 2014, satisfaction surveys were hand delivered by Family Support Workers to 75 families receiving home visitation services. Families were asked to complete surveys in the FSW's absence and return them in a sealed envelope to their Family Support Worker. Of the 75 surveys, 54 (72%) surveys were returned. The majority agreed that FSWs provide information on parenting, health and development for the child. Also, that they find the staff to be non-judgmental. In addition, our host agency conducts confidential, voluntary "Customer Satisfaction" surveys on an annual basis. See below responses from clients regarding what they like best about the program and how they want to see our program improve. **If the program has helped you, please explain how?** ✓ "The program has helped me to bond more with my baby". ✓ "Cynthia has always brought me information on health and safety" ✓ "The program has helped me stay motivated to meet my goals" ✓ "The program has helped me build confidence as a first time mother". **Is the program meeting your expectations?** ✓ 54 families responded yes **What can the program do differently to improve its services?**

	✓ "More groups". ✓ "Nothing, continue to hire case workers like Anggela" ✓ "To provide supplies, toys, pampers, wipes, and formula" ✓ "Everything is good"
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program** Level of services will be decreased from 179 to 149 as of June 30th, 2015 due to the ending of the SSBG funding.
4b	**Identify changes you will make that stem from stakeholder feedback.** No changes
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** 179 expected case weight until June 30th, 149 expected case weight from July 1st – September 2015
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals: 164** **# of unduplicated families: 82**
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site's level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** As mentioned in 5a, the

	program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.
5c	**How do you collaborate with community partners?** Healthy Families-TIP Hudson County works collaboratively with other community services to identify appropriate services to meet our targeted objectives. Healthy Families identify family strengths and needs and make referrals to community resources as needed. HF-TIP collaborates with: Nurse Family Partnership, Jersey City Medical Center, Metropolitan Health Network clinic, Central Intake Hudson County, and Family Success Center. In addition, HF-TIP collaborates with the welfare office to assist families with educational and employment goals. Healthy Families TIP participates in a joined advisory board committee with NFP, Central Intake Hudson County, and Parent as Teachers.

2015 PSSF Update Report

	Section 1 – Identifying Information	
1a	**Provider**: Care Plus NJ, org	**1b Program Name:** Healthy Families – TIP Bergen County
1c	**Relevant PSSF Program**: ___FPS, _X__FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 611 46 West – Hasbrouck Heights NJ 07604	
1e	**Objective**: Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.	
1f	**Outcome(s) Addressed**: _X_ Safety _X_ Permanency _X_ Well-Being	
	Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)	
2a	**Overview of Service**: The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families' culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.	
2b	**Population Served**: First Time mothers residing in Bergen County, screened at Holy Name Hospital in Teaneck and North Hudson Community Action Corporation (NHCAC) in Englewood.	
2c	**Geographical Area of Services**: Bergen County	
2d	**Referral Sources**: Holy Name Hospital, North Hudson Community Action Corporation, Bergen County CAP, Englewood Hospital, WIC.	
	Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)	
3a	**Provide a summary of program accomplishments on goals.** **Include data where available.** 6. 100% of children were enrolled in health insurance 7. 90% of participating infants/children *were* up-to-date on immunizations. 8. 97% of participants increased their interpregnancy interval (birth to conception) to	

	18 months 9. 100% of participating infants/children had a medical home 10. 100% of participating infants/children received developmental screening and appropriate referrals.
3b	**How did this improve outcomes for children and families?** Program accomplishments increased: • the number of children and parents linked to a primary health care provider • number of children receiving up to date immunizations • number of families use of community resources • appropriate identification and referral of infants and children for developmental delays
3c	**Identify specific factors that contributed to this improvement.** Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child's emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child's immunizations and well-child visits.
3d	**Identify significant barriers to goal accomplishment** One barrier is the decrease of prenatal referrals. The program also had a maternity leave during this period.
3e	**Definition of Level of Service as per contract**: In Healthy Families, the level of service is measured by "case weight." Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.
3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14** 158
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14** 126.80
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting**

	period should be counted only once. **# of unduplicated individuals: 200** **# of unduplicated families: __ 100**
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** In May 2014, satisfaction surveys were hand delivered by Family Support Workers to 86 families receiving home visitation services. Families were asked to complete surveys in the FSW's absence and return them in a sealed envelope to their Family Support Worker. Of the 86 surveys, 71 (83%) surveys were returned. The majority agreed that FSWs provide information on parenting, health and development for the child. Also, that they find the staff to be non-judgmental. In addition, our host agency conducts confidential, voluntary "Customer Satisfaction" surveys on an annual basis.
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program** Healthy families TIP Bergen County will collaborate with Holy Name Hospital, Bergen County schools district, Partnership for Maternal and Child Health, WIC, Birth Right, Light House, OB/GYN offices to present the program. The program goal is to obtain more prenatal referrals.
4b	**Identify changes you will make that stem from stakeholder feedback.** No changes to report
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** 158 case weight expected until June 30, 2015 128 case weight expected from 7/1/15 to 9/30/15
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals:** _256 **# of unduplicated families: ____128**
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site's level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client

	feedback, the annual service review and feedback from the advisory board.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.
5c	**How do you collaborate with community partners?** Healthy Families Bergen County works in collaboration with other community services to identify appropriate services to meet our targeted objectives. Healthy Families identify family strengths and needs and make referrals to community resources as needed. The Family Support Worker models self-advocacy skills to increase parental competency. Such examples include, The Hispanic Institute continues to offer families with scholarships for ESL classes. Healthy Families will continue to receive ongoing screens and referrals through Holy Name Hospital and North Hudson Community Action Corporation. In addition, the program will continue to do outreach and presentations at the WIC office in Englewood and other agencies. The Program Manager will continue to attend Lead Coalition meetings as well as Case Management meetings at the One Stop Center. The program will collaborate with Family Success Center to increase referrals. A list of community partners includes: Center for Food Action (Food Pantry), Bergen's Promise, Bergen Family Success Center, The Volunteer Center of Bergen County, Birth Right Program, Light House Program, Jersey College, NJ Community Foundation, and Englewood Hospital community Affairs.

2015 PSSF Update Report

<table>
<tr><th colspan="3">Section 1 – Identifying Information</th></tr>
<tr><td>1a</td><td>Provider: Burlington County Community Action Program (BCCAP)</td><td>1b Program Name: Burlington County Healthy Families-TIP Program</td></tr>
<tr><td>1c</td><td colspan="2">Relevant PSSF Program: ___FPS, _X__FSS, ___TLFRS, ___APSS</td></tr>
<tr><td>1d</td><td colspan="2">Program Address: 718 Route 130 South – Burlington, NJ 08016</td></tr>
<tr><td>1e</td><td colspan="2">Objective: Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.</td></tr>
<tr><td>1f</td><td colspan="2">Outcome(s) Addressed: _X_ Safety _X_ Permanency _X_ Well-Being</td></tr>
<tr><th colspan="3">Section 2 – Service Description Basics FFY ’15 (10/1/13 – 9/30/14)</th></tr>
<tr><td>2a</td><td colspan="2">Overview of Service: The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families’ culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.</td></tr>
<tr><td>2b</td><td colspan="2">Population Served:
Race/Ethnicity:
White, non-Hispanic: 19
Black, non-Hispanic: 73
Hispanic/Latina/Latino: 5
Multiracial: 11

Caregiver Age:
Under 16 years old: 0
16-19 years old: 12
20-29 years old: 75
Over 30 years old: 21

Marital Status:
Single, never married: 75
Living together, not married: 19
Married, first time: 9
Other/Missing/Unknown: 5

Education:
Less than 12: 42
HS/GED: 38
Vocational/Some College: 19
Associates: 4
Bachelor’s Degree or Higher: 4</td></tr>
</table>

2c	**Geographical Area of Services**: Burlington County, NJ
2d	**Referral Sources**: The program receives referrals from WFNJ, EA, and Central Intake. Central Intake received referrals from SJFMC, DCP&P, Virtua Center for Women, Project Teach, Virtua Community Nursing Services, SNJPC, Virtua Memorial Hospital, Youth Family Success Center, staff referrals, and self-referrals.
Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)	
3a	**Provide a summary of program accomplishments on goals.** **Include data where available.** 11. 94% of children were enrolled in health insurance 12. 77% of participating infants/children were up-to-date on immunizations. 13. 100% of participants increased their interpregnancy interval (birth to conception) to 18 months 14. 100% of participating infants/children had a medical home 15. 93% of participating infants/children received developmental screening and appropriate referrals.
3b	**How did this improve outcomes for children and families?** Program accomplishments increased: • the number of children and parents linked to a primary health care provider • number of children receiving up to date immunizations • number of families use of community resources • appropriate identification and referral of infants and children for developmental delays
3c	**Identify specific factors that contributed to this improvement.** Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child's emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child's immunizations and well-child visits.
3d	**Identify significant barriers to goal accomplishment.** Barriers included a reduction in the number of referrals received by the program which led to a decrease in level of service. In response to this the program assisted the local Central Intake in conducting outreach and promotion.

3e	**Definition of Level of Service as per contract**: In Healthy Families, the level of service is measured by "case weight." Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.
3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14** **125**
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14** **76.25**
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals: 59** **# of unduplicated families: 118**
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** 61 surveys were distributed and 44 were received back. Overall response was positive with the majority of responses indicting that they either agreed or strongly agreed to the questions.
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program** There are no planned changes.
4b	**Identify changes you will make that stem from stakeholder feedback.** There are no planned changes.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** 125
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.**

	# of unduplicated individuals: 250 **# of unduplicated families: 125**
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site's level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.
5c	**How do you collaborate with community partners?** Quarterly Advisory Board Meetings are held in collaboration with the local Improving Pregnancy Outcomes Initiative. Staff members also participate in a variety of county and planning meetings such as Healthy Mothers/Healthy Babies. Community partners include representatives from transitional housing, domestic violence, mental health, substance abuse, child protective services, and SBYSP.

2015 PSSF Update Report		
Section 1 – Identifying Information		
1a	**Provider**: Center for Family Services	**1b Program Name:** Healthy Families-TIP Camden
1c	**Relevant PSSF Program**: ___FPS, _X__FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 180 S. White Horse Pike, Clementon, NJ 08021	
1e	**Objective**: Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.	
1f	**Outcome(s) Addressed**: _X_ Safety _X_ Permanency _X_ Well-Being	
Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)		
2a	**Overview of Service**: The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families' culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.	
2b	**Population Served**: First time mothers and mothers who are receiving TANF benefits and have a child under 12 months.	
2c	**Geographical Area of Services**: Camden County	
2d	**Referral Sources**: Central Intake, Board of social Service, Local Hospitals, Prenatal Clinics, Federally Qualified Health Centers, OB/GYN Physicians, WIC, Local Schools, School Based Youth Services.	

Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)	
3a	**Provide a summary of program accomplishments on goals.** **Include data where available.** 16. 95__% of children were enrolled in health insurance 17. 92__% of participating infants/children were up-to-date on immunizations. 18. 100__% of participants increased their inter pregnancy interval (birth to conception) to 18 months 19. 93__% of participating infants/children had a medical home 20. 100__% of participating infants/children received developmental screening and appropriate referrals.
3b	**How did this improve outcomes for children and families?** Program accomplishments increased: • the number of children and parents linked to a primary health care provider • number of children receiving up to date immunizations • number of families use of community resources • appropriate identification and referral of infants and children for developmental delays
3c	**Identify specific factors that contributed to this improvement.** Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child's emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child's immunizations and well-child visits.
3d	**Identify significant barriers to goal accomplishment.** The program continues to experience problems retaining mothers who return to work/school/training. The enrollment of pregnant women has increased but is still an issue. The staff salaries are low and they have not received a raise in 6 years. Staff has left for better paying jobs.
3e	**Definition of Level of Service as per contract**: In Healthy Families, the level of service is measured by "case weight." Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.

3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14** The contracted level of service was case weight 180
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14** The actual contract level of service was 143
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals:** _302**____** **# of unduplicated families:** _151**______**
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** In March 2014 The Healthy Families-TIP Camden program distributed the Annual Client Satisfaction Survey to 50 families who were in the program a minimum of three months. Forty two surveys were returned. The survey contained 13 statements and clients were asked to rate their level of agreement with the statements as follow: Strongly agree 1; Disagree 2; Agree 3; Strongly agree 5; Neutral N. A score of 5 would be the highest possible rating. All 42 surveys were rated 4.4 or highest. Three statements received overall ratings of 4.9.
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program** No changes are planned at this time.
4b	**Identify changes you will make that stem from stakeholder feedback.** No changes have been identified at this time.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** Case weight 188
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals: _360____** **# of unduplicated families: ___180____**

Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site's level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.
5c	**How do you collaborate with community partners?** Supervisor and Program Manager participate in the Central Intake committee of Camden County. The Healthy Families Advisory Board is composed of representatives from the Nurse Family Partnership, Federal Qualified Health Center (Camcare), Camden City School system; Southern New Jersey Perinatal Cooperative/Addictions Prevention; Healthy Mothers-Healthy Babies/Healthy Start/Parents as Teachers.

2015 PSSF Update Report

Section 1 – Identifying Information		
1a	**Provider**: Central Jersey Family Health Consortium	**1b Program Name:** Middlesex/Somerset Healthy Families-TIP
1c	**Relevant PSSF Program**: ___FPS, _X__FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 2 King Arthur Court Suite B North Brunswick, N.J.08902	
1e	**Objective**: Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.	
1f	**Outcome(s) Addressed**: _X_ Safety _X_ Permanency _X_ Well-Being	
Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)		
2a	**Overview of Service**: The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families' culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.	
2b	**Population Served**: Any pregnant women or new mothers with an infant less than 3 months of age that meets Healthy Families criteria and any women receiving TANF, GA, or EA.	
2c	**Geographical Area of Services**: Middlesex/Somerset Counties	
2d	**Referral Sources**: Local hospitals, prenatal clinics, Federally Qualified Health Centers, OB/GYN Physicians, IC Local Schools, School Based Youth Services, County Social Services, DCPP and other community organizations. All referrals are processed through the Central Intake. They screen and process referral in order to be assigned to the appropriate program.	
Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)		
3a	**Provide a summary of program accomplishments on goals. Include data where available.**	

	21. 91% of children were enrolled in health insurance 22. 44% of participating infants/children were up-to-date on immunizations. 23. 52% of participants increased their interpregnancy interval (birth to conception) to 18 months 24. 67% of participating infants/children had a medical home 25. 95% of participating infants/children received developmental screening and appropriate referrals.
3b	**How did this improve outcomes for children and families?** Program accomplishments increased: • the number of children and parents linked to a primary health care provider • number of children receiving up to date immunizations • number of families use of community resources • appropriate identification and referral of infants and children for developmental delays
3c	**Identify specific factors that contributed to this improvement.** Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child's emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child's immunizations and well-child visits.
3d	**Identify significant barriers to goal accomplishment.** A challenge that the program faces is getting families to be on time with getting their children immunized and understanding the importance of immunizations.
3e	**Definition of Level of Service as per contract**: In Healthy Families, the level of service is measured by "case weight." Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.
3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14** The contracted level of service for this period was 195.
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the**

	period of 10/1/13 – 9/30/14 The actual level of (units) of Service during this period was 141.
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals: _151____** **# of unduplicated families: ___151____**
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.**
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program** No planned changes have occurred.
4b	**Identify changes you will make that stem from stakeholder feedback.** None were suggested from stakeholders.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** The Level of Service to be delivered during this period is 195.
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals: _101____** **# of unduplicated families: _101______**
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site's level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.

5c	**How do you collaborate with community partners?** The Middlesex-Somerset Healthy Families site participates in a county network advisory committee in Middlesex and Somerset counties. There are also meetings with the Middlesex and Somerset County Board of Social Services.

2015 PSSF Update Report

Section 1 – Identifying Information		
1a	**Provider**: Partnership for Maternal and Child Health of Northern New Jersey	**1b Program Name:** Healthy Families/TANF Initiative for Parents-Essex
1c	**Relevant PSSF Program**: ___FPS, _X__FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 50 Park Place, Suite 700, Newark , New Jersey 07102	
1e	**Objective**: Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.	
1f	**Outcome(s) Addressed**: _X_ Safety _X_ Permanency _X_ Well-Being	

Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)	
2a	**Overview of Service**: The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families' culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.
2b	**Population Served**: The Healthy Families/TIP-Essex Program (HF/TIP-E) serves new and expectant parents in Urban Essex County which includes Newark, Irvington, East Orange, and Orange. We also provide home visitation services to expectant women in their third trimester and/ or with children under the age of 12 months who are TANF (Temporary Assistance to Needy Families) eligible throughout Essex County. TANF includes General Assistance, Emergency Assistance, and Food Stamps.
2c	**Geographical Area of Services**: The Healthy Families/TIP-Essex Program (HF/TIP-E) serves new and expectant parents in Urban Essex County which includes Newark, Irvington, East Orange, and Orange and women with children under the age of 12 months who are TANF eligible throughout Essex County.
2d	**Referral Sources**: The HF/TIP-E Program receives referrals from the Essex Pregnancy & Parenting Connection (Central Intake) and via on and off-site free pregnancy testing

	services which identifies women in early pregnancy.
Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)	
3a	**Provide a summary of program accomplishments on goals. Include data where available.** 26. 96% of children were enrolled in health insurance 27. 67% of participating infants/children were up-to-date on immunizations. 28. 100% of participants increased their interconception interval (birth to conception) to 18 months 29. 81% of participating infants/children had a medical home 30. 91% of participating infants/children received developmental screening and appropriate referrals.
3b	**How did this improve outcomes for children and families?** Program accomplishments increased: • the number of children and parents linked to a primary health care provider • number of children receiving up to date immunizations • number of families use of community resources • appropriate identification and referral of infants and children for developmental delays
3c	**Identify specific factors that contributed to this improvement.** Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child's emotional and intellectual growth. HF follows an evidence-based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child's immunizations and well-child visits.
3d	**Identify significant barriers to goal accomplishment.** The HF/TIP-E program experienced a hardship due to one part-time FSW waiting to be trained and a vacant part-time FSW position. The HF/TIP-E program also experienced the loss of two full-time family support workers and struggled to hire a part-time family support worker. The HF/TIP program was able to hire two full-time family support workers, but due to their limited training they were only able to carry a limited caseload.
3e	**Definition of Level of Service as per contract**: In Healthy Families, the level of service is measured by "case weight." Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program

	(weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.
3f	**Enter your contracted Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14.** 210
3g	**Enter your actual Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14.** 132.66
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals:** 137 **# of unduplicated families:** 100
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** During the period 10/01/13-09/3014 a total of 180 surveys were completed. Please see attached survey results.
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.** There are no planned changes to the Healthy Families/TIP-E target population or service area.
4b	**Identify changes you will make that stem from stakeholder feedback.** As a result of the feedback provided, the HF/TIP-E program has revised direct service staff ratios for service delivery. In an attempt to improve trust-building relationships between staff and potential families, several FSWs are performing a dual role of FSW/FAW.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** 190
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals:** 135 **# of unduplicated families:** 98
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	

5a	**How will you measure progress?** The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site's level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey, which serves to provide consumer feedback, will be used to make adjustments and improvements, as needed.
5c	**How do you collaborate with community partners?** The collaborations established through partnerships ensure that potential HF/TIP-E participants have access to quality care. The following agencies, hospitals, clinics, and schools are located within our target service area and provided many of our clients with referral services. • The University Hospital • Columbus Hospital • Saint Barnabas Medical Center • Newark Beth Israel Medical Center • The City of Orange Department of Health • The City of East Orange Department of Health • Newark Community Health Centers, Inc. • City of East Orange Department of Health, East Orange and Orange Women, Infant, Children (WIC) Program • Newark Department of Health & Human Services • Turning Point, Inc. • Renaissance House • St. Rocco's Family Shelter • Furniture Assist • Tri-City Peoples Corporation • North Porch • Various Church based Food Pantries • DCP&P The HF/TIP-E program also has a very committed Advisory Board which meets quarterly to discuss program strengths and challenges. The Advisory Board members are committed individuals from community agencies that are invested in our program goals and outcomes.

2015 PSSF Update Report	

Section 1 – Identifying Information		
1a	**Provider**: Partnership for Maternal and Child Health of Northern NJ	**1b Program Name:** Healthy Families Morris
1c	**Relevant PSSF Program**: ___FPS, _X__FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 73 Bassett Highway Dover, NJ 07801	
1e	**Objective**: Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.	
1f	**Outcome(s) Addressed**: _X_ Safety _X_ Permanency _X_ Well-Being	
Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)		
2a	**Overview of Service**: The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families' culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.	
2b	**Population Served**: Our service population is predominately White (88%); Black (5%), Multi-racial (4%) and other (2%) make up the next three smallest racial groups in our service population. Of those families, (79%) reported to be of Hispanic Ethnicity and the other (21%) reported no Hispanic descent. These statics directly reflect our target population. Our target population is predominately White (89%); Black (2%), other (2%) and Multi-racial (<.01%) being the smaller three racial groups in the target population. There is however a new population of people utilizing the prenatal clinics; 7% of our target population identified themselves as Middle Eastern. Their ethnicities included Egyptian, Bosnian, Syrian, and Iranian. Throughout the fiscal year, our program did have to close some screens have due to "No FAW/FSW available to speak participants language". We will continue to monitor this demographic by keeping in touch with the Clinic Directors to	

see if this a growing need in our target population. Of the above participants (61%) reported to be of Hispanic Ethnicity and the other (38%) reported no Hispanic descent.

Of the 81 families enrolled throughout fiscal 2014, 67% speak Spanish as their primary language and 33% speak English. Although the program's current data base system does not determine how many of our children are being raised in multi-lingual homes, FSW report that many of their families have at least one family member that speaks another language.

Our target population reflects a slightly different demographic. Of the 792 participants within our target population, 50% are identified as speaking English, 40% as speaking Spanish, 8% as speaking another language and 1% as speaking Arabic. This is a very interesting demographic and one that our program has already investigated throughout the year. Our program was struggling to obtain English speaking screens for outreach. The Program Supervisor contacted the Clinic Directors to inquire about their process for determining a patients' language preference. It is here where the difference lies between the service and target population. When our FAW/FSW is completing a face-to-face screen, they want to determine the level of English the participant is comfortable with, since long-term services may be offered. In the clinic setting however, if the clients know some English, they may be identified as such. The clinics also have interpreters on hand in case there are particular situations where one is needed.

Our service population's age is made up of, 9% of participants under the age of 19, 42% between the ages of 20-29 and 49% above thirty years old. Our target population directly reflects that with 9% under the age of 19, 48% between the ages of 20-29 and 43% above thirty years old.

Our service population shows that 44% of program participants are single, with 48% of our children growing up with their fathers not living in the home. FSWs report that many single mothers live at home with extended families members or other people within the community. Currently, 10% of our families live with a grandparent, relatives or other caregivers in their home. Married couples account for 11% of our service population, while 41% are engaged in a cohabitating relationship; that accounts for 52% of our children growing up with their father in the home. This is a positive statistic for the program because it shows that more than half of the children in our service population are growing up in homes where parenting is shared by the mother and father.

Again, our target population reflects the participants we serve with the predominant demographic being single (61%) and the remaining (39%) being married.

When analyzing levels of education, 39% completed less than 12th grade, and 28% completed high school or received a GED. The remaining participants have some college 25%, Associates degree 1% and Bachelor's degree or higher 7%.

	This year, 36 (44%) of our PC1 were active in school/work activity or held some form of employment. However, statistics showing our families' incomes still demonstrate economic hardship with 91% of our families living at or below 185% of poverty and only 5% living over 185% the poverty line. There are a number of important things to note here. One, FSW report that some Latina women report not knowing about the household income. They report that the father is responsible for that information and "will not share" it with the mother. Two, families that "house share" and are "day laborers" work inconsistently and often do not know what their monthly or annual incomes are. Three, any family (regardless of race) who is working inconsistent hours and pool their money together with other family members, have a difficult time providing an accurate number for household income. These are all issues that have been noted and discussed at team meetings. As a program we have discussed strategies to get the most accurate data, but found it relevant to document these struggles. Another thing to mention here is that some families will not apply for public assistance due to immigration status. If members are applying to become citizens or sponsors for family members to come into the United States, they avoid using any sort of assistance, even if they are struggling financially. There are however, a number of families within our service population that do access public services such as Medicaid, Food Stamps, TANF, SSI, WIC and Housing Assistance. The following demonstrates the percentages of our participants enrolled during fiscal 2014 in one or more of these services: **Receiving TANF: 9%** **Receiving Emergency Assistance: 10%** **Receiving WIC: 85%** **Receiving Food Stamps: 40%** **Receiving SSI: 4%**
2c	**Geographical Area of Services**: Morris County, NJ
2d	**Referral Sources**: Our two primary referral sources are Morristown Medical Center and Saint Clare's prenatal clinic. We also receive referrals from DCP&P, FSC, and local FHQC.
	Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)
3a	**Provide a summary of program accomplishments on goals.** **Include data where available.** 31. _100_% of children were enrolled in health insurance 32. _52_% of participating infants/children were up-to-date on immunizations. 33. _93_% of participants increased their interpregnancy interval (birth to conception) to 18 months 34. 100__% of participating infants/children had a medical home

	35. _88_% of participating infants/children received developmental screening and appropriate referrals.
3b	**How did this improve outcomes for children and families?** Program accomplishments increased: • the number of children and parents linked to a primary health care provider • number of children receiving up to date immunizations • number of families use of community resources • appropriate identification and referral of infants and children for developmental delays
3c	**Identify specific factors that contributed to this improvement.** Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child's emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child's immunizations and well-child visits.
3d	**Identify significant barriers to goal accomplishment.** Our largest barrier over the past year has been staff turnover. Staff vacancies significantly contribute to our programs ability to service families and meet our objectives. Many of the staff who has left went on to continue their educations or seek career advancement. Our program has worked on the interviewing process and job expectations prior to hiring, in hopes that candidates will consider their commitment to the position prior to accepting the position.
3e	**Definition of Level of Service as per contract**: In Healthy Families, the level of service is measured by "case weight." Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.
3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14** **87**
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14** **60% average monthly**

3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.** **# of unduplicated individuals: _81____** **# of unduplicated families: __162_____**
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** This year we provided 19 annual surveys and received 11 back. Of all the questions asked the participants answered Strongly Agree and Agree 99% of the time. The program received very positive feedback stating for example, that they felt much support from the FSW, the information was informative and helpful, and the program made them feel like a more confident mother. All, 100% stated that the program was meeting their expectations. When asked if they could provide any suggestions on how the program may improve, only one mother had asked if the program could integrate more conversation with the father. The program has a number of materials geared toward engaging fathers. This information was shared with the FSW and she made sure to emphasis inclusion of the father into the home visit.
Section 4 – The Year Ahead FFY ’16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program** Our target population is mothers who use the prenatal clinics at Morristown Medical Center and Saint Clare’s Hospital; and any mother, with a child under the age of 12 months, in Morris County receiving welfare benefits. Morris County is currently awaiting the creation of a central intake system. This will change our target population and the process of how we receive screens.
4b	**Identify changes you will make that stem from stakeholder feedback.** Not at this time.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** **87**
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals: _81____** **# of unduplicated families: _162______**
Section 5 – Evaluating Progress FFY ’16 (10/1/14 – 9/30/15)	

5a	**How will you measure progress?** The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site's level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.
5c	**How do you collaborate with community partners?** Our program has a number of professional community providers who sit on our Advisory Board. Throughout this year we have made stride in collaborating with other home visitation programs within the county. This has assisted to decrease the number of duplicated families within the home visitation programs. We are also beginning to discuss a framework for communication and collaboration for a central intake system in Morris County. The relationships we have with our professional community providers are valuable as they assist with being able to provide a well-rounded support system to our families. We make a number of referrals to these providers, as they do to us. Open communication and knowledge of each other's services assist with diminishing any barriers families may confront when accessing services.

2015 PSSF Update Report

Section 1 – Identifying Information		
1a	**Provider**: Partnership for Maternal and Child Health of NNJ	**1b Program Name:** Passaic County HF-TIP
1c	**Relevant PSSF Program**: ___FPS, _X__FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 1 Otillio Terrace Paterson, NJ 07502	
1e	**Objective**: Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.	
1f	**Outcome(s) Addressed**: _X_ Safety _X_ Permanency _X_ Well-Being	
Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)		
2a	**Overview of Service**: The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families' culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.	
2b	**Population Served**: Any new mother and mothers under 25 years of age with multiple children and any new mother receiving TANF residing in Passaic County.	
2c	**Geographical Area of Services**: Passaic County	
2d	**Referral Sources**: All referrals are provided through Central intake. Referrals sources include: Local Hospitals, Prenatal Clinics, Federally Qualified Health Centers, OB/GYN Physicians, WIC, Local Schools, School Based Youth Services, County Social Services.	
Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)		
3a	**Provide a summary of program accomplishments on goals.** **Include data where available.** 36. 96% of children were enrolled in health insurance 37. 75% of participating infants/children were up-to-date on immunizations. 38. 97% of participants increased their interpregnancy interval (birth to conception) to 18 months	

	39. 83% of participating infants/children had a medical home 40. 91% of participating infants/children received developmental screening and appropriate referrals. (5 children scored below the cut off. They were all already enrolled in EI services when the evaluation was administered.)
3b	**How did this improve outcomes for children and families?** Program accomplishments increased: • the number of children and parents linked to a primary health care provider • number of children receiving up to date immunizations • number of families use of community resources • appropriate identification and referral of infants and children for developmental delays
3c	**Identify specific factors that contributed to this improvement.** Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child's emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child's immunizations and well-child visits.
3d	**Identify significant barriers to goal accomplishment.** *Staff vacancies significantly contribute to our program's ability to service families and meet our objectives* Passaic County Healthy Families/TIP has experienced staffing changes and maternity leaves which led to our low level of service. Appropriate individuals were hired to replace staff vacancies as soon as possible. The program utilized a temporary FSW fill in for two FSW's on maternity leave. An additional factor affecting our case weight was our involvement in the Mother and Infant Home Visiting Program Evaluation (MIHOPE). Central intake and the Community Health Workers have been working hard to help us to make up for the number of clients that were assigned to the control group. Also, the program continues to experience difficulty having up dated immunization records, we have found that may of the doctors are not entering the immunizations into NJIIS. We have also found that some of the doctors experiences immunization shortages while other implemented an alternative immunization schedule. Another challenge is that many of our parents are not eligible for health insurance. Therefore, some of them do not have a medical home. We continue to work with the clients on self-sufficiency while providing community resources to encouraged client to see a doctor. However, 100% of the children do have a primary care provider.

3e	**Definition of Level of Service as per contract**: In Healthy Families, the level of service is measured by "case weight." Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.
3f	**Enter your contracted Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14** 255
3g	**Enter your actual Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14** 165.39
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals: _300_** **# of unduplicated families: __150___**
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** 84 surveys were sent and 60 clients responded. When asked if the program is meeting their expectations 58 clients said yes while the remaining two did not respond. In general clients feel that the program is providing them with culturally competent services while providing them with information on child development and community resources.
	Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program** Currently we are not making any changes to the program.
4b	**Identify changes you will make that stem from stakeholder feedback** According to the survey two clients did not feel that the educational materials used in the home visits reminded them of their own families. The existing materials will be reviewed by the Community Advisory Board (CAB) and the feedback provided by CAB will be the catalyst for the adaption of new educational materials.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** 255
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals: _300__**

	# of unduplicated families: _150___
	Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)
5a	**How will you measure progress?** The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site's level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.
5c	**How do you collaborate with community partners?** Passaic County Healthy Families-TIP (PCHF/TIP) has memorandums of agreement with agencies in the community. Collaborators are members of the PCHF/TIP Home Visiting Advisory Board. The Board meets on a quarterly basis. During the meetings, strengths and challenges are discussed. Central intake and the Community Health Workers provide outreach and educational services throughout our target area. Family Support Worker, Family Assessment Workers and well as Program Supervisor are also on hand to do outreach at special community events through the year. The relationship between PCHF/TIP, Central Intake and agencies within the community is based on mutual respect, caring and respect for the community and for those reasons the ties with our community partners remains strong and intact.

2015 PSSF Update Report

Section 1 – Identifying Information		
1a	**Provider**: Holy Redeemer	**1b Program Name:** HF-TIP CMC
1c	**Relevant PSSF Program**: ___FPS, _X__FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 1801 Route 9 North Swainton, NJ 08210	
1e	**Objective**: Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.	
1f	**Outcome(s) Addressed**: _X_ Safety _X_ Permanency _X_ Well-Being	
Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)		
2a	**Overview of Service**: The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families' culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.	
2b	**Population Served**: Cape May Healthy Families-TIP program serves first time parents who screen positive for stressors. Other parents may participate if they are on GA or TANF prenatal or have a child less than 12 months of age. Alumni, students in local high schools and referrals from DCP&P and other local agencies are considered on a case by case basis. All services are free and voluntary.	
2c	**Geographical Area of Services**: All of Cape May County.	
2d	**Referral Sources**: Our referrals come through Central Intake.	
Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)		
3a	**Provide a summary of program accomplishments on goals.** **Include data where available.** 41. _98_% of children were enrolled in health insurance 42. _80_% of participating infants/children was up-to-date on immunizations. 43. _98_% of participants increased their interpregnancy interval (birth to conception)	

	to 18 months 44. _95_% of participating infants/children had a medical home 45. _88_% of participating infants/children received developmental screening and appropriate referrals.
3b	**How did this improve outcomes for children and families?** Program accomplishments increased: • the number of children and parents linked to a primary health care provider • number of children receiving up to date immunizations • number of families use of community resources • appropriate identification and referral of infants and children for developmental delays
3c	**Identify specific factors that contributed to this improvement.** Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child's emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child's immunizations and well-child visits.
3d	**Identify significant barriers to goal accomplishment. Holy Redeemer is currently involved with the Central Intake with Robin's Nest. There are now three agencies sharing the referrals. TIP referrals historically are lower in the summer months however this fall they have stayed low. Due to level X clients not available during the appropriate time for ASQs our percentage didn't meet the standard. As of September 2014 our staffing is at 100%.**
3e	**Definition of Level of Service as per contract**: In Healthy Families, the level of service is measured by "case weight." Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.
3f	**Enter your contracted Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14 204 Which includes 30 units for the SSBG funding.**
3g	**Enter your actual Level (units) of Service that is Title IV-B funded delivered for the**

	period of 10/1/13 – 9/30/14 122
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.** **# of unduplicated individuals: _263____** **# of unduplicated families: __132_____**
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results. In March 2015, Holy Redeemer sent 119 Satisfaction Surveys. At the end of the month 72 were returned or 61%. Our results were very satisfactory, 99% stated that the program has helped them. The parents had very positive responses in the various areas including the staff, goal setting, assistance, and parenting. One example, "They helped me grow as a mother and I appreciate everything they have done".**
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program** **The SSBG funding will stop as of June 30, 2015. This will return our LOS to 174. The F/T FSW hired to cover this grant will also be finished at that time. Our regular grant does not have any openings for her to transfer to.** **Our program goal is to increase admissions by doing more outreach. There are OR sets for the Supervisor and Staff. Example would be for staff to ask clients if they have family or friends who might be interested. Supervisor to reach out to possible community recourses.**
4b	**Identify changes you will make that stem from stakeholder feedback.** **Two areas a concern were transportation and evening events for the working families. Our county does not have adequate public transportation; we continue to provide information to Fare Free Transportation for our events. For our families who requested evening events we refer to the Family Success Center. If possible the staff member of that family will meet them there.**
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15? 204**
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals: _263____** **# of unduplicated families: __132_____**

Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site's level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.
5c	**How do you collaborate with community partners?** **Healthy Families Cape May collaborates with many community partners and events. Our staff facilitates the Infant Playgroup bi-monthly at the Family Success Center. All staff attends the Healthy Mothers/Healthy Babies Coalition Meetings. On April 10, 2015, we will be participating in the Third Annual Baby Shower hosted by the three home visiting agencies in Cape May. (Caring for Kids, Nurse Family Partnership, and Healthy Families). This year the event will be held at the Atlantic Cape Community College. On April 25, 2015 we will be participating in a Family Fun Walk at the Healthcare Resource Day and Parent Information Session at the Wildwood Convention Center and Boardwalk.** **Monthly, the Program Supervisor attends an Operations Meeting at the Board of Social Services to discuss our TIP LOS, challenges and work opportunities in the county. Program Supervisor is on the DCP&P Advisor Board, and the Central Intake Committee which meets quarterly. Most recently participation with the Prevention Partnership and CMC Council for Young Children.** **Our monthly playgroups and Breastfeeding Meetings are open to the public.** **Four times yearly we have a Planning Board meeting with our community partners and referral sources. Past and present program participants are part of this Board. Community partners that are represented on our Advisory Board include:** • **DCF Contract Administrator** • **Holy Redeemer Food Panty** • **CM Catholic Charities** • **Project Care – Lower Twp. High School Program** • **Project Teach / DCF Tech School** • **Cape May Health Department** • **CM Special Child Health Services** • **CM Early Intervention Program**

	• **Rutgers Home Cooperative Extension** • **Community Liaison (S. Keen)** • **Christ Child Society representatives**

2015 PSSF Update Report

	Section 1 – Identifying Information	
1a	**Provider**: Mercer Street Friends	**1b Program Name:** Healthy Families-TIP Mercer County
1c	**Relevant PSSF Program**: ___FPS, _X__FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 222 N Hermitage Ave Trenton. NJ 08618	
1e	**Objective**: Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.	
1f	**Outcome(s) Addressed**: _X_ Safety _X_ Permanency _X_ Well-Being	
	Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)	
2a	**Overview of Service**: The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families' culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.	
2b	**Population Served**: The program serves pregnant/parenting women residing in the East and West Wards of the City of Trenton, identified either prenatally or within 14 days of giving birth, and any pregnant/parenting woman residing in Mercer County receiving TANF, GA or EA with a child under12 months of age.	
2c	**Geographical Area of Services**: All of Mercer County (226 square miles)	
2d	**Referral Sources**: Central Intake and WIC, Local Schools, Self Referrals Private Physicians, and County Social Services.	
	Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)	

3a	**Provide a summary of program accomplishments on goals.** **Include data where available.** 46. 100% of children were enrolled in health insurance 47. 89 % of participating infants/children were up-to-date on immunizations. 48. 100% of participants increased their interpregnancy interval (birth to conception) to 18 months 49. 100% of participating infants/children had a medical home 50. 94 % of participating infants/children received developmental screening and appropriate referrals.
3b	**How did this improve outcomes for children and families?** Program accomplishments increased: • the number of children and parents linked to a primary health care provider • number of children receiving up to date immunizations • number of families use of community resources • appropriate identification and referral of infants and children for developmental delays
3c	**Identify specific factors that contributed to this improvement.** Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child's emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child's immunizations and well-child visits.
3d	**Identify significant barriers to goal accomplishment.** Barriers to goal achievement include: the impact of parents living in poverty, unresolved childhood abuse issues, difficulty in engaging families, and lack of understanding of the importance of health care and the health care system, homelessness resulting in increased transiency. The program supervisor continues to see the importance of working diligently to identify various ways to motivate and nurture staff as they are challenged with responding to the various barriers to service delivery. During monthly staff meetings and team building exercises, staff is given the opportunity to share frustrations and to brainstorm solutions; this may include role playing a home visit, an assessment conversation, or a discussion about strategies related to presenting the Program in an honest and appealing manner. Accomplishments are recognized during team meetings as well as in Statewide site networking meetings as they occur. Sources for additional training that will support staff in effective service delivery continue to be accessed.

3e	**Definition of Level of Service as per contract**: In Healthy Families, the level of service is measured by "case weight." Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.
3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14 165**
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14 137**
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals**: **174** **# of unduplicated families: 87**
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** **Annual Client Satisfaction Survey** **Results** **2013-2014** 87 surveys distributed (20 S – 67 E (10 level X)) 65 surveys returned (20 S – 45 E) 75% of all surveys distributed were returned 100% of all Spanish language surveys distributed were returned 67% of all English language surveys distributed were returned Of the 65 returned: 31% were from H parents 52% were AA parents 10% multi culture parents 3% were from African parents 2% were from C parents 2% were Asian **<u>Summary of parent feedback:</u>** ▪ All families surveyed felt that their culture (race, language, family style, age, parental expectations), were accepted and respected. ▪ All families said that they could communicate feelings freely with their FSW

<table>
<tr><td></td><td>without the concern of being judged.
▪ Most participants felt that the materials that they were given were age appropriate, (parent and child), respectful, culturally relevant and easily understood.
▪ All families expressed that they benefited from the Program and felt that the information provided assisted them in developing a better understanding of their child's growth and development.
▪ Most mothers indicated that their quality of life was improved in many ways through their Program participation; such as having more patience with their children, increased problem solving skills, being satisfied with themselves, controlling their temper, and taking better care of their own personal health.

<u>What participants liked best about the program's services</u>
Upon reviewing the individual participant's responses to this question, it seems evident that parents appear to enjoy the opportunity to access teaching, support, role modeling, and information offered to them about being a healthy individual and parent; provided to them through a relationship with a caring, respectful and culturally sensitive home visitor.

<u>How participants have benefited from the program:</u>
Upon reviewing the individual participant's responses to this question it seems that most participants feel that have gained additional skills/strategies in a variety of areas related to their role as parents and in their journey to be healthy individuals.</td></tr>
<tr><td colspan="2">Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)</td></tr>
<tr><td>4a</td><td>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program
There are no planned changes at this time to the program.</td></tr>
<tr><td>4b</td><td>Identify changes you will make that stem from stakeholder feedback.</td></tr>
<tr><td>4c</td><td>How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?
165</td></tr>
<tr><td>4d</td><td>Indicate how many unduplicated individuals and unduplicated families you expect to serve.

# of unduplicated individuals: 330
# of unduplicated families: 165</td></tr>
<tr><td colspan="2">Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)</td></tr>
</table>

5a	**How will you measure progress?** The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site's level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.
5c	**How do you collaborate with community partners?** Mercer Street Friends is part of a formalized, broad based collaborative of service providers. This is a network of medical and social service agencies sharing resources; training, support, information, planning, data and trend analysis, as well as philosophy of the importance of a series of integrated strength based intervention strategies to support young families in the City of Trenton. In addition, MSF works with a wide variety of community agencies and organizations in mutual support of young families. Members of The Community Advisory Network committee include HF-TIP, Parents As Teachers, Nurse Family Partnership, Children's Futures Central Intake, Health Resource and Service Administration and Community Health Workers. Members of the Committee come from a number of community agencies including: WIC, Early Head Start, Project Teach, RWJ Hamilton, Trenton Health Team, Teen Pregnancy Prevention, Home Front, Trenton Health Team, Capital Health Prenatal Clinic and consumers.

2015 PSSF Update Report

Section 1 – Identifying Information		
1a	**Provider**: Preferred Children's Services	**1b Program Name:** Healthy Families/ TIP Ocean County
1c	**Relevant PSSF Program**: ___FPS, _**X**__FSS, ___TLFRS, ___APSS	
1d	**Program (Mailing Address):** Preferred Children's Services Healthy Families/ TIP Ocean County P.O. Box 2036, Lakewood, New Jersey 08701 **(Office Location):** 1191 Lakewood Avenue, Toms River, NJ. 08753	
1e	**Objective**: Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.	
1f	**Outcome(s) Addressed**: _**X**_ Safety _**X**_ Permanency _**X**_ Well-Being	
Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)		
2a	**Overview of Service**: The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families' culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.	
2b	**Population Served**: The Service Population consists of two tiers. The Healthy Families program component serves all first time expectant mothers; and teenage mothers under the age of twenty-one years old who may have one or more births. The second tier of the Healthy Families/TIP Ocean County Program serves mothers and families who are receiving TANF (Temporary Assistance for Needy Families). The TIP component may enroll families up until the baby is twelve-(12) months old, and the birth order is irrelevant. Specifically, these mothers/families receive EA (Emergency Assistance) and SR (Special Response). In total, the Healthy Families/TIP Ocean County Program served one hundred and three - (103) families. During FFY 2014, the description of the Population Served is as follows: Cultural Sensitivity Review: 75% of the service population was predominantly of Hispanic descent. The primary language spoken was Spanish. The next prevalent ethnicities were White / non-Hispanic at 15% and Black/African American was at 10%.	

	The demographics of Enrollees: 23% are 19 years old or younger; 57% are between 20 through 29 years old; and finally 20% are 30 years old and over. 95% of the enrollees were single/never married, or living together and not married. The educational range was: 55% had between a sixth grade education and less than 12th grade. 27% had a GED or High School degree. The remaining 18% had vocational school, some college; including 3 with college degrees.
2c	**Geographical Area of Services**: The targeted service area for the Healthy Families component (all first time mothers and teenage mothers) is Lakewood Township, Brick Township, and Point Pleasant Borough. The targeted service area for TIP or "TANF Initiative for Parents" component is northern and central Ocean County, New Jersey.
2d	**Referral Sources**: Local Hospitals, Prenatal Clinics, Federally Qualified Health Centers, Local Schools, School Based Youth Services, County Social Services, Board of Social Services, and the Division of Children Protection and Permanency.
Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)	
3a	**Provide a summary of program accomplishments on goals.** **Include data where available.** 51. 96% of children were enrolled in health insurance. 52. 80% of participating infants/children were up-to-date on immunizations. 53. 95% of participants increased their interpregnancy interval (birth to conception) to 18 months. 54. 98% of participating infants/children had a medical home. 55. 95% of participating infants/children received developmental screening and appropriate referrals.
3b	**How did this improve outcomes for children and families?** Program accomplishments increased: • the number of children and parents linked to a primary health care provider • number of children receiving up to date immunizations • number of families use of community resources • appropriate identification and referral of infants and children for developmental delays
3c	**Identify specific factors that contributed to this improvement.** Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child's emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child's immunizations and well-child visits.

3d	**Identify significant barriers to goal accomplishment.** There are three-(3) identifiable barriers which impeded the goal accomplishment. The first identifiable barrier entails receiving up-to-date immunizations. The majority of the population served is undocumented who have transient living conditions. The population served may relocate several times per year. In addition, understanding how to access health care coverage proves to be extremely difficult. Application for insurance renewal is even more frustrating. The Family Support Workers (FSW's) are proactive. The FSW's guide and assist through the entire process to secure the initial medical coverage, and also to obtain medical insurance renewals. If not for the efforts of the FSW's, the children would not receive the necessary immunizations and health care. During the FFY 2014, the approval for medical insurance was delayed due to systematic processing. Secondly, the fathers/partners are unable to find viable employment. They are day laborers or seasonal, temporary workers. This compels the mothers to become the primary bread winners and to seek full-time employment. These families become less accessible and have difficulty maintaining consistent home visitation. This adversely affects face-to-face percentages of achieved home visitation rates; and all the program goal attainments. There are efforts to re-engage the families; involve the fathers and other family members; incentive efforts; and to continue with positive outreach attempts. Thirdly, the transportation in Ocean County New Jersey is minimal. There is only one bus route which runs along the Route 9 corridor. Whenever warranted, the FSW's transport the families to secure medical insurance, health care, SNAP, WIC in order to improve the quality of life. Although vital to the well-being of the families, this extended length of direct face-to-face time is not calculated as additional completed home visits.
3e	**Definition of Level of Service as per contract**: In Healthy Families, the level of service is measured by "case weight." Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.
3f	**Enter your contracted Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14.** During the Federal Fiscal Year 2014 (from October 1st, 2013 through September 30th, 2014), the case weight was 137.
3g	**Enter your actual Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14.** The average case weight maintained during the year was 108.62.
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**.

	# of unduplicated individuals: _206_ **# of unduplicated families: __103__**
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** During the annual December "Holiday Fiesta," the Client Satisfaction Surveys were distributed. Fourteen-(14) Client Satisfaction Surveys were distributed and fourteen-(14) Client Satisfaction Surveys were completed and returned. The Quality Improvement Department of Preferred Children's Services analyzed the results. In summary, the results testified that the overwhelming majority of replies yielded the highest response of "Strongly Agree." During FFY2014, the Healthy Families Advisory Board met on December 5th, 2013 and June 5h, 2014. The Advisory Board Members represent key referral sources and community service provides. The Advisory Board Members remain proactive and intensely focused on the goals of Healthy Families America. Throughout FFY 2014, the community and stakeholders received regular feedback, updates, notifications, and promotional announcements. ➢ The Manager reports to the Ocean County One-Stop Collaborative Meetings at the Board of Social Services. Feedback is received and assimilated. ➢ The Manager leads the quarterly TIP (TANF Initiative for Parents) Operational Meetings. ➢ The Manager participates at the Ocean County Maternal and Child Health Network Meetings. ➢ Finally, the Healthy Families/TIP Ocean County Program participates at the various community/agencies open house events, resource fairs and provides Trainings upon request. ➢ The Program is also represented at the IPO- Improved Pregnancy Outcome Meetings.
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.** Currently, the Healthy Families Program component accepts first time expectant mothers; and teenage mothers who are under twenty-one years old who may have one or more births. The target service area is specifically Lakewood, Brick Township, and Point Pleasant, New Jersey. ➢ The Program Manager has requested to redefine the Healthy Families Program Target Population. There remain a high percentage of births in Lakewood which cannot be factored into the Healthy Families Program statistical base. The Program Manager reported that the geographical service area of the current Target Population cannot be tracked or fully defined due to its expansiveness. It has been requested that the referrals generate from solely one source. For example, all first time births served/treated at all the satellites of Ocean Health Initiatives, Inc. (FQHC- federally qualified health center) in Northern Ocean County, New Jersey.

	This would allow for the tracking of birth rates amongst first time mothers, who are socio-economically needy. In addition, only first-time births would be part of the Healthy Families Program Target Population. No longer would the Target Population expand to include teenage mothers with multiple births. The established parameters of the TIP Ocean County Program will remain unchanged. TIP serves all northern and central Ocean County mothers who are receiving TANF. The mothers/families may be enrolled up until the baby is twelve-(12) months old, and birth order is irrelevant. ➢ As a direct result of the feedback from the Client Satisfaction Surveys, the Healthy Families Program will continue to research, obtain, and provide culturally competent Parent/Child educational materials and curriculum.
4b	**Identify changes you will make that stem from stakeholder feedback.** As July 2014, the Central Intake process became fully operational in Ocean County, New Jersey. The referrals are received, screened and funneled through one processing entity. All referrals are generated by this state-wide database referral system. It has been a learning process. Guidance and feedback have been provided to assure that the referrals coincide with the appropriate target populations. In addition, many of the referrals are post-natal not pre-natal.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** From October 1st, 2014 through June 30th, 2015, the anticipated Level of Service will be 137 Case Weight. From July 1st, 2015 through September 30th, 2015, the anticipated Level of Service will be 107 Case Weight.
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals: 106** **# of unduplicated families: 93**
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site's level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the Advisory Board. There are well-defined impact measures and outcome measures. Quarterly Reports are forwarded to the primary stakeholders and Prevent Child Abuse-New Jersey. Along with these detailed reporting forms, there is a corresponding Quality Improvement Grid to identify causal

	factors, interventions, and proposed remediation.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.
5c	**How do you collaborate with community partners?** Annually, the Healthy Families/TIP Ocean County Program reviews the existing "Memorandums of Understanding" (MOU's) with all the referral sources and collaborating entities. The Program will continue to participate in local community and state-wide functions; as well as providing In-Service Trainings. Alliances are well-established with the numerous referral sources which generate the prospective intakes: The Family Planning Center of Ocean County, Ocean Health Initiatives (FQCHC), Lakewood School Based Youth Program, Ocean Medical Center (hospital), the three-(3) Brick Township School Based Youth Programs, Preferred Behavioral Health of N.J., Early Head Start/Head Start, Monmouth Medical Center, Jersey Shore Medical Center, Children's Home Society, Early Intervention of the Ocean County Health Department, WIC, the Ocean County Board of Social Services, and Central Jersey Family Health Consortium. All of the above-mentioned have participated on the Healthy Families/TIP Ocean County Advisory Board. The Healthy Families/TIP Ocean County is a member of the Early Head Start/Head Start Advisory Board; and also a member of the Family Planning Center of Ocean County Advisory Board. The Program Manager continues to attend all relevant Home Visitation Task Force Committee Meetings, quarterly TIP Operational Meetings, and the regularly scheduled Ocean County One-Stop Collaborative Meetings. This includes the planning meetings and all relevant focus groups.

2015 PSSF Update Report	

Section 1 – Identifying Information		
1a	**Provider**: Prevent Child Abuse New Jersey	**1b Program Name:** Healthy Families NJ
1c	**Relevant PSSF Program**: ___FPS, _**X**__FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 14 host agencies, with 17 PSSF Healthy Families programs, within a 22 site network (see Healthy Families New Jersey Data attached as Table A). **Provider Address:** 103 Church Street, Suite 210, New Brunswick, NJ, 08901	
1e	**Objective**: Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.	
1f	**Outcome(s) Addressed**: _**X**_ Safety _**X**_ Permanency _**X**_ Well-Being	
Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)		
2a	**Overview of Service**: The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families' culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.	
2b	**Population Served**: The program serves new and expectant parents who meet at risk screening and assessment criteria for the Healthy Families Program.	
2c	**Geographical Area of Services**: Statewide	
2d	**Referral Sources**: Local hospitals, prenatal clinics, Federally Qualified Health Centers (FQHCs), OB/GYN physicians, pediatricians, WIC, local schools, School Based Youth Services, Family Success Centers, regional Maternal-Child Health Consortia, community-based organizations and County Boards of Social Services (Welfare Boards).	
Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)		
3a	**Provide a summary of program accomplishments on goals.** **Include data where available.**	

- Prevent Child Abuse NJ maintains statewide data on all HFNJ sites in order to assure that they are meeting their level of service.
- Each site has to meet a certain "case weight" (see 3e below), which takes into consideration families at multiple stages of progress in the program. The actual statewide case weight expected on September 30, 2014 was 2,886. The actual case weight on September 30, 2014 was 2,560. These figures correspond to 88% utilization of services for the Healthy Families programs.
- The Healthy Families New Jersey program goals for project year 2013-2014 were:
  - Preventing of abuse and neglect of children under three years of age by providing early identification and support services to families at risk;
  - Providing assistance to over-burdened parents in promoting positive child development among infants and children at risk;
  - Providing links for families to the appropriate health and supportive services;
  - Promoting parent-child interaction, healthy childhood growth and development and household safety; and
  - Identifying and building on family strengths to support parents as the primary caregivers and nurturers of their children.
- From October 2013 to September 2014, there were 3 trainings for new Family Support Workers, 4 trainings for new Family Assessment Workers, and 1 training for new Supervisors.
- 38 additional trainings were held in order to expand the workers knowledge on issues related to home visiting. These trainings provided information on Great Beginnings Start Before Birth-Prenatal Curriculum, Family Issues, Child Health/Safety, Infant/Child Development, Parent/Child Interaction, FamSys Database Trainings, PATSys Database Trainings, Child Abuse and Neglect, Parents As Teachers, Developmental Screening Tools, Tools for Reducing Parental Stress, Advanced Supervisor's Training, Family Support Worker Refresher and Family Assessment Worker refresher trainings.
- The Program Specialists at PCA-NJ provided 1,242 contacts and/or technical assistance sessions for the 17 PSSF sites, and conducted 86 on site visits.
- There are currently 21 Healthy Families New Jersey sites. All sites are accredited.
- Four PCA-NJ staff members are trained as Healthy Families America National Peer Reviewers for the accreditation process. This knowledge of the requirements and experience in analyzing how well an organization meets program standards is invaluable as they provide technical assistance to the New Jersey Healthy Families sites.
- New Jersey has two Healthy Families America Family Support Worker Trainers and one Family Assessment Worker Trainers. Another staff person is in the process of becoming a Certified Family Assessment Worker trainer through HFA. Having the trainers based in New Jersey keeps training costs to a minimum and ensures that training needs are met expeditiously.
- All Healthy Families New Jersey sites enter client data into the FamSys Database Program.
- From October 1, 2013 to September 30, 2014, Healthy Families New Jersey sites conducted 4,817 screens. A formalized assessment tool, the Kempe Family Stress Checklist, is used to determine a participant's eligibility for the Healthy Families

	program. 2,332 assessments were conducted. Families scoring 45 or below on the Kempe Family Stress Checklist can be offered program services. ➢ From October 1, 2013 to September 30, 2014, 1,495 new families were enrolled into the Healthy Families programs. ➢ From October 1, 2013 to September 30, 2014, the programs discharged 1,418 families. ➢ From October 1, 2013 to September 30, 2014, the Healthy Families programs served 3,301 families with home visitation services. ➢ In addition, within the 21 Healthy Families Sites: • 96% of infants/children had a medical home • 92% of eligible children are enrolled in WIC. • 90% of participating infants/children are up to date on well-child visits • 94% of participating infants/children received developmental screening and appropriate referrals 97% of participants increased their inter-pregnancy interval (birth to conception) to 18 months
3b	**How did this improve outcomes for children and families?** PCA-NJ's role in quality assurance, training and technical assistance ensures that all HF New Jersey programs adhere to Healthy Families America model fidelity. Program accomplishments: • Increased the number of children and parents linked to a primary health care provider • Increased the number of children receiving up to date immunizations • Increased the number of families who make use of available community resources • Increase in the appropriate identification and referral of infants and children at risk for developmental delays
3c	**Identify specific factors that contributed to this improvement.** Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child's emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child's immunizations and well-child visits.
3d	**Identify significant barriers to goal accomplishment.** Flat funding to Healthy Families New Jersey programs for the past ten plus years also makes it difficult to attract and retain experienced home visitors.

3e	**Definition of Level of Service as per contract**: In Healthy Families, the level of service is measured by "case weight." Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.
3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14:** See Healthy Families New Jersey Data attached as Table A.
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14:** See Healthy Families New Jersey Data attached as Table A.
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals: _N/A____** **# of unduplicated families: __N/A_____**
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** ➢ In 2014, each Healthy Families New Jersey site distributed surveys to the families they served to assess client satisfaction. The results of those surveys are contained within each site's individual PSSF Update Report, submitted under separate cover. ➢ In 2014, Prevent Child Abuse NJ distributed site satisfaction surveys to all active programs that we serve. 22 surveys were distributed and 12 surveys were returned from the sites with the following themes: o When asked if they are pleased with the support provided by PCANJ, 95% strongly agreed/agreed, 5% (1 individual) was neutral. o When asked if the database gives them tools to measure progress, 85% strongly agreed/agreed and 15% disagreed. o When asked of PCA has made advanced trainings available for staff including explanation and information about ELearning opportunities, 100% strongly agreed/agreed. o When asked if Quarterly Supervisors Meetings have been valuable for peer networking and sharing of ideas from other programs, 85% strongly agreed/agreed and 15% were neutral. Comments included requests for: • More on-site trainings for home visiting staff • Faster database system

Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program:** ➢ To prevent all incidents of child abuse and neglect for participating families by providing education on child development and promoting positive parent child interaction; ➢ To have 100% of participating children receive developmental screening and assistance with appropriate referrals; ➢ To have 100% of participating children referred to and followed by an appropriate medical provider for scheduled well care visits; ➢ To increase family functioning and financial security; and ➢ To have participating parents and children linked to primary health care services and appropriate community resources as needs are identified.
4b	**Identify changes you will make that stem from stakeholder feedback.** We are hoping to incorporate more trainings on Motivational Interviewing Techniques to our network this upcoming year. An overview on the topic is needed by all, and a more in-depth focus on how to use MI skills when working with families experiencing substance abuse, domestic violence, and mental health issues will also be conducted. We also continue to make improvements to our web-based data collection systems on an ongoing basis. See also, each site's individual PSSF Update Report, submitted under separate cover.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** See Healthy Families New Jersey Data attached as Table A.
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals: __N/A___** **# of unduplicated families: __N/A_____**
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site's level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client

	feedback, the annual service review and feedback from the advisory board. PCANJ also utilizes Microsoft Report Builder, which allows us to pull data from the back end of our database system for more customized reports as needed.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.
5c	**How do you collaborate with community partners?** PCA-NJ collaborates with all agencies that provide Healthy Families services in New Jersey. The Healthy Families New Jersey staff also collaborates with the various maternal child health consortiums, birthing hospitals, community organizations, state agencies, local boards of social services, among others, to ensure programs have the latest data on births and eligible families in each county.

2015 PSSF Update Report

Section 1 – Identifying Information		
1a	**Provider**: Robins' Nest, Inc.	**1b Program Name:** Healthy Families/TIP
1c	**Relevant PSSF Program**: ___FPS, _X__FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 42 South Delsea Drive Glassboro, NJ 08028	
1e	**Objective**: Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.	
1f	**Outcome(s) Addressed**: _X_ Safety _X_ Permanency _X_ Well-Being	
Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)		
2a	**Overview of Service**: The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families' culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.	
2b	**Population Served**: All parents in Salem County who are pregnant or have an infant 3 months old or younger, or have an infant 12 months or younger if receiving TANF or GA.	
2c	**Geographical Area of Services**: Salem County	
2d	**Referral Sources**: Local Hospitals, Prenatal Clinics, Federally Qualified Health Centers, OB/GYN Physicians, WIC, Local Schools, School Based Youth Services, Family Success Centers, and County Social Services.	
Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)		
3a	**Provide a summary of program accomplishments on goals.** **Include data where available.** 56. 100% of children were enrolled in health insurance 57. 85% of participating infants/children were up-to-date on immunizations. 58. 92% of participants increased their interpregnancy interval (birth to conception) to 18 months	

	59. 100% of participating infants/children had a medical home 60. 100% of participating infants/children received developmental screening and appropriate referrals.
3b	**How did this improve outcomes for children and families?** Program accomplishments increased: • the number of children and parents linked to a primary health care provider • number of children receiving up to date immunizations • number of families use of community resources • appropriate identification and referral of infants and children for developmental delays
3c	**Identify specific factors that contributed to this improvement.** Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child's emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child's immunizations and well-child visits.
3d	**Identify significant barriers to goal accomplishment.** While the program experienced strong outcomes and was able to accomplish its goals, some of the barriers for families in Salem County include limited financial resources and lack of transportation to access services. These barriers were addressed mainly through referrals to and education about appropriate services to address needs. The site also experienced a staff vacancy near the end of the report period. The site was able to retain many of these clients through contact from the supervisor and visits covered by other staff and minimize the impact on disruption of program services.
3e	**Definition of Level of Service as per contract**: In Healthy Families, the level of service is measured by "case weight." Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.
3f	**Enter your contracted Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14** 120

3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14** 97
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals: 156** **# of unduplicated families: 78**
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** Thirty satisfaction surveys were distributed and fourteen were returned for the year. All 14 responded “Yes” when asked if the program was meeting their expectations. When asked “What do you like best about the program’s services?” many of the clients expressed that the program helped them to understand their child’s development and what to expect. They liked the information about how to encourage child’s development. Clients also stated that the program helped them set and achieve goals and that their worker encouraged them to look at things differently. When asked what could be done differently to improve services, several clients expressed a need for concrete services.
Section 4 – The Year Ahead FFY ’16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program** There are no planned changes to the program.
4b	**Identify changes you will make that stem from stakeholder feedback.** There are no planned changes to the program.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** 120
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals: 240** **# of unduplicated families: 120**
Section 5 – Evaluating Progress FFY ’16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site’s level of service, number of families, number of expected home visits, number of home visits completed and number of

	screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.
5c	**How do you collaborate with community partners?** The program maintains a collaborative relationship with many other agencies which can provide assistance to our families such as the Salem County Board of Social Services, Tri-County WIC Center, PRAC, One-Stop Career Center, Family Success Centers, the local hospital and pre-natal clinic, etc. These agencies not only facilitate our ability to obtain needed services for our families but are a rich source of referrals. The program has recently been able to partner with the local Family Success Center for events such as a Baby Shower and Mom's Spa Day. In delivering services, staff also works closely with the local clinic and OB/GYN, which welcome Healthy Families at their sites to outreach to mothers. WIC clinic staff has also welcomed Healthy Families presence on site. In addition, school nurses, DYFS caseworkers, and social workers identify potential candidates and make referrals. Finally, staff collaborates with a broad array of services (such as medical providers, employment services, vocational training, day care, etc.), linking new families to the resources they need to provide their baby a loving, financially viable home. Representatives from local schools, children's protective services, child care centers, other parenting programs, health department, and resource development are represented on our advisory board as community partners.

2015 PSSF Update Report

Section 1 – Identifying Information		
1a	**Provider**: Robins Nest Inc	**1b Program Name:** Healthy Families Cumberland County
1c	**Relevant PSSF Program**: ___FPS, _X__FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 42 South Delsea Drive Glassboro NJ 08028	
1e	**Objective**: Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.	
1f	**Outcome(s) Addressed**: _X_ Safety _X_ Permanency _X_ Well-Being	
Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)		
2a	**Overview of Service**: The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families' culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.	
2b	**Population Served**: The target population of Healthy Families-TIP Cumberland County is all pregnant women and parents regardless of age that reside in Cumberland County with infants younger than three months old and GA/TANF eligible parents and their babies until 12 months old. The service population of Cumberland County HF-TIP is primarily, White, African American, and Hispanic. The average mothers are between 20 to 30 years of age. Most of the participants are single mothers. Also the majority of the parents have less than high school diploma. Many of the fathers are not involved with the family. Most of the families, (144) 88% receive public assistance. Of those families (12) 7% received TANF, (12) 7% received emergency Assistance, (2) 1% of them received General Assistance, (69) 42% received WIC, (108) 66% received Food Stamps and the (12) % remaining received Social Security.	
2c	**Geographical Area of Services**: Cumberland County	
2d	**Referral Sources**: Local Hospital, Complete Care Prenatal Care Clinics, OB/GYN	

	Physicians, WIC, Local Schools, School Based Youth Services, County Social Services.
Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)	
3a	**Provide a summary of program accomplishments on goals.** **Include data where available.** 61. 100% of children were enrolled in health insurance 62. 87% of participating infants/children were up-to-date on immunizations. 63. 98% of participants increased their interpregnancy interval (birth to conception) to 18 months 64. 100% of participating infants/children had a medical home 65. 95% of participating infants/children received developmental screening and appropriate referrals.
3b	**How did this improve outcomes for children and families?** Program accomplishments increased: • the number of children and parents linked to a primary health care provider • number of children receiving up to date immunizations • number of families use of community resources • appropriate identification and referral of infants and children for developmental delays
3c	**Identify specific factors that contributed to this improvement.** Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child's emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child's immunizations and well-child visits.
3d	**Identify significant barriers to goal accomplishment.** The challenges this site faced in the past year were the absence of one FSW for Maternity Leave and the training in progress of a new staff member. We assigned the cases of the FSW in leave among FSWs until her return at the beginning of October. After the new staff was trained her case load started to be build ending the year with a case weight of 18 (9) families.
3e	**Definition of Level of Service as per contract**: In Healthy Families, the level of service is measured by "case weight." Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family

	Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.
3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14: 150 Case Weight**
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14: 127 Case Weight 85% Level of Services**
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals:** <u>256</u> **# of unduplicated families:** <u>128</u>
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** Thirty satisfaction surveys were distributed and Twenty- Six were returned. The results from the most recent survey revealed the following findings: 26 of families strongly agreed or agreed that their Family Support Worker is respectful and understands their culture as well as the parenting information that they receive was easy for them to understand. 23 families strongly agreed they that their Family Support Worker talks with them about their child, parenting, health and development every visit. When asked if they have participated in forming goals with the FSW, 30 families responded yes. 20 "My FSW understands and respects my family's expectations for my child's development", 29 "My FSW is able to answer my questions in a way that I can understand. Other comments included: "My Family Support Worker works with my schedule and my son is very attached to her, she is very friendly", "and The program is wonderful as it is", "I am a new mom and my FSW has helped me build confidence as a mom. I can ask her for questions and she helps me anytime and not judges me"
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program** There are no planned changes to the program
4b	**Identify changes you will make that stem from stakeholder feedback.** We will maintain our efforts in providing quality services to enhance parents' knowledge, self-efficacy and family functioning.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** 150 Case Weight
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.**

	# of unduplicated individuals: 256 **# of unduplicated families:** 128
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site's level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.
5c	**How do you collaborate with community partners?** Healthy Families collaborates with the county's local hospital. Hospital's staff identifies families to refer to Healthy Families-TIP for a comprehensive assessment. In addition, pre-natal clinic staff, school nurses and social workers identify potential candidates. Also Healthy Families-TIP partnered with the County Board of Social Services to serve GA/TANF eligible parents as well as participated in the monthly Cumberland County Work First New Jersey Local Partnership meetings. Finally the Healthy Families-TIP Advisory Board has representation of members of the Cumberland County Health Department, Success Centers, Perinatal Cooperative and Nurse Family Partnership Program, that collaborate in planning, implementing, and assessing program services.

2015 PSSF Update Report

Section 1 – Identifying Information		
1a	**Provider**: Robins Nest Inc.	**1b Program Name:** Healthy Families Gloucester County
1c	**Relevant PSSF Program**: ___FPS, _X__FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 42 S. Delsea Drive Glassboro, NJ 08028	
1e	**Objective**: Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.	
1f	**Outcome(s) Addressed**: _X_ Safety _X_ Permanency _X_ Well-Being	
Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)		
2a	**Overview of Service**: The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families' culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.	
2b	**Population Served**: Any parent who is pregnant or has an infant 3 months or younger is eligible for Healthy Families-TIP Gloucester. Additionally, the program is available to parents with an infant up to twelve months old if they are currently receiving or eligible to receive Temporary Assistance to Needy Families (TANF), Emergency Assistance (EA) or General Assistance (GA). Potential clients are screened for a variety of risk factors, including but not limited to teen pregnancy, first-time or subsequent pregnancy, low income, inadequate or no prenatal care, unstable housing, social isolation, depression, substance use, domestic violence and other indicators that place a child at risk of abuse and neglect.	
2c	**Geographical Area of Services**: Gloucester County	
2d	**Referral Sources**: Local Hospitals, Prenatal Clinics, Federally Qualified Health Centers, OB/GYN Physicians, WIC, Local Schools, School Based Youth Services, County Social Services.	

Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)	
3a	**Provide a summary of program accomplishments on goals. Include data where available.** 1. 100% of children were enrolled in health insurance 2. 75% of participating infants/children were up-to-date on immunizations. 3. 95% of participants increased their inter pregnancy interval (birth to conception) to 18 months 4. 100% of participating infants/children had a medical home 5. 96% of participating infants/children received developmental screening and appropriate referrals.
3b	**How did this improve outcomes for children and families?** Program accomplishments increased: ● the number of children and parents linked to a primary health care provider ● number of children receiving up to date immunizations ● number of families use of community resources ● appropriate identification and referral of infants and children for developmental delays
3c	**Identify specific factors that contributed to this improvement.** Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child's emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child's immunizations and well-child visits.
3d	**Identify significant barriers to goal accomplishment.** Our challenge continues to be with recruitment and enrollment of families. We are impacted by our participation with MIHOPE. All families must be interviewed/surveyed by the MIHOPE representative before we can consider offering home visitation services. The MIHOPE interview is lengthy and asks a number of personal questions. Half of all families who agree to services are not allowed to be enrolled by us as they have been randomized out of the process.
3e	**Definition of Level of Service as per contract**: In Healthy Families, the level of service is measured by "case weight." Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of

	each FSW vary between 15-25 families, depending on the intensity of service.
3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14** The contracted level of service was 120.
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14** 96 case weight or 80% level of service.
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals: 78** **# of unduplicated families: 156**
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** Fifty satisfaction surveys were distributed to participating families. Twenty-one surveys were returned. Seven respondents were African American, nine were Caucasian, two Hispanic, two multi-ethnic and one "other". All twenty-one respondents felt that the program met their expectations. All respondents strongly agreed or agreed with activities offered by their Family Support Worker and program services. There were no areas where any respondents disagreed with services.
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program** There are no planned changes to the program.
4b	**Identify changes you will make that stem from stakeholder feedback.** There are no planned changes to the program due to stakeholder feedback.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** The expected case weight is 120.
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals: 78** **# of unduplicated families: 156**
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site's level of service, number of families,

	number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.
5c	**How do you collaborate with community partners?** The program maintains a collaborative relationship with many other agencies which can provide assistance to our families such as the Gloucester County Board of Social Services, local WIC Center, One-Stop Career Center, the local hospitals pre-natal clinic, etc. These agencies not only facilitate our ability to obtain needed services for our families but are a rich source of referrals. Using a simple pre-screen instrument, local hospital staff identifies families to refer to Healthy Families for a comprehensive assessment. In addition, prenatal clinic staff, school nurses, social workers and community agencies identify potential candidates and contact our central intake system to make a referral. Program staff works closely with WIC which welcomes Healthy Families at their site to outreach to parents. Staff collaborate with a broad array of services (such as medical providers, employment services, vocational training, day care, etc.), linking new families to the resources they need to provide their child(ren) with a loving and financially viable home. Representatives on our Advisory Board are from: Salem County Health Department, Underwood Hospital Prenatal Clinic, South Jersey Perinatal Cooperative, and Cumberland County Health Department. Relationships with the Board of Social Services, Workforce Investment Board and Gloucester County One-Stop have strengthened due to the addition of TIP (TANF Initiative for Parents). Healthy Families provides in home parenting education for families who receive cash assistance, food stamps, temporary rental assistance, education/employment counseling. These families are able to receive credit with the Board of Social Services for their participation in the program.

2015 PSSF Update Report

<table>
<tr><th colspan="3">Section 1 – Identifying Information</th></tr>
<tr><td>1a</td><td>Provider: Southern NJ Perinatal Cooperative</td><td>1b Program Name: Atlantic County Healthy Families/TIP</td></tr>
<tr><td>1c</td><td colspan="2">Relevant PSSF Program: ___FPS, _X__FSS, ___TLFRS, ___APSS</td></tr>
<tr><td>1d</td><td colspan="2">Program Address: Southern NJ Perinatal Cooperative, 2922 Atlantic Avenue 2nd Floor Atlantic City, NJ 08401</td></tr>
<tr><td>1e</td><td colspan="2">Objective: Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.</td></tr>
<tr><td>1f</td><td colspan="2">Outcome(s) Addressed: _X_ Safety _X_ Permanency _X_ Well-Being</td></tr>
<tr><th colspan="3">Section 2 – Service Description Basics FFY ’15 (10/1/13 – 9/30/14)</th></tr>
<tr><td>2a</td><td colspan="2">Overview of Service: The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families’ culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.</td></tr>
<tr><td>2b</td><td colspan="2">Population Served: The Atlantic County Healthy Families-TIP Program serves families who are either currently pregnant or have a newborn younger than 3 months of age. Our program also provides services to families who are emergency assistance eligible and/or TANF eligible who are pregnant or have a child under the age of 12 months.</td></tr>
<tr><td>2c</td><td colspan="2">Geographical Area of Services: We provide services to families residing in Atlantic City, Ventnor, Brigantine, Pleasantville, Egg Harbor Township, Absecon, Galloway Township, Egg Harbor City, and Mays Landing.</td></tr>
<tr><td>2d</td><td colspan="2">Referral Sources:
Southern Jersey Family Medical Center: Atlantic City location
Southern Jersey Family Medical Center: Pleasantville location
Southern Jersey Family Medical Center: IPO Community Health Workers
AtlantiCare Regional Medical Center - AC Division: Case Management
DCP&P of Atlantic County</td></tr>
</table>

	Atlantic County Project Teach (DCF Regional) High School Inspira Hospital AtlantiCare Regional Medical Center-Center for Childbirth Self-Referral (Info into PRA/SPECT & assigned to HF-TIP) AtlantiCare Physician's Group - Pavilion OB/GYN (Egg Harbor Township) Shore Medical Center Reliance Medical Center of Atlantic City Reliance Medical Group of Somers Point Robin's Nest
Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)	
3a	**Provide a summary of program accomplishments on goals.** **Include data where available.** 66. 100% of children were enrolled in health insurance 67. 69% of participating infants/children were up-to-date on immunizations. 68. 100% of participants increased their interpregnancy interval (birth to conception) to 18 months 69. 100% of participating infants/children had a medical home 70. 93% of participating infants/children received developmental screening and appropriate referrals.
3b	**How did this improve outcomes for children and families?** Program accomplishments increased: • the number of children and parents linked to a primary health care provider • number of children receiving up to date immunizations • number of families use of community resources • appropriate identification and referral of infants and children for developmental delays
3c	**Identify specific factors that contributed to this improvement.** Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child's emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child's immunizations and well-child visits.
3d	**Identify significant barriers to goal accomplishment.** A barrier to accomplishing our target goal of achieving 85% of our participating infants/children being up-to-date on immunizations is definitely a documentation/data entry issue on behalf of the pediatrician offices. Our program staff utilizes the online New Jersey Immunization Information System (NJIIS) in order to obtain all immunization dates for each participating target child. When medical providers do not update the

	immunization information successfully, this information is then unavailable to our home visiting staff. It is important to note that majority of the families we serve do not maintain up-to-date child health records or document immunization dates to provide to their designated Family Support Worker.
3e	**Definition of Level of Service as per contract**: In Healthy Families, the level of service is measured by "case weight." Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.
3f	**Enter your contracted Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14:** 173
3g	**Enter your actual Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14:** 104.8
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals:** 192 **# of unduplicated families:** 96
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** Please see the attached 2013-2014 Client Satisfaction Survey data. Out of 80 surveys distributed, 24 surveys were completed and returned to us.
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.** There are currently no planned changes for the program.
4b	**Identify changes you will make that stem from stakeholder feedback.** Each year, the Program Supervisor/Manager compiles all of the responses from the completed Client Satisfaction Surveys and creates one document with all of the aggregate responses, which is then shared annually with both the program staff and the Advisory Board. While our site will not technically be changing any policies or procedures, the following strengths and strategies for Culturally Sensitive growth were identified and discussed during our December 2nd, 2014 Advisory Board meeting: - After reviewing our 2014 ASR and seeing that families without the Biological

	father living in the home are more likely to join AC HF-TIP, our male Planned Parenthood health educator wanted to then discuss fathers (and males in general). He stated that he has noticed that males are generally less interested or uninterested in perusing sexual/reproductive health services, even though these services are available to the uninsured or underinsured either free or at a reduced cost. Other Advisory Board members were interested in discussing this further, and some members suggested that perhaps it is a combination of both pride and also that males and/or "fathers of the home" may feel better-equipped to succeed without the assistance of community resources and/or home visitation services. Another female representative (retired professional and now community member) then mentioned that historically, the opposite is actually true: women are more well-equipped at meeting the needs of themselves and their families." Our female SNAP-ED representative and other members also touched on possible "pride in men" and even the possibility of males feeling some shame when admitting they are in need of assistance. Our conversation concluded with an enriching discussion on different members' experiences "meeting men where they're at" especially when offering services in the home, and how important it is to be extra sensitive of a male's character (ego) when discussing possible needs and/or assistance available to better serve him and his family. - To comment on previous practice conducting outreach/recruitment, our female SNAP-ED representative shared her experience with utilizing text messaging with families and reported that she has found most people prefer not to use up their minutes but would rather text. Each of our home visitors were recently provided with a new iPhone, on behalf of our overseeing agency SNJPC, and therefore texting with families has become much easier and more frequent. - Overall, everyone agreed that having home visiting staff continues to maintain culturally sensitive practices and also continue pointing out and emphasizing family strengths will ultimately aid in our program's participation and retention.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** 173
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals:** Approximately 173 **# of unduplicated families:** Approximately 86
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site's level of service, number of families,

	number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.
5c	**How do you collaborate with community partners?** In spring, 2013, a Central Intake referral hub was established in Atlantic County. The Central Intake hub in Atlantic County is funded by the New Jersey Department of Health as a component of the Improvement of Pregnancy Outcome project and oversees the home visiting referrals. The 5 home visitation programs in Atlantic County get together for planning meetings and have established business rules that are based on program eligibility criteria and outline how the referrals are assigned to each program. All local prenatal care providers and other referring agencies have been instructed on the Central Intake process and utilize the Perinatal Risk Assessment, the Community Health Screening, or the general home visitation referral form. SNJPC (SNJPC) is the designated Central Intake agency for Atlantic County. Family Health Initiatives (FHI) is the sponsor of the web-based Perinatal Risk Assessment/Single Point of Entry Client Tracking System (PRA/SPECT) used by all NJ Central Intake hubs. FHI is a subsidiary company of SNJPC. SNJPC/FHI has business and data sharing agreements with the prenatal care sites using the PRA/SPECT system and with all the home visiting programs who receive referrals from Central Intake in Atlantic County. Additionally, our program supervisor attends the bimonthly Atlantic County Healthy Mothers Healthy Babies Coalition meetings and the Atlantic County United Way Success by Six meetings. These meetings are comprised of a variety of maternal, infant, and early childhood health professionals, and networking amongst everyone is ongoing. All meeting members provide ongoing updates regarding their specific programs and/or agencies. Community partners that are represented on our HF-TIP Advisory Board include: - Ivy Daniels – RN, BSN, Supervisor of Community Health Nurses – Atlantic City Health Department (English speaking, African American female) - Betty Sherman – Community Resource Coordinator -- Division Of Child Protection and Permanency (English speaking, Caucasian female) - Christine Zellers – Senior Program Coordinator of SNAP-Ed Program of Atlantic County (English speaking, Caucasian female) - Stacey DeCore – MSW, LSW – Shore Medical Center (English speaking, Caucasian female) - Dianne McDevitt – PNP, BC Atlantic County Department of Community Health (English speaking, Caucasian female) - Amanda McGowan – Director of Community Initiatives United Way of Greater

	Philadelphia and Southern New Jersey (English speaking, Caucasian female) - Luis Valentino – Planned Parenthood of Southern NJ (Bilingual English/Spanish speaking male) - Carol Gaffney – Retired Professional/ Community Member (English speaking, Caucasian female) - Chris Neil – Retired Professional/ Community Member (English speaking, Caucasian female) - Priscilla Williams – HF-TIP participant (English speaking, African American female) - Anais Garcia – HF-TIP participant (Bilingual English/Spanish speaking, Hispanic female)

2015 PSSF Update Report		

Section 1 – Identifying Information		
1a	**Provider**: Visiting Nurse Association of Central Jersey	**1b Program Name:** Monmouth Healthy Families/TIP
1c	**Relevant PSSF Program**: ___FPS, _**X**__FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 1301 Main Street Asbury Park, NJ 07712 and 200 Broadway Long Branch, NJ 07740	
1e	**Objective**: Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.	
1f	**Outcome(s) Addressed**: _**X**_ Safety _**X**_ Permanency _**X**_ Well-Being	
Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)		
2a	**Overview of Service**: The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families' culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.	
2b	**Population Served**: Monmouth Healthy Families/TIP program serves first time parents living in Asbury Park and its surrounding areas, the town of Long Branch, and also serves parents in Monmouth County who are receiving TANF/GA benefits and have a child younger than 12 months in age. The program's goal is to engage and enroll women prenatally or within three months of the birth of the baby. In addition, parents who are receiving welfare cash benefits may be enrolled in HF/TIP until the baby turns twelve months old.	
2c	**Geographical Area of Services**: Monmouth Healthy Families/TIP program serves first time parents living in Asbury Park and surrounding areas, the town of Long Branch, and also serves parents receiving TANF/GA benefits and have a child younger than 12 months in age that are residing within Monmouth County.	
2d	**Referral Sources**: The Monmouth Healthy Families/TIP receives referrals from the Monmouth/Ocean Family Connections Central Intake Program, local hospitals, Prenatal	

	Clinics, Federally Qualified Health Centers, OB/GYN Physicians, WIC, local schools, Project Teach, and Monmouth County Social Services.
Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)	
3a	**Provide a summary of program accomplishments on goals.** **Include data where available.** 71. _100_% of children were enrolled in health insurance 72. _85_% of participating infants/children were up-to-date on immunizations. 73. _98_% of participants increased their interpregnancy interval (birth to conception) to 18 months 74. _100_% of participating infants/children had a medical home 75. _92_% of participating infants/children received developmental screening and appropriate referrals.
3b	**How did this improve outcomes for children and families?** Program accomplishments increased: • the number of children and parents linked to a primary health care provider • number of children receiving up to date immunizations • number of families use of community resources • appropriate identification and referral of infants and children for developmental delays
3c	**Identify specific factors that contributed to this improvement.** Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child's emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child's immunizations and well-child visits.
3d	**Identify significant barriers to goal accomplishment.** The site has experienced challenges with meeting the expected case weight of 261. The site is looking to expand the target population to allow for more families to be served by program services in Monmouth County. This year the Monmouth Healthy Families/TIP program experienced staff turnover. The site had three long time Family Support Workers leave the program. Two of the Family Support Workers moved on to pursue other job opportunities and one of the Family Support Workers retired after 19 years of service. The site has hired three new Family Support Workers and is currently fully staffed. The site is working to enroll families and work towards meeting expected case weight.

3e	**Definition of Level of Service as per contract**: In Healthy Families, the level of service is measured by "case weight." Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.
3f	**Enter your contracted Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14** Monmouth HF/TIP programs expected number of units is 261.
3g	**Enter your actual Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14** 84% of units delivered
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals: __332___** **# of unduplicated families: ___166____**
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** **See Below Attachment #1**
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.** The site is considering expanding the current target population to include families that are not first time parents. This expansion would provide our site the opportunity to provide home visitation services to more families in Monmouth County.

4b	**Identify changes you will make that stem from stakeholder feedback.** Based on feedback from members of the Advisory Board, the site is considering expanding target population so that the program can provide home visitation services to more families in Monmouth County. This idea was presented to the all members of the Advisory Board and Central Intake at the September 2014 meeting and was received positively.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** Monmouth HF/TIP programs expected number of units is 246. The site's SSBG funding will be ending 6/30/15, which will decrease the site's current case weight from 261 to 246.
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals: _492____** **# of unduplicated families: __246_____**
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site's level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.
5c	**How do you collaborate with community partners?** In June 2014, Monmouth County began participating in the Central Intake process. Through this participation the site is anticipating an increase in screens and referrals. The site meets with the Central Intake program to discuss strengths and challenges of the Central Intake process. To help maintain and build community partnerships, the Monmouth Healthy Families/TIP program participates in the Monmouth County MCH network and Home Visitation quarterly advisory board meeting. The HF site staff meets and networks with community partners interested in maternal child health at these

	meetings. The Monmouth Healthy Families/TIP program has established a relationship with the new Improving Pregnancy Outcomes grant, which utilizes Community Health Workers to outreach and engage women of childbearing age into medical care. **See Below Attachment #2**

Attachment #1(Section 3i)

Survey Results of Annual Client Satisfaction Survey 2014
Monmouth Healthy Families/TIP

TOTAL # SENT =100

TOTAL # RECEIVED = 51

TOTAL ENGLISH = 31

TOTAL SPANISH = 20

DEMOGRAPHIC INFORMATION

	White	**Asian**	**Multi.**	**Hispanic**	***AA**	**Other**		
1. Please indicated which racial/ethnic background best represents you.	8		1	25	15	2		
	<or =17	**18-24**	**25-30**	**30-34**	**> or =35**	**◊U**		
2. Please indicate the age range that you fall within.	2	25	19	2	2	1		
	K-8	**9-11**	**HS Grad.**	**GED**	***VS**	**Some College**	**Assoc.**	**> or =Bach.**
3. Please indicate the highest level of education that you have completed.	10	19	9	1	1	9	2	
	Single, NM	***Dom. Partner**	**Single, Divorced**	**Married**	***Sep.**	***Wid.**	**◊U**	
4. Please indicate your current relationship status.	37	12		1	1			
	Yes	**No**	**◊U**					
5. Please indicate if you are a TANF recipient.	11	38	2					

FAMILY SUPPORT WORKER(S)

	>1 year	**1 year**	**2 years**	**>or = 3 years**				
5. How many years have you worked with you current FSW?	19	10	18	4				
	Weekly	**Every other week**	**Monthly**	**Once every 3 months**	**None**	◊U		
6. How often do you currently receive visits from you FSW?	23	14	13			1		

If none…Please explain:

N/A

	◊SA	**◊A**	**◊N**	**◊D**	**◊SD**	**◊N/A**	**◊U**
7. My FSW is respectful and understands my culture or way of living, even though it may be different from hers/his	40	10	1				
8. My FSW helps me find and connect to other community services/resources that I may need	39	11	1				
9. My FSW brings parenting information to my home that is easy for me to understand	39	10	1				1
10. My FSW talks with me about my parenting on every visit	39	12					
11. My FSW talks with me about child health and safety	40	11					
12. My FSW talks with me about child development	40	11					
13. My FSW understands and respects my family's expectations for my child's development	39	12					

	◊SA	◊A	◊N	◊D	◊SD	◊N/A	◊U
14. My FSW is able to answer my questions in a way that I can understand	40	11					
15. I have participated in forming goals with my FSW	36	14				1	

PROGRAM SERVICES

	>1 year	1 year	2 years	>or = 3 years	◊U		
16. How many years have you been enrolled in the program	20	6	19	4	2		
	◊SA	**◊A**	**◊N**	**◊D**	**◊SD**	**◊N/A**	**◊U**
17. The program gives me opportunities to share feelings about the program and services	35	15	1				
18. The program uses pictures, videos, posters, and materials that remind me of my own family	29	17	1		1	3	
19. The program has helped me	41	9	1				

*If the program has helped you, please explain how:

- My worker provides me with information to help me be a better parent, and improve my parenting skills.
- The program educated me on some of the resources that I didn't know about for me and my family.
- The program provided me and my baby with books and activities to do together.

- It has helped me to be better informed about choices I make as a parent.

- I have learned to play with my child and help with his development. I am very happy with my worker.

- It helps that I have someone to talk to every week as a first time mom with no experience with kids. My worker has also helped to teach me different activities to do with my daughter and has put me in touch with organizations to help when I have needed it.

- The program and my FSW have helped me in all areas. I have learned how to budget, how to take care of my son, and also it has helped me get a part time job. I really enjoy the program.

- I learn a lot from the information my FSW gives to me.

20. Is the program meeting your expectations, Yes or No? If No, please explain:

** 50 clients checked "Yes"
**1 client wrote in "N/A"-with no comment on this question.

- Yes, my worker is always able to provide me with an answer to any questions I may have about my baby, and if she does not know the answer she always follows up with me on the next home visit with an answer. I'm really so thankful for the program.

- Yes, it helped me meet some of my personal goals for myself and my child.

21. What can the program do differently to improve its services?

- Maybe have more outings for the dads.

- The program should provide transportation.

- Nothing the program is a great resource for new moms in the community.

- I liked the movie day. I would like to have it happen again.

- Probably hire more people and expand services, its great help!

- Keep people like my worker.

- I would like more family events.

2015 PSSF Update Report

<table>
<tr><th colspan="3">Section 1 – Identifying Information</th></tr>
<tr><td>1a</td><td>Provider: Visiting Nurses Association</td><td>1b Program Name: Healthy Families Perth Amboy</td></tr>
<tr><td>1c</td><td colspan="2">Relevant PSSF Program: ___FPS, _X__FSS, ___TLFRS, ___APSS</td></tr>
<tr><td>1d</td><td colspan="2">Program Address:
313 State St Suite 416 Perth Amboy, NJ 08861</td></tr>
<tr><td>1e</td><td colspan="2">Objective: Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.</td></tr>
<tr><td>1f</td><td colspan="2">Outcome(s) Addressed: _X_ Safety _X_ Permanency _X_ Well-Being</td></tr>
<tr><th colspan="3">Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)</th></tr>
<tr><td>2a</td><td colspan="2">Overview of Service: The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families' culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.</td></tr>
<tr><td>2b</td><td colspan="2">Population Served: Healthy Families Perth Amboy (HFPA) serves low income, pregnant women or women parenting a child less than 3 months of age who live in the city of Perth Amboy. The Target Population for Healthy Families Perth Amboy was determined in the year 2008 based on demographics and the presence of two other home visitation programs serving Middlesex County. Nurse Family Partnership Middlesex services first time mothers. HFPA saw an opportunity to serve mothers prenatally or parenting a child less than 3 months whether they have other biological children in the home or not.</td></tr>
<tr><td>2c</td><td colspan="2">Geographical Area of Services: Healthy Families Perth Amboy (HFPA) serves low income, pregnant women or women parenting a child less than 3 months of age who live in the city of Perth Amboy. The Target Population for Healthy Families Perth Amboy was determined in the year 2008 based on demographics and the presence of two other home visitation programs serving Middlesex County.</td></tr>
</table>

2d	**Referral Sources**: Central Intake
	Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)
3a	**Provide a summary of program accomplishments on goals.** **Include data where available.** 76. 95% of children were enrolled in health insurance 77. 89% of participating infants/children were up-to-date on immunizations. 78. 0% of participants increased their interpregnancy interval (birth to conception) to 18 months 79. 98% of participating infants/children had a medical home 80. 80% of participating infants/children received developmental screening and appropriate referrals.
3b	**How did this improve outcomes for children and families?** Program accomplishments increased: • the number of children and parents linked to a primary health care provider • number of children receiving up to date immunizations • number of families use of community resources • appropriate identification and referral of infants and children for developmental delays
3c	**Identify specific factors that contributed to this improvement.** Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child's emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child's immunizations and well-child visits.
3d	Identify significant barriers to goal accomplishment. Family Support Workers are educating participants about the lead screens but are learning that the doctors are screening around 14-16 months. Another barrier is when the providers do not enter the lead results on the NJIIS.
3e	Definition of Level of Service as per contract: In Healthy Families, the level of service is measured by "case weight." Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.

3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14** –The LOS increased from 62 to 77 due to Sandy Funding in the month of October 2013. The site's expected case weight is 77.
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14 -** The average case weight delivered by HFPA during the 2014 FY was 62.
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals: 53** **# of unduplicated families: 106**
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** Healthy Families Perth Amboy distributed eight Client Satisfaction Surveys and received eighteen in return. *See attachment #1*
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program** Healthy Families Perth Amboy (HFPA) serves low income, pregnant women or women parenting a child less than 3 months of age who live in the city of Perth Amboy. The Target Population for Healthy Families Perth Amboy was determined in the year 2008 based on demographics and the presence of two other home visitation programs serving Middlesex County. Nurse Family Partnership Middlesex services first time mothers. HFPA saw an opportunity to serve mothers prenatally or parenting a child less than 3 months whether they have other biological children in the home or not. HFPA is consistently close to capacity, therefore there is no need to change the Target Population according to current demographics and client needs.
4b	**Identify changes you will make that stem from stakeholder feedback.** The Healthy Families Perth Amboy program recognizes the suggestions for the families meet more often and has collaborated with the Jewish Renaissance Foundation/ Family Success Center to provide the families with a family themed dinner on a quarterly basis.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** Healthy Families Perth Amboy is expecting a decrease in the site's case weight due to Sandy funding ending on June 30, 2015. The case weight will decrease

	from 77 to 62.
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals: 62** **# of unduplicated families: 124**
	Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)
5a	**How will you measure progress?** The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site's level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.
5c	**How do you collaborate with community partners?** HFPA has collaborated with the Family Success Center in Perth Amboy on many events during the fiscal year. The events include, but are not limited to, the 2nd Annual Block Party, Sahara Sams Indoor Waterpark, Storytime (biweekly), Latin Dance Class, Citizenship& ESL classes, etc. HFPA and the FSC have a formal MOU for upcoming joint events such as monthly *Storytime* and quarterly themed family dinners. Collaboration and outreaching to gain recognition can be used as a strategy that may increase the target population screened. We aim for community members to want to be part of our programs. Other referral sources include Catholic Charities, Raritan Bay Mental Health Clinic, Good News Pregnancy Crisis Center, Fatima Church for baby items, Jewish Renaissance Foundation, PRAB, etc. The Program Supervisor participates and attends the Maternal Child Health Advisory Board which is held on a quarterly basis. The HFPA site provides the Advisory Board with updates and networks and connects with community partners. *See Attachment #2*

Attachment 1

Survey Results of Annual Client Satisfaction Survey 2014
Perth Amboy Healthy Families/TIP

TOTAL # SENT= 28

TOTAL # RECEIVED= 18

TOTAL ENGLISH= 3

TOTAL SPANISH= 15

DEMOGRAPHIC INFORMATION

1. Please indicated which racial/ethnic background best represents you.	**White**	**Asian**	**Multi.**	**Hispanic**	***AA**	**Other**		
	0	0	1	16	1	0		
2. Please indicate the age range that you fall within.	**<or =17**	**18-24**	**25-30**	**30-34**	**> or =35**			
	1	8	4	3	2			
3. Please indicate the highest level of education that you have completed.	**K-8**	**9-11**	**HS Grad.**	**GED**	***VS**	**Some College**	**Assoc.**	**> or =Bach.**
	3	3	1	1	1	7	0	2
4. Please indicate your current relationship status.	**Single, NM**	***Dom. Partner**	**Single, Divorced**	**Married**	***Sep.**	***Wid.**		
	9	**3**	**0**	**6**	**0**	**0**		
5. Please indicate if you are a TANF recipient.	**Yes**	**No**						
	2	**15**						

FAMILY SUPPORT WORKER(S)

5. How many years have you worked with you current FSW?

>1 year	1 year	2 years	>or = 3 years				
5	4	7	1				

6. How often do you currently receive visits from you FSW?

Weekly	Every other week	Monthly	Once every 3 months	None			
7	5	4	0	0			

If None…Please explain:

	◊SA	◊A	◊N	◊D	◊SD	◊N/A	◊U
7. My FSW is respectful and understands my culture or way of living, even though it may be different from hers/his	17	1					
8. My FSW helps me find and connect to other community services/resources that I may need	17	1					
9. My FSW brings parenting information to my home that is easy for me to understand	17	1					
10. My FSW talks with me about my parenting on every visit	17	1					
11. My FSW talks with me about child health and safety	17	1					
12. My FSW talks with me about child development	17	1					
13. My FSW understands and respects my family's expectations for my child's development	17	1					

◊SA	◊A	◊N	◊D	◊SD	◊N/A	◊U

14. My FSW is able to answer my questions in a way that I can understand	17	1					
15. I have participated in forming goals with my FSW	17	1					

PROGRAM SERVICES

	>1 year	1 year	2 years	>or = 3 years			
16. How many years have you been enrolled in the program	5	4	8	1			
	◊SA	**◊A**	**◊N**	**◊D**	**◊SD**	**◊N/A**	**◊U**
17. The program gives me opportunities to share feelings about the program and services	14	4					
18. The program uses pictures, videos, posters, and materials that remind me of my own family	14	4					
19. The program has helped me	15	3					

*If the program has helped you, please explain how:

- Helped me become more self-sufficient.
- Educate on the development of my children
- Going back to school, being there for my son how to be a mother.
- I learn new things that I did not know.
- Helped me be a better mother, person and develop as a mother and wife.
- Providing different information.
- Helped me achieve my goals and I got Christmas presents for my children.
- Teaches me to care of my son and enjoy him.
- The program helps me define my goals for the future and find other opportunities to improve my lifestyle.
- Contact with other city programs.

- Giving ideas to care my baby.
- In the development of my child and finding best doctors for my children.
- Emotional support and giving me the foundation to care for my son plus a beautiful friendship.
- Be more patient with my son and understand each situation.
- Doing activities that help the baby's development.

20. Is the program meeting your expectations, Yes or No? If No, please explain:

YES= 18

21. What can the program do differently to improve its services?

- More activities and social groups for the parents.
- Doing activities with others mothers.
- Doing activities outside.
- The level one last longer.
- Children last longer in the program not only three years.

2015 PSSF Update Report

	Section 1 – Identifying Information	
1a	**Provider**: VNAHG	**1b Program Name:** Essex Healthy Families/TIP
1c	**Relevant PSSF Program**: ___FPS, _X__FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 274 South Orange Ave 3rd Fl, Newark, NJ 07103	
1e	**Objective**: Primary objectives for Healthy Families Program are: 1) prevention and early identification of child abuse and neglect in at-risk families; 2) improving the health and well-being of participating infants, children and families.	
1f	**Outcome(s) Addressed**: _X_ Safety _X_ Permanency _X_ Well-Being	
	Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)	
2a	**Overview of Service**: The Healthy Families (HF) Program model provides in-home education and supportive services to new and expectant parents, especially those families who are overburdened by stressors that put them at risk of child abuse and neglect. HF identifies families of unborn or newborn children who may be at risk of maltreatment through a systematic screening and assessment process which begins during pregnancy or at birth. Families who have a positive screen and assessment are offered intensive, long-term home visitation services from pregnancy to age three (participation is voluntary). Trained home visitors, who often share the families' culture and community, link new or expectant parents to existing social service and health care resources, and promote positive parenting and healthy child growth and development.	
2b	**Population Served**: The Essex VNACJ Healthy Families/TIP program can service first time mothers at any age who reside in the cities of Newark, Irvington and the Oranges. The site can also serve clients who are not first time mom, live in Essex County, receive TANF benefits, and are parenting a child less than twelve months old.	
2c	**Geographical Area of Services**: The geographical area of services for the site includes: Newark, Irvington and the Oranges for Healthy Families. In addition, parents who are receiving TANF (GA) benefits and have a child under twelve months old who reside in Essex County.	
2d	**Referral Sources**: Central Intake	
	Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)	
3a	**Provide a summary of program accomplishments on goals. Include data where available.**	

	81. 97% of children were enrolled in health insurance 82. 91% of participating infants/children were up-to-date on immunizations. 83. 96% of participants increased their interpregnancy interval (birth to conception) to 18 months 84. 97% of participating infants/children had a medical home 85. 100% of participating infants/children received developmental screening and appropriate referrals.
3b	**How did this improve outcomes for children and families?** Program accomplishments increased: • the number of children and parents linked to a primary health care provider • number of children receiving up to date immunizations • number of families use of community resources • appropriate identification and referral of infants and children for developmental delays
3c	**Identify specific factors that contributed to this improvement.** Family Support Workers (FSWs) provide information to families in a strength-based, culturally sensitive manner which may include role modeling desired behavior and assisting with linkages to additional supportive services. All FSWs complete a mandatory training program which includes parent education and child development. FSWs promote positive parent-child interaction; teach appropriate parenting skills and ways to stimulate their child's emotional and intellectual growth. HF follows an evidence based model and utilizes standard evaluation tools during the course of home visitation services. Developmental screens are conducted on all target children and referrals are made, if appropriate. FSWs assist families with connecting children to a pediatrician, as well tracking the child's immunizations and well-child visits.
3d	**Identify significant barriers to goal accomplishment.** A major barrier to maintaining case weight was our participation in the MIHOPE study. We have also been working with a fairly new team and lost a few cases when they were transferred to new workers.
3e	**Definition of Level of Service as per contract**: In Healthy Families, the level of service is measured by "case weight." Each enrolled family is assigned a case weight based on the intensity of service they need. Every family is offered weekly home visits for a minimum of 6 months. The level may change over time as the family progresses through the program (weekly visits, bi-weekly visits, monthly visits, quarterly visits). Each full time Family Support Worker carries a caseload with a maximum case weight of 30. The caseloads of each FSW vary between 15-25 families, depending on the intensity of service.
3f	**Enter your contracted Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14** 189

3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14** 79%
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals:** <u>216</u> **# of unduplicated families:** <u>108</u>
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** Client Satisfaction surveys are randomly distributed yearly to active participants to ensure program's quality assurance and cultural competency. The site distributed 50 surveys to enrolled participants and 32 surveys were returned. Of those 32 returned 21 were English and 11 were Spanish. Overall, the participants offered many comments which will assist the program in making improvements. Overall moms were satisfied with the services they received from the program. Many comments included statements about learning how to handle their new baby and learning how to express and advocate for themselves. In regards to program improvements, about half of the moms stated they liked the program and would not change anything and the other half would like to have more activities and events that will allow them to socialize with other moms.
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program**
4b	**Identify changes you will make that stem from stakeholder feedback.** Based on the client satisfaction surveys, we will work on having more events and activities will allow moms to engage with each other. We also plan to work on strengthening our relationship with other community based programs such as family success centers and other home visiting programs to collaborate with for events.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** 189
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals:** <u>216</u>

	# of unduplicated families: 108
	Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)
5a	**How will you measure progress?** The program will track progress through the FamSys database system. Monthly reports are sent to Prevent Child Abuse New Jersey, the agency that provides the technical assistance, quality assurance and training for our HF program. Reports include, but are not limited to: the site's level of service, number of families, number of expected home visits, number of home visits completed and number of screens/assessments conducted for that month. Progress is also measured through client feedback, the annual service review and feedback from the advisory board.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** As mentioned in 5a, the program will monitor and track progress, as well as services through the FamSys database system. Information from the annual client satisfaction survey will be used to make adjustments and improvements, as needed.
5c	**How do you collaborate with community partners?** In addition to being active members in the Essex Home Visiting Advisory Board, Essex VNA HF/TIP program has a team member sitting on the board of the following work groups in Essex County: Project LAUNCH Steering Committee/Youth Wellness Council, March of Dimes' HBWW Advisory Board, Essex HSAC, Essex County CIACC (Children's Inter-Agency Coordinating Council). We continue to connect with local stakeholders in an effort to reach as many new and expectant moms as possible.

2015 PSSF Update Report

	Section 1 – Identifying Information	
1a	**Provider**: Family and Children's Services	**1b Program Name:** Family Stabilization Services
1c	**Relevant PSSF Program**: ___FPS, *X* FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 40 North Avenue, Elizabeth, NJ 07208 16 Jefferson Avenue, Elizabeth, NJ 07201	
1e	**Objective**: Objectives are to: resolve family crisis; provide brief psychotherapy; identify and facilitate ancillary services; and stabilize the family through the provision of a full complement of supportive services.	
1f	**Outcome(s) Addressed**: ___X_Safety __X__Permanency __X__Well-Being	
	Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)	
2a	**Overview of Service**: The program provides comprehensive assessments, short-term therapy, and case management services to families and/or individuals to address current levels of functioning, child abuse and neglect issues, reduce potential risk factors and minimize conflict. Case management services address concrete needs in the family environment that can be best managed with referrals to ancillary service providers or the provision of basic education and support. The primary goal of the program is to achieve stability and ultimately to improve child safety, permanency and well-being.	
2b	**Population Served**: Children who are at risk of out of home placement or who have been placed out of the home due to a family crisis. Families in which there is a risk of child abuse or neglect.	
2c	**Geographical Area of Services**: Union County, NJ	
2d	**Referral Sources**: Union County Local Offices of the Division of Child Protection and Permanency	
	Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)	
3a	**Provide a summary of program accomplishments on goals.** **Include data where available.** 129 families completed initial assessments; 97 families achieved at least 2 objectives in their Treatment/Service Plans; 79families demonstrated an improvement in their level of functioning as measured by their Global Assessment of Functioning (GAF) scores; and 68 families achieved stabilization.	

3b	**How did this improve outcomes for children and families?** Families/individuals who received services in this program exhibited an improvement in their overall level of functioning and moved forward with the objectives developed in their treatment/service plans. Subsequently, the risk of abuse and/or neglect was reduced and children were able to remain safely in their own homes.
3c	**Identify specific factors that contributed to this improvement.** Contributing factors include: the ability to complete a comprehensive assessment of client needs in a natural environment for the family; the flexibility of the program regarding the location, time and frequency of client contacts; intensive outreach efforts; and a close working relationship with DYFS.
3d	**Identify significant barriers to goal accomplishment.** Clients who participate on an involuntary basis can be reluctant to commit to services.
3e	**Definition of Level of Service as per contract**: 1 unit of service = 1 family served
3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14** 62 families
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14** 128 families
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals: 280** **# of unduplicated families: 132**
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** 200 Client Surveys were distributed, and 59 were returned. Client feedback gathered through surveys was generally very positive, and did not indicate any necessary change to services. Feedback obtained through ongoing contact with referral sources, community, and the courts, through phone contacts and meetings, was also very positive.
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program** Trauma focused counseling services will be implemented for children (ages 5-17) where indicated.
4b	**Identify changes you will make that stem from stakeholder feedback.** None indicated.

4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** 62 units
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals**: 186 **# of unduplicated families:** 62
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** Improvement in the Global Assessment of Functioning (GAF) scores is indicative of an increase in the overall level of functioning. The program also considers the number and extent to which clients achieve the Objectives that are outlined in their Treatment/Service Plans and the completion of Comprehensive Initial Assessments.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** Information obtained through record/chart reviews, periodic consumer satisfaction surveys, and working closely with the stakeholders/referral source is used to assess and improve program services.
5c	**How do you collaborate with community partners?** Family and Children's Services links clients to accessible community resources and actively communicates with other community entities to obtain needed supports for the clients. Agency staff are also an integral part of Family Team Meetings.

2015 PSSF Update Report

Section 1 – Identifying Information		
1a	**Provider**: Urban League of Hudson County	**1b Program Name:** MENTORS Report
1c	**Relevant PSSF Program**: ___FPS, __x_ FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 253 Martin Luther King Jr. Drive, Jersey City, NJ 07305	
1e	**Objective**: To provide a mentor to referred youth. The mentor's role is to help youth improve their decision making, social communication skills and, if applicable, academic performance.	
1f	**Outcome(s) Addressed**: X Safety __ Permanency X Well-Being	
Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)		
2a	**Overview of Service**: To identify and train adult mentors that will be matched with a youth of the same gender. The mentor will provide the youth with companionship and guidance. The youth will identify personal goals and the mentor/mentee relationship will assist the youth in achieving the youth identified personal goals.	
2b	**Population Served**: Youth between the ages of 13 to 18	
2c	**Geographical Area of Services**: Hudson County	
2d	**Referral Sources**: DCP&P referrals and referrals from DCP&P funded youth programs.	
Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)		
3a	**Provide a summary of program accomplishments on goals. Include data where available: During the review period, six matches of an adult to a child were accomplished. The youth involved benefitted from the relationships.**	
3b	**How did this improve outcomes for children and families? The mentors program provides an interested adult for the youth. This interested adult serves as a component of an overall supportive community network.**	
3c	**Identify specific factors that contributed to this improvement: Mentors and mentees were also advised of agency programs, employment and**	

	employment training opportunities.
3d	**Identify significant barriers to goal accomplishment:** **Recruitment of mentors remained difficult until the ULOHC web site was redesigned in August/September 2014. The redesigned web site now enables mentors to reach out directly to the Mentors program. Prospective mentors complete an on line inquiry and submit a simple statement. Prospective mentors are contacted within 48 hours.**
3e	**Definition of Level of Service as per contract:** A unit of service is one child/adolescent matched with one mentor.
3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14:** 12 units
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14:** **6 units**
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals: 6** **# of unduplicated families: 6**
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** **Only anecdotal information is collected. Prospective mentors now attend orientation sessions and these sessions will be evaluated.**
	Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.** **Orientation sessions are now held. Prospective mentors that don't follow through – complete an application and sign up for the background check - are now contacted and surveyed. Our match rate has increased dramatically.**
4b	**Identify changes you will make that stem from stakeholder feedback.** **All mentors are now required to attend periodic training classes.**
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** 20 – 25 units of service
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals**: 20 – 25

	# of unduplicated families: 20 - 25
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** **Number of matches made. Review of match logs, progress reports and report cards. The ULOHC will also track whether or not specific client goals were realized. We will measure mentor satisfaction with the support that the agency provided for the match through satisfaction surveys.**
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** **Written reports, face to face interviews with mentors/mentees.**
5c	**How do you collaborate with community partners?** **The Urban League of Hudson County collaborates through membership in social service networks including the Hudson County Human Services Advisory Council (HSAC), the Hudson County Council for Young Children, and a Jersey City Board of Education community partnership network for social services. The agency also tables at resource and health fairs throughout the county.**

2015 PSSF Update Report

<table>
<tr><th colspan="3">Section 1 – Identifying Information</th></tr>
<tr><td>1a</td><td>Provider: Mercy Center</td><td>1b Program Name:
Family Resource Center</td></tr>
<tr><td>1c</td><td colspan="2">Relevant PSSF Program: ___FPS, __x_ FSS, ___TLFRS, ___APSS</td></tr>
<tr><td>1d</td><td colspan="2">Program Address:
1108 Main Street
Asbury Park, NJ 07712</td></tr>
<tr><td>1e</td><td colspan="2">Objective:
To establish a Family Resource Center/Community Based Drop-in Center in Asbury Park where consumers from Asbury Park and Neptune have access to a continuum of services that address the needs of underserved children and families.</td></tr>
<tr><td>1f</td><td colspan="2">Outcome(s) Addressed: __x__ Safety ____ Permanency __x__ Well-Being</td></tr>
<tr><th colspan="3">Section 2 – Service Description Basics FFY ’15 (10/1/13 – 9/30/14)</th></tr>
<tr><td>2a</td><td colspan="2">Overview of Service:
The FRC’s overall purpose is to provide an array of supportive and treatment services to prevent or reduce the incidence of child abuse and neglect. All services are implemented in a context that assures the physical, psychological, and spiritual wellbeing of the children and families of the Asbury Park and Neptune. Services are tailored to the families’ needs and situations.
The FRC serves as a community based social service agency, and service delivery methods are designed to address the needs, and empower of the residents of the community. Families have the ability to access and obtain information regarding community resources. Presentations, educational workshops, community resource guides are offered to organizations, churches and schools. Crisis intervention services are available to walk-ins in crisis. Families have the option of receiving direct support services on-site or be referred to the appropriate agency to adress their needs/situations. FRC's services are provided within an unrestricted, family friendly environment where customers feel free to drop in during a crisis. In the situation of a family crisis, services are immediately put in place to deflate the situation and create some level of stability. If the FRC is unable to provide direct services on site, every effort is made to link the family with the appropriate appropriate agency.</td></tr>
<tr><td>2b</td><td colspan="2">Population Served:
The FRC assists the vulnerable/fragile families in Asbury Park, Neptune and the immediate surrounding areas, who are experiencing some level of family crisis that has put their children and family welfare at risk of out of home placement. FRC also serves individuals and families whose behaviors/issues produced an instability and dysfunction that impact their ability to maintain a healthy family unit.</td></tr>
</table>

	Population Profile: • 40 % are single mothers with at least 3 children • 61 % are under or unemployed • 56 % % have not completed high school • 5 % have no child care • 40 % indicate they have some concrete needs, that they do not know how to get met • 61% Females • 39% Males • 65 % have history of substance abuse • 56 % African American • 22 % Latino • 7% Other • 13% Caucasian During this reporting year, FRC over 2,000 phones requesting information about a range of resources; concrete services, social service, emergency assistance and referrals. In addition to an increase in office visits seeking services to address the issues contributing to the families' distress. The FRC continues to serve a significant number of males but even if many of these males appear motivated to complete mandatory treatment services and become self-sufficient; they are often faced with the obstacle of their criminal history that hinders their ability to obtain gainful employment. On a positive note, more fathers are beginning to undertake their role and responsibilities of custodial parents; others are taking a more active role in their children's lives. Unfortunately, lack of funding to support the Fatherhood Program has a significant impact on the FRC's ability to adequately address the needs of many young fathers. Approximately 192 children/youth between the ages of 5 and 18 years old participated in individual counseling and group sessions. These referrals came mainly from the local school districts and or parents. The demographic continues to change, consequently there are different ethnic groups seeking supportive and clinical services. There is a consistent increase in the Latino population seeking support services and becoming more involved in the child welfare system.
2c	**Geographical Area of Services**: Asbury Park and Neptune areas in Monmouth County
2d	**Referral Sources**: The following number reflects clients who participated in treatment services • 33% are DCPP formally DYFS involved • 40% Self-referrals • 27% Community providers The number of self-referrals is an indicator of how FRC has successfully established itself as a Community Based Drop-In Center. It also suggests that families/individuals appear to be

	more motivated and proactive in seeking services and utilizing the program services. There is also a regular flow of referrals from DCP&P, Judicial System, County & Local Social Services, Faith Community Providers, local school districts & the Health Care System. Walk-Ins (self-referrals) continue to increase, which serves an indicator that the community has knowledge of the program and its services.
Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)	
3a	**Provide a summary of program accomplishments on goals. Include data where available.** Mercy Center has expanded services under the umbrella of the FRC by exploring funding opportunities to implement a Community Intervention Coaches project to reduce the incidents of probation violations. The agency continues to seek funding to more adequately address the needs of the spanish speaking population. The program has increased the utilization of masters' level graduate students. During this reporting year, the FRC has seen a significant increase walk-ins/self-referrals seeking and ulitizing program services which suggest that the community residence are more aware of the program. Aproximately 3200 families and children benefited from an array of services not limited to; family preservation, family support, family reunification, camperships, Christmas gifts, thanksgiving baskets, conference/workshop presentations, concrete services, advocacy, community events, information resources and referrals. • 27 families received Family Preservation services/ 16 families remained intact with children maintained safely in their homes at the completion of services • 41 families received Family Reunification services /22 children were returned home from foster care • 121 families received Family Support services/75 families were stabilized • 36 individuals enrolled in parenting classes/ 23 completed; 5 partially completed • 44 enrolled in adult substance abuse intervention 24 completed • 31 enrolled in adult anger management 21 completed; 10 incomplete • 117 participated in individualized/comprehensive services that include but not limited to mental health counseling through individual, family and or group modality.
3b	**How did this improve outcomes for children and families?** Children and families experienced better outcomes as a result of a combination of factors: the increased community awareness regarding child abuse and neglect prevention programs, and the available family support services. Families also obtain information at community presentations and through the distribution of educational and informational materials including updated resource guides (with links to website: www.mercycenternj.org for calendar of program activities). By maintaining visibility and activities in the community, more families were linked to needed resources such as summer camp, after-school and recreation programs. More families were connected to the appropriate services to address crisis situations and basic needs in an effort to stability and strengthen the family unit. Program staff participated in DCP&P team meetings; Monmouth Cares Family Team meetings; immediate link to crisis screening/suicide prevention; linkage to Perform Care for mental health assessment and referrals. In addition to access to job training /employment, housing and emergency assistance information and resources.

	Families demonstrated improvement in family functioning and stability through participation in individualized services such as parenting education, substance abuse counseling, individual and family counseling, anger management and wraparound services. Intervention such as parenting classes helped to strengthen/enhance parental relationship by using more appropriate and effective parenting practices. Wraparound approach provides the families with the support, skills, techniques and resources to reduce their stress level. The most important indications of improved outcomes are reflected by the number of families who had their child welfare cases closed by DCP&P; the number of individuals who successfully completed their probation requirements; The children and youth who maintained stable school placements and the number of individuals who obtained and retain jobs.
3c	**Identify specific factors that contributed to this improvement.** The following factors have contributed to families and children having improved outcomes: • Access to a continuum of on-site services • Connection and follow up with the appropriate services • Ongoing professional development training for staff • Effective working relationship with staff • Delivery of culturally sensitive services • An environment that is friendly, non-threatening, and accessible • Additional support services from other funding sources, e.g. such as parent aide (in–home) services and bilingual staff • Access to computers with internet availability, use of telephone and fax machine • Maintaining good working collaborative relationships with other agencies and stakeholders • Maintaining an active role on local, county and state human services/advocacy committees and advisory councils
3d	**Identify significant barriers to goal accomplishment.** The city's revitalization/redevelopment plan has not adequately addressed the needs of the underserved residents of the west side of the city of Asbury Park. Issues related to unemployment; unaffordable housing; and the escalation in gang violence within the community have created an increasingly stressful and dangerous environment for the families and children in Asbury Park. Street violence sometimes prevents families from accessing services, and parents mired by the feeling of helplessness and hopelessness struggle to provide and maintain a healthy, safe and nurturing environment. Other barriers: the lack of transportation, transient living situations due to unaffordable housing, and the inability to maintain communication due to unreliable phone system. There are also the arduous and time consuming efforts to engage the more guarded families. The undocumented immigrants (mainly Latinos) with children experience major difficulties in creating an environment of safety and stability for their children. The fear of deportation and lack of trust in the system prohibits many families from accessing needed help for their children. To address these barriers, FRC continues to advocate and engage other interested community stakeholders to review polices and interventions that hinder families and children's safety and stability.
3e	**Definition of Level of Service as per contract**: A unit of service consists of one hour of direct service provided to clients and case management: individual/family counseling, team meetings, meeting with collaterals, concrete services-

	transportation, clothing, program meals, emergency assistance, urine testing; and education and information workshops.
3f	**Enter your contracted Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14** LOS per year 4,800
3g	**Enter your actual Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14** FRC delivered 5,000 actual units of service which reflects the increase in the utilization of the FRC services.
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals: _NA__** **# of unduplicated families: 189 families** Note: These numbers represent only those who received on-site direct treatment services. Approximately 3,200 individuals received referral services, educational & resource information via phone calls or on-site visits to the office and community resource fairs. FRC also served approximately 300 individuals seeking crisis intervention services and access to computers for job searches and resume writing to walk-in clients.
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** Fifteen (15) questionnaires were sent out to referral sources (stakeholders) to gather feedback about the services provided at the FRC. Ten **(10)** were completed and returned. The questionnaire contained a series of items referencing the accessibility of services, services delivery, staff professionalism and cultural competency and sensitivity. Responses were based on a Liker scale, responses ranged from strongly agree to strongly disagree or not sure/not applicable. Respondents were asked to state the degree to which they considered the services were delivered according to appropriate standards of practice. Overall the responses were very positive. Responses indicated a high level of satisfaction in the following areas: services delivered in a timely manner; the organization's convenient location and accessibility; services provided were culturally sensitive; organization works with other community organizations to advocate on behalf of the persons it serves; organization reputation with the community is favorable and the organization's personnel are qualified and competent in the performance of their jobs. Few respondents suggested expansion to provide services tailored to the needs of fathers, especially those with a history of incarceration and enrichment /treatment services for boys and young adults.

	Seventy-five (75) consumer satisfaction surveys were distributed on-site or via mail. Overall the evaluations were very positive. Over ninety percent **(90%)** rated the services as excellent. All participants indicated that the services were provided in a timely manner and the workers were friendly and helpful. Some indicated having more evening hours and Saturday hours. In addition to more social and behavioral services for children.
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program** Mercy Center has expanded its behavioral treatment services to children between the ages of 5-12, as a result of a small grant for the New Jersey Natural Gas (NJNG). This program is designed to address the needs of children who have experienced trauma in their homes and communities. The agency is also vigorously exploring funding opportunities to implement a sustainable fatherhood program. This program needs additional funding to provide the need services to adequately and effectively address the needs that strengthen families and reduce the incidences of child abuse and neglect.
4b	**Identify changes you will make that stem from stakeholder feedback.** FRC will be make efforts to increase the residents' knowledge of available community resources and information, maintain and an updated website with a monthly calendar of program activities and events, distribute information through the local social service providers and the United Way of Monmouth County Liserv, present information regarding community resources at various events and, continue to explore funding opportunities to sustain the Fatherhood Empowerment Project.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** An anticipated 4,800 units of services will be delivered. Units of Service will include direct services, case management, information and referrals.
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals: _NA__** **# of unduplicated families: 150** *Since FRC's goal is to strengthen and support families, services are centered on the family as a unit.*
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** FRC has a customized computer case management system to track client information, service outcome data and level of service delivery. The progress will be evaluated by establishing a baseline of the family's level of functioning at the start of the services and by evaluating and monitoring benchmarks to which families accomplish their goals. Each client will develop a personalized treatment plan, and or service plan with measurable goals and attainable outcomes.

5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** The following components will be used to assess and improve services: Client service plan evaluation; treatment plan goals and objectives; staff observation regarding changes in client behavior and attitude; consumer satisfaction surveys and stakeholders questionnaires; and staff participation in family team meetings. In addition, staff will administer a pre and post-test depending on the treatment modality.
5c	**How do you collaborate with community partners?** FRC continues to build and maintain successful collaborative relationships by sharing resources, partnering on different community initiatives and utilizing program services through partnerships, referrals and networking. As a result of these collaborative relationships, clients now have easier access to services and programs such as child abuse and prevention programs, domestic violence counseling, substance abuse education and prevention, camp scholarships, Christmas and Thanksgiving assistance, medical assistance, housing assistance, recreation, job training /employment opportunities and community events. In an effort to increase awareness of child abuse and neglect in Asbury Park, in April- Prevent Child Abuse month, the Family Resource Center and the City of Asbury Park collaborate with other social service agencies, the school district, DCP&P formally DYFS, organizations and the faith community to organize community events. Maintain dialogue with other community providers to closely monitor the gaps in services, and reduce the chances of the duplication of services and maximize community resources.

2015 PSSF Update Report

Section 1 – Identifying Information		
1a	**Provider**: The North Ward Center, Inc.	**1b Program Name:** Permanency Links Program NWC – Life Links Program
1c	**Relevant PSSF Program**: _____ FPS, __X___ FSS, _____ TLFRS, _____ APSS	
1d	**Program Address**: 286 Mt. Prospect Avenue Newark, New Jersey 07104-2008	
1e	**Objective**: The purpose of the program is to provide permanent connections with caring adults that can assist and support youth. The North Ward Center staff will act as advocates for the youth in the engagement of these adults and in the process of securing a commitment for a permanent caring relationship. The youth will be assisted in identifying and implementing a plan of self-sufficiency and identifying lifelong connections.	
1f	**Outcome(s) Addressed**: ___X___ Safety __X___ Permanency ___X____Well-Being	

Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)	
2a	**Overview of Service**: The goal of the program is to identify connections that will lead to permanency pacts that support the adolescent. The process includes the identification of caring adults who will provide a safe and supportive relationship for the youth as he/she transitions from out of home placement. Potential supportive adults will be identified through discussion with youth, the DCP&P caseworker and a review of the case file by North Ward Center staff. The DCP&P caseworker will help screen identified adults as necessary. Adults to be considered may include a resource parent, teacher, CASA advocate, mentor, or members of the biological or adoptive family as indicated. North Ward staff will prepare the youth for a conversation with the identified adult resource(s) and will reach out to prepare the adult as well. If appropriate and amenable, a permanency pact that specifies the support to be received will be developed between the youth and the caring adult. It is envisioned that some of the individuals to be considered will emanate from the DCP&P worker's family team meeting. For those youth referred for the permanency pact program, it will be advantageous for the North Ward staff member assigned to participate in the family team meeting. The North Ward Center will service all youth deemed appropriate and referred by DCF/DCP&P. Upon receipt of a referral, the North Ward Center will contact the referring caseworker within two business days and arrange for an intake appointment. The caseworker will be encouraged to accompany the youth to the initial session.

	Upon acceptance, the permanency pact worker will visit the DCP&P Office in order to mine the case records. They will contact potential supports, maintain communication with DCP&P to facilitate contact, and upon clearance will formalize permanency pact(s) with the youth and the individual(s). Youth served in the permanency pact program will have access to all supportive services offered by the North Ward Center. Efforts will be made to identify youth from the Life Skills Program who need life long connections to successfully transition to adulthood. The program intends to support the youth in creating, implementing, and sustaining a network of caring adults that will assist the youth with the transition to independence. They will also sustain a relationship into the young adult's independent life. All referrals must be screened by the DCF Office of Adolescent Services (OAS) prior to engagement.
2b	**Population Served**: The North Ward Center will serve youth that reside in Essex County that are in DCP&P authorized out of home placement. Ages served are youth 14 to 21 years old that require permanency services and who are aging out of placement. They may be legally free for adoption and/or lack a permanent plan. Youth in adolescent housing programs as well as youth placed through PerformCare are eligible for permanency services. Services provided help ensure that permanent relationships are established and sustained with caring indivduals. It is the agreements between the service providers and the service recipient that constitutes the permanency pact.
2c	**Geographical Area of Services**: The North Ward Center will serve all children/youth that reside in Essex County that are in DCP&P authorized out of home placement and most will be expected to "age out" of that placement. Exceptions may be made at the mutual discretion of DCP&P and The North Ward Center.
2d	**Referral Sources**: DCF/DCP&P Essex County Local Offices; Essex County Child Advocacy Center; Essex County Family Court; and contracted DCP&P providers. All referrals must be screened by the DCF Office of Adolescent Services (OAS) prior to engagement.
Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)	
3a	**Provide a summary of program accomplishments on goals.** **Include data where available:**

	Fourteen youth ages 14 to 21 years old participated in the NWC Life Links Program. Youth are more involved in the planning process. Youth were able to identify adults that they believed to be reliable and willing to work with them beyond the child welfare system.
3b	**How did this improve outcomes for children and families?** 93% of the youth agreed to other alternative arrangements and/or delayed the connection. 93% of youth know at least one adult they can depend on when they exit care. 93% of the youth felt no need to "formalize" a permanent connection. 57% of youth participated in the intake process 57% of youth understood the purpose of a permanent connection 93% of youth know at least one adult they can depend on when they exit care 30% of youth graduated Life Skills 7% of the youth who participated in the program was able to establish a permanency pact. 7% of the youth have at least one formalized permanent connection to a caring adult. 7% of the permanency pacts remained intact for 6 months+.
3c	**Identify specific factors that contributed to this improvement:** All meetings are held in a neutral, homelike setting apart from the DCP&P Local Offices. All youth feel that their ideas and opinion are valued; they are listened to and have a major part and vital input into their permanency planning process.
3d	**Identify significant barriers to goal accomplishment:** Few referrals were being received. Staff meetings with OAS and DCP&P Local and Area Offices were conducted to discuss the Program and value of initiating this planning for the aging-out population. As a result of these efforts, the program has seen a small increase in the number of referrals for the Life Links Program. The North Ward Center has continued to train staff and MSW interns to facilitate, assist in the linkages, and fill any void as needed.
3e	**Definition of Level of Service as per contract:** A unit of service entails a youth referred to the program in an effort to develop a permanent connection with at least one caring supportive adult.
3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14:** 20 youth per year.
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14:**

	14 youth received services.
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals:** 14 . **# of unduplicated families:** N/A .
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** Fourteen Participant Surveys were sent to all who participated in the NWC Life Links Program. A total of 1 response was received during this reporting period. Every response was positive.
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.** Greater emphasis will be placed on increasing referrals for aging-out youth as many seem to be unprepared to function independently outside of the child welfare system. Consideration will be given to Deputy Attorney General/Law Guardian referrals.
4b	**Identify changes you will make that stem from stakeholder feedback.** Maintain constant contact with the DCP&P Local and Area Offices. Countinued efforts will be made to identify youth from the Life Skills Program who need life long connections to successfully transition to adulthood.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** It is anticipated that the contracted level of service will be achieved, i.e., 20 youth will be serviced annually.
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals**: 20 . **# of unduplicated families:** N/A .

Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** In order to comply with federal reporting requirements, (program name) program will report on NYTD Independent Living Services funded by the Department of Children and Families. The mechanism for electronic reporting is done by utilizing the provided excel spreadsheet and submitting the report via DataMotion. There are two components, which are outlined below. 1. Monthly summary reports will be completed electronically on the excel spreadsheet provided. No modifications will be made to the form format and (agency/program name) will complete all requested information. Monthly summary reports are due to the Office of Research, Evaluation and Reporting (RER) by the first Friday of each month. Each report will capture data from the previous month's activities. 2. Supporting documentation (i.e. a case notes summary) of the activities and work that was completed, for the previous month with the specific adolescent, are submitted to the assigned DCP&P caseworker for each adolescent. Also, monthly reports are completed by program staff that indicates the service levels maintained, progress made in preparing their permanent pact for each youth that is referred to the program. These reports are monitored by the Coordinator and Project Director. Corrective action measures are developed and implemented to address any apparent deviation from achieving program objectives.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** All pending and completed permanent pacts are reviewed by the Coordinator and Project Director to ensure that they address all concerns that have been indicated through the process. All pending/considered connections are cleared through the DCP&P staff. Stakeholder and consumer satisfaction feedback surveys are reviewed by program staff, evaluated and used as a tool to identify weaknesses and implement program improvement.
5c	**How do you collaborate with community partners?** The North Ward Center has partnered with Robin's Nest and Children's Aid and Family Services to identify any possible gaps in services. The program has also established connections with the various Family Success Centers in the County to ensure that youth that receive support from these agencies and may also access additional planning services through the program.

2015 PSSF Update Report

Section 1 – Identifying Information		
1a	**Provider**: Robins" Nest	**1b Program Name:** Family Ties
1c	**Relevant PSSF Program**: ___FPS, ___ FSS, _X_TLFRS, ___APSS	
1d	**Program Address**: 42 Delsea Drive South Glassboro NJ 08028	
1e	**Objective**: The goal of the program is to help attain permanency for children in out of home placement by facilitating visits between parents and children; assisting parents in their ability to meet their child's physical, emotional and developmental needs during visits.	
1f	**Outcome(s) Addressed**: ____Safety _X_Permanency ____Well-Being	
Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)		
2a	**Overview of Service**: This program assists with permanency planning in a manner consistent with the Adoption and Safe Families Act (ASFA). The program provides services that address the goals of: maintaining family bonds; supporting parent/child relationships; providing parents with opportunities to learn and practice new skills; decreasing the length of time children remain in out of home placement; successfully reunifying children with parents or relatives; and providing documentation to support permanency planning. Services provided include: transporting children to and from visits; supervising visits; coaching parents on their parenting skills, debriefing after each visit to reinforce what went well and to plan ways to meet their child's needs during future visits, and providing comprehensive relevant documentation regarding our observations and interactions. During visits, staff assess and document the parent's parenting skills and interaction with their children. Staff utilizes Visit Coaching which supports the parents in meeting their children's needs and building upon their strengths. Staff intervenes as needed to ensure the child's physical and emotional safety and to teach, model, and coach parenting skills. Staff utilizes feelings exploration while transporting the children to and from visits to help the children process their feelings. A therapist may become involved, partnering with the visit coach to effectively address the families' needs related to their child's permanency. The therapist can work with the parent and/or children; addressing a variety of topics, including issues that are impacting the progression of visits, preparing for successful reunification, educating parents on the impact out of home placement has on children, as well as exploring ways to reestablish trust and a sense of security and stability for their children. The degree of involvement of the therapist	

	is determined through the assessment process and collaboration with the Division and the Family Ties Program Director and visit coach. The progressive nature of our visits allows parenting responsibilities to be gradually shifted back to the parent. Typically visits begin with two-hour fully supervised visits in the parent's home and may progress to partially supervised day visits, overnight visits, and extended visits. If the family is reunified during the visitation component of the program, they can receive up to three months of in-home post-reunification services. Once post-reunification services end, families receive follow-up phone calls at 6 and 12 months post reunification. Throughout the entire program, the parent has access to their FT visit coach and therapist (if applicable) 24 hours a day, 7 days a week. The parent is encouraged to call for assistance before a problem or situation escalates, placing the children at risk.
2b	**Population Served**: DCP&P involved parent whose children (birth to 18) are in an out of home placement in our service area and in the legal custody of DCP&P.
2c	**Geographical Area of Services**: Burlington, Camden, Gloucester, Salem, Cumberland, Atlantic, and Cape May counties in New Jersey.
2d	**Referral Sources**: Local DCP&P caseworkers, supervisors, RDS' from our coverage area.
Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)	
3a	**Provide a summary of program accomplishments on goals.** **Include data where available:** The primary goal of the program is: 85% of the cases will achieve permanency within 12 months of case assignment. Between 10/1/13 - 9/30/14, FT provided visits to 163 families. Of the 63 families who reached a case disposition by 9/30/14, 54 (86%) achieved permanency. Of the 54 that achieved permanency, 39 (72%) were reunified with a parent or relative. Another goal of the program is for 90% of parents to achieve or partially achieve their service plan goals. Between 10/1/13 - 9/30/14, FT provided visits to 163 families. Of the 56 families who reached a case disposition by 9/30/14, 165/180 (92%) of their service plan goals were either achieved or partially achieved. A third goal of the program is for 90% of reunified families to remain together for six months after reunification. Between 10/1/13 - 9/30/14, 33 families were reunified. 51

	children were reunified for six months as of the writing of this report and 92% were still together after six months. 45 children were reunified for twelve months as of the writing of this report and 96% were still together after twelve months. A fourth goal of the program is for 90% of parents to improve in readiness/parental capacity as measured by the North Carolina Family Assessment Scale-for Reunification (NCFAS-R). Of the 55 families with pre and post NCFAS-R results, 47 (85%) improved in readiness/parental capacity, with 97% of reunified families improving in readiness/parental capacity.
3b	**How did this improve outcomes for children and families?** By helping children achieve permanency, the children were able to begin to heal from their past and move forward in planning for their future in a safe, stable home environment. By helping parents improve their parental readiness and parental capacity, more families reunify and parents are able to meet the physical, emotional and safety needs of their children so they remain reunified. By maintaining permanency post reunification, we help support the child's developmental need for continuity and stability in family and community relationships and help reduce the damage that is caused when children have continual placement disruptions.
3c	**Identify specific factors that contributed to this improvement:** The design of our program; providing in-home treatment, progressive visitation and debriefing with the family each week, allows us to specifically target the parenting issues the parent needs to work on to achieve their ultimate goal of being reunified with their children. The progressive nature of our visitation is tremendously beneficial. It allows for extended assessment, opportunities to practice learned parenting skills and provides comprehensive documentation of the parents' abilities and parent-child interactions as we work with DCP&P to gradually shift parenting responsibilities back to the parent. Our use of Visit Coaching provides families with a strength-based approach to identifying their children's needs and meeting them all on an individual basis. Staff provides support, empowerment, modeling and feedback throughout each visit. The documentation we provide gives DCP&P and the court an objective picture of the parent's parenting skills and interaction with their children during visits. Staff complete a detailed training on writing a thorough and relevant DAP note. Each DAP note reflects directly to the goals on the family interaction plan, allowing progress and areas for improvement to be assessed and reported on weekly. Our three months of in-home post-reunification services provide support to recently reunified families through their transition home, helping them stabilize and preventing placement recurrence.

3d	**Identify significant barriers to goal accomplishment:** Many parents have a history of severe and chronic mental health issues. If a parent is not stable with their mental health, this may delay or prevent visits from progressing or may cause progressed visits to regress. We are addressing this issue by helping parents advocate for appropriate diagnosis and treatment as well as utilizing the therapeutic component of the program to educate parents on their diagnosis and what it means for their future. We are also looking at their issues and needs through a trauma lens. Many parents also have a history of or currently use substances, both prescription and illegal. If a parent is not clean and sober from substances or involved in a program to assist them with becoming clean and sober, it inhibits the parents' ability to recognize and respond to their child's needs in a consistent and safe manner. To address this prevalent issue, FT visit coaches and therapists are working with parents on recognizing how their own trauma and needs impact their ability to meet their child's needs. Collaboration with caseworkers to identify concerns regarding substance abuse issues and link parents to services are vital components to effective service provision. Therapists are utilized when appropriate to compliment the parent's substance abuse treatment. Our program also utilized a Licensed Clinical Alcohol and Drug Counselor to conduct thorough trainings for staff and hold case consultations in order to educate staff, provide resources and identify appropriate interventions on a case by case basis. In addition, to further their understanding of the issue, staff completed a webinar training on substance abuse and relapse prevention. Many parents also have a history of domestic violence. If a parent is in a relationship where domestic violence is present or if they are unable to identify how to keep their children safe from witnessing a domestic violence relationship, it could prevent visits from progressing or may cause progressed visits to regress. In order to address this need, staff attended a Domestic Violence training series in order to be more informed and equipped in servicing families with a domestic violence history. Another identified challenge is parents with diagnosed and undiagnosed developmental disabilities. Parents lacking the ability to understand information presented may require specialized care to assist them in progressing with visitation. To address these needs, staff assists families with being connected to the Department of Developmental Disabilities and referring to other services that can effectively advocate for the family to receive appropriate services and supports. Staff has also attended in-service trainings on how to effectively work with this population. Robins' Nest and all program staff have unlimited access to Netsmart/MyLearningPointe, a web-based training system in which training is readily available to staff on various topics that they may face while working with families. This is utilized by staff for case specific topics in order to best support parents in their goal of reunification. Some of the many relevant trainings topics include foster care, trauma, child development and substance abuse.
3e	**Definition of Level of Service as per contract:**

	Level of service is defined as visits for the visit coach and session hours for the therapist. A visit is defined as one hour with the visit coach observing the parent and their children. The same definition applies if the parent does not attend the visit, but the visit still takes place so siblings who do not reside in the same out of home placement can visit with each other. If a visit coach picks up a child for a visit and the visit does not take place, the visit coach will get credit for the visit due to the time invested in transporting the child. If the travel time for one visit coach to transport more than one child exceeds 2.5 hours because the case involves multiple counties, then two visit coaches may be assigned and each visit coach will count one visit for each hour spent in the visit. In addition, there will be a ratio of one visit coach to three children unless all three children are under the age of five. If the ratio is exceeded, then additional visit coaches will be assigned and each visit coach will count one visit for each hour spent in the visit.
3f	**Enter your contracted Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14:** (42% of contract is Title IV-B funded) 3800 contracted visits; 1596 Title IV-B funded visits 850 contracted therapeutic hours; 357 Title IV-B funded therapeutic hours
3g	**Enter your actual Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14:** 1469 (92%) visits and 380 (106%) therapeutic hours provided with Title IV–B funding
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals: 178** **# of unduplicated families: 68**
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** 100% of families surveyed were either very satisfied or satisfied with their relationship with the Family Ties visit coach. 100% of families surveyed were either very satisfied or satisfied with the program services. 100% of referral sources surveyed were either very satisfied or satisfied with the Family Ties visit coach. 100% of referral sources surveyed were either very satisfied or satisfied with the program services.

Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.** In 2014, Family Ties started a monthly therapeutic/support group for reunified families and families about to reunify. This group is conducted by a Master's Level therapist and provides families with peer support as they celebrate successes and receive feedback on challenges and issues they are now facing. Peer support and treatment in a group setting have been found to increase the likelihood of families maintaining success. Family Ties staff will engage in additional trauma-focused training in order to be more informed and equipped in addressing trauma that families have experienced, not only in the past but the trauma related to the removal as well. FT will continue to utilize Visit Coaching during visits to empower parents to successfully meet their children's individual needs. Evidenced based practices will continue to be used by therapists where relevant. FT staff will continue to attend a series of Domestic Violence trainings in order to be more aware, informed and equipped in servicing families with a domestic violence history. FT will, when appropriate, continue to facilitate visits at doctor's appointments and school meetings so the parent could have the opportunity to learn more about their child's strengths and needs. This also provides an opportunity for the FT visit coach to assess how the parent handles everyday situations.
4b	**Identify changes you will make that stem from stakeholder feedback.** During contract meetings, stakeholders voiced concerns regarding how long families were waiting for supervised visitation services through Family Ties. As a result, the waiting list has been re-prioritized based on removal date, potential reunification date, or permanency hearing date; allowing for efficient and effective managing of cases in need of permanency planning. To further solidify our collaboration and partnership with all resource parents, we've expanded our orientation process with them. Staff supplies informational materials to resource parents regarding the roles of all parties involved with the children, including service providers, birth parents and the resource parent. This information increases awareness and involvement of the resource parents, creating a supportive network around visits and increasing the likelihood of a positive rapport and collaborative process toward the goal of permanency being achieved.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** (42% of contract) 1596 visits and 357 therapy session hours

4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals**: 100 **# of unduplicated families:** 50
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** The parent's customized family interaction plan identifies specific and measurable needs and objectives that drive staff's interventions. Families with therapeutic involvement have a family interaction plan not only with their visit coach, but a coordinating treatment plan with their therapist to address therapeutic issues. Goals are reviewed and tracked after 90 days and at the end of services to determine the areas of progress the family made. Follow up phone calls with the reunified families provide data on whether the family is stable and still reunified at 6 and 12 months post reunification. The NCFAS-R will continue to be used as a pre and post assessment tool in order to determine improvement in significant life domains, including readiness/parental capacity from the beginning or our services to the end. The Permanency Information Form will continue to be used as a tracking tool of how many children achieve permanency within 12 months of our services beginning. This tool will be completed at the time permanency is achieved or at the end of services. Family Ties uses an electronic record process (Qualifacts CareLogic) in which data can be compiled and immediately accessed to determine progress toward performance benchmarks. Program performance outcomes will be reviewed monthly during staff meetings, allowing for a timely review; recognition of what went well and readjustments as necessary.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** The agency hired a Quality Improvement and Planning Director to enhance the amount of data collected and feedback that is received from both consumers and stakeholders. As part of his initiative, all agency programs track performance outcomes on a monthly basis and they get reviewed at monthly management team meetings. On a quarterly basis, programs complete Program Performance Scorecards, highlighting areas where outcomes have been exceeded, met, or fall short of the benchmark. The agency's Child Protection and Permanency Department Director meets quarterly with the program director and program staff to review results and discuss how to maintain successes and improve areas in need of enhancement. In addition to staff involvement and feedback in the quality process, we seek feedback from our clients/customers as well. During opening paperwork, parents are given the opportunity to participate in a confidential phone survey during the visit component of the program. Parents are randomly selected and contacted for their feedback. Receiving feedback while we are still providing services to

	the parent allows us to adapt our services and improve customer satisfaction. At the end of the program, the parent is given a confidential self-administered mail survey with a pre-stamped envelope to provide their feedback. A percentage of randomly selected DCP&P caseworkers receive an e-mail asking them to participate in a confidential survey. These surveys ask the parent and caseworker to indicate their level of satisfaction with the visit coach/therapist and program services.
5c	**How do you collaborate with community partners?** In addition to a strong DCP&P-Family Ties partnership, staff has established relationships with community providers involved in the family's treatment. Staff recognizes that family's outcomes are better when there is timely open communication and collaboration amongst those involved with the family. Staff willingly participates in Family Team Meetings when requested and encourage families to enhance their formal and informal support system. Our relationship with these community providers helps us link families to the community services and resources they need. The Family Ties program also collaborates with community Family Success Centers. Through this community partner, families are able to get connected to information, support and programs in their neighborhood and county. Staff frequently utilizes this community link, encouraging families to have a positive support system in place long term. Staff recognize that Family Success Centers can serve as aftercare for reunified families once they've completed the Family Ties program.

2015 PSSF Update Report

Section 1 – Identifying Information		
1a	**Provider**: Family Connections, Inc.	**1b Program Name:** Reunity House South Orange
1c	**Relevant PSSF Program**: ___FPS, ___ FSS, __X_TLFRS, ___APSS	
1d	**Program Address**: 122 Irvington Ave. South Orange, NJ	
1e	**Objective**: To expand and enhance the number and range of services to families and children in order to support family reunification and permanency	
1f	**Outcome(s) Addressed**: ____Safety _X___Permanency ____Well-Being	

Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)	
2a	**Overview of Service**: This program facilitates permanency planning for children in a manner that is consistent with the requirements of the Adoption and Safe Families Act (ASFA). The program provides services that address the goals of: maintaining family bonds; supporting the parent/child relationship; improving parenting skills; decreasing the length of time children remain in foster care; successfully reunifying children with parents or relatives; and providing documentation to support case goals. Services include: supervised visitation, transportation, parenting skills training, parent support groups, and information and referral. The benchmark timeframe for services is six months with additional aftercare services available for up to one year. Program activities focus on supporting the parent-child relationship and on providing the parent with opportunities to learn and practice new skills. The program model builds on current skills and practices, and reflects a family-focused and community-based collaboration.
2b	**Population Served**: Serves families with children in out of home placement
2c	**Geographical Area of Services**: Essex, Union and Middlesex Counties in New Jersey
2d	**Referral Sources**: All referrals are received from the Division of Child Protection and Permanency. The DCP&P case manager makes the referral for a family whose case goal is family reunification.

Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)	
	Provide a summary of program accomplishments on goals.

3a	**Include data where available:** **During the reporting period of October 1, 2013 to September 30, 2014, a total of 70 families received services. 35 families were enrolled in the program at the start of the reporting period. 35 new families were referred; and 14 families were reunified.** **A total of one hundred and forty-three (143) families have been reunified since the program's inception in April 2002. One hundred thirty six of those families (95%) have remained intact for at least twelve (12) months following family reunification. All seven (7) families that were reunified during the prior reporting period of October 1, 2011 to September 30, 2012, have remained reunified.**
3b	**How did this improve outcomes for children and families?** **Given the complexity and chronic challenges that families have to address, the program's ability to provide a continuum of services positively impacts outcomes in achieving desired goals. In addition to the services provided within the Reunity House Program, additional Family Connections' services enhance reunification for many of our families. Within Reunity House, the combination of therapeutic visitation and group treatment, supervised overnight visitation, and in-home aftercare services enhance each family's ability to sustain long-term successful reunification. Collaboration with Family Connections' Reunity House Programs in East Orange and Paterson have also provided opportunities for increased case management services, and access to specialized parent-child bonding activities, such as Infant Massage and Music Together.** **Reunification opportunities for families with substance abuse issues are improved with Family Connections' intensive outpatient program for both mothers (Strong Mothers Program) and fathers (Strong Fathers Program). Due to the large percentage of clients with substance abuse histories, collaboration related to substance abuse treatment is a crucial part of assessing for reunification readiness.** **Reunity House also utilizes a trauma based framework with families, the Attachment, Self Regulation and Competency (ARC) model. This model helps to build parental capacity to regulate self as well as provide a structured environment for their children, as there is a multigenerational trauma experience for families involved with child welfare.**
3c	**Identify specific factors that contributed to this improvement:** **The ability to collaborate with intensive outpatient (Strong Mothers and Strong Fathers) substance abuse and mental health services affords clients immediate access to treatment at the same agency.** **Reunity House, a completely renovated three-story house, is centrally located within Essex County. It affords a homelike environment that includes a large reception area, private visitation rooms, a large room for group meetings, and two family suites each with a kitchen, living room with fold-out couch, playroom with another fold-out couch, and a bedroom with two bunk beds and a crib. The suites provide for the availability of overnight visitations. The flexible design of the house enhances the program's**

	ability to provide individualized services to the children and their families in a comfortable and pleasant environment. **Utilizing a trauma lens with families at Reunity House allows the Clinician to join with the family at a place of understanding that they are partners in moving forward from the trauma, and not blaming them for their maladaptive coping.**
3d	**Identify significant barriers to goal accomplishment:** **Difficulties associated with transportation costs for the program continue to be challenging, as bus fares and gas prices continue to escalate. The costs of maintaining the safety and effectiveness of program vehicles have also continued to increase. Transportation is time-consuming, with parking, scheduling, and logistical challenges. However, children residing in foster placements within their community have significantly increased; this improves the number of children able to remain in their own community, and decreases some of the program's transportation challenges.** **Services at Reunity House South Orange are primarily delivered in English. A Haitian-Creole speaking Clinician has been hired, which has expanded the capacity for Reunity House to serve Haitian-Creole speaking families, not only with case management services, but with therapeutic supervised visitation. A Spanish speaking clinician at the East Orange site provides services to Spanish-speaking families who are referred there. This has improved service delivery, as the program works toward meeting the community's diverse language needs. There is a Case Manager/Driver and a full-time Driver that speaks Creole to increase the language needs of our Haitian families. The Family Connections' Cultural Competence Committee collects data on the language capacities of all Family Connections staff, which can then be utilized for clinical support and referral resources for other languages. Reunity House is committed to hiring bilingual staff to address the needs of population referred. Language needs will continue to be tracked through the Cultural Competence Committee, and shared with the Quality Assurance Program.** **The Consumer Satisfaction Survey indicated a need for more Case Management services within Reunity House South Orange. Reunity House South Orange has been able to hire two Bachelor's level Case Manager/drivers**
3e	**Definition of Level of Service as per contract:** A "unit" of service is identified as a family of up to five children. Families that have more than five children are considered two units
3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14:** For the reporting period October 1, 2013 to September 30, 2014, Reunity House is expected to serve eight (80) families/units of service. Families with more than five children will be counted as two units of service.
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14:** 70 units of service were delivered.
3h	**How many unduplicated individuals and unduplicated families were served for this**

<table>
<tr><td></td><td>period? Each individual and family who received services during the reporting period should be counted only once.

# of unduplicated individuals: 229
# of unduplicated families: 70</td></tr>
<tr><td>3i</td><td>Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.
Family Connections, Quality Assurance (QA) Committee conducts a yearly consumer satisfaction surveys or focus groups. Outcomes are identified and utilized to make improvements in services to clients. A focus group was held at the end of 2014, and the following feedback was given.
1. Generally, clients feel that staff are open and welcoming.
2. Clients feel that staff advocate for clients. One client talked about not having a voice prior to attending Reunity House.
3. Clients noted that staff empathizes with clients and their experiences.
4. The site is homey, comfortable and clean.
Some follow ups from the feedback were as follows:
1. Safety should be discussed and creating schedules that allow for more safety.
Staff has agreed to ask questions in sessions happening before or after the visit about any active safety concerns; consider the time of visits and whether or not to schedule visits in the evenings; offer to reschedule visits/groups when safety issues are a concern (ie. Halloween); and incorporate discussions about community and safety planning during treatment plan meetings, individual sessions and group.
2. Some clients reported having little to no information regarding Reunity House prior to coming for an intake.
Staff plans to create a client-appropriate brochure regarding Reunity House and mail the brochure to client and distribute to DCPP offices.
Clinicians will follow up with the DCPP worker to see if they have had discussions with clients regarding Reunity House.
When appropriate, Clinicians will meet with clients and workers at DCPP office prior to intake.</td></tr>
<tr><td colspan="2" align="center">Section 4 – The Year Ahead FFY ’16 (10/1/14 – 9/30/15)</td></tr>
<tr><td>4a</td><td>Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.

At this time, there are no immediate changes that are being made to the program. Based on recent feedback that some clients with teenage children felt that Reunity House was not geared towards their family, and was more geared to families with younger children, Reunity House South Orange created a teen-friendly space for visits on the 3rd floor. The families with pre-teens and teenagers have been utilizing this space and have welcomed the change.</td></tr>
<tr><td>4b</td><td>Identify changes you will make that stem from stakeholder feedback.
Based on the feedback that some clients reported having little to no information</td></tr>
</table>

	regarding Reunity House prior to coming for an intake. **Staff plans to create a client-appropriate brochure regarding Reunity House and mail the brochure to client and distribute to DCPP offices.** **Clinicians will follow up with the DCPP worker to see if they have had discussions with clients regarding Reunity House.** **When appropriate, Clinicians will meet with clients and workers at DCPP office prior to intake. Reunity House staff also presents the program at Local Division offices on a regular basis to ensure that the caseworkers are aware of the service, and can present the information to clients.**
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** For the reporting period October 1, 2014 to September 30, 2015 Reunity House is expected to serve eighty (80) families/units of service. Families with more than five children will be counted as two units of service.
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals**: 200 **# of unduplicated families:** 80
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** **Program progress will be measured through the extent to which Reunity House achieves its performance outcomes. The two identified performance based outcomes for the reporting period are: thirteen (13) families will achieve reunification; and all families that achieve reunification will remain stable twelve months following reunification.** **Reunity House clients are also given the Adult-Adolescent Parenting Inventory (AAPI-2) pre and post test to measure their progress in the following constructs: Inappropriate Expectations of Children; Parental Lack of Empathy Towards Children's Needs; Strong Parental Belief in the Use of Corporal Punishment; Reversing Parent-Child Family roles; and Oppressing Children's Power and Independence. This information is utilized to identify treatment goals and formulate assessments regarding family reunification. Reunity House is also addressing trauma in clients utilizing Reunity House through the ARC Model.** **Reunity House staff will continue to work collaboratively with substance abuse and mental health service providers as well as DCPP staff to promote client progress in the program, support follow through with court requirements, and potentially reduce the amount of time children spend in foster care. In addition, stakeholder feedback from community partners will be utilized to improve program services.**
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.**

	The Family Connections' Quality Improvement Program is responsible for continually ensuring that the latest and generally recognized "best practice" standards for service delivery are met and exceeded, and that desirable service outcomes are achieved for all Family Connections' consumers. **Both the Consumer Satisfaction Survey (CSS) and Stakeholder Survey are self-administered, anonymous, and facilitated through a handout/mail-back format, as well as during focus groups. Participants in the supervised visitation program are given the survey after they attend group or a supervised visit. Those consumers who do not come into the agency for services (i.e. those involved in the aftercare program component) are provided an addressed, postage-paid envelope and encouraged to mail the survey to our agency. These surveys are recognized "outcome" tools that can be helpful in evaluating interventions, staff, the agency as a whole, or individual programs. This process is overseen by the Family Connections Quality Improvement Committee (QIC). Data is reviewed and correlated, which are then presented to the Executive Director, Program Directors, Program staff, and consumers. The data is presented and reviewed in the QI Committee meeting. Agency and programmatic changes are proposed and implemented based on data outcomes.** **In May of 2015, the NJ Department of Children and Families (DCF) is scheduled to complete a monitoring visit in which the will view records, and meet with clients and staff of Reunity House. A monitoring report will be completed by DCF to provide feedback and note any areas requiring program improvement and development. As a result of this process, Reunity House will be able to improve documentation regarding visitation, treatment planning, and communication with the Division of Child Protection and Permanency. This monitoring visit is a valuable means of providing stakeholder feedback, and will continue to occur on a regular basis.** **Following each supervised visitation session at the Reunity House, the Clinician continues to document in NJ SPIRIT so the caseworker has immediate access to information. That process is now implemented in all NJ Visitation Programs and notes are entered within a week of the contact occurring.**
5c	**How do you collaborate with community partners?** **Collaboration efforts with community partners (i.e. substance abuse treatment, mental health treatment providers, DCPP, court, schools, and other community agencies) are made through attendance at staff and/or clinical meetings to address client and program needs. Collateral contacts are made with community partners regarding program development or client progress and attendance in the program when indicated. Program managers, clinicians, and case managers outreach to community resources and are present at community health fairs in efforts to educate and inform our community partners and the families in the community about the Reunity House services. The program conducts stakeholder survey once every three years to assess areas needing improvement as suggested by community partners.**

2015 PSSF Update Report

	Section 1 – Identifying Information	
1a	**Provider**: Care Plus NJ	**1b Program Name:** Adoption House
1c	**Relevant PSSF Program**: ___FPS, ___ FSS, ___TLFRS, _X__APSS	
1d	**Program Address**: 1360 Morris Avenue Union, NJ 07083	
1e	**Objective**: To expand and enhance the number and range of adoption and/or permanency services for children and families.	
1f	**Outcome(s) Addressed**: _X__Safety ___X_Permanency ____Well-Being	

	Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)
2a	**Overview of Service**: Service Components of Adoption House include: **birth family/child visitation, sibling visitation,** and **preparatory groups.** All children attending Adoption House services also receive round-trip transportation. Adoption House provides three weekly supervised visitation sessions for **birth parents and children** under the supervision of DCP&P. Children and families attending this service will participate in a sixty or ninety-minute supervised visitation session. The sessions are designed to provide families a structured therapeutic environment for parents to visit with their children. The goal of the program is to decrease the amount of time children spend in out of home placements and assist them in moving towards permanent placement either with their biological parents or in adoptive homes. Children attending the **sibling visitation** program participate in a 60-minute supervised visitation session, offered two evenings per week. The goal is to maintain meaningful relationships between siblings living in separate placements. During the sessions, staff introduce therapeutic activities that facilitate sibling interaction. The focus is to address underlying issues such as trauma, unresolved grief, and depression. Additionally, staff strives to promote healthy self-esteem, support self-worth, and acknowledge any feelings of loss, grief, or rejection. The 60-minute **preparatory groups** assist school-age children in addressing issues that they experience while residing in foster care and being removed from the care of their biological family. The groups provide children with support and allow open discussion among children sharing a common life event. The groups address underlying issues such as trauma, loss and unresolved grief, as well as feelings of isolation, rejection, shame, guilt, depression, and anger. Further, our staff strives to promote healthy self- esteem and support self-worth through the use of group discussion and therapeutic activities. Preparatory groups

	are held three times a year for eight week sessions, each. It should be noted that all staff working with the Adoption House Program have completed the Certificate Program in Adoption through Rutgers University, School of Social Work.
2b	**Population Served**: Children ages newborn to 17 years of age and families, who are affiliated with the Division of Child Protection and Permanency. Primary recipients are children and families from the surrounding counties such as; Union, Essex, Bergen, Passaic, Hudson, Somerset, and Monmouth. All children and families under the supervision of DCP&P Local/Area Offices will be eligible for services with the Adoption House Program.
2c	**Geographical Area of Services**: Statewide, with the primary recipients being from the Metropolitan Region
2d	**Referral Sources**: Division of Child Protection and Permanency Local/Area Offices
Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)	
3a	**Provide a summary of program accomplishments on goals.** **Include data (where available):** Program accomplishments and goals will be broken down by the three service components: **Birth Family/Child Visitation** This service decreased the amount of time children spent in out of home placements and assisted families in moving towards permanent placement, either with their biological parents or in adoptive homes. This outcome was measured by the documentation of the family's goals/progress in the weekly/biweekly observational summaries as well as outlined in the initial service planning meetings. As a result, 54% of families served between 10/1/13 and 9/30/14, achieved permanency by being either reunified or finalizing adoption. The remaining families continue to receive ongoing services by Adoption House to facilitate permanency. **Sibling Visitation:** This service assisted children in improving the relationships they share with their siblings. This outcome was measured by the documentation of the siblings' goals/progress in the weekly/biweekly observational summaries. As a result, 100% of sibling sets exhibited significant improvement in their interactions with one another. Further, during this reporting year 25% of the served sibling sets graduated from the Adoption House program. This was due to the program's ability to collaborate with the Division to assist the caretaker's facilitation of bonding time outside of the program. The children reported their satisfaction in being able to maintain visits with one another outside of the parameters of Adoption House which in turns provides the program the ability to service more families. It should also be noted that 50% of the served sibling sets during the identified time period continue to be engaged in therapeutic visitations and continue to visit with one another consistently.

	Adoption Preparatory Groups: This service facilitated open discussion regarding children's feelings of foster and adoptive placement in a group setting. The specific goal of increased awareness of the adoption process as measured by pre and posttests resulted in 100% of participating children demonstrating increased awareness. Upon completion of the program children felt they knew what it meant to be adopted, had become increasingly aware of the feelings, and emotions associated with adoption, and were better able to discuss these feelings openly with someone they trusted.
3b	**How did this improve outcomes for children and families?** **Birth Family Visitation**: Participants were able to improve communication and address sources of conflict. Parents were educated on appropriate parenting techniques and encouraged to engage in positive interaction with their child(ren). This expedited the permanency planning process with all parties effectively communicating and working together to achieve this goal. **Sibling Visitation:** Siblings utilized therapeutically oriented activities designed and implemented by professional staff to increase positive interaction, improve supportive relationships and elicit effective communication amongst the siblings. This process provided the siblings with the opportunity to engage in open dialogue concerning events leading up to their removal from their biological families and their experiences in the foster care system. The children demonstrated a positive change in their emotional reaction to their transition to permanency planning and displayed a decrease in feelings of isolation, as well as improve their self-esteem. **Preparatory Groups**: The groups provided children with support and allowed open discussion among children sharing their common experiences. The groups addressed issues of loss and unresolved grief, self-esteem, as well as feelings of isolation, rejection, shame, guilt, depression, and anger.
3c	**Identify specific factors that contributed to this improvement:** The implementation of the Case Practice Model has ensured better communication and synergy in service planning. In addition, Care Plus NJ was awarded funding to partner with several Local Offices for the roll out of the Case Conference Model for Focus on Supervision. This partnership has provided our teams with more access to Resource Development Specialists, Case Work Supervisors and their teams. As a result, we have seen an increase in awareness about the valuable services that the Adoption House Program provides, as evidenced by more referrals forwarded by Local Offices. Further, the Adoption House Case Manager invites Division Case Workers to attend the intake session with each family, in order to increase participation and achievement of established goals with the Adoption House Program.
3d	**Identify significant barriers to goal accomplishment:** All referrals made to the Adoption House Program have a case plan of Termination of

	Parental Rights. Adoption House staff often encounters families who are inconsistent with participating in the program. Many of the families present with a history of untreated mental health and substance abuse. Some families present with consistent legal involvement that inhibits their ability to participate (i.e. incarceration). When families are not in treatment it is challenging to engage them in services. The program collaborates directly with families and the Division to identify appropriate services to address the aforementioned service needs. In addition, Adoption House continues to struggle with the great distances required to travel to transport children to the program. A number of children who attend services at Adoption House reside a significant distance from the location of the program and therefore may spend up to two hours in a vehicle. These are less than desirable circumstances for children. Unfortunately, given children are at times separated into foster homes across the state, we are aware there is not a simple remedy to this challenge. Since the Adoption House program is unable to transport parents to the visitation sessions, there are many instances in which parents do not participate in services due to the unavailability of transportation. Adoption House staff communicate with the parents, as well as the DCP&P caseworkers in order to advocate for public transportation fare and give detailed scheduling/availability of the public transportation outlets in the area.
3e	**Definition of Level of Service as per contract:** A Unit of Service is defined as – **number of services days (5 per week)**, which includes birth parent/child visitation, sibling visitation, and preparatory groups (including round trip transportation of the child for all services).
3f	**Enter your contracted Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14:** **The contracted number of units of service, which includes birth parent/child visitation, sibling visitation, and preparatory groups:** 250 service days
3g	**Enter your actual Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14:** **The actual number of units of service, which includes birth parent/child visitation, sibling visitation, and preparatory groups:** 219 service days or 88%
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. Adoption House served 83 unduplicated individuals/ 26 unduplicated families during this time period.
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include** **how many surveys were sent, responses received and the results.**

	Care Plus NJ participates annually in the National Mental Health Association Consumer Satisfaction Survey and all clients are invited to participate. Adoption House distributed surveys to participating families during the month of October. Results yielded that clients served by Care Plus were more satisfied in every category compared to the national database of other mental health centers. Professionalism of staff was the highest rated item following confidentiality. Overall, Outcome and Reputation at Care Plus NJ scored higher than the national database of other mental health centers. It is important to note that Care Plus NJ has been ranked number one, or number two, nationally overall in staff satisfaction for agencies that have five or more programs.
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.** Services will remain the same
4b	**Identify changes you will make that stem from stakeholder feedback.** Care Plus NJ received positive feedback from stakeholders. Unless a needed change is identified, we will continue to maintain our standards of excellence.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** The estimated number of units served will be: 251
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **Birth Visit: # of unduplicated individuals**: 55 **Birth Visit: # of unduplicated families**: 20 **Sibling Visit: # of unduplicated individuals**: 45 **Sibling Visit: # of unduplicated families**: 10 **Prep group: # of unduplicated individuals**: 10 **Prep group: # of unduplicated families**: N/A
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?**

	A case file is created for every family and child referred to and accepted to any of the services provided by the Adoption House Program. Staff complete weekly summary reports concerning each child's and/or family's participation in services. An initial service plan is developed between the Case Manager, the DCP&P caseworker and/or the biological parents. The Case Manager maintains weekly contact with the family's DCP&P caseworker via telephone. Case Manager is able to attend and encourage quarterly meetings with the family and the DCP&P case worker. A final meeting is held with the caseworker to develop a discharge plan. The service plans as well as the discharge plan will be maintained in child/family's case file. The DCP&P Caseworkers will receive a copy of the weekly/bi-weekly summaries by the 10th of the following month. All the Weekly/Biweekly summaries document the family's progress. Preparatory Groups complete a questionnaire to measure progress. The questionnaire evaluates twenty areas that address feelings that surround the adoption process. The rating scale was designed to be child friendly. Responses include: Never, A little bit, Sometimes, A lot, and Always. The participants complete a questionnaire during the first group which serves as a pre-test. Participants also complete a questionnaire during their final group, which serves as a post-test. This has been successful with measuring increased knowledge of the adoption process as well as feelings surrounding adoption. All communication (verbal and written) to and from DCP&P offices, families, foster parents, adoptive parents, and other service providers are maintained in the case file. All the documentation provided by DCP&P, birth, foster, and adoptive parents will also be maintained in the case file. When a family's involvement in any of the services ends, a termination summary will be completed, maintained in the case record and a copy will be forwarded to the assigned DCP&P caseworker. Adoption House also tracks children and families participation/attendance in services using the DCP&P network database, NJ Spirit. As per the request of DCPP, beginning July 1, 2014 the Adoption House Program started reporting new performance based outcomes for birth family/child visitation. They are as follows: In TPR cases, parents will attend visit 65% of the time. Of those parents that do attend visits, they will demonstrate appropriate interaction with their children: -25% of cases at 90 days post intake -50% of cases at 6 months post intake -50% or more of cases thereafter as measured at 90 day intervals These outcomes continue to be measured using a parent/child interaction checklist.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** Care Plus NJ will continue to participate annually in the National Mental Health Association Consumer Satisfaction Survey. We will continue to encourage families to participate in this process as we value their feedback and depend on it to enhance the Adoption House program. In addition, staff will continue to take advantage of the depth of

	training and consultation offered by Care Plus NJ and the Care Plus Foundation. This ensures that staff is staying abreast of the most current methods and treatments for the families we serve. Any new Adoption House staff will attend and complete the Adoption Certificate Program through Rutgers University School of Social Work.
5c	**How do you collaborate with community partners?** The Program Director and Director of Children and Family Services have conducted presentations to Local/Area DCP&P offices in an effort to educate DCP&P staff on the services that the Adoption House program offers. In addition, the Program Director and Director and Children and Family Services have attended DCP&P Resource Fairs, PAC and Adoption Provider meetings, DCP&P Visitation outcome focus groups, and facilitated various meetings with DCP&P Resource Developmental Specialists, Supervisors and Caseworkers regarding families currently participating in services offered at Adoption House. Further, as mentioned in sections above, Care Plus NJ was awarded funding to partner with several Local Offices for the roll out of the Case Conference Model for Focus on Supervision. This partnership has provided our teams with more access to Resource Development Specialists, Case Work Supervisors and their teams. Adoption House has collaborated and facilitated meetings with outside service providers such as; individual therapists, Child Advocate Caseworkers, and extended family members to ensure the goals for the family are attainable and achieved while they are engaged in the Adoption House Program. In addition, upper administration, such as the VP and the President/CEO participate in many community meetings (such as CIACC, NJAMHA, Rotary, etc.) to ensure that community partners are aware of the services provided by Adoption House and the agency at large.

2015 PSSF Update Report

Section 1 – Identifying Information		
1a	**Provider**: The Children's Home Society of NJ	**1b Program Name:** Promoting Safe and Stable Families (PSSF) NOW Post-Adoption and Post-KLG
1c	**Relevant PSSF Program**: ___FPS, _X__FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 635 South Clinton Avenue, Trenton, New Jersey 08611	
1e	**Objective**: The objective of the Promoting Safe and Stable Families (PSSF) Program is to strengthen and preserve adoptive families through the provision of therapeutic, educational, support and advocacy services. The therapist provides intensive, short-term, in-home therapy to the children and families. The therapist works through emotional and behavioral issues with the child and offers effective parenting techniques, as well as psycho-education for the parents in order to stabilize the placement, improve the child's overall well-being and maintain permanency. This program has been merged with post-KLG cases since the last reporting period. The numbers you see here will be higher than in previous years.	
1f	**Outcome(s) Addressed**: __ Safety _X_ Permanency _X_ Well-Being	
Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)		
2a	**Overview of Service**: A therapist is sent into the home to work with the child on emotional and behavioral issues that are causing a degree of disruption in the home. The therapist provides education to the parents regarding adoption issues that arise at various developmental stages, and helps them provide consistent, effective parenting for the child. The therapist also uses talk, play, art, sandplay, EMDR and books, as well as other therapeutic tools to help the child through the adjustment issues he or she is experiencing in the adoptive home or at school. The goal is to help stabilize the family cohesiveness, improve the child's overall well-being, and maintain permanency.	
2b	**Population Served**: DCP&P families, who have finalized their adoptions or have finalized Kinship Legal Guardianship, take priority over other finalized adoptive families, including International adoptions. All of these families are experiencing some distress and need help to stabilize the adoption. The social worker helps the child feel safe, stable, have an improved sense of belonging and connectedness with the adoptive family, and have a stronger sense of well-being.	
2c	**Geographical Area of Services**: Mercer, Monmouth, Ocean, Somerset, Hunterdon, and Middlesex Counties in New Jersey	
2d	**Referral Sources**: Families refer themselves to CHS, or DCP&P caseworkers may inform CHS	

	that there is a family that has finalized an adoption or KLG, but would like to continue receiving therapeutic services after the adoption or KLG has been finalized. In that case, the CHS supervisor would contact the family to make arrangements to assign the case to a therapist.
Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)	
3a	**Provide a summary of program accomplishments on goals.** **Include data where available.** Therapy helps the children feel heard and understood about their concerns and the confusion that they are experiencing at the different developmental stages in their lives. Education and therapy are provided to the parents as well, helping them to better understand the emotional and behavioral difficulties the child is experiencing, and to normalize the child's experience. For example, the therapist explores such questions as why the child cannot live with her/her birth parents. In KLG cases, the child may wonder why they cannot live with their birth parents, but are able to visit with them. Behavior modification, play therapy, social skills, peer relationship skills, and ego strengthening are some of the ways in which the therapist provides stabilization and a sense of security and well-being. In many of the cases, it is the adoptive parents or family caregivers who have difficulty changing their behaviors and parenting skills to help meet the children's emotional needs. In those cases, the therapist works with the adoptive parents or kin caregivers to help them understand the developmental process that an adoptive child experiences, as well as giving them a better understanding of the needs of the adopted child, which change as they mature and the children have different questions and feelings. 35 children were seen during this time period. Twenty-five cases were closed. Of the 25, 19 achieved their goals (76%) of maintaining placement and feeling secure in their adoptive or Kinship homes. Two children were referred out for more appropriate services; but remained in the home; one child returned to birth parents; one child moved out of the contracted area; and three withdrew. There are currently 10 post adopt or kinship cases open, with 3 on the waiting list.
3b	**How did this improve outcomes for children and families?** When adoptive parents and kin caregivers better understand the reasons behind the child's behaviors or emotional issues, and receive the skills needed to help them cope with these confusing feelings, they become more relaxed. Normalizing the situation for the parents is helpful. When the child is able to give voice to his or her concerns and questions, the child can settle into the family again. When everyone in the family feels a sense of belonging and stability, it improves the total family functioning and well-being of the child, and an adoption disruption or KLG is prevented. This program, in Performance Standards, is under the heading of Behavioral Supports Services. These services focus on maintaining the child in the home, supporting the adoptive parent, and providing behavioral assistance to children and families in their current living arrangements. This requires that 80% of children will maintain placement at 3 months and 6 months and that 85% of children will show improvement through measurement by an objective tool. For the latter, CHS utilizes the CSQ 8, which is a researched and evidence-based instrument. (See 3i).

	In this reporting period, 76% of the children reached their goals of maintaining placement. The Level of Functioning, which is a scale to assess functioning of the child in the areas of Impulse Control, Peer Relationships, Family Relationships, Orientation to Authority, and Personal Functioning, is rated at the beginning of therapy and again at the end. 19 out of 25 children (in closed cases) increased their level of functioning, three remained the same, and 3 decreased in level of functioning. Parents and Caregivers were are also given a Client Satisfaction Questionnaire at the end of therapy and asked to send it back to CHS of NJ to rate the helpfulness of the therapy. Out of the 25 families, who received the Client Satisfaction Questionnaire, two families returned the form, and both found services to be excellent.
3c	**Identify specific factors that contributed to this improvement.** The therapist uses talk, play, art and book therapeutic techniques, therapeutic games, sand tray, education, EMDR, CBT, coaching and other therapeutic techniques which lend themselves well to working with children and teens in distress. The therapist models empathy and patience for the parents. This, in turn, helps the child become successful as they work to improve their relationships with the child(ren). Funding for activities for these children and families has been successful in improving the childrens' confidence levels, peer relationships and family connectedness.
3d	**Identify significant barriers to goal accomplishment.** There were more children referred, who have been sexually abused or have been witness to sexual acts. We refer thee children for sexual abuse specific services, while we work with the children on adoption issues. Often, there is a waiting period for scheduling formal psychiatric and psychological evaluations, as well as the fact that some of the parents cannot afford the cost. An additional wait can occur for obtaining the written evaluation and acquiring the prescribed medication. As a result, this can prolong services and delay successful treatment. The prohibitive cost of formal evaluations adds to the burden of feelings of guilt and shame for the family, because they feel incapable of helping their child appropriately. Some parents do not want their children taking medication, yet continue to be frustrated by symptoms of ADHD that their child exhibits. Various stressors impact the family unit, such as marital difficulties or depression that a parent may be experiencing. It is during these times that families do not function well, and the child(ren) feels unwanted or unloved. It is imperative that the family seeks therapeutic interventions and be willing to participate so that the family unit can improve their relationships and help the child feel safe and secure. Much of what we do in the home is parent education, as well as trauma therapy for the child.
3e	**Definition of Level of Service as per contract**: CHS of NJ is currently contracted to work with as many families as need services, on a weekly or bi-weekly basis for one or more hours a session, depending on the severity of the difficulties the family is experiencing. CHS of NJ is contracted to work with the family for a period of six (6) months. The average for working with the families is actually 8 months. Each therapist works with 13 – 16 children in both pre and post adoption/KLG services, so there is no longer a limit of 6 for post-adoption services.

3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14** The contracted Level of Service is only limited by the number of pre-adoption or Select Adopt Homes that are referred. Families that are in danger of disruption and Select Adopt Homes are our priority.
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14** The actual Level of Service for this time period was 25 families
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals: __25__** **# of unduplicated families: ___2____**
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** Adoptive parents are given a Client Satisfaction Questionnaire at the end of therapy, and asked to return it to CHS of NJ. This is used to rate the helpfulness of the therapy and the satisfaction of the client and family. Out of 25 questionnaires given to families, only two were returned. The responses were excellent. The CSQ8 is an instrument that CHS of NJ purchases. This Client Satisfaction Questionnaire is a researched and evidence-based instrument.
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program** This contract, as explained, has changed: Each child is counted as one client. All post-adoption and post-KLG cases will be under one contract, which includes pre adoption and pre-KLG.
4b	**Identify changes you will make that stem from stakeholder feedback.** Therapists will continue to investigate new techniques to work with families and attend trainings that will enhance their skill levels. Three staff are trained in EMDR, all staff were trained in Beginner Sandplay. The Adoption Certificate Program is taken by all staff providing pre and post-adoption and post-subsidy Kinship Legal Guardianship in-home counseling services. It is provided by The Rutgers School of Social Work. This program enhances their knowledge of the issues of adoption for the adoptive parents and adopted children at the varying developmental stages.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15 20** families are expected to be seen in the next reporting period.

4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals: _25____** **# of unduplicated families: ___4____**
	Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)
5a	**How will you measure progress?** Progress will be monitored through monthly reports, weekly and bi-weekly sessions, self-reports, caregiver feedback, Global Assessment of Functioning Scales, Trauma Symptom Checklist (pre and post), school reports, observable changes in family functioning and stability, as well as Client Satisfaction Questionnaires. There are also pre and post-tests regarding how the activity funds helped the parents and the child with self-esteem, confidence and lower frustration levels.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** As of July 2014, CHS of NJ has been utilizing a pre/post-assessment called the Trauma Symptom Checklist. This is completed at Intake, and again at Discharge. This shows the level of trauma the child experiences prior to therapy and again after therapy has concluded. Global Assessment of Functioning is reported by the therapist at pre-and post-therapy. The adoptive parents are given a Client Satisfaction Questionnaire to complete and return to the agency anonymously. Quality Assurance Feedback from reviews are also performed on a quarterly basis to determine whether the family received appropriate and effective treatment. The families are contacted at 3 and 6 months post-therapy to see if the child still remains in the home.
5c	**How do you collaborate with community partners?** CHS of NJ therapists cover 6 central counties in New Jersey – Mercer, Monmouth, Middlesex, Ocean, Somerset and Hunterdon. They have a list of community resources in those areas that they feel comfortable utilizing as referrals for the families on their caseload. Our therapists collaborate with several of our community partners to offer as much support to the families as possible. We often call on behalf of our clients to provide linkages to other community resources to ensure that they offer the services we have assessed the client to need. Our therapists have accompanied the family to IEP meetings at schools, participating as needed, and have partnered with other service providers, when appropriate, and in the best interest of our clients. The family is requested to sign Releases of Information so that the therapist may share information with the child's other service providers and schools so that there is no duplication of service and to ensure that everyone is working towards the same goal of helping the families be successful and improving the child's well-being.

2015 BSAF Update Report

	Section 1 – Identifying Information	
1a	**Provider**: The Children's Home Society of NJ	**1b Program Name:** Behavioral Supports for Adoptive Families (BSAF) – Now Pre-adoption Counseling/Pre-KLG Counseling
1c	**Relevant PSSF Program**: ___FPS, _X__FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 635 South Clinton Avenue, Trenton, New Jersey 08611	
1e	**Objective**: The objective is to decrease or eliminate negative behaviors of pre-adoptive or kinship children, whose case goal is adoption or KLG, and who are under the supervision of DCP&P.	
1f	**Outcome(s) Addressed**: _X_ Safety __ Permanency _X_ Well-Being	
	Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)	
2a	**Overview of Service**: The purpose of the Behavioral Supports for Adoptive Families (BSAF) program, which is now, simply, Pre-adoption/Pre-KLG Counseling, is to provide intensive, short-term, in-home counseling, support, parent education, and advocacy to DCP&P children and foster/pre-adoptive families or Kinship families, whose case goal is adoption or KLG, and who are under the supervision of DCP&P. The therapist utilizes a variety of techniques, including talk, book, play and art therapy, as well as behavior modification, EMDR, Sandplay, and Cognitive-Behavioral Therapy. The therapist also educates the parents about the traumatic and difficult issues foster children face and how the parents can better help the child(ren) cope through understanding, patience, nurturance and structure. The therapist also helps the families understand trauma and its effects on the development of the brain.	
2b	**Population Served**: DCP&P foster children in resource homes, pre-adoptive homes and relative care homes. Any child in foster care, at the age of five or older must participate in PAC counseling services, as per DCP&P.	
2c	**Geographical Area of Services**: The therapist travels to homes in Mercer, Monmouth, Ocean, Somerset, Middlesex, and Hunterdon Counties in New Jersey.	
2d	**Referral Sources**: All referrals come through DCP&P. The DCP&P caseworker may be from another New Jersey county, but as long as the child is in our contracted area, the CHS therapist is assigned the case.	
	Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)	
3a	**Provide a summary of program accomplishments on goals. Include data where available.** 83 children were closed in this contracted period. Of the 83 children that participated in therapy, and whose cases were closed, 73 achieved their goals (88%). Four children moved out of our contracted area, four withdrew from services, one wanted a male therapist and one moved to a	

	residential placement. 60 pre-adoptive and KLG cases remain open at this current time, with 12 on the waiting list.
3b	**How did this improve outcomes for children and families?** The children, who accomplished their goals, felt safe and stable at the conclusion of therapy, were happy in their homes and negative behaviors were decreased or eliminated. Caregivers were better able to provide the structure, nurturance and understanding needed to help the child(ren) feel a sense of belonging and improved well-being, better understand the adoption process, cope with the separation and loss from the birth family and feel more connected to the resource or kinship family. The children were also better able to cope with other changes in their lives, such as school, friends, and new family members. Negative behaviors were decreased or eliminated. This program, in Performance Standards, is under the heading of Behavioral Support Services. These services focus on maintaining the child in the home, improving behaviors and feelings of safety and stability, supporting the resource parent, and providing behavioral assistance to children and families in their current living arrangements. This requires that 80% of children will maintain placement at 3 months and 6 months, and 85% of children will show improvement through measurement by an objective tool. For the latter, we utilize the CSQ 8, which is a researched and evidence-based instrument. (See 3i.) In this reporting period, seventeen 88% of the children reached their goals of maintaining placement. We have 77 cases open at this time, with 12 on the waiting list. The Level of Functioning, which is a scale to assess functioning of the child in the areas of Impulse Control, Peer Relationships, Family Relationships, Orientation to Authority, and Personal Functioning, is rated at the beginning of therapy and again at the end. 60 children increased their level of functioning by the end of therapy, 7 remained the same, and 6 decreased Level of Functioning.
3c	**Identify specific factors that contributed to this improvement.** An average of 12 sessions of weekly or bi-weekly therapy sessions, behavior modification, Cognitive Behavioral Therapy, EMDR, Sandplay, therapeutic books, games, art and other techniques were utilized to help the children understand their relationship to the foster or kinship family, grieve the separation from or loss of their birth family, and understand the process of adoption and permanency within the new family or possible reunification, depending on the Division's goal. The children's questions are answered honestly and at an age appropriate level for their understanding.
3d	**Identify significant barriers to goal accomplishment.** More children were either sexually abused or witnessed sexual acts. More of the children witnessed Domestic Violence, and the largest percentage of children had parents addicted to illegal substances. Visitations with birth family, or promises made by birth family during visits, that cannot occur, leave children feeling confused and insecure about the current placement and the child's position in the foster or kinship family. Concurrent planning is confusing for the child and the foster parents, and is often very limiting for the therapist. The child very often feels loyalties to the birth parents during this time and may not listen to the resource or kinship parents. When there is hope for the child that he or she may return to the birth parents, and then the birth parents experience a relapse or become incarcerated, the child re-experiences trauma, loss and disappointment. Negative behaviors may increase and foster/pre-adoptive or kinship parents are, again, unsure of their status with the child. The courts may give the birth parents extra time to

	bring their lives back into focus so that they can have their child returned, and the long, emotionally painful process starts again. When courts have returned some of these children to their birth parents, it has not typically been with a process that is conducive to preparing the children and foster or kinship parents for that move. This creates instability for everyone, feelings of loss, disillusionment with the system of care, and confusion. We refer to sexual abuse specific therapists, while we work with the children on adoption issues. Psychological, psychiatric and neurological evaluations can take a long time to be scheduled, which also extends the need for services, especially if the family is struggling with serious behavioral issues and possible medication needs. Parents who refuse to allow their child to take medication that could help them, make it difficult for the therapist to provide a successful outcome to therapy when medication would help the child function better. Sometimes caregivers are inconsistent in putting therapist recommendations in place to make needed behavioral changes. It often takes time for them to realize how important consistency is to the process of change for the better. The therapists spend a great deal of time with the caregivers to educate them about trauma and its effects on the brain, behavior and emotions. Serious sexual and physical abuse issues in the birth home have made it difficult for children to trust. Exhibiting angry, aggressive, or sexualized behavior in the foster home is a challenge for the resource and kinship caregivers.
3e	**Definition of Level of Service as per contract**: Children and families are seen for one or more hours per week or bi-weekly, depending on the degree of need and complexity of the issues to be addressed. Families are seen, by contract, up to 10 sessions in a period of four months, which normally averages out to about 9 months. The constant level of service is approximately 65 cases. The number of contracted sessions may be extended at the request of the DCP&P caseworker and supervisor. If the child still has concerns, and is working towards resolution of the issues, we may continue in the home.
3f	**Enter your contracted Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14** The contracted level of service is approximately 60 children per year.
3g	**Enter your actual Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/12 – 9/30/13** The actual level of service for this time period is up to approximately 60 children.
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals: __60___** **# of unduplicated families: ___4____**
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** Pre-adoptive and kinship parents are given a Client Satisfaction Questionnaire at the end of

	therapy, and asked to send it in to CHS of NJ to rate the helpfulness of the therapy. They are based on a scale of 1 to 4, with 1 being the most satisfied. Out of the 83 given to families, 22 were returned. All of these families were satisfied or very satisfied with the services. The CSQ8 is an instrument that CHS of NJ purchases. This Client Satisfaction Questionnaire is a researched and evidence-based instrument.
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program** As of July 2014, all pre/post-adoption and pre/post KLG cases have been under one contract. Also, each child is counted as a case. We have also added a pre/post Trauma Symptom Checklist to our Intake and Discharge process to show a decrease in trauma reactions that the child experiences. Not everyone has been trained in this as yet, and in this time period, we have had only a few who received the pre-TSC. Two were done at discharge, and both showed successful outcomes.
4b	**Identify changes you will make that stem from stakeholder feedback.** Stakeholder feedback has been consistently positive in this program. We continually search for useful community resources for the families we serve, such as parent support groups or activities that will help the children with focus, self-esteem and confidence. The therapist utilizes yoga to help the child become centered and find some peace. This will continue, as the children find it very helpful. All CHS therapists have been trained in Beginner Sandplay training, which is useful in trauma therapy. The children respond well to the therapist, who creates a safe, comfortable environment in which to discuss the difficult issues the child needs to face. Each social worker participates in the Rutgers School of Social Work Adoption Certificate Program, which includes 9 classes on adoption issues.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15** We still expect to continue to serve a constant level of service of approximately 60 families, in a 6 month period of time, which is often extended, but averages to about 9 months
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals: __60___** **# of unduplicated families: ___4____**
Section 5 – Evaluating Progress FFY '16 (10/1/13 – 9/30/14)	
5a	**How will you measure progress?** The Trauma Symptom Checklist will be added to the Intake and again at Discharge to show, through a reliable and valid measurement, when there is a decreased level of trauma experienced by the child. A Global Level of Functioning is reported by the therapist at Intake and again at termination of therapy. Caregivers complete a Client Satisfaction Questionnaire. Monthly summaries, monthly case conferences, self-reports and observable changes in the child's behaviors will be documented. CHS also holds quarterly quality assurance case reviews

5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** A Trauma Symptom Checklist will be added at Intake and Discharge. Caregivers will complete the checklist for younger children and adolescents may complete their own, which is a different set of statements. Each instrument is specifically for males and females and measures anxiety, anger, depression, and trauma. A Global Assessment of Functioning will be used to assess the behavioral changes of the client in the areas of their lives at home and school. Client Satisfaction Questionnaires are given to families to assess the family's satisfaction with services received. Regular supervision sessions are held with the social worker to discuss cases and family needs, monthly case conferences are held with DCP&P and CHS social workers and supervisors to discuss the needs and goals of each case, the progress and changes in case plans, and quality assurance reviews are held quarterly to ensure that the families are reaching their goals and getting their needs met through therapy, support and advocacy.
5c	**How do you collaborate with community partners?** Our pre-adoption/pre-Kinship therapists are knowledgeable about services in the area of Ocean, in particular, but are always searching for new and helpful community resources in each county, such as neurologists, psychologists, psychiatrists, community activities, child care, after school programs, etc. The State of NJ is in need of child psychologists and psychiatrists. The therapists also receive suggestions from DCP&P caseworkers and supervisors and the Resource Development Specialist, who have other available resources to offer. CHS of NJ maintains a directory of services in our offices, based on the counties within which we work. We also have a variety of child and family-centered programs within our agency that could prove helpful to families, depending on their needs and where the family is located. Releases of Information are signed in order to maintain professional and ethical standards.

2015 PSSF Update Report

Section 1 – Identifying Information		
1a	**Provider**: The Children's Home Society of NJ	**1b Program Name:** Child Summary Writers
1c	**Relevant PSSF Program**: ___FPS, _X__FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 635 South Clinton Avenue, Trenton, New Jersey 08611	
1e	**Objective**: The objective of the Child Summary Writers program is for The Children's Home Society of New Jersey to provide support to the Division of Child Behavioral Health to complete Child Summaries which helps to facilitate the adoption process for children under the care of the Division whose parental rights have been terminated.	
1f	**Outcome(s) Addressed**: __ Safety _X_ Permanency ___ Well-Being	

Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)	
2a	**Overview of Service**: The Child Summary Writers work in the various DCP&P local offices. They are assigned children for whom to write summaries by the Concurrent Planning Specialists and are given access to the necessary case files. From the information in the case files, the Child Summary Writers create the child summary, which is used as a part of the adoption process.
2b	**Population Served**: Children in the care of the Division of Child Protection and Permanency who are free for adoption and who require a Child Summary to be completed.
2c	**Geographical Area of Services**: There are Child Summary Writers who serve all 21 counties in New Jersey.
2d	**Referral Sources**: Children are referred to the Child Summary Writers by the Concurrent Planning Specialists in the local Division of Child Protection and Permanency offices.

Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)	
3a	**Provide a summary of program accomplishments on goals.** N/A – Please refer to 3b **Include data where available.** N/A – Please refer to 3b
3b	**How did this improve outcomes for children and families?** As this is not a counseling program and there is no client contact, it is difficult to determine the impact this service directly has on the children for whom child summaries are written. However, the completion of the child summaries does help to facilitate the adoption process for these children.
3c	**Identify specific factors that contributed to this improvement.** N/A – Please refer to 3b

3d	**Identify significant barriers to goal accomplishment.** N/A – Please refer to 3b
3e	**Definition of Level of Service as per contract**: The definition of level of service for this contract is 7 child summaries per child summary writer per month. There are currently 21 child summary writers associated with this contract. Therefore there is a monthly level of service of 147 child summaries per month, and 1764 per year.
3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14** The contracted level of service for this time period is 1764 child summaries.
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14** The number of Part B summaries that were completed from 10/1/13 through 9/30/15 was 1334.
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. There is no client contact for this program. **# of unduplicated individuals: _1334___** **# of unduplicated families: _______**
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** N/A – Please refer to 3b
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.** There are currently no planned changes to the program.
4b	**Identify changes you will make that stem from stakeholder feedback.** There are no planned changes to the program.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15** Bases on the level of service for the program we are expecting 1764 Child Summaries to be completed.
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** There is no client contact for this program. **# of unduplicated individuals: _1764____** **# of unduplicated families: _______**

Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** N/A – Please refer to 3b
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** While there is no direct client contact for this program the quality of the Child Summaries is monitored by both the Concurrent Planning Specialists at the Division of Child Behavioral Health Services and the Chief Program Officer at The Children's Home Society of New Jersey. When there is an identified quality issue additional training is given to the Child Summary Writer to help improve his or her skills.
5c	**How do you collaborate with community partners?** N/A – Please refer to 3b

2015 PSSF Update Report

Section 1 – Identifying Information		
1a	**Provider**: Volunteers of America - Northern NJ Sector	**1b Program Name:** Parenting Skills Partnership Program – Adoption Support
1c	**Relevant PSSF Program**: ___FPS, ___FSS, ___TLFRS, **_X__APSS**	
1d	**Program Address**: 205 West Milton Ave., Rahway, NJ 07065	
1e	**Objective**: The objective of the Parenting Skills Partnership Program is to stabilize and preserve the family unit. The program provides tools for caring parents of adoptive children to effectively work with children to stabilize the family, increase adaptive behaviors, and decrease inappropriate behaviors in order to achieve a successful adoption.	
1f	**Outcome(s) Addressed**: __ Safety **_X_ Permanency** __ Well-Being	
Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)		
2a	**Overview of Service**: A comprehensive module of in-home parenting education and support is provided to the adoptive parents. The overall purpose of the training is to give parents the skills necessary to reduce negative behaviors and to teach the youth appropriate positive behaviors. Parents learn to motivate the adoptive child to practice positive adaptive behaviors. The staff provides intake and assessment to determine family needs. Staff uses a strength-based approach while working with families to teach alternative parenting approaches, problem solving techniques and behavior management techniques. Staff also works with the parents to learn self-advocacy skills in order to promote family empowerment.	
2b	**Population Served**: Pre and post adoptive families	
2c	**Geographical Area of Services**: Northern New Jersey including Bergen, Hudson, Morris, Passaic, Sussex, and Warren counties.	
2d	**Referral Sources**: Department of Children and Families, Division of Child Protection and Permanency (DCP&P) District Office's, Foster and Adoptive Family Services of New Jersey, and self-referral.	
Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)		
3a	**Provide a summary of program accomplishments on goals. Include data where available.** Overall the goals and objectives of the program were for parents to learn effective parenting techniques, implement effective parenting strategies, and sustain effective parenting skills in order to stabilize placement, promote permanency, and assist in adoption finalization when appropriate. Pre and post family assessments are completed with the families. Data demonstrates that families report reduction in child negative behaviors and increased feelings of parenting competency. Our bilingual Parent Educator was able to assist with the increased number of clients who speak Spanish only.	
3b	**How did this improve outcomes for children and families?** The parents completing the program report improved relationships with their children, they are better able to problem-solve and can better control their emotional reactions with their children. Further, families report they are able to use consequences to improve their children's behaviors.	

3c	**Identify specific factors that contributed to this improvement.** The Parenting Skills Partnership Program closely coordinates with individual families and their DCP&P representatives. The program utilizes an evidence supported model to improve parenting practices. The marketing plan created in 2008 continues to the present. Presentations were offered to all referring agencies and completed at all referring DCP&P offices at multiple times throughout the year. Staff conducted outreach such as attending a walk for Foster and Adoptive Family Services. The utilization of bilingual staff also provided the program an opportunity to provide services to an additional population as identified by DCP&P.
3d	**Identify significant barriers to goal accomplishment.** Due to the in home design and the flexibility of accommodating the families' schedule, the families referred to the program and participate in services do not experience barriers to goal accomplishment. Since the program became an approved trainer for the Foster and Adoptive Family Services continuing education requirement, there has been increased visibility with the program.
3e	**Definition of Level of Service as per contract**: A unit of service is one referral.
3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14** The contracted level of service was 24 referrals.
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14.** There were 21 referred families.
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals: _65____** **# of unduplicated families: __21_____**
3i	➢ **Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** Feedback from stakeholders includes an annual client satisfaction survey and quarterly meetings with the referral source. Feedback from our referral source in quarterly meetings is overall positive. The client satisfaction survey indicates that the parents who responded are overall satisfied with all aspects of the program. The overall average score for the program was 6.56 on a seven point Likert scale.
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.** Will speak with contracting to see if there is a need for services in other counties. Review catchment area to possibly include other counties. Current marketing and outreach strategies will be reviewed for increasing referrals for the upcoming year. A new clinician will be hired as the full-time clinician is scheduled to retire in September 2014.

4b	**Identify changes you will make that stem from stakeholder feedback.** Stakeholders consistently report they are pleased with the service provided. We plan to continue to offer parenting support in English and Spanish.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** In the report year 10/1/14-9/30/15, we plan to deliver 36 units of service.
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals: _68____** **# of unduplicated families: __36_____**
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** In FY '15 Volunteers of America will continue to measure progress through program evaluations, outcome measures, consumer satisfaction, family assessments, the continued permanency of adoptive families served, and feedback from funder and referral sources.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** Our Sector has a quality department that reviews program outcomes, safety issues, incident reporting, and performance improvement initiatives. Program outcomes are tracked on a monthly basis and reported to the Assistant Vice President and the Executive Office. Each year a consumer satisfaction survey is distributed to all participating families. The scores and comments are reviewed by the quality department, Program Director, and Assistant Vice President. Any suggestions for improvements to the program are reviewed and implemented when appropriate. Community organizations, families, and DCP&P outreaches will continue to provide feedback through our satisfaction surveys, treatment team meetings, and quarterly meetings.
5c	**How do you collaborate with community partners?** The program works closely with the individual DCP&P caseworkers and with the DCP&P Resource Development Specialists. We make recommendations to the caseworkers for specialized assessments and additional identified services that may be necessary for family stabilization. We advocate on our clients' behalf in order to expedite recommended services. DCP&P relies on VOA to assess and evaluate the family situation and the ability of the parents to continue working towards success with these children. They expect us to inform them of new situations in the family. Staff will continue to connect families to community resources for physical and mental health services, school child study teams for educational support, and social welfare providers as needed. The bilingual parent educator collaborates with adoption agencies in the counties we serve. One parent educator is trained as a Parents Anonymous trainer and will assist any family who would like to start a group. VOA will continue to attend various staff, team leader, RDS, and Practice Forums through DCF to educate them on the services available.

2015 PSSF Update Report

Section 1 – Identifying Information		
1a	**Provider**: Catholic Charities, Diocese of Metuchen	**1b Program Name:** Adoption Support and Advocacy Program (ASAP)
1c	**Relevant PSSF Program**: ___FPS, ___ FSS, ___TLFRS, __X__ APSS	
1d	**Program Address**: 319 Maple Street Perth Amboy NJ 08861	
1e	**Objective**: To provide behavior management, play therapy, and parent skill-building services designed to support adoptive families, enhance family functioning and prevent disruptions, thus promoting permanency.	
1f	**Outcome(s) Addressed**: ____Safety __X__Permanency ____Well-Being	

Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)	
2a	**Overview of Service**: Catholic Charities, Diocese of Metuchen provides in-home behavioral supports for adoptive and pre-adoptive families via the Adoption Support and Advocacy Program (ASAP). ASAP serves children in out-of-home placements and the majority of these children cannot or have not benefited from traditional psychotherapy. The children's behavioral and emotional difficulties are causing significant stress on the adoptive or pre-adoptive family functioning to the point where placement disruption is possible. It is the philosophy of ASAP that a comprehensive behavioral approach to serving this population is beneficial in preventing disruption of the child's permanency plan. The overall goal of ASAP is to provide in-home behavioral support services to strengthen family functioning and increase parental ability and effectiveness, to facilitate adoption finalization plans and prevent adoption disruption/dissolution. ASAP uses a family therapy approach focusing on behavior management and adoption preparation. When clinically appropriate, clients and foster/adoptive parents are seen individually.
2b	**Population Served**: The Adoption Support and Advocacy Program is available to children of any age who are in need of in-home behavioral support services to strengthen family functioning in order to prevent placement disruption, facilitate adoption finalization plans, and assist DCP&P with permanency achievement.

2c	**Geographical Area of Services**: These children are under the supervision of the DCP&P Local Offices in Essex, Middlesex, and Union counties.
2d	**Referral Sources**: Referrals are accepted from the DCP&P Local Offices in Essex, Middlesex, and Union counties as well as directly from adoptive families identified through DCP&P and Foster and Adoptive Family Services.
Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)	
3a	**Provide a summary of program accomplishments on goals.** **Include data where available:** During the course of treatment, 94% of clients served were stabilized and had improved at the conclusion of treatment.
3b	**How did this improve outcomes for children and families?** The clinical and behavioral interventions provided to the children and families were able to support and help facilitate adoption finalization and prevent adoptive placement disruption.
3c	**Identify specific factors that contributed to this improvement:** It is believed that the quick response to providing services when first requested contributes to assisting the family at a difficult time, and provides key insight to the nature of the issues. The agency also has a strong commitment to focusing on the family unit as a whole to assure all members are able to learn and support each other.
3d	**Identify significant barriers to goal accomplishment:** To enhance awareness of the program and generate referrals, recruitment efforts are facilitated on a regular basis. For example, regular emails and phone calls are facilitated to the Resource Development Specialists in each of the contracted DCP&P Local Offices as well as to DCP&P Caseworkers who have provided previous referrals to the program. Of the appropriate referrals received, 100% were provided services.
3e	**Definition of Level of Service as per contract:** The Adoption Support and Advocacy Program is contracted to serve 108 unduplicated individuals per year. Each client is provided with 10 weeks of in-home therapy for a minimum of one hour per week.
3f	**Enter your contracted Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14:** The contracted Level of Service for the ASAP Program is 108 unduplicated individuals.

3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14:** 31
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals:** 31 **# of unduplicated families:**
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** The program conducted Customer Satisfaction Surveys at the conclusion of treatment. Out of 31 surveys requested, 16 were completed. Out of those returned, 88% scored their answers to the question "Did we help you?" between an 8 and a 10 with 1 being "not at all" and 10 being "a great deal".
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.** There are no planned changes to this program.
4b	**Identify changes you will make that stem from stakeholder feedback.** The program will continue to work with stakeholders to identify additional avenues to generate referrals.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** 108 Units of Service will be delivered between 10/1/14 and 9/30/15.
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals**: 108 **# of unduplicated families:**
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** Monitoring of the program for customer satisfaction, discharge and post-discharge status will be done through paper or phone surveys. Customer Satisfaction Surveys are forwarded to all clients upon termination of services either in person at the last home visit or via mail

	along with a self-addressed stamped envelope to aide in the return of the surveys. Upon receipt of the completed surveys, the Case Manager aggregates the data.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** To ensure consumer focused feedback, satisfaction surveys are disseminated at the conclusion of treatment. This information is aggregated on a quarterly basis and annually. Any areas that fall below an 80% approval rating will be targeted for improvement. During contract renewal and at various times throughout the year, communication with DCP&P is paramount to continued program quality initiatives.
5c	**How do you collaborate with community partners?** During the initial and on-going assessment process Behavioral Specialists are working with other community providers to ensure all client needs are being met. Recommendations are also indicated during the discharge planning process.

2015 PSSF Update Report

Section 1 – Identifying Information		
1a	**Provider**: Robins' Nest, Inc.	**1b Program Name:** PACS (Pre and Post Adoption and Kinship Counseling)
1c	**Relevant PSSF Program**: ___FPS, ___FSS, ___TLFRS, X APSS	
1d	**Program Address**: 42 South Delsea Drive, Glassboro, NJ 08028	
1e	**Objective**: To help the child and family negotiate the transition created by the adoption and to build positive family interaction in order to strengthen and stabilize the pre or post adoptive placement.	
1f	**Outcome(s) Addressed**: __ Safety _X_ Permanency _X_ Well-Being	
Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)		
2a	**Overview of Service**: The Building Stronger Adoptive Families program (which as of 7/1/14 merged with other similar programs into the Pre and Post Adoption and Kinship Counseling (PACS) program) provides in home individual and family therapy focusing on the presenting and underlying symptoms. While the child's acting out behaviors and poor school functioning are addressed in order to stabilize and enhance the placement, the focus of the intervention is on adoption, loss issues and attachment. Traumatic issues such as loss, rejection, abandonment, trust, loyalty and birth family issues are explored. Supportive and therapeutic groups are available for pre and post adopted teens and their families. Therapy, education, family bonding and attachment building, client advocacy, wrap around services, linkage to services and supports and six months of aftercare (follow up phone calls and booster sessions as appropriate) are implemented to increase permanency**.** In addition, if termination of parental rights or an identified surrender occurs, therapists prepare for, process and conduct good bye/closure visit between birth parent and client to assist the child in the grieving process.	
2b	**Population Served**: All pre and post adoptive families (children twenty one years and younger)	
2c	**Geographical Area of Services**: Burlington, Camden, Gloucester, Cumberland, Salem, Cape May and Atlantic Counties.	
2d	**Referral Sources**: Referrals come from DCP&P caseworkers and adoption and permanency workers if the child is DCP&P involved. Non-DCP&P involved families self refer.	
Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)		
3a	**Provide a summary of program accomplishments on goals. Include data where available.** 1. 15/15 (100%) families' cases closed having made progress.	

	2. 36/36 (100%) case goals were achieved or partially achieved. 3. 13/15 (87%) families improved their functioning and familial relationships by the end of in-home intervention as measured by the Child Well Being Scale. 4. 9/11 (82%) children remained stable in their pre/post adoptive home three months post treatment. 1/2 (50%) of the children who moved were placed in a select adoption home. 5. 12/15 (80%) children remained stable in their pre/post adoptive home six months post treatment. 1/3 (33%) of the children moved were reunified with family. 6. During this time period, 13 children with whom we worked had their adoptions finalized
3b	**How did this improve outcomes for children and families?** Through our family focused, integrative approach to therapy, staff provides support, adoption education; advocacy and attachment focused parenting strategies to increase family success. By educating families and increasing awareness and understanding, combined with the implementation of tools for effectively managing challenging behaviors, we see families increase their stability and report more positive interactions. Parents continue to report that increasing their understanding of the reasons behind negative behaviors helps them to effectively address those behaviors. With therapeutic insight, guidance and support, parents are able to implement successful strategies for strengthening bonding and attachment in addition to minimizing or extinguishing negative behaviors. All of these factors improve outcomes for families by increasing their ability to remain stable.
3c	**Identify specific factors that contributed to this improvement.** Specialization in adoption work is not common and due to extensive training through Rutgers' Adoption Certificate Program, staff is competent in providing adoption related individual and family therapy. Therapists attend ongoing trainings related to adoption work, especially related to trauma and its effect on the family system. Staff also utilizes both peer consultation and staff meetings to benefit from the expertise of their peers, which strengthens their skill level. As part of our work, therapists educate families through use of the *Foster and Adoptive Parent Awareness Curriculum* and *Kinship Curriculum,* which was approved by Robert Ring (Director of DCF's Child Welfare Training Department) for 4-6 credits for foster parents. Therapists are also trained to clinically conduct good bye/closure visits following Termination of Parental Rights to promote best practice. A positive collaborative approach with the DCP&P caseworker is critical to facilitating positive relationships that impact the child and their understanding of the adoption process, and staff work to maintain open and informative communication to aid in this process. Recognizing adoption is a lifelong process, therapists address ongoing adoption issues and triggers and are available to clients via cell phone twenty four hours a day/seven days a week. Support groups and wraparound/respite support services are additional components that lead to positive outcome results.

	Monthly adoption support groups are available for families before, during and following in-home services. Groups meet monthly to discuss such topics as successful birth family communication, cultural identity and supporting development of healthy relationships. These groups also incorporate family outings of picnics and game nights to increase positive family interactions on a regular basis. Finally, wraparound/respite support is provided to link families to extracurricular activities and events to strengthen family bond and attachment and enhance the child's self-esteem. During this reporting period, children benefited from participation in activities such as summer and zoo camps, Girl Power groups, tutoring, gymnastics and attendance at a statewide adoption conference.
3d	**Identify significant barriers to goal accomplishment.** As children remain in the system for long periods of time, it remains challenging to address loss and trauma in a timely manner. Children lack a solid understanding of the reasons for placement and desire greater communication. Therapists are tasked with both supporting caseworkers and assisting in the telling of a child's story in a manner they can understand. Complex factors such as concurrent planning, appeal of TPR and delay of court hearings all create challenges for both children and pre-adoptive parents in feeling stable and require sensitivity and forthrightness in addressing by therapists. In an effort to address these systemic challenges, we work closely with caseworkers and adoption liaisons regarding communication of case goals and permanency and educate other professionals on how a lack of permanency impacts children's emotional well-being. Our adoption therapists attend meetings to advocate on behalf of the child's needs, prepare adoptive parents to effectively manage children's behaviors and increase empathy, and provide support during traumatic times (i.e., after a visit with birthparent or sibling, when TPR has occurred, after a closure visit). The Attachment Symptom Checklist, while very effective at identifying problematic and difficult behaviors for families is not always a reliable indicator of family stability as it does not factor in the parent's ability to manage and address identified behaviors. As such, outcome results are more indicative of attachment difficulties rather than a family's overall ability to succeed and remain stable. In addition to systemic issues, the need for services consistently exceeds our contracted level of service requirements. If appropriate, waiting families are referred to participate in the adoption support group and/or other Robins' Nest programs such as outpatient counseling, Resource Family Support or Children's Mobile Response and Stabilization to maintain stability while families wait for the specialized adoption counseling our program provides. Families are also linked to the New Jersey Adoption Resource Clearing House (NJ ARCH) and Foster and Adoptive Family Services (FAFS) for additional support.
3e	**Definition of Level of Service as per contract**:

	The level of service is based on hours of service for 40 unduplicated families. An hour of service includes face-to–face session time, travel time, telephone time with clients, collateral contacts/ linkages and case related paperwork.
3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14** Based on the DCP&P Contract, 37% is Title IV-B funded. 37% = 989.38 hours and 15 unduplicated families. On 7/1/14, the State merged all adoption and kinship programs and converted Level of Service to number of children.
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14** 957.15 hours (97%) and 15 families served. Note: After 7/1/14, new cases were assigned to and tracked in the merged PACS program rather than the Building Stronger Adoptive Families program, so this did impact the reported level of service.
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals:** 25 **# of unduplicated families:** 15
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** 100% (29 of 29) of clients surveyed (through random phone surveys and self-administered mail survey) reported being satisfied or very satisfied with services and staff. No referral source surveys were returned during this reporting period.
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program** As the need for this specialized service is great and our contract cannot promptly address the needs of adoptive families in our community, we continue to explore ways to expand our services so that we may have an even greater impact on children's well-being and permanency. Local DCP&P offices have expressed the need for contract expansion to meet the growing needs of adoptive families. We continue to work with Adoption Office Liaisons, local office staff and our contract administrator to explore ways in which we can accommodate this consistent and growing need. In our efforts to provide a comprehensive trauma informed treatment approach, our clinicians have developed a trauma curriculum for parents which will be implemented in the Spring of 2015. This curriculum is based on materials from the National Child Traumatic Stress Network (NCTSN). Increasing parents' awareness and understanding of the physical, emotional, and developmental impact complex trauma has on children will better equip them to effectively empathize, support and interact with their children, and in turn, help them heal.

	Finally, due to the program mergers done by the State, our various adoption and kinship programs have been merged into one Pre and Post Adoption and Kinship Counseling Services (PACS). As such, our Level of Service is now being tracked by number of children served, no longer by hours or families.
4b	**Identify changes you will make that stem from stakeholder feedback.** It was the feedback from our families on their lack of understanding of the impact of a child's history on their ability to thrive in a placement setting that drove us to research, develop and implement the Trauma Curriculum, which was adapted from the National Child Traumatic Stress Network's *Caring for Children Who Have Experienced Trauma.* We will continue to listen and respond to the feedback from our funders and clients to effectively serve them.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** As three programs merged in to one, the percentage of this contract that is Title IV-B has decreased. 16.16% is Title IV-B funded, therefore 22 children is the unit of service we expect to deliver.
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals:** 22 **# of unduplicated families:** 14
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** The program uses pre and post measurement tools such as the Attachment Symptom Checklist and the Child Well Being Scale. In addition to these pre and post scales, therapists assess case disposition and progress made towards goals. Follow up phone calls with the families at three and six months post treatment allows us to assess stabilization of the family unit. In addition, mail, phone and referral source surveys provide additional subjective feedback on the provision of our services. In addition, as part of the new trauma initiative, to effectively measure each parent's understanding and behavioral change, we have created a pre-/post-assessment tool to measure the parent's understanding of trauma. This tool is being utilized prior to review of the curriculum, immediately following the review of the curriculum, and again at the close of services to measure retention of the information provided. As most other tools measure child behaviors, this tool will afford us the opportunity to assess the parent's impact on the child's success in the home.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** The agency randomly conducts client satisfaction phone interviews during the intervention. Obtaining feedback on services and staff gives the agency an opportunity to improve customer satisfaction and services while the case is still active. All clients also receive, at

	closing, a self-administered mail survey giving clients another opportunity to provide feedback. This includes questions specific to participation in the teen adoption support group to obtain feedback about its effectiveness. A referral source survey is emailed to the referent, giving them the opportunity to assess service quality and to offer input for program improvement. The agency is accredited by the Council on Accreditation for Children and Families through 2016. Adhering to best practice COA standards and incorporating feedback from our PAC liaison and annual DCP&P monitoring reviews, helps us to maintain our quality provision of service.
5c	**How do you collaborate with community partners?** Partnering with our community providers is an essential component to providing quality services. Program director and program supervisor participate in the Post Adoption Counseling Providers meetings, Adoption Services Advisory Committee and trainings, presents the program and promote the support group component to DCP&P resource fairs, DCP&P staff meetings, DCP&P new employee trainings, foster parent meetings and PRIDE trainings as well as participates in Family Court Adoption Resource events and other community resource events. In addition, program director and supervisor participate in regular meetings with Local Office staff to discuss specific cases, address services needed and identify ways in which various supports can help the child succeed. When given the opportunity, program director conducts adoption loss trainings as well as promotes the need for adoption counseling to DCP&P adoption workers and supervisors, Mobile Response, Traumatic Loss Coalitions, medical intern students and school personnel. Program director has consistent and frequent communication with adoption liaisons, Jill Carmody-Burns and Beth Ann Tarver, to ensure a close collaboration with the Division, exploring obstacles, case updates and the delivery of services. Program director, supervisor and therapists maintain ongoing phone and face to face contact with caseworkers, supervisors and RDS' to discuss concerns and progress.

2015 PSSF Update Report

	Section 1 – Identifying Information	
1a	**Provider**: Family & Children's Services	**1b Program Name:** Post Finalization Program
1c	**Relevant PSSF Program**: ___FPS, ___ FSS, ___TLFRS, __X_APSS	
1d	**Program Address**: 40 North Avenue Elizabeth NJ 07208	
1e	**Objective**: To provide counseling and support services to adoptive families. To strengthen attachment among family members and preserve the family unit. To provide support and counseling services to pre-adoptive and KLG families.	
1f	**Outcome(s) Addressed**: ____Safety __X__Permanency ____Well-Being	
	Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)	
2a	**Overview of Service**: Counseling and support services were provided to families on a weekly basis. The focus of counseling services was to facilitate adjustment to adoption finalization, strengthen parent/child attachment and provide psycho-education to all family members about the psychological issues relevant to the adoption experience. Support services include advocacy, linkage to adoption resources, linkage to community resources and respite.	
2b	**Population Served**: Services were provided to families of diverse ethnic backgrounds, religions, socioeconomic levels and cultures. Our client population included same-sex parents, single and two-parent families, multi-racial families and clients with chronic disabilities and medical challenges.	
2c	**Geographical Area of Services**: Families in this program reside in Union and Essex counties and Middlesex county.	
2d	**Referral Sources**: Clients entered the program via referral from DCPP, self-referral, intra-agency referral or via linkage from other social service/community agencies.	
	Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)	
	Provide a summary of program accomplishments on goals.	

3a	**Include data where available:** **Program Goal#1:** Stabilize the family unit to ensure permanency (adoption dissolution does not occur) **Projected Outcome:** 90% of families will remain intact (no dissolution). Outcome: Permanency was maintained for all (100%) of the children although one child who remained in the legal custody of her adoptive parents chose to return to live in her country of birth with adoptive relatives when she turned age 18 years of age. Goal #2: Ensure the safety of the child in the home. Outcome Projected: There will be no allegations of safety concerns such that DCPP must be contacted. Outcome: DCPP was contacted about one (4%) child/family. The investigation was initiated by DCPP. Per report, the child has remained in the home. Goal #3: Family counseling will facilitate the child's adjustment to the home over time, as measured by a decrease in problematic behaviors at home and in school or community, per parent's report or as indicated by referral to a higher level of care. Outcome: 3 (12%) children de-stabilized and entered residential treatment; two of whom had been in an RTC prior to receiving PACS services. All 3 stabilized and returned home. Goal#4: Parents' understanding of adoption issues (separation, loss etc.) will improve as measured by an increase in their recognition of the impact of adoption on their child. Outcome: Based on therapists' report, change in parental perception at close of services occurred for 100% of parents.
3b	**How did this improve outcomes for children and families?** These outcomes suggest that family participation in counseling, and psycho-education for parents, are key factors in strengthening attachment and ensuring permanency. Parental commitment to supporting the child emotionally was strengthened by their understanding of adoption issues. When parents actively engaged in the counseling process, their willingness to adapt their parenting style to the unique needs of the adopted child increased.
3c	**Identify specific factors that contributed to this improvement:** Factors such as flexible service availability, respite resources and continuity of care contribute to positive outcomes in this program. Children who received services from the pre-adoption stage through to adoption finalization were most often able to continue working with the same therapist. This enabled all family members to establish rapport and a level of comfort working with the same therapist. Our PACS therapists offer flexible service delivery, offering appointments Monday through Saturday and evenings. This enables us to accommodate parents' work schedules and allows children the opportunity to participate in after-school activities, yet still receive services. Families who used respite services enrolled their children in enrichment activities, camps

	and cultural events. These activities strengthened the child's self-image and improved their social skills, which improved their ability to relate to family members. Family respite activities (movies, parent-child activities) provided families with the opportunity to interact with each other in a positive context.
3d	**Identify significant barriers to goal accomplishment:** There were no significant barriers to goal accomplishment during this contract period.
3e	**Definition of Level of Service as per contract:** A unit of service in the Post Finalization Program is defined as (1) family seen once per week on average for six to nine months. Per contract the LOS is (13) families per month; 26 serviced per year. If continuation of services is indicated after 6 months the family is counted as an additional unit of service. During this contract period 25 families were seen for Post Finalization services. Note that per DCPP, as of 7/1/2014, contract was changed so as to maximize each agency's ability to meet the needs of these families. In this report, however, only Post Finalization families are counted.
3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14:** The contracted LOS is 26 families per contract year.
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14:** The actual LOS was 25 families.
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals: 57** **# of unduplicated families: 25**
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** At initial intake all clients are informed of the Agency's grievance procedure should they wish to report dissatisfaction with or concern about any aspect of service provision. The program supervisor responds to all concerns directly with the parent and confers with the Associate Executive Director in accordance with agency policy. No grievances were filed. Referral sources provided direct positive feedback about services to the program director and the Associate Executive Director. We have placed a suggestion box in the FACS waiting room so that clients can anonymously provide comments or suggestions about services. In addition, satisfaction surveys were sent to all agency clients. Surveys inquired about overall satisfaction as well as: perceived comfort when visiting the agency, convenience of appointment scheduling, whether they felt they were treated with respect, etc. While some clients (28%) returned the

	satisfaction survey, others spoke with the program supervisor by phone or sent short notes. Our clients expressed positive feedback about their level of comfort when at the agency. They expressed a high degree of satisfaction about their rapport with their therapist.
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.** Per DCPP, the PACS contract has been changed as of 7/2014. In order to improve each agency's ability to meet the needs of PACS families, the expected LOS has been merged for all three programs: KLG, PreAdopt and Post Finalization. We have noted that as more adoptions are finalized or as permanency plans are solidified, more families are requesting KLG or Post Finalization services. This contract change enables us to provide services to a greater number of adoptive/KLG families.
4b	**Identify changes you will make that stem from stakeholder feedback.** FACS continually works to maintain up-to-date information about resources available to clients on our website and in our newsletters.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** We expect to provide Post Finalization services to a minimum of 26 families during this contract period. This actual number is likely to be higher now that the three program LOS's have been combined per DCPP contract stipulation, as this means that we can see more adoptive families if the need arises.
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals**: 52 **# of unduplicated families:** 26
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** Progress will be measured as: 1) Permanence of placement for 90% children served in the program. 2) An increase in community awareness and utilization of the program as measured by an increase in the number of referrals from the community.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** FACS utilizes an internal Quality Assurance/Utilization Review system for review of client records. FACS therapists are licensed or certified as applicable by their respective

	professions. Therapists in this program receive training in the Adoption Certificate Program as sponsored by DCPP and Rutgers University. Consumer satisfaction will be measured via telephone follow-up at 3 and 6 months after termination of services, and via program review during service implementation. Clients are given the opportunity to provide suggestions about service delivery.
5c	**How do you collaborate with community partners?** We value collaboration with our community partners, as this enhances our ability to provide comprehensive, quality care to our clients. Our outreach worker participates in resource fairs, community meetings and adoption activities in order to advertise our availability to the community. We continue to work closely with DCPP and other agencies to identify the needs of families and provide an array of services (e.g. therapy, support services, respite). We also provide linkages to resources in the community. We schedule case conferences with DCPP on a regular basis to coordinate client care. Interagency referrals are provided for those clients who are referred to us but who reside too far away to consistently benefit from services.

2015 PSSF Update Report

Section 1 – Identifying Information		
1a	**Provider**: Twin Oaks Community Services	**1b Program Name:** • 10/1/13-6/30/14: ACT II • 7/1/14-9/30/14: Pre-Post Adopt/KLG Counseling (PACS)
1c	**Relevant PSSF Program**: ___FPS, ___ FSS, ___TLFRS, _X_APSS	
1d	**Program Address**: 175 Route 70 West, Unit 12 Medford, New Jersey 08055	
1e	**Objective**: Use of a strength-based and solution-focused multi-systemic model of services to improve permanency outcomes.	
1f	**Outcome(s) Addressed**: ____Safety _X_Permanency ____Well-Being	
Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)		
2a	**Overview of Services**: During this reporting period, there were two distinctly different contracts in effect. From 10/1/13-6/30/14, contracted services reported on the PSSF report were under the program name "ACT II" (Adoption Commitment Team). It was a home-based post-adoption program, which originally was designed to last four months. If a crisis situation continued, however, and there still was a risk of disruption, services extended to a longer period of time. Historically, services were extended for an average of 6 to 12 months. Each family was seen a minimum of one time per week for a minimum duration of one hour; critical situations sometimes required more frequent or more lengthy sessions. From 7/1/14-9/30/14, contracted services were under the program name "PACS" (Pre-Post Adopt/KLG Counseling). This is also a home-based program, which includes pre-adoption, pre-KLG, post-adoption and post-KLG services. Although the duration of services is not clearly defined in the contract, in practice the duration typically falls within the 6 to 12 month range. Adoption-specific services focus on grief and loss, and the significant trauma many foster and adoptive children experience. The underlying belief is that adoptive placements will stabilize as the children and the families resolve complex issues and move towards bonding and attachment. The PACS contract more specifically defines required services to include therapeutic assistance and support, life book work, parent education, respite services, educational support, advocacy services and follow-up contacts. Each of the therapists working in both ACT II and PACS completes the Adoption Certificate program offered through Rutgers University in New Brunswick. The goals of both programs are to stabilize the family; to finalize adoption and KLG; to prevent the dissolution of an adoption; to maintain stability post-discharge; and for consumers to be deemed "goals achieved" at discharge.	
2b	**Population Served**: The target population in the ACT II contract was families who had finalized an adoption and lived in one of six counties in Southern New Jersey (see 2c).	

	There had to be a demonstrated need for therapeutic services and the adoptee who was the focus of treatment was under 21 years of age or younger. In the PACS contract, the additional target population is children whose permanency plan is adoption, who are either placed in a home with the goal of adoption or for whom DCP&P is seeking a permanent adoptive placement.

2c	**Geographical Area of Services**: For Pre-Adoption, Pre-KLG, and Post-Adoption: Atlantic, Burlington, Camden, Cumberland, Gloucester and Salem counties in New Jersey. For Post-KLG: Burlington County only.
2d	**Referral Sources**: For ACT II: Referrals can be sent by the DCP&P Caseworker in the local office in which the child's adoption or KLG was finalized. The local DCP&P RDS can be the link for a family to locate these services. The majority of referrals are from families who self-refer directly to the Program Supervisor. The families get information about the program from a variety of sources, including therapists who specialize in adoption, through NJ Arch or from other families who previously received our services. Some families have self-referred more than once, if a crisis evolves or re-occurs. For PACS: Pre-adoption and pre-KLG referrals are sent by the assigned Caseworker. Referrals can come from any DCP&P office in the State of New Jersey, as long as the child is placed within the geographical area served (2c).
Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)	
3a	**Provide a summary of program accomplishments on goals. Include data where available:** *ACT II (10/1/13 – 6/30/14):* • Performance Outcome: 75% of families at the time of discharge have their adopted child living with them and have no imminent plans for dissolution. 86%. For this reporting period, 7 consumers (5 families) were discharged. 6 consumers remained with their adoptive family and there were no plans for dissolution. • Performance Outcome: At six-month post-discharge, 75% of the families will have their adopted child living in their home and have no imminent plans for dissolution or residential care. 100%. For this reporting period, 5 families provided 6-month follow-up data. All of those families were stable. • Performance Outcome: 75% of consumers who complete our services and are discharged are deemed "goals achieved." 86%. From 10/1/13 through 6/30/12, 7 consumers were discharged from our program. 6 were deemed "goals achieved." *PACS (7/1/14-9/30/14):* • Performance Outcome: 80% of youth served will remain in their homes at time of discharge. 100%. For this reporting period, 12 consumers (12 families) were discharged. 12 consumers remained in their homes at time of discharge. • Performance Outcome: At six-month post-termination of services, at least 80% of the consumers served will have a finalized adoption or be in a permanent placement (i.e. pre- or post-adoptive home or KLG home). 100%. For this reporting period, families provided 6-month follow-up data for 6 children. All of those consumers were stable in their placement. • Performance Outcome: At least 75% of total clients who complete services in the program during the contract period will be deemed "goals achieved." 100%. From 7/1/14 through 9/30/14, 12 consumers were discharged from our program.

	12 were deemed "goals achieved."
3b	**How did this improve outcomes for children and families?** Data measured on all Performance Outcomes indicate that program services were successful in stabilizing many families. As the above data indicates, there were significant degrees of impact resulting from our services, with an average of 95% of families intact and not considering out-of-home placement at discharge. 100% of families remained intact at 6-months post-discharge.

3c	**Identify specific factors that contributed to this improvement:** The emphasis is to ensure that services for the consumer are not presented in an isolative fashion. Therapists recognize that therapy must be inclusive and family-centered to be successful. Therapists provide a high intensity of services, conducting many sessions that are two to four hours in duration. They also focus on providing services in a collaborative fashion with representatives of other agencies, school personnel, mental health practitioners, etc. who are also involved in the lives of the consumer(s) and family. Since we are home-based, we are able to reach more families, regardless of transportation issues of the family. Therapists are available by cell phone 24 hours per day, 7 days per week and parties can speak to the Program Supervisor, if needed, at any time. Since our therapists are professionally trained specifically in adoption issues, their interventions are very directed and focused on the most essential issues that could pose a risk to permanency. Because of their collaborative experience, therapists are able to share available resources within the community, to extend success beyond the services we offer. Our staff members also plan events that bring multiple families and children together, to demonstrate the value of and encourage families to do fun activities with their children. During this period, we hosted one Family Bowling Parties and one Youth Skating Party. All who participated, in addition to having fun, expressed that they found it very helpful and supportive to get to know other families experiencing common challenges.
3d	**Identify significant barriers to goal accomplishment:** The greatest barriers to accomplishing the goals of the programs are: 1. Lengthy wait lists – While waiting for services, some families make a decision to ask for their foster or adoptive child's removal from their home. Some consumers experience extreme distress and require other interventions (i.e. crisis screening, CMO) and other services are put in place. Fortunately, some cases have been stabilized when Twin Oaks Community Services is able to offer support through the Foster Home Support Program while the consumer/family waits for adoption-specific services. 2. Referrals while consumers are still in Permanency. This is a major contributor to lengthy wait lists. Therapists begin to work with consumers prior to the termination of parental rights. With lengthy court appeals, cases can remain "in limbo" for long periods of time. During that time, the therapists establish a trusting and productive therapeutic relationship with the consumers. However, they are restricted from working directly on adoption issues, while the consumer continues to visit with biological family members. 3. Changes in status of case. Often, when therapists plan to discharge a case, to create an opening, there are major changes in terms of TPR and/or the consumer moves to a different home. During these difficult times of transition, it is clinically unsound to discharge the consumer or assign them to a different therapist. Often, the therapist is the only "constant" in a consumer's life.
3e	**Definition of Level of Service as per contract:** *ACT II (10/1/13-6/30/14):* One Unit Equals One Hour Face-To-Face Individual and Family Services, one-half of Travel Time and All Activities That Involve Consultation and Collaboration with DCP&P

	Personnel, Representatives of Other Agencies, School Personnel, Mental Health Practitioners, Etc. *PACS (7/1/14-9/30/14):* Contracted units of service are defined as the number of children in adoptive or relative care placements who are served by the program. A separate case is opened for each child in placement. Siblings that are placed together are counted as separate cases.

3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14:** *ACT II (10/1/13-6/30/14):* Contracted LOS is 1,088 units of service (1,450 per year, divided by 12 months, multiplied by 9 months). *PACS (7/1/14-9/30/14):* Contracted LOS is 29 consumers (115 per year, divided by 12 months, multiplied by 3 months).
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14:** *ACT II (10/1/13-6/30/14):* In this period, ACT II provided 1,058.75 units of service (97% of contracted LOS). *PACS (7/1/14-9/30/14):* In this period, PACS provided services to 65 consumers.
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. *ACT II (10/1/13-6/30/14):* **# of unduplicated individuals:** 21 **# of unduplicated families:** 6 *PACS (7/1/14-9/30/14):* **# of unduplicated individuals:** 65 **# of unduplicated families:** 54
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** To ensure accurate outcome data, we give all families satisfaction surveys at various points throughout treatment. These surveys measure satisfaction with program services and with the assigned therapist. The Program Supervisor supports satisfaction through periodically accompanying therapists to conduct topic-specific family meetings and meetings including other providers. He or she also speaks via telephone with the families served, to elicit feedback on services and suggestions for program improvement. The Program Supervisor calls the families six months post-discharge to assess if services were satisfactory, in terms of whether stability was maintained. During the period 10/1/13 through 9/30/14, 13 families and 18 children returned Satisfaction Surveys. The 31 Satisfaction Surveys all indicated overall satisfaction with the PACS program. The following families provided feedback at 6-months post-discharge. *ACT II (10/1/13-6/30/14):* Five (5) families provided feedback at 6-months post-discharge. Five (5) of those families reported that their child was still living in the home and they had no plans for dissolution or placement in an out-of-home setting. *PACS (7/1/14-9/30/14):* Six (6) families provided feedback at 6-months post-discharge. Six (6) of those families reported that their child was still living in the home and they had no plans for dissolution or placement in an out-of-home setting.
Section 4 – The Year Ahead FFY ’16 (10/1/14 – 9/30/15)	

4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.** There are no planned changes to the program, since specific services are dictated by the contract for PACS.

4b	**Identify changes you will make that stem from stakeholder feedback.** No changes.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** 115 consumers
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals**: 115 **# of unduplicated families:** n/a (varies, based on specific referrals received)
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** Since we believe that the methodology we currently employ to measure outcomes historically has provided valid data, we will continue this model of evaluation.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** We measure three markers of outcomes: • Families at the time of discharge that have their adopted child living with them and have no imminent plans for residential or other out-of-home placement (goal 80%). • Families at six months post-discharge that have their adopted child living in their home and have no plans for dissolution or out-of-home placement (goal 80%); • Consumers who complete our services and are discharged are deemed "goals achieved" (goal 75%).
5c	**How do you collaborate with community partners?** It is the responsibility of the Program Supervisor, or an assigned alternate, to attend regularly scheduled statewide PACS meetings. The Program Supervisor visits local DCP&P offices and sends written materials to educate personnel on the services offered. If DCP&P is involved in a case, therapists and the Program Supervisor participate in any telephone or face-to-face meetings. Throughout the course of treatment, our therapists attend any other community meetings regarding their clients (i.e. Child Study Team/IEP meetings). They also provide written summaries of services to appropriate parties as required (i.e. DCP&P, PerformCare, Youth Case Management, treating psychiatrist).

2015 PSSF Update Report

<table>
<tr><th colspan="3">Section 1 – Identifying Information</th></tr>
<tr><td>1a</td><td>Provider: Catholic Charities of the Archdiocese of Newark</td><td>1b Program Name: Pre/Post-Adoption/Kinship Counseling</td></tr>
<tr><td></td><td colspan="2">Relevant PSSF Program: ___FPS, ___ FSS, ___TLFRS, ___APSS</td></tr>
<tr><td>1d</td><td colspan="2">Program Address: : 249 Virginia Ave, Jersey City, NJ 07304</td></tr>
<tr><td>1e</td><td colspan="2">Objective: The program strengthens families, promotes the well-being and permanency of children through home-based individual and family counseling, parenting support and skill building, and play therapy. This is supplemented by socialization groups and activities, concrete services, educational training, and summer programming in order to address issues of loss, family conflict, and parent-child issues. The program's focus is:
To prevent the dissolution of adoptions;
To prevent residential placement of adopted children;
To build and/or strengthen skills, family relationships and coping strategies to all members of the adoptive family where dissolution or disruption is a threat;
To strengthen skills, family relationships and coping strategies to all members of the adoptive family to address adoption related challenges and to improve the health and well-being of the family.</td></tr>
<tr><td>1f</td><td colspan="2">Outcome(s) Addressed: __X_ Safety ___X__ Permanency __X__ Well-Being</td></tr>
<tr><th colspan="3">Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)</th></tr>
<tr><td>2a</td><td colspan="2">Overview of Service: (describe): Since 1992, the Catholic Charities Family Resource Center (FRC) has had a contract with the Division of Youth and Family Services, now the Division of Child Protection and Permanency, to provide post adoption counseling services to Hudson County families. The program was developed in response to a dire need for supportive services for adoptive families with "special needs" children (children with emotional and behavioral problems, minority children, older children, and children with long foster care histories) in a variety of placement situations (foster homes, kinship care, and select adoptive families).

The Pre/Post-Adoption/Kinship counseling program offers services to special needs children and their families in their homes for periods of up to one year or longer (in select cases). Through supportive counseling and education, parents learn to understand and cope with the host of emotional and behavioral issues the child often brings into their adoptive family. Individual, family, and therapeutic group counseling assist the children in dealing</td></tr>
</table>

	with issues of separation, loss, and abandonment; histories of abuse and neglect; and resulting maladaptive behaviors. Parents gain support, information, skills and insights in ways to best meet the needs of their adopted child and to manage the various related issues that the whole family may be experiencing as an adoptive family. Pre/Post-Adoption/Kinship services provide counseling and support to families where kinship legal guardianship has occurred and there is a need to services and supports to stabilize and/or strengthen the family to insure that wellbeing for the children and family, and permanency, are maintained.
2b	**Population Served**: The program serves Hudson County Pre/Post-Adoption/Kinship counseling services provides services to "Families" population served can include the adoptive parents, grandparents, siblings, foster siblings, or other family members living in the household and kinship legal guardians.
2c	**Geographical Area of Services**: Hudson County
2d	**Referral Sources**: Division of Child Protection and Permanency, self-referred Hudson County families, school, churches and any other social service agency.
Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)	
3a	**Provide a summary of program accomplishments on goals.** **Include data where available:** We provided services to **48** families and we provided seventy-one **(71)** children with pre/post adoption services from October 1, 2013 to September 30, 2014. Twenty-nine **(29)** were pre adoptive, seventeen (**17**) were post adoptive, and two (2) were KLG families. A range of services were available to the families with services geared to the individual needs and goals of each child and family. During this reporting period, parents improved their understanding of core adoption and KLG issues and expanded their skills in key areas, as evidenced by: • Improved understanding of why their children displayed negative behaviors; • More realistic expectations of their children; • Improved understanding of how separation from biological parents plays a major role in children's behavior; • Increased understanding that a child's disruptive behavior is not only the child's problem; it affects the entire family. Once parents acknowledge that the impact is on the whole family, they became more involved and more supportive in the problem solving process; • Increased parental knowledge of medications, the potential side effects of

	medication on a child's behavior, and the importance of communicating this information to school officials. As a result, school behavioral issues decreased and children remained in the school system. • Adoptive parents improved their understanding of the importance of their child/children's continued relationship with biological parents. • Implementing new approaches to help their children cope with feelings of loss. They were also able to identify in what stage of the grieving process the children were in and how to help them process their losses. In our work with individual children and adolescents, measurable improvements were made, as evidenced by: • Improved self-esteem • Improved parent-child relationships • Improved behavior at home and at school • Improved ability to express feelings and process difficult emotions • Improved ability to connect and socialize with their peers • Improved ability to manage emotions resulting in a reduction of explosive outbursts and aggressive behavior.
3b	**How did this improve outcomes for children and families?** Catholic Charities Pre/Post Adoption/Kinship Counseling Services is one part of a larger program offering ancillary services of benefit to both parents and children. Some of the parent training and support, the healing arts activities, and the afterschool program groups provided additional support that complemented post adoption individual and family counseling. This expanded time with parents and children, and the opportunity to work through different modalities, allowed us to develop strong and trusting relationships with both parents and children, and provided additional insights and advantage in supporting change during the counseling process. Another service we have extended to Pre/Post Adoption teens is the Teen Enrichment Program Services. This program targets teens between ages 13-15 providing them with pre-vocational training and employment related training and support to help youth develop the knowledge, skills and habits that will prepare them for the world of work. Overall, the Teen Enrichment Program (TEP) serve approximately 20 teens yearly, placing them in local agencies and businesses who are willing to provide supervision and to train youth in the tasks and activities of the program or business they are working in. To the work site, they are like an intern, with the FRC paying a stipend for each hour "worked". This is a mutually beneficial arrangement –the assigned youth gets a "real" experience in a work environment with supervision and guidance both by the site and the TEP coordinator so that they will be successful. The worksite gets extra help and the chance to mentor youth interested in working and gaining new skills. The TEP also provides workshops, group activities and occasional outings to youth involved in the program to create a network of support for the teens, as well as to provide them with new experiences via "enrichment" activities.

3c	**Identify specific factors that contributed to this improvement:** Expanded use of supports to teens through involvement with the Teen Enrichment Program (TEP) has helped improve youth engagement and outcomes. Additionally, we have concentrated on making extra efforts to build our relationships with local offices to help us educate foster parents so as to have them become more engaged and participatory in sessions with the children placed with them. As a result of these better connections with foster parents, we were able to provide much needed education which helped expand their understanding of trauma and its correlation with the difficult and disruptive behaviors the children were showing in the home. This, in turn, allowed for a new look at what was happening with the children's behavior, and informed new strategies could be more effective in addressing difficult behaviors. The program is connected with an array of other services designed to work with children involved with DCP&P and this is an advantage because we are able to provide outreach, respite, after school program, and services for teens. The use of the formal measurement tools and scales to identify the degree of difficulty children and their parents had in key areas was useful. Clinicians had the opportunity to share their findings with family members and this helped parents to be committed to addressing key issues to improve their child's functioning and/or well-being. Successive administration of the indexes provided concrete evidence to parents and children that change was occurring and this provided motivation for additional change and/or for sustaining the positive changes made. Another factor that contributed to the accomplishment of goals was providing staff with training in areas solely related to adoption. Educating adopted parents in the area of attachment and asking them to participate in art expression activities was also helpful. Some of the families became involved in services with us originally in the pre-adoptive phase and the therapeutic alliance formed during that time led to a beneficial connection with the program during times of family need after the finalization of the adoption. Individualized goal setting and linkages to community resources were also important as parents felt supported in the things that were important to them. Parents appreciated learning new techniques to help them with their children disruptive behavior. Staff brought our "Active Parenting" materials to families as a tool to help them with parenting skills. They found this helpful because they were able to try other ways of disciplining their children and making a shift that concentrates on changing the behavior and not the child. Some parents appreciated creating a "life book" with their children and others liked being included in some of the "family fun" activities with their children.
3d	**Identify significant barriers to goal accomplishment:** One of the challenges we have encountered this past year is that children in the system are receiving a variety of services and as a result, parents feel overwhelmed with many services that children have to attend. Some of these services, because they are all concurrent, are conflicting with one another, creating stress and overload for the family, and the child. For example, in addition to a child's scheduled visitation sessions with parents, they may also have been referred/scheduled for mentoring sessions, mental health appointments, behavioral assistance, in home counseling - in addition to the FRC referral/services. While

	all these services are potentially useful, the sequencing of the services would provide a longer horizon of support to the child/family and could more appropriately meet the needs with fewer conflicts and less stress on the family. Foster parents have limited knowledge about children with trauma and many times mistake a child's attachment issue- and the behaviors that result- as willful behavior or as a personal attack against the foster parent. The experience of some of our foster parents is that they are frightened to be perceived as incompetent. Another situation we encountered often is that many children are placed in foster care and the family does not receive services until after the child starts presenting unmanageable behavior issues. Sometimes we find that services have been arranged for the family, but with professionals that have very little knowledge of adoption/attachment issue. We have observed that in such cases, the recommended interventions were not effective and as a result, the child's behavior was interpreted as unmanageable. If this has been the previous experience of the foster parent, then, when we are called in to work with the family, on many occasions a year later, we find that the foster parents belief level in the helpfulness of professionals very low or no longer there. Thus, skillful engagement and support is the precursor to getting to the significant challenges foster parents need help with but may be afraid to talk openly about.
3e	**Definition of Level of Service as per contract:** Each unit of service is defined as one "family".
3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14:** The contracted level of services for this reporting period was 37 families.
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14:** We provided services to 48 families and served 71 children.
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals:** 71 **# of unduplicated families**: 48
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** In October 2014, a total of 20 satisfaction surveys were mailed out to families receiving services during the reporting period of Oct 1, 2013 through September 30th 2014. Eight (8) surveys were returned to us by mail. Surveys responses are scored on a scale of "1" to "5" where "1" is "strongly disagree" and "5" is "strongly agree". A "5" indicates that, in the aggregate, families were very satisfied with program services. Our aggregated score from the surveys returned was a 4.55. Some included comments which were all very positive. For

	instance, one of the questions asks "how can our services be better?" To this, one of the parents commented that "they are the best and cannot get any better." Another commented was "the program is great!" In another section which allows for additional comments, one of the parents said that staff is "loving and caring".
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.** We plan to continue providing services as we are now; we will continue providing respite hours and healing arts where children will be engaged in therapeutic activities and skill building designed to improve self-expression, management of difficult feelings and create healthy and practical outlets for stress relief. Life book work will continue. The use of Pre and Post-test measures to track improvements in peer relationships and self-esteem, both relevant issues among children who have been adopted, will continue. Teen Enrichment services and expanding education and support to parents as implemented this year, will continue into the new year.
4b	**Identify changes you will make that stem from stakeholder feedback.** We are identifying needed community services and supports with our clients, based on their identified needs.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** 45 families and 80 children/teens
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals**: 77 **# of unduplicated families:** 40
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** The program uses a combination of methods currently, including pre and post-test measures for our support groups and after school programming; client progress is also assessed and measured by the tracking of goal attainment on each family's Plan of Care. The treatment team discusses the progress on identified client goals quarterly, or more regularly, as appropriate to the family's need and Care Plan. We are also using standardized measures to measure client and program progress. The tools include, but are not limited to: the Family Resource Scale, the Family Support Scale, the Parent-Child Relationship Inventory, the Inventory of Self-Esteem, the Peer Relations Scale Index.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** The agency has a formal continuous quality improvement committee comprised of the agency's Division Directors and the Executive Director. This PQI steering committee meets monthly and reviews program related data to monitor quality. This includes the review of client

	satisfaction survey data, focus group data, aggregated pre-and post-test measures of program performance, community stakeholder feedback including community partners, DCP&P workers and supervisors, and contract monitoring, performance improvement initiative activities and outcomes, and risk management issues. Feedback and recommendations are made by the committee back to the program through each Division Director for follow through in each program. The PQI steering committee receives follow-up reports on program improvements and follow-through on a schedule determined by the committee. The program sends out satisfaction surveys to all families served, every 6 months, to get feedback. We provide a stamped addressed envelope which comes back to the administrative office, not the program, and is aggregated and then reviewed at the program level. Families can respond anonymously to the standard questions and have space to write in their comments. Feedback from consumers, whether received through focus groups, formal satisfaction surveys, or informal feedback, is discussed and reviewed at the program, division and agency level. Whenever appropriate and feasible, feedback is integrated back into the program operations, in order to improve and/or enhance the program.
5c	**How do you collaborate with community partners?** The program has many community partners –these include local service providers that also serve the needs of families. We work closely with the school systems, local mental health providers and psychiatrists when involved, community faith based programs, local family courts, recreational and mentoring programs and concrete service providers (e.g. the Red Cross when one family lost their home due to a fire, the United Way to access emergency financial assistance etc.). We actively communicate and collaborate with any and all partners, with the family's permission, to insure comprehensive care rather than duplication, and coordinated care that provides a good base of support for the family. We also provide advocacy as needed and planning for ongoing support after leaving the program if appropriate.

2015 PSSF Update Report

	Section 1 – Identifying Information	
1a	**Provider**: Children's Aid and Family Services	**1b Program Name:** Kinship Legal Guardianship Services (KLG)
1c	**Relevant PSSF Program**: ___FPS, ___ FSS, ___TLFRS, __X_APSS	
1d	**Program Address**: (a) 76 South Orange Avenue Suite 209, South Orange NJ 07079 (b) 148 Prospect Street, Ridgewood, NJ 07450	
1e	**Objective**: To support and stabilize children and their families who have achieved Kinship Legal Guardianship through the Division of Child Protection and Permanency (DCP&P) through counseling, psycho-education and case management; to avoid disruption of the kinship care placement and assess needs of family to maintain stability; to conduct ongoing outreach to DCP&P offices regarding the service; to meet targeted level of service.	
1f	**Outcome(s) Addressed**: ____Safety ___X_Permanency ____Well-Being	
	Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)	
2a	**Overview of Service**: Six months (more is possible as appropriate) of in-home counseling is provided to stabilize children, previously under the care of DCP&P, and families who have finalized Kinship Legal Guardianship. Clinical modalities include, but are not limited to, family therapy, play therapy, lifebook work, and individual therapy. In addition, case management when appropriate involves thorough assessment of the family and child's overall needs, support, and direct advocacy to address educational needs. There are funds available to financially support out of home activities for children, giving respite time from active caregiving for families. Outreach activities increase awareness of the service in the community.	
2b	**Population Served**: Children age 18 and younger, and their families, who have achieved Kinship Legal Guardianship through DCP&P. Counseling may begin prior to finalization when KLG is anticipated to occur soon after referral. Caregivers must be amenable to receiving services.	
2c	**Geographical Area of Services**: The catchment area is Bergen, Passaic, and Essex Counties, excluding Newark	
2d	**Referral Sources**: Referrals are accepted from DCP&P caseworkers when KLG is imminent and the KLG caregivers after finalization. KinKonnect and other state/community based organizations can refer, but the caregiver must contact the coordinator to initiate.	
	Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)	
3a	**Provide a summary of program accomplishments on goals.** **Include data where available:** The coordinator for kinship counseling continued outreach to support referrals. Early in 2014, the state made the decision to collapse the contract for kinship legal guardianship	

	counseling services with the contract for pre and post adoption counseling. This change took effect July 1, 2014. Kinship families will continue to be addressed as service population, without a separate program and efforts toward referrals.
3b	**How did this improve outcomes for children and families?** All placements were supported and no child disrupted from their home. All therapeutic goals were met for the families who ended services during this time period. Parenting was supported, the meaning of kinship care was processed, and for one child the coordinator supported the family in achieving a more suitable, stabilizing educational setting for the child.
3c	**Identify specific factors that contributed to this improvement:** The clinicians' expertise regarding issues in kinship care, ongoing training, and utilization of supervision and consultation all contributed to positive family outcomes. The clinician possesses a wealth of experience and skill clinically, outside of kinship issues, and a keen ability to build relationships with both children and caregivers. Given the crisis state kinship caregivers/families often are experiencing, the person of the therapist and their ability to connect is key in family stabilization. The clinician provided information for all clinicians for the July programmatic change. Most clinicians have had extensive experience already with kinship adoptive placements, so the population and issues are familiar.
3d	**Identify significant barriers to goal accomplishment:** Increasing utilization of the program remained the greatest challenge for the program. All stakeholders recognized the area of need, but caregiver utilization remained low. Limitation of the services to families finalized through the Division eliminated a large pool of potential client families.
3e	**Definition of Level of Service as per contract:** Level of Service is defined by number of new, unduplicated cases seen in a year.
3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14:** The contracted Level of Service was 13 new, unduplicated cases per year; this level of service ended with the contract on 7/1/14.
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14:** Five new, unduplicated children were seen this year.
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals: 5** **# of unduplicated families: 5**
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** Feedback was solicited via three surveys (initial, discharge, and 6month post discharge) sent to all consumers of the PACS and KLG counseling programs. In total, 74 surveys were sent and 17 responses were received. All but one respondent agreed that the services they received were positive, helpful and productive for their families. They agreed they felt more comfortable and more informed relative to adoption and adoption concerns. There was little commentary even though surveys provided opportunity for open ended feedback. The one

	family who did not respond positively responded feeling "neutral" in all areas, but did not clarify with written feedback. Since surveys are anonymous, the ability to discern KLG client responses from PACS client responses was not possible.
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.** As of July 1, 2014, Kinship counseling was subsumed under the Pre/Post Adoption Counseling (PACS) program, as per the contract with the DCP&P. Kinship families served will be counted with adoptive families served. The contractual change will also allow for kinship stabilization services before finalization of the Kinship Legal Guardianship agreement.
4b	**Identify changes you will make that stem from stakeholder feedback.** The change is the result of consistent, statewide underutilization of the services, not as a result of stakeholder feedback.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** N/A
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals**: N/A **# of unduplicated families:** N/A
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** As Kinship Legal Guardianship families will continue to be seen under PACS, progress will continue to be measured by achievement of treatment plan goals, and outcomes from pre and post measures: Strengths and Difficulties Questionnaire; Attachment Symptom Checklist; and the Trauma Symptom Checklist for Children. Prevention of disruption and feedback through stakeholders' surveying will measure overall program performance.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** Surveying processes are continually being revised. Clients are given the opportunity for formal feedback following the creation of the first treatment plan and at discharge. Clients are offered access to the program director at any time for feedback about services, needs and areas for improvement. Clinicians will follow up with families at three and six months post discharge to gauge continued stabilization, ongoing need and satisfaction.
5c	**How do you collaborate with community partners?** Close collaboration with DCP&P offices and staff is ongoing. With family permission, the clinicians work collaboratively with any community providers, as appropriate, to enhance client treatment and success. The program director attends the monthly Children's Inter Agency Coordinating Council in Essex County to extend collaboration and enhance service provision.

2015 PSSF Update Report

Section 1 – Identifying Information		
1a	**Provider**: Children's Aid and Family Services	**1b Program Name:** Post Adoption Counseling Services
1c	**Relevant PSSF Program**: ___FPS, ___ FSS, ___TLFRS, _X_APSS	
1d	**Program Address**: (a)76 South Orange Avenue Suite 209, South Orange NJ 07079 (b) 148 Prospect Street, Ridgewood, NJ 07450	
1e	**Objective**: To stabilize or maintain stabilization of children who have been adopted; to reduce adoption disruptions/dissolution; to support children and families post-finalization; to provide counseling, support and psycho-education to this population.	
1f	**Outcome(s) Addressed**: ____Safety __X__Permanency ____Well-Being	

Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)	
2a	**Overview of Service**: The Post Adoption Counseling Program (PACS) provides services to stabilize adoptive and enable parents to meet the unique needs of children who have experienced abuse/neglect, removal from birth parents and adoption. Individual and family therapy and psycho-education are provided for children/families up to the age of 21. The service is available to children and their families who have finalized adoption regardless of age at adoption or whether adoption was through public or private sector. The length of service is flexible, and sessions are typically weekly and can be adjusted based on client needs. Goals are to strengthen family functioning, stabilize adoptive placements, and minimize the possibility of disruptions or dissolution. The program embodies a family-focused, strength-based methodology to provide therapy and supports with specialization in clinical issues related to adoption and foster care, including but not limited to: identity issues; loss and separation; attachment issues; trauma/abuse/neglect; and multiple placements. In addition to counseling, support is provided through reimbursement for respite activities and support groups. To support post-adoption counseling goals, families can seek reimbursement to offset costs for children's out of home activities. The respite funding supports children's participation in meaningful pursuits and time for parents' renewal from the challenges of parenting. Pre-teen and teen adoption support groups provide children ages nine to seventeen the opportunity to meet other adopted children and engage in group discussions and adoption related activities. Groups are held on a monthly basis, with breaks between group cycles to allow for continuation and introduction of new group members.
2b	**Population Served**:

	Children up to age 21, and their family, to support stabilization, preserve adoption, and process adoption related concerns to increase family bond.
2c	**Geographical Area of Services**: Catchment areas are Bergen, Passaic and Essex Counties, plus the portion of Union County that borders Newark. Services are provided at our offices in South Orange and Ridgewood, and may be provided in home when needed and appropriate.
2d	**Referral Sources**: Referrals are made by the parent(s) in families that reside within the catchment areas described. All referrals are made to the program director located in the South Orange office.
	Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)
3a	**Provide a summary of program accomplishments on goals.** **Include data where available:** The teen support groups continued expansion, with the start of a group in the South Orange office. Twenty-six children participated in the three groups; seven in Essex County, ten in the Bergen pre-teen and nine in the Bergen teen groups. There were no adoption dissolutions in families receiving services during the year of review. Of the cases that were discharged during the period of review, approximately 86% (19) achieved all or some goals. The other 14% (3) were seen for 3 or less sessions and did not develop treatment goals. Thirty thousand dollars in respite funds were paid out to support out of home activities and summer camp; the greatest majority of funds supported summer camp. Many families reported that they would not have been able to pay for the activities for their children without the support of the funds. All felt that their children's and family's stability goal achievement was enhanced by the respite activities.
3b	**How did this improve outcomes for children and families?** Adoption informed counseling and information, with added support from respite and support groups, increased healthy parent-child interaction patterns and overall stability, thus avoiding disruption/dissolution. Improved individual functioning and increased positive discourse regarding adoption carried forward post discharge. Follow-up post discharge reflected enduring family stability.
3c	**Identify specific factors that contributed to this improvement:** All clinical staff members current with the program have completed the Certificate in Adoption through the Rutgers Continuing Education program. Longevity and commitment of clinicians to the work contributes, as stable clinical relationships serve as support for the same within families. Weekly team meetings, including monthly consultation with a clinical psychologist who has been with the program for over ten years, as well as individual supervision, support effective therapeutic intervention. The continuing availability of respite funds for distribution provides valued and at times crucial opportunities for positive activities that support and strengthen parent/child relationships.
3d	**Identify significant barriers to goal accomplishment:** Post adoption counseling continues to be utilized much less frequently in Essex County when compared especially to Bergen County. Outreach to community groups, individuals, service providers and coordination with staff at the Division of Child Protection and Permanency (DCP&P) offices is continual, and has historically not yielded an increase in referrals. Contact with other service providers in Essex revealed similar challenges in service utilization. An increase over last year's utilization was seen, but was still far less that Northern region program use.
3e	**Definition of Level of Service as per contract:** Until July 1, 2014 a unit of service was equal to an hour of therapeutic service utilized by the

	child/family. For cases families seen in home or out of office, travel time was also counted toward service. The level of service is defined was 80% of the contracted total units of service provided per month. Following contract revisions that took effect July 1st, the level of service is defined by number of new, unduplicated children seen in a year.
3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14:** Northern Post: 831.6 hours annual (69.3 hours per month) Essex Post: 1248 hours annual (104 hours per month) With the contract change to unduplicated clients served, the number served per year is one flat number for both pre and post adoption services. The total contracted level of service is 145 new, unduplicated children served annual, without designation for pre or post.
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14:** Northern Post: 942.28 hours for a full year time period Essex Post: 586.8 hours calculated for the full year with initial LOS
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals: 45** **# of unduplicated families: 53**
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** Feedback was solicited via three surveys (initial, discharge, and 6month post discharge) sent to all consumers of the PACS and KLG counseling programs. In total, 74 surveys were sent and 17 responses were received. All but one respondent agreed that the services they received were positive, helpful and productive for their families. They agreed they felt more comfortable and more informed relative to adoption and adoption concerns. There was little commentary even though surveys provided opportunity for open ended feedback. The one family who did not respond positively responded feeling "neutral" in all areas, but did not clarify with written feedback.
Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.** Effective July 1, 2014 the Division of Child Protection and Permanency made changes to the Post Adoption Counseling contract to achieve consistency across programs statewide. Clinical goals and objectives for the service remained the same, with increased clarity in the language of the document. The defined level of service changed from hours of service to unduplicated individuals (children) served, and the age limit for eligible children increased

	from 18 to 21. In addition, Kinship Legal Guardianship counseling will no longer be a separate contract, and those services will be provided as part of the PACS contract.
4b	**Identify changes you will make that stem from stakeholder feedback.** Stakeholder feedback was wholly positive and no areas for improvement or change were identified. There are no targeted program changes at this time.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** We anticipate that a minimum of 25% of the 145 clients for the contracted level of service will be post adoption or post Kinship Legal Guardianship, or 37 children.
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals**: 37 **# of unduplicated families:** 30
Section 5 – Evaluating Progress FFY '16 (10/1/14 – 9/30/15)	
5a	**How will you measure progress?** We will continue to utilize treatment plans and discharge to measure clinical progress. The program also will use the Strengths and Difficulties Questionnaire, the Attachment Symptom Checklist and the Trauma Symptom checklist to support goal development and measurement of progress. An additional instrument will be used if the Trauma Symptom checklist indicates the possibility of a Post-Traumatic Stress Disorder. We will continue to measure programmatic progress through the surveys described below to assess client satisfaction and needs.
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** Clients will be given the opportunity to evaluate the program in an initial survey and a survey at the end of treatment. Clinicians will follow up with families at three months and six months post discharge to gauge continued stabilization, ongoing need and satisfaction with services. Clients are offered access to the program director at any time for feedback about services, needs and areas for improvement.
5c	**How do you collaborate with community partners?** Close collaboration with DCP&P offices and staff is ongoing to support long term stabilization of their families. With family permission, clinicians work collaboratively with any community providers as appropriate to enhance client treatment and success. The program director attends the monthly Children's Inter Agency Coordinating Council (CIACC) in Essex County to extend collaboration and enhance service provision. Directors in other segments of the agency attend CIACC meetings in Bergen County.

2015 PSSF Update Report

Note: Provide all information requested. Retain 12 pt Times Roman font and 1-inch margins.

Section 1 – Identifying Information

1a) Provider: Children's Aid and Family Services, Inc.

1b) Program Name: Kinship Legal Guardianship Resource Clearing House (KinKonnect)

1c) Relevant PSSF Program (check one):

_____Family Preservation Services ___x__Adoption Promotion and Support Services

_____Family Support Services _____Time Limited Family Reunification Services

1d) Program Address: 76 South Orange Avenue, Suite 209, South Orange, NJ 07079

1e) Program Objective(s) (purpose of service):

The objective of the Kinship Legal Guardianship Resource Clearing House (KinKonnect) is to provide information and resources for those touched by Kinship Care in New Jersey. The program objective is to assist in meeting the needs of kinship care families, whether through Department of Child Protection and Permanency (DCP&) or privately through the courts. The program provides information and resources for Kinship families by offering a web site, www.kinkonnect.org, phone and e-mail warm line, free lending library as well as training for Kinship Legal Guardian (KLG) families and support groups around the state.

1f) Outcomes Addressed (check all that apply)**:**

_____Safety ___x__Permanency _____Well-Being

Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)

2a) Overview of Service(s) (describe):
The Kinship Legal Guardianship Resource Clearing House (KinKonnect) is an information center for Kinship families in NJ. KinKonnect provides resources, support and education through the web site, www.kinkonnect.org, phone and warm line e-mail support as well as training workshops. The program also includes a free lending library focusing on Kinship Care with over 275 books, articles and videos available for the public to borrow. In addition, there are

4,293 books, articles and videos available from the NJ Adoption Resource Clearing House (NJ ARCH) free lending library.

2b) Population Served (describe): All members of touched by Kinship Care and the professionals who work with them.

2c) Geographic Area of Service (what areas are covered)**:** State of NJ

2d) Referral Sources (from whom you accept referrals):
We serve as resource to the Kinship Navigator program, Department to Children and Families, DCP&P Kinship Legal Guardianship (KLG) Subsidy unit, KLG support groups around the state, Foster and Adoptive Family Services (FAFS) for those involved with Kinship Care, Advocates for Children of NJ (ACNJ), Family Support Organizations (FSO's), community supports, mental health professionals, various KLG related-related conferences or events, additional resources when appropriate as well as anyone interested or have questions or request information and/or resources about Kinship Care.

Section 3 – The Year in Review FFY '15 (10/1/13 – 9/30/14)

3a) Provide a summary of the program accomplishments and goals. Use data to support your comments.

- The KinKonnect program officially launched its program and website www.kinkonnect.org in March, 2008. The website consists of over 615 web pages of information and resource material, which is an increase of 6% from last year's number of 589 web pages. This website has been a major success increasing from the Level of Service (LOS) hits to the website of 2,000 per month to an average of 4,909 per month during the 2013 and 2014 time period which is 245% over the anticipated Level of Service.

- KinKonnect created two training workshops that were offered to Kinship audiences such as Grandma KARES in Essex County, Grandparents Raising Grandchildren monthly support group sponsored by the Family Support Organizations of Bergen County and Morris and Sussex Counties, as well as the Grandparents Forum held in Newark, sponsored by Programs for Parents, Inc. During this time period 2 training workshops were presented to various organizations that included 125 participants.

- There are numerous resource fact sheets available that may be requested and/or downloaded from the KinKonnect website. The free lending library has more than 225 books, articles and videos related to Kinship Care for the consumer or professional to review or borrow. In addition, the Kinship Care consumer has approximately 4,293 books, articles and videos available to them through the NJ Adoption Resource Clearing House (NJ ARCH) free lending library located at the same location.

- The Fall 2013 and Spring 2014 issues of the "NJ Kinship Connections" newsletters were created and distributed during this period. To date, we have over 400 contacts who have requested the KinKonnect newsletter in paper form and another 450 requesting it via e-mail. All newsletters can be found on the www.kinkonnect.org website. Consumer feedback to the "NJ Kinship Connections" newsletters has been positive.

  3b) How did this improve outcomes for children and families? (indicate benefit/impact and be certain to relate these to the identified Division of Child Protection and Permanency (DCP&P) Performance Based Outcomes.

- The high number of hits to our website implies that Kinship Care families and children are benefiting from this information and service.

- With the resource fact sheets and KLG related resources to various community supports (Kinship Navigator, Kinship related support groups, DCP&P KLG Subsidy, etc.), New Jersey Kinship families are receiving additional support and resources.

3c) Identify specific factors that contributed to the improvements/accomplishments.
During this time period, the KinKonnect web hits have continually been higher than anticipated, with an average of 4,909 hits per month compared to the 250 hits per month originally anticipated. Although the KinKonnect web hits are high, the warm line calls and e-mails are lower than anticipated. We attribute this trend to consumers using the website for information vs. contacting the warm line directly. Due to this ongoing trend, the Division increased the website hits Level of Service (LOS) from 3,000 to 24,000 per year, but lowered warm line phone calls LOS from 504 to 240 and warm line e-mail LOS from 120 to 60 per year. The program has made great strides in working with various Kinship related support groups in the state, specifically Grandma KARES located in Essex County and Grandparents Raising Grandchildren sponsored by the Bergen County Family Support Organization as well as the Family Service Organization in Morris and Sussex Counties and Programs for Parents that holds a yearly conference in Newark NJ for Grandparents Raising Grandchildren. Numerous outreach presentations have taken place to help spread the word of KinKonnect and KLG Counseling services in the state.

3d) Identify significant barriers to goal accomplishment and how you addressed them.
The warm line e-mails and calls continue to be lower than the anticipated LOS, however the hits to the website are much higher than anticipated as we believe that consumers tend to find resource information on the website than contact the warm line for information.

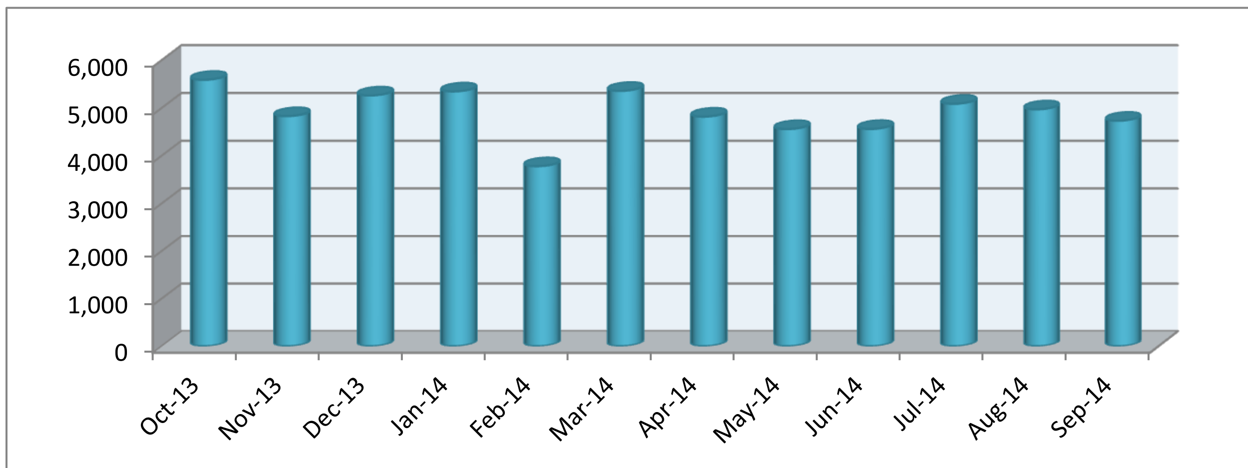
3e) Define a Unit of Service as per contract: (If more than one, include each)
A unit of service is defined as one website hit, one warm line call, one warm line e-mail, one service to a support group and one training workshop.

3f) Enter your <u>contracted</u> Level of Service portion (# of units expected) **that were Title IV-B funded for the period 10/1/13 -9/30/14.**
Per Year: 24,000 website hits, 240 Warm line Contacts, 60 e-mails, one (1) Service to Support Groups, two (2) Training Workshops per year.

3g) Enter your <u>actual</u> Level of Service (# of units delivered) **that were Title IV-B funded for the period 10/1/13 – 9/30/14.**

Website Hits for time period: <u>58,902</u>
Warm Line contacts for time period: <u>114 (phone calls)</u>
E-mails per time period: <u>10</u>
Services to support groups: <u>1</u>
Training Workshops for time period: <u>2</u>

The website hits are indicated in graphic form below.



Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
5,590	4,830	5,263	5,347	3,781	5,359	4,819	4,558	4,561	5,088	4,972	4,734

3h) How many unduplicated individuals and unduplicated families were served for this period? (Each individual and family who received services during the reporting period should be counted only once.)
___249___**# of unduplicated individuals**_______**# of unduplicated families**
<u>Unable to differentiate between individual and families due to medium of service provided.</u>

The above number is based on the following:
During this period, we received 124 unduplicated contacts to the warm lines: 114 via phone and 10 via e-mail that were indicated as unduplicated. In addition, 125 who attended the KinKonnect workshops indicated that they were unduplicated as they had not attended a KinKonnect

workshop, received services and/or were new to the KLG community, **totaling 249.** We are unable to differentiate between individual and families, due to the medium of service provided.

3i) Provide stakeholder feedback information, e.g. satisfaction surveys, referral source information. (Include the number of surveys sent, responses received and the results.)
The KinKonnect warm line contact form includes a question whether the contact with the KinKonnect Warm Line had increased the consumer's knowledge of some aspect of Kinship Care/ Kinship Legal Guardianship. Out of the 124 phone/e-mail warm lines received during the time period of **10/1/13 – 9/30/14,** 93% stated that their knowledge was increased, 3% stated that it was Somewhat Increased, 0% responded that it was Not Increased, and 4% stated that they were Unsure.

There were two (2) training workshops presented during this time period and out of the 125 who attended the training sessions, the 53 who responded via the training evaluations 93% stated that they were either Very Satisfied or Satisfied with the training workshop.

Warm Line Telephone Survey to the Question:
Out of the 114 phone Warm Line contact forms, 79 were asked the following question:
"Did your contact with the KinKonnect Warm Line increase your knowledge of some aspect of Kinship Care/ Kinship Legal Guardianship?"

Yes	Somewhat	No	Unsure	Total
93%	3%	0%	4%	100% out of 100% of surveys

Training Evaluation Survey: Out of the 53 training surveys distributed, 53 responded and below are the results from that survey**:**

Very Satisfied	Satisfied	Neutral	Dissatisfied	Total
88%	9%	3%	0%	100% of out 100% of surveys

Out of the total 132 above (79 from Warm Lines and 53 from Training Evaluation Surveys) <u>returned</u> surveys from the above categories reviewed during the **10/1/13 to 9/30/14** time period, <u>96</u>% were either **Very Satisfied or Satisfied** with the service, <u>4</u>% were **Neutral or Unsure** and <u>0</u>% were **Dissatisfied** with services; there were no Strongly Dissatisfied with services. The feedback that was noted as" dissatisfied" were reviewed by Program Assistant Director in collaboration with the Program Director to evaluate any correction needed on our part.

<u>Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)</u>

4a) Identify any changes you are making to the services described in Section 2 and why.
(This may include projected goals and objectives identified by vendors for their programs. Indicate if there are no planned changes to the program.)
We will continue to maintain, update and enhance the KinKonnect website. We have translated approximately 20 KinKonnect web pages into Spanish and about 10 web pages include the Microsoft "Language Translator" option. During this next period we will continue to add Spanish pages as well as add Language Translator to many pages on the KinKonnect website, allowing consumers to choose most any language to translate the information displayed.

4b) Identify changes you will make that stem from stakeholder feedback.
We will continue to ask the consumer via phone warm line contacts if our services increased their knowledge of some aspect of Kinship Care/ KLG. We receive little stakeholder feedback via e-mail or Lending Library surveys; however we will continue to enhance and increase the number of resources available for Kinship Families.

4c) How many Units of Service are you expecting to deliver with IV-B funding for the period 10/1/14 – 9/30/15?
In late 2012, our program requested and it was approved by the State Division of Child Protection and Permanency (DCP&P) to change the current Level of Service to the following: 24,000 website hits, 240 Warm line Contacts, 60 e-mails, 1 Services to Support Groups, 2 Training Workshops. These new Level of Service (LOS) reflects an increase to the web hits per year, from 3,000 to 24,000 per year. However due to the continued low number for the warm line calls and e-mails we were approved to lower the yearly LOS for warm line calls from 504 to 240 yearly. We were also approved to lower the warm line e-mails from 120 to 60 per year. This reduction was due to the continued increase of web hits but consistently low numbers for warm line calls and e-mails. We attribute these low numbers to consumers researching their questions on the website verses contacting the warm line representative. In addition we have found that the questions that come into the Warm Line have been more difficult /complex in its research, therefore taking additional time to resolve.

4d) Indicate how many unduplicated individuals and unduplicated families you expect to serve.
___200____ **of unduplicated individuals** _______**# of unduplicated families**
<u>Unable to differentiate between individual and families due to medium of service provided.</u>
As more and more people call us back on our warm line, the number of unduplicated families will most likely decrease, since consumers are either taking our training workshops and/or calling our warm line more than once (as indicated on our warm line form asking if they have contacted KinKonnect before.

Section 5 – Evaluating Progress FFY'16 (10/1/14 – 9/30/15)

5a) How will you measure progress? (note methods)
By collecting data via 1and1.com web hosting report (via web host company) to track the number of web site hits, the number and quality of Customer Satisfaction Surveys from the phone and e-mail warm lines, Lending Library Satisfaction Surveys, Training Workshop Evaluations, consumer reports and comments of those who utilize our services.

5b) Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.
By sending out Needs Assessments to new consumers and Satisfaction Surveys to identified users of KinKonnect. Returned Satisfaction Surveys will be reviewed by the program Assistant Director and data is entered into the Statistical Database, SPSS maintained by the Program Evaluator. Satisfaction Surveys that are marked lower than satisfactory are followed up individually by the Program Assistant Director and Program Administrator. Once the cause of dissatisfaction is determined, the Assistant Director will meet with the staff to discuss the issue and develop improved methods of handling the particular issue.

5c) Describe how you collaborate with community partners.
We work collaboratively with the follow community partners:

- Kinship Navigator Program by referring consumers to their program. Kinship Navigator refers many consumers to our program as well.
- Division of Child Protection and Permanency (DCP&P) Kinship Subsidy Unit for subsidy and payment questions.
- Foster and Adoptive Family Services (FAFS) for families involved with KLG.
- Advocates for Children of NJ (ACNJ) by referring consumers for legal and trend information as well as distribute and promote their materials and services.
- Kinship care support groups around the state such as Grandma KARES in Essex County, Grandparents Raising Grandchildren sponsored by the Family Support Organization of Bergen County (FSOBC), yearly Grandparents Forum sponsored by Programs for Parents in Essex County as well as Grandparent/ KLG seminars and conferences, around the state.
- KLG Counseling Services throughout the state.
- Other KLG related services as listed on the KinKonnect Resource pages.
- Assist in sharing Kinship related community events via the KinKonnect Newsletter.
- KLG related events and programs as listed on the KinKonnect Events pages.

2015 PSSF Update Report

Note: Provide all information requested. Retain 12 pt Times Roman font and 1-inch margins.

Section 1 – Identifying Information

1a) Provider: Children's Aid and Family Services, Inc.

1b) Program Name: NJ Adoption Resource Clearing House (NJ ARCH)

1c) Relevant PSSF Program (check one):

_____Family Preservation Services ___x__Adoption Promotion and Support Services

_____Family Support Services _____Time Limited Family Reunification Services

1d) Program Address: 76 South Orange Avenue, Suite 209, South Orange, NJ 07079

1e) Program Objective(s) (purpose of service):
The purpose of the New Jersey Adoption Resource Clearing House, www.njarch.org is to provide information and resources for those touched by adoption and foster care in New Jersey. The program's objective is to meet the needs of pre and post adoptive parents, adult adoptees, those who wish to search for their birth relatives as well as information and resources to assist them in their adoption journey. We also provide services to adoption and foster care professionals and those in the community by offering information and resources to help meet the needs of their clients or consumers.

1f) Outcomes Addressed (check all that apply)**:**

_____Safety ___x_ Permanency _____Well-Being

Section 2 – Service Description Basics FFY '15 (10/1/13 – 9/30/14)

2a) Overview of Service(s) (describe):
The New Jersey Adoption Resource Clearing House (NJ ARCH) provides adoption advocacy, support, education, information and resources through a web site, phone and e-mail warm line, on-line chat rooms, support group advocacy as well as buddy mentoring/ training workshop offerings for adoption support groups, conferences, etc. throughout the state. The program also includes an extensive lending library which includes 1,408 books, 2,751 articles, and 134 videos totaling over 4,293 books, articles and videos.

2b) Population Served (describe): All members of the adoption constellation: birth parents, adoptive parents, adopted persons, and the professionals who work with them.

2c) Geographic Area of Service (what areas are covered)**:** State of NJ.

2d) Referral Sources (from whom you accept referrals): We serve as resource to the Division of Child Protection and Permanency (DCP&P) subsidy and search and reunion units, other state agencies such as Foster and Adoptive Family Services (FAFS), Advocates for Children of NJ (ACNJ), adoption agencies, adoption and foster care support groups, mental health professionals, other users, various adoption-related conferences, outreach and training events around the state, additional resources when appropriate as well as anyone interested in adoption or foster care.

Section 3 – The Year in Review FFY ’ 15 (10/1/13 – 9/30/14)

3a) Provide a summary of the program accomplishments and goals. Use data to support your comments.

- The current NJ ARCH website, www.njarch.org consists of over 2,215 web pages of information and resource material. This website has been a major success; the current Level of Service (LOS) is 5,000 web hits per month; the average web hits per month was 16,364 for the 2013 and 2014 time period.

- The NJ ARCH training workshops previously developed were approved by Division of Child Protection and Permanency (DCP&P) Training Academy in 2007 and have been presented to foster and adoptive parent support groups all around the state. Since 2007 we have developed new NJ ARCH training workshops which have been approved by the DCP&P Training Academy. During this time period 21 training workshops were presented to various support groups and conferences around the state.

- During this time period three NJ ARCH "*Under the ARCH*" newsletter issues were created and each time distributed to over 1,600 consumers; 1100 via e-mail distribution and 600 via US Mail distribution. All past newsletters can be found and downloaded from the NJ ARCH website.

3b) How did this improve outcomes for children and families? (Indicate benefit/impact and be certain to relate these to the identified DCP&P Performance Based Outcomes).

- The increase in hits to our website implies that families and children are benefiting from this information/and resource service.

- The majority of the NJ ARCH training workshops were approved by the DCP&P Training Academy in 2007 for Resource Parent training. These workshops assist Resource Parents in obtaining training credits for Resource Family certification. Many of these workshops were and continue to be presented to the Foster and Adoptive Family Services (FAFS) support groups, adoption parent support groups as well as state wide conferences.

- These workshops have been and will continue to be presented to adoptive and foster families to increase their knowledge of adoption issues and child development, to find mental health services for their children, and to learn about adoption events and support groups around the state. Prospective parents have used the service to obtain information on children needing families.

3c) Identify specific factors that contributed to the improvements/accomplishments.
During this period 21 NJ ARCH training workshops were provided to adoption support groups, conferences and Foster and Adoptive Family Services (FAFS) around the state. The free lending library continues to be popular with 39 book requests submitted via e-mail or phone warm line during this period of time. We continue to enhance the www.njarch.org website this year with a cleaner, more modern look and increased the number of web pages by 9% increasing from approximately 2,125 web pages to approximately 2,215 web pages of information on the website. We translated the NJ ARCH handbooks into Spanish into the website on our Handbook page. These handbooks include: *How to Adopt in NJ: A Roadmap to Family Building, Now that you are a Family: A Guide to Adoption Issues and Services as well as A Guide to Search and Reunion,* which totaled over 65 pages of information into Spanish. We have also translated 12 NJ ARCH website pages into Spanish, currently offer several (10) handbooks in Spanish and offer our advertisement flyers in Spanish. We have added a “Language Translator” to some of our website pages.

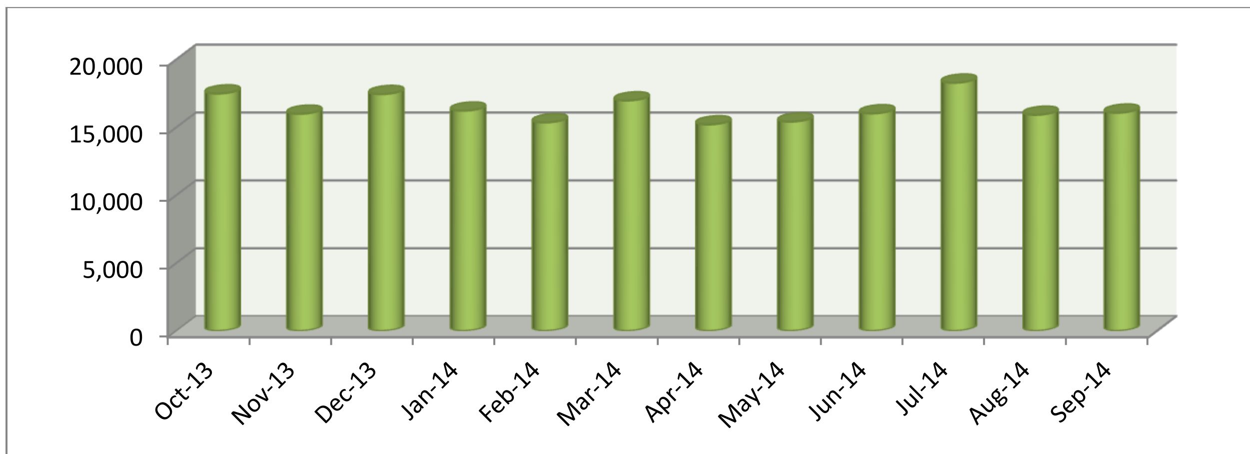
3d) Identify significant barriers to goal accomplishment and how you addressed them.
It continues to be difficult to recruit buddy mentors; therefore we continue to offer numerous training workshops to support groups and adoption agencies. While we offer the chat rooms regularly, attendance continues to be very low. The warm line e-mails and phone calls continue to be lower than the LOS, but we attribute it to the high web hits per month, as we believe consumers are obtaining resource information directly from the website, therefore not necessitating calls or e-mails to the NJ ARCH warm line.

3e) Define a Unit of Service as per contract: (If more than one, include each)
A unit of service is defined as one website hit, one warm line phone call, one warm line e-mail, one moderated chat room, assisting one adoptive family support group, and one buddy families/ training workshop offered.

3f) Enter your contracted Level of Service portion (# of units expected) **that were Title IV-B funded for the period 10/1/13 -9/30/14.**
96,000 website hits per year, 600 warm line phone contacts per year, 240 e-mails per year, 120 Chat Rooms per year and average of two training workshops per month (22).

3g) Enter your actual Level of Service (# of units delivered) **that were Title IV-B funded for the period 10/1/13 – 9/30/14.**
Website Hits for time period: 196,364
Warm Line contacts for time period: 256 (phone calls)
E-mails per time period: 58
Chat Room hours for time period: 141
Buddy Training/ Training Workshops for time period: 21

The website hits are indicated in graph form below:



Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
17,483	15,990	17,443	16,219	15,355	16,971	15,205	15,414	16,020	18,279	15,916	16,069

3h) How many unduplicated individuals and unduplicated families were served for this period? (Each individual and family who received services during the reporting period should be counted only once.)

__717 (warm line contacts plus training participants) # **of unduplicated individuals ____ # of unduplicated families**
Unable to differentiate between individual and families due to medium of service provided.

Above number is based on the following:
During this time period the program received at total of 314 unduplicated contacts to the warm line (256 via phone and 58 via e-mail) that were indicated as unduplicated.

In addition, the 403 who attended NJ ARCH workshops (identified by returned evaluations) indicated that they were unduplicated as many have not attended an NJ ARCH workshop or received services and/or were new to the adoption / foster care community, **totaling 717**. In addition, there were 28 book requests completed which included a Satisfaction Survey to the services provided. These 28 are part of the 314 number as they were a "warm line" contact. We are unable to differentiate between individual and families, due to the medium of service provided.

3i) Provide stakeholder feedback information, e.g. satisfaction surveys, referral source information. (Include the number of surveys sent, responses received and the results.)

Satisfaction surveys were distributed to consumers who contact the Warm Line either by phone or e-mail. Satisfaction Surveys were also sent via the free Lending Library service and distributed after each NJ ARCH training workshop. Below are the results from those Satisfaction Surveys:

The NJ ARCH warm line contact form includes a question whether the contact with the NJ ARCH Warm Line had increased the consumer's knowledge of some aspect of adoption. Out of the 314 phone/e-mail warm lines received during the time period of **10/1/13 – 9/30/14,** 94% stated that their knowledge was Increased, 5% stated that it was Somewhat Increased, 0% stated No, and 1% stated that they were Unsure.

Out of the 314 phone/e-mail Warm Line contact forms, 235 returned, were asked the following question:

"Did your contact with the NJ ARCH Warm line increase your knowledge of some aspect of Adoption?

Warm Line Telephone Survey to the Question:

Yes	Somewhat	No	Unsure	Total
94%	5%	0%	1%	99% out of 100% of surveys answered "yes".

Out of the 28 Lending Library Surveys sent out 12 were returned and below are the results from that survey.

Lending Library Evaluation Survey:

Very Satisfied	Satisfied	Neutral	Dissatisfied	Total
36%	50%	14%	0%	86% of out 100% of surveys were either Very Satisfied or Satisfied

Out of the 403 Training evaluations 311 were returned and below are the results from those evaluations.

Training Evaluation Survey:

Very Satisfied	Satisfied	Neutral	Dissatisfied	Total
77%	17%	6%	0%	94% of out 100% were either Very Satisfied or Satisfied

Surveys returned were consistently positive:

Out of the total 558 returned surveys from the above categories (235 from Worm Lines, 12 from Lending Library and 311 from Training Evaluations) reviewed during the **10/1/13 to 9/30/14** time period, 93% were either **Very Satisfied or Satisfied** with the service, 7% were **Neutral or Unsure** and 0% were **Dissatisfied** with services; there were no Strongly Dissatisfied with services. The feedback that was noted as" dissatisfied" were reviewed by Program Assistant Director in collaboration with the Program Director to evaluate any correction needed on our part.

Section 4 – The Year Ahead FFY '16 (10/1/14 – 9/30/15)

4a) Identify any changes you are making to the services described in Section 2 and why. (This may include projected goals and objectives identified by vendors for their programs. Indicate if there are no planned changes to the program.)

We will continue to manage, update the current NJ ARCH website. Since there have been numerous enhancements and capabilities of websites since the initial launch of NJ ARCH in 2003 and the current website software is no longer being supported by Microsoft Office, the agency is planning to upgrade the NJ ARCH website to a newer technology platform. These new capabilities would allow for updating improvements as well as possible website search tools, on-line library resources, e-learning capabilities and compatibility with hand-held devices. Our goal is to develop, implement and launch this new and improved NJ ARCH website by the end of 2015/early 2016.

4b) Identify changes you will make that stem from stakeholder feedback.
Stakeholder feedback has been very positive, however due consumer feedback we are targeting that the new redesigned NJ ARCH website has a searchable database for the free lending library so consumers may search books and articles by topic, category, etc.

4c) How many Units of Service are you expecting to deliver with IV-B funding for the period 10/1/14 – 9/30/15
In late 2012, our program requested and was approved by the Division of Child Protection and Permanency (DCP&P) to change the current yearly Level of Service (LOS) to the following: 96,000 web hits, 600 phone contacts, 240 e-mail contacts, 120 Chat Rooms and 22 workshops per year.

These new LOS reflects an increase to the web hits per year, from 60,000 to 96,000, however decreasing the warm line calls from 1200 to 600 per year and decreasing warm line e-mails from 600 to 240 per year. This reduction was due to the continued increase of web hits but consistently lower numbers for warm line calls and e-mails. We attribute these lower numbers to consumers researching their questions on the website verses contacting the warm line representative. In addition we have found that the questions that come into the Warm Line have been more difficult /complex in its research, therefore taking additional time to resolve.

4d) Indicate how many unduplicated individuals and unduplicated families you expect to serve.
_750 **_# of unduplicated individuals _______# of unduplicated families**
We are unable to differentiate between individual and families due to the medium of service provided. As more and more people call us back on our warm line, the number of unduplicated families will most likely decrease, since consumers are either taking our training workshops and/or calling our warm line more than once (as indicated on our warm line form asking if they have contacted NJ ARCH before).

Section 5 – Evaluating Progress FFY'16 (10/1/14 – 9/30/15)

5a) How will you measure progress? (note methods)
By collecting data via 1and1.com web hosting report (via web host company) to track the number of web site hits, the number and quality of Customer Satisfaction Surveys from the phone and e-mail warm lines, Lending Library Satisfaction Surveys, Training Workshop Evaluations, consumer reports and comments of those who utilize our services.

5b) Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.

We continue to send Needs Assessments to new consumers and Satisfaction Surveys to identified users of NJ ARCH services. Returned Satisfaction Surveys are reviewed by the program Assistant Director and data is entered into the Statistical Database, SPSS, maintained by the Program Evaluator. Satisfaction surveys that are marked lower than satisfactory are followed up individually by the Assistant Director and Program Director. Once the cause of dissatisfaction is determined, the Assistant Director will meet with the NJ ARCH staff to discuss the issue and to develop improved methods of handling the particular issue.

5c) Describe how you collaborate with community partners.

We work collaboratively with the following community partners:

- Division of Child Protection and Permanency (DCP&P) Local Offices including DCP&P Adoption Subsidy and Search and Reunion units.
- Foster and Adoptive Family Services (FAFS) by offering free NJ ARCH training workshops for Resource Parent training credits around the state.
- Advocates for Children of NJ (ACNJ) by referring consumers for legal and trend information as well as distribute and promote their materials and services.
- Adoption Agency Council of NJ (AACNJ), where the Assistant Director is an active member during the monthly state-wide meetings. Share with Council trends and issues on adoption; Council shares information with NJ ARCH for consumer distribution and information.
- Adoption support groups around the state such as Concerned Persons for Adoption (CPFA), Adoptive Parents Committee (APC), Monmouth, Ocean County Parents Support Group, and alike by offering guest speakers, training workshops as well as advertise their events and meetings on the NJ ARCH website.
- Members of the Adoption Advisory Committee and Post-Adoption Counseling Service providers.
- Adoption conference coordinators by listing events and/or hosting resource tables to promote services provided in New Jersey.
- Adoption or foster care related events and programs as listed on the NJ ARCH Events pages.

SECTION B:

Populations at Greatest Risk of Maltreatment

&

Services for Children under the Age of Five

Services to Populations at the Greatest Risk of Maltreatment

The Department of Children and Families Division of Family and Community Partnerships' (DFCP) goal is to build a continuum of child abuse prevention and intervention programs that are culturally competent, strengths-based and family-centered, with a strong emphasis on primary child abuse prevention. The Standards for Prevention Programs developed by the New Jersey Task Force on Child Abuse and Neglect, defines prevention efforts as follows:

Primary Prevention targets the general population and offers services and activities **before** any signs of undesired behaviors may be present; there is no screening.

Secondary Prevention is directed at those who are "**at risk**" of possibly maltreating or neglecting children. Determining who is at risk is based upon etiological studies of why maltreatment may occur and include parents of young children, racial and ethnic minorities, children as well as parents with disabilities, homeless families and those who are at risk of homelessness, unaccompanied homeless youth, adult former victims of child abuse and neglect and/or domestic violence and members of underserved or underrepresented groups such as fathers. Secondary prevention efforts and services are provided before child abuse or neglect occurs.

Tertiary Prevention is provided **after** maltreatment has occurred, to reduce the impact of maltreatment and to avoid future abuse. Tertiary Prevention is treatment, working with children who have been abused, or working with families where abuse has occurred.

DFCP is committed to provide the resources and technical assistance needed to maintain a robust network of public/private partnerships and programs. Schools and community-based organizations are two prime locations for prevention and intervention services. These two portals are the broadest access to services for families.

The Division of Family and Community Partnerships Offices

Assembled of three primary offices, the Division of Family and Community Partnerships (DFCP) strives to carry out the priorities of the NJ Task Force on Child Abuse and Neglect Statewide Prevention Plan, the DCF Strategic Plan, and the Standards for Prevention Programs. Division administrators and staff actively engage community stakeholders through ongoing prevention activities at the state and local level. Collaborations with public agencies, private non-profit organizations, faith-based groups, parents, and additional consumers assist in building a comprehensive continuum of family centered prevention services for children and families. DFCP program offices include:

Office of Early Childhood Services (OECS)

DFCP Office of Early Childhood Services (OECS) has been integrally involved in NJ's development of a comprehensive system of care to link pregnant women and parents with necessary health and social support services. OECS works closely across state departments with health, human services, education, juvenile justice, and other state and local advocates to ensure that services and supports more effectively reach families early, before birth, to prevent child neglect and abuse. Prevention focused initiatives including Evidence Based Home Visiting, Central Intake, Strengthening Families, County Councils for Young Children, Grow NJ Kids Quality Rating and Improvement System, The Early Childhood Comprehensive Systems Grant/Help Me Grow, and Project Linking Actions for the Unmet Needs in Children's Health (LAUNCH), are housed in OECS.

Office of Family Support Services (OFSS)

OFSS collaborates with community entities in an effort to coordinate and consolidate services provided to families and children. Responsible for the long term development of New Jersey's Family Success Centers and Kinship Navigator Program, OFSS ensures the prosperity, growth, and adaptability of these programs to ensure children and families are receiving appropriate and beneficial services.

Office of School-Linked Services (OSLS)

New Jersey school districts and various non-profit organizations provide a wide array of prevention and support services to youth in public elementary, middle, and high schools. Capitalizing on these services, OSLS contracts and works in partnership with a number of these districts and organizations throughout the State. As a result, young people, and at times their families, are able to access services such as mental health services, employment assistance, substance abuse counseling, preventive health care, violence prevention programs, learning support, mentorship, teen parent skill development, and recreation programs. Initiatives such as School Based Youth Services, Child Assault Prevention, 2nd Floor Youth Helpline, Adolescent Pregnancy Prevention, Traumatic Loss Coalition, Family Friendly Centers, Parent Linking Program, Prevention of Juvenile Delinquency, and Newark School Based Health Centers are based in OSLS.

The Division on Women Offices

Also aiming to align services with New Jersey's established prevention priorities, the Division on Women (DOW) continues the tradition of advocating for women's rights and opportunities through funding and collaborating with organizations, agencies, and programs that provide a variety of services to the women of New Jersey. The staff develop, promote, and expand women's rights in the areas of poverty and welfare, employment and wages, work and family, economic and social aspects of healthcare, violence against women, and women's civic and political participation in their communities. DOW implements such initiatives as the Sexual

Assault Program, Sexual Assault, Abuse, and Rape Care, Address Confidentiality, Rape Prevention and Education, Displaced Homemakers, and statewide Hotlines.

Office of Domestic Violence Services (ODVS)

As the sole office within DOW, ODVS works with community stakeholders in an effort to improve and enhance services that are culturally-competent, strength-based, empowering, accessible, and non-stigmatizing to those who voluntarily request services. ODVS core services were identified in collaboration with the New Jersey Coalition for Battered Women and the provider community. These services are regarded as essential program components to meet clients' needs on a short and long-term basis. In addition to the ODVS core services, the Domestic Violence Liaisons, Peace: A Learned Solution, and the Batterers Intervention initiatives are implemented by ODVS.

Division of Family and Community Partnerships Initiatives

DFCP, in collaboration with DOW, is leading child abuse and neglect prevention activities in the State of New Jersey through the implementation of 28 initiatives. DFCP and DOW administrators and staff continuously strive to identify and implement programs and initiatives which will strengthen families and promote child well-being. Collaboration, partnerships, and priority focused activities allow for a continuum of holistic services to be offered throughout the State.

The Office of Early Childhood Services (OECS) is responsible for the implementation of statewide **Evidence Based Home Visiting (EBHV). EBHV** services target families (pregnant women, parents, infants and children up to age five) in at-risk communities who are at risk for abuse and neglect. In April 2010, DFCP developed a formal partnership with the NJ Department of Health (DOH) (lead administrative agency) on development of the NJ State Home Visiting Plan for the implementation of the **Maternal, Infant and Child Health Home Visiting (MIECHV) grant**. DFCP and DOH collaborated to complete a comprehensive needs assessment that is driving the **EBHV** expansion in the State's most at-risk counties and municipalities. In FFY 2011, NJ submitted three applications to the Health Resources and Services Administration (HRSA). The formula funding was awarded in July 2011 ($2 million annually) and in April 2012 NJ was selected for the second round of HRSA funding for the Competitive **MIECHV** grant with an award of $9.4 million. In FFY2014 with State, federal formula and competitive grants support for home visiting services in NJ reached nearly $22 million annually.

New Jersey has received national recognition as a leader in **home visiting (HV)** with **EBHV** programs in all 21 counties. Through blended funding and interdepartmental collaboration, DFCP OECS oversees the implementation of direct **EBHV** services. In select communities, support and technical assistance is provided for a central intake point of access to coordinate referrals and offers families linkages to needed services that include home visitation and/or other community-based supports. NJ has been actively involved in sharing our experiences and

providing technical support to other communities and states for **HV** and systems coordination planning efforts through webinars, conference calls and site visits.

With the expansion of **HV**, NJ now offers three **EBHV** models, **Nurse Family Partnerships, Healthy Families, and Parents as Teachers,** in all 21 counties, with three counties offered four **EBHV** programs based on community need. NJ has the capacity to serve 5,000 families statewide. In 2014 approximately 4,800 families received home visitation services. **MIECHV** funding strengthens HV's collaboration with Early Head Start Home-Based Option and provides additional support for the **Home Instruction for Parents of Preschool Youth (HIPPY)** funded program in Bergen County.

Also implemented through OECS, **New Jersey Central Intake (CI)** is a comprehensive prevention system that provides one single point of entry for access, assessment and referral to family support services in a community. **CI** strengthens care coordination and systems integration across sectors by improving communication between families and providers. The county based single point of entry allows for easy access to information, eligibility, assessment, and referrals to local family support services. This accessibility reduces duplication of services and increases supports for families to improve prenatal care, birth outcomes, early learning, and preventive care. Attachment B provides a diagram of New Jersey's Central Intake process.

In FFY2014 DFCP supported **Central Intake** in seven counties – Essex, Middlesex/Somerset, Passaic, and Cumberland/Salem/Gloucester. MIECHV formula and competitive funding was utilized to support **CI** in the seven counties supported by DFCP. In August 2014 the Department of Health, utilizing Race to the Top Early Learning Challenge funding, released an RFP to expand **CI** in the remaining six counties. **Central Intake** in all 21 counties will integrate healthcare, childcare, education, and family support services.

Strengthening Families (SF) is embedded in various programs throughout the State. **SF** is a multifaceted approach to preventing child abuse and neglect by strengthening families through the early care and education system. The Center for the Study of Social Policy developed the Strengthening Families Protective Factors Framework, which builds on the fundamental principle that certain protective factors contribute to family resiliency and strength. These protective factors include parent resiliency, nurturing parent-child relationships, parent/caregiver knowledge of infant/child development, family social connections, and linkages to needed concrete supports.

Child Care Resource and Referral (CCR&R) Agencies assist in the implementation of **SF** in all 21 counties. Child care providers play a prominent role in building the protective factors among the families they serve, implementing seven key strategies to effectively prevent child abuse and neglect. Four main components of **SF** provide a structure for successful implementation. First is the collaboration among DFCP, NJ Department of Human Services' (DHS) Division of Family Development (DFD) to provide core training to selected staff in county CCR&R agencies. These

trainers work with local child care providers (center-based and family-based) to educate early care professionals about protective factors research; and provide hands-on support to providers, offering strategies for engaging families and integrating SF principles into daily interactions with children and families. CCR&R trainers meet regularly to share challenges and successes, and to develop innovative methods to working with centers, staff and families. The second component of **SF** implementation is the submission of an annual work plan by each participating Strengthening Families child care provider. The work plan proposes two to three program activities which will promote protective factors for parents and families. The third component is the planning and implementation of a County-wide Parent Leadership event. A collaborative effort among parents, community agencies and the CCR&R, the parent leadership event is developed with the intention of promoting one or more of the protective factors through various activities and supports. Lastly, OECS coordinates ongoing quarterly **SF** meetings with CCR&R trainers to provide information, education and strategies to integrate SF principles into early care and education programs.

Through DFCP's partnership with DFD, a relationship with Prevent Child Abuse NJ (PCANJ) was developed to incorporate **SF** with the NJ Family Outreach Program (FOP). Each state funded preschool program is provided one Family Outreach Worker (FOW) for every 45 children enrolled at the center. The FOW help parents to locate and link parents to services and resources they need, organize and implement parent meetings, oversee documentation and record keeping, conduct home visits, and help mediate family circumstances. The goals of the Family Outreach Program are to increase each family's involvement in their child's early education; to develop activities to increase parent participation at the child care center; to help families access and use local resources that result in healthy outcomes for children; and to increase parent's knowledge of child development. **SF** will provide PCANJ with training and technical assistance to assist the FOWs with implementing the Protective Factors Framework as a strategy for family engagement.

The Strengthening Families Protective Factors Framework is encompassed in the standards of **New Jersey's Quality Rating and Improvement System (QRIS), Grow NJ Kids. Grow NJ Kids** is a collaborative effort among DCF, the Department of Education (DOE), and the Department of Health and Human Services (DHHS) which aims to raise the quality of early care and education for infants and children from birth through pre-school. This quality rating and improvement system hosts a two-pronged approach to quality improvement. It will assist early care and education providers in continuously improving the quality of their programs, and provide parents and caregivers information to guide them to make informed decisions when selecting child care. **Grow NJ Kids** provides the framework for child care programs to continue to meet high quality standards in each of the following areas: Safe, Healthy Learning Environment; Curriculum and Learning Environment; Family and Community Engagement; Workforce/Professional Development; and Administration and Management. In FFY 2014, DFCP staff continued active participation on the state-level Interdepartmental Planning Group

(see Section VIII for a completed description of the Interdepartmental Planning Group). Through this effort, **SF** principles and the Protective Factors Framework are now included in the Family and Community Engagement standard of **Grow NJ Kids**. By infusing **SF** into the Family and Community Engagement standard of quality, OECS is able to promote and support the application of the Protective Factors Framework across the State while also assisting child care programs in engaging and supporting the families they work with.

In addition to **SF** implementation through the CCR&Rs, the Family Outreach Program, and Grow NJ Kids, DCF began to strategize for statewide expansion and integration of the Strengthening Families Protective Factors Framework. Planning for an in-state train-the-trainer program for the **Strengthening Families "Bringing the Protective Factors to Life in Your Work"** began in August and September 2014. An expected 30 trainees from both child welfare and early childhood will participate in the train-the-trainer program, enabling NJ to have in-state capacity as the focus on the expansion of the Protective Factors Framework across sectors at both the county and State levels continues.

County Councils for Young Children (CCYC) are rapidly developing in every county in NJ, following the lead of Cumberland County's County Council for Young Children. In FFY 2014, OECS in collaboration with the New Jersey Council for Young Children (NJCYC) released a Request for Proposal for statewide implementation of **CCYCs.** Utilizing funds from the Race to the Top Early Learning Challenge Grant, New Jersey is now able to implement **CCYCs** in all 21 counties. The purpose of the **County Council** is for parents, caregivers, and interested community members to come together as active partners to share and learn about issues that affect the health, education, and well-being of women and children from pregnancy to age eight; offer ideas, opinions, and solutions for ways to build stronger connections for children and families through the lens of the Protective Factors Framework; and to build successful collaborations among community agencies.

Through collaboration between OECS and the Division of Child Protection and Permanency (DCP&P), community-based prevention partners in Burlington, Cape May and Ocean counties piloted a project to decrease risk and increase protective factors for "Frequently Encountered Families", with infants and young children, in child welfare during FFY 2013. This Capstone Project sought to lay the groundwork for a Prevention System of Care, increase the knowledge and skills of all system partner staff, and promote "teaming" and the Protective Factors Framework. Aiming to achieve the priority of "Expanding opportunities to integrate early childhood expertise across DCF", as outlined in the DCF Strategic Plan, DCF began planning the replication of the Capstone project in other areas of the State. DFCP took the lead on this initiative and, seeking funding to add an evaluation component, made a presentation to Casey Family Programs in February 2014. Following the expressed interest from Casey Family Programs, a logic model and proposal were drafted throughout the next several months. The proposal, **"Improving Outcomes for Families of Infants and Young Children in New**

Jersey: Integrating Best Practices in Child Welfare and Early Childhood" aims to improve outcomes for families of infants and young children who come to the attention of DCP&P through staff development, enhanced planning, assessment, and service access, and systems collaboration.

Since April 2012, DFCP OECS has been the lead office for **Early Childhood Comprehensive Systems (ECCS)** and an affiliate of the Help Me Grow National Center. **Help Me Grow (HMG)** promotes development of an integrated early childhood system that supports children (pregnancy to age eight) and their families to achieve optimal wellness. **HMGNJ** is building upon New Jersey's strong foundation in early childhood services to improve coordination and integration, and streamline services across systems of care that encompass four core departments: Health; Human Services; Education; and Children & Families. As a result, pregnant women and parents and families of infants and young children will have easier and earlier access to a range of prevention, early identification, early intervention, and treatment services to promote healthy pregnancies and births, positive infant/child growth and development, and nurturing parent-child relationships. Through the work of various workgroups, **ECCS/HMGNJ** goals are to focus on promoting a comprehensive, coordinated preventative health and early childhood system that addresses the physical, social-emotional, behavioral and cognitive aspects of child wellness from pregnancy to three.

Project LAUNCH (Linking Actions for Unmet Needs of Children's Health) is an essential initiative in OECS for the prevention of child abuse and neglect efforts. The mission of **New Jersey Project LAUNCH (NJPL)** is to link and enhance efforts to improve overall young child wellness in Essex County. With the support of the Substance Abuse and Mental Health Services Administration (SAMHSA) and DCF, **NJPL** brings together culturally competent, evidenced-based programs that address the physical, social, emotional, behavioral and cognitive well-being of children birth- eight years old, along with targeted training for providers, families and early childhood partners across sectors statewide. By providing targeted training and the necessary tools for families and early childhood partners across sectors; health/behavioral health, home visiting, childcare and early childhood education, early intervention, infant-child mental health, child welfare and family support; a comprehensive, coordinated system that supports child and family health and eliminates racial and ethnic disparities is created. In September 2013 OECS received a five year federal grant from SAMHSA to confirm the sustainability of **NJPL** and ensure New Jersey's children are thriving in safe, supportive environments.

Family Success Centers (FSCs) are a primary focus of OFSS. **FSCs** provide community-based, family-centered neighborhood gathering places where community residents can go for family support, information, referrals and access to services at no cost to them. State and CBCAP funds support a network of **FSCs** as "one stop" sites to provide wrap-around resources and supports for families before they find themselves in crisis. Services provided by **FSCs** include, but are not limited to:

- Providing information and referrals for local services

- Advocating for families to receive services
- Providing opportunities for families to make social connections
- Participating in annual Strengthening Families event
- Offering group activities regarding topics such as:
  - Parent education/parent child activities
  - Life Skills
  - Family Health
  - Housing
  - Employment
  - Caregiver and Senior Outreach

The goal of the **FSC** is to strengthen families and empower individuals to acquire the knowledge necessary to have successful families as well as raise healthy and happy children. Parents as well as other members of the community share in the governance for each **FSC** and aid in **FSC** implementation and development. **FSCs** offer primary and secondary child abuse prevention services to families and bring together community residents, parents, leaders and community agencies to address problems that threaten the safety and stability of families and the community.

In FFY 2014, enhancements to existing **FSCs** were paired with an expansion of **FSCs** as New Jersey continued to respond to the fall-out from Hurricane Sandy. Two new **FSCs** joined the network of state funded Family Success Centers in FFY 2014; the Meadowlands FSC, serving southern Bergen County, and Palisades FSC serving northern portions of Hudson County. DCF also provided additional funding to ten existing **FSCs** in Bergen, Cape May, Cumberland, Essex, Hudson, Middlesex, Monmouth, Ocean, and Union Counties. The goal for this expansion project was to ensure that community residents, particularly families with limited income in the counties severely impacted by Sandy, will have psychosocial support services they need to recover. In total, OFSS funded **52 FSCs** reaching over 49,000 families in FFY 2014.

In addition to FSC's, OFSS also provides oversight for the **Kinship Navigator Program (KNP). KNP** was established to assist caregivers raising non-biological children in "navigating" through various government systems to find local supports and services. The complete program encompasses Wraparound Services, Kinship Legal Guardianship Services, Kinship Care Subsidy Services, and Information and Referral Services. The program provides financial assistance, support, information and referral services, and a wide range of other services available to caregivers through four agency providers serving all 21 counties.

KNP Case Managers help determine eligibility for special services, such as Kinship Child Care Subsidy or Kinship Wrap Around services. Linkages for support services may include: grandparent/family support groups, insurance coverage and health services, child support collection, housing, legal and financial services, and special items/services related to the child's needs. The program can also assist with obtaining kinship legal guardianship. **KNP** granted 438 Kinship Legal Guardianship (KLG) applications and 2682 Wraparound applications in FFY 2014.

School-Based Youth Services (SBYS) are collaborative efforts developed and implemented by OSLS. OSLS **SBYS** contract with various private non-profit organizations and school districts in order to provide prevention and support services to students and their families. Youth in NJ's public schools are able to access a wide variety of services through the implementation of **SBYS.** Services provided by **SBYS** include group and individual counseling, healthy youth development services, life skills and social skills groups, relationship management, employment readiness, academic support, pregnancy prevention, substance abuse prevention, conflict resolution, violence prevention, recreational activities, preventative healthcare services, summer programs, and promoting volunteerism and community service for youth.

The **New Jersey Child Assault Prevention (NJCAP) Program** is a statewide prevention program that provides training to children, parents and teachers to prevent peer assault, stranger abduction and known adult assault. **NJCAP** staff work closely with local school districts, parent/teacher associations, home school groups and other community groups. **CAP** has a threefold educational approach to prevention which includes staff in-service, parent programs and classroom workshops for children and teens.

2ND FLOOR Youth Helpline is a statewide, 24-hour interactive telephone line for youth and young adults (ages 10-24), staffed by professional counselors and specially trained volunteers. The goal of **2ND FLOOR** is to promote healthy youth development by providing immediate, interactive, respectful, and professional helpline services with linkage to information and services that address the social and health needs of youth. During FFY 2014, the Helpline received an average of 15,000-20,000 calls per quarter.

The **Traumatic Loss Coalition's (TLC)** primary focus is to provide suicide prevention services to public schools throughout the State. The **TLC** model utilizes a holistic approach in building an informed and competent community by offering training and technical assistance to school administrators, teachers, and parents in NJ's public, charter and private schools, faith based organizations, social service & mental health agencies, law enforcement, primary care physicians. Basic components of all **TLC** curricula include: suicide prevention, intervention and post-intervention, and trauma incident training and technical assistance to schools and communities for the benefit of school age youth.

The goal of **Family Friendly Centers (FFC)** is to offer a wide range of services to enhance after school programming for elementary/middle-school students and their families. There is an emphasis on parental participation as well as collaboration among school and community stakeholders to meet the needs of students and parents. OSLS strives to continually enhance collaborations between schools and communities to provide the most appropriate services for families.

DCF was awarded funds by the US Department of Health & Human Services' Office of Adolescent Health to strengthen the supports for expectant teens, teen mothers, young fathers and their children. This work is identified as the **Parent Linking Program (PLP)** expansion project **Promoting Success for Expectant and Parenting Teens NJ (PSNJ).** Through the implementation of **PSNJ**, programs were educated about the importance of including young fathers. Programs developed a specific component of their service offerings to specifically address the needs of young fathers. At this time, each program is expected to demonstrate that 20% of their enrolled students are young fathers. In addition, prior to this funding, the **PLP** sites did not systemically address intimate partner violence with adolescents. Through a partnership with Prevent Child Abuse-NJ (PCA-NJ), 90% of the **PLP** sites received training in the evidence based curricula Safe Dates to promote healthy relationships. This training was also extended to the staff of Project TEACH, a comprehensive alternative education program for pregnant and parenting teens (13-21 years old) operated by the DCF's Office of Education (OOE). Furthermore, OSLS implements the **Adolescent Pregnancy Prevention Initiative (APPI).** The goal of APPI is to reduce the birth risk of adolescent boys and girls enrolled in the contracted school sites that are most at risk of adolescent pregnancy.

OSLS also delivers the **Prevention of Juvenile Delinquency (PJD)** initiative in four designated high schools in New Jersey. The goal of **PJD** is to integrate and coordinate services, both in and out of the school setting, with a focus on the prevention of juvenile delinquency and/or intervention for students who have a first time contact with the juvenile justice system for a misdemeanor.

Finally in OSLS, **the Newark School Based Health Centers (SBHC)** aim to provide primary medical, dental and behavioral health care services to students and families (up to age 21) in the school where the health center is located and members of its surrounding community.

Below displays the level of service for the OSLS initiatives described above.

- SBYSP (37, 762)
- NJ Child Abuse Prevention (76,492 youth, 11, 652 adults)
- Traumatic Loss Coalition (98 schools, 3,109 youth, 6,530 adults)
- Family Friendly Centers (2476 youth)
- Parent Linking Program (208 youth)
- Adolescent Pregnancy Prevention Initiative (2024 youth)
- Prevention of Juvenile Delinquency (441 youth)
- Newark Health Centers (11,528 medical / 1690 behavioral health / 4147 dental)

Division on Women Initiatives
While child abuse and neglect prevention services are provided through the array of initiatives in DFCP, there are additional family-centered preventive efforts conducted through various initiatives in DOW. The **Sexual Assault Services Program (SASP) and Sexual Assault, Abuse, and Rape Care (SAARC)** offer free services to victims of sexual violence and their significant others twelve years of age and older in all 21 counties. **SASP** and **SAARC** provide free 24/7 crisis and informational hotlines, crisis counseling as requested, victim advocacy, referrals and follow-up support, as well as provide sensitivity training for professionals who work with victims and their families.

The **Address Confidentiality Program (ACP)** strives to assist victims of domestic violence remain safe and develop advocacy skills. Currently providing service to over 300 victims of domestic violence and their families, ACP offers services which allow domestic violence programs to better advocate for victims around issues related to address confidentiality, as well as allowing program participants to regain stability through the ability to obtain safety.
DOW also implements the **Rape Prevention and Education Initiative (RPE)** for vulnerable and high risk individuals as defined in New Jersey's Primary Prevention and Education Plan. These individuals receive Bystander Intervention and Media Literacy Strategies through one of 22 local **RPE** providers. Providers of **RPE** focus on policy and social norm change activities, and establish partnerships with community stakeholders and participate in capacity building of a sustainable coalition. **RPE** allows for risk factors of sexual violence and victimization to be reduced while also enhancing the protective factors.

The **Displaced Homemaker Program (DH)** provides services for women who have worked in the home for a number of years and through the death, disablement, or divorce of a spouse find themselves as the primary source of household income. **DH** programs provide clients with a myriad of personal, educational and career development services toward achieving their goal of economic self-sufficiency. Providers offer case management services for participants in **DH**, in addition to training and workshops related to computer literacy and job readiness. Employment and education services are also available for participants in the **DH** program.

Lastly, implemented through DOW are two statewide hotlines. The **New Jersey Domestic Violence Hotline** is available 24 hours a day 7 days a week and provides confidential access for victims of domestic violence and others seeking information about domestic violence, and increases the accessibility of services to domestic violence victims and their supporters that request crisis intervention, information, referral, and advocacy. Additionally, the **Women's Referral Central Hotline** is also available 24 hours a day 7 days a week and offers information regarding such topics as child care, discrimination, displaced homemaker, divorce, housing, job training, legal assistance, single parenting, and social services.

The Office of Domestic Violence Services (ODVS) further promotes family strength and stability through several initiatives. **The domestic violence core services** were identified in collaboration with the New Jersey Coalition for Battered Women (NJCBW) and the provider community. ODVS is the primary funding source and oversight agency for 22 domestic violence shelters and three non-shelter programs. There is at least one DCF-designated lead domestic violence program in each of the State's 21 counties. Domestic Violence Services lead agencies provide leadership, support, and development to communities and organizations addressing domestic violence. Core services for survivors and victims' experiencing domestic violence and their families include: 24 –hour Hotline; 24-hour access to emergency shelter; information and referral; counseling; support groups, financial, housing assistance, legal services, general advocacy; children's services; and community education and awareness activities, networking and non-residential Support. In FFY 2014 a total of 110,039 shelter nights were provided by ODVS funded shelters.

ODVS collaborates with NJCBW and the Department of Children and Families Division of Child Protection and Permanency (DCP&P) to implement the **Domestic Violence Liaison (DVL)** initiative. **DVLs** are domestic violence professionals co-located at DCP&P local offices to provide on-site case consultation to DCP&P staff as well as support and advocacy for domestic violence victims and their children. The purpose of this collaboration is to increase safety and improve outcomes for children and their non-offending parents/caregivers in domestic violence situations and to strengthen DCP&P capacity to provide effective assessments and intervention for families in domestic violence situations. In FFY 2014 32 **DVL**s served 5,716 non-offending parents.

Developed specifically to promote the well-being of children who have witnessed domestic violence, the **Peace: A Learned Solution (PALS)** initiative is a research based, intensive therapeutic program model of creative arts therapy. Utilizing unique therapeutic strategies such as art, dance, movement and drama, children ages 4 – 12 years old experience creative counseling and healing. **PALS** also offers services for the non-offending parent, and operates in 11 counties in New Jersey. Over 1,225 children and 747 parents/ caregivers received services through **PALS** in FFY 2014.

The **Batterers Intervention Program (BIP)** was developed in an effort to encourage, assess, and engage fathers into responsible fathering behaviors. **BIP** provides services to fathers who perpetrate domestic violence in households where children are present with the goals of reducing or eliminating the safety and risk concerns posed by batterers, increasing safety within households and setting clear boundaries to prevent future violence. A safety plan must be in place for the victim as well as the children. **BIP** has two primary components: training for DCP&P caseworkers and implementation of a new intervention with male perpetrators of domestic violence, administered by community domestic violence providers. **BIP** is being piloted Sussex, Middlesex, Morris and Atlantic Counties. In FFY 2014, **BIP** enrolled 292

fathers/intimate partners with 232 of those enrolled known to child protection. BIP providers held 704 group sessions, and 2,427 units of case management services were provided.

Community Based Child Abuse Prevention (CBCAP) Program

CBCAP provides funds for the implementation and coordination of prevention services under the direction of the Assistant Commissioner of the Division of Family and Community Partnerships and Division on Women. Funds from the CBCAP program support primary and secondary prevention services targeting children and families in at-risk communities throughout the State. For FFY 2014, CBCAP supported the following initiatives in the DFCP Offices:

Office of Early Childhood Services (OECS):

The Strengthening Families Initiative

Early Childhood Comprehensive Systems Grant/Help Me Grow

South Jersey Health Care (INSPIRA): Cumberland County Council for Young Children

Office of Family Support Services (OFSS)

Family Success Centers in Cape May County, Gloucester County, Hunterdon County, Morris County, and Somerset County

Family Success Center Statewide Conference

Family Success Center Family Development Credential Training

Office of School Linked Services (OSLS)

New Jersey Child Assault Prevention (NJCAP) and Bullying Prevention

Additional, CBCAP funding supports the following initiatives in the Division on Women (DOW):

Office of Domestic Violence Services (OVDS)

Domestic Violence Liaisons in Cape May County, Hudson County, Hunterdon County, Mercer County, Monmouth County, Passaic County, Salem County, Sussex County, and Warren County

New Jersey Children's Trust Fund (CTF)

The New Jersey Children's Trust Fund (CTF) is a private/public partnership created by law in 1985 to fund child abuse and neglect prevention programs in New Jersey communities. The CTF supports local child abuse and neglect prevention programs that implement evidence-based and

evidence-informed programs. Funds come to the CTF primarily from residents through the NJ state income tax check-off; and other private donor contributions.

The funding priority through June 30, 2014 with the Children's Trust Fund, established by the NJTFCAN, is to promote positive parent-child attachment and support infant and early childhood metal health programs. Grants were awarded through a competitive process and funded for a three-year cycle. Funding in the first year was $85,000, second year funding $79,000 with a 10 percent match requirement and third and final year of funding is $76,500 with a 15 percent match requirement. These grantees are overseen by DCF, DFCP, OECS. OECS provides technical assistance that builds program capacity in using evaluation for continuous quality improvement. OECS worked with each CTF grantee to develop a program logic model and evaluation plan. These tools help guide the grantee in quality implement, measuring performance and monitoring ongoing quality improvement. OECS implemented an electronic quarterly reporting format in the first quarter of FFY 2013. This allowed DFCP to look at the program outputs and performance indicators more closely for the entire portfolio of grantees. The following CTF grantees ended June 30, 2014:

- **Jewish Family and Children Services, Positive Parenting serving Mercer County**
- **Family Connections, Incredible Parents! Incredible Kids! serving Essex County**
- **South Jersey Health Care, Triple P -Positive Parenting Program in Cumberland County**

With the Children's Trust Fund (CTF), a number of evidence based programs are offered to children and families in New Jersey's most vulnerable communities. The **Incredible Parents=Incredible Kids** curriculum is offered in Newark and Essex County through lead agency Family Connections, Inc. Newark and Essex County experience challenges of crime, gang violence, high unemployment rates, and poverty, leading to potential increases in child abuse and neglect, poor school performance, behavior and anger problems, and social and emotional deficits in children. Targeting African American Children and their parents in various preschools and additional parents in the community, **Incredible Parents=Incredible Kids** operates with a combination of CTF and Newark Preschool council funding. The program incorporates Incredible Years Children and Parenting Series; Talking about Touching Safety Curriculum and the Music Together Curriculum. This preventative program aims to promote strong healthy families, prevent child abuse and neglect and increase school readiness and success. Successful implementation demonstrated a decrease in children's problem behaviors, and increase in positive social skills, and an increase in parent's confidence to manage behaviors of the child(ren).

The child component of the **Incredible Parents=Incredible Kids** program consists of The Incredible Years DINA Curriculum, Talking about Touch and Music Together. Incredible years DINA curriculum is for three to five year olds and covers topics such as: problem solving; understanding and communicating feelings; anger management; behaving appropriately; friendship and communication skills. Talking about Touch is a second step safety curriculum

focusing on teaching fire safety, gun safety, good touch/bad touch, street safety and car safety. Music Together is a music curriculum for one and a half to two year olds that focuses on the development of language skills and fine/large motor skills.

The parenting component provides three psycho-educational parent training groups for: Parents of Babies, Parents of Toddlers and Parents of Preschoolers. The group format for all the groups consists of vignettes, group discussions, role playing and worksheets. The Parent of Preschoolers Group focuses on parental self-care, time management, school readiness, development of rules/routines, positive discipline skills and strengthening parent/child attachments/bonds. The Parents of Toddlers Group focuses on separation/reunions, parental self-care, potty-training, strengthening social skills, development of language, importance of routines, positive behavior management and strengthening parent/child bonds. The Parents of Babies Group focuses on: getting to know you're your baby, understanding baby's cues, self-care/ time management, developmental milestones and providing appropriate stimulations.

Below is a description of the various activities and outputs the **Incredible Parents=Incredible Kids** program accomplishes in a year's time:

- Professional Training in Incredible Years:
  - Incredible Years DINA curriculum -3 full days of training/ 24 hours total for community professionals
  - Incredible Years Parents Group Leader – 5 full day training/40 hours for Clinical Coordinator.
- Relationship Building and Development with Newark Preschool Council- monthly meetings for one hour each meeting.
- Incredible Years DINA Curriculum (3-6 year olds): 4 pre-school cycles/24 sessions per cycle/ 15-30 minutes each session. A total of 96 sessions will be held serving 55 children.
- Talking About Touch (3-5 year olds): 4 pre-school cycles/15 sessions per cycle/ 15-30 minutes each session. A total of 60 sessions will be held serving 55 children.
- Music Together (1.5-2 year olds): 2 cycles/7 sessions per cycle/ 15 minutes each session. A total of 14 sessions will be held serving 20 toddlers.
- Parents of Preschoolers: 2-3 parent cycles/12 sessions per cycle/ 2 hours each session. A total of 24 sessions will be held serving 12 -18 parents.
- Parents of Toddlers: 2-3 parent cycles/9 sessions per cycle/ 2 hours each session. A total of 18 sessions will be held serving 12-18 parents.
- Parents of Babies: 1-2 parent cycles/7 sessions per cycle/ 2 hours each session. A total of 14 sessions will be held serving 6-12 parents.

Progress and Accomplishments in FFY 2014 include:

- Adjusted the target number of parents that will be served for the *Parents of Preschoolers Group; Parent of Toddlers Group, and Parent of Babies Groups* based on lessons learned in the prior year. The implementing agency decided to focus recruitment on parents of

toddlers, learning that parents were more able to make a commitment to group sessions when their child was older.

- 83 preschoolers participated in the Incredible Years DINA Curriculum and Talking about Touch providing the following outcomes:
  Incredible Years DINA Curriculum:
    - 85 % of children demonstrated an increase in positive social skills as measured by the pre and post Preschool and Kidergartin Behavior Subscale (PKBS) test social skills compositie score
    - 79% of children demonstrated a decrease in problem behavior as measured by the pre and post PKBS test problem behavior composite score

  Talking about Touching second step curriculum:
    - 95% of students demonstrated increased knowledge about safety rules for touching private body parts
    - 92% of students demonstrated increased knowledge regarding car/seat belt safety; stranger safety and how to respond/stay safe if someone tries to touch private body parts
    - 86% of students demonstrated increased their ability to identify private areas of bodies
    - 84% of students demonstrated increased knowledge regarding traffic safety
    - 81% of students demonstrated increased knowledge for staying safe if they get lost

The implementing agency practiced ongoing CQI and shifted their practice during the year to meet the needs of community parents. There were more parents of toddlers needing services resulting in five cycles of parents of toddlers groups held as opposed to only offering two to three cycles as initially planned. There was less demand from parents of preschoolers, leading to only one group cycle for this target held as opposed to the initial target of offering two to three cycles. Thirty three parents graduated from the groups, which was below the targeted forty eight. Parenting groups were held at the following three locations: Family Connections (FC) East Orange, Central High School (CHS) Newark and Queen of Angels in Newark. One hundred percent of parents that completed either the Parents of Toddlers or the Parents of Preschoolers Group indicated that they were "confident" or "very confident" in managing their child's behavior in the home on their own following the course.

Serving children and parents in two preschools in Mercer County, the **Positive Parenting-Padres Positivos** evidence based program is implemented with funding from the CTF, Division of Mental Health and Addictions Services, and the United Way. Jewish Family & Children's Services of Greater Mercer County, the only provider of mental health services for preschoolers in the Hightstown area, serves as the implementing agency for this program. The program is implemented by a mental health professional, who is bilingual and bicultural. The **Positive Parenting/Padres Positivos** program targets at risk, low income Spanish and English speaking

Latino immigrant and refugee parents with pre-school children ages two and a half to five in Mercer County, where the Latino population continues to rapidly increase. **Positive Parenting/Padres Positivos** incorporates Common Sense Parenting Curriculum (CSP) for Parents and Mental Health Psychosocial Curriculum for preschoolers. When implemented effectively, this program displays and increase in family functioning, social support, concrete supports, nurturing and attachment among family members, and an increase of understanding of child development.

CSP was developed, researched and distributed by Boys Town USA and is endorsed by the National Center for Mental Health Promotion and Youth Violence Prevention as a Best Practice. It has been normed on a multicultural population, including Latinos. The CSP Group is a parenting skills training group that includes behavior management, child development, nurturing, parenting skills and self-control as well as how to calm the child when emotionally upset. The Mental Health Psycho-educational Preschool Groups is an in classroom social emotional group for preschool children ages two to five years old. Topics are individualized and tailored based on the needs of the preschool children. Topics can include grief; bullying; making friends; following rules; anger management; appropriate expression of feelings/thoughts; and social skills. Goals for this prevention program include the prevention of child abuse and neglect, increased school readiness and supporting healthy and strong families.

Activities and outputs of the **Positive Parenting/Padres Positivos** program include:

- *Outreach/Recruitment*: develop marketing and recruitment efforts.
- *Common Sense Parenting Groups:* 8 series/cycles of CSP groups, 2 series/cycles each quarter, one in Spanish and one in English; 7 classes in each series at 2 hours each; 65-75 parents will graduate.
- *Individual Parent Consultation:* 1-3 consultation sessions, .5 – 1 hour each for 15 parents.
- *Mental Health Psycho-educational Preschool Groups:* Implement in a total of 9 classes (5 classes in Better Beginnings and 4 classes at the YWCA) Minimum of 1X/week in each classroom for, .25-.5 hours classroom, a minimum of 16-20 weeks in the school year. Serve a total of 149 children.

Positive Parenting/Padres Positivos progress and accomplishments in FFY 2014 include:

- Positive Parenting-Padres Positivos received one technical assistance site visit, for a total of two hours, from DFCP. Reviewed and revised logic model to reflect realistic outputs based on second year implementation, targeted performance indicators and ongoing CQI.
- Common Sense Parenting (CSP) Group
    - 75 parents were recruited, of which 58 (77%) enrolled.
    - 44 (75%) of parents that enrolled, completed the program.

To evaluate the effectiveness of the Common Sense Parenting Groups, JFCS began administering the FRIENDS National Resource Centers Protective Factor Survey (measures Family Functioning; Social Support; Concrete Supports; Nurturing and Attachment and understanding of Child Development) to all participants. The program was able to aggregate the

data and showed increases in Protective Factors (PF) for the overall program. Although interesting, JFCS wanted to understand the statistical significance of the increases for each of the PFs and which protective factors the Common Sense Parenting program was most impacting. JFCS contracted with Central Jersey Family Health Consortium to perform an external evaluation of the Common Sense Parting Program. The results of the evaluation are as follows: Parents showed improvement within each area with the largest improvement witnessed in family functioning and social support. All factors, except for concrete support, showed statistically significant improvements. These results suggest that the program is effective at improving understanding of family functioning, social support, nurturing and attachment, and child development; however, there is only limited impact on concrete support.

- 163 children benefited from the Mental Health Psycho-educational Preschool Groups
- 93 parents participated in the Individual Parent Consultation offered.

Lastly, funded in full with CTF, the **Triple P- Positive Parenting evidence based Program** is implemented in Vineland, Millville, and Bridgeton within Cumberland County through lead agency INSPIRA Health Care. Cumberland County has the highest rate of abuse/neglect investigations and teen pregnancy in New Jersey, and ranks high in children in out-of-home placements, children living in poverty and unemployment. The **Triple P-Positive Parenting Program** targets parents and caregivers of children birth to age five. The overall goal of this program is to prevent child abuse and neglect through increasing parents' and caregivers' understanding of realistic expectations for a child's behavior, modeling behaviors parents and caregiver wish for their children to adopt, and correcting and redirecting a child's inappropriate behaviors without corporal punishment. With successful implementation, parents and caregivers present a decrease in over-reactivity, laxness, and verbosity; while children display a decrease in emotional symptoms and conduct problems, with an increase in pro-social behavior.

Triple P Positive Parenting Program is an evidence based program with more than thirty years of clinical trials. **Triple P -Positive Parenting Program** offers the Group Triple P- Level 4 Parenting Sessions and Pathways Triple P – Level 5. The Group Triple P- Level 4 Parenting Sessions is an eight session program that provides opportunities for parents to learn through observation, discussions, practice and feedback. Segments from DVD's, the parent workbook and power points are used to demonstrate positive parenting skills. Parents complete homework to consolidate the learning from the group sessions. Two to three telephone sessions are provided to parents as follow up to the group and provide additional support. Pathways Triple P – Level 5 is a service for parents that have completed Group Triple P. This is a more intensive family intervention for parents and caregivers experiencing relationship conflict, parental depression and/or high levels of stress. Three modules are provided in private sessions with Triple P Practitioner. INSPIRA also provides monthly, ninety minute seminars using materials from the Group Triple P – Level 4 parenting sessions. This format is not a component of the

Triple P model, but is a strategy for INSPIRA to increase the number of parents exposed to the materials.

Below is a description of activities and outputs of the Triple P Positive Parenting Programs:

- *Professional Training*:
  Group Triple P:
  - *Initial Training* Triple P Group Level 4: 3 full days of training in Group Triple P with National Office Trainers. 17 professionals will complete training in FY 2011-2012
  - *Pre-Accreditation Visit/Training:* One full day of training with National Office Trainers. 17 Professionals will complete training in FY 2011-2012
  - *Accreditation Visit/Training:* One and a half days of half day accreditation training/visit with 5-7 professionals in each group. 17 professionals will become accredited. Professionals will become accredited in FY 2011-2012

  Pathways Triple P
  - *Initial Pathways Training*: 2.5 full days of training in Pathways for 4 SJHC staff in Atlanta. SJHC staff will attend in FY 2012-2013
  - Accreditation for Pathways: Accreditation through video submission for 4 SJHC Professionals, completed in FY 2012-2013.
- *Outreach & Recruitment* Scheduling for Group Triple P groups/classes:
  - Monthly Meeting with Trainers for 3 months (beginning in February 2013), then quarterly following. Meeting for two hours. Develop recruitment plans and group/class schedules.
- *Group Triple P- Level 4 Parenting Sessions:* 10-12 cycles of 8 week group/classes: first 4 weeks 2 hour group class sessions, fifth – seventh week 15 minute phone follow up with each parent participant; 7th group/class session, 1.5 hours. 50 parents will complete.
- *Pathways Triple P – Level 5:* Up to 2 individual meetings with caregivers, one hour each, for 9 caregivers/year.
- *Select Seminars Series:* At least 1 seminar per month (minimum of 12 each year); 90 minute each, for 84 parents/year.

With the lower than anticipated numbers of families enrolling and graduating from the Triple P Parenting Groups in year's one and two of implementation, INSPIRA once again revised their strategy in year three. Starting in October 2013, INSPIRA decided to offer a Selected Seminar Series in Triple P. The Selected Seminar Series in Triple P was structured so that parents could attend one, two or three seminars based on their needs and availability. Seminars were offered monthly for ninety minutes and covered the following topics; The Power of Positive Parenting; Raising Confident, Competent Children; Raising Resilient Children. With this strategy, INSPIRA was able to reach ninety three parents, the majority Spanish speaking, with many parents attending three seminars.

The prevention programs described above are able to thrive and expand to reach additional families and children each year with the assistance of CBCAP and CTF funding. These initiatives have displayed an effort and ability to align with New Jersey's Statewide Prevention Plan, and the Department of Children and Families Strategic Plan. CBCAP funding is strategically provided to initiatives which support the mission of enhancing community based child maltreatment prevention efforts and which align activities and services with New Jersey's priorities in prevention.

CBCAP Funded Programs Level of Service

CBCAP Funded Program	Families	Children	Parents	Professionals
Strengthening Families Initiative	5,244	6,061		126 centers
Cumberland County Council for Young Children	114	18	120	109
(5) Family Success Centers	3,002			320
New Jersey Child Assault Prevention Program (NJCAP)		91,475	11,932*	11,932*
Domestic Violence Liaison (DVL)			5,716**	
Public Awareness/Education Activity				
Safe Haven	32.4 million campaign ad impressions 170,000 water safety magnets			68,892 through participation in 11 conferences

* This number reflects the total number of adult participants in NJCAP, parents and professionals combined
** This number reflects the non-defending parents. Often work with these parents includes work with children

In addition to those services listed above for children under the age of five, the following additional activities and services also are targeted to promote the safety, permanency and well-being of this at risk population.

Concurrent planning is required for all children in out of home placement. This practice provides planning for reunification while simultaneously implementing an alternative or back up permanency plan in the event that reunification is not successful or in the best interests of the child.

When out of home care is necessary, the case planning will offer opportunities to engage the family, identify relatives and friends who may provide support, and begin the formation of a team. Placement has a significant impact on parents and children. The identification of needs and strengths, as well as assessment and planning, especially concurrent planning, must begin immediately. The needs of the family and child are ascertained through the structured decision making tools, review of history and collateral information, engagement with the members of the family themselves, and sharing and understanding their story. At every stage of placement, there are decision points and discussions required between worker and supervisor, as well as tasks to ensure the health and well-being of the child. Throughout the course of the out of home placements, parents' strengths and needs are assessed in relation to the child's safety, permanency and well-being.

Following is a summary of procedures and time frames that are in place to reduce the length of time children in foster care under the age of five are without a permanent family:

Within Five Days of Placement

- 72 hour pre-placement conference with family
- Initial court hearing
- Initial MVR with child
- Family team meeting (FTM) prep
- Arrange and conduct 5 day parent/child visit and develop visitation plan
- Conduct safety assessment of out of home placement
- Request for home evaluation for relative providers

Within Thirty Days of Placement

- Initial FTM
- 30 day staffing between supervisor and caseworker
- Case plan developed
- MVR schedule reviewed
- Structured Decision Making Tools discussed
- Safety Assessment reviewed
- Prepare for the 45 day Child Placement Review Board enhanced review
- Review/Maintain visitation schedule

Within 90 Days of Placement

- First Quarterly FTM
- 90 Day staffing with Casework Supervisor, Supervisor and worker
- Update Family Agreement and Case Plan as necessary
- Maintain visitation schedule

Within Four to Eight Months in Placement

- 5 month enhanced review conducted by the Administrative Placement reviewer
- Update case plan
- Complete out of home safety assessment
- Completed the reunification assessment caregiver strength and needs assessment

Within 10 months of Placement

- Third Quarterly FTM
- Ten month Family Discussion
- Ten month Family Enhanced Review
- Pre-Permanency Hearing Litigation conference

At the tenth month, families with children in care are reaching a critical decision point. The progress of the parents and the ability of their team to support and sustain them may create circumstances where reunification is viable. Visitation, parenting supports, and other activities to ensure the long term safety and stability of the home are intensified to bolster the likelihood of successful reunification.

If a lack of progress has made continued placement likely, the ten month family discussion offers an opportunity to redouble reunification efforts or to look at formalizing the alternate permanency plans that are in place. The decision to seek termination of parental rights or an ASFA exception is made, and the preparation for completion of adoption or Kinship Legal Guardianship begins.

Through the practice of making the child's first placement, the best placement and the use of relative resources the child is able to maintain family and community connections. If reunification is not possible, many of our children are able to remain in their current placement and be adopted. If a child's goal is selected home adoption and there are no available homes, a child specific recruitment plan is developed. The goal is to have every child achieve adoption within 9 months of termination of parental rights.

NJS tracks all children in out of home placement to ensure timeliness of case plans, family team meetings, five month enhanced reviews, ten month enhanced reviews ASFA compliance, recruitment plans, Structured Decision Making safety and risk assessments. Screens also capture contacts/visitation with parents and children- see Update on Performance and Progress section for performance in these areas.

In order to evaluate a child's health care needs upon placement in an out of home setting, a pre-placement assessment is completed within 24 hours. The Child Health Unit (CHU) in each local office is notified of the placement and a nurse is assigned to provide health care management. Staff from the CHU schedules the child for a Comprehensive Medical Examination within 30 days of placement. A CME involves a comprehensive physical, including a developmental history and evaluation, and an initial mental health screening. Mental

health screenings determine if a child has a suspected mental health need. In addition to the CME providers, the CHU and DCP&P casework staff is also required to routinely screen children for suspected mental health need. If a child is suspected to have a mental health need, a full mental health evaluation is then expected to be conducted. The CME medical practitioners provide DCP&P with a report identifying the child's medical history, current health issues and recommendations for follow-up treatment. The assigned nurse arranges for follow up treatment to meet the developmental and health needs of the child. In addition, the CHUs engage in nursing interventions in collaboration with DCP&P around coordinating specialty care, monitoring medications for chronic health conditions and behavioral health needs, and providing education and guidance to resource providers on how to meet the needs of children in their care. This includes preparing an initial health passport within 72 hours of placement and periodically updating the document as medical, mental health and developmental information becomes available. This document is prepared for every child in out of home placement and a copy is given to the care provider and the DCP&P worker.

Services to address the developmental needs of the under 5 population include referral to early intervention services as well as enrollment in a preschool program.

In addition there are numerous training courses are offered to resource families and DCF staff with respect to this population that can be viewed in Attachment D: Training Plan Updates

Outreach & Collaborative Efforts to Populations at Greatest Risk of Maltreatment

The wide diversity of New Jersey's population requires that funded programs and staff be culturally representative and culturally responsive to the needs of program participants and families. In addition to addressing community-specific ethnic and cultural diversity and barriers to care, Division of Family and Community Partnerships (DFCP) funded programs integrate outreach functions as a core component of services to ensure that the State's underserved and underrepresented families (pregnant women, children, mothers and fathers, and other caregivers) have access to needed services and supports. Special need is broadly defined in New Jersey to include medical, behavioral, and mental health needs; substance use; disability; developmental delays; educational/ literacy needs; homelessness/near homelessness; unaccompanied homeless youth; adult former victims of abuse/neglect; victims of domestic violence; incarceration; unemployment; uninsured/underinsured; immigrants and refugee populations. A primary focus of NJ's funded prevention programs is on populations where special needs are coupled with poverty and related socio-economic barriers.

Efforts to reach NJ's most at-risk families and communities occur consistently across all DCFP and DOW Offices. In its role as the CBCAP lead agency, DFCP has utilized available funding (CBCAP, state match and CTF) to advance efforts to reach special populations and provide culturally competent and responsive services. These funded community partner agencies implement grant programs that strive to be responsive to special populations. Community

partners work more intimately with individuals and families to identify and address barriers, and when needed, fulfill the role of a cultural broker.

Parents with young children are a priority population for various initiatives in the Office of Early Childhood Services (OECS). Strengthening Families is implemented primarily through early child care and education settings in order to target the parents and caregivers of the young children enrolled. The Early Childhood Comprehensive Systems Grant/Help Me Grow, as well as Project LAUNCH target and provide services for families with children birth to age eight. In addition, Evidence Based Home Visiting and Central Intake target pregnant women and families with children up to age five. Community members and parents from all ethnic and racial backgrounds are essential participants in all County Councils for Young Children and advisory boards for the identification of diverse community needs. Also in FFY 2014, DFCP continued to expand its network of partner organizations that help to ensure responsiveness to the special needs of children, mothers, fathers and families. DFCP deepened key relationships with the following partners to further efforts to reach families with special needs: The Elizabeth M. Boggs Center on Developmental Disabilities/University Center for Excellence in Developmental Disabilities, Statewide Parent Advocacy Network (SPAN)/Community of Care Consortium for Children and Families with Special Health Care Needs (CYSHCN), Early Intervention Services (Part C) in the Department of Health, and Preschool Special Education (Part B) in the Department of Education. All of these agencies have active participation in the systems integration work of ECCS/HMG grant workgroups and Race to the Top Early Learning Challenge.

Family Success Centers (FSCs), under the Office of Family Support Services (OFSS), maintain parent advisory boards which aim for representation of the ethnic and cultural diversity that characterizes the surrounding community. FSCs offer programs and services specifically driven by the self-identified needs of the local community, which include services for young children and their parents, parents and children with disabilities, parents and children from underrepresented cultures and ethnicities, and homeless families or families and children at risk of homelessness. By providing services based on needs of the families within the community, all populations receive assistance and support from the FSCs.

Fathers are an underrepresented population which the Office of School Linked Services (OSLS) focuses many programs and services. Key staff from all DFCP Offices actively participate on the NJ Division of Family and Community Partnership Fatherhood Committee. The focus of this Committee is to partner with communities to promote safe and healthy father involvement in the lives of their children and families. The Fatherhood Committee worked with Federal, State and local partners throughout FFY 2014 to integrate fatherhood programs throughout the State. Planning for the 2015 Fatherhood Conference, hosted by OSLS, also began in FFY 2014. This annual conference provides workshops and resources related to responsible fatherhood. In addition, New Jersey in collaboration with the Administration for Children and Families (ACF) encouraged schools and Head Start programs across the State to welcome fathers as they

recognize Dads Take Your Child to School Day New Jersey. On Friday, September 19, 2014 schools throughout New Jersey celebrated “Dads Take Your Child to School Day (DTYCTS)”, a special day to encourage the involvement of fathers and other significant male caregivers in the lives of their children, starting with a trip to school. OSLS worked collaboratively with 22 schools in the State to plan events for fathers and father figures to take their children to school in an effort to jump-start and renew a commitment to participate in their children’s education. ACF Region II shared the NJ DTYCTS Planning Guide with its Head Start providers. Over 1,200 fathers participated in DTYCTSD.

The Division on Women (DOW) and the Office of Domestic Violence Services (ODVS) provide supports and services for all individuals throughout New Jersey experiencing domestic and/or sexual violence. DOW establishes connections with State departments and other public and private agencies involved with laws, regulations and program development affecting women in joint efforts to expand opportunities for women. In this capacity, DOW collaborates with other State departments to understand and address the changing needs and concerns of women. The Domestic Violence Liaison (DVL) program in ODVS offers specific services and supports to families experiencing the co-occurrence of child abuse and neglect and domestic violence. ODVS also provides services for fathers through the Responsible Fatherhood/Batterers Intervention program in Sussex, Middlesex, Morris and Atlantic Counties. This program aims to assist fathers and families in moving towards a non-violent, non-coercive family structure, to increase safety within households, and to set clear boundaries to prevent future violence.

SECTION C:

Services for Children Adopted from Other Countries

Inter-Country Adoptions

Children adopted internationally do not usually interface with the public system as the families interested in adopting children from other countries work in concert with the private adoption agencies.

Though the New Jersey Division of Child Protection and Permanency (DCP&P) is not involved in the initial adoption proceedings for children placed internationally, the agency funds a network of post adoption support services that any adoptive family in the state may utilize. Thus the Department of Children and Families (DCF) does make post-adoptive services accessible to any adoptive family living in New Jersey with a minor child, regardless of the source of the adoption.

New Jersey maintains a statewide Post Adoption Counseling (PAC) program that is administered locally by a network of contract agencies with adoption expertise. Through this program, adoptive families can access a variety of adoption-related supports. The PAC services are covered by contractual agreements between DCF and the specific agency and thus are offered to the adoptive family free-of-charge. The vast majority of program resources are devoted to a few core services: (1) in-home therapeutic services; (2) child and family counseling; (3) behavioral supports to adoptive families; (4) education, resource and referral services through an online adoption clearinghouse (www.NJARCH.org), as well as, a warm line for immediate support; and (5) family respite through structured child activity.
These services are directed towards:

- Preventing adoption disruption and dissolution
- Preventing the residential placement of adopted children
- Promoting the successful reunification of children to their adoptive families from residential placement
- Providing therapeutic support and guidance to adoptive families where dissolution or disruption is not a threat

Progress and Accomplishments:

- The Department of Children and Families' Office of Licensing has a process in place to identify the New Jersey adoption agencies that handle inter-country adoptions by New Jersey families. The agencies are required to maintain information regarding the number of their inter-country adoptions and the countries from which the children originate. This information is accessible by the Office of Licensing.

- In the event of an inter-country adoption disruption, New Jersey will work with International Social Services (ISS) to determine if there is a kinship home in the child's country of origin. If so DCF will work with ISS to facilitate the placement.

- Data on inter-country adopted children entering state custody was gathered by Area Quality Coordinators, inquiring of all DCP&P Local Office Managers whether any children in their office caseload met the criteria. In FFY 15, there was one child who was adopted from another country that entered into State custody in New Jersey as a result of the disruption of a placement for adoption or the dissolution of an adoption.

SECTION D:

Program Support

DCF has continued work with consultants at National Resource Center for Diligent Recruitment (NRCDR) at Adopt US Kids around Market Segmentation through onsite visits, teleconferences and via e-mail. With the assistance of the consultants at the NRCDR, we have been able to build our capacity to translate the data and use the information to better inform our recruitment efforts. As a result, our targeted recruitment efforts have become more strategic as we take into account lifestyle characteristics, population densities as well as the locations of where children in need of placement are coming from.

In FFY 2014, following statewide and local initiatives have been implemented using Market Segmentation:

- We continue to use the lifestyle characteristics of our current successful families to drive our recruitment strategies in targeted communities
- Continue to update recruitment materials/publications that are customer centered and reflective of the lifestyle characteristics in our market segmentation tool
- Promotional Items will be purchased to reinforce the message that will be developed
- Use lifestyle characteristics to target advertising opportunities within local geographic areas
- Continue use of tracking tools for market segmentation outcomes and targeted geographic and subpopulation outcomes
- With the assistance of the NRCDR at Adopt US Kids, We are developing a method of analyzing data captured that is reflective of the impact of our recruitment efforts
- Recruiters continue to develop new partnerships with businesses/organizations as informed by the market segmentation lifestyle characteristics as well as maintain current relationships
- Participate in peer to peer calls with other States in an effort to learn from each other
- In collaboration with NRCDR at Adopt US Kids, we are developing a workshop for recruiters to more effectively translate Market Segmentation data using communication marketing techniques while out in the community

New Jersey has, for the past several years, focused and succeeded in building a robust pool of licensed families. Our success has allowed us to shift our focus on ensuring that we properly support and retain our current pool of licensed families while continuing to license the right types of families for our children in out-of-home care. Our goal being that it will lead to positive outcomes for both, our children and families. As a result, we requested and received assistance from the National Resource Center for Diligent Recruitment (NRCDR) at Adopt US Kids and have collaborated on developing our capacity to more effectively support all resource families. We have made progress in developing our plan.

In FFY 2014, we implemented or continued the following statewide and local retention initiatives:

- NJ developed a new methodology of identifying local needs that focuses on engagement and retention of current licensed families
- We continue to work with consultants from the National Resource Center for Diligent Recruitment at Adopt US Kids (NRCDR) on-site and through teleconferences
- NRCDR at Adopt US Kids conducted an on-site assessment that included facilitating discussions with staff in different areas of practice as well as licensed resource families

- NJ finalized a framework for retention based practices that will lead to a retention case practice plan and provide the structure to implement changes to policy and practice
- NJ Commissioned the Rutgers University School of Social Work to conduct a study on the perspectives of NJ resource families. The study focused on the experiences of resource parents to gain a better understanding of what are the causes of attrition from the foster care program
- We received the study conducted by the Rutgers University School of Social Work on resource families' perspectives which provided great insight into areas where we are enhancing our practice
- We are in the process of finalizing tools that will allow DCF to gauge family's perspectives regularly
- We are planning a kick off meeting with DCF leadership in the first quarter of 2015 to begin the process of exploring methods to develop a plan of action to implement changes that will strengthen our States ability to effectively retain our current pool of families
- We are developing a statewide taskforce that will include licensed resource families, youth and staff. This taskforce will drive the action steps that will ultimately lead to NJ's retention case practice plan

NJ is dedicated to developing effective strategies that can be implemented to recruit and retain foster and adoptive families that reflect the race and ethnicity of children entering care. We are also determined to continue implementing new and innovative ways of recruiting and retaining families that will result in positive outcomes for our children. We will continue to identify areas of need and work toward continually improving our performance.

The Office of Research Evaluation and Reporting supervises all research related activities and the following represents those activities during the reporting period:

Mother and Infant Childhood Home Visiting Program Evaluation (MIHOPE)	The purpose of the study is to identify the effects of home visiting programs on parent and child outcomes to better understand how local programs operate and to investigate the link between the features of local programs and their effects.
Home visitation enhancing linkages project (HELP): Enhancing evidence based home visitation to address substance abuse, mental health and DV.	The purpose of the study is to evaluate a standardized protocol for home visiting services that will aid home visitors in better identifying substance abuse, mental health and domestic violence problems with their clients and provide linkages to needed services. It compares treatment and control groups on risk identification and treatment engagement outcomes.

HomeStyles: Shaping Home Environments and Lifestyles Practices to Prevent Childhood Obesity	The purpose of this study is to determine whether a novel in-home intervention enables and motivates parents in NJ and AZ to shape their home environment & lifestyle behavioral practices (diet, exercise, sleep) to prevent excessive weight gain in preschool kids (ages 2-5 y.o.) to a greater extent than a control group. It will determine if the effectiveness of the intervention is impacted by home visiting personnel versus independent learning (online delivery).
Youth Perspectives on the Youth Advisory Boards	The purpose of the study is to understand how youth are benefitting from Youth Advisory Boards. It will assess how effective YABs are at empowering youth, identify which YABs may be more effective and which youth seem to engage with YABs and benefit more.
Domestically Trafficked Adolescents	This study will identify best practices and create a replicable model of providing residential services for domestically trafficked adolescents (DTAs).
The Assessment of Parent Linking Programs Project	This project will help determine the efficacy of the Parent Linking Program (PLP) for the current teen parent participants of the program. It will describe the resources, logistics and activities of each PLP site and assess knowledge of parenting skills and healthy child development, as well as reductions in involvement with child protection services.

In addition to the research activities, RER provides on-going training and technical assistance at the local, area and statewide level to DCF staff on performance indicators, data and outcomes. Monthly Key Performance Indicator calls with CP&P local office staff is one example. These calls focus on the review of key performance indicators for that office and identify areas of strength as well as areas to improve upon both from a quantitative and qualitative perspective. RER further engages with external stakeholders when requests are made for performance data outcomes and/or explanation of published data. RER frequently attends collaborative external stakeholder meetings to review and educate on DCF performance data indicators. RER provides on-going technical assistance to the Federal Monitor who oversees NJ Modified Settlement Agreement.

NJ DCF provides several opportunities of Training and Technical Assistance to internal staff as well as external partners at the local, area and statewide level. Several training opportunities are described in detail in Attachment D: Training Plan Update.

Local Resource Development Specialists provide training and technical assistance to community partners regarding CP&P policies and practices.

CP&P Executive leadership along with Area Office and local leadership presented training to CP&P staff and external partnerships on the Back to Basics concept. This supervisory model focuses on the use of family history to help inform decision making as well as enhance engagement with families. CP&P leadership partnered with local offices in developing their individual framework to meet the needs of the populations they serve.

The Office of Adolescent Services provided the following program support to DCF staff as well as community partners:

- Through the Adolescent Practice Forums which includes CP&P, Children's System of Care, Care Management Organization, and DCF Office of Education staff, several informational presentations and mini trainings were held on a variety of topics including Medicaid Extension, educational initiatives, youth engagement, trauma informed care, employment resources, expectant and parenting youth and permanency initiatives.
- OAS provided the Got Adolescents? Training to CP&P staff. The training covers adolescent policy, practice and resources.
- The Post BA Certificate in Adolescent Advocacy was offered to 40 DCF staff. The program at Montclair State University is a fifteen credit certificate focused on adolescent advocacy and case practice. It is designed to provide students with a multidisciplinary understanding of the role of the adolescent advocate seen through the disciplines of law, sociology, and psychology.
- DCF provided human trafficking prevention trainings to community contracted providers, Resource Parents and youth through a contracted provider.
- OAS provided in-service training to the Safe Space Liaisons on a variety of topics including New Jersey's anti-bullying bill of rights, holistic LGBTQI services for youth, and working with LGBTQI families.

- DCF provided the Value of Permanency training in conjunction with the Permanency Roundtables which included information on the importance of legal permanency for older youth.
- OAS provided training on the new Transitional Plan for YOUth Success for adolescent serving CP&P staff.
- OAS provided training on the NJ Career Assistance Navigator to CP&P staff as well as contracted providers.

OAS provides ongoing adolescent case practice technical assistance to all CP&P staff statewide.

NJ has also begun the process with assessing additional Training and Technical Assistance needs through the Capacity Building Center Collaborative. NJ completed the introductory call with the Capacity Building Centers for States in May 2015 and will be completing the Capacity Assessment in the following months. One area of focus for assistance that NJ anticipates in working with the Capacity Building Collaborative is around enhancing NJ Continuous Quality Improvement. Other areas for further exploration of T/TA from the Capacity Building Collaborative are:

- Talk to and learn from other jurisdictions who provide services to youth 18-21
- NYTD data collection
- Supervisory level transfer of learning
- Savings accounts for youth in care (including minors)
- Serving expectant and parenting youth

SECTION E:

Consultation and Coordination between States and Tribes

Tribal Consultation - Indian Child Welfare Act (ICWA)

New Jersey has no federally recognized tribes, but three State-recognized tribes. The Ramapough Mountain, Nanticoke-Lenape, and Powhatan-Renape, as well as Inter-tribal people who lack a formal tribal affiliation reside in NJ. The Department of Children and Families may provide services to children who are members of one of NJs State-recognized tribes, as well as children who currently reside in New Jersey but are members of, or eligible for membership in, tribes outside of New Jersey. New Jersey seeks to appropriately serve Indian children within the requirements and spirit of the Indian Child Welfare Act, regardless of their tribal affiliation. In an ongoing effort to build collaborative relationships with communities throughout New Jersey, DCF has in the past solicited feedback from the Commission on Indian Affairs, which is administered through the New Jersey Department of State.

The number of Indian children who come into services through CP&P is small. CP&P has developed policies and procedures to address the provisions of ICWA relative to identifying a child of Indian heritage; addressing removal and placement; and selection of a resource home, including an adoptive home. NJs work in this area has included outreach to the Commission, which continues to provide advice on a case specific basis, as well as consultative services in order to meet the requirements set forth.

All new adoption workers are trained on the rules and guidelines of ICWA. With this, an integrated practice guide is available to assist staff in appropriately identifying any tribal affiliations of youth within the first five days of placement. Concurrent Planners also regularly discuss a child’s possible tribal affiliation to ensure staff is continually following up on the issue and appropriately collaborating or transferring cases to tribes when necessary.

The Administrative Office of the Courts has also worked to strengthen its protocol to handle cases under ICWA. In ongoing practice, the courts and the Deputies Attorney General apply the provisions of the Indian Child Welfare Act successfully. They require that tribal affiliations be included in all final adoption papers. Matters which must be transferred to tribal jurisdiction are handled appropriately, focus on the law, and their interactions with staff are maintained as necessary.

In discussion with the Commission about ICWA, the following feedback was received:

- While ICWA addresses Federally-recognized tribes, it is important to abide the intent relative to State-recognized tribes so that Indian children are provided culturally appropriate services.

- The Commission has developed a web-site that provides information to all state departments and the general public about issues of concern to the tribes, background on tribal origins and important events.

- The Division’s case practice reform efforts continue to expand with key components focused on engagement of families and their ability to share their own background and history. The core of the practice reform focuses on services customized for the family’s

needs, the use of self-selected family supports and community resources and the use of family meetings as a planning mechanism. All offer tribal members a means to keep children within their communities and enable them to receive supports that fit their needs. DCF has presented information regarding these reforms, and on the process of relatives and kin becoming caregivers to tribal leaders and the larger community.

- The Commission continues to be available to help the child welfare agency to resolve a child's status.

- Commission representatives will be involved in the Round 3 CFSR process in 2017. Their input will continue to be sought in child welfare processes.

SECTION F:

Monthly Caseworker Visit Formula Grants

Funding to Support Casework Visits

The Caseworker Visitation Grant provided DCF the opportunity to purchase 330 iPad 2s (accessories & licenses) to further support casework staff in documenting parent/child visits in a timely manner. Workers will use the "Go to my PC" software to access their desktop computer and enter information directly into NJ SPIRIT.

New Jersey Monthly Caseworker Visits Data for APSR

Procedure to Track and Report Caseworker Visit Data

DCF utilizes NJSPIRIT, its SACWIS system, as its source for reporting Monthly Caseworker Visits and Visits-In-Home. The calculations for this requirement are done in compliance with the Federal methodology to provide the aggregate number of children served in foster care, the number and percentage of child contacts made with children in foster care for each reporting month, and the total number of visit months in which at least one visit occurred in the child's residence. The procedure for reporting on monthly visit compliance is to archive the data after a selected period and to use that data for compilation.

In addition to data from NJSPIRIT, New Jersey uses SafeMeasures as a reporting tool to track numerous outcome measures. This allows DCF to track and report on compliance in several outcome measures at various points and at different levels of the organization – worker, supervisor, Local Office, Area Office and statewide.

SafeMeasures reports for complete months. The compliance rating is based on having a contact in the selected month with children who are in care. Children without contacts who have exited care during the selected month, or who entered care during the selected month in conjunction with the opening of a new case, are not included in the compliance reporting for that month.

In compliance with the Federal requirement *for Monthly Caseworker Visits*, New Jersey has set a target of 30% for MVC for FFY08, 50% for FFY09, 65% for FFY10 and 90% for FFY11. During this period of time, NJ targeted VIH compliance at 85%.

During FFY11, New Jersey did not meet its target of 90% for Monthly Caseworker Visits. New Jersey's compliance level of 81.5% for FFY11 was partly due to the challenges that we had in the months of August and September 2011 as a result of the impact of Hurricane Irene. New Jersey, however, exceeded its target of 85% for Visits-in-Home. The percentage of visits that occurred in the child's residence during FFY11 was 96.8%.

During FFY12, New Jersey's compliance level of 96% exceeded the federal Monthly Caseworker Visits Target of 90% for FFY2012. New Jersey's compliance level of 96% also exceeded the federal Visits- in Home Target of 50% for FFY2012.

During FFY13, New Jersey's compliance level of 98% exceeded the federal MCV Target of 90% for FFY2013. New Jersey's compliance level of 96% also exceeded the federal VIH Target of 50% for FFY2013.

During FFY14, New Jersey's compliance level of **99%** exceeded the federal **MCV** Target of 90% for FFY 2014. New Jersey's compliance level of **96%** also exceeded the federal **VIH** Target of 50% for FFY 2014.

Below is the data for Monthly Caseworker Visits with children in placement and Visits –in-Home for FFY2014:

MCV and VIH data for FFY14		
1	Aggregate number of children in the Data Reporting population	10,290
2	Total number of monthly caseworker visits made to children in the reporting population	79,465
3	Total number of complete calendar months children in the reporting period spent in care	80,448
4	Total number of monthly visit made to children in the reporting population that occurred in the child's residence	76,235
5	**MCV** - Percent of Monthly Caseworker Visits Made to children in the reporting population	**99%**
6	**VIH** - Percentage of monthly visits made to children in the reporting population that occurred in the Child's residence	**96%**
	MCV TARGETS	90%
	VIH TARGETS	50%

SECTION G:

Adoption & Legal Guardianship Incentive Program

&

Child Welfare Demonstration Activities

Adoption Incentive Award

We currently do not have an Adoption Incentive Award.

Child Welfare Demonstration Projects

We currently do not have child welfare demonstration project.

SECTION H:

Quality Assurance System

Continuous Quality Improvement
Plan Implementation Update

New Jersey's Department of Children and Families (DCF) has made the development of a robust and fully functional Continuous Quality Improvement (CQI) system a priority through both its department-wide Strategic Plan for 2014-2016 as well as its Child and Family Services Plan (CFSP). DCF has laid the groundwork to ensure the integrity and quality of DCF's CQI system is measurable and informs internal and external stakeholders of the results and outcomes achieved. The goal is to make CQI a seamless part of the way DCF works each day.

The DCF has embraced the five key components of the CQI system and is actively designing, planning and implementing an array of activities in order to have a fully functioning system in the near future. For example, one of our first steps is to engage the leadership and raise basic awareness of CQI activities occurring at DCF while simultaneously continuing to strengthen the foundation of CQI within the department.

In this update each of the five components will be addressed to provide an update of the DCF's identified strengths, concerns and enhancements.

I. Foundational Administrative Structure:

Goal: *Administrative structure requires that every CQI system have a strong administrative oversight to ensure that its CQI system is functioning effectively and consistently, and is adhering to the process established by its leadership. There is a systemic approach to review, modify, and implement any validated CQI process. Additionally, it requires that the state has established written CQI standards, approved training process for CQI, written policies, procedures, and practices and has resources to sustain an ongoing process.*

- **Strengths**
  - New Jersey established the Office of Performance Management and Accountability (OPMA) as the foundational structure having oversight, coordination and guidance of numerous CQI activities statewide. OPMA has 12 staff and 15 staff in the Office of Research Evaluation and Reporting (ORER) dedicated to CQI projects which encourages sustainability of initiatives as well as gives the agency personnel resources to assist with implementation of new or existing projects.

  - OPMA requires specialized training with a certification process for staff who participates in Qualitative Reviews (QR). New Jersey also offers training for reviewers participating in targeted reviews that covers elements of the review tool, policies, protocol and an evaluation process which is standardized. The

process includes stakeholders as reviewers and invites stakeholders to the Exit Presentation and the resulting Program Improvement Plan development.

- New Jersey has makes data available to stakeholders and the public on the QR process and results.
- New Jersey recently implemented a section of the DCF public web site, the DCF Policy Manuals, devoted to communicating the policies and procedures by which DCF provides its services. Policy and procedures are issued by the Department and its divisions and offices.
- New Jersey continues to build clear written policies, procedures and practices for all activities within CQI. New Jersey is drafting an Administrative Order (a uniform policy impacting all DCF employees) which sets consistent expectations across the state regarding CQI activities.
- DCF hold weekly Data Quality and Compliance meetings with DCP&P during which data is used to inform decision making and to focus on CQI activities.
- DCF has drafted a CQI plan and established the Department Wide CQI logo and supporting documentation for posting on the DCF website.
- DCF held a statewide educational data on CQI and drafted an employee training on the elements of CQI, and will seek its integration into new worker orientation.
- DCF help Area data meeting with DPC&P 10 Areas and include both Area and their respective Local Office leadership. These meeting utilized outcome, longitudinal, qualitative and quantitative data.
- DCF is collaborating on several Federal and statewide projects (i.e. YARH, Dept. of Agriculture, Dept. Of Education, MIECV) with different stakeholders to build a stronger partnerships on behalf improving outcomes for our families, children and youth

❖ **Needs**

- New Jersey developed draft policy and procedures to ensure consistency and uniformity across the state specifically for CQI related activities. Once finalized, this policy will be incorporated in the DCF Policy Manuals and available on the DCF public website. New Jersey intends to build upon some of the elements of the QR training for other training focused on developing CQI team members locally.
- New Jersey currently does not have uniform training for staff members that engage in CQI activities.

II. <u>Quality Data Collection:</u>

<u>Goal:</u> *Quality data collection is the collecting of both quantitative and qualitative data from a variety of sources and is the foundation of CQI systems. The data must be accurate complete and timely and must be used and defined consistently across the state. Quality data collection can identify areas of strengths, concerns, establish targeted strategies for improvement.*

❖ **Strengths**

- NJ's SACWIS system, New Jersey Spirit (NJS) is the system of record for the Division of Child Protection and Permanency (CP&P). NJS has system edits and validations, required fields, supervisory approvals, ticklers, and an Exception window all of which are utilized in various ways to ensure accurate, timely, data entry and supervisory oversight.
- Data from NJS is extracted via batch code to meet federal reporting requirements for AFCARS, NCANDS, and NYTD submissions.
- The State AFCARS and NCANDS Coordinator reviews ongoing periodic reports designed to monitor the timely entry and compliance. The Coordinator then works directly with the Area Office Quality Coordinators to improve the accuracy of this data as applicable. The Coordinator provides training as needed for new system functionality and for ongoing data quality improvement initiatives.
- New Jersey is in an AFCARS Improvement Phase (AIP) and making steady progress in mitigating findings rendered including identifying and implementing activities, tasks, and system changes directed at on-going data quality improvement.
- NJS data is also transformed through the SafeMeasures (SM) software application into a reporting system available as a case management tool. SM is available to frontline caseworkers, supervisors, and managers throughout the agency. SM contains over 100 screens with child level data and displays data monthly to casework and administrative staff and is used to guide workflow, track timely data entry, ensure data quality, and measure performance.
- Key Performance Indicator calls (KPI) calls are facilitated by OPMA and involve those in decision making and leadership capacity in the Area and Local Offices. The calls are enormously successful in refining focus on several critical areas of practice as well as providing a tool for performance management. Some areas of practice reviewed in the KPI calls include: Case Plan timeliness, caseworker contacts with children in placement and their parent(s), parent/child visits, sibling visits, and Family Team Meetings. The focus is on current and upcoming work, overdue work and outliers in performance. The KPI calls allow Local Offices to identify and address local and systemic issues and are solution focused in nature.
- New Jersey has a mechanism for tracking staff training through the Office of Training and Professional Workforce Development that includes an electronic transcript available and staff and supervisor electronic notifications of class related information.
- DCF has expanded its efforts to be more transparent by posting Department

wide data on its public website. We also share our data via requests from other stakeholders. This includes data through specified data collections from Children's System of Care and Family and Community Partnerships.

- New Jersey continues to build capacity through training, the Fellows program, and the use identified positions to ensure that data is current and when needed training is occurring to share strategies for improving data accuracy.
- DCF has initiated the 3 year Needs Assessment to look at the needs of children, youth and families and the services that are contracted to assist them. In addition DCF completed the DCF Trauma Needs Assessment and the Youth Needs Assessment.

❖ **Needs**

- New Jersey continues to work on steps to improve data accuracy through ongoing training, oversight, and incorporation into CQI process. In particular, New Jersey is piloting a process to engage front line staff in a learning opportunity aimed at improving documentation and the overall quality of data input.
- New Jersey is in an AFCARS Improvement Phase and working toward completing all tasks/revisions with the approval by the Children's Bureau. DCF will need to demonstrate that the quality of the data has improved and been maintained.
- OPMA staff is working to transition the facilitation and oversight of the KPI calls from OPMA to the Area Director (AD) who oversees the Local Offices.
- New Jersey is developing a sustainable process for internal audit process.

III. Case Record Review and Data Process

A CQI system that has ongoing case review components that includes reading case files that are served by the agency under the title IV-B and IV-E plans and interviewing parties involved in the cases is present. Case reviews help states understand what is behind the safety, permanency and well-being numbers in terms of day to day practice in the field and how the practice is impacting child and family functioning and outcomes.

- **Strengths**
  - New Jersey operates a case review process called the Qualitative Review (QR). The largest metro area is reviewed annually in through the QR.
  - New Jersey finds consistent themes in strengths and areas needing improvement across multiple years through the QR. Sixteen of the twenty-one counties are reviewed annually. Quality performance on prior QRs is one element used to determine which counties are reviewed annually.
  - New Jersey has detailed procedures and processes in place related to the QR. Procedures are reviewed and updated annually. There is a manual for the QR which is posted on the DCF internet. Internal forms and tools are also posted on the intranet to encourage transparency and consistency. There is training and a certification process for all QR reviewers and Team Leads from PMA who lead the review process and perform quality assurance processes during the review. Reviewers are also paired to provide mentorship to less experienced reviewers as well as to provide inter-rater reliability.
  - New Jersey conducts multiple targeted reviews and audits and uses the result to inform and enhance practice and child and family outcomes. For example, New Jersey has reviewed its practice with older adolescents to see what that process outcomes are achieved with this population. Results are disseminated broadly.

- **Needs**
  - New Jersey will work to develop specific plan for Title IV-E and Title IV-B sampling and a have continuous training for Title IV-E and Title IV-B staff.
  - New Jersey continues to assess the case review process as part of the CSFR and how it relates to the QR process in existence.
  - New Jersey is working on policies to clarify areas like reviewer conflicts of interest.
  - New Jersey continues to develop capacity to conduct targeted reviews on a variety of practice areas. Currently, staff resources are a combination of PMA and local field staff with expertise in the area of review. Such a practice has been beneficial in dissemination of lessons learned quickly. This process needs further refinement to ensure expectations are clear and targeted reviewer staff can translate their experience into CQI activities on a local level.

IV. Analysis and Dissemination of Quality Data

The state should have the ability to collect data from various sources, and have varying capacities to track, organize, process and regularly analyze information

and results. The state should have a consistent and well defined mechanism in place for collecting and analyzing data.

- **Strengths**
  - Data from NJS is extracted via batch code to meet federal reporting requirements for AFCARS, NCANDS, and NYTD submissions. DCF routinely incorporates the use of the federal validation tools such as the AFCARS Compliance, Frequency, and Quality Utility reports in assessing the quality and accuracy of AFCARS data, and the Enhanced Validation and Analysis Application (EVAA) used to validate and analyze NCANDS Child File data.
  - ORER provides DCF with quantitative and qualitative information necessary to measure and support organizational performance; report on the outcomes of service delivery to children and families; and to comply with state and federal requirements. It strives to produce information that can be used effectively by front-line staff; management and administration; and stakeholders.
  - SafeMeasures (SM) software application is available to frontline caseworkers, supervisors, and managers throughout the agency and is used to guide workflow, track timely data entry, ensure data quality, and measure performance.
  - Hornby Zeller Associates, Inc., transform data recorded in NJS into longitudinal data reports. DC&P, OPMA, and ORER management staff meet regularly to review and discuss longitudinal child welfare outcomes data to assess strengths and challenges, and for program and case practice planning and analysis. Management staff from OPMA, ORER, and CP&P held meetings with Area and Local Office staff to present the longitudinal data and provided guidance on interpreting and utilizing the data in their day to day work. RER and HZ staff also presented the longitudinal data to the Area Quality Coordinators with guidance on interpreting and utilizing the data.
  - The Manage by Data Initiative (DCF Fellows Program) enables managers to learn how to better use data to support improved case practice and outcomes for children and families with a focus on data analysis skill building and dissemination of data via presentations to management and case practice staff statewide.
  - New Jersey is committed to improving stakeholder engagement through the regular posting on the DCF internet page of various child welfare related reports. These reports are used to guide decision-making as well as to manage workloads. Reports have been well received by stakeholders.
  - New Jersey QR has a consistent mechanism in place for gathering, organizing and tracking information and results regarding safety, permanency, and well-being.

- **Needs**
  - New Jersey acknowledges there is still work to be done to help stakeholders use the available data for analysis as well as to make more data available.
  - New Jersey makes reports and recommendations from targeted reviews available on the internet and more work is needed to improve the timeliness of the

dissemination of the reports.

- DCF is in the process of a more complex statistical analysis to look at family risk and protective factors to predict outcomes for children and families.
- DCF has initiated the 3 year Needs Assessment to look at the needs of children, youth and families and the services that are contracted to assist them. In addition DCF completed the DCF Trauma Needs Assessment and the Youth Needs Assessment.

V. Feedback to Stakeholders

Goal: A functioning CQI system demonstrates the state's ability to share critical information and data collected with stakeholders, and agency staff. This is a critical component to driving change within the organization. Such collaborative efforts are critical to improving outcomes for children and families.

❖ Strengths

- New Jersey is committed to sharing results of its assessment processes publically with internal and external stakeholders. For example, results from the QR process, prior CFSR rounds and targeted reviews are shared with staff and the results are placed on the DCF website in an effort to help inform all of strengths and areas of improvement.
- New Jersey has successfully piloted monthly conference calls with local leadership and staff from PMA to track and monitor key areas of performance to improve outcomes. On-going work is reviewed, upcoming work is anticipated and barriers to performance are identified through the calls.
- Using a SharePoint site, monthly reports are routinely posted for local leadership to access. Reports have recently included data on local key child welfare outcomes.
- Stakeholders are invited to participate in a range of CQI activities including development of local QR PIPs, attendance and participation at ChildStat as well as providing input and feedback on the DCF Strategic Plan.
- New Jersey also has implemented a process by which resource (foster) parents can offer feedback on the system on an annual basis through a survey. The survey is analyzed and actionable next steps are formulated.
- DCF is a learning organization and committed to transparency in sharing critical data with agency staff and stakeholders. This commitment is evidenced by the multitude of data reports made available on the public website, some of which include:
    1. The Commissioner's Dashboard - a monthly report of selected data points that helps us understand the families we serve and how we are doing. It reflects work across the department. The Commissioner's Dashboard helps guide our efforts as we strive daily to fulfill our department-wide vision and mission.
    2. Caseworker Visits for Children in Foster Care - a critical indicator of performance that we monitor very closely.

3. Foster Care Entry Rate per 1,000 children - significant changes in the entry rate may reveal trends that require further analysis to understand the fluctuations, point to the need to consider changes to the services available, and provide important trend information for planning and budgeting purposes.
4. Time To Reunification – one of the various ways we can use data to examine our performance from a broad perspective.
5. Exits to Reunification – informs whether efforts made to improve reunification outcomes are improving over time as new initiatives are put in place.
6. Absence of Maltreatment While in Foster Care - continually monitors performance relating to the small percentage of children who are harmed while in placement so that we can take further steps to further insure the safety of those individual children, while also potentially learning from the situation to inform our future work.
7. Children Re-Entering Foster Care Within 12 Months of a Previous Episode - re-entry rates to help us further examine issues such as assessment processes that precede reunification, as well as the effective of services delivered to the family to assist with reunification. The rate of re-entry is also valuable information to our system partners, such as the Family Courts who also involved in determining whether children should be reunified.
8. Children Without a Recurrence of Maltreatment Within 6 Months of a Previous Incident - Being able to assess the recurrence of maltreatment within a short period of time is important feedback for quality improvement systems.

- DCF has initiated the 3 year Needs Assessment to look at the needs of children, youth and families and the services that are contracted to assist them and is utilizing an external stakeholder advisory boards to assist with recommendations and improvement input.
- DCF introduced leadership to CQI and received critical feedback via focus groups and survey monkey.
- New Jersey uses ChildStat to offer technical assistance and feedback to staff on how data results link to practice change. The goal is to help staff understand the meaning behind the data as well as the larger outcomes that are the most meaningful.
- OPMA and CP&P are hosts to data meetings aimed at examining long term outcomes for the children, youth and families served. Practice trends and data are shared and discussed to determine areas in need of focus, planning and implementation steps.
- Special Reports on Targeted Case Reviews such as DCF Investigations Review, Measuring Services for Youth 18-21 and others: see link for other reports and details http://nj.gov/dcf/about/divisions/opma/
- DCF Office of Advocacy gathers feedback from Constituents and identifies issues and trends to help DCF work in collaboration with its partner agencies to

improve services to children and families.

- **Needs**
    - DCF will introduce leadership to CQI and receive critical feedback via focus groups and survey monkey. This will enhance planning, collaboration and buy-in and implementation.
    - New Jersey will use ChildStat forums to offer training and technical assistance to staff on how data results link to practice change. The goal is to help staff understand the meaning behind the data as well as the larger outcomes that are the most meaningful.

SECTION I:

Child Abuse Prevention and Treatment Act State Plan Requirements & Update

CAPTA Coordinator/State Liaison Officer:

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NEW JERSEY DEPARTMENT OF CHILDREN AND FAMILIES

The State of New Jersey

CHILDREN'S JUSTICE ACT

Performance Report – Federal Fiscal Year (FFY) 2014

The New Jersey Task Force on Child Abuse and Neglect (NJTFCAN) and the New Jersey Department of Children and Families (DCF) is pleased to submit a program report for the Children's Justice Act (CJA) grant. In FFY 2014, CJA funds were used to develop, implement and administer programs designed to improve:

- the handling of child abuse and neglect cases, particularly cases of child sexual abuse and exploitation, in a manner which limits additional trauma to the child victim;
- the handling of cases of suspected child abuse or neglect related fatalities;
- the investigation and prosecution of cases of child abuse and neglect, particularly child sexual abuse and exploitation; and,
- the handling of cases involving children with disabilities or serious health-related problems who are victims of abuse or neglect.

CJA FFY 2014 Grant Activities

In FFY2014, CJA funds were used for child-centered programs and designed to prevent additional trauma to child victims. Since its inception, NJTFCAN has advocated for a statewide multidisciplinary approach to the investigation, prosecution and treatment of cases of child physical and sexual abuse. Model programs funded through CJA provided state-of-the-art training in the identification, investigation and prosecution of child abuse and neglect and improved diagnostic and therapeutic services to child victims and their families.

Model/Demonstration Programs

NJTFCAN Professional Development & Training Programs

Each year, NJTFCAN sponsors multidisciplinary training programs to improve the handling of cases of child abuse and neglect. All NJTFCAN sponsored professional training programs are child-focused and designed to promote skills that prevent additional trauma to child victims and their families.

In FFY 14, CJA funds were used to support the following professional development projects to enhance the knowledge of persons involved in the investigation, prosecution, assessment and treatment of child abuse and neglect.

$76,000 Finding Words-New Jersey: Forensic Interviewing Training

Statement of Purpose

Since 2002, the DCF and NJTFCAN have supported Finding Words-New Jersey, a forensic interviewing program originally developed in collaboration with the American Prosecutors' Research Institute (APRI) and based on the national Corner House protocol RATAC and subsequently disseminated by the National Child Protection Training Center (NCPTC). The goal of the project is to train frontline professionals involved in the investigation and prosecution of child abuse to conduct an effective and legally defensible interview of alleged child sexual abuse victims of various ages and prepare children for court. At the completion of the five day training, participants have a meaningful understanding of important concepts and practices including: child abuse dynamics, children's language and development, memory and suggestibility, the impact of questions on the process of abuse disclosure and factors associated with a credible and reliable child statement.

Forensic Interviewing is one of the steps in most child protective services investigations, including those conducted by DCF's Child Protection & Permanency (CP&P). A professional investigator interviews a child to ascertain whether that child has been abused or neglected. Forensic interviewing not only brings out information that is needed to determine if abuse or neglect has occurred, it may also provide evidence that is admissible in court should the investigation lead to criminal prosecution. A legally sound forensic interview relies on interviewer objectivity, the use of non-leading questioning techniques and precise documentation.

Target Population

- Prosecutors, CP&P child abuse investigators, law enforcement, multidisciplinary teams, and professionals involved in interviewing alleged child victims of maltreatment.

Approach

- Intensive classroom curriculum provided by professionals with expertise in civil and criminal cases of child abuse.

- Lecture, group discussion, role play and videotaped mock interviews.

- Videotaped interviews are critiqued by the teaching faculty with suggestions for improvement.

- Participants evaluate the training and make suggestions for improvement.

Outcomes

Finding Words-New Jersey trainings were held/will be held for a maximum of 40 participants each as follows:

- May 12-16, 2014 – Held in Northern New Jersey in Passaic County (detective/AP from prosecutor's offices, NJSP, DCP&P):
    - 40 participants* from Bergen, Essex, Hudson, Morris, Monmouth, Passaic, Sussex, Warren, IAIU Northern Region.
    - 5 Observers** from Audrey Hepburn Children's House, Dorothy B. Hersh CPC, Center for Evaluation and Counseling Parsippany, Morris County Prosecutor's Office, St. Joseph's Hospital Child Protection and Safety Center.
- October 20-24, 2014 – Held in Central New Jersey in Middlesex County:
    - 40 participants* and 9 observers**:
        - Mercer County: 7 from prosecutor's office, local PD, and CP&P
        - County: 8 from prosecutor's office and CP&P, and Dorothy B Hersh. 3 Observers** from Dorothy B. Hersh.
        - Monmouth County: 4 from prosecutor's office and CP&P
        - Ocean County: 4 from prosecutor's office and CP&P
        - Somerset County: 2 from prosecutor's office and CP&P and 1 observer**
        - Union County: 6 from prosecutor's office and CP&P
        - IAIU: 1 from central region
        - Essex County: 1 from the prosecutor's office
        - Sussex County: 1 from the prosecutor's office
        - Hudson County: 4 from the prosecutor's office
        - Passaic County: 2 from the prosecutor's office
        - AHCH: 5 observers** from the Audrey Hepburn Children's House
- March 9-13, 2015 – Held in Southern New Jersey in Cumberland County:
    - 40 participants* and 3 observers**:

o Atlantic County: 8 from Prosecutor's Office, Local PD's, and CP&P

o Burlington County: 5 from Prosecutors Office and CP&P

o Camden County: 8 participants*, 1 observer**: from Prosecutor's Office and CP&P

o Cape May County: 3 from Prosecutor's office and CP&P

o Cumberland County: 5 participants*, 1 observer**: from Prosecutor's Office, Local PD's, and CP&P

o Gloucester County: 5 from Prosecutor's Office, Local PD's, and CP&P

o Salem County: 4 from Prosecutor's Office, Local PD, and CP&P

o Monmouth County: 1 from Prosecutor's Office

o IAIU: 1 from Southern Region

***Observers did not complete the test and therefore did not complete the training or receive a certificate of attendance.*

- June 1-5, 2015 (Northern New Jersey) - 40 Anticipated

- October 5-9, 2015 (Central New Jersey) - 40 Anticipated
  *[*Actual number of attendees reported]*

  Observers do not conduct the mock interviews with both the child (non-abuse event) and actor (portraying a child victim and using the interview protocol). They attend all the lectures, sit in on the break-out room discussions and take the post test. Observers receive a certificate of attendance while participants get a certificate of completion.]

<u>Impact of the Program on the Child Protection System</u>

The *Finding Words-New Jersey* child-focused forensic interviewing project continues to reform the investigation and prosecution process and improve civil and criminal court proceedings.
To date, over 1,700 professionals involved in investigating child sexual abuse have been trained in the *Finding Words-New Jersey* protocol and have demonstrated, through role play, effective child sensitive interviewing skills. Multidisciplinary team members are more knowledgeable about the process of disclosure, age appropriate guidelines in questioning, child development, barriers to disclosure, memory, perpetrator/victim relationships, suggestibility and problems encountered during the interview.

Some of the outcomes of the training are:

- Prosecutors have adopted Finding Words - NJ as their protocol of choice when interviewing alleged child abuse victims.

- Criminal cases are strengthened with accurate information to withstand legal scrutiny and child victims are better prepared for courtroom testimony.

- Child victims experience fewer traumas during the investigation and prosecution process
- Prosecutors are more sensitive to the special needs of child victims and actively support the development of Child Advocacy Centers (CAC).
- The project is in compliance with the goals of the Task Force CJA Three-Year Assessment to reform the investigation and prosecution process and improve civil and criminal court proceedings.
- NJTFCAN continues to work with DCF to facilitate child-focused forensic training for CP&P child abuse investigative units.

$25,000 - Multidisciplinary Team (MDT) Training

Statement of Purpose

In FFY 2014 CJA funds were used to support one or more statewide training conferences for members of the MDT, child welfare/protection workers and prosecutors' child abuse units.

In 1990, NJTFCAN collaborated with the New Jersey Department of Children and Families' CP&P to develop a training curriculum and implement a multidisciplinary case management approach to handling criminal cases of child abuse. Children's Justice Act funds provide annual training to multidisciplinary teams made up of professionals in law enforcement, prosecution, child protective services, mental health, medicine, and victim witness advocacy.

The MDT provides case supervision from the initial criminal and civil investigation to case disposition.

The MDT coordinator ensures that members are informed about changes in the case and that child victims receive the appropriate physical and mental health assessments and support services to prevent additional trauma during the investigation and prosecution process.

Target Population

- Statewide multidisciplinary teams and professionals in law enforcement, child protection, social work, mental health, domestic violence, and juvenile justice.

Approach

- Classroom training in a multidisciplinary case management approach to facilitate investigations, prosecution and treatment of child physical and sexual abuse from investigation to case disposition.
- Training seminars conducted by State and national experts in joint investigations, child deaths, psychological and medical evaluations, child safety, prosecution issues, expert witness testimony, victim witness advocacy and issues related to the MDT process.
- Ongoing evaluation of training needs by the NJTFCAN, and partners.

Outcomes

- **June 5, 2014** - 222 professionals attended "*The MDT Approach to Challenging Issues in Child Maltreatment*" conference held at the Sheraton Eatontown in Eatontown, New

Jersey. Attendees included: prosecutors, law enforcement, child protective service workers, medical professionals, mental health professionals, victim advocates, CAC Directors, MDT Coordinators, RDTC professionals, guidance counselors. Presenters included Barbara Bonner, Ph.D, of Oklahoma University and Scott Modell, Ph.D., Deputy Commissioner for the Tennessee Department of Children's Services. Each presenter spoke at a morning plenary session and each conducted two concurrent afternoon sessions.

- **September 18, 2014** - 81 professionals attended the "*MDT Approach to Recantation: Best Practices"* training held at the RWJ Conference Center in Mercerville, New Jersey. Attendees included detectives, mental health professionals, DAG, prosecutors, DCP&P caseworkers, victim-witness, family advocate, student interns, and MDT coordinators. Professionals from RDTCs and CACs were present and attendees came from 15 New Jersey counties. Presenters included Sarah Frietes, Chair, NJMDTCA; Evelyn Mejil, Board President, NJCA, Joe DelRusso, Former Chief Assistant Prosecutor, SVU, Passaic County, Peter Boser, Assistant Prosecutor Monmouth County Prosecutor's Office, Sue Rekedal, MDT Coordinator, Monmouth County, Anne Lynn, Project Director Northeast Regional CAC, Chris Freid, Chief Assistant Prosecutor, SVU, Passaic County, and Victoria Galinski, Deputy Attorney General, Northern Region.
- **May 7, 2015** – The **"***Cultural Competence in Interviewing and Treating Child Abuse Victims Conference*" will be held at the Sheraton Eatontown in Eatontown, New Jersey for approximately 300 child protection professionals. Presenters will include: Lisa Aronson Fontes, Ph.D., Joseph DelRusso, JD, Michele Friel Mullen, LCSW, Janet Fine, MS, Penny Paparteys, DVS, and Michele Fesler, MS. Social work CEUs will be provided by the Monmouth University School of Social Work Professional Education Program (PEP) and are recognized by the New Jersey State Board of Social Work Examiners. Also, this conference will offer New Jersey CLE credits under the approved provider status of the Camden County Prosecutor's Office.

Impact on the Child Protection System

- County prosecutors continue to embrace the MDT case management approach to the prosecution of child abuse.

- Child victims are referred to regional diagnostic treatment centers for medical and mental health assessment.

- Ongoing training enables law enforcement, social workers; medical and mental health providers to learn about changes in the law, prosecution issues, forensic interviewing, and treatment protocols.

- The MDT supports the expansion of child advocacy centers throughout the State where child victims can be interviewed and receive support services in a neutral setting.

- Prosecutors' cases are strengthened through the MDT case management approach.

- Child victims and their families are better informed about the progress of the case and children are emotionally strengthened for courtroom testimony.

- Ongoing training strengthens MDT best practice standards and education about child abuse issues, and team functioning.

- Child death cases will be investigated to identify child abuse factors.

$60,000* – Biennial Conference**
****The budget for the 2015 NJTFCAN Biennial Conference was increased to $83,000.**

Statement of Purpose

NJTFCAN, in collaboration with DCF, and with the logistical assistance of Rutgers University, Office of Continuing Professional Education, are planning to host a statewide conference for professionals in the field of child welfare on Wednesday, September 9, 2015 at the Hyatt Regency Hotel in New Brunswick, NJ entitled, "Kinship Care and Family Connections." This interdisciplinary conference will provide the target audience an opportunity to learn from experts in child welfare/protection issues and disciplines serving children and families. The keynote speaker for this event will be Dr. Joseph Crumbley.

Project Objectives

- To provide training for up to 700 professionals and advocates working with children and families.

Target Population

- Professionals in child welfare, law enforcement, social work, educators and daycare providers, mental health, medicine, juvenile justice, domestic violence, law guardians, and CASA volunteers.

Approach

- Workshops conducted by experts in their respective fields.

Impact on the Child Protection System

- Professionals, volunteers and advocates will be better informed and learn new strategies for responding to child maltreatment.
- Children and families will be better served by the child protection system.

Projected Outcome

- This event will focus on building professional knowledge and collaborative partnerships to improve the effectiveness of New Jersey's child maltreatment protection and prevention efforts and sought to encourage working relationships among volunteers and professionals in prevention, protective services, health, law enforcement, and juvenile justice to create child- and family-focused systems.

$23,000 – Skill Building Conference

Statement of Purpose

NJTFCAN in collaboration with DCF hosted a statewide multidisciplinary skill building conference on September_30, 2014 at DCF's Professional Center for 369 child protection professionals as part of a 2014-2015 Series on Trauma Informed Care. Dr. Bruce Perry was the keynote for this event and spoke on, "Neurodevelopment, Trauma and its Effects on the Brain."

Project Objectives

- To enhance the knowledge of approximately 250 child protection professionals.

Target Population

- Professionals in child welfare, law enforcement, social work, educators and daycare providers, mental health, medicine, juvenile justice, domestic violence, law guardians and CASA volunteers.

Approach

- Classroom style workshop conducted by an expert in his respective field.
- Selected expert will present on a topic of relevance in child abuse and neglect.

Outcome

- Professionals from various disciplines will improve their knowledge concerning the latest research and emerging child welfare issues.
- Enhanced knowledge and professional development of multidisciplinary teams and CASA volunteers.

Impact on the Child Protection System

- Provided an overview of key principles of neurodevelopment crucial for understanding the role of experience in defining functional and physical organization of the brain
- Described the emerging clinical and research findings in maltreated children that suggest the negative impact of abuse, neglect and trauma on brain development
- Outlined the clinical implications of a neurodevelopmental approach to child maltreatment
- Discussed the role of public policy and preventative practices in context of the impact of maltreatment on children's emotional, behavioral, cognitive, social and physical health

$252,303** – CJA New Initiatives via Community Request for Information**

*****As noted on page 6 of this report, the budget for the CJA New Initiatives via Community Request for Information was decreased to $229,303 due to the $23,000 increase in the 2015 NJTFCAN Biennial Conference budget.*

Statement of Purpose

NJTFCAN and DCF distributed a request for information/plan to solicit projects and ideas to improve the State's child protection system in accordance with CJA criteria. Three of the 2013/2014 New Initiatives include trainings on the following topics:

Human Trafficking Awareness
Domestically Trafficked Adolescents (DTA) Evaluation Project

The goal of the Domestically Trafficked Adolescents (DTA) evaluation project is to identify best practices and create a replicable model of providing residential services for DTAs. To accomplish this goal, the evaluation project is meant to guide the evaluation of a new DCF residential program for DTAs.

2014-2015 Series on Trauma Informed Care

As per the NJTFCAN's recommendation, DCF and its stakeholders are working toward becoming a trauma-informed system of care. To assist in this process, DCF launched a 2014-2015 symposia *Series on Trauma Informed Care* that features experts in the field to educate staff, stakeholders, and the community-at-large. This included the previously reported annual NJTFCAN Skill Building Conference in September 2014.

The 2014-2015 Series on Trauma Informed Care was held at DCF's Professional Center in New Brunswick, NJ. The Series' featured keynote speakers include:

- June 9, 2014: Dr. Vicky Kelly - Overview of Trauma Informed Care / Impact on the Child and Family Worker
- September 29, 2014: Dr. Bruce Perry – Neurodevelopment, Trauma and its Effects on the Brain
- January 23, 2015: Daniel Siegel – Trauma Impact and Reversibility
- June 11, 2015: Ken Verni – Mindfulness and Vicarious Trauma

Handheld Device Project

In 2011 DCF allocated CJA funding for a mobile solution for investigative workers. The focus was on after hours (SPRU) investigators, as the majority of their work was completed in the field with families and away from the secure DCF network. This presented a delay in workers accessibility to information within NJ SPIRIT (DCF's Statewide Automated Child Welfare Information System) as well as a barrier to immediate documentation of investigative work completed while in the field.

In 2014, DCF utilized CJA funding toward a mobile solution. DCF ascertained that the Institutional Abuse Investigation Unit (IAIU) would benefit from remote NJ SPIRIT access from the field. These IAIU workers are charged with investigating allegations of abuse of children by staff within schools, facilities, foster homes, etc.

<u>Project Objectives</u>

- To solicit innovative projects to improve the state's response to child maltreatment and prevent additional trauma to child victims involved in the court process.
- To support best-practice standards in the identification, investigation, prosecution, and treatment of child maltreatment.
- To implement the goals and recommendations in the NJTFCAN CJA Three-Year Assessment.

<u>Target Population</u>

- Prosecutors, Human Service Advisory Councils, the Administrative Office of the Courts, caseworkers, educators and daycare providers, mental health providers, public/private agencies, regional diagnostic treatment centers and child advocacy centers**.**

<u>Approach</u>

- The request for information/plan will be sent out to the public/target audience via DCF's statewide e-mail list.
- The request for information is advertised on the DCF website.
- Proposals are reviewed by a selection committee.

Results Expected

- Partnerships will be developed with County and State entities as well as private, nonprofit agencies to implement the goals and recommendations of the NJTFCAN CJA Three-Year Assessment.
- Effective programs will grow in order to improve child protection systems.

Impact on the Child Protection System

- Partnerships will be developed to implement improvements in the child protection system and respond more effectively to child maltreatment.
- The child protection system will adopt improved strategies for handling civil and criminal cases of abuse and neglect.
- Professionals will receive specialized training to work with children and families involved in the investigation and prosecution process and child victims will experience less trauma.
- Families and children involved in the prosecution process will be informed about the services of child advocacy centers, multidisciplinary teams and RDTC's.
- Understanding the co-occurrence of child abuse and domestic violence

Outcomes

Domestically Trafficked Adolescents (DTA) Program

DCF partnered with the Rutgers' Center on Violence Against Women & Children to evaluate the Domestically Trafficked Adolescents (DTA) Program. The DTA project was designed to be implemented in two phases. During Phase One of the project (July 1 through the Fall 2014), the research team engaged in the following activities:

o Obtained approval from DCF, Twin Oaks, and the IRB for all aspects of the project

o Secured Rutgers IRB and DCF Research Review Board approval for all aspects of the evaluation plan

o Conducted interviews with key stakeholders

o Conducted literature and online review

o Drafted at least one Research to Practice Brief

o Completed a content analysis on at least five (5) case records

Due to administrative changes at DCF, Phases One and Two of the project were blended and focus was directed toward best practices for DTAs moving forward. The research team will be conducting a more comprehensive analysis of the quantitative SPIRIT data and the qualitative data derived from the case record review.

The final deliverables for this project include:

- Three (3) Research-to-Practice Briefs including:
  - Identification and Assessment of Domestic Minor Sex Trafficking
  - Secondary Trauma and Domestic Minor Sex Trafficking
  - Micro and Macro-level Interventions for Survivors of Domestic Minor Sex Trafficking
  - The information for these briefs came from a comprehensive literature and website review of existing research and best practices for working with DTAs.
- Interim Key Stakeholder Report presenting the key findings of the qualitative analysis of the key stakeholder interviews
- A final report including:
  - Comprehensive findings from the case record review
  - Consideration of risk and protective factors in CP&P & CSOC case records of confirmed or suspected DTAs
  - Summary of SPIRIT data pertinent to DTA cases, including timing and geographic location of reports; caregiver and youth risk factors; demographic features; subsequent placement and treatment factors
  - Recommendations on best practices for DTAs
  - Identification of next steps for practice and policy
  - Identification of a subsequent potential research plan to measure efficacy of services provided to DTAs

2014-2015 Series on Trauma Informed Care

- **June 9, 2014** - The Trauma Series launched on June 9, 2014 at DCF's Professional Center in New Brunswick, New Jersey. Dr. Vicky Kelly, Psy.D., MSW, MHA, Director of the Delaware Division of Family Services in the Department of Services for Children, Youth, and Families, served as the keynote speaker and presented to 208 child protection professionals on the topic, "Overview of Trauma Informed Care / Impact on the Child and Family Worker."
- **September 29, 2014** – The second Trauma Series training was held on September 29, 2014 at DCF's Professional Center in New Brunswick, New Jersey. Dr. Bruce D. Perry, MD, PhD, Senior Fellow of The Child Trauma Academy, a not-for-profit organization based in Houston, TX, and adjunct Professor in the Department of Psychiatry and Behavioral Sciences at the Feinberg School of Medicine at Northwestern University in Chicago., served as the keynote speaker and presented to 328 child protection professionals on the topic, "Examining Child Maltreatment Through a Neurodevelopmental Lens."
- **January 23, 2015** – The third Trauma Series training was held on January 23, 2015 at DCF's Professional Center in New Brunswick, New Jersey. Dr. Daniel J. Siegel, clinical professor of psychiatry at the UCLA School of Medicine and founding co-director of the Mindful Awareness Research Center, served as the keynote speaker and presented to 201 child protection professionals on the topic, "An Interpersonal Neurobiology Approach to Trauma and its Treatment."

June 11, 2015 - The final Trauma Series training will be held on June 11, 2015 at DCF's Professional Center in New Brunswick, New Jersey. **Dr. Ken A. Verni, PsyD,** a Clinical Psychologist and Director of the NJ Center for Mindful Awareness*,* will serve as the keynote

speaker and present to approximately 245 child protection professionals on the topic, “Mindfulness and Vicarious Trauma.”

Handheld Device Project

In 2011, the initial CJA funding enabled DCF to purchase 163 iPad 2s (and accessories & licenses) for specific SPRU investigators. Using the "Go to my PC" software, these investigators were provided with immediate and direct access to critical information available in NJ SPIRIT. It also allowed for prompt entry of the investigation documentation and findings into NJ SPIRIT avoiding duplicate data entry. DCF successfully implemented the training and roll out of all 163 iPads to identified staff across the state in multiple offices and regions within the calendar year 2012.

In 2014, DCF chose to apply the CJA funding to test an alternate mobile solution, not previously available in years prior. DCF settled on a Windows-based tablet, Dell Venue, which has mobile broadband capabilities. The workers connect directly to NJ SPIRIT via the State’s Virtual Private Network (VPN). In addition, these Venues will also fill the role of desktop machines for the investigators while in the office. They will have their own docking stations and desktop monitors. The windows operating system allows for this interchangeable and seamless computing solution. DCF will have successfully implemented this most recent solution by spring 2015.

Annual Progress and Services Report (APSR) for FFY (10/1/2013 – 9/30/2014)

Community-Based Child Abuse Prevention (CBCAP) and Children's Trust Fund (CTF) Grants

Community Based Child Abuse Prevention (CBCAP) Program
CBCAP provides funds for the implementation and coordination of prevention services under the direction of the Assistant Commissioner of the Division of Family and Community Partnerships and Division on Women. Funds from the CBCAP program support primary and secondary prevention services targeting children and families in at-risk communities throughout the state. For FFY 2014, CBCAP supported the following initiatives in the DFCP Offices:

Office of Early Childhood Services (OECS):

The Strengthening Families Initiative
Early Childhood Comprehensive Systems Grant/Help Me Grow (funding match)
South Jersey Health Care (INSPIRA): Cumberland County Council for Young Children

Office of Family Support Services (OFSS)
Family Success Centers in Cape May County, Gloucester County, Hunterdon County, Morris County, and Somerset County
Family Success Center Statewide Conference
Family Success Center Family Development Credential Training

Office of School Linked Services (OSLS)

New Jersey Child Assault Prevention (NJCAP) and Bullying Prevention

Additional, CBCAP funding supports the following initiatives in the Division on Women (DOW):

Office of Domestic Violence Services (OVDS)
Domestic Violence Liaisons in Cape May County, Hudson County, Hunterdon County, Mercer County, Monmouth County, Passaic County, Salem County, Sussex County, and Warren County

New Jersey's wide array of services provides families and children vast opportunities for support, education, and growth. Decisions impacting the prevention service array, supported by CBCAP, will be determined by Department of Children and Families (DCF) leadership in alignment with established strategic priorities. CBCAP funds are issued to support primary and secondary prevention services for diverse population needs within local communities in New Jersey. The programs and initiatives implemented by the Division of Family and Community Partnerships (DFCP) and the Division on Women (DOW) primarily focus on priority populations defined by CBCAP, such as parents of young children, parents and children with disabilities, racial and ethnic minorities, and underserved of underrepresented populations. Funded programs address the core services of parent education, mutual support and self-help, leadership services, outreach, community and social service referrals, follow-up services, voluntary home visiting

and respite care services. In addition, CBCAP funded programs are encouraged to use evidence based/evidence informed or promising practices in their work to prevent child abuse and neglect.

Prior to receiving funding in New Jersey, applicants must adhere to the DCF Request for Proposal (RFP) process. Divisions within DCF adhere to a standardized RFP policy, developed in January 2010. A standardized RFP process ensures that all programs under DCF possess the desired components for overall child maltreatment prevention. The division or office within DCF procuring the RFP first provides a request to develop the RFP to the Grants Management Committee. Upon approval from the Grants Management Committee, the RFP is finalized and publicized on DCF's website, as well as announced publically. A bidder's conference is often held in order to answer questions or concerns from potential applicants prior to the submission of proposals. Proposals received from applicants are evaluated by a committee selected by the division or office obtaining the RFP. The Evaluation Committee utilizes a point score methodology to score all proposals. An Award Recommendation Letter is compiled by the Evaluation Committee with a suggested recipient. The final decision of the awardee is made by the Commissioner of DCF. Awardees are notified in writing of their receipt of funding. The RFP process in total does not exceed 120 days of publication.

In addition to the requirement for background information regarding the applicant's mission, history, goals, services, activities, structure, collaborations, accessibility, and cultural competency; all RFP's incorporate a request for a needs justification. Applicants are required to describe the identified needs of the local community for the proposed services, demonstrating an understanding of the problems and needs of the target population the agency will serve. Applicants are also required to provide a summary of existing services and activities which meet the needs of the targeted population and identify gaps in provisions and availability of the services. Relevant statistics and discussions of studies that reflect the prevalence of the problem and unmet needs of the target population must be cited in the proposal as well. Proposals received without a complete needs justification are disqualified from review. The standardized RFP process allows DFCP to assess the unmet needs of the state as a whole, as well as in local communities, and provides evidence for informed decisions regarding the distribution of CBCAP funds to be made.

The DCF Strategic Plan and Statewide Prevention Plan were developed in collaboration with a broad range of stakeholders representing the community, including parents and caregivers. Quantitative data sources included National Child Abuse and Neglect Data System and a recently developed statewide comprehensive needs assessment for NJ Home Visiting State Plan through the MIECHV grant. Qualitative data from surveys, interviews and focus groups also informed the plans. Additionally, program performance measures and demographics data, Child and Family Services Review (CFSR) Statewide Assessment, CFSP Five-Year Plan, NJ KIDS Count, 2010 US Census data, DHS TANF data, and DOH Title V maternal-child health data are incorporated in planning efforts at DCF.

DCF has made significant progress in establishing a core set of prevention services in all 21 counties of New Jersey. This core set of services includes:

- 66 Evidence-Based Home Visiting Programs
- 52 Family Success Centers

- Domestic Violence Services in all 21 counties and Child Protection and Permanency Offices
- School-Based Youth Services in 67 high schools, 19 middle schools and 6 elementary

In FFY2014, the Office of Early Childhood Services' (OECS) Strengthening Families Initiative, as well as the Cumberland County Council for Young Children received CBCAP funding. Currently in the Office of Family Support Services (OFSS), five Family Success Centers utilize CBCAP funding to sustain the services offered to families and children. OFSS also received partial CBCAP funding to support the Family Development Credential and the annual Family Success Center Conference. The New Jersey Child Assault Prevention Program (NJCAP), implemented through the Office of School-Linked Services (OSLS) operates with CBCAP funding. DOW's Office of Domestic Violence Services (ODVS) applies CBCAP funding to the Domestic Violence Liaison (DVL) program in nine counties throughout the State. Finally, in the Office of Communications, the Safe Haven program provides various services with funding from CBCAP. With CBCAP funding distributed to various offices and programs, many opportunities arise for all of New Jersey's diverse population to obtain necessary services and supports. Attachment C offers estimates for the level of service for each CBCAP funded program. In addition to CBCAP funded programs, New Jersey's Division of Family and Community Partnerships (DFCP) also supports Incredible Parents = Incredible Kids, Positive Parenting, and Triple P: Positive Parenting Program; prevention programs funded through the Children's Trust Fund (CTF).

The **Strengthening Families Initiative (SFI)** is implemented through lead agency DFCP and with a Memorandum of Understanding (MOU) with the Department of Human Services' (DHS) Division of Family Development (DFD), and the New Jersey Council for Young Children (NJCYC). **SFI** targets all 21 counties in New Jersey through collaborations with Child Care Resource and Referral Agencies (CCR&R's). Revisions to the MOU with DHS' DFD in FFY2014 included adding **SFI** to existing CCR&R contracts. The initiative receives blended funding from CBCAP and State funds. The main objective of the **Strengthening Families Initiative** is to facilitate, monitor, expand, and enhance community-based prevention focused programs and activities designed to strengthen and support families to prevent child abuse and neglect. **SFI** is an approach to preventing child abuse and neglect by strengthening families through early care and education settings. The Center for the Study of Social Policy (CSSP) developed the Strengthening Families Protective Factors Framework (SF-PFF) with the fundamental principle that certain protective factors contribute to family resiliency and strength.

The Child Care Resource and Referral staff responsible for the implementation of the **Strengthening Families Initiative** must complete New Jersey's **SFI** trainer requirements prior to working with child care providers. Once training is complete, the CCR&R **SFI** staff member is able to work with participating child care providers, both in centers and family child care settings, to train staff in the Strengthening Families Protective Factors Framework and offer on-site technical assistance for integrating the protective factors into their work with families. Trainers are required to provide a minimum of 12 hours of training to child care staff and parents, conduct monitoring visits, and ensure all requirements of a participating **SFI** center are complete. Additional trainings and stakeholder meetings are offered by CCR&R staff for community service providers. Trainers assist child care providers in developing innovative means to incorporate the SF-PFF in everyday actions and interactions with families and children.

Currently there are 35 Strengthening Families trainers in all CCR&Rs throughout New Jersey. Integrating the SF-PFF allows parents to grow confident in parenting skills and abilities to develop socially and emotionally healthy children. Participating childcare providers conduct a self-assessment of the center, including staff and family interactions, and develop an annual work plan to improve communication, collaboration and interaction with children and families. This work plan also provides opportunities for parents to participate in planning and implementing activities with their childcare provider. Childcare providers collaborate with local partners, local school districts, public libraries, the Division of Child Protection and Permanency (DCP&P) and other community agencies to ensure that parents and families are connected to needed resources.

The OECS SFI staff provides oversight of the training and technical assistance grants issued to the CCR&Rs in each county. OECS staff provide program development and management, data collection, evaluation and analysis; facilitate training and technical assistance meetings with the CCR&R staff at least quarterly; conduct periodic site visits to county level grantees; and offer informal technical assistance as needed.

New Jersey's **Strengthening Families Initiative** continues to progress. DFCP is deepening its relationships with other Early Childhood partners such as the Department of Human Services, Division of Family Development, Department of Education, NJ Council for Young Children (NJCYC), NJ Head Start/Early Head Start Collaboration Office, college-level early childhood educators, Department of Health Shaping NJ initiative, NJ Child Care Resource and Referral Agencies (NJCCR&RA), Prevent Child Abuse NJ and Professional Impact New Jersey (PINJ), NJ's designated early childhood state registry. This is resulting in the infusion of the protective factors and family support principles into NJ's early childhood credentialing curriculum. Offering the "Bringing the Protective Factors Framework to Life in Your Work" training to early childhood professionals throughout the state allows for further integration of the Strengthening Families Protective Factors Framework in various early childhood systems. **SFI** is implemented in 126 childcare centers and family child care homes in all 21 counties. An estimated **6,061 children and 5,244 families** received information and support from **SFI** this year.

In FFY2013 CBCAP implemented an enhanced process that helps funded agencies identify measures for program effectiveness and consumer satisfaction, and monitors core elements/ activities for continuous quality improvement (CQI). In addition to reviewing and updating the logic models, early childhood grantees are required to submit quarterly reports and an end of year program analysis consisting of an evaluation of progress in achieving the level of service for each activity and performance outcomes, process/compliance measures and measures of consumer satisfaction. Reports are reviewed by designated DCF staff and comments and suggestions for quality improvement are discussed with grantees. Training and technical assistance is provided in quarterly meetings and one on one program site visits. Corrective actions are initiated when required. While OECS did not have any active CBCAP-funded grants during this report period (six grants concluded 6/30/13), the evaluation and CQI process established in 2013 remains as a template for new CBCAP grants across offices and divisions.

Designated OECS staff oversee the work of the CCR&Rs in all 21 counties as they implement the SF-PFF with childcare centers and family child care providers. The evaluation monitoring

and CQI process is similar to the process described above—quarterly and end-of-year reports and analysis for level of service and core activities. Reports are reviewed by designated DCF staff and quality improvement recommendations are discussed with CCR&Rs at quarterly SF meetings and annual site visits.

Through collaboration with the New Jersey Council for Young Children (NJCYC) and the Department of Education (DOE), the **Cumberland County Council for Young Children (CCCYC)** was established as a pilot program for the subsequent development of statewide county councils. The purpose of a **County Council for Young Children (CCYC)** is to facilitate active, strong and successful community engagement with input from parents and other interested community members. Parents and community members are encouraged through participation on the **CCYC** to come together as active partners to share and learn about issues that affect the health, education and well-being of their children; offer ideas, opinions and solutions for ways to build stronger connections for children and families through the lens of the Protective Factors Framework; and build a successful collaboration while achieving the identified objectives. **CCYC's** across New Jersey are developing and will follow the lead of the pilot CCCYC for effective implementation. The **CCYC's** are a collaborative work of the DCF, DOE, DOH, DHS, NJ Head Start Collaborative Office and the NJCYC. The Protective Factors Framework will be infused in the work of the **CCYC** so that parents and practitioners alike will become grounded in the Protective Factors framework.

There are seven core elements of the County Councils for Young Children which each of the 21 councils will strive to attain. These priorities include:

- **Shared Leadership:** Parents, caregivers, and agency or organization representatives share the leadership roles of the CCYC to ensure success.
- **Recruitment:** Each council is required to recruit and retain parents, caregivers, and agency or organization representation as active members. This is an ongoing responsibility of all members. Special consideration should be given to recruit families with children (birth-age eight), early learning programs, education systems, health services, and Early Intervention services.
- **Parent Leadership:** Councils must select a parent leadership curriculum which will guide the process of training for parents and providers to collaborate and accomplish the goals of the CCYC.
- **Committees:** Working committees must be established which will accomplish the work of the council, with a steering committee at the lead.
- **Election of Leader:** Council members will elect co-chairs for committees.
- **Environmental Scan:** Councils will conduct a joint needs assessment, environmental scan, and strategic planning process in order to identify gaps in services to inform priorities for the work of the CCYC.
- **Consultation:** CCYCs will provide input to improve early childhood service coordination and systems integration through collaboration with Central Intake, Community Health Workers, and Grow NJ Kids.

Successfully achieving all of the core elements of the County Councils for Young Children will allow for members to inform, impact, and develop local and state policies, services, and/or practices for improved responsiveness to the needs of families and children in the county and state. Efforts of the CCYC will also inform professional development and training opportunities for the local workforce to support proposed policies, services, and practices.

In FFY2014, seventeen county councils were identified through an RFP to join the statewide network of County Councils. Three additional County Councils are anticipated to be identified, ensuring one CCYC in each county. CCYCs remain in various stages of development as lead agencies continue to be identified. Demonstrating one of the core elements of the CCYC, the Cumberland County Council for Young Children (CCCYC) established the following committees in FFY2014:

- **Steering Committee**: To focus on the Governance of the CCCYC.
- **Community Resources Subcommittee**: To inventory existing resources available, identify resource that are needed and mobilize the community to work together to obtain the desired resources.
- **Education Subcommittee**: Will access early childhood services, access special education services and develop a relationship with the local school district.
- **Health & Prenatal Supports Subcommittee**: Will address health issues, access medical services and healthcare.
- **Transportation Subcommittee**: To assess and address transportation needs of the community.

Committees may vary in each CCYC based on the needs established by the community. The identified grantees for the CCYCs have begun recruitment for membership on the council. Once membership is established, the CCYC's will conduct a community needs assessment in order to inform future work, goals, and training. The Cumberland County Council for Young Children served **18 unduplicated children, 120 unduplicated parents, 114 unduplicated families, and 109 professionals in FFY2014.**

Since April 2012, DFCP OECS has been the lead office for **Early Childhood Comprehensive Systems/Help Me Grow New Jersey (ECCS/HMG)** and an affiliate of the Help Me Grow National Center. CBCAP provides a funding match for **ECCS/HMG. Help Me Grow** promotes development of an integrated early childhood system that supports children (pregnancy to age 8) and their families to achieve optimal wellness. **HMGNJ** is building upon New Jersey's strong foundation in early childhood to improve coordination and integration, and streamline services across systems of care that encompass four core departments: Health; Human Services; Education; and Children & Families. As a result, pregnant women and parents/ families of infants and young children will have easier and earlier access to a range of prevention, early identification, early intervention, and treatment services to promote healthy pregnancies and births, positive infant/child growth and development, and nurturing parent-child relationships. Through the work of various workgroups, **ECCS/HMG NJ** goals are to focus on promoting a comprehensive coordinate preventative health and early childhood system that addresses the physical, social-emotional, behavioral and cognitive aspects of child wellness from pregnancy to three. The strategies are to:

- Coordinate the expansion of developmental screening activities in early care and education settings.
- Connect pediatric and other health care leaders with child health consultants and/or Central Intake to link families for referrals to medical homes, prenatal care, early intervention, services, child care programs and families.

- Provide local systems consultation, professional development and parent education on the importance of early developmental screening to state and local entities.

New Jersey's statewide network of **Family Success Centers (FSCs)** continues to expand through funding and support from the Division of Family and Community Partnerships (DFCP). These "one-stop shops" provide wrap-around resources and supports to keep families from experiencing crisis. **FSCs** are neighborhood-based gathering places which offer community residents an array of resources and services at no cost. New Jersey has one of the only statewide systems in the United States with publicly supported **Family Success Centers.**

The primary goal of **FSCs** is to strengthen families and empower individuals to acquire the knowledge and skills necessary to build successful families and raise healthy, happy children. **FSCs** promote community and parent involvement through Parent Advisory Boards, a vital element of each **FSC**. Through shared governance and participation on the Parent Advisory Board, parents and community members can become stewards of their respective communities, identifying services and resources that are unique to their geographic area. **FSCs** offer primary and secondary child abuse prevention services, and bring together community agencies, residents, parents, and leaders to address issues which compromise the safety and stability of families and the community.

Each **FSC** is a warm and welcoming location which offers convenient access to information, support, and resources. With the overarching goal of preventing child maltreatment, the activities and services provided by **FSCs** strengthen individual and family functioning; enhance parental capacity for growth and development; increase the stability, health and well-being of children and families; and empower community residents to acquire the knowledge, skills and resources required to succeed and provide optimal outcomes for children and families.
Five **FSCs** operated with CBCAP funding in FFY2014. Though 52 FSCs operate to date, each operates at varying levels of capacity. Well established FSCs are balanced with numerous FSCs at the beginning stages of development and operation. CBCAP funding was distributed to an array of **FSCs** in an effort to display **FSCs** across the spectrum of development. Providing insight to **FSCs** in high functioning capacities, as well as those in beginning stages of operation, offers the opportunity for CBCAP funded **FSCs** to display varying levels of barriers and improvements. CBCAP funded **FSCs,** as with all **FSCs,** are encouraged to continue evaluating and enhancing their practice. The CBCAP funded **FSCs** in Cape May County, Somerset County, Hunterdon County, Morris County, and Gloucester County offer insight to **FSC** functioning at various levels.

The **Cape May Family Success Center, Cape Counseling Services,** serves all children, families, and residents in Cape May County. **Cape Counseling Services** offers the following services and supports for Cape May County families:

- Access to Child, Maternal and Family Health Services: Provides blood pressure screening, flu shots and assistance with the Health Insurance Marketplace.
- Family Success Plans: Staff partners with families in the development of functional plans to help the families attain their identified goals.
- Parent Education: Offer groups, classes and activities: infant, toddler and preschool playgroups; breastfeeding support group; grandparents raising grandchildren support

group; various parenting classed including a curriculum focused on fathers, and parent-child activities that create opportunities for intergenerational learning and bonding.
- Employment-Related Services: Assistance with resume writing and job applications and also provide referrals to Vocational Assistance programs.
- Life Skills: Offer Family Enrichment, Teen Groups and Safe Sitters life skill workshops.
- Housing Related Services: Assist families with energy assistance applications and provide referrals to housing assistance programs.
- Advocacy & Related Support:
    - Advocate for all community residents as needed and appropriate by interceding, supporting and/or advancing the cause of individuals and families in their dealings with public and private entities.
    - Staff accompany families/individuals to meetings, appointments, or visits with other service providers to assist them in navigating the system and facilitating direct linkages, communication and/or problem solving.
- General Information and Referral/Linkages: Maintains an up-to-date information and referral directory of available local, county, and state supported services as well as non-traditional service providers such as houses of worship and grassroots organizations.

Cape Counseling Services also experienced a number of accomplishments and improvements in FFY 2014, such as:
- FSC Advisory Board actively participates in the governance of the FSC.
- Cape May FSC staff were trained in father training and created resources for fathers.
- FSC offered a weekly food pantry for families in need and served hundreds of families during the reporting period.
- FSC offered laundry and shower services for families in need during the reporting period.
- During this reporting period the Cape May FSC provided the following workshops:
    - Monthly mental health presentations by Family First
    - Turning the Tides – group education for adolescents
    - Support group for families dealing with an incarcerated parent
    - Support group for families with children with autism
- **Served 752 families during the reporting period.**

Empower Somerset, Somerset County's Family Success Center, is conveniently located in downtown Somerville, providing services within walking distance of many community services and businesses. Throughout FFY 2014, **Empower Somerset FSC** offered a variety of services including:

- Family Success Plans: Staff partner with families in the development of functional plans to help the families attain their identified goals.
- Parent Education: Provides the following parent education programs/ activities:
    - Strengthening Families
    - Proactive Parenting
    - Raising a Confident Child from Toddler to Teen
    - How to Develop Critical Thinking Skills in Your Child and
    - family story time and craft.
    - For fathers: "I'm Not the Babysitter" workshop and 24/7 Dads.

        - Parent-child activities that create opportunities for intergenerational learning and bonding.
- Employment-Related Services:
    - Mastering the Interview workshop,
    - Coping with Work and Family Stress workshop
    - Talent Development Group
- Housing Related Services: Link families to community programs providing affordable housing, rental assistance, down payment assistance, legal services, weatherization, and heating/utility assistance.
- Advocacy & Related Support: Staff advocate for all community residents and accompany families/individuals to meetings, appointments, or visits with other service providers to assist them in navigating the system and facilitating direct linkages, communication and/or problem solving.
- General Information and Referral/Linkages – The Empower FSC maintains an up-to-date information and referral directory of available local, county, and state supported services as well as non-traditional service providers such as houses of worship and grassroots organizations.

Accomplishments and progress at **Empower Somerset** in FFY 2014 were:

- FSC Advisory Board actively participates in the governance of the FSC.
- Implemented the following groups and activities: Women's Wellness Support group; walking club; Take Control of Your Health workshop; Affordable Health Care Act workshop and "Quick Peek" Developmental Screenings
- Implemented the following classes: English as a series of educational workshops designed to improve life skills of individual and families participating in the life of the center. Offered English as a Second Language (ESL) , Citizen Preparation Classes, Managing Money Wisely, Tough Choices, Girls Youth Partnership, Reading Workshop and SAT Preparation classes.
- During this reporting period Somerset FSC partnered with a local church & businesses to provide cooking, sewing, financial management, fatherhood Life Skills classes.
- Provided free swimming lessons, 2 weeks of summer camp, and other activities during the summer.
- In collaboration with Middle Earth (local non-profit that serves at-risk youth) offered workshops for parents; one session offered in Spanish to benefit non English speaking families.
- The FSC provided over 12 "Family Fun nights" this reporting period.
- Somerset FSC presented a workshop at the Child Abuse Prevention Awareness conference held at the College of New Jersey. Workshop was dedicated to the enhancement the Family Success Centers Advisory Boards.
- **Served 463 families during the reporting period.**

In addition to the above mentioned accomplishments, **Empower Somerset** was also awarded the DCF grant to implement Somerset County's County Council for Young Children.

Also located in an area densely populated with additional community resources, **Hunterdon Prevention Resources FSC** provides supports and services for all families and residents of Hunterdon County. Hunterdon Prevention Resources FSC provides the following services:

- Access to Child, Maternal and Family Health Services:
    - Infant Massage workshop is offered twice a week to teach new moms how to soothe their baby through a nurturing touch.
    - A Take Control of Your Health workshop provides self-management tools and discusses topics such as: nutrition, portion control, how to read food labels, exercise, difficult emotions, talking with your healthcare provider, etc.
    - A Diabetes Self-Management Program discusses proper nutrition for regulating insulin levels.
- Family Success Plans: Staff partners with families in the development of functional plans to help the families attain their identified goals.
- Parent Education: The following parent education services are provided:
    - Strengthening Families Curriculum - focuses on improving family relations by working with both parents and child(ren) in a group setting.
    - Unifying Families with a different topic discussed each month, such as Blended Families, Cyber Safety, Talking to Your Kids about Drugs and Alcohol, Improving Communication Skills, etc.
    - Parent-child activities that create opportunities for intergenerational learning and bonding.
- Employment Related Services:
    - Collaborate with Middle Earth to provide a job readiness program to at-risk youth.
    - Laptops are available to anyone who needs computer access for working on resumes and job hunting.
    - A one hour resume writing workshop is offered monthly.
- Life Skills:
    - Budgeting workshop is offered monthly. Topics include: Planning for Emergencies; Creating a Savings Plan; Creating a Household Budget; Improving your Credit Score and Financial Fitness for Kids.
    - Girls Night In, a weekly empowerment program for girls 12 years of age or older. Topics include: Journaling; Self-Defense; Empowerment; Yoga; Child Assault Prevention; Living, Loving and Growing Up in a Healthy Family; and Decision Making.
    - Homework Help is provided weekly to kids of all ages. Translation Assistance is provided.
- Housing Related Services: Collaborates with several local organizations to assist families in finding a place to stay if they are homeless or providing the needed money for a deposit on a new apartment or to prevent the shut-off of utilities.
- Advocacy & Related Support: Advocate for all community residents as needed and appropriate by interceding, supporting and/or advancing the cause of individuals and families in their dealings with public and private entities. The Hunterdon County FSC staff accompanies families/individuals to meetings, appointments, or visits with other service

providers to assist them in navigating the system and facilitating direct linkages, communication and/or problem solving.

- General Information and Referral/Linkages: Hunterdon FSC maintains an up-to-date information and referral director of available local, county, and state supported services as well as non-traditional service providers such as houses of worship and grassroots organizations.

Hunterdon Prevention Resources had numerous accomplishments and improvements in FFY 2014, including:

- The Hunterdon County FSC was the lead agency in planning and putting forth the NJ Central Region Child Abuse Prevention and Awareness Month Event. The event took place at the College of New Jersey campus and was attended by over 170 families. The adults took part in informative and interactive workshops while the children had fun with the volunteers from various civic organizations that had game stations set up.
- Hunterdon FSC presented a workshop titled "Eight Dimensions of Wellness" at the 2014 Family Success Conference held in New Brunswick, NJ.
- Hunterdon County FSC created collaboration with Wal-Mart to have some new items donated year around. Hunterdon County FSC has put on multiple yard sales and the proceeds have gone to benefit the families they work with.
- One of the most successful programs for Hunterdon County FSC has been Girls' Night In for girls 12 – 17 years old which is held every Tuesday evening during the school year. This program started out as a pampering event – high school girls giving manicures to tweens – and evolved into an empowerment series of activities and workshops.
- **The Hunterdon FSC has served over 762 families during this reporting period.**

Currently, the **Hunterdon FSC** has plans to relocate to a structure which is not in need of major repairs, as their current location. **Hunterdon FSC** is developing strategies for collaborating with the Kinship Navigator Program to provide services and support to Kinship caregivers, as well as with Fatherhood Now to create additional services for fathers. **Hunterdon Prevention Resources FSC** is also the lead agency for the 2015 Child Abuse Prevention Month Activities in Hunterdon County, and plans on creating a community garden to emphasize the importance of socialization, outdoor play and interaction, and physical activity. In addition, **Hunterdon FSC** has plans of developing and implementing a pilot program in conjunction with the Division of Child Protection and Permanency (DCP&P) in order to provide a non-stigmatizing and family friendly environment for parents to visit with their children who are under DCP&P supervision.

The **Northern NJ Maternal and Child Health Consortium, Inc.** offers services for all residents in Morris County. The **Morris County FSC** provides access to health information, assists with the development of family success plans, offers support for employment related and housing related services, provides information and referrals to numerous community resources, and conducts life skills training and parent-child activities. Many of the services and supports provided by **Northern NJ Maternal and Child Health Consortium, Inc** are offered in English and Spanish in order to address the needs of the families in the community. FFY 2014 offered numerous accomplishments and enhancements for the **Morris County FSC,** including but not limited to:

- Re-opened the FSC with a rich service array after a horrible car accident which resulted in one of the vehicles to enter the building that houses the FSC. The Re-Open House on March 6, 2014 was a success with many families and providers attending.
- Continued to grow the Advisory Board which now has over 25 members.
- Has established "Connecting Dover" which is a coalition of business owners in the city of Dover. This coalition has put together full response plan in the event of another Hurricane or other major catastrophe.
- Has established a presence in Morristown and offer developmental services there on a weekly basis such as ESL or basic computer classes. 'Wind of the Spirit' in Morristown offers space for Morris County FSC to use free of charge.
- **Served 435 families during the reporting period.**

At this time, **Northern NJ Maternal and Child Health Consortium, Inc** is planning on developing a walking club to highlight the importance of physical activity and socialization. Also highlighting the importance of physical activity and socialization for children, the **Morris County FSC** petitioned their town to rehabilitate a local park, where they are planning on starting a youth basketball league. The FSC will also participate in planning councils for Child Abuse Prevention Month Activities. Numerous activities and supports will be implemented as **Northern NJ Maternal and Child Health Consortium Inc** builds collaborations and partnerships with other agencies in the community.

The final CBCAP funded Family Success Center lies in Gloucester County. The **Hispanic Family Center of Southern NJ,** or the **Woodbury Family Success Center,** is available to serve the needs of all families, children, and residents in Gloucester County. The **Woodbury FSC** maintained a full calendar of services and events throughout FFY 2014, as described below:

- Access to Child, Maternal and Family Health Services: In partnership with Rutgers University, the Woodbury FSC provides health education workshops (i.e. nutrition, fitness, diabetes prevention) and provides several non-invasive health screenings such as blood pressure, respirator, and heart checks among other things. This FSC hosts a yearly health fair on site inviting community agencies to provide health information as well as administer health screenings.
- Family Success Plans: Staff partners with families in the development of functional plans to help the families attain their identified goals.
- Parent Education:
  - Offers parent-child activities that create opportunities for intergenerational learning and bonding. These intergenerational activities include family literacy events.
  - Plans monthly theme-based activities for FSC participants providing an opportunity for intergenerational learning and interaction. These themes are driven by the interests and recommendations of families that submit ideas through the suggestions box and/or the Parent/Community Advisory Board
- Employment-Related Services: Offer weekly workshops related to job readiness. Speakers present on topics such as : dressing for success, using your local One Stop Career Center and future job and training opportunities available through Gloucester County

- Workshops: Offer nutrition based educational workshops to parents and families; adult English as a Second Language classes and local banks provide workshops on budgeting, banking and fiscal management for families.
- Housing Related Services:
    - Refers families to the Low Income Home Energy Assistance Program (LIHEAP) and Weatherization programs.
    - Legal Services of Southern New Jersey provides workshops on tenant and landlord issues.
    - Families in need of housing assistance are linked to the Gloucester County Housing Authority.
- Advocacy & Related Support:
    - Staff advocates for all community residents as needed and appropriate by interceding, supporting and/or advancing the cause of individuals and families in their dealings with public and private entities.
    - Staff accompanies families/individuals to meetings, appointments, or visits with other service providers to assist them in navigating the system and facilitating direct linkages, communication and/or problem solving.
- General Information and Referral/Linkages: Maintains an up-to-date information and referral directory of available local, county, and state supported services as well as non-traditional service providers such as houses of worship and grassroots organizations.

FFY held numerous accomplishments for **Woodbury FSC,** such as:

- The Woodbury FSC has worked closely with the local school system, who has allowed them to post their flyers and calendars, as well as present to parents, teachers and students. Woodbury school district has also secured volunteer tutors to assist children with their studies at the FSC. During this reporting period, the FSC also established a relationship with the Girl Scouts of America and they now host their own troop. This has proven to be an excellent way to get young girls and their families involved in the life of the center.
- **Served 590 families during the reporting period.**

Woodbury FSC continues to offer parenting skills workshops reinforcing positive discipline and positive behavioral supports, financial literacy workshops, job readiness, nutrition, and English as a second language workshops. **Woodbury FSC** also collaborates with the Kinship Navigator Program to provide services and support to Kinship caregivers.
In addition to funding the FSCs described above, CBCAP funds were essential for the implementation of the FSC Family Development Credential Training. The Family Development Credential training was offered every other week for a period of eight months throughout FFY2014. This training provides FSC frontline staff with the skills and competencies to work with families to attain a healthy self-reliance and interdependence with their communities. Staff competency is evaluated based on participants' completion of assessments throughout the training.

It was also a productive year for evaluation planning with the CBCAP funded Family Success Centers. OFSS convened a workgroup with a representative from RER, Rutgers School of Social Work, Institute for Families, FSC providers, and the Deputy Director of FCP to develop the logic model, performance standards and an evaluation. Kerrie Ocasio, PhD. From Rutgers developed a

performance standard self-assessment tool with three developmental stages of the FSCs: basic, intermediate and advanced. In combination with the logic model, OFSS now has clear and detailed documentation of New Jersey's Family Success Center model.

The workgroup also developed an evaluation plan. They determined that Jerry Ender's Matrix tool piloted in the last reporting period was not the right tool to capture the voluntary, community-based prevention services provided by FSCs. Instead, Rutgers School of Social Work will conduct an evaluation of the FSCs using a retrospective post-test only design to minimize the data entry burden on providers, yet still produce useful evaluation data. For a week long period at two pre-determined times in the spring and fall, FSC staff and volunteers offer a small incentive or fun activity as individuals enter the center if they complete an anonymous survey. The response rate will be tracked using assent forms to provide some information on the representativeness of the sample. The survey includes information on participation (frequency and activity types), participants' perception of how the center has affected them in the area of each protective factor, relevant demographics and general program satisfaction.

The FSC model as an emerging/promising practice has required NJ to closely consider the evaluation of the FSC approach. Although each FSC is required to implement core components of the model, the makeup of core components is quite different based on the community in which the FSC sits. Before DFCP can strategically build the local capacity of CBCAP grantees in evaluation and continuous quality improvement, DFCP needed to identify and develop a menu of targeted performance indicators for FSCs at the local level from which to choose. Indicators and mid-term outcomes provide a foundation for evaluating the accomplishments of the FSCs. Indicators and mid-term outcomes include:

- 70% of parents demonstrate improved parenting skills and enrich their relationship with their child.
- 70% of parents report increased nurturing and attachment in relationships with their children
- 70% of participants report increased social emotional competence
- 70% participants demonstrate increased resilience
- 70% of the participants increase social connections
- 70% of the participants improve their ability to provide for their children as evidenced in successful linkages to formal and informal concrete supports.

Also funded by CBCAP, the seventh annual statewide Family Success Center Conference was held on June 20, 2014 at the DCF's Professional Center located in New Brunswick, NJ. This event brought together parents, participants and staff from all New Jersey's Family Success Centers for a day of educational workshops, facilitated discussions, networking and learning opportunities. Each of the workshops was co-facilitated by at least one parent from a Family Success Center. There were approximately 320 Family Success Center parents, participants and staff in attendance.

Implemented through DFCP Office of School Linked Services (OSLS), the **New Jersey Child Assault Prevention (NJCAP) Project** is funded by CBCAP. In 2014, OSLS approached the Office of Research, Evaluation, and Reporting (RER) to develop a new data-informed system for allocating funding based on need. In consultation with the provider, RER calculated a weighted formula using the following county-level data: rate of K – 8 population, rate of children in

poverty, rate of child abuse substantiations and Department of Education statistics on school violence, weapons and harassment, intimidation and bullying (HIB). OSLS successfully used this formula to update the funding allocated to NJCAP programs to reflect recent demographic changes in New Jersey.

NJCAP is a statewide community based prevention program. **NJCAP** seeks to reduce children's vulnerability to abuse, neglect, and bullying through prevention workshops for school-age children, parents and teachers. **NJCAP** staff work closely with local school districts, parent/teacher associations, home school groups and other community groups. **NJCAP** has a threefold educational approach to prevention which includes staff in-service, parent programs and individual classroom workshops for children and teens. CBCAP funding provides **NJCAP** the opportunity to continue to expand services and supports to school districts throughout the state.

During this reporting period, the NJ Child Assault Prevention initiative (NJ CAP) refined the outcomes in their contract. The performance outcomes are:
1. Participating students who believe they are at risk of harm will seek a trusted adult or CAP facilitator to discuss or disclose situational problems
2. 80% of teachers, school administrators and parents will report that they feel more knowledgeable about abuse and bullying including prevention and intervention strategies
The provider currently has a private data system and collects the following indicators for outcome one: the number of children attending Review Time, number of problems the facilitator helped resolve, number of problems requiring referral to school and number of problems requiring referral to SCR or police. For outcome two, the provider uses Teacher Evaluation Forms, Administrative Exit Forms, and Parent Evaluation Forms. However, currently there is no system to report this outcome data to DCF. OSLS began the process of developing a reporting tool to collect quantitative outcome data during this period, and expects to complete it in 2015.

Domestic Violence Liaisons (DVL) in nine counties functioned with CBCAP funding in FFY2014. A **Domestic Violence Liaison** works to assist victims of domestic violence who are also involved in the child protective services system. The **DVL Program** is a partnership of the Department of Children and Families (DCF), Office of Domestic Violence Services (ODVS), Division of Child Protection and Permanency (DCP&P) and New Jersey Coalition for Battered Women (NJCBW) at the state level, and the DCP&P local offices and domestic violence lead agencies at the county level. A total of 32 **DVLs** are co-located in 46 DCP&P local offices four days per week. Services are provided on site in DCP&P Area/Local Offices, client homes, family team meetings and at the domestic violence lead agency within the county. The goal of this program is to strengthen and enhance the service coordination between New Jersey's child protection and domestic violence systems. This coordination aims to improve safety and wellbeing outcomes for women and children experiencing the co-occurrence of child abuse or neglect and domestic violence. **DVLs** assist DCP&P casework staff in assessing and responding to domestic violence, and making referrals and connections to domestic violence services. **DVLs** also assist domestic violence services providers in the identification of protective service cases that should be referred to DCP&P. Daily activities provided by the DVLS include:

- **Referral:** All services are initiated by CP&P case managers via the DVL Referral and Case Practice Form

- **Confidential Client Communications:** And/or team interviews with CP&P and adult victim. Minimum of 500/year
- **Case Consultation and Planning**: Assess Domestic Violence, Domestic Violence Safety Planning and Referrals for services. Minimum of 100 per year to include:
    - DVLs assisting caseworkers in assessing domestic violence in co-occurring cases of dv and child abuse for adult victims.
    - DVLs participating in developing CCP&P case plans for non-offending parents, and consistent with the DCF DV Protocol, may assist with separate case planning for batterers
    - Developing domestic violence safety plans with non-offending parents and children when age appropriate
- **Education, Training and Mentoring**: DVL provides education, mentoring and training that builds capacity of at least 800 CP& P intake, permanency and other staff to understand the unique needs of adult victims and their children and safe interventions that will produce the best outcomes for adult victims and their children
- **Collaboration**: Collaborate with CP&P caseworkers during protective service investigations, home visits, case planning, FTMs for families under CP&P Supervision
- **Face to Face Contact:** On-going face-to face contact with both DCF staff and the non-offending parent

In FFY2014, **services provided by DVLs reached 5,716 non-offending parents, 12,688 case consultations with safety plans were developed, 7,273 confidential client communications or team meetings with DCP&P staff and adult victims were conducted, and 625 home visits were completed.** CBCAP funding has aided in the DVL program expansion from five DVLs in 2008 to 32 in 2015, providing additional services, supports, education, and referrals for families experiencing the co-occurrence of domestic violence and child abuse or neglect.

The Domestic Violence Liaisons initiative staff worked with RER to develop new monthly reports and definitions. However, this is still in the process of further refinement. RER identified some data quality issues with the current system of aggregate monthly reporting, and began work to clarify the definitions during this reporting period. ODVS collects outcome data for DVL clients regarding increased strategies for enhancing their safety and increased knowledge of available options and community resources. ODVS collects outcomes as part of their overall Family Violence Prevention and Services Act (FVPSA) evaluation, along with the core residential and non-residential services provided by this office. FVPSA is a federally required outcomes evaluation conducted through program participant survey in four areas: Shelter; Counseling; Support Services & Advocacy; and Support group. Two questions must be answered for each component, however only the shelter component is mandatory. Some DVL clients do submit this data, however at this time it is not possible to separate DVL specific data from other domestic violence programs due to confidentiality concerns. A minimum benchmark of 65% is set for the following shelter indicators:

- At least 65% of clients served will demonstrate increased strategies for enhancing their safety
- At least 65% of clients served will demonstrate increased knowledge of available options and community resources

At this time, it is not possible to analyze the data by program for confidentiality reasons. New Jersey's Domestic Violence Liaison Program is an innovate model and may be one of the only

statewide programs of this nature. DCF is very interested in developing a robust evaluation of this program and has slated it as one of the first four programs to be created in phase one of the new data system when it is procured.

In addition to the FVPSA evaluation, Catherine L. Cummings, Doctoral Candidate, Fordham University Graduate School of Social Service has been conducting an implementation case study for the Co-Location of Domestic Violence Liaisons in local Child Protection and Permanency (DCP&P) Offices in New Jersey. This study aims to inform state and national efforts utilizing the co-location of DVLs to improve collaborative practice, explore the impact of DVL co-location with families experiencing co-occurring domestic violence and child maltreatment, and identify local implementation factors associated with effectiveness of DVL co-location. Research methods include a review of written records from DCF and the New Jersey Coalition for Battered Women (NJCBW), interviews and focus groups with DCP&P staff, and field notes from site visits and focus groups. Findings have not yet been disclosed to ODVS, however Ms. Cummings anticipates a final executive summary to be complete in June 2015.

Lastly, the NJ Safe Haven Program, a program implemented through the Office of Communications receives partial CBCAP funding. In June 2000, the State Legislature passed the New Jersey Safe Haven Infant Protection Act. The Safe Haven law allows a parent, or a parent's designee, to anonymously surrender an infant 30 days old or less to any hospital emergency room or police station in the state and without threat of criminal prosecution as long as the infant shows no signs of abuse or neglect. It was initially believed that pregnant teens were responsible for the majority of unsafe abandonment of infants. However, information from Safe Haven surrenders and abandonment cases where the mother was identified displayed a range of ages from young adolescents to women in their 40s. This suggests that the primary target audience for this program is all females of childbearing age.

In FFY2014, the Department of Children and Families (DCF) purchased transit advertising space on the exterior sides of 260 NJ Transit buses to increase public awareness of the Safe Haven program. Advertising space on the interiors of 600 buses was provided at no charge. The campaign ran from April 21, 2014 to July 27, 2014. The ads enabled DCF to reach New Jerseyans where they live, work, and shop in Essex, Passaic, Hudson, Union, Camden, Monmouth, Middlesex, Atlantic, Cumberland, Burlington, Gloucester, Ocean and Mercer counties. The exterior bus ads measuring 30 inches high and 144 inches wide and 30 inches high and 88 inches wide respectively, reached an infinite amount of pedestrian and vehicular traffic. The interior bus ads, 11 inches high and 28 inches wide, reached a significant number of passengers traveling on NJ Transit buses each day. Ads appeared in the spring and summer months when people are inclined to spend more time outdoors, providing greater exposure. The transit ads ran in three phases. The first phase of the campaign ran from April 21, 2014 to May 18, 2014, providing nearly 13.2 million ad impressions. The second phase ran from May 19, 2014 to June 15, 2014, providing nearly 9 million ad impressions. The final phase ran June 16 to July 27, 2014 providing nearly 10.2 million additional impressions. In addition to the outreach conducted through NJ Transit advertisements, DCF distributed Safe Haven outreach materials to schools, community organizations, medical professionals and other partner agencies during FFY2014. All materials are available in both English and Spanish. Additional requests for materials are satisfied on an ongoing basis.

Safe Haven also utilized CBCAP funding in FFY2014 to address child drowning, one of the leading causes of child deaths each year. DCF recognizes that one of the most effective tools in preventing child fatalities from drowning is to help raise greater awareness around the issue. To this end, DCF produced 170,000 magnets with its *Not Even for A Second* water safety campaign. The magnets provided parents and caregivers a list of important tips to help ensure the safety of children while in and around water. DCF partnered with the New Jersey Chapter of the Academy of Pediatrics to distribute the magnets to families served by their network of nearly 1,700 pediatricians across the state.

The **New Jersey Children's Trust Fund (CTF)** is a private/public partnership created by law in 1985 to fund child abuse and neglect prevention programs in New Jersey communities. The CTF supports local child abuse and neglect prevention programs that implement evidence-based and evidence-informed programs. Funds come to the CTF primarily from residents through the NJ state income tax check-off; and other private donor contributions.

With the Children's Trust Fund (CTF), a number of evidence based programs are offered to children and families in New Jersey's most vulnerable communities. The **Incredible Parents=Incredible Kids** curriculum is offered in Newark and Essex County through lead agency Family Connections, Inc. Newark and Essex County experience challenges of crime, gang violence, high unemployment rates, and poverty, leading to potential increases in child abuse and neglect, poor school performance, behavior and anger problems, and social and emotional deficits in children. Targeting African American Children and their parents in various pre-schools and additional parents in the community, **Incredible Parents=Incredible Kids** operates with a combination of CTF and Newark Pre-school council funding. The program incorporates Incredible Years Children and Parenting Series; Talking about Touching Safety Curriculum and the Music Together Curriculum. This preventative program aims to promote strong healthy families, prevent child abuse and neglect and increase school readiness and success. Successful implementation demonstrated a decrease in children's problem behaviors, and increase in positive social skills, and an increase in parent's confidence to manage behaviors of the child(ren).

The child component of the **Incredible Parents=Incredible Kids** program consists of The Incredible Years DINA Curriculum, Talking about Touch and Music Together. Incredible years DINA curriculum is for 3-5 year olds and covers topics such as: problem solving; understanding and communicating feelings; anger management; behaving appropriately; friendship and communication skills. Talking about Touch is a second step safety curriculum focusing on teaching fire safety, gun safety, good touch/bad touch, street safety and car safety. Music Together is a music curriculum for 1.5-2 year olds that focuses on the development of language skills and fine/large motor skills.

The parenting component provides 3 psycho-educational parent training groups for: Parents of Babies, Parents of Toddlers and Parents of Preschoolers. The group format for all the groups consists of vignettes, group discussions, role playing and worksheets. The Parent of Pre-schoolers Group focuses on parental self-care, time management, school readiness, development of rules/routines, positive discipline skills and strengthening parent/child attachments/bonds.

The Parents of Toddlers Group focuses on separation/reunions, parental self-care, potty-training, strengthening social skills, development of language, importance of routines, positive behavior management and strengthening parent/child bonds. The Parents of Babies Group focuses on: getting to know you're your baby, understanding baby's cues, self-care/ time management, developmental milestones and providing appropriate stimulations.
Below is a description of the various activities and outputs the **Incredible Parents=Incredible Kids** program accomplishes in a year's time:

a) Professional Training in Incredible Years:
    - Incredible Years DINA curriculum -3 full days of training/ 24 hours total for community professionals
    - Incredible Years Parents Group Leader – 5 full day training/40 hours for Clinical Coordinator.
b) Relationship Building and Development with Newark Preschool Council- monthly meetings for one hour each meeting.
c) Incredible Years DINA Curriculum (3-6 year olds): 4 pre-school cycles/24 sessions per cycle/ 15-30 minutes each session. A total of 96 sessions will be held serving 55 children.
d) Talking About Touch (3-5 year olds): 4 pre-school cycles/15 sessions per cycle/ 15-30 minutes each session. A total of 60 sessions will be held serving 55 children.
e) Music Together (1.5-2 year olds): 2 cycles/7 sessions per cycle/ 15 minutes each session. A total of 14 sessions will be held serving 20 toddlers.
f) Parents of Pre-Schoolers: 2-3 parent cycles/12 sessions per cycle/ 2 hours each session. A total of 24 sessions will be held serving 12 -18 parents.
g) Parents of Toddlers: 2-3 parent cycles/9 sessions per cycle/ 2 hours each session. A total of 18 sessions will be held serving 12-18 parents.
h) Parents of Babies: 1-2 parent cycles/7 sessions per cycle/ 2 hours each session. A total of 14 sessions will be held serving 6-12 parents.

Progress and Accomplishments in FFY2014 include:

- Adjusted the target number of parents that will be served for the *Parents of Pre-schoolers Group; Parent of Toddlers Group, and Parent of Babies Groups* based on lessons learned in the prior year. The implementing agency decided to focus recruitment on parents of toddlers, learning that parents were more able to make a commitment to group sessions when their child was older.
- 83 preschoolers participated in the Incredible Years DINA Curriculum and Talking about Touch providing the following outcomes:

Incredible Years DINA Curriculum:

- 85 % of children demonstrated an increase in positive social skills as measured by the pre and post Preschool and Kidergartin Behavior Subscale (PKBS) test social skills compositie score
- 79% of children demonstrated a decrease in problem behavior as measured by the pre and post PKBS test problem behavior composite score

Talking about Touching second step curriculum:

- 95% of students demonstrated increased knowledge about safety rules for touching private body parts
- 92% of students demonstrated increased knowledge regarding car/seat belt safety; stranger safety and how to respond/stay safe if someone tries to touch private body parts

  - 86% of students demonstrated increased their ability to identify private areas of bodies
  - 84% of students demonstrated increased knowledge regarding traffic safety
  - 81% of students demonstrated increased knowledge for staying safe if they get lost

- The implementing agency practiced ongoing CQI and shifted their practice during the year to meet the needs of community parents. There were more parents of toddlers needing services resulting in 5 cycles of parents of toddlers groups held as opposed to only offering 2-3 cycles as initially planned. There was less demand from parents of preschoolers, leading to only one group cycle for this target held as opposed to the initial target of offering 2-3 cycles. 33 parents graduated from the groups, which was below the targeted 48. Parenting groups were held at the following three locations: Family Connections (FC) East Orange, Central High School (CHS) Newark and Queen of Angels in Newark. 100% of parents that completed either the Parents of Toddlers or the Parents of Preschoolers Group indicated that they were "confident" or "very confident" in managing their child's behavior in the home on their own following the course.

Serving children and parents in two pre-schools in Mercer County, the **Positive Parenting-Padres Positivos** evidence based program is implemented with funding from the CTF, Division of Mental Health and Addictions Services, and the United Way. Jewish Family & Children's Services of Greater Mercer County, the only provider of mental health services for pre-schoolers in the Hightstown area, serves as the implementing agency for this program. The program is implemented by a mental health professional, who is bilingual and bicultural. The **Positive Parenting/Padres Positivos** program targets at risk, low income Spanish and English speaking Latino immigrant and refugee parents with pre-school children ages 2 ½ to 5 in Mercer County, where the Latino population continues to rapidly increase. **Positive Parenting/Padres Positivos** incorporates Common Sense Parenting Curriculum (CSP) for Parents and Mental Health Psychosocial Curriculum for preschoolers. When implemented effectively, this program displays and increase in family functioning, social support, concrete supports, nurturing and attachment among family members, and an increase of understanding of child development.
CSP was developed, researched and distributed by Boys Town USA and is endorsed by the National Center for Mental Health Promotion and Youth Violence Prevention as a Best Practice. It has been normed on a multicultural population, including Latinos. The CSP Group is a parenting skills training group that includes behavior management, child development, nurturing, parenting skills and self-control as well as how to calm the child when emotionally upset. The Mental Health Psycho-educational Preschool Groups is an in classroom social emotional group for preschool children ages 2-5 years old. Topics are individualized and tailored based on the needs of the preschool children. Topics can include grief; bullying; making friends; following rules; anger management; appropriate expression of feelings/thoughts; and social skills. Goals for this prevention program include the prevention of child abuse and neglect, increased school readiness and supporting healthy and strong families.
Activities and outputs of the **Positive Parenting/Padres Positivos** program include:

a) *Outreach/Recruitment*: develop marketing and recruitment efforts.
b) *Common Sense Parenting Groups:* 8 series/cycles of CSP groups, 2 series/cycles each quarter, one in Spanish and one in English; 7 classes in each series at 2 hours each; 65-75 parents will graduate.

c) *Individual Parent Consultation:* 1-3 consultation sessions, .5 – 1 hour each for 15 parents.
d) *Mental Health Psycho-educational Preschool Groups:* Implement in a total of 9 classes (5 classes in Better Beginnings and 4 classes at the YWCA) Minimum of 1X/week in each classroom for, .25-.5 hours classroom, a minimum of 16-20 weeks in the school year. Serve a total of 149 children.

Positive Parenting/Padres Positivos progress and accomplishments in FFY2014 include:

- Positive Parenting-Padres Positivos received one technical assistance site visit, for a total of two hours, from DFCP. Reviewed and revised logic model to reflect realistic outputs based on second year implementation, targeted performance indicators and ongoing CQI.
- Common Sense Parenting (CSP) Group
    - 75 parents were recruited, of which 58 (77%) enrolled.
    - 44 (75%) of parents that enrolled, completed the program.
- To evaluate the effectiveness of the Common Sense Parenting Groups, JFCS began administering the FRIENDS National Resource Centers Protective Factor Survey (measures Family Functioning; Social Support; Concrete Supports; Nurturing and Attachment and understanding of Child Development) to all participants. The program was able to aggregate the data and showed increases in Protective Factors (PF) for the overall program. Although interesting, JFCS wanted to understand the statistical significance of the increases for each of the PFs and which protective factors the Common Sense Parenting program was most impacting. JFCS contracted with Central Jersey Family Health Consortium to perform an external evaluation of the Common Sense Parting Program. The results of the evaluation are as follows: Parents showed improvement within each area with the largest improvement witnessed in family functioning and social support. All factors, except for concrete support, showed statistically significant improvements. These results suggest that the program is effective at improving understanding of family functioning, social support, nurturing and attachment, and child development; however, there is only limited impact on concrete support.
- 163 children benefited from the Mental Health Psycho-educational Preschool Groups
- 93 parents participated in the Individual Parent Consultation offered.

Lastly, funded in full with CTF, the **Triple P- Positive Parenting evidence based Program** is implemented in Vineland, Millville, and Bridgeton within Cumberland County through lead agency INSPIRA Health Care. Cumberland County has the highest rate of abuse/neglect investigations and teen pregnancy in New Jersey, and ranks high in children in out-of-home placements, children living in poverty and unemployment. The **Triple P-Positive Parenting Program** targets parents and caregivers of children birth to age five. The overall goal of this program is to prevent child abuse and neglect through increasing parents' and caregivers' understanding of realistic expectations for a child's behavior, modeling behaviors parents and caregiver wish for their children to adopt, and correcting and redirecting a child's inappropriate behaviors without corporal punishment. With successful implementation, parents and caregivers present a decrease in over-reactivity, laxness, and verbosity; while children display a decrease in emotional symptoms and conduct problems, with an increase in pro-social behavior.
Triple P Positive Parenting Program is an evidence based program with more than 30 years of clinical trials. **Triple P -Positive Parenting Program** offers the Group Triple P- Level 4

Parenting Sessions and Pathways Triple P – Level 5. The Group Triple P- Level 4 Parenting Sessions is an 8 session program that provides opportunities for parents to learn through observation, discussions, practice and feedback. Segments from DVD's, the parent workbook and power points are used to demonstrate positive parenting skills. Parents complete homework to consolidate the learning from the group sessions. Two to three telephone sessions are provided to parents as follow up to the group and provide additional support. Pathways Triple P – Level 5 is a service for parents that have completed Group Triple P. This is a more intensive family intervention for parents and caregivers experiencing relationship conflict, parental depression and/or high levels of stress. Three modules are provided in private sessions with Triple P Practitioner. INSPIRA also provides monthly, 90 minute seminars using materials from the Group Triple P – Level 4 parenting sessions. This format is not a component of the Triple P model, but is a strategy for INSPIRA to increase the number of parents exposed to the materials. Below is a description of activities and outputs of the Triple P Positive Parenting Programs:

- *Professional Training*:

Group Triple P:

- o *Initial Training* Triple P Group Level 4: 3 full days of training in Group Triple P with National Office Trainers. 17 professionals will complete training in FY 2011-2012
- o *Pre-Accreditation Visit/Training:* One full day of training with National Office Trainers. 17 Professionals will complete training in FY 2011-2012
- o *Accreditation Visit/Training:* One and a half days of half day accreditation training/visit with 5-7 professionals in each group. 17 professionals will become accredited. Professionals will become accredited in FY 2011-2012

Pathways Triple P

- o *Initial Pathways Training*: 2.5 full days of training in Pathways for 4 SJHC staff in Atlanta. SJHC staff will attend in FY 2012-2013
- o Accreditation for Pathways: Accreditation through video submission for 4 SJHC Professionals, completed in FY 2012-2013.

- *Outreach & Recruitment* Scheduling for Group Triple P groups/classes:
  - o Monthly Meeting with Trainers for 3 months (beginning in February 2013), then quarterly following. Meeting for two hours. Develop recruitment plans and group/class schedules.
- *Group Triple P- Level 4 Parenting Sessions:* 10-12 cycles of 8 week group/classes: first 4 weeks 2 hour group class sessions, fifth – seventh week 15 minute phone follow up with each parent participant; 7th group/class session, 1.5 hours. 50 parents will complete.
- *Pathways Triple P – Level 5:* Up to 2 individual meetings with caregivers, one hour each, for 9 caregivers/year.
- *Select Seminars Series:* At least 1 seminar per month (minimum of 12 each year); 90 minute each, for 84 parents/year.

With the lower than anticipated numbers of families enrolling and graduating from the Triple P Parenting Groups in year's one and two of implementation, INSPIRA once again revised their strategy in year three. Starting in October 2013, INSPIRA decided to offer a Selected Seminar Series in Triple P. The Selected Seminar Series in Triple P was structured so that parents could attend one, two or three seminars based on their needs and availability. Seminars were offered monthly for 90 minutes and covered the following topics; The Power of Positive Parenting; Raising Confident, Competent Children; Raising Resilient Children. With this strategy,

INSPIRA was able to reach 93 parents, the majority Spanish speaking, with many parents attending three seminars.

APSR Child Protection Substance Abuse Initiative CAPTA

2015 PSSF Update Report

Section 1 – Identifying Information		
1a	**Provider**: Catholic Charities, Diocese of Metuchen	**1b Program Name:** Child Protection Substance Abuse Initiative
1c	**Relevant PSSF Program**: X FPS, ___ FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 26 Safran Avenue, Edison, NJ 08837	
1e	**Objective**: To provide substance abuse assessments, extended assessments, treatment referrals, case management and counselor aide services to caregivers and families, referred to us by DCP&P, where it has been determined that the children are at risk of abuse or neglect. Individuals are referred to rule out or determine if there is a substance abuse or dependence problem. Once the assessment or extended assessment is completed and treatment is the recommendation, CPSAI will work together with DCP&P to enroll those customers in treatment, and manage the case for a minimum of 30 days, to ensure compliance, and reduce any barriers that may allow the customers to refuse to comply; or work to reduce any issues that may arise within the early treatment phase. To provide education and a better understanding of the disease concept of substance abuse / dependence to the DCP&P family service workers through trainings surrounding topics related to working with substance abusing families	
1f	**Outcome(s) Addressed**: X Safety ____Permanency ____Well-Being	
Section 2 – Service Description Basics FFY '14 (10/1/13 – 9/30/14)		
2a	**Overview of Service**: The Catholic Charities CPSAI Program outposts Substance Abuse Counselors, counselor aides, and Case Managers in the local DCP&P offices in the counties of Middlesex, Union, and Essex. This program provides consultation services with DCP&P workers as needed, to identify appropriate cases to be assessed for substance abuse, to assess DCP&P clients for Substance Abuse, per referral, and to manage those cases referred to treatment, for a minimum of 30 days. CPSAI provides early identification and assessment of the severity of	

	the addictive disorder, and identifies the risk of harm to children shaped by the addiction. Catholic Charities CPSAI Program provides referral to the appropriate level of care for substance abuse treatment, at a facility best suited or available to the client's individual situation. Catholic Charities CPSAI Program provides collaboration with treatment agencies for treatment coordination, follow up, and monitoring of treatment compliance in keeping with the current case closing protocols. Catholic Charities CPSAI Program provides transportation services within all three counties, and system coordination between Essex and Union County DCP&P and the Local County Welfare Agencies. Catholic Charities provides Extended Assessment services to customers where it is clinically indicated such as having risk factors that appear to be related to substance abuse, or self-reported substance abuse different from collateral information provided by DCP&P. The CPSAI Program also offers an immediate response to workers needing their customers assessed via our immediate assessment process. Workers can have their customers seen that day or the first working day after, if the case is deemed an emergency and the client meets the criteria for emergency assessments, through the DCP&P office. Urine drug screen testing is taken throughout the processes of assessment, whether it is an initial or an extended assessment. The CPSAI Program provides trainings throughout the year for the DCP&P family service workers surrounding substance abuse and the impact substance abuse can have on families.
2b	**Population Served**: Caregivers of children that are customers of DCP&P; adults that live in the household with the child(ren) who are customers of DCP&P and adults who are being considered as Adoptive or Resource Families. In addition there are adults who are referred from Family Court and / or Family Drug Court that are customers of DCP&P.
2c	**Geographical Area of Services**: DCP&P cases are served within the counties of Middlesex, Union and Essex.
2d	**Referral Sources**: DCF, DCP&P's Case Workers, Supervisors and Gatekeepers.
Section 3 – The Year in Review FFY '14 (10/1/13 – 9/30/14)	
3a	**Provide a summary of program accomplishments on goals.** **Include data where available:** Out of 4048 referrals received 2545 customers were assessed; 1449 customers were given a diagnostic impression; 1158 customers were referred to treatment; 672 customers were reported to have enrolled in the treatment process; Customers that were referred to extended assessment from the initial assessment equaled 78; there were 39 SAI eligible customers who were transferred to SAI for services. We continue to improve and revamp the data collection and statistics for more precise information. We are able to produce report more accurately and faster, than in the past. Using this information has allowed our program to locate and improve services, in our local offices. Catholic Charities continues to collaborate with the Division of Mental Health and

	Addiction Services (DMHAS), working together, improving data collection through the New Jersey Substance Abuse Monitoring System (NJSAMS). There were also four DCP&P trainings completed and six in-service workshops completed.
3b	**How did this improve outcomes for children and families?** 1) Determining the severity of substance use disorder in the home, and customers following through and enrolling in treatment, reduces the potential for continued substance use including alcohol and/or neglect of the children thereby allowing the families to remain intact and increases the safety of children. **2)** We provided in house trainings to educate the family service workers in assisting their families and identifying potential for substance use disorders.
3c	**Identify specific factors that contributed to this improvement:** 1) Customers identified with substance use disorders that engaged in the treatment process and began to get well, allowed their families to remain intact, get healthy, and the environment became safer for the children. **2)** Customers that did not follow recommendations, since identified, were able to be discussed by DCP&P, and then decisions could be made, by them, as to the safety of the children.
3d	**Identify significant barriers to goal accomplishment:** 1) Lack of enough dedicated interview space creates a barrier when we could conduct more than one assessment which would reduce scheduling time. We have discussed this in meetings and here in this report. 2) The complexity of working with a large system like DCP&P, often results in communication problems. Those communication issues can result in the customers not following through with treatment recommendations, which can create a barrier for us accomplishing our goal of clients getting into treatment, as well as getting them assessed**.** We are working harder than ever to increase better communication with DCP&P via email to all parties involved, as well as voice mail and speaking with the worker and or supervisor in person. 3) Lack of understanding of the disease of addiction within the DCP&P worker population creates a lack of awareness of how a parent or caregiver using substances including alcohol in the household can impact a child/children, on an emotional and behavioral level. We are providing substance abuse trainings to the DCP&P employees that will enhance their understanding of clients with substance use disorders and general overall information on Drug and Alcohol and their effects.
3e	**Definition of Level of Service as per contract:** Assessments, Extended Assessments, Immediate Assessments, Case Management Cases, Counselor Aide Services, and DCP&P Trainings
3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period**

	of 10/1/13 – 9/30/14: 4800 comprehensive LOCI-2R, NJSAMS assessments with treatment recommendations, 75% who did not receive a diagnostic impression with the initial assessment, excluding those where a V71.09 diagnostic impression was applied, will complete extended assessments with written reports, and 60% of customers with treatment recommendations will be enrolled in an appropriate treatment program.
3g	**Enter your actual Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14:** 4048 Referrals were received. Out of those referrals, 2545 assessments were completed. 1449 customers were diagnosed and out of that number 1158 customers were provided with a referral to treatment; 672 of the customers referred to treatment, were enrolled.
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals:** 3595 unduplicated individuals referred and 2484 unduplicated individuals were assessed. **# of unduplicated families:** Unable to provide accurate data, at this time. Improvements to data collection focused on identifying families along with individuals will be made.
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** Feedback from the RDS/Gatekeepers is positive. The RDS/Gatekeepers feel the counselors are an important part of their team. Stakeholder feedback has also been presented as positive with the communication between all parties increasing, and improving. Communication is also improved between the provider agencies, as well as, consortium meetings. A further effort for face to face and closer communication with case workers has been a priority.
Section 4 – The Year Ahead FFY '15 (10/1/14 – 9/30/15)	
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.** 1) Continue to outreach the customer by implementing new protocol for Missed Substance Abuse Evaluations: a) Family member does not come in: Within 1 business day CC, DCP&P worker and/or supervisor have a conversation (not email) to resolve barriers for family member. During the conversation, CC and DCP&P worker call family member TOGETHER to arrange appointment #2, either at home or in-office (with transportation provided by CC or DCP&P as needed) b) Family member misses appointment #2: Within 1 business day CC, DCP&P worker and/or supervisor will call family member TOGETHER and discuss: • Making arrangements for appointment #3 to be held in the DCP&P office, or at home, as needed

	• Third and final opportunity-if this appointment is missed, a report from CC will be provided as documentation that the case will be closed out after the 3rd missed appointment and a new referral will need to be generated. (Original document can be re-submitted if all contact information remains the same). • A DAG conference will take place for in-home cases to discuss possible court intervention. 2) Continue to provide immediate emergency assessments, to meet the needs of the DCP&P offices, based on the criteria to determine an emergency from a regular referral. 3) Continue to provide case management services to help ensure admission to treatment programs for clients that is referred. 4) Continue to utilize our new vender that expedites the reporting process on drug screen results. 5) CPSAI has added three Bi-lingual Counselors and a Bi-lingual Clinical Supervisor to accommodate Spanish speaking customers. 6) CPSAI provides ongoing training to update Counselors on new ASAM Criteria and DSM-5 improving assessment skills 7) CPSAI continues to improve communications with DCPP staff 8) CPSAI has arranged to have upcoming trainings in local office instead of at the Fire Academy.
4b	**Identify changes you will make that stem from stakeholder feedback.** Stakeholder feedback results in continued increase in communication within the DCP&P offices by attending more staff meetings and increasing the number of RDS/Gatekeeper meetings, in order to develop and maintain consistent, open lines of communication.
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?** 4800 comprehensive LOCI-2R, NJSAMS assessments with treatment recommendations, 75% who did not receive a diagnostic impression with the initial assessment will complete extended assessments with written reports, and 60% of customers with treatment recommendations will be enrolled in an appropriate treatment program.
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals: 4800** **# of unduplicated families: 4800**
	Section 5 – Evaluating Progress FFY '15 (10/1/14 – 9/30/15)
5a	**How will you measure progress?** 1) Evaluate program level of service 2) # of assessments completed (Initial, Extended, Immediate) 3) # of customers diagnosed 4) # of customers referred to treatment

	3) # of Case Management Service 4) # of clients enrolled in treatment 5) Track time frame of assessment / recommendation / engaging client / case closure
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** 1) Supervisor Case Record Review 2) Consistent increased training with staff on all facets of the contracted services. 3) Continued participation at DCP&P Staff meetings 4) RDS/Gatekeeper meetings on a frequent basis 5) Frequent scheduled meetings with the contract administrators. 6) Implement Customer Satisfaction Survey.
5c	**How do you collaborate with community partners?** 1) Ongoing communication with DCP&P 2) Coordination with other service providers i.e.: Substance Abuse Imitative (SAI) 3) Participation in the County Consortium Meetings 4) Attendance to DCP&P Family Team meetings, if requested 5) Treatment Program Open Houses and treatment program information sessions at CPSAI staff meetings presented by the treatment programs 6) Various substance abuse trainings for up to date knowledge on current drug trends. 7) Brainstorming / group meetings with the team to discuss concerns and ideas for improvement. 8) Various public engagements to inform public and private institutions of substance abuse / dependence issues, increasing awareness regarding signs and symptoms of substance abuse / dependence and what resources are available.

2015 PSSF Update Report

Section 1 – Identifying Information		
1a	**Provider**: Center for Family Services	**1b Program Name:** CPSAI
1c	**Relevant PSSF Program**: _X__FPS, ___ FSS, ___TLFRS, ___APSS	
1d	**Program Address**: 594 Benson Street Camden, NJ 08103	
1e	**Objective**: **To provide substance abuse assessments, urine drug screens, referral to treatment, referral to extended assessments, case management, and supportive**	

	services for parents/caregivers who are referred due to current or suspected substance abuse. This supports the achievement of family safety, permanency and well-being.
1f	**Outcome(s) Addressed**: ___x_Safety ____Permanency ____Well-Being
Section 2 – Service Description Basics FFY '14 (10/1/13 – 9/30/14)	
2 a	**Overview of Service**: **The Center for Family Services CPSAI Program provides:** a. **Consultation with DCP&P workers as needed to identify appropriate cases to be assessed.** b. **Standardized substance abuse assessments, including urine drug screens, referral and case management to, and advocacy for, appropriate levels of treatment.** c. **Substance abuse training to DCP&P staff to facilitate the early identification of potential substance abuse issues.** d. **Identification of cases appropriate for Work First New Jersey Substance Abuse Initiative (SAI) and coordination of treatment placement.** e. **Collaboration with provider agencies for treatment coordination, follow up and monitoring of treatment compliance in keeping with current case closing protocols.** f. **Transportation and support services.** g. **Ongoing written and verbal case conferencing with DCP&P Staff** **Systems coordination facilitating communication between DCP&P (Camden County) and local county welfare agency.**
2b	**Population Served**: ***:*** **The population served consists of adult caregivers who are under investigation or supervision to rule out substance abuse or dependence as a precipitating or co-existing factor to child abuse/neglect Adult caregivers who received a DSM IV diagnosis were referred to the appropriate level of treatment.**
2c	**Geographical Area of Services**: **Services are provided on site at DCP&P offices throughout the Southern Region. This includes Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester and Salem.**
2d	**Referral Sources**: **Department of Children and Families/Division of Child Protection and Permanency.**
Section 3 – The Year in Review FFY '14 (10/1/13 – 9/30/14)	
3a	**Provide a summary of program accomplishments on goals.** **Include data where available: Out of the** 5,206 **referrals that we received,** 3,463

	assessments were completed. 2350 clients were referred to treatment, and 1,392 clients were enrolled into treatment. 137 clients that did not enter treatment were referred to the extended assessment program throughout the southern region. There were 265 clients who were referred to receive a second (UDS) Urine Drug Screens. There were 106 clients SAI eligible and transferred to SAI for services. **There were three joint trainings given for CP-SAI and DCP&P staff covering topics of: Current Drug Trends and Emerging Drugs of Abuse; Stress Management and Relapse Prevention; Motivational Interviewing.** **There were also on-going In-service trainings on the process of assessment, staff meetings, new hire orientation, and ethics training**
3b	**How did this improve outcomes for children and families? By determining the severity of substance abuse in the home and assisting clients in entering the treatment process, the risk of harm to the children was reduced thereby promoting the safety, reunification and preservation of the family. It also provided an opportunity for joint trainings and discussions**
3c	**Identify specific factors that contributed to this improvement:** **(1) Improvements were accomplished through ongoing communication/engagement with the clients, DCP&P caseworkers and substance abuse treatment agencies.** **(2) The services provided include: case management, counselor aide contact, home visits to deliver appointment letters as well as phone contact and transportation to the assessment and treatment intake appointment.**
3d	**Identify significant barriers to goal accomplishment:** **1) Unanticipated increase in number of referrals in some DCP&P local offices** **2) Staff vacancies** **3) Lack of available treatment within the Southern Region** **4) Inability to contact clients i.e. no phone, homeless** **5) Lack of treatment for male clients** **6) Lack of transportation** **7) Long waiting lists for treatment slots** **8) Financial difficulty** **9) Client refusal and/or non-compliance** **10) Lack of treatment options for Spanish speaking clients** **11) Lack of space within certain DCPP offices for conducting assessments**
3e	**Definition of Level of Service as per contract: A service unit is the substance abuse assessment which includes a urine drug screen, referral to treatment when clinically indicated, and referral to extended assessment. It also includes Case Management Cases, Counselor Aide Services, and DCP&P Trainings.**
3f	**Enter your contracted Level of Service portion that is Title IV-B funded for the period**

	of 10/1/13 – 9/30/14: Level of service expected 5100 assessments to be completed, 3,825 clients will be placed in treatment, 25 families per Counselor Aide per month will be receive case management services from the Counselor Aides. **Extended Assessment Services- 1,275 clients will receive Extended Assessment Services.**
3g	**Enter your actual Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14: The actual level of service units were** 3,463 **completed assessments out of the** 5,206 **referrals received.**
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once.** **# of unduplicated individuals: 3937** **# of unduplicated families: 3937**
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** **Feedback information is provided through several sources. Through participation at the Child Welfare DCP&P Consortium Meetings, regularly scheduled Resource Development Specialist Meetings as well as ongoing communication with local and State representatives of the CP-SAI project, positive feedback was reported in support of the ongoing services provided by CP-SAI.**
	Section 4 – The Year Ahead FFY '15 (10/1/14 – 9/30/15)
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.** • **CPSAI will continue to provide case manager services to enhance client outreach thereby supporting a continuum of care.** • **Substance abuse training to DCP&P staff to facilitate the early identification of potential substance abuse issues at local DCP&P offices.** • **Combined Substance Abuse Educational workshop series are presented at offsite location to DCP&P/CP-SAI staff throughout the year.** • **Providing additional resources to the RDS' to share with their staff at the RDS meeting held every other month**

4b	**Identify changes you will make that stem from stakeholder feedback.** 1. **During the year FFY 2015 we will increase the number of assessments scheduled per CADC to increase the number of assessments being completed and number of clients entering treatment.** 2. **Assign and move staff to other offices with the greatest need, where there is a higher number of referrals, to improve our levels of service including splitting staff between more than one office if needed.** 3. **Continue to utilize CADC call out policy to provide backup services when CADC's are out of the office so as not to interrupt services.** 4. **In the Atlantic East/Atlantic City DCP&P local office, we have added a second CA to assist with transporting clients and case management.** 5. **We filled the spots of those staff out on medical leave with temporary staff so as to not disturb the flow of services.**
4c	**How many IV-B units of service are you expecting to deliver for the period of 10/1/14 – 9/30/15?**
	Level of service expected 5100 assessments to be completed, 3,825 clients will be placed treatment, 25 families per Counselor Aide per month will be receive case management services from the Counselor Aides. **Extended Assessment Services- 1,275 clients will receive Extended Assessment Services**
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals**: 5100 **# of unduplicated families: 5100**
	Section 5 – Evaluating Progress FFY '15 (10/1/14 – 9/30/15)
5 a	**How will you measure progress?** 1. **Monitoring state mandated spreadsheets for contracted goals** 2. **Implementation of Electronic Record Keeping** 3. **Reviewing monthly CADC assessment logs** 4. **Clinical supervisors reviewing each assessment completed by CADC, office referrals and CA progress notes to assess case management hours** 5. **Doing a monthly report that is sent to central office**
5 b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** 1. **Continue to meet with DCP&P Resource Development Specialists to address areas needing improvement as well as reviewing monthly data and contract**

	obligations. Meetings scheduled approximately every 2 months. **2. Continue to work closely with DCP&P staff on a case by case basis to support families and provide child protection.** **3. Continue to attend and participate in monthly county consortium meetings** **4. Ongoing CPSAI staff trainings/staff development on all aspects of the contracted services as well as substance abuse education/training for the clinical staff.** **5. Weekly review of all records by Clinical Supervisor.** **6. Continued participation @ DCP&P staff meetings and RDS/Gatekeeper meetings on a regular basis.** **7. Stakeholder satisfaction surveys.** **8. Consumer satisfaction survey through the Case Manager position.** **Meetings with Contract Administrator and Statewide Manager of Substance Abuse Services at DCP&P Central Office.**
5c	**How do you collaborate with community partners?** **1. Attend and participate in Consortium meeting with DCP&P staff, treatment providers and staff from SAI to address specific issues that create treatment barrier for clients.** **2. Attend and participate in Resource Fairs for DCP&P** **3. Continue to build relationships with treatment providers by contacting them weekly for follow-ups on clients who have entered treatment.** **4. Continue to provide Substance Abuse specific training that will be open to DCP&P staff from all 7 counties.** **Participated in Women's Steering Committee Meeting, CP-SAI providers meeting and CP-SAI statewide meetings.**

2015 PSSF Update Report

Section 1 – Identifying Information		
1a	**Provider**: Preferred Children's Services Child Protection Substance Abuse Initiative	**1b Program Name:** Child Protection Substance Abuse Initiative (CPSAI)
1c	**Relevant PSSF Program**: _X__FPS, ___ FSS, ___TLFRS, ___APSS	
1d	**Program Address**: P.O. Box 2036, Lakewood, New Jersey 08701	
1e	**Objective**: *The result expected by the Department of Children and Families is protection of the child through:* ❖ *Comprehensive Substance Use Assessment (DCP&P Offices & the Community)* ❖ *Identification of Substance Use Related Disorders*	

	❖ *Extended Assessment* ❖ *Collaboration with DCP&P about case recommendations* ❖ *Referral to Substance Use Treatment Program with appropriate Level of Care* ❖ *Transportation to Evaluation or Substance Use Treatment* ❖ *Transportation to Extended Assessment* ❖ *Drug Screens – Chain of Custody, GC/MS* ❖ *Presentation of difficult cases at Consortiums monthly to collaborate with Child Welfare Providers, DCP&P and Social Services* ❖ *Participation in Family Team Meetings and Focus on Supervision (where applicable).* ❖ *Follow-up with treatment providers once client admitted into treatment facility.*
1f	**Outcome(s) Addressed**: __X__Safety _X___Permanency __X__Well-Being
Section 2 – Service Description Basics FFY '14 (10/1/13 – 9/30/14)	
2a	**Overview of Service**: *Preferred Children's Services, Child Protection Substance Abuse Initiative provides substance use assessments, extended assessments, referral, case management, motivational interviewing, transportation, and chain of custody drug screenings for families associated with the Department of Children and Families, Division of Child Protection and Permanency. The overall goal is to ensure child safety and well-being, by assisting DCP & P with the identification of parents/guardians that have issues with a substance use disorder. The CPSAI program, through a comprehensive assessment, intends to determine the severity of the substance use disorder and the potential risk to the child(ren). The results of the assessment will enable the Assessment Counselor to establish an appropriate Level of Care recommendation and to make the most appropriate referral for substance use treatment or collaborate with other professionals to ensure the safety and will being of the child(ren) in their care.*
2b	**Population Served**: *The target population for this program are parents/guardians involved with the Department of Children and Families affected by substance use. Many of these cases are high risk and require experience and specialized clinical skills. Preferred Children's Services had demonstrated experience with the target population since 2000.*
2c	**Geographical Area of Services**: *We currently operate the CPSAI Program in eleven counties: Bergen, Hudson, Hunterdon, Mercer, Monmouth, Morris, Ocean, Passaic, Somerset, Sussex and Warren, located in 20 Local DCP&P offices.*
2d	**Referral Sources**: *Division of Child Protection and Permanency*

Section 3 – The Year in Review FFY '14 (10/1/13 – 9/30/14)	
3a	**Provide a summary of program accomplishments on goals.** **Include data where available:** *CPSAI has met the multifaceted needs of our clients through seamless and prompt referrals, as well as, to other services whenever possible.* ❖ *We received 11,862 referrals* ❖ *We completed 8,422 substance use assessments.* ❖ *Of the 8,422 clients assessed 5,024 clients were given a substance use/dependence diagnosis.* ❖ *We referred 2,438 clients to Extended Assessment for further evaluation.* ❖ *There were 5,024 clients referred to treatment and 2,612 clients enrolled in treatment.* ❖ *There were 5,024 clients who received Case Management Services.* ❖ *There were 271 clients who were eligible for and referred to services with the SAI.* *Additionally,* • *All clients identified as needing additional services were referred for Mental Health Treatment, Medical Evaluations and Social Services* • *CPSAI participates in five Consortium meetings per month (Ocean, Monmouth, Mercer, Passaic and Hudson).* • *CPSAI attended the Professional Advisory Committee on Alcoholism and Drug Abuse (PACADA) as scheduled in various counties where we provide DPC&P services* • *CPSAI staff attended Gatekeepers meetings in the North and Central Regions as scheduled* • *CPSAI staff attended the Statewide CPSAI Providers Meetings (as scheduled)* • *CPSAI staff have attended the DCP&P /CW, Women's and Father Steering Committee Meetings* • *CPSAI staff have attended the Referral Guidelines Meetings with Local Office Managers and Gatekeepers* • *CPSAI has been enriched through training and education; many staff members are pursuing their Licensure and Certification towards Mental Health and Addictions. Such as LCADC, CADC, LSW, LCSW, LAC, LPC.* *PCS/CPSAI provided 15 trainings to DCP&P and CPSAI staff, 25 in-service workshops to DCP&P Caseworkers and Supervisors and 28 in-service workshops for CPSAI Staff.*
3b	**How did this improve outcomes for children and families?** *Providing substance use assessments to determine if there is a substantiated substance use problem, allows DCP&P to become actively involved with the family. This results in the safety for the child/children. The CPSAI Staff removed barriers for assessments and treatment admissions by providing transportation and using culturally sensitive staff from*

	the local communities to motivate clients hard to engage.
3c	**Identify specific factors that contributed to this improvement:** **Specific factors that contributed to this improvement are as follows:** • *Monthly Consortium Meetings* • *Relationships with providers to be able to initiate immediate access to treatment* • *CPSAI Assessment Counselors are able to utilize the Division of Mental Health and Addiction Services, DCP&P treatment slots designed specifically to meet the needs of DCP&P clients* • *Participation in Family Team meetings and ongoing communication with Caseworkers, Supervisors, Gatekeepers, Local Office Managers and Community Providers* • *CPSAI stays current with best practices in all areas of addiction, including continually updating our drug screening capabilities* • *CPSAI Staff participates in internal and external Cultural Competency Trainings*
3d	**Identify significant barriers to goal accomplishment:** **Significant barriers are as follows:** ***1. Limited treatment slots in many geographical areas*** *CPSAI continues to address this through our Extended Assessment Programs and Case Management strategies* ***2. Limited bi-lingual services in all Regions*** *CPSAI address this through utilizing our bi-lingual staff that has relationships with programs throughout the State* ***3. Due to the complicated nature of many of the DCP&P clients evaluated, many of them fall short of admission criteria for example those clients on pain medication and /or medication assisted therapy*** *CPSAI utilizes ASAM Criteria to refer client to appropriate services* ***4. Lack of residential services, especially when related to co-occurring clients without insurance*** *CPSAI has dually licensed staff and supervisors to identify and expedite all admissions especially relating to the Co-Occurring clients needing services.*
3e	**Definition of Level of Service as per contract:** *A Level of Service is as follows:* • *Substance Use Assessment (Adult/Adolescent)* • *Drug Screen (Chain of Custody, GC/MS Screening)* • *In-home Substance Use Assessments and Drug Screening* • *Transportation* • *Extended Assessment* • *Case Management* • *Family Meetings* • *Consortiums* • *Trainings*
3f	**Enter your <u>contracted</u> Level of Service portion that is Title IV-B funded for the period of 10/1/13 – 9/30/14:**

	CPSAI is contracted to complete 7,800 Substance Use Assessments *CPSAI is contracted to complete approximately 1,800 Extended Assessments*
3g	**Enter your <u>actual</u> Level (units) of Service that is Title IV-B funded delivered for the period of 10/1/13 – 9/30/14:** *CPSAI received 11,862 referrals for the contract year from the Division of Child Protection and Permanency, CPSAI completed 8,422 assessments, of the 8,422 assessments completed 5,024 clients were diagnosed and referred to the appropriate Level of Care. CPSAI referred 2,438 clients to Extended Assessment.*
3h	**How many unduplicated individuals and unduplicated families were served for this period? Each individual and family who received services during the reporting period should be counted only once**. **# of unduplicated individuals**: *8,422 clients and families were served* **# of unduplicated families:** *8,422 clients and families were served* *Of the above 8,422 clients assessed, 5024 clients were diagnosed and referred to treatment.*
3i	**Provide stakeholder feedback information, e.g. satisfaction surveys, referrals source info. Include how many surveys were sent, responses received and the results.** *CPSAI Supervisors attend the Women's and Father's Steering Committee Meetings, Monthly Consortiums, DCP&P Staff Meetings, Gatekeeper's meetings as scheduled, Communication with Local Office Managers and Gatekeepers, Contract Administrators and Statewide Meetings to discuss programmatic changes, issues, etc.*
	Section 4 – The Year Ahead FFY '15 (10/1/14 – 9/30/15)
4a	**Identify any changes you are making to the services described in Section II and why. This may include projected goals and objectives that were identified by vendors for their programs. Indicate if there are no planned changes to the program.** *CPSAI continues to recruit certified and licensed bi-lingual staff and dually licensed clinicians to complete assessments. Recognizing a wide range of cultural and ethnic differences, we continue to recruit and hire staff, who live in the communities we serve. We will continue to provide in-service workshops to DCP&P staff for the next contract year, as participation in the workshops provided increases their knowledge of addiction disorders, CPSAI recognizes a need to do more in-home assessments, coordinate with DCP&P to help motivate clients to engage in treatment. Preferred has implemented the DSM 5 and the ASAM Third Edition to determine the severity of the substance use disorder and the potential risk to the child(ren).*
4b	**Identify changes you will make that stem from stakeholder feedback.** *N/A*
4c	**How many IV-B units of service are you expecting to deliver for the period of**

	10/1/14 – 9/30/15? *7,800 Substance Use Assessments and 1,800 Extended Assessments.*
4d	**Indicate how many unduplicated individuals and unduplicated families you expect to serve.** **# of unduplicated individuals**: 7,200 **# of unduplicated families:** 7,200
	Section 5 – Evaluating Progress FFY '15 (10/1/14 – 9/30/15)
5a	**How will you measure progress?** *CPSAI will measure progress through the data collected utilizing the tracking reports submitted monthly along with the New Jersey Substance Abuse Monitoring System (NJSAMS) in real time. CPSAI will measure progress through ongoing feedback from DCP&P at Gatekeepers Meetings, Statewide Provider Meetings, Women's and Father's Steering Committee Meetings, DCP&P Staff Meetings, meetings with Gatekeepers and Local Office Managers and Consortiums. CPSAI will also measure progress through completing the required level of service in our Annex A.*
5b	**Describe the quality system you will use to assess and improve services, including consumer satisfaction and stakeholder feedback methods.** *Our Quality Improvement process starts at the initial referral. The professionalism and Quality Care that CPSAI provides to our DCP&P clients, evaluation assessments and any other service units CPSAI delivers. Also ongoing communication with DCP&P until the client has completed the evaluation process and/or referred and engaged in treatment. CPSAI uses best practices when completing assessments. Preferred uses a high standard drug screening, all tests are Chain of Custody and GC/MS confirmed which gives validity in testimony in court CPSAI has a Toxicologist available to testify if called. Staff also has the ability to perform assessments and drug screening in the field. CPSAI stays current with the trends of various drug use in the different geographic areas in the State. We continue to experience a heroin epidemic in many of the Counties we serve, the increase in prescription medication use continues to increase and we are working with medical professionals to collaborate effectively.*
5c	**How do you collaborate with community partners?** *CPSAI will collaborate with community partners and/or providers through in-service workshops, open houses, case conference with outside providers, consortiums, Professional Advisory Committee on Alcoholism and Drug Abuse. Women's and Father's Steering Committee Meetings and trainings. CPSAI attends the Quarterly Statewide Meetings with Contract Administrators and the Monitoring Body of this grant.*

NJ Citizen Review Panel Reports

NJ has three statutorily required Citizen Review Panels:

1. New Jersey Task Force on Child Abuse and Neglect (NJTFCAN)
2. New Jersey Staffing and Oversight Review Subcommittee (SORS)
3. New Jersey Child Fatality and Near Fatality Review Board (CFNFRB)

Each panel submits and publishes an annual report that can be reviewed publically at the DCF Public Website. The following links represent the latest Citizen Review Panel Reports:

NJTFCAN: Forth Annual Report July 1, 2013-June 30, 2014
http://nj.gov/dcf/news/reportsnewsletters/taskforce/njtfca_reports.html

SORS: Eighth Annual Report July 1, 2014- June 30, 2015
http://nj.gov/dcf/news/reportsnewsletters/taskforce/njtfca_reports.html

CFNFRB: 2013 Annual Report- Issued November, 2014
http://nj.gov/dcf/news/reportsnewsletters/taskforce/fatality_reports.html

DCF is committed to the partnerships with the Citizen Review panels and continues to work in collaboration with them. Each year the three primary Citizen Review panels submit an annual report and DCF is given the opportunity to respond. The following represents the DCF responses to the previous year's annual reports:

State of New Jersey
DEPARTMENT OF CHILDREN AND FAMILIES
P.O.Box 729
TRENTON, NJ 08625-0729

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

ALLISON BLAKE, PH.D., L.S.W.
Commissioner

September 2, 2014

Martin A. Finkel, DO, FACOP, FAAP
Co-Chair, NJ Task Force on Child Abuse and Neglect
Professor of Pediatrics
Medical Director
Child Abuse Research Education Services (CARES) Institute
Rowan University - School of Osteopathic Medicine
42 E. Laurel Road, Suite 1100
Stratford, NJ 08084

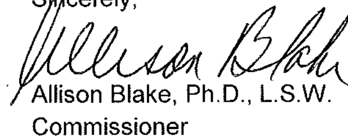
Dear Dr. Finkel:

The Department of Children and Families values the feedback and recommendation of the New Jersey Task Force on Child Abuse and Neglect in its 2013-2014 Fourth Annual Report. DCF is committed to expanding our use of data throughout the department and strive for the incorporation of measurable outcomes and strategies in our programs and services.

To that end, I want to formally thank you and the Task Force for your continued commitment to New Jersey's children and families and I look forward to continuing our work with the Task Force as you continue to provide the opportunity to build on our successes and address areas for continued improvement in our work. Together, we can shape the future of New Jersey's child welfare system to ensure a better today and even a greater tomorrow for every individual we serve.

Thank you for your leadership, service and commitment.

Sincerely,



Allison Blake, Ph.D., L.S.W.
Commissioner

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P.O. BOX 729
TRENTON, NJ 08625-0729

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

ALLISON BLAKE, PH.D., L.S.W.
Commissioner

June 2, 2015

Rita Gulden, MSW, Chairwoman
Staffing and Oversight Review Subcommittee
Court Appointed Special Advocate
945 West State Street
Trenton, NJ 08618

Dear Ms. Gulden:

This letter is to formally thank you and the members of the Staffing and Oversight Review Subcommittee (SORS) for the SORS 8th Annual Report as well as your volunteerism and continued commitment to New Jersey's children, youth and families. As you are aware, DCF strives to build a culture of partnership; collaborating with stakeholders and community partners to improve outcomes for New Jersey's children, youth and families.

As a result, we look forward to continuing our work with SORS as you continue to provide the opportunity to build on our successes and address areas for improvement in our work. Together, we can shape the future of New Jersey's child welfare system to ensure a better today and even a greater tomorrow for every individual we serve.

Thank you for your leadership, service and commitment.

Sincerely,

Allison Blake, Ph.D., L.S.W.
Commissioner

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CHRIS CHRISTIE
Governor

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Lt. Governor

ALLISON BLAKE, PH.D., L.S.W.
Commissioner

June 30, 2015

Kathryn McCans, MD
Judy L. Postmus, PhD, ACSW
Child Fatality and Near Fatality Review Board
PO Box 717
Trenton, New Jersey 08625-0717

Dear Dr. McCans and Dr. Postmus;

The Department of Children and Families (DCF) is in receipt of the 2014 Annual Report issued by the Child Fatality and Near Fatality Review Board (CFNFRB or Board). We have thoroughly reviewed the report and have prepared the following letter in response to recommendations assigned to DCF.

The Department welcomes the opportunity to discuss the recommendations or our responses with the Board.

Child Protection and Permanency - Risk Reassessment

Board Recommendation:

> *The CFNFRB has observed that DCP&P's risk assessment and reassessment tool has not been consistently implemented, with particular concerns in cases where an override exists without the use of the tool to inform that decision. The CFNFRB is aware that DCP&P is currently evaluating the appropriateness of the tool, and the effectiveness of its implementation. The CFNFRB believes that a systematic, consistent, protocol should be created as a standard to determine how to make decisions when risk has been mitigated. During the interim period of the Division's evaluation, all cases where risk is lowered should be documented with the current available tools. There should also be a mechanism where multiple referrals, regardless of outcome, create an elevated degree of risk, which cannot be overridden without dynamic and clear guidelines.*

DCF Response:

As acknowledged in the CFNFRBs annual review report, the SDM tools are at present being re-evaluated to determine how best to make the usage of the tools consistent statewide. The CP&P Risk Assessment is generated to identify families which have low, moderate, high, or very high probabilities of future child abuse or neglect. By completing this assessment, the caseworker obtains an objective appraisal of the likelihood that a family will maltreat their children in the next 18 to 24 months. The risk reassessment, combines items from the original risk assessment tool with additional items to evaluate a family's progress towards the case plan goals. This assessment is used to reassess risk and evaluate a family's progress toward fulfilling the case plan and achieving its case goals.

As it relates specifically to the override process, at the time of the initial risk assessment, an override may be applied by the worker and supervisor to increase the risk level in any case in which the risk level set by the assessment tool is too low, based on unique case circumstances the worker or supervisor believes warrant a higher risk level. This may occur when the worker is aware of conditions affecting risk that are not captured within the items on the risk assessment. It is important to note that with the risk assessment, the override may only increase the risk level not decrease it.

The discretionary overrides are used mostly by permanency workers and their supervisors whenever unique case circumstances suggest that the risk score does not accurately portray the family's actual risk level. Unlike the initial risk assessment in which the risk level could only be increased, the risk reassessment permits the worker or supervisor to increase or decrease the risk level by one step because after a minimum of six months, the worker has acquired significant knowledge of the family. The worker is obligated to document the reason for the discretionary override and the override risk level needs to be indicated. Anytime a caseworker is recommending a discretionary override, supervisory review and consultation is required.

With cases where there are multiple referrals, the current risk assessment/reassessment tool would in fact elevate the risk score. However, as stated above, the discretionary override can be utilized as the caseworker in consultation with the supervisor to increase the risk level where their firsthand knowledge of the family's dynamics, growth since the initial concern, and the progress towards safety and stability to allow them to incorporate these factors into the case planning.

Kathryn McCans, MD
Judy L. Postmus, PhD, ACSW
June 30, 2015
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As CP&P continues the work around re-evaluating the current tools, in the interim communication will be sent to all CP&P staff about the importance of supervisory consultation and oversight on any case situation requiring an override. Additionally, this memo will be reviewed with Area Directors at an Area Director meeting and with all Local Office Managers at a Statewide Manager's meeting.

Domestic Violence Joint Task Force:

Board Recommendation:

> *The CFNFRB recognizes that a multidisciplinary joint task force was recently established by the DCF Commissioner; including members representing the court system as well as the Domestic Violence Fatality and Near Fatality Review Board. The intended purpose of the task force was to clarify what information domestic violence reports should include, the protocol for sharing with DCP&P, and the role of the domestic violence liaison within the DCP&P local offices. The CFNFRB supports the creation of this joint task force and requests periodic reports on their work.*

DCF Response:

The Department welcomes the support of the Board and will keep the Board abreast of developments.

Child Protection and Permanency (CP&P) - Clinical Consultants:

Board Recommendation:

> *The CFNFRB acknowledges that DCF has made available to Local Office staff through contracts a Clinical Consultant, whose role is to consult with staff when there are questions/concerns about a child's mental health status, treatment, diagnosis or needs. The CFNFRB recommends the role of the Clinical Consultant be standardized to provide for better consistency statewide. Furthermore, the CFNFRB recommends that DCF create performance standards for use when evaluating the effectiveness of the service. The CFNFRB has commended DCF in the past for the successes and accomplishments of the Child Health Units and would suggest that model be examined for this process.*

Kathryn McCans, MD
Judy L. Postmus, PhD, ACSW
June 30, 2015
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DCF Response:

Whenever multiple systems partners are involved in any given case, the CP&P supervisor should be taking the lead in coordinating case conferences to include all partners, the worker, supervisor and anyone else deemed necessary to ensure that the work to support the children and families is thoughtful and consistent. In many instances, the consultants who are co-located in the CP&P Local Offices have participated in in case practice planning with and for families as demonstrated by their participation in family team meetings and the enhanced review process. The clinical consultant is often called upon when any of the circumstances below are a factor in a case situation:

- The youth/child is hospitalized for mental health reasons;
- The parent/caregiver is hospitalized for mental health reasons;
- The youth/child has frequent / several visits to screening and does not get hospitalized;
- The youth/child exhibits high risk, bizarre behaviors or actions (hallucinations or delusions);
- Assistance with accessing services through Children System of Care;
- The youth/child has recently experienced a trauma - sexual abuse, physical abuse, domestic or other violence, sudden removal from home;
- The youth/child or adult needs an evaluation and worker is not sure what type of evaluation is appropriate;
- Worker needs assistance with interpreting a mental health report or evaluation and its recommendations;
- Youth/child has had mental health services in place for in home / residential program for several months and no progress has being made;
- Youth/child has been discharged from community services (outpatient or partial care program) or keeps getting rejected from community services;
- If a parent/caregiver would benefit from further explanation about the child's mental health issues and services; or
- Youth/child is refusing to attend school, has truancy issues, multiple suspensions from school.

Caseworkers are not limited to consults solely by the scenarios above and may certainly ask a Clinical Consultant to become involved in any case to help understand the mental health/ behavioral issues of the child/family. To ensure this message around the consultants is clear to CP&P staff, the CP&P Directors Office will distribute correspondence to staff regarding the role of the Clinical Consultants and how they can best be utilized.

Children's System of Care (CSOC) - Extended Hospitalization Services:

Board Recommendation:

> *The CFNFRB acknowledges that the CSOC has a range of services available through contracted agencies to meet the needs of children and youth with mental/behavioral health needs. The CFNFRB is concerned about the availability of services for extended assessments/hospitalizations for youth whose behaviors necessitate treatment in a secure facility. The CFNFRB therefore recommends expanding the availability of inpatient psychiatric intermediate care facilities, and creating other means of admissions to these services, aside from a referral by a Children's Crisis Intervention Services (CCIS) unit.*

DCF Response:

Insofar as this request seeks to develop a secure facility allows for admission to occur without screening from a screening center or stabilization on a CCIS unit, this presents significant legal and ethical issues as it would allow a youth who does may not meet the threshold for hospitalization be locked in a secure facility. That said, we regularly monitor the utilization trends of the Intermediate Units and will work with the Department of Human Services (responsible for screening centers) and the Department of Health (licenses the secure, hospital based programs) to develop additional capacity if a need is identified.

Additionally, ensuring appropriate planning and communication between Screening Centers, CCIS units, and Care Management Organizations as well as the continuing development of appropriate non-secure programs for children and youth allows for appropriate step-down into the least restrictive environment necessary to treat children and youth. CSOC continues to monitor service needs and develop services as necessary and appropriate to ensure an appropriate spectrum of care. In this past year CSOC has created a host of additional residential services, including the recent establishment of a new program for adolescents with autism in need of residential crisis stabilization and the current development of a comparable program for children with autism.

Kathryn McCans, MD
Judy L. Postmus, PhD, ACSW
June 30, 2015
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Reporting To CP&P:

Board Recommendation:

> *The CFNFRB recommends that the CSOC contact the DCP&P in cases where a child has severe mental health issues and has either voluntarily terminated or is non-compliant with their CSOC treatment services, whereby placing them at high risk. The CFNFRB acknowledges that services provided through the CSOC to children, youth and families are done so on a voluntary basis. However, in limited circumstances, the failure or non-compliance of families to address the mental/behavioral health needs of the child/youth may contribute to increased risk and may warrant child welfare involvement.*

DCF Response:

The state's child abuse and neglect reporting law requires that all individuals in the state report suspected child abuse and neglect to the State Central Registry (SCR). If a child's family terminates treatment or is grossly or willfully non-compliant with treatment for severe mental health issues, that may be child abuse or neglect as defined by New Jersey law and should be reported to SCR. The contracted care management and licensed treatment providers are aware of their obligations to report child abuse and neglect and CSOC will reiterate this point in future conversations with provider organizations.

In closing, I would like to thank the Board for your partnership with DCF and your commitment on behalf of New Jersey's children and families. I look forward to our continued work together.

Sincerely,

Allison Blake, Ph.D., L.S.W.
Commissioner

SECTION J:

Chafee Foster Care Independence Program

&

Education and Training Voucher Program

CHAFEE Services Annual Update: Accomplishments and Plans

During the federal fiscal year of **October 1, 2013 to September 30, 2014**, Chafee funded services have been utilized to meet the intended purposes of the funds as described below. In addition to the accomplishments and planned activities, information regarding collaboration, program support, and service description are included. Organizationally the primary responsibility for administering, coordinating and assessing the delivery of Chafee funded services as well as the Education and Training Vouchers was organized by the Department of Children and Families, Office of Adolescent Services (OAS). For a complete list of services, description and how many youth will be served please see Attachment E. Adolescent Services Grid.

The Office of Adolescent Services collaborated with a variety of internal and external stakeholders and partners to provide services to adolescents who are involved with child welfare. These include:

- DCF continues to fund and use 25 slots in the New Jersey Youth Corps through the New Jersey Department of Labor for CP&P involved adolescents. New Jersey Youth Corps engages young adults in full-time community service, training and educational activities. Staff who serve as mentors guide the youth. The youth receive education development, employability skills instruction, personal and career counseling, and transition services.
- DCF contracts with community agencies to provide transitional housing for older youth. DCF currently funds 370 beds throughout the state.
- DCF partners with Montclair State University to provide the Post BA Certificate in Adolescent Advocacy Program for DCF staff who primarily works with adolescents.
- DCF continued to collaborate with stakeholders, service providers and youth across the state through the Task Force on Helping Youth Thrive in Placement (HYTIP). HYTIP is tasked with ensuring that children and youth involved in out of home placements have the right to live the most normal childhood and adolescence possible.
- DCF continued to partner with an organization, EverFi, that provides a computer based financial literacy program. Approximately 90 students completed the program.
- DCF continues to collaborate with Foster and Adoptive Family Services to provide ETV to eligible youth who have aged out of foster care or left care for kinship legal guardianship or adoption through the New Jersey Foster Care (NJFC) Scholars program.
- DCF collaborated with the National Resource Center for Youth Services and the Center for the Study of Social Policy to have training developed utilizing the Youth Thrive Framework.
- OAS provides several different mentoring opportunities/services for adolescents and young adults through Rutgers, The State University of NJ, Project Myself and through faith-based organizations and private non-profits. The Summer Housing and Internship

Program (SHIP) and Summer Internship Program (SIP) is an additional support to NJ Foster Care Scholars.

- DCF partnered with the NJ Department of Education in collaboration with the John J. Heldrich Center at Rutgers University to provide training on the New Jersey Career Assistance Navigator (NJCAN). NJCAN is an online career guidance website.
- DCF collaborated with LGBTQI community partners to provide safe space liaisons with information on coaching peers, locating resources, changing culture in the office and understanding sexual orientation/identity. In addition OAS has partnered with the Polaris Project and the U.S. Department of Homeland Security to five presentations on LGBTQI youth involved with human trafficking and cyber –bullying.
- DCF partnered with national experts on a two year planning grant through ACYF in order to conduct data analysis, a needs assessment, and refine an intervention framework in order to address ongoing service gaps related to the need for evidence-based, trauma-informed, protective factor focused and comprehensive life skills and other critical program for adolescent and young adults being served through CP&P.
- DCF worked with the New Jersey Department of Labor and Workforce Development and the State Employment and Training Commission to identify, evaluate and expand access to employment programs models and partnerships.
- DCF contracts with community providers for Homeless Youth Outreach Programs to provide rescue intervention for cases of human trafficking of youth, prevent human trafficking, provide stabilization, resources and supported services they need and prepare youth for independence.

The Office of Adolescent Services provided the following program support to DCF staff as well as community partners:

- Through the Adolescent Practice Forums which includes CP&P, Children's System of Care, Care Management Organization, and DCF Office of Education staff, several informational presentations and mini trainings were held on a variety of topics including Medicaid Extension, educational initiatives, youth engagement, trauma informed care, employment resources, expectant and parenting youth and permanency initiatives.
- OAS provided the Got Adolescents? Training to CP&P staff. The training covers adolescent policy, practice and resources.
- The Post BA Certificate in Adolescent Advocacy was offered to 40 DCF staff. The program at Montclair State University is a fifteen credit certificate focused on adolescent advocacy and case practice. It is designed to provide students with a multidisciplinary understanding of the role of the adolescent advocate seen through the disciplines of law, sociology, and psychology.
- DCF provided human trafficking prevention trainings to community contracted providers, Resource Parents and youth through a contracted provider.

- OAS provided in-service training to the Safe Space Liaisons on a variety of topics including New Jersey's anti-bullying bill of rights, holistic LGBTQI services for youth, and working with LGBTQI families.
- DCF provided the Value of Permanency training in conjunction with the Permanency Roundtables which included information on the importance of legal permanency for older youth.
- OAS provided training on the new Transitional Plan for YOUth Success for adolescent serving CP&P staff.
- OAS provided training on the NJ Career Assistance Navigator to CP&P staff as well as contracted providers.
- OAS provides ongoing adolescent case practice technical assistance to CP&P staff.

OAS would like the following technical/capacity building assistance:

- Talk to and learn from other jurisdictions who provide services to youth 18-21
- NYTD data collection
- Supervisory level transfer of learning
- Savings accounts for youth in care (including minors)
- Serving expectant and parenting youth

Purpose 1: Assist Youth in Making the Transition to Self-Sufficiency

Accomplishments:

- The transitional plan policy and form for CP&P involved youth was revamped and renamed the Transitional Plan for YOUth Success (TPYS). The new TPYS was restructured in order to promote a youth driven and strengths based, and protective factors focused planning process. It includes domains that are integral to a youth transitioning to self-sufficiency.
- LGBTQI training and support was provided to the DCF Safe Space Liaisons and staff throughout the state.
- The "Got Adolescents?" training, covering adolescent policy, practice and resources, continued to be offered to CP&P staff as well as other interested DCF staff. The training was revised to include specific information on the restructure and new policy for the Independent Living Stipend.
- Data collection for DCF Lesbian, Gay, Bisexual, Transgender, Questioning, and Intersex (LGBTQI) youth and families served is ongoing.
- Community based contracted Life skills programs continued to provide services to youth ages 14-21.
- During the summer of 2013 the Youth Advisory Boards (YABs) were restructured and expanded to include 15 boards representing all counties in NJ to continue providing policy and practice feedback and recommendations to DCF, an opportunity for peer networking, and to develop leadership and advocacy skills. The YAB launch event was held to kick off the

new structure and introduce the new staff to the youth and bi-monthly YAB meetings were held.

- Ensured provider community delivered life skills in line with specific elements of the independent living skills as defined by the National Youth in Transitions Database (NYTD).
- DCF continued to partner with an organization that provides a computer based financial literacy program to youth and expanded access to additional contracted providers as well as staff within DCF.
- DCF was awarded a contract from the Department of the Treasury, Internal Revenue Service to create an electronic distribution process of independent living stipend funds through a debit card. In addition the project will also provide a mobile application that assists with budgeting and financial literacy.

- Homeless youth street outreach programs were expanded to additional counties throughout the state, to promote rescue, intervention and prevention of human/sex trafficking of youth, provide youth linkages to stabilization and needed resources as well as prepare youth for independence.
- A training utilizing the Youth Thrive framework was created by the National Resource Center for Youth Services (NRCYS) to be offered to DCF staff, contracted agencies and resource parents. The NRCYS provided a train the trainer to a group of DCF staff, youth, and interested parties from other jurisdictions.
- The Post BA Certificate in Adolescent Advocacy continued to be offered primarily to CP&P staff who work with adolescents to provide staff with a multidisciplinary understanding of the role of the adolescent advocate as seen through the disciplines of law, sociology, and psychology.
- Adolescent Practice Forums were held across the state for CP&P, CMO and DCF Office of Education staff to share information on a variety of topics that are pertinent to assisting youth who are involved with child welfare.
- OAS participated in Aging Out events that are designed to provide information to youth who are aging out of care to help with their transition.

Planned Activities:

- The Adolescent Training will be updated to include the Youth Thrive Framework and will be offered to DCF staff, contracted agencies and resource parents.
- DCP&P staff will continue to work with youth on life skills training and/or refer them to the appropriate services to assist them in their transition to self-sufficiency.
- Continue to reinforce independent living skills development and service delivery by focusing on and tracking the delivery of specific elements of independent living skills as defined by the National Youth in Transitions Database (NYTD).

- Continue to provide training on Adolescent policy, practice and resources for caseworkers who have adolescents on their caseload.
- Create a new NYTD data collection process to ensure accurate documentation of independent living services youth are receiving.
- Expand the financial literacy program to more DCF providers and offices.
- Continue to assess services that are available for pregnant or parenting youth including fatherhood programs.
- Collaborate with local agencies to plan LGBTQI youth conferences.
- Through the Youth At-Risk of Homelessness Federal Planning Grant, DCF will complete a comprehensive analysis of data and complete a needs assessment in order to identify new strategies to best meet the needs of transitioning youth.
- The Youth Advisory Boards will continue to meet on a bi-monthly basis as well as provide feedback on DCF policy and services.
- A statewide community resource guide for pregnant and parenting youth is being created to provide information to staff.
- A new youth friendly website is being created to provide resources and information for services and supports for youth.

Purpose 2: Assist Youth in Obtaining Education, Training and Services Necessary to Obtain Employment

Accomplishments:

- Training on the NJ Career Assistance Navigator (NJCAN) was provided to DCF staff as well as contracted providers to assist youth in exploring career and post-secondary options.
- DCF continues to fund and use 25 slots in the New Jersey Youth Corps through the New Jersey Department of Labor for DCP&P involved adolescents. New Jersey Youth Corps engages young adults in full-time community service, training and educational activities. Staff who serve as mentors guide the youth. The youth receive education development, employability skills instruction, personal and career counseling, and transition services.
- OAS continues to provide mentoring services (Rutgers, The State University of NJ, Project MYSELF) to youth who are scholarship recipients. The goal of this mentoring is to help youth stay in school and navigate the challenges of college life. Special attention is being given to first year students enrolled in remedial courses and students on academic probation.
- Continued to provide the Summer Housing Internship Program (SHIP) for 40 NJ Foster Scholars. The SHIP program, located on four college campuses, provides youth with coaching, mentoring, a paid internship, a 3-credit elective course, housing and enrichment activities for 11 weeks during summer break.

- The Summer Internship Program (SIP) was launched in May 2013 and offers 20 NJ Foster Scholars the same opportunities offered by the SHIP program but who do not need the housing component.
- Employment resources were added to the DCF website.

Planned Activities:

- Continue to collaborate and partner with the NJ Labor and Workforce Development and the State Employment and Training Commission (SETC).
- Work with the SETC to create a state shared youth vision for employment.
- Develop employment workgroups for foster care youth.
- Provide a Summer Housing Internship Program (SHIP) for 40 youth who are in college. The SHIP program provides youth with support, mentoring, internship, 3 college credits, and housing during college summer break.
- Provide a Summer Internship Program (SIP) for 20 youth who are in college. The SIP program provides support, mentoring, internship, and 3 college credits during the summer break.
- Continue to provider NJCAN training to staff, stakeholders, and providers.

Purpose 3: Assist Youth to Prepare for and Enter Post-Secondary Training and Educational Institutions

Accomplishments:

- Foster and Adoptive Family Services (FAFS) continues to administer the New Jersey Foster Care (NJFC) Scholars program, which provides financial assistance to eligible youth to pursue post-secondary education programs.
    - During the 2013-2014 academic year (July 1, 2013-June 30, 2014) FAFS:
        - Hosted or participated in 63 outreach events including closed events (invitation-only events open to potentially eligible youth and provider agencies serving these youth), public events, and reapplication events throughout New Jersey and webinars. FAFS Staff presented on topics such as the NJFC Scholars program, how to request a ward of the court letter (which provides verification enabling youth to declare independent status on the Free Application for Federal Student Aid) through OESP or the youth's CP&P worker (if open), applying for college and applying for financial aid using the Free Application for Federal Student Aid (FAFSA). FAFS directly communicated with a total of 379 students and 165 adults at these outreach events.
        - For the 2013-2014 contract year, 241 students participated in workshops where they completed financial aid information and New Jersey Foster Care

Scholars information. Of those, 167 submitted applications to the NJFC Scholars program; 104 applications for the 2013-2014 academic year, and 86 for the 2014-2015 academic year.

- In addition to the above outreach, FAFS presented at conferences throughout the state and met with Financial Aid Offices or Educational Opportunity Fund (EOF) Staff at New Jersey post-secondary institutions to familiarize the staff about the NJFC Scholars program.
- OESP and OAS continued to raise awareness of the NJFC Scholars program and discussed the importance of planning for youth's post-secondary education during regional education stability liaison meetings and during meetings with CP&P local office management including supervisors, casework supervisors, and case practice specialists.
- OESP and OAS provided technical assistance to CP&P adolescent workers and supervisors regarding the importance of educational planning, choosing a post-secondary program, and the availability of Education Training Vouchers (ETV) through the NJFC Scholars program.
- OESP and OAS provided technical assistance to CP&P case managers and supervisors to ensure youth have access to flex funds to enable them to receive academic supports such as tutoring and college preparatory courses, books, extracurricular activities, and college fees.
- Meetings were held with the EOF programs at Bloomfield College, William Patterson University and Caldwell College to discuss collaborative services and partnership opportunities.
- OESP piloted its first training to Education Stability Liaisons on June 12, 2013 regarding the importance of educational planning with youth beginning in 8th grade. This training included the review important benchmarks all workers should be aware of for their youth in middle and high school, the steps to choosing a post-secondary program and the availability of scholarships and supports.
- OESP presented on topics such as education stability, planning for post-secondary education, the NJFC Scholars program and the DCF Scholarship Fund at the Adolescent Practice Forums in September and December 2013.
- The Education Support Specialist reviewed eligibility criteria, deadlines and program supports for the NJFC Scholars program and DCF Scholarship Fund at regional Education Stability Liaisons meetings on October 18, 2013, October 30, 2013 and on November 18, 2013. Education Liaisons from Essex, Middlesex, Union Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Salem, Hunterdon, Mercer, Somerset, and Warren counties participated.

Planned Activities:

- First Star Academy at Rowan University will pilot in the southern region and provide academic support and enrichment to foster youth from 7th thru 12th grade while offering exposure to college life. The ultimate outcome is that students that participate will apply and be accepted to a 2 or 4 yr. college or university in their senior year of high school.

- OESP will continue to develop a training regarding education planning and provide technical assistance and support to CP&P adolescent workers and supervisors regarding the importance of educational planning, choosing a post-secondary program, and the availability of Education Training Vouchers (ETV) through the New Jersey Foster Care Scholars program.
- OAS will develop and share information in regards to Educational Alternatives by county in New Jersey. This information includes alternative high school programs, vocational schools, career and technical schooling, specialized programs present for county youth in and out of school and general resources benefiting youth in their development state-wide.
- Continue to refine the NJFC Scholars program as well as establish specific goals and measurable program learning outcomes for assessment purposes.
- Monitor retention via weekly reports prepared by Foster and Adoptive Family Services (FAFS) in regards to Project MYSELF information. The report contains: student contact info, post-secondary contact info, academic info (GPA, # of credits, registration status), student's academic standing (highlighting first year NJFC Scholars, probation/remedial instruction/students readmitted on appeal, students who are pending removal, students who have been removed and students who have graduated) and semester notes.
- Use NJFC Scholars retention rates for post-secondary institutions posted on the US Department of Education as a baseline for NJ Foster Care Scholars' year to year retention. For the 2014-2015 academic year, OAS/OESP and FAFS hopes to serve a 10% increase in population served.
- OESP will participate in the OAS Quarterly Adolescent Practice Forums (APFs) and provide information to participants (including case workers, case managers, care managers and other CP&P staff working directly with youth) regarding college tour information, the New Jersey Foster Care (NJFC) Scholars program, Ward of the Court letter, and basic information on applying for federal financial aid using the Free Application for Federal Student Aid (FAFSA).
- Focus outreach efforts using a monthly report run by DCF's Office of Evaluation, Research and Reporting, providing the number of eligible youth based on CP&P placement history and those who exited care for KLG or Adoption. This outreach will help streamline specific reports, resources and outreach for the NJFC Scholars program.
- Shift FAFS outreach efforts to directly target CP&P Local Offices with the highest concentrations of eligible youth currently under supervision of CP&P.
- Begin process of reaching out to local high schools, specifically those in counties where there is a large population of youth in out of home care, to supply resources on financial aid opportunities, timelines for college applications, information on "independent status" and additional opportunities specified for youth who are or were in care.
- OAS and OESP will continue discussions with New Jersey Higher Education institutions to increase awareness of ETV and Tuition Waiver availability and feasibility of identifying eligible youth through "independent" status on FAFSA application.

- Increase collaboration efforts with post-secondary support programs for high school-to-college transitions, specifically the Educational Opportunity Fund (EOF) programs in New Jersey institutions.
- Begin research on developing additional mentoring, training, informational opportunities, support services and networks within NJFC Scholars to create positive youth identity within the program.
- Explore collaboration with high school to college “bridge” programs, such as TRIO programs like Upward Bound, and NJ GEAR UP program.
- Respond to educational needs and requests as appropriate, ranging from resources for non-traditional students, pregnant and parenting teens, mentorship and other educational needs of our population.
- Research possible funding avenues and grants or fundraising opportunities to replenish the DCF Scholarship Fund for youth in their pursuit of higher education.
- Further implement the YouthThrive framework in practice and application within OAS/OESP services and programs.
- A Financial Aid Resource Guide will be created with detailed information on the financial aid and college application process. The guide includes information on federal aid, such as grants, loans, scholarships and federal work studies. Descriptions, deadlines, direct links, contact information and eligibility requirements are included for a variety of scholarships for youth in foster care and adoption, minority groups, subject-related and online search tools.
- County-based in-school educational resources will also be developed as a tool for youth in high school who desire alternative methods in attaining a degree. The hope of these county-based guides is to provide additional resources, such as high school equivalency programs, alternative high schools, career and technical schools and other methods to encourage youth to continue their education until completion.

Purpose 4: Provide Personal and Emotional Support to Youth through Mentors and Interactions with Dedicated Adults

Accomplishments:

- A permanency program expanded their services to additional CP&P offices to assist older adolescents in achieving relational or legal permanency.

- Piloted the Permanency Roundtable (PRT) process for older adolescents involved with CP&P who are in need of permanency. In addition, a survey was distributed to the PRT participants to get feedback on the process to help inform a NJ program model.

- OAS continues to support DCP&P staff and community partners by providing on-going training on the importance of life long connections and working with youth to ensure they do not age out of care without connections to caring adults.
- A workgroup continues to meet to look at the current permanency support services that exist for youth and work to increase knowledge about these services and the number of youth in need of permanency that are referred.

Planned Activities

- Work with community providers to create resource, respite and holiday homes for older adolescents who are in care, including those in college.
- Permanency workgroup will continue to meet to redefine the existing permanency programs for better utilization. Convene Permanency Roundtables for older youth in care who have not achieved legal permanency.

Purpose 5: Provide Financial, Housing, Counseling, Employment, Education, and Other Appropriate Support and Services to Former Foster Care Recipients between 18 and 21 years of age

Accomplishments:

- The Medicaid Extension for Young Adults (MEYA) was extended to the age of 26 for eligible youth. Information was shared with internal and external stakeholders in an effort to offer this resource to as many eligible youth as possible. A phone number was created for youth, staff, and stakeholders to call regarding MEYA.

- OAS continues to partner with the Middlesex Human Service Advisory Council (HSAC) and the Mercer Homeless Youth Subcommittee to look at options for housing that may exist or that can be established.

- The Adolescent Housing Hub, an online reservation system, continues to provide access to housing programs for DCF involved and homeless youth.

- DCP&P continues to allow youth to remain in foster care until age 21; as such, they are eligible to receive financial, housing, counseling, employment, education and other appropriate services.

- DCF continues to offer the DCF Scholarship Fund to young adults who were in foster care for 6 months or longer (cumulative) after their 12th birthday.

- DCF continues to provide Ward of the Court letters to young adults pursuing post-secondary education who experienced foster care at age 13 and after. These letters provide verification

of the students' independent status on the Free Application for Federal Student Aid (FAFSA).

- Beginning in June 2012, OESP provided a flyer regarding eligibility and contact information for the NJFC Scholars program to the Office of Adoption Operations to include in the Adoption and KLG Subsidy Letters for Children Turning 18 and in the Annual Verification of Child's School Attendance letters.
- DCF continues to provide new and updated information on resources and services for DCF involved and non-involved youth on the DCF website.

- Continue to share information about the Adolescent Housing Hub to share with staff and community providers.

Planned Activities:

- Enhanced and standardized program expectations for housing programs will be created and be informed by the Taskforce on Helping Youth Thrive in Placement Taskforce using the Youth Thrive protective and promotive factors framework.

- OAS will work with additional HSACs to look at options for housing that may exist or that can be established for 18-21 year olds.

Purpose 6: Make Available Vouchers for Education and Training (ETV), Including Post-Secondary Education, To Youth Who Have Aged Out of Foster Care

Accomplishments:

There has been no change in how ETV program is administered. DCF continues to provide ETV to eligible youth who have aged out of foster care or left care for kinship legal guardianship or adoption through the New Jersey Foster Care (NJFC) Scholars program. The program is overseen by the Office of Educational Support and Programs (OESP) within the Office of Adolescent Services (OAS), and administered by the community provider, Foster and Adoptive Family Services (FAFS).

- The number of youth who received ETV awards for the 2013-2014 academic year (July 1, 2013 through June 30, 2014) is as follows:
  - 367 unduplicated youth participated in the NJFC Scholars Program
    - Of those, 296 unduplicated youth utilized funding during the academic year (Federal ETV or State funding)
    - 232 unduplicated youth utilized ETV funding. 113 of those were new.

  - The remaining students did not utilize NJFC Scholars program funding because financial aid packages provided by their post-secondary institutions covered their expenses during the academic year.
- Transitions for Youth at the Rutgers University School of Social Work continue to provide coaching and support in the areas of academic, social and physical and mental well-being to all NJFC Scholars through Project MYSELF and beyond.
- Collaboration between OESP, OAS, FAFS, and Project MYSELF is central to the program's operation. OESP communicates regularly with FAFS and Project MYSELF staff to provide program support and resolve any issues surrounding a student's academic performance, social well-being, or financial status at a post-secondary institution.
- Mentoring and educational services are provided through the contracted Project Myself program, coordinated by Rutgers, The State University of NJ, to youth who are scholarship recipients in the NJFC Scholars program. The goal of this mentoring is to support youth in college, and to assist in their transition into college life. Specific outreach and program support is given to first year students enrolled in remedial courses and students on academic probation. This outreach includes face to face meeting with their Project Myself coach and referrals to on-campus services, such as tutoring or academic advising.
- OAS continues to provide the Summer Housing Internship Program (SHIP) for 40 NJ Foster Care Scholars. The SHIP program, located on the four college campuses of Rutgers University-Camden, Newark and New Brunswick, and Montclair State University, provides youth with coaching, mentoring, a paid internship, a 3-credit elective course, housing and enrichment activities for 12 weeks during summer break. This program serves this population during a time where housing is most beneficial to college students in transition to their next academic year.
- The Summer Internship Program (SIP) was launched in May 2013 and offers 20 NJ Foster Care Scholars the same opportunities offered by the SHIP program, but who do not need the housing component. SIP is a 12-week program that includes academic and support coaching, mentoring, a paid internship, a 3-credit elective course and enrichment activities. Transportation, bus passes and resources from the SIP program and provided to assist youth in attending their internship and specific activities and class.
- FAFS continued to hold year-round workshops throughout the state for current and former foster youth, their caregivers and caring adults to assist them in applying for ETV and provide assistance with completing the Free Application for Federal Student Aid (FAFSA).

Planned Activities:

- FAFS will continue to hold year-round workshops throughout the state for current and former foster youth, their caregivers and caring adults to assist them in applying for ETV and will provide assistance with completing the Free Application for Federal Student Aid (FAFSA). More direct support and information will be presented at local offices and high schools where there is a larger population of youth in out of home care.
- Continue to refine the NJFC Scholars program as well as establish specific goals and measurable program learning outcomes for assessment purposes.

- OAS/OESP will continue discussions with New Jersey Higher Education institutions to increase awareness of ETV and Tuition Waiver availability and feasibility of identifying eligible youth through "independent" status on FAFSA application.
- Increase collaboration efforts with post-secondary support programs for high school-to-college transitions.
- Begin research on developing additional mentoring, training, informational opportunities, support services and networks within NJFC Scholars to create positive youth identity within the program, such as YAB partnerships and other avenues focusing on resilience, self-sufficiency and positive youth development.

Purpose 7: Provide Services to Youth Who Attained Kinship Guardianship or Adoption at age 16 and Older.

Accomplishments:

- Youth who exit foster care at 16 or older and attain Kinship Legal Guardianship or Adoption continue to be eligible for services including but not limited to life skills, aftercare, wraparound funds and housing. These services continue to be provided through contracted agencies.

Planned Activities:

- DCF is working to expand knowledge and information regarding service availability for youth who exit foster care at 16 or older and attain KLG or Adoption.
  - OAS to continue to ensure that all agency providers are aware of the policy by meeting with them collectively at Quarterly Networking Meetings, and individually at contract monitoring meetings.
- DCF policy will be updated and available to the public via the website.
- OAS will share information on available services to adoptive and kinship legal guardianship families.

Purpose 8: Ensure children who are likely to remain in foster care until 18 years of age have regular, on-going opportunities to engage in age or developmentally-appropriate activities as defined in section 475(11) of the Act.

DCF has policy, practice, resources, and initiatives in place to ensure that youth have opportunities to engage in developmentally-appropriate activities. For example, DCF's flex fund policy (400) outlines how funds can be used towards "enrichment" activities such as camp, entertainment, games, driving lessons, bicycle gear, activity and membership fees, sports, fees, vacation, and classes. Additionally, in 2012 DCF created the Task Force on Helping Youth

Thrive in Placement (HYTIP) to identify areas of practice where more strategies were needed to help promote "normalcy" for youth in care. A recommendations report was created and DCF has been following up to achieve these recommendations. The new Transitional Plan for YOUth Success (TPYS) which deployed in September of 2014 highlights a youth's hobbies, activities, and interests at the beginning of the plan. DCF also received a train the trainer on the Youth Thrive framework with the goal to design a 3 day intensive training for staff and providers. The Youth Thrive training will provide guidance on how to engage, assess, and plan with and for a young person through a protective and promotive factor lens ultimately supporting developmentally appropriate and realistic goal setting and activities for and with youth. In addition, through the Youth Advisory Board restructure and enhancement in 2013-2014 the program model was designed to provide youth with opportunities to develop peer networks, engage in community service events, and cultural/recreational activities.

Planned Activities:

- Launch the Youth Thrive training to staff, stakeholders, and providers.
- Update the children's bill of rights and other policy regarding providing opportunities for young people to engage in age or developmentally-appropriate activities.
- Provide training and support to resource parents to help promote these activities.
- Update contracts and program models for adolescent community based programs to ensure they are promoting developmentally appropriate activities.

National Youth in Transitions Database (NYTD)

- One of the partners DCF is working with for the ConnectingYOUth Federal planning grant is Child Trends who is reviewing NJ data (including NYTD) to get an understanding of the youth we serve. In addition to that, DCF has collected data via the needs assessment and is currently figuring out how to use this information to inform service delivery as well as any changes/restructuring of services. Since 2010, DCF has been collecting NYTD data from contracted agencies that provide independent living services as well as data from the outcomes survey. DCF is working towards reviewing and analyzing the NYTD data to help inform the work.

- DCF is currently examining and updating existing databases to streamline NYTD data collection. We are looking at possibly providing an interface for providers to enter the independent living services that are provided to youth/young adults. In addition, DCF has contracted with a community agency to administer the NYTD survey to youth ages 19 and 21 who are no longer involved with DCF to ensure better continuity and engagement with youth.

OAS holds quarterly meetings with contracted community agencies who provide services for youth who are or were involved with CP&P. These meetings provide an opportunity for networking, as well as a forum to provide updates on adolescent policy, practice and resources. In addition, through the Youth at Risk of Homelessness (YARH) planning grant, a cross section of internal and external stakeholders were brought together via a systems mapping and charrette to provide feedback and input that was used in planning for the proposed intervention.

DCF partners with and coordinates services with several community agencies in NJ that are funded under the Part B title III of the Juvenile Justice Delinquency Prevention Act of 1974. The agencies provide the basic center programs, transitional living programs and street outreach for youth who are homeless. OAS collaborates with these agencies when there are current or former CP&P involved adolescents who are in need of housing or who have runaway or are missing. We do not currently coordinated services with abstinence programs. In addition, DCF life skills providers are required to provide pregnancy prevention inclusive of education and information regarding abstinence. DCF endeavors to involve youth/young adults in all aspects of our work including, but not limited to, reviewing and providing comments on adolescent policy, getting feedback on services/supports that are offered to adolescents as well as providing internship opportunities within the Office of Adolescent Services. Through the Youth Advisory Boards we also receive feedback on CP&P practice and policies.

Indian Tribe Consultation:

New Jersey does not have any federally recognized Indian Tribes.

SECTION K:

Statistical and Supporting Information

Workforce Information

DCF is committed to hiring an educated, diversified workforce and providing them with the necessary training and tools to fulfill the Department's mission to ensure and promote the safety, well-being and success of New Jersey's children and families. Social workers seeking employment with DCF must meet stringent requirements in order to be hired. Extensive training for all new caseworkers is mandatory as is 40 hours of continuing education per year for all other caseload carrying workers and supervisors. DCF also has established caseload standards so that workers have the ability to effectively meet the needs of the children and families on their caseloads.

Summary of Recruitment Plan for Family Service Specialist Trainee (FSST)

The Department of Children and Families takes a proactive approach to hiring by maintaining a pool of pre-screened, pre-qualified candidates to fill vacancies for our entry level case manager position, Family Service Specialist Trainee. Since our Department receives more than 11,000 resumes for this position each year, candidates are prioritized based on their education and experience in order to select those candidates most likely to succeed in public social work. Our recruitment efforts are centered on a massive interviewing process known as a Job Fest. A Job Fest generally includes 25 to 35 candidates scheduled for an AM session and the same for a PM session and consists of:

A. Introduction

1. Overview of the Department of Children and Families, Division of Child Protection and Permanency, and DCP&P and the role of the Family Service Specialist
2. Instructions for completing the pre-employment forms/paperwork
3. Overview of the Hiring Process
4. Video presentation-the realities of the job

B. Initial Interview

1. Each candidate is interviewed separately by a panel of two interviewers.
2. Each fest has eight to twelve interview panels
3. Interview questions for the most part are scenario-based and designed to assess the following skills:
    a. Judgment/Decision Making
    b. Oral Communication
    c. Problem Analysis
    d. Interpersonal Responsiveness
    e. Organization
    f. Time Management

C. Writing Sample

1. Each candidate participates in preparing a writing sample in ten minutes
2. The writing sample is evaluated to determine if it is relevant, coherent, in a narrative format, and reflects proper spelling/grammar/punctuation

D. Credential/Paperwork Checkout

1. Each candidate meets with an HR representative to:
    a. Review employment application for completeness
    b. Review and verify documents (valid driver's license, social security card, college transcript, list of references)
    c. Ensure candidate signs necessary releases, consents, and affidavits

d. Advise candidate of any outstanding documentation needed to complete the application process

Candidates successfully completing the Job Fest and background check processes are added to a hiring matrix which is distributed each week to the 46 Local Offices throughout the State. Managers and supervisors in the Local Offices use the hiring matrix to select candidates to fill positions as vacancies occur. This proactive process allows our agency to fill caseload carrying positions as soon as vacancies become available. By doing so, we are better able to maintain mandated caseload standards.

Degree and certifications required for case workers and professionals responsible for the management of cases and child protective services staff

Family Service Specialist Trainee:

- Graduation from an accredited college or university with a Bachelor's degree. Preference is given to those with a Bachelor’s or Master’s degree in Social work or a related degree with six months of social work experience.

Family Service Specialist 2

- Graduation from an accredited college or university with a Bachelor's degree. One (1) year of experience in professional social work, direct support counseling, guidance, or case management involving high risk child abuse and neglect or other problematic situations involving counseling services to clients with social, emotional, psychological, or behavioral problems including gathering and analyzing information, determining needs, and planning and supporting and/or carrying out treatment plans.

- A supervised social work field placement of three hundred (300) hours serviced through an accredited college or university or performed in a social service agency may be substituted for the indicated experience.
- A Master's degree in Social Work, Psychology, Guidance and Counseling, Divinity, Marriage and Family Therapy, or other related behavioral science area may be substituted for the indicated experience.
- Applicants who do not possess the required degree may substitute additional professional support work experience related to case management on a year for year basis with one (1) year of experience being equal to thirty (30) semester hour credits.

Family Service Specialist 1

- Graduation from an accredited college or university with a Bachelor's degree.
- Two (2) years of experience in professional social work, direct support counseling, guidance, or case management involving high risk child abuse and neglect or other problematic situations involving counseling services to clients with social, emotional, psychological, or behavioral problems including gathering and analyzing information, determining needs, and planning and/or carrying out treatment plans.

- A maximum of one year of non-caseload carrying experience may be credited toward the experience requirement listed above.

- A supervised social work field placement of three hundred (300) hours serviced through an accredited college or university or performed in a social service agency may be substituted for one (1) year of indicated experience.
- A Master's degree in Social Work, Psychology, Guidance and Counseling, Divinity, Marriage and Family Therapy, or other related behavioral science area may be substituted for one (1) year of indicated experience.
- Applicants who do not possess the required degree may substitute additional professional case management experience on a year for year basis with one (1) year of experience being equal to thirty (30) semester hour credits.

Supervising Family Services Specialist 2

- Three (3) years of experience in professional social work, direct support counseling, guidance, or case management involving high risk child abuse and neglect or other problematic situations involving counseling services to clients with social, emotional, psychological, or behavioral problems, including gathering and analyzing information, determining needs, and planning and/or carrying out treatment plans.
- A maximum of one year of non-caseload carrying experience may be credited toward the experience requirement listed above.
- A supervised social work field placement of three hundred (300) hours serviced through an accredited college or university or performed in a social service agency may be substituted for one (1) year of indicated experience.
- A Master's degree in Social Work, Psychology, Guidance and Counseling, Divinity, Marriage and Family Therapy, or other related behavioral science area may be substituted for one (1) year of indicated experience.
- Applicants who do not possess the required degree may substitute additional experience as indicated on a year-for-year basis with one (1) year of experience being equal to thirty (30) semester hour credits.

Supervising Family Service Specialist 1 (Casework Supervisor)

- Four (4) years of experience in professional social work, direct support counseling, guidance, or case management involving high risk child abuse and neglect or other problematic situations involving counseling services to clients with social, emotional, psychological, or behavioral problems including gathering and analyzing information, determining needs, and planning and/or carrying out treatment plans, one (1) year of which shall have been a supervisory capacity.
- A maximum of one year of non-caseload carrying experience may be credited toward the non-supervisory experience requirement listed above.
- A supervised social work field placement of three hundred (300) hours serviced through an accredited college or university or performed in a social service agency may be substituted for one (1) year of non-supervisory experience.
- Applicants who do not possess the required degree may substitute additional experience as indicated on a year-for-year basis with thirty (30) semester hour credits being equal to one (1) year of non-supervisory experience.

- A Master's degree in Social Work, Psychology, Guidance and Counseling, Divinity, Marriage and Family Therapy, or other related behavioral science area may be substituted for one (1) year of non-supervisory experience.

Training Requirements for staff

See Attachment D: Training Plan Updates

Caseload Requirements

DCF is committed to maintaining caseload standards that will allow workers to effectively address the needs of the families on their caseloads. The standards to which we work to adhere are:

- Intake workers (Investigators) have no more than 12 families at a time and no more than 8 new intakes per month.
- Permanency workers have no more than 15 families with ten children in placement.
- Adoption workers have no more than 15 children.
- No more than 5 workers assigned to a supervisor

Figures 30 through 34 represent data gleaned from NJS to demonstrate caseload requirement compliance. Adoption caseloads fluctuate statewide on a quarterly basis and additional supports are given to those areas by the Office Adoption Operations, Resource and Interstate Services.

Figure 30

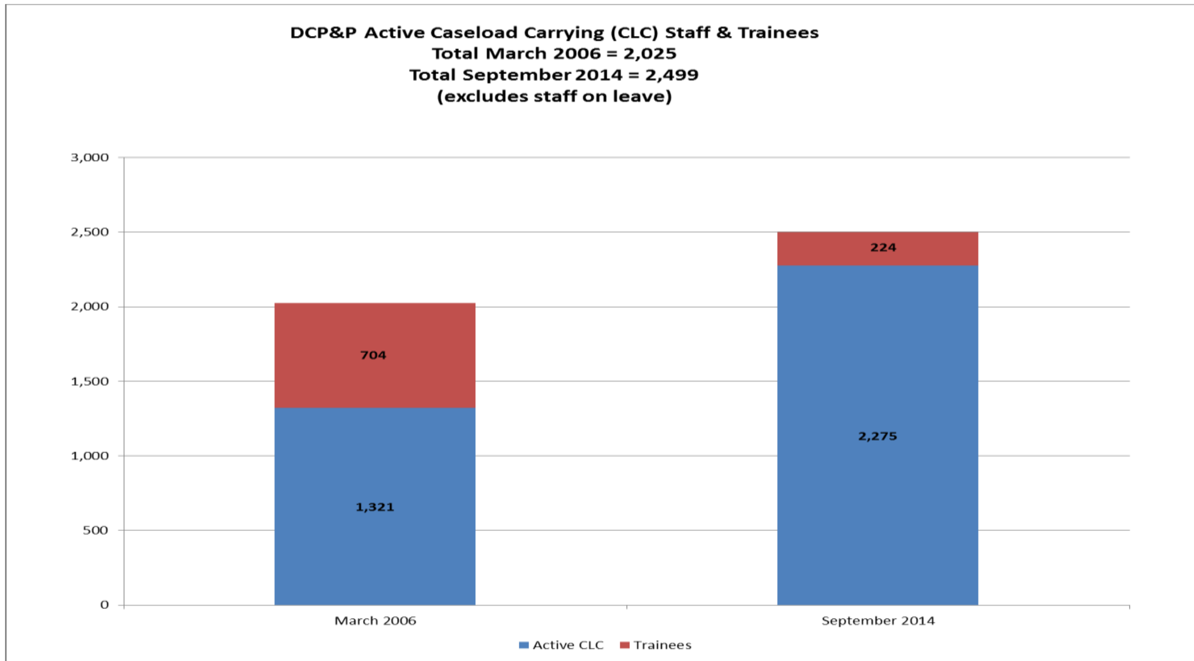

Figure 31

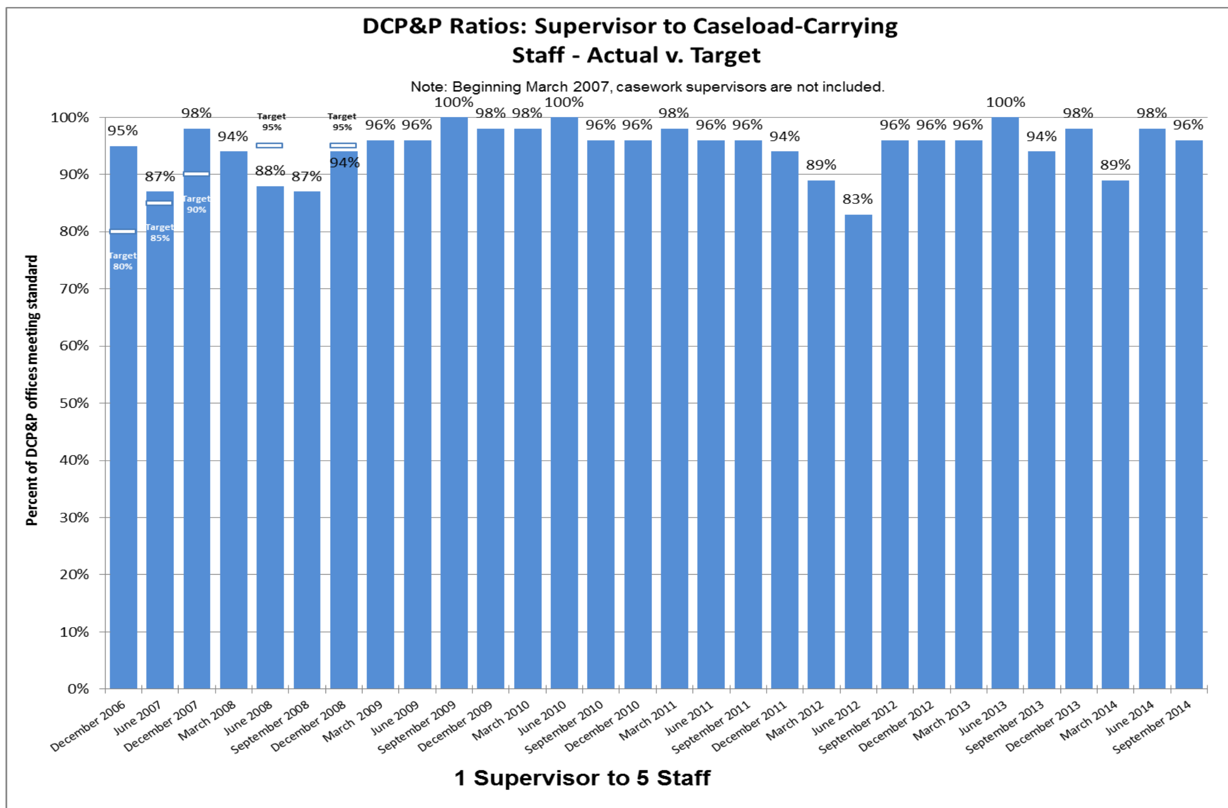

Figure 32

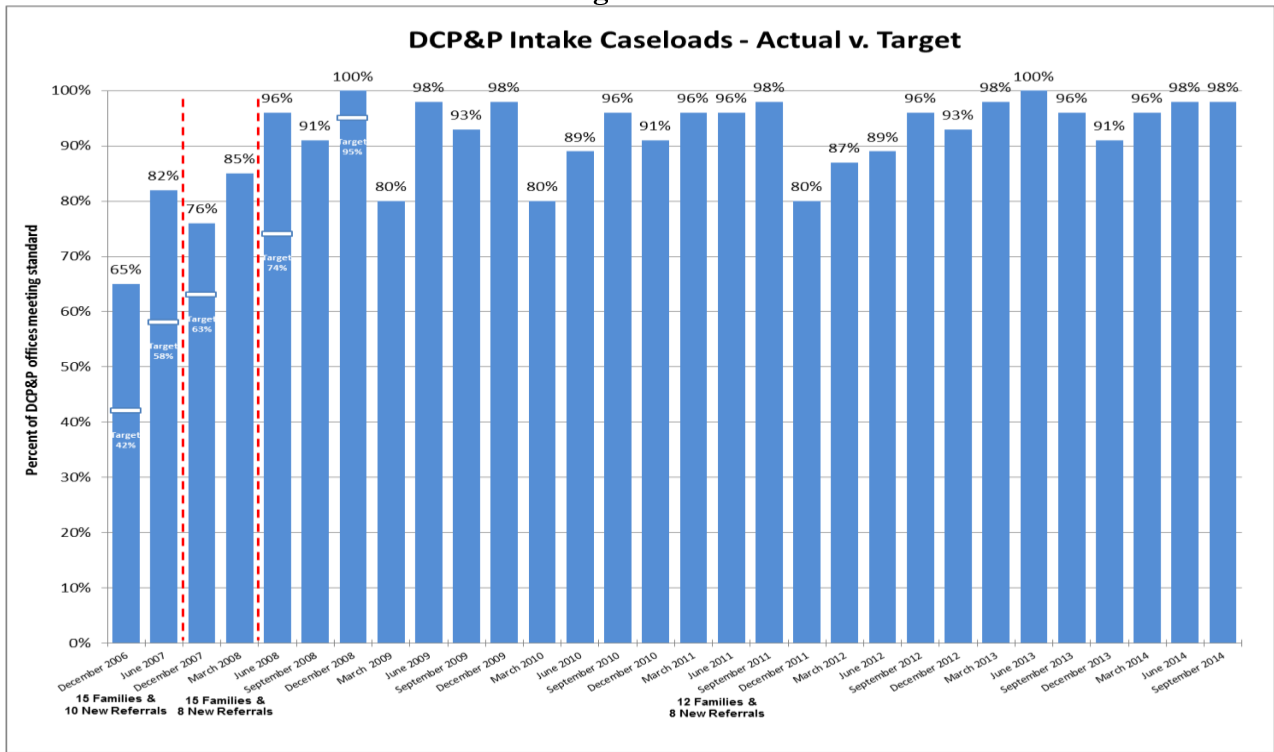

Figure 33

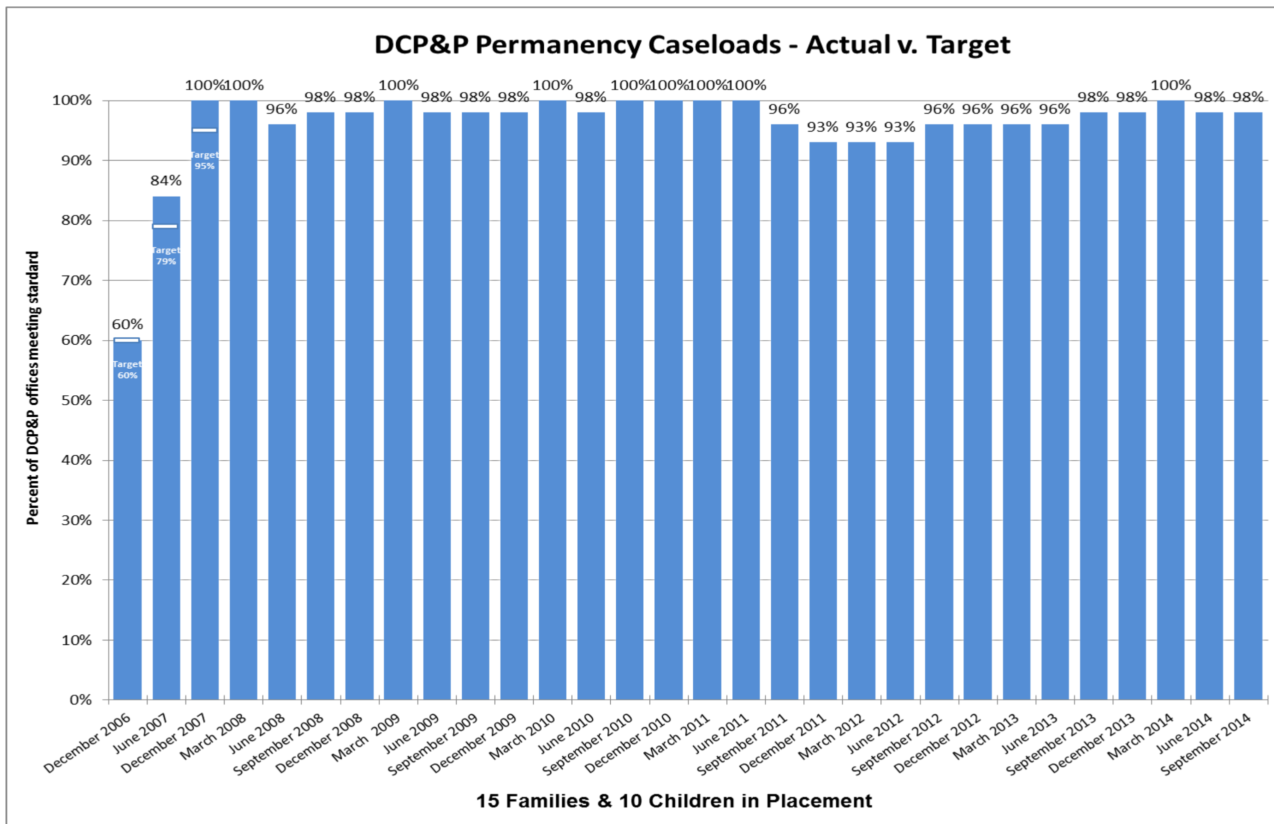

Figure 34

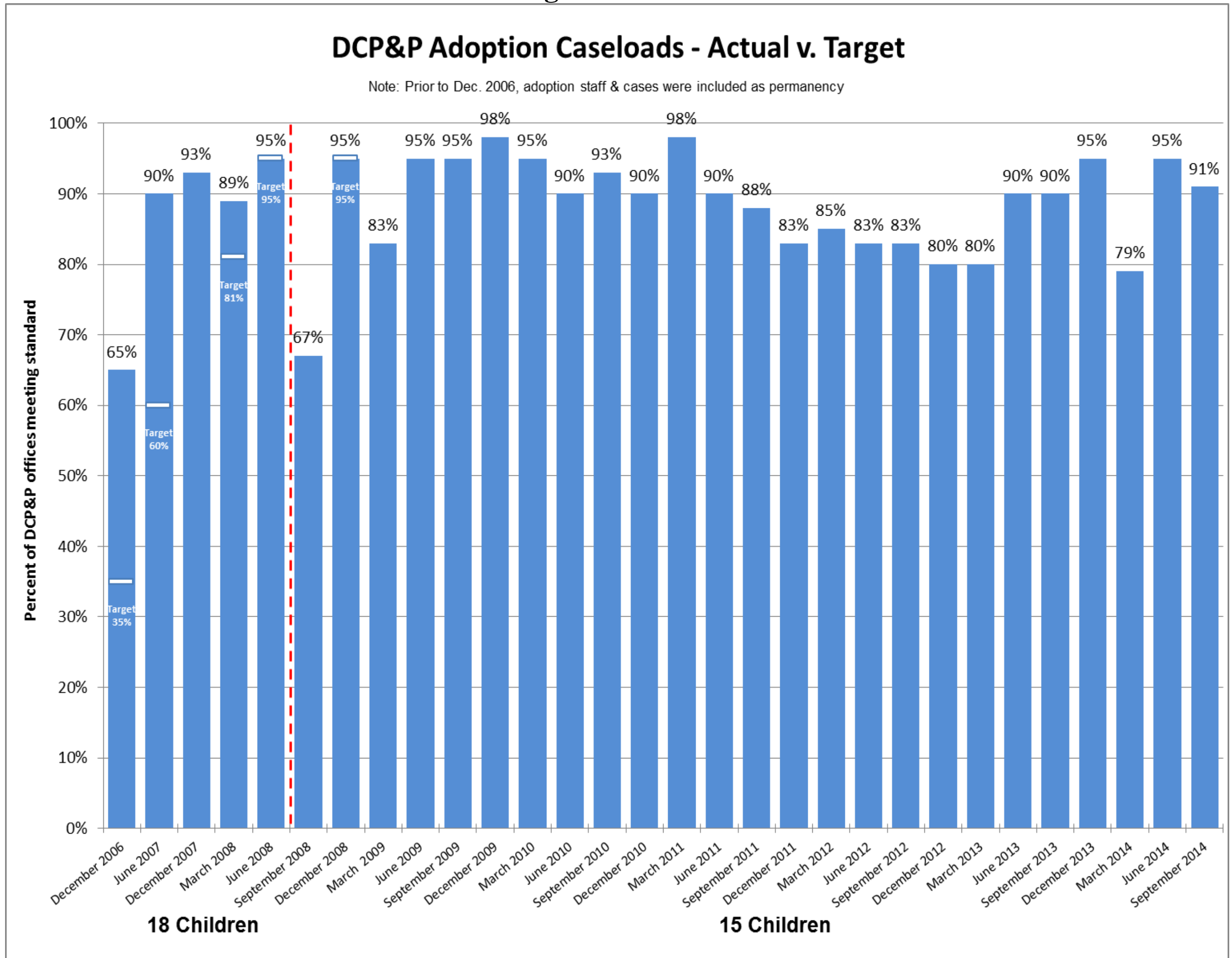

Figure 35- Educational Degrees by Job Title

All Child Welfare Staff by Job Title as of September 30, 2014	**MSW**	**Other Masters**	**BSW**	**Other Bachelors**	**Law Degree**	**PhD**	**No 4-year Degree**		**Staff Totals**
Family Service Specialist Trainee	20	22	51	141					**234**
Family Service Specialist 2	115	161	373	1497		1	23		**2170**
Family Service Specialist 1	54	52	66	513	1		14		**700**
Front Line Supervisor (SFSS 2)	100	38	61	417	3		17		**636**
Case Practice Specialist (CSS)	18	10	9	47					**84**
Case Work Supervisor (SFSS 1)	38	19	19	119	1		5		**201**
Local Office Manager	16	7	7	12					**42**
Area Office Support Staff	6	6	6	19			5		**42**
Area Office Manager	7	1	1	7					**16**
Degree Totals	**374**	**316**	**593**	**2772**	**5**	**1**	**64**		**4125**
New Hires by Job Title for October 1, 2013 through September 30, 2014	**MSW**	**Other Masters**	**BSW**	**Other Bachelors**	**Law Degree**	**PhD**	**No 4-year Degree**		**Staff Totals**
Family Service Specialist Trainee	18	17	48	126					**209**
Family Service Specialist 2		1	1	8					**10**
Local Office Manager		1							**1**
Area Office Support Staff									**0**
Degree Totals	**18**	**19**	**49**	**134**	**0**	**0**	**0**		**220**

Figure 36- Educational Degrees by Job Function

All Child Welfare Staff by Job Function as of September 30, 2014	MSW	Other Masters	BSW	Other Bachelors	Law Degree	PhD	No 4-year Degree	Staff Totals
Adoption Worker	20	18	37	127			3	**205**
Adoption Supervisor	8	6	6	26			1	**47**
Intake Worker	57	57	154	672			7	**947**
Intake Supervisor	29	16	23	136	2		2	**208**
Permanency Worker	76	128	257	1039		1	15	**1516**
Permanency Supervisor	56	14	25	193	1		10	**299**
Resource Family Worker	19	19	22	148			4	**212**
Resource Family Supervisor	6		4	35			2	**47**
Local Office Support Staff	16	10	17	146			7	**196**
Local Office Support Supervisor	2	2	3	26			2	**35**
Case Practice Specialist	17	9	8	43				**77**
Case Work Supervisor	38	19	19	119	1		5	**201**
Local Office Manager	16	7	7	12				**42**
Area Office Support Staff	7	10	10	43	1		6	**77**
Area Office Manager	7	1	1	7				**16**
Degree Totals	**374**	**316**	**593**	**2772**	**5**	**1**	**64**	**4125**

New Hires by Job Function for October 1, 2013 through September 30, 2014	MSW	Other Masters	BSW	Other Bachelors	Law Degre e	PhD	No 4-year Degree	Staff Totals
Adoption Worker			2					**2**
Intake Worker		2	3	10				**15**
Permanency Worker	18	16	43	124				**201**
Resource Family Worker			1					**1**
Local Office Manager		1						**1**
Area Office Support Staff								**0**
Degree Totals	**18**	**19**	**49**	**134**	**0**	**0**	**0**	**220**

Figure 37- Race/Ethnicity/Gender by Job Title

All Child Welfare Staff by Job Title as of September 30, 2014	Asian	Black	Hispanic	Native American	White	Total Female	Asian	Black	Hispanic	Native American	White	Total Male	Staff Totals
Family Service Specialist Trainee	2	71	5	1	115	194		10			30	40	**234**
Family Service Specialist 2	22	812	104	3	800	1741	7	220	26	1	175	429	**2170**
Family Service Specialist 1	9	260	24	3	287	583	1	55	7	1	53	117	**700**
Front Line Supervisor (SFSS2)	6	223	30		274	533	3	43	4		53	103	**636**
Case Practice Specialist (CSS)		21	4		48	73		2	1		8	11	**84**
Case Work Supervisor (SFSS1)	5	74	6		87	172		13	3		13	29	**201**
Local Office Manager		11	1		23	35		5			2	7	**42**
Area Office Support Staff		11	4		19	34	2	1			5	8	**42**
Area Office Manager		3			11	14		2				2	**16**
Totals	**44**	**1486**	**178**	**7**	**1664**	**3379**	**13**	**351**	**41**	**2**	**339**	**746**	**4125**

New Hires by Job Title for October 1, 2013 through September 30, 2014	Asian	Black	Hispanic	Native American	White	Total Female	Asian	Black	Hispanic	Native American	White	Total Male	Staff Totals
Family Service Specialist Trainee	2	62	3	1	107	175		9			25	34	**209**
Family Service Specialist 2		3			6	9					1	1	**10**
Local Office Manager					1	1						0	**1**
Area Office Support Staff						0						0	**0**
Totals	**2**	**65**	**3**	**1**	**114**	**185**	**0**	**9**	**0**	**0**	**26**	**35**	**220**

Figure 38- Race/Ethnicity/Gender by Job Function

Child Welfare Staff by Job Function as of September 30, 2014	Asian	Black	Hispanic	Native American	White	Total Female	Asian	Black	Hispanic	Native American	White	Total Male	Staff Totals
Adoption Worker	3	81	6	2	88	180		12	2		11	25	**205**
Adoption Supervisor		13			27	40		2			5	7	**47**
Intake Worker	5	321	88	2	354	770	2	81	19	1	74	177	**947**
Intake Supervisor	1	49	26		100	176		12	3		17	32	**208**
Permanency Worker	20	571	34	1	585	1211	4	165	9	1	126	305	**1516**
Permanency Supervisor	3	122	2		119	246	3	23	1		26	53	**299**
Resource Family Worker	1	94	2		77	174	2	10	1		25	38	**212**
Resource Family Supervisor	1	24	2		16	43		2			2	4	**47**
Local Office Support Staff	4	65	2	2	88	161		16	1		18	35	**196**
Local Office Support Supervisor	1	14			13	28		4			3	7	**35**
Case Practice Specialist		20	3		44	67		2	1		7	10	**77**
Case Work Supervisor	5	75	6		86	172		13	3		13	29	**201**
Local Office Manager		11	1		23	35		5			2	7	**42**
Area Office Support Staff		23	6		33	62	2	2	1		10	15	**77**
Area Office Manager		3			11	14		2				2	**16**
Totals	**44**	**1486**	**178**	**7**	**1664**	**3379**	**13**	**351**	**41**	**2**	**339**	**746**	**4125**

New Hires by Job Function for October 1, 2013 through September 30, 2014	Asian	Black	Hispanic	Native American	White	Total Female	Asian	Black	Hispanic	Native American	White	Total Male	Staff Totals
Adoption Worker		1			1	2						0	**2**
Intake Worker		7			6	13					2	2	**15**
Permanency Worker	2	57	3	1	105	168		9			24	33	**201**
Resource Family Worker					1	1						0	**1**
Local Office Manager					1	1						0	**1**
Area Office Support Staff						0						0	**0**
Totals	**2**	**65**	**3**	**1**	**114**	**185**	**0**	**9**	**0**	**0**	**26**	**35**	**220**

State of New Jersey, Department of Children and Families

Child Welfare Workers and Supervisors

Worker to Supervisor Ratios by Job Function

Figure 39

Child Welfare Staff by Job Function as of September 30, 2014	Number Staff	# Staff per Supervisor
Adoption Worker	205	4.36
Adoption Supervisor	47	
Intake Worker	947	4.55
Intake Supervisor	208	
Permanency Worker	1516	5.07
Permanency Supervisor	299	
Resource Family Worker	212	4.51
Resource Family Supervisor	47	
Local Office Support Staff	196	5.60
Local Office Support Supervisor	35	
Total Local Office Workers	3076	4.84
Total Front-Line Supervisors	636	
Total Front-Line Supervisors	636	3.16
Case Work Supervisor	201	

The target ratio for worker to front-line supervisor is 5:1

The target ratio for front-line supervisor to case work supervisor is 3:1

State of New Jersey, Department of Children and Families

Child Welfare Workers, Supervisors and Managers

Years of Service and Salary Ranges by Job Title

Figure 40

All Child Welfare Staff by Job Title as of September 30, 2014	Average Years of Service	Minimum Annual Salary	Maximum Annual Salary
Family Service Specialist Trainee	0.74	$49,263.43	$51,529.95
Family Service Specialist 2	6.66	$53,910.34	$76,393.06
Family Service Specialist 1	13.02	$59,031.79	$83,803.57
Front Line Supervisor (SFSS 2)	14.58	$64,677.09	$92,011.89
Case Practice Specialist (CSS)	16.24	$67,714.29	$96,415.56
Case Work Supervisor (SFSS 1)	20.79	$70,903.32	$101,039.55
Local Office Manager	20.83	No official salary range	
Area Office Support Staff	22.06	$53,910.34	$105,891.38
Area Office Manager	25.85	No official salary range	

Figure 41-Separations from DCF by Job Title

All Child Welfare Staff Separations by Job Title from October 1, 2013 through September 30, 2014	Retirement	Resignation in Good Standing	Resignation Not in Good Standing	Resignation Pending Disciplinary Action	Removal	Appointment Discontinued	Transfer to another Department	Death	Title Totals
Family Service Specialist Trainee		10		1	3	5			**19**
Family Service Specialist 2	10	97	3	11	20		4	1	**146**
Family Service Specialist 1	15	7	1	2	1		1		**27**
Front Line Supervisor (SFSS 2)	11	6							**17**
Case Practice Specialist (CSS)	2								**2**
Case Work Supervisor (SFSS 1)	10				1			1	**12**
Local Office Manager	3								**3**
Area Office Support Staff									**0**
Area Office Manager	4								**4**
Separation Totals	**55**	**120**	**4**	**14**	**25**	**5**	**5**	**2**	**230**

Juvenile Justice Transfer

There were 22 children in placement under the legal authority of the Division of Child Protection & Permanency (DCP&P), during this reporting period that were transferred from DCP&P to the Juvenile Justice Commission (JJC). The Office of Information Technology generated a report that listed all children in placement, with a placement ending reason of "Custody and Care Transferred to Another Agency". All children listed on the report were reviewed through SACWIS, and the DCP&P Area and Local office staff identified the children who were transferred to the JJC.

Sources of Data on Child Maltreatment Deaths

Child fatalities are reported to the NJ Department of Children and Families Child Death Review Unit by many different sources including, law enforcement agencies, medical personnel, family members, schools, medical examiners offices and occasionally child death review teams. In addition the Bureau of Vital Statistics confirms all child fatalities and supplies the birth as well as death certificates when available. The DCP&P Director makes a determination as to whether the child fatality was a result of child maltreatment.

The State NCANDS liaison consults with the Child Death Review Unit Coordinator to insure that all child maltreatment fatalities are reported in the State NCANDS files.

The New Jersey State SACWIS system (NJS) is the primary source of reporting child fatalities in the NCANDS Child File. Specifically, child maltreatment deaths are reported in the NCANDS Child File in data element 34, Maltreatment Death, from data collected and recorded by Investigators in the Investigation and Person Management screens in the NJS.

Other child maltreatment fatalities not reported in the Child File due to data anomalies, but which are designated child maltreatment fatalities by the Child Death Review Unit under the Child Abuse Prevention and Treatment Act (CAPTA), are reported in the NCANDS Agency File in data element 4.1, Child Maltreatment Fatalities not reported in the Child File.

Education and Training Vouchers

The total number of ETV awards granted for the 2013-2014 School Year was 232 with 113 new ETV awards.

The total number of ETV awards estimated for the 2014-2015 School Year is 220 with an estimated number of 93 new ETVs- see Section N Financial Information.

Inter-Country Adoptions

See Section D: Services for Children Adopted from Other Countries.

Monthly Caseworker Visit Data

Section F: Monthly Caseworker Visit Formula Grant provides preliminary data. Final Data will be submitted By December 15, 2015 as required.

SECTION L:

Financial Information

CFS-101, Part I
U. S. Department of Health and Human Services
Administration for Children and Families

Attachment B
OMB Approval #0970-0426
Approved through September 30, 2017

CFS-101, Part I: Annual Budget Request for Title IV-B, Subpart 1 & 2 Funds, CAPTA, CFCIP, and ETV

Fiscal Year 2016, October 1, 2015 through September 30, 2016

1. State or Indian Tribal Organization (ITO): New Jersey	**2. EIN: 216000928**
3. Address: 20 West State Street, 4th Floor, Trenton, NJ 08625	**4. Submission:** [X] New [ ] Revision
5. Total estimated title IV-B Subpart 1, Child Welfare Services (CWS) Funds	$5,245,851
a) Total administration (not to exceed 10% of title IV-B Subpart 1 estimated allotment)	$524,585
6. Total estimated title IV-B Subpart 2, Provides Safe and Stable Families (PSSF) Funds. This amount should equal the sum of lines a - f.	$5,253,870
a) Total Family Preservation Services	$1,241,148
b) Total Family Support Services	$1,131,619
c) Total Time-Limited Family Reunification Services	$1,266,535
d) Total Adoption Promotion and Support Services	$1,614,568
e) Total for Other Service Related Activities (e.g. planning)	$0
f) Total administration (FOR STATES ONLY: not to exceed 10% of title IV-Bsubpart 2 estimated allotment)	$0
7. Total estimated Monthly Caseworker Visit (MCV) Funds (FOR STATES ONLY)	$330,616
a) Total administration (FOR STATES ONLY: not to exceed 10% of estimated MCV allotment)	$33,061
8. Re-allotment of title IV-B subparts 1 & 2 funds for States and Indian Tribal Organizations:	
a) Indicate the amount of the State's/Tribe's allotment that will not be required to carry out the following programs: CWS $__0__, PSSF $__0__, and/or MCV(States only)$__0__.	
b) If additional funds become available to States and ITOs, specify the amount of additional funds the States or Tribes requesting: CWS $524,585, PSSF $525,387, and/or MCV(States only) $33,061.	
9. Child Abuse Prevention and Treatment Act (CAPTA) State Grant (no State match required): Estimated Amount plus additional allocation, as available. (FOR STATES ONLY)	$660,815
10. Estimated Chafee Foster Care Independence Program (CFCIP) funds	$2,297,848
a) Indicate the amount of State's or Tribe's allotment to be spent on room and board for eligible youth (not to exceed 30% of CFCIP allotment)	$619,091
11. Estimated Education and Training Voucher (ETV) funds	$735,895
12. Re-allotment of CFCIP and ETV Program Funds:	
a) Indicate the amount of the State's or Tribe's allotment that will not be required to carry out CFCIP Program	$0
b) Indicate the amount of the State's or Tribe's allotment that will not be required to carry out ETV Program	$0
c) If additional funds become available to States or Tribes, specify the amount of additional funds the State or Tribe is requesting for CFCIP Program	$229,785
d) If additional funds become available to States or Tribes, specify the amount of additional funds the State or Tribe is requesting for ETV Program	$73,590

13. Certification by State Agency and/or Indian Tribal Organization.

The State agency or Indian Tribe submits the above estimates and request for funds under title IV-B, subpart 1 and/or 2, of the Social Security Act, CAPTA State Grant, CFCIP and ETV programs, and agrees that expenditures will be made in accordance with the Child and Family Services Plan, which has been jointly developed with, and approved by, the Children's Bureau.

Signature and Title of State/Tribal Agency Official: Chief Administrator, Business Operations	**Signature and Title of Central Office Official**
Doris Windle 6/18/15	

CFS-101, Part II
U. S. Department of Health and Human Services
Administration for Children and Families

Attachment B
OMB Approval #0970-0426
Approved through September 30, 2017

CFS-101 Part II: Annual Estimated Expenditure Summary of Child and Family Services

State or Indian Tribal Organization (ITO) New Jersey — For FFY OCTOBER 1, 2015 TO SEPTEMBER 30, 2016

SERVICES/ACTIVITIES	TITLE IV-B			(d) CAPTA*	(e) CFCIP	(f) ETV	(g) TITLE IV-E**	(h) STATE, LOCAL, & DONATED FUNDS	(i) NUMBER TO BE SERVED		(j) POPULATION TO BE SERVED	(k) GEOG. AREA TO BE SERVED
	(a) Subpart I-CWS	(b) Subpart II-PSSF	(c) Subpart II-MCV *						Individuals	Families		
1.) PREVENTION & SUPPORT SERVICES (FAMILY SUPPORT)	2,272,133	1,131,619		660,815				112,774,071	163,752		[illegible] Children & Familes	Statewide
2.) PROTECTIVE SERVICES	2,272,133							90,916,000	7,281		Children in out of home cre	Statewide
3.) CRISIS INTERVENTION (FAMILY PRESERVATION)		1,241,148						2,454,239	140	211	Eligible Children & Families	Statewide
4.)TIME-LIMITED FAMILY REUNIFICATION SERVICES		1,266,535						1,720,128	300	130	Eligible Children & Families	Statewide
5.) ADOPTION PROMOTION AND SUPPORT SERVICES		1,614,568						1,886,618	1,539	176	Eligible Children & Families	Statewide
6.) FOR OTHER SERVICE RELATED ACTIVITIES (e.g. planning)		0										Statewide
7.) FOSTER CARE MAINTENANCE:												Statewide
(a) FOSTER FAMILY & RELATIVE FOSTER CARE							24,196,612	46,690,000	6,461		All children in Foster Care	Statewide
(b) GROUP/INST CARE							5,510,513	8,964,487	164			Statewide
8.) ADOPTION SUBSIDY PMTS.	177,000						44,000,000	95,346,000	14,031		[illegible] Children	Statewide
9.) GUARDIANSHIP ASSIST. PMTS.							1,096,000	21,999,000	1,931			Statewide
10.) INDEPENDENT LIVING SERVICES					2,297,848		235,701	8,424,451	600		Eligible Children	Statewide
11.) EDUCATION AND TRAINING VOUCHERS						735,895		622,351	220		All eligible children	Statewide
12.) ADMINISTRATIVE COSTS	524,585		33,061				73,321,030	213,022,691				
13.) STAFF & EXTERNAL PARTNERS TRAINING							3,795,338	5,816,978				
14.) FOSTER PARENT RECRUITMENT & TRAINING							2,206,997	3,661,895				
15.) ADOPTIVE PARENT RECRUITMENT & TRAINING							2,410,635	2,676,703				
16.) CHILD CARE RELATED TO EMPLOYMENT/TRAINING							688,174				All eligible children	Statewide
17.) CASEWORKER RETENTION, RECRUITMENT & TRAINING			297,555									
18.) TOTAL	5,245,851	5,253,870	330,616	660,815	2,297,848	735,895	157,461,000	616,975,612				

*** These columns are for States only; Indian Tribes are not required to include information on these programs.**
**** Only states or tribes operating an approved title IV-E waiver demonstration may enter information for rows 1-6 in column (g), indicating planned use of title IV-E funds for these purposes.**

CFS-101, Part III
U. S. Department of Health and Human Services
Administration for Children and Families

Attachment B
OMB Approval #0970-0426
Approved through September 30,2017

CFS-101, PART III: Annual Expenditures for Title IV-B, Subparts 1 and 2, Chafee Foster Care Independence (CFCIP) and Education And Training Voucher (ETV) : Fiscal Year 2013: October 1, 2012 through September 30, 2013

1. State or Indian Tribal Organization (ITO): New Jersey
2. EIN: 216000928
3. Address: 20 West State Street, 4th Floor, Trenton, NJ 08625
4. Submission: [X] New [ ] Revision

Description of Funds	*Estimated Expenditures*	*Actual Expenditures*	*Number served*		*Population served*	*Geographic area served*
			Individuals	Families		
5. Total title IV-B, subpart 1 funds	$5,469,036	$5,080,888	1,378		Eligible Children & Families	Statewide
a) Total Administrative Costs (not to exceed 10% of title IV-B, subpart 1 total allotment)	$546,903	$508,088				
6. Total title IV-B, subpart 2 funds (This amount should equal the sum of lines a - f.)	$4,751,687	$4,672,361	7,332	2,883	Eligible Children & Families	Statewide
a) Family Preservation Services	$1,136,919	$1,136,919				
b) Family Support Services	$1,210,945	$1,131,619				
c) Time-Limited Family Reunification Services	$1,019,278	$1,019,278				
d) Adoption Promotion and Support Services	$1,384,545	$1,384,545				
e) Other Service Related Activities (e.g. planning)	$0	$0				
f) Administrative Costs (FOR STATES: not to exceed 10% of total title IV-B, subpart 2 allotment after October 1, 2007)	$0	$0				
7. Total Monthly Caseworker Visit Funds (STATE ONLY)	$300,189	$201,945				
a) Administrative Costs (not to exceed 10% of MCV allotment)	$30,018	$0				
8. Total Chafee Foster Care Independence Program (CFCIP) funds	$2,297,848	$2,297,848				
a) Indicate the amount of allotment spent on room and board for eligible youth (not to exceed 30% of CFCIP allotment)	$481,363	$619,091	105		Eligible youth under age 21	Statewide
9. Total Education and Training Voucher (ETV) funds	$751,313	$673,040	232		youth under	Statewide

10. Certification by State Agency or Indian Tribal Organization (ITO). The State agency or ITO agrees that expenditures were made in accordance with the Child and Family Services Plan, which has been jointly developed with, and approved by, the Children's Bureau.

Signature and Title of State/Tribal Agency Official: Chief Administrator, Business Operations	*Date*	*Signature and Title of Central Office Official*	*Date*
Doris Windle (JHD)	6/8/15		

CFS-101 ADDENDUM

Title IV-B Subpart 1 – Payment Limitations

The amount of FY2005 Title IV-B, subpart 1, funds New Jersey expended for child care, foster care maintenance, and adoption assistance payments totaled $724,011.

The amount of non-federal funds expended by New Jersey for foster care maintenance payments and used as part of the Title IV-B, subpart 1 state match for FY2005 was $0.

Title IV-B Subpart 2 – Non-supplantation Requirement

The 1992 base year amount of state expenditures for the purposes of Title IV-B, subpart 2 totaled $31,021,000.

The FY2013 amount of state expenditures for the purposes of Title IV-B, subpart2 totaled $84,732,000.

Attachment E

Annual Reporting of Education and Training Vouchers Awarded

Name of State: New Jersey

	Total ETVs Awarded	**Number of New ETVs**
Final Number: **2013-2014 School Year** (July 1, 2013 to June 30, 2014)	232	113
2014-2015 School Year* (July 1, 2014 to June 30, 2015)	220	93

Comments:

We are projecting that the numbers of students who utilize ETV funding will remain stable for the 2015-2016 academic year. This projection is based on this year's increase in students who are being served by state dollars.

*This is an estimated number as we are continuing to process requests and ETV disbursements through June 30th, 2015, the time in which APSR is due.

CFS-101, Part I
U. S. Department of Health and Human Services
Administration for Children and Families

Attachment B
OMB Approval #0970-0426
Approved through September 30, 2017

CFS-101, Part I: Annual Budget Request for Title IV-B, Subpart 1 & 2 Funds, CAPTA, CFCIP, and ETV

Fiscal Year 2015, October 1, 2014 through September 30, 2015

1. State or Indian Tribal Organization (ITO): New Jersey	**2. EIN: 216000928**
3. Address: 20 West State Street, 4th Floor, Trenton, NJ 08625	**4. Submission:** [ ] New [X] Revision
5. Total estimated title IV-B Subpart 1, Child Welfare Services (CWS) Funds	$5,256,844
a) Total administration (not to exceed 10% of title IV-B Subpart 1 estimated allotment)	$525,684
6. Total estimated title IV-B Subpart 2, Provides Safe and Stable Families (PSSF) Funds. This amount should equal the sum of lines a - f.	$5,253,870
a) Total Family Preservation Services	$1,241,148
b) Total Family Support Services	$1,131,619
c) Total Time-Limited Family Reunification Services	$1,266,535
d) Total Adoption Promotion and Support Services	$1,614,568
e) Total for Other Service Related Activities (e.g. planning)	$0
f) Total administration (FOR STATES ONLY: not to exceed 10% of title IV-Bsubpart 2 estimated allotment)	$0
7. Total estimated Monthly Caseworker Visit (MCV) Funds (FOR STATES ONLY)	$330,616
a) Total administration (FOR STATES ONLY: not to exceed 10% of estimated MCV allotment)	$33,061
8. Re-allotment of title IV-B subparts 1 & 2 funds for States and Indian Tribal Organizations:	
a) Indicate the amount of the State's/Tribe's allotment that will not be required to carry out the following programs: CWS $ 0 , PSSF $ 0 , and/or MCV(States only)$ 0 .	
b) If additional funds become available to States and ITOs, specify the amount of additional funds the States or Tribes requesting: CWS $525,684, PSSF $492,212, and/or MCV(States only) $30,981.	
9. Child Abuse Prevention and Treatment Act (CAPTA) State Grant (no State match required): Estimated Amount plus additional allocation, as available. (FOR STATES ONLY)	$662,372
10. Estimated Chafee Foster Care Independence Program (CFCIP) funds	$2,297,848
a) Indicate the amount of State's or Tribe's allotment to be spent on room and board for eligible youth (not to exceed 30% of CFCIP allotment)	$613,916
11. Estimated Education and Training Voucher (ETV) funds	$735,895
12. Re-allotment of CFCIP and ETV Program Funds:	
a) Indicate the amount of the State's or Tribe's allotment that will not be required to carry out CFCIP Program	$0
b) Indicate the amount of the State's or Tribe's allotment that will not be required to carry out ETV Program	$0
c) If additional funds become available to States or Tribes, specify the amount of additional funds the State or Tribe is requesting for CFCIP Program	$229,785
d) If additional funds become available to States or Tribes, specify the amount of additional funds the State or Tribe is requesting for ETV Program	$73,480
13. Certification by State Agency and/or Indian Tribal Organization. The State agency or Indian Tribe submits the above estimates and request for funds under title IV-B, subpart 1 and/or 2, of the Social Security Act, CAPTA State Grant, CFCIP and ETV programs, and agrees that expenditures will be made in accordance with the Child and Family Services Plan, which has been jointly developed with, and approved by, the Children's Bureau.	
Signature and Title of State/Tribal Agency Official: Chief Administrator, Business Operations Doris Windle (JWP) 6/18/15	**Signature and Title of Central Office Official**

2015 APSR

Attachment A

Foster and Adoptive Diligent Recruitment Plan Update

June 30, 2015

New Jersey Department of Children and Families

Foster and Adoptive Diligent Recruitment Plan

2015-2019

Foster and Adoption Recruitment and Retention Initiatives

New Jersey is committed to diligent recruitment and retention efforts of potential resource families who reflect the cultural diversity, racial, and ethnic characteristics of children in out-of-home care. NJ is committed to recruiting families in communities where our children reside and to build a supportive network of resources to support their needs. We will continue to accomplish this goal by utilizing data driven approaches for strategic targeted recruitment and retention.

The results of our commitment are reflected in the number of families licensed. We have had great success with increasing and maintaining a robust pool of families for children in care. This is a result of the diligent recruitment efforts that have been made statewide. While NJ has been successful increasing the pool of resource families who reflect the racial, ethnic, and religious diversity of children in care, we continue to have a need for several populations of children including sibling groups, adolescents, and children with increased medical needs. NJ remains committed to the diligent targeted recruitment of families for these specific populations.

In addition, our success in recruitment has allowed us to shift our focus on ensuring that we properly support and retain our current pool of licensed families while continuing to license the right types of families for our children in out-of-home care. NJ recognizes the importance of maintaining our current pool of families and has committed to improving our ability to effectively provide the proper supports to families caring for our children will lead to positive outcomes for both, our children and families.

The following plan for 2015-2019 has been implemented to continue diligent targeted recruitment:

- A major organizational change was implemented that resulted in local recruiters coming under the auspices of Central Office, Office of Resource Families. This will allow the recruiters to concentrate their efforts, full time, and improve efficiency.
- Recruiters continue to use data driven methods to develop local targeted recruitment plans that determine geographic and subpopulations areas of need
- We continue to support and provide guidance to recruitment staff with the goal of continuously enhancing our recruitment efforts and developing effective strategies to reach the right types of families
- Continue the practice of bi-monthly Group Engagement orientations with inquiries in each County
- Continue the use of resource parent adjunct recruiters and youth recruiters for events and trainings to share their experiences as current resource parents and as a youth in care
- Continue to encourage current resource parents to help in recruitment by offering an honorarium program, travel reimbursement, and child care expenses to attend events and trainings
- Recruiters will continue to host presentations, informational tables, participate in fairs, parades, cultural events, and partner with religious and nonprofit organizations and local schools

- We continue our ongoing partnerships with hospitals, healthcare centers, and local health organizations for targeted recruitment of children with specialized medical needs.
- Work diligently in our efforts to educate communities and develop partnerships with local organizations.
- We continue to actively make updates to the public website as policies, new initiatives and or practice changes
- Continue to support Child Specific Recruitment Activities for Adolescents and Waiting Children
- Continue to allocate funds for recruitment events, adjunct recruiters, and local advertisements from our statewide recruitment budget
- Continuously assessing and identifying needs of the local recruitment staff and implementing new tools to ensure their success in meeting local office objectives
- NJ expanded the requirement that recruiters host 4 statewide targeted events to 6. These include two events targeting siblings, two targeting adolescents, one targeting the LGBT population and one targeting families willing to accept children with increased medical needs.
- In an effort to become more sophisticated with our recruitment practices, The use of market segmentation has been phased in statewide. Market segmentation is a tool for targeted recruitment that looks to identify households that can be targeted that are most “like” our current successful resource homes.
- We continue to use the lifestyle characteristics of our current successful families to drive our recruitment strategies in targeted communities
- Continue to update recruitment materials/publications that are customer centered and reflective of the lifestyle characteristics in our market segmentation tool
- Promotional Items will be purchased to reinforce the message that will be developed
- Use lifestyle characteristics to target advertising opportunities within local geographic areas
- Continue use of tracking tools for market segmentation outcomes and targeted geographic and subpopulation outcomes
- With the assistance of the NRCDR at Adopt US Kids, We are developing a method of analyzing data captured that is reflective of the impact of our recruitment efforts
- Recruiters continue to develop new partnerships with businesses/organizations as informed by the market segmentation lifestyle characteristics as well as maintain current relationships
- Participate in peer to peer calls with other States in an effort to learn from each other
- In collaboration with NRCDR at Adopt US Kids, we are developing a workshop for recruiters to more effectively translate Market Segmentation data using communication marketing techniques while out in the community
- In an effort to enhance the expertise of our recruitment staff, we have developed workshops that addressed their ability to communicate more successfully, build coalitions and enhance their networking potential as well as strategies to break down communication barriers in the context of recruitment
- We continue working to enhance the skills of recruitment staff through exercises that improve their ability to engage, build relationships and team with others
- In order to focus on recruiting sibling groups of 5 or more a statewide plan was developed and implemented. The plan established a SIBS (Siblings in Best Settings) program.
- A SIBS Coordinator was hired to monitor and track all placements of 5 or more siblings statewide. This program also provides SIBS families with increased supportive services and additional subsidy to maintain an open home for siblings of 5 or more only.
- NJ is the first state child welfare agency to have achieved the Human Rights Campaign, All Children - All Families Seal of Recognition for reaching all benchmarks of LGBT cultural competency and being fully welcoming of LGBT individuals and families.

- NJ continues its efforts of promising practices with LGBT families by committing to a seal reassessment that is conducted every three years.
- Training by national experts is currently being explored. This will continue to enhance our competency skills among staff and allow us to be more effective with our outreach efforts to LGBT communities statewide.
- Continue our partnership with *RaiseAChild.org* a national LGBT organization connecting LGBT parents with foster and adoption agencies who are cultural competent and welcoming.
- Continue to host large and small events statewide partnering with LGBT organizations for LGBT prospective parents.
- NJ continues to emphasize and support local recruitment activities in the communities where children reside
- Continue working with the Human Rights Campaign's -All Children, All Families initiative
- Continued statewide development of partnerships with national and state organizations such as the RaiseAChildUS.org
- NJ has a Statewide Retention Specialist, Recruitment & Retention Communications Specialist, and a Statewide Recruitment Specialist who continue to lead statewide recruitment and retention efforts by improving and strengthening support and customer service for our licensed families, managing and promoting market segmentation initiatives, and continuing to focus on targeted recruitment for specific populations of children in care.
- We recognize that recruitment and retention go hand in hand and therefore are currently in the development stage of a statewide retention plan to improve our services and strengthen our partnership with our resource families.
- We will continue to contract with Foster and Adoptive Family Services (FAFS) resource family support organization. FAFS provides various supportive services to licensed foster and adoptive families which includes but not limited to:
    - Providing peer to peer support and advocacy
    - In-service training that is offered through various modalities including workshops, home correspondence courses, e-learning and webinars.
    - Online support groups, blogs, chat rooms, Facebook, Twitter, and Pinterest to keep resource families connected.
    - Respond to all inquiries through the toll-free hotline and online.
- NJ developed a new methodology of identifying local needs that focuses on engagement and retention of current licensed families
- We continue to work with consultants from the National Resource Center for Diligent Recruitment at Adopt US Kids (NRCDR) on-site and through teleconferences
- NRCDR at Adopt US Kids conducted an on-site assessment that included facilitating discussions with staff in different areas of practice as well as licensed resource families
- NJ finalized a framework for retention based practices that will lead to a retention case practice plan and provide the structure to implement changes to policy and practice
- NJ Commissioned the Rutgers University School of Social Work to conduct a study on the perspectives of NJ resource families. The study focused on the experiences of resource parents to gain a better understanding of what are the causes of attrition from the foster care program
- We are in the process of finalizing tools that will allow DCF to gauge family's perspectives regularly
- We are planning a kick off meeting with DCF leadership in the first quarter of 2015 to begin the process of exploring methods to develop a plan of action to implement changes that will strengthen our States ability to effectively retain our current pool of families

- We are developing a statewide taskforce that will include licensed resource families, youth and staff. This taskforce will drive the action steps that will ultimately lead to NJ's retention case practice plan

FOSTER AND ADOPTIVE FAMILY SERVICES TRAINING OPPORTUNITIES

TRAINING MODALITY	HOURS
Webinars	
Approved between October 1, 2013- September 30, 2014	
Caring for Children with Incarcerated Parents	3
Post Adoption Issues	2
Introduction to Social Emotional Learning	1.25
Introduction to Emotion Coaching	1.25
Introduction to Supporting Problem Solving	1.25
Online Training	
Approved between October 1, 2013- September 30, 2014	
Post High School Options	1.5
Disaster Preparedness One	4.0
Home Correspondence Courses	
Approved New between October 1, 2013- September 30, 2014	
Critical Thinking: Skill Development for Children	1.5
Disaster Preparedness Part 1: Preparing Your Family Before an Emergency (Spanish)	3
Disaster Preparedness Part 2: Staying Safe During an Emergency (Spanish)	3
Disaster Preparedness Part 3: Recovering and Coping with Disaster	3
Revised between October 1, 2013- September 30, 2014	
Building Healthy Relationships	3
Chew on This a Guide to Diet and Nutrition	4

Childhood Skin Disorders	3.5
Special Education: Answers to Important Questions	3.25
Fetal Alcohol Spectrum Disorder: Hard Facts to Swallow	2.25

County-Based Training

Approved between October 1, 2013- September 30, 2014

Overcoming the Effects of Being Raised in a Dysfunctional Family	1.5
Cumberland County Council for Children	1.5
Q&A with DCP&P Director	2
IAIU	2
Life Books	2
Allergies & Asthma in Children	2
Psychotropic Medications and Children	1.5
Camden County OOL	2
Family Crisis Intervention Unit	1
Procedural Safeguards	2

All Available County-Based Trainings

Available trainings during October 1, 2013-September 30, 2014

A Circle of Partners for Children and Families	2
Addicted/Alcoholics vs. Healthy Families	2
Adoption and Foster Care in the Schools	1.5
Adoption: A Life Long Loss: How Adoption Issues Impact Life Transitions	1.5
Adult, Child and Infant CPR	2

Aging Out, Don't Miss Out	1
Ask. Advise. Refer	2
Bullying Among Children and Youth	1.5
Care Management Organization and Youth Management Program	2
Changes in DYFS for Foster Parents	1.5
Changes in the Foster Care System	1.5
Child Health Unit Service Overview	2
Child Passenger Safety	2
Child Placement Review Boards Overview (CPR Board)	1
Child Welfare	2
Children’s Mental Health and Wellness	2
Common Sense Parenting	2
Creative Community Options Program	2
Cumberland, Gloucester and Salem County Family Support Organization	2
Current Trends of Abuse	2
Division of Developmental Disabilities Overview	2
Domestic Violence Workshop for Parents	2
Drug and Alcohol Information for Parents	2
Educational Stability	2
FAS/FASD/ and Children's Behavior	2
FASD and Practical Implications for Caregivers	2
Fetal Alcohol Spectrum Disorders- The Basics	2
Forming a Secure Bond	1.5
Foster Parent Recruitment	2
Foster Children, Trauma and How to Respond	2

Fostering a Relationship Intended to Last a Lifetime	1.5
From Termination of Parental Rights to Adoption	1.5
Get the Lead Out	2
Guardianship Need of Individuals with Development Disabilities	1.5
Helping Foster Parents Deal with Difficult Behaviors	1.5
Hudson County Family Support Organization (FSO)	2
Juvenile Justice	2
Lifebooks, Foster Care and Adoption	1.5
Mental Health Association	2
Mental Health Services for Children and Young Adults	2
Preparing Your Children For A Child in Foster Care	1.5
Resource Family Grief	2
Salem County Recruitment	2
Securing Technology for Children	2
The Adopted Child's Journey: Questions Along the Way	2
Understanding Child Mental Health	2
Volunteers of America Parenting Skills Partnership Program	1.5
What Every Parent Should Know About Children and Sexual Abuse	2
Overcoming the Effects of Being Raised in a Dysfunctional Family	1.5
Cumberland County Council for Children	1.5
Q&A with DCP&P Director	2
IAIU	2
Life Books	2
Allergies & Asthma in Children	2
Psychotropic Medications and Children	1.5

Camden County OOL	2
Family Crisis Intervention Unit	1
Procedural Safeguards	2

Foster and Adoptive In-Service Training Usage From

October 2013– September 2014

Training Modality	**Unduplicated Users for Individual Training Modalities**	**Total Completed Training for Each Modality**	**Total Unduplicated Users for Combined Training Modalities**
Home Correspondence	1264	2969	N/A
County-based Training	381	854	N/A
Online Training	1085	3570	N/A
Webinar	114	251	N/A
Combined	2844	7644	2844

The term unduplicated user indicates that the parent is counted only one time during the specified reporting period. The ***2,844*** represents the total unduplicated number of parents who took training provided by Foster and Adoptive Family Services during the reporting period.

Approved Non- FAFS Foster Parent Training

Atlantic Behavioral Courses	Hours	Date Approved
Addiction	2	8/31/11
Attention Deficit/Hyperactivity Disorder	2	4/25/12
Building Positive Relationships	2	4/25/12
Building Positive Self-Esteem in Children	1.5	8/20/13
Child Trauma, Developmental Impact, & Interventions	2	8/31/11
Cutting Behaviors Among Adolescents	1.5	10/24/11
Cutting Intervention	2	8/20/13
Cyberbullying	2	5/8/15
Eating Disorders	2	10/3/11
Family Care Network & How We can cope with stress	2	
Incorporating Clients Family Traditions into Foster Parent Celebrations	2	
Internet Safety and Cyber Bullying	2	5/23/14
LGBT 101	1.5	4/23/13
Minding Your Minds	1.5	4/16/13
Positive Parenting Skills	2	3/14/12
QPR	2	3/14/12
Recognizing Substance Abuse in Adolescence	2	5/8/15
Statewide Parent Advocacy Network (SPAN)	2	5/8/15
Substance Abuse	2	3/31/14
Taking Control of Stress	2	8/31/11
Time Management	2	10/3/11

Adoption Conferences	Hours	Date

		Approved
2015 CPFA Spring Mini Conference	2.25	
Concerned Persons for Adoption: Let's Talk Adoption Conference	4	
Let's Talk Adoption 2012	5	8/13/2012
NJ's 30th Annual Let's Talk Adoption Conference	5	7/25/2011
NJ's 33rd Annual Let's Talk Adoption Conference	5	9/18/2014

Babyland Courses	Hours	Date Approved
Abuse, Neglect, and Emotional Maltreatment	2	5/22/2012
Discipline	3	3/13/2013
Discipline Considering the Stages of Development	2	5/22/2012
Effective Listening Skills	2	5/22/2012
Understanding Adolescent Suicide	3	3/17/2014

Children’s Home Society Courses	Hours	Date Approved
Adopting Foster Children	2 or 3	
Adopting Foster Children Present Unique Challenges	2 or 3	
Beating Burnout- Reducing Foster Parents' Stress	2	
Behavioral Support for Foster Parents	2	6/26/2012
Better Navigating the Court System	2	
Brain Boxes	1	
Brain Development & Infant Massage	1	
Child Development	1	3/21/2011
Childhood Attachment	3	4/24/2013
Confidentiality- Understanding the Regulations: What Foster Parents	1.5	

Need to Know		
CPR & AED Training	5	11/14/2013
Culturally Competent Foster Care, Committing to Diversity & Acceptance	1	
Current Trends of Abuse	1	
Diet and Nutrition	1	10/5/2012
Discipline: Considering Stages of Development	1	
Disruptive Disorders, Understanding and Managing ODD & CD	5	
Do You Know what Your kids are doing online?	1	
Early Intervention Program	3	5/12/2011
Ethnic Hair and Skin Care Training	2	
Finding Common Ground, Work Together, Remember that Foster Care is Temporary	1	
First Aid and Universal Health Precautions	4	5/12/2011
Foster parent manual/agency policy	1	
Foster Parent Manual/agency Policy	3	2/12/2015
Giving Medications Safely and Effectively	1	1/25/2011
Goal Setting	1	
Hair and Skin Care for African American and Biracial Children	2	2/12/2015
Helping Foster Youth Transition to Adulthood	3	
How the Point System Improves Behavior	4	
Impact of Substance Abuse on Foster Children	1	
Impact of Substance Abuse on Foster Children Disruptive Disorders	2	6/28/2011
Importance of Bonding	1	6/28/2011
Importance of Setting Goals	1	4/25/2012
Informational & Educational Training Program	1	6/28/2011
Managing Pediatric HIV/AIDS	1	
Mindfulness Meditation	3	3/17/2014

Nutrition, Health & Wellness	1	
Nutrition, Health & Wellness	1	
On Separation and Loss: A handbook for foster families	2	6/4/2014
Openness in adoption	4	7/26/2011
Pikes Peak Learning	1	4/14/2011
Post-partum Depression	1	10/5/2011
Presentation of Adoption Issues	4	
Prevent Child Abuse and Neglect	2	
Preventing Lying & Stealing Behavior	1	
Reiki	1	10/3/2011
Reporting Child Abuse and/or Neglect	3	12/6/2011
Review of Agency Policy	4	11/14/2013
SAFE Sleep for your baby	3	
Save the Children and the Children's Home Society of NJ present: The Journey of Hope	3	6/4/2014
Secondhand Smoke	1	
Sensible Discipline: A handbook for foster families strategies and techniques for foster families	3.5	6/4/2014
Sensible Discipline: Strategies & Techniques for Family Foster Care	1	
Setting Goals in 5 Areas of Life	1	8/3/2011
SHSP Training, Medically fragile children	4	4/12/2011
Stopping the Pain, Better Understanding of Self-harm behavior	1	
Stress Managing- Finding Couple Time, Staying Committed	3	
Talking to Your Child about Difficult Issues	3	3/17/2014
Teen Substance abuse, recognizing newer, not just traditional drugs	3	
Teens at a Crossroads	4	
The use of birth control	1	4/12/2011
Three S's to success	1	5/12/2011

Tools to prevent abuse allegations	1	
Universal Health Precautions	1	
Using Environment to Reach gross motor milestones	1	
What you need to know about bedwetting	1	
Why do kids throw tantrums?	1	
Women and the progression of addiction	3	
Women's Health and wellness dinner	1	4/26/2012
Encouraging Kids FRC		
Redirecting Children's Behavior	15	8/6/2014
The Explosive Child	6	8/6/2014

Children's Aid & Family Service Courses	Hours	Date Approved
Annual Pediatric Update 2013	2	3/14/2013
Answering Difficult Questions about a Child's History	2	
Autism Awareness	2	
Court Ordered Mediation	2	
Developing and Supporting Emotional Intelligence in Children	2	10/18/2012
Developmentally Appropriate Practice: How Children Learn Through Play	2	3/14/2013
DYFS Family Engagement Model	2 or 3	
Hair and Skin Car for Chilren of Color	2	2/16/2012
In Their Own Words	2	11/1/2011
Language Development: Supporting the Child with Speech Delays	2	
Learning Disabilities Part 1	2	
Leaving Home is hard to Do: Special Issues for Adoptive and Foster Families	3	
Making and Maintaining Birth Family Connections	2 or 3	
Pediatric Update	2	

Pediatric Update 2012	2	
Prenatal Exposure to Alcohol	2 or 3	
Preventing Substance Abuse in Our Youth	2	2/8/2012
Process from Placement to Permanency	2	12/6/2011
Sexuality and Our Children	2	2/8/2012
Skills Training for Toddlers, Session One	2 or 3	
Skills Training for Toddlers, Session Three	2	
Skills Training for Toddlers, Session Two	2 or 3	
Suicide Prevention	2	2/8/2012
Teaching Model of Discipline for School Age Children	2	
Telling Children Difficult Birth History	2	
The Adopted Child's Journey	2 or 3	

Harvest of Hope Courses	Hours	Date Approved
A Teenager is Living my Home	2	3/31/2014
Breathe, Relax, De-stress: Start the Year Right By Taking Care of Yourself	2	1/24/2014
Caring for the Caring- Obesity- Say Yes to Healthy Eating	2	4/10/2013
Life Books "Being Creative and Fun"	2	2/25/2014
Preparing your child for the best school year yet!	2	10/1/2013

Helping Hands	Hours	Date Approved
Children's Personal and Cultural Identity	3	10/19/2012
Understanding and Promoting Teen Development	3	10/19/2012
Working as a Professional Team Member	4	4/25/2012

SPAN Courses	Hours	Date Approved
Transition Teleconferences SPAN Structured Learning Experience	3	

Twin Oaks Courses	Hours	Date Approved
Advocating for the Educational Needs of Children in Foster Care	1	
Anger Outbursts	1	12/8/2011
Attachment and Foster Parenting	2	9/8/2011
Birth Family Visitation- Making it Work	1	
Bullying	1	3/14/2012
Confidentiality and Foster Parenting	1	1/24/2012
Documenting Medication Administration	1	11/19/2012
Educational Advocacy/Adjustment	1	8/20/2012
Foster Parents as Facilitators of Children's Moral Development	1	11/23/2011
Grief and Loss Within Foster Families	1	3/20/2012
Healthy Sleeping Habits	1	5/21/2012
Lying as a Problematic Behavior Displayed by Some Children in Foster Care	1	9/8/2011
Stealing	2	11/18/2011
Wetting and Soiling	2	3/21/2011

2015 APSR

Attachment B

Health Care Oversight and Coordination Plan Update

June 30, 2015

New Jersey Health Care Oversight and Coordination Plan for 2015 – 2019

The Department of Children and Families (DCF) Office of Clinical Services (OCS) is charged with providing support, guidance and leadership across DCF on child and family health related matters. DCF's commitment to child health has been operationalized though a strategic investment in child health resources grounded in the Department's child health values; leveraging existing relationships and developing new partnerships; and strengthening policy and practice.

In the spring of 2007, DCF issued the Coordinated Health Care Plan for Children in Out of Home Placement. DCF articulated child health values including: care is provided in a manner sensitive to the child; continuity of care; healthcare access; healthcare quality; integration of child health and well-being into case practice is essential; and partnership with the recognition that DCF cannot do this work alone.

This plan has directed the majority of the efforts during the past 7 years in building and maintaining a strong program to ensure the medical needs of children in foster care are identified and met. The outline developed in the plan has been accomplished and is being maintained and enhanced. It is anticipated that within the next two years, a revised/updated Coordinated Health Care Plan for Children in Out of Home Placement will be developed.

Child Health Program

In order to achieve the goal of providing strong coordination of children's health care needs and services on a local level, within the 46 DCP&P local offices, DCF partnered with the Rutgers University School of Nursing (formerly UMDNJ School of Nursing) Francois-Xavier Bagnoud Center (FXBC) to develop and implement a robust Child Health Program (CHP). The CHP relies on a Child Health Unit based model of care coordination. Each Local DCP&P Office includes a Child Health Unit (CHU), led by nurses charged with ensuring timely, quality health care for children in DCP&P custody. Each child in DCP&P out of home placement is assigned to a nurse for case management. The CHU model calls for one nurse health administrator per fifty children in out-of-home placement and one administrative support person per one hundred children in placement.

In close coordination with DCP&P management and casework staff, the primary focus of the CHP has been to ensure that core health indicators are achieved for all DCP&P children in out of home placement. The CHP goals and objectives are based on the healthcare recommendations of the American Academy of Pediatrics and the Child Welfare League of America for children and adolescents

in out-of-home care and include healthcare recommendations specific to children coming into care, such as a Comprehensive Medical Exam within 30 days, as well as preventative and ongoing healthcare that is recommended for the general pediatric population including: well child care; immunizations; and semiannual dental exams. The CHU staff are responsible for ensuring that health information is documented and shared as appropriate with the child's case worker, HMO care manager, resource family, and biological family.

In addition to coordinating the healthcare mentioned above, the CHUs engage in nursing interventions in collaboration with DCP&P around coordinating specialty care, monitoring medications for chronic health conditions and behavioral health needs, and providing education and guidance to resource providers on how to meet the needs of children in their care. Nurses are also active participants in treatment team meetings for those children living in congregate care settings or in treatment homes. Nurses are regularly asked to participate in Family Team Meetings. The capacity of the CHU allows DCP&P case workers to focus on safety and permanency while the CHU's provide support and guidance around child well-being.

Schedule for Initial and Follow-up Health Screenings that Meet Reasonable Standards of Medical Practice

The continuum of health care for children in out of home placement includes the following components:

Pre-placement Assessment (PPA) Every child entering placement for the first time in an episode must receive a PPA prior to placement or no later than 24 hours after placement. The purpose of the pre-placement evaluation is to:

- Ensure that the child is free of communicable disease
- Identify and address any immediate physical and mental health care needs
- Document the presence of any injuries or markings that are present
- Identify any non-urgent unmet health needs
- Provide necessary referrals for additional services
- Provide documentation of the child's current health status
- Identify the presence of any serious medical conditions that might require the caseworker to obtain a specialized foster placement for the child

This can be performed by CP&P CHU nurse in the Local Office; Child's Primary Physician; a community provider who has a PPA agreement with CP&P; and, **by exception only,** in the ER.

Child's Health and Medical Examination Record, known as the Medical or Health Passport In April, 2011 CP&P adopted use of the Health Passport and Placement Assessment. The form documents a child's health history and follows a child throughout placement. The form is updated to document new

health information while a child is in placement and the updated version is distributed to the resource parent or residential placement provider. It is utilized by the Division in making a safe placement decision and to alert the child's health care practitioner to the child's health history. The form is also provided to an adolescent who is exiting care at or beyond age 18. This form is completed by a Child Health Unit nurse at the request of the case manager. It is to be completed within 72 hours, and given to the resource parent within 5 days of placement. It is to be updated and delivered within the same time parameters to each new caregiver. Form is available on the CP&P SACWIS system, NJ SPIRIT. It is completed and updated on line as needed.

The following information is collected and reflected in the form: birth history, history of hospitalizations, injuries and/or illnesses, significant childhood diseases, developmental history, education classification, current counseling services, special transportation needs, family medical history, current health problems/illnesses/conditions, allergies, dental health, current medications, all medical providers, testing, summary, acuity level, care giver requirements, and health plan.

Comprehensive Medical Exam (CME) Within 30 days of a new placement episode, every child must have a comprehensive medical exam. As long as the criteria are met, this can be done by one of the CP&P partnered/contracted sites, including the Regional Diagnostic and Treatment Centers (RDTCs); or by the child's primary MD as an EPSTD new child well visit, which is the exam that meets criteria.
(Through a partnership with the Division of Medical Assistance and Health Services (DMAHS), the state Medicaid agency, contracted providers are entitled to receive an enhanced rate from Medicaid and are required to complete two forms, an Initial Report at the time of the visit, and the Final Report within 14 days. If a non-contracted primary MD is used, the Initial Form is given to the provider at the time of the visit, with a request it be completed and returned to CP&P as soon as possible.)

Mental Health Screening Every child entering placement is to receive a mental Health screening. CME's performed at a contracted site are required to utilize the Pediatric Symptoms Checklist. LO nurses may also utilize this tool. In all cases where it is recommended or need is indicated, child is to receive a Comprehensive Mental Health Exam as soon as possible. RDTC's, contracted CME Mental Health sites, or other community resources may be used for this purpose.

Dental Children in placement over the age of three are required to have a dental exam every 6 months; children under age 3 are to receive a dental screening as part of their EPSDT well child visits, according to periodicity schedule.

Immunizations Every child entering placement is to have an immunization status assessment. Any child who is not up to date with immunizations must have a plan for achieving up to date status developed.

EPSDT Children are required to have well child doctor visits in accordance with EPSDT periodicity schedule: 2 weeks, 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, then annually until age 18.

<u>Monitoring and Treating Health Needs Identified Through Screenings, Including Emotional Trauma Associated With a Child's Maltreatment and Removal from Home</u>

In NJ, the delivery model for Medicaid is Managed Care. Every Medicaid recipient, which includes all children in CP&P foster care, is enrolled in a Managed Care Organization. Through their contract with DMAHS, each HMO is required to provide care management for every child in CP&P foster care. The Child Health Unit (CHU) nurses have the prime responsibility for Health Care Case Management for children in foster care through CP&P. They work closely with the assigned HMO care manager to ensure that appropriate resources are identified and any barriers to service are addressed and resolved.

Each child who enters DCP&P out of home placement is assigned to a nurse for case management. The assigned nurse:

- Prepares a Health Passport with all (though often limited) available information within 72 hours and provides it to the resource (foster) parent within 5 days. A copy is shared with the child's HMO care manager.
- Visits the child and resource parent in the foster home within two weeks, and documents visit in NJ SPIRIT on a Pediatric Nursing Report (PNR).
- Assigns an acuity level to every child that enters foster care; there is a schedule of time frames for required visits based on this acuity level.
- Works with the CHU Staff Assistant to request/obtain medical records from previous providers, to schedule the child's CME within 30 days, and to send all available pertinent materials to the provider prior to the scheduled CME.
- Receives the report, including Findings and Recommendations, from the CME provider. A copy of the Findings and Recommendations section only of the report is shared with the resource family, the CP&P case manager, the HMO care manager, the child's PCP when identified. Information is also discussed with the biological family as appropriate.
- Continues to work closely with the resource family to follow up on all recommendations and ensure they are resolved.

Every six months a statistically valid random sample of all children in CP&P out-of-home placement is generated by DCF IT. Case reviews are conducted on all sample cases, and results to survey questions for each case are recorded on Survey Monkey. The Health Care Case Record Review is designed to assess the health care experience of children entering out-of-home placement. The components reviewed and measured are the number/percentage of children who:

- received follow-up care subsequent to CMEs;
- received a mental health screening;
- had a suspected mental health need and received a mental health assessment
- had identified follow-up care and treatment needs and received needed treatment and/or had appointments scheduled.; and
- had evidence of health information given to resource family in a timely fashion (i.e. the Health Passport Form);

Additionally, every six months the following measures are analyzed and reported:

- Children entering an initial placement episode who:
  --Received a PPA within the prescribed time frames.

  --Received a PPA in the ER, distinguishing between those that were justified, and that were not.

  --Received a CME within 30 days; within 60 days; greater than 60 days, with explanation for delay; not done, with explanation.
- EPSDT compliance children ages 12-24 months
- EPSDT compliance for children 25 months of age and above
- Immunization: number/percentage of children in foster care with up to date immunizations, and that do not, with evidence of a corrective action plan
- Dental: number/percentage of children in foster care with evidence in NJ SPIRIT of a semi-annual dental exam; with an annual dental exam.

Updating and Appropriately Sharing Medical Information

The Local Office Child Health Unit nurses are responsible for maintaining the health care record for every child in CP&P foster care. The Health Passport is maintained in NJ SPIRIT and updated any time there is a change – in location, provider, medication, other. Every time a passport is updated it is shared with the resource family and the Medicaid HMO care manager, as well as with the child's CP&P caseworker. Nurses also participate in Family Team Meetings to share information. When appropriate, the nurses work with the birth parent as part of CP&P Family Engagement and in anticipation of child's reunification with family. Nurse conducts a transition visit with the family when child is returned.

Ensuring Continuity of Health Care Services (Which May Include Establishing a medical home for every child in care)

Establishing a medical home for every child in placement is an on-going consideration within DCF and OCS. Various barriers have been identified for which resolutions have not yet been identified. However, efforts are made to provide for continuity of care to the extent possible.

- Primary Care Physician: when feasible, child's care continues to be provided by PCP prior to placement. Barriers: proximity of child's placement, logistical needs of the resource family, child's need for protection.
- HMO: when PCP needs to be changed, an effort is made to maintain child in same HMO, for continuity of care

- Services: identified services are continued as needed, through same provider whenever possible
- Communication: between and among CHU, CP&P case manager, HMO care manager, resource family, biological family.
- Health Passport: Maintained and updated. Resource families are encouraged to take passport to every medical visit for the child, for provider's information and to assist with continuity

Psychotropic Medication Policy and Mental Health Initiatives

Oversight of Prescription Medicines, Including Protocols for the Appropriate Use and Monitoring of Psychotropic Medications

DCF has developed a comprehensive policy concerning the prescribing, use and monitoring of psychotropic medication for DCF children who are in out of home placement and any child under DCP&P custody. Policy was formally adopted in January 2010 and revised in May 2011. DCF's goal has been to ensure the policy helps position the Department and its partners to promote good practice in the interest of better serving children and families. Key components of the policy include Psychotropic Medication Prescribing Parameters; Psychotropic Medication Monitoring Guidelines; Informed Consent; and Treatment Plan.

Policy Advisory Group on Psychotropic Medication continues to provide consultation and support to the Department around key implementation issues and to work with DCF to update prescribing parameters and medication monitoring guidelines on an ongoing basis. Recent activities regarding the Psychotropic Policy included seminars for DCP&P and Child Health Unit staff on the psychopharmacology and the role of medication in treatment; expansion of policy and prescribing parameters to include more medications, common off-label use, and to reflect the FDA black box warning and other warnings and precautions.

DCFs' Advisory Group on Psychotropic Medications will be providing direction, support and technical assistance as policy and prescribing parameters are revised I 2014-2015 to reflect the new DSM.

The Office of Child and Family Health has participated in CHCS's **Psychotropic Medication Quality Improvement Collaborative** to ensure psychotropic medication policy compliance and review the progress of individual children/youth as well as at-risk cohorts on psychotropic medications. Children in out of home placement, who are taking three or more psychotropic medications, are being monitored by the CHP and OCS.

Trackers CHU nurses maintain a tracker of all children in foster care on Psychotropic Medications including detailed info on each medication, the diagnosis for which it is prescribed, the presence of a

signed consent for each and verification of a treatment plan with interventions in addition to pharmacology. Children are tracked by age and number of prescribed psychotropic medications. Trackers are submitted to DCF OCS quarterly for quality review by Child and Adolescent Psychiatrist, and the Child Health Program APN for Child Behavioral Health. All children under age 6, and those on more than three medications are reviewed individually.

Training for workers to build their knowledge base on psychotropic medications and enhance their capacity to empower parents to ask appropriate questions regarding this topic, was developed by University Behavioral HealthCare (UBHC). This curriculum will be implemented in the training of CP&P and CSOC/CMO staff.

Engagement of Community Medical and non-Medical Professionals

Engagement With Physicians or Other Appropriate Medical or Non-medical Professionals in Assessing the Health and Well-being of Children in Foster Care and in Determining Appropriate Medical Treatment for the Children

In the 2007 Coordinated Health Care Plan for Children in Out of Home Placement, DCF made a philosophical commitment to leveraging existing health care resources and relationships as part of an overarching effort to meet the healthcare needs of children in foster care. DCF employs/contracts with an array of medical professionals who work actively across the organization on child health related matters, including:

Pediatricians: DCF contracts the services of pediatricians who, working through one of the RDTCs, are available to assist DCP&P by conducting medical chart reviews; strategizing with DCP&P Case Work staff and the Child Health Unit nurses on addressing care for children with particularly complex health issues; providing guidance around consenting for non-routine medical procedures; and serving as liaison between health care providers and DCP&P local offices to address emergent issues and concerns. Additionally they provide 24/7 phone access to CP&P field staff and the screening center.

Child/Adolescent Psychiatrist: works with CP&P field staff, CHU nurses, and DCF/CP&P leadership; provides leadership around quality assurance efforts in the area of psychotropic medication utilization; provides oversight of the DCP&P Mental Health Screening Program; works to maintain and strengthen DCF's psychotropic medication policy; provides guidance and training on the identification, evaluation, diagnosis and treatment of children and youth with mental health needs; conducts medical chart reviews; engages in dialogue with providers regarding specific children and the appropriate treatment plan; and provides guidance and support to DCP&P Local Office staff through case consultation on a day to day basis.

Pediatric Neuropsychologist: utilizes knowledge of learning, behavior and the association with the development of brain structures and systems in all aspects of work as the Pediatric Neuropsychologist Consultant; provides training about typical development and specific behavioral and psychological disorders such as ADHD, Autism Spectrum Disorder, and PTSD (These trainings are available to all LOs and occur on an on-going basis, as requested. An LO may also request a specific topic not on training menu but of interest to that particular LO, based on a case); engages in dialogue with educators and others regarding the treatment for specific children; conducts evaluations when appropriate; and supports DCP&P caseworkers with consultations on cases where clarification is needed about a child's behavioral or educational needs.

Regional Diagnostic and Treatment Centers (RDTC) receive funding from DCF for Child Abuse and Child Sexual Abuse, serve as legislatively mandated Centers of Excellence in this area, prepare reports and testify at court proceedings as necessary. These centers are also contracted to conduct Comprehensive Medical Exams (CME) and Comprehensive Mental Health Exams.

County based Multi-Disciplinary Treatment (MDT) teams: DCP&P staff, in addition to medical personnel from the State's RDTC and law enforcement, participate in MDT teams charged with reviewing individual children's cases and determining how to meet the child victim's needs.

DCF contracts with **health care sites to provide Comprehensive Medical Exams (CME)** for children in out-of-home placements. The CME medical practitioners provide DCP&P with a report identifying the child's medical history, current health issues and recommendations for follow-up treatment.

Policy Advisory Group on Psychotropic Medication, convened by DCF and co-chaired by the DCF's Child/Adolescent Psychiatrist and the Director of the DCF Children's System of Care to assist the Department with efforts around strengthening psychotropic policy and practices for children in the care of DCF. The Advisory Group is an inter-disciplinary group of experts (psychiatrists, other medical doctors, social workers, psychologists, Advanced Practice Nurses, and DCF professional staff). This group provides ongoing consultation and support to the Department around key implementation issues and works with DCF to update prescribing parameters and medication monitoring guidelines on an ongoing basis.

Contracted Psychologists: In November 2012 **Guidelines for Expert Evaluations: Child Welfare/Child Abuse and Neglect Forensic Assessments (Mental Health)**, the Department's first comprehensive effort to address the use of expert evaluations in child welfare and child protective services proceedings, was adopted as policy. The guidelines lay out best practices for forensic evaluations and assessments that may be needed during child welfare/child abuse/neglect investigations or to assist with permanency

planning, and are intended to improve the quality of expert forensic evaluations provided for DCP&P and the courts, as well as the ability of stakeholders involved in child welfare proceedings and child protective service matters to make better use of them. Following the release of the Guidelines, DCF issued a Request for Qualifications for Forensic Evaluation Services by Psychologists in December 2012 as a means of expanding our existing pool of psychologists who perform forensic (mental health) examinations. The RFQ was designed to not only increase the number of resources available to CP&P but also to improve upon the quality of psychologists by establishing some minimum standards those psychologists must meet. In July 2014, all agencies and/or individuals under contract with DCF to perform forensic evaluations attested to their compliance with the credentialing and training requirements set forth in the RFQ d and are required to demonstrate compliance with continuing education requirements every two years thereafter.

Ensuring Health Care Needs of Youth Aging out of Foster Care, Including the Requirements to Include Options for Health Insurance, Information about a Health Care Power of Attorney, Health Care Proxy, and to Provide the Child with the Option to Execute such a Document, Are Met

Effective September 2010, DCF enacted new policy and practice whereby youth aging out of foster care will receive additional instruction related to their health care needs. This policy requires that youth, as they approach their 18th birthday, are provided with instruction regarding the importance of selecting a health care proxy and are provided with the option to execute such a document, as well as information regarding health insurance and health related resources. The instruction takes place in coordination with development of youth-directed Transition Plans. This instruction augments other State efforts to build life skills competencies with youth as they age into adulthood. Tools developed to assist casework staff and Child Health Unit nurses include: a tri-fold pamphlet, medical proxy form, revised Transitional Plan for Adolescents, descriptive policy, and an updated health services section of DCF's Adolescent Services Guide. Ongoing tracking of the practice is done through supervisory review of the transitional and case plans.

CHU nurses engage with youth ages 18-20 with open CP&P cases who are receiving services, whether or not they are in placement. Nurse engagement includes an assessment of the young adult's ability to engage and navigate the health care system. The nurse provides the youth with ongoing health education and guidance to improve their ability to independently navigate the healthcare system once they leave the system of care.

The Office of Child and Family Health has administered the Medicaid Extension for Young Adults or MEYA, for 18-21 year olds since 2001, based on the Chafee Act. With the advent of the new Federal Health Care Law effective January 1, 2014, this program was collaboratively adjusted to provide for Medicaid for eligible former foster youth through age 26. The DCF OCS took the lead in designing the

program and developing the plan for implementation. Efforts involved a high level degree of cooperation with various units within the DHS Division of Medical Assistance and Health Services (NJ's single state agency for Medicaid), as well as the DCF Office of Information Technology, the DCF Office of Adolescent Services, and CP&P. This program subsumes the former "Chafee" eligible youth ages 18-21, and the entire program, for 18 to 26 year olds, is known in NJ as MEYA. As part of the project, informational materials were developed, and efforts to familiarize youth and entities serving these youth were begun.

The Child Health Units continue to train DCP&P staff on recognizing pediatric health "red flags", using the enhanced Pediatric Health and Red Flags Tool developed in 2012 and completed in 2014. The final section of the tool, specific to Adolescents and Young Adults, was accepted in April 2014, and a training module on the Adolescent tool began in the Summer of 2014.

Health Care Services Update

Engaging and Consulting Physicians and Medical Professionals

The Department of Children and Families' (DCF) Office of Clinical Services (OCS) is charged with providing support, guidance and leadership across DCF on child and family health related matters. A major focus of the OCS has been the implementation and monitoring of DCF's Coordinated Health Care Plan for Children in Out of Home Placement (2007). To support the implementation and expansion of the 2007 plan, OCS partners with internal and external stakeholders to improve practice and enhance service delivery to children. This includes partnering with physicians and other medical professionals.

DCF employs/contracts with an array of medical professionals who work actively across the organization on child health related matters, including:

- **DCF Pediatricians**: effective July 1, 2014, DCF changed from employing a full-time pediatrician, to serve as the CP&P Medical Director, to contracting the services of physicians employed by one of the state's Regional Diagnostic Treatment Centers (RDTCs)[1] to: assist DCP&P by conducting medical chart reviews; strategize with DCP&P Case Work staff and the Child Health Unit nurses on addressing care for children with particularly complex health issues; provide guidance around consenting for non-routine medical procedures; and serve as liaison between health care providers and DCP&P local offices to address emergent issues and concerns. Additionally, they provide 24/7 phone access to CP&P field staff and the Child Welfare screening center.
- **DCF Child/Adolescent Psychiatrists**: DCF contracts with one full-time and one part-time Child/Adolescent Psychiatrist who provide guidance and training on the identification, evaluation, diagnosis and treatment of children and youth with mental health needs: conducting medical chart reviews, engaging in dialogue with providers regarding specific children and their appropriate treatment plan, and providing guidance and support to DCP&P Local Office staff through case consultation on a day to day basis; providing leadership around quality assurance efforts in the area of psychotropic medication utilization and ongoing efforts to strengthen DCF's psychotropic medication policy and practice; and assisting in the development of the DCP&P Mental Health Screening Program.
- **DCF Pediatric Neuropsychologist:** DCF contracts with a full-time Pediatric Neuropsychologist Consultant. The work of the Pediatric Neuropsychologist includes providing leadership around learning, behavior and the association with the development of brain structures and systems through brief trainings within the Local DCP&P offices; engaging in dialogue with educators and others regarding the treatment for specific children; and supporting DCP&P caseworkers with consultations on cases where clarification is needed about a child's behavioral or educational needs.

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[1] **The State's four RDTCS are legislatively mandated to provide diagnostic and treatment services to children believed to be victims of physical abuse and neglect or sexual abuse. DYFS refers children it believes have suffered abuse or neglect to the RDTC for evaluation and treatment and DYFS utilizes RDTC reports as one component of its investigations into allegations of abuse and neglect.**

FFY 15: The OCS implemented systematic tracking of all requests for pediatric consultation. Previously, the consultation and case work activities of the Medical Director were not formally tracked or evaluated. Under the new pediatric consultation model and tracking system, the OCS is able to capture and evaluate data regarding volume and trends in medical issues for children served by DCP&P. The OCS intends to organize and analyze the data to identify unmet service needs, areas requiring policy development or revision, and training and technical assistance needs among case workers and Child Health Unit nurses. A similar tracking protocol will soon be implemented for psychiatric and psychological consultation.

Specific to the Neuropsychology Consultant, this partner engaged in the provision of clinical services as well as educational outreach for DCF. In terms of her clinical duties, the Neuropsychology Consultant provided neuropsychological consultation for children and family members involved with DCPP. Consults include record review, provision of feedback to DCF staff, attendance at treatment or school meetings, and neuropsychological evaluations as appropriate. The Neuropsychology Consultant was a member of the Interdisciplinary Team (I-Team), an intradepartmental group whose mission was to develop policies and provide input to care for children with significant developmental disabilities. In terms of educational support, the Neuropsychology Consultant provided educational seminars to DCP&P and Educational Stability staff in the areas of neuropsychological and psychological assessment as well as specific developmental disabilities such as Autistic Spectrum Disorder and Attention Deficit Hyperactivity Disorder.

Supporting Best Health Care Practices and Outcomes

DCF allocates State funds for services provided by New Jersey's four **Regional Diagnostic and Treatment Centers**. DCP&P staff, in addition to medical personnel from the State's RDTCs and law enforcement, participate in **county based Multi-Disciplinary Treatment (MDT) teams** charged with reviewing individual children's cases and determining how to meet the child victim's needs.

DCF's **Guidelines for Evaluations in Child Abuse/Neglect Proceedings**, the Department's first comprehensive effort to address the use of expert evaluations in child welfare and child protective services proceedings, were adopted as policy in November 2012. The guidelines lay out best practices for forensic evaluations and assessments that may be needed during child welfare/child abuse/neglect investigations or to assist with permanency planning, and are intended to improve the quality of expert forensic evaluations provided for DCP&P and the courts, as well as the ability of stakeholders involved in child welfare proceedings and child protective service matters to make better use of them.

Following the release of the Guidelines, DCF issued **a Request for Qualifications for Forensic Evaluation Services by Psychologists** in December 2012 as a means of expanding the existing pool of psychologists who perform forensic (mental health) examinations. The RFQ was designed to not only increase the number of resources available to CP&P but also to improve upon the quality of psychologists by establishing some minimum standards those psychologists must meet.

DCF contracts with various types of health care sites to provide **Comprehensive Medical Exams (CME)** for children in out-of-home placements. The CME creates a "snapshot" of a child's physical, behavioral, and developmental health. The CME medical practitioners provide DCP&P with a report identifying the child's medical history, current health issues and recommendations for follow-up treatment.

FFY 15: In September 2014 DCF announced the availability of $400,000 for the purpose of establishing a **Coordination Center for Child Abuse and Neglect Forensic Evaluation and Treatment** to assist the Department, its network of Regional Diagnostic Treatment Centers, and other providers conducting forensic evaluations and providing treatment recommendations for the Department with:

- Ensuring that NJ DCF's Division of Child Protection and Permanency (CP&P), and children and families have access to Centers of Excellence in the area of child abuse and neglect assessment and treatment within New Jersey;
- Supporting and disseminating best practices to improve the quality of child abuse and neglect assessment/evaluation and treatment;
- Training, coaching, and providing technical assistance to the forensic evaluation provider community;
- Advancing understanding and scholarship in the area of child abuse assessment; and,
- Assisting DCF with ongoing planning activities in the area of child abuse neglect evaluation and treatment.

The Coordination Center for Child Abuse and Neglect Forensic Evaluation and Treatment will review current models of practice across all RDTCs, partner with DCF and the RDTCs to define common measures to support outcomes, encourage consistent use of best practice and existing guidelines, identify recurring systems and practice issues and developing strategies to resolve them, and develop and implement a quality assurance and peer review process with the RDTC network and among providers of forensic mental health evaluations within the context of DCF's existing guidelines and best practice.

The OCS worked with the Office of Training and Professional Development to design and implement a day-long course for DCP&P case workers and supervisors to support implementation of DCF's **Guidelines for Evaluations in Child Abuse/Neglect Proceedings**. The training is intended to strengthen the understanding among CP&P staff about the role of forensic evaluations; when to use them; how to formulate good and appropriate evaluation questions; what information to provide to evaluators; and what to expect in terms of a deliverable.

In addition to enhanced training for DCP&P staff, all contracted forensic evaluators were required to submit an attestation to their DCF contract administrator by July of 2014 indicating their adherence to the guidelines requirements for initial training and supervision, continuing education, and licensure in good standing. The attestation will be required biennially moving forward to monitor CE and licensure status.

Health Care Services Plan

DCF's commitment to child health has been operationalized though a strategic investment in child health resources grounded in the Department's child health values; leveraging existing relationships and developing new partnerships; and strengthening policy and practice.

In the spring of 2007, DCF issued the Coordinated Health Care Plan for Children in Out of Home Placement. DCF articulated child health values including care is provided in a manner sensitive to the child; continuity of care; healthcare access; healthcare quality; integration of child health and well-being into case practice is essential; and partnership with the recognition that DCF cannot do this work alone. At the same time, DCF made a philosophical commitment to leveraging existing health care resources and relationships as part of an overarching effort to meet the healthcare needs of children in foster care.

The Coordinated Health Care Plan for Children in Out-of-Home Placement (2007) outlined DCF's commitment to build capacity to provide strong coordination of children's health care needs and services within the 46 DCP&P local offices. To accomplish the goals set forth in the plan, DCF partnered with the Francois-Xavier Bagnoud Center (FXBC) and the School of Nursing at the University of Medicine and Dentistry of New Jersey (UMDNJ) to implement a robust Child Health Program (CHP). The CHP relies on a Child Health Unit based model of care coordination. Each Local DCP&P Office includes a Child Health Unit (CHU), led by nurses charged with ensuring timely, quality health care for children in DCP&P custody. Each child in DCP&P out of home placement is assigned to a nurse for case management. The CHU model calls for one nurse health administrator per fifty children in out-of-home placement and one administrative support person per one hundred children in placement.

In close coordination with DCP&P management and casework staff, the primary focus of the CHP has been to ensure that core health indicators are achieved for all DCP&P children in out of home placement. The CHP goals and objectives are based on the healthcare recommendations of the American Academy of Pediatrics and the Child Welfare League of America for children and adolescents in out-of-home care and include healthcare specific to children coming into care, such as a Comprehensive Medical Exam within 30 days as well as preventative and ongoing healthcare that is

recommended for the general pediatric population including: well child care; immunizations; and semiannual dental exams. The CHU staff are responsible for ensuring that health information is documented and shared as appropriate with the child's case worker, resource family, and biological family.

In addition to coordinating the healthcare mentioned above, the CHUs engage in nursing interventions in collaboration with DCP&P around coordinating specialty care, monitoring medications for chronic health conditions and behavioral health needs, and providing education and guidance to resource providers on how to meet the needs of children in their care. Nurses are also active participants in treatment team meetings for those children living in congregate care settings or in treatment homes. Nurses are regularly asked to participate in Family Team Meetings. The capacity of the CHU allows DCP&P case workers to focus on safety and permanency while the CHU's provide support and guidance around child well-being.

FFY 15: Recognizing the strength of the CHUs, in October 2013 DCF expanded its nursing programs to address the needs of families in the 10 counties most impacted by Superstorm Sandy through the use of SSBG supplemental funding to establish the **Child and Family Nursing Program**. Understanding the need of families involved with the child welfare system, Rutgers was well- positioned to implement a Child and Family Nursing Team for families receiving in-home services. The aim of this initiative was to develop a team of nurses to assess family health needs, identify resources, coordinate care and empower caregivers within the family. The 10- county program will sunset with the end of the SSBG funding in September 2015, however DCF intends to refine the service model and pilot the program in selected counties after the SSBG program concludes, and to evaluate the effectiveness of the program in improving health outcomes for families and potentially reducing out of home placement.

Psychotropic Medication Policy

DCF has developed a comprehensive policy concerning the prescribing, use and monitoring of psychotropic medication for DCF children who are in out of home placement and any child under DCP&P custody that was formerly adopted in January 2010 and revised in May 2011. DCF's goal has been to ensure the policy helps position the Department and its partners to promote good practice in the interest of better serving children and families. Key components of the policy include Psychotropic Medication Prescribing Parameters; Psychotropic Medication Monitoring Guidelines; Informed Consent; and Treatment Plan.

DCF convened a **Policy Advisory Group on Psychotropic Medication**, chaired by the Director of the DCF Children's System of Care and the DCF's Child/Adolescent Psychiatrist to assist the Department with efforts around strengthening psychotropic policy and practices for children in the care of DCF. The Advisory Group is an inter-disciplinary group of experts (psychiatrists, other medical doctors, social workers, psychologists, Advanced Practice Nurses, and DCF professional staff). This group provides ongoing consultation and support to the Department around key implementation issues and works with DCF to update prescribing parameters and medication monitoring guidelines on an ongoing basis. The

work of this Advisory Group has included reviewing existing policy and making recommendations regarding the current prescribing parameters and participating in a psychotropic medication provider forum, to formally present the DCF policy on psychotropic medication prescribing parameters and medication monitoring guidelines to the various parties that provide services to children and youth in DCF's care.

New Jersey is one of the states chosen to participate in the **Psychotropic Medication Quality Improvement Collaborative (PMQIC)** through the Center for Health Care Strategies, Inc. The overall collaborative project aim was to reduce the inappropriate use of psychotropic medications among children in foster care. New Jersey's goals included improving compliance with components of the New Jersey Psychotropic Medication Policy, developing a quality assurance tool to assess the progress of individual children and youth who are taking psychotropic medications, developing a process for on-going quality assurance reviews of at-risk cohorts of children on psychotropic medication, increasing capacity in NJ SPIRIT to capture additional information regarding psychotropic medications, utilization and policy compliance, and working toward a strategy to crosswalk data between child health units and children's system of care.

FFY 15: The Office of Clinical Services continued to participate in CHCS's Psychotropic Medication Quality Improvement Collaborative to ensure psychotropic medication policy compliance and review the progress of individual children/youth as well as at-risk cohorts on psychotropic medications. Over the course of the year 2013 – 2014 the rates of policy compliance were consistently high (average 87.75% had treatment plans, 88.6% had consents for medication). The quality assurance tool, which highlights the health and well-being of children on psychotropic medications, was folded into the "Red Flags Tool" and training was provided. A process for regular review of higher risk cohorts of children on psychotropic medications (children under 6 years old, children on more than 3 medications concurrently) was developed and implemented. This was also supported by a "Psychotropic Medication Update" training series provided to all of the Child Health Unit nurses in Spring 2014 to enhance their ability to provide health care case management for children with mental health need. The ability to track behavioral health need and treatments, including psychotropic medications, on a medical screen in NJ SPIRIT was finalized during this period.

In addition to the Psychopharmacology Updates provided to the Child Health Units in the early 2014, the New Jersey Psychotropic Medication Policy and its implementation and monitoring were the focus of a presentation to the Mental Health Association of New Jersey in December 2013, a call on New Jersey's Efforts for Safe and Appropriate Psychotropic Medication Use with Foster Children, presentation to Rutgers University Graduate School of Applied Professional Psychology regarding psychiatric diagnosis and treatment foster children, and a symposium at the Georgetown Institutes in July 2014 on

"Strategies for Using Medicaid and Monitoring Psychotropic Medications: Improving Services for Children in Child Welfare."

DCP&P Mental Health Screening Program

In August 2011, DCF implemented the DCP&P Mental Health Screening Program to assist with identification of children with a suspected mental health need. DCF intent is to strengthen the capacity among frontline staff to recognize children with a suspected mental health need. For children in out of home care, DCF utilizes three avenues of mental health screening to facilitate targeted mental health assessments at the time that children and youth are experiencing symptoms. DCP&P Case Workers, CHU nurses, and CME providers each play a role in the mental health screening program.

DCF's robust mental health screening program offers the benefit of not relying on a point in time evaluation and will help ensure that children identified as having a suspected mental health need throughout their time in placement receive an appropriate assessment and follow up. Children who are currently receiving mental or behavioral health services are not candidates for the screening tools. In addition, children entering placement with mental health histories (not currently in treatment); children with a history of physical and sexual abuse (not currently in treatment); children whose primary caretaker has a history of mental illness; children with a history of multiple changes in placement; and, children with a history of running away from placements are referred directly for a mental health evaluation.

- Child Health Unit Nurses. The Child Health Program is administering a mental health screening tool as part of their initial health assessment for children (age 2 years and up) who are in out of home placement as they are opened for health care case management and periodically after that. The Bright Futures Pediatric Symptom Checklist (PSC, Y-PSC) is a psychosocial screening tool designed to facilitate the recognition of cognitive, emotional and behavioral problems. The PSC obtains the parent's report of the child's behavioral/emotional problems, and the Y-PSC obtains the child's/adolescent's report of their own behavioral/emotional problems. The screening tool helps ensure that appropriate mental health intervention is initiated for a child as early as possible.
- DCP&P: Case Workers. Under leadership and direction of DCF's Child/Adolescent Psychiatrist, DCF has identified, adapted and piloted a Mental Health Screening Tool (MHST) that is now used by DCP&P caseworkers to engage in mental health screening of children on their caseloads as indicated. The NJ MHST is an observational tool and will be completed by the DCP&P caseworker. Curriculum was drafted in 2010 and staff training was implemented in August of 2011. The screening tool is expressly not a mental health assessment tool, but an instrument to help identify children who have a greater need for assessment. Children who fit within certain criteria (i.e. family history of mental illness) continue to be referred directly for a mental health

assessment. The Mental Health Screening Tool Training continues to be provided to DCP&P staff.

- Comprehensive Medical Exam Providers: As part of DCF's Comprehensive Medical Exam program for children in DCP&P out of home placement, providers are required to conduct a mental health screen on children as part of the exam.

Following screening, a referral for Mental Health assessment is completed on any child who presents with a mental health need.

Adolescents and Health Care

Effective September 2010, DCF enacted new policy and practice whereby youth aging out of foster care will receive additional instruction related to their health care needs. This policy requires that youth, as they approach their 18th birthday, are provided with instruction regarding the importance of selecting a health care proxy and are provided with the option to execute such a document, as well as information regarding health insurance and health related resources. The instruction takes place in coordination with development of youth-directed Transition Plans. This instruction augments other State efforts to build life skills competencies with youth as they age into adulthood. Tools developed to assist casework staff and Child Health Unit nurses include: a tri-fold pamphlet, medical proxy form, revised Transitional Plan for Adolescents, descriptive policy, and an updated health services section of DCF's Adolescent Services Guide. Ongoing tracking of the practice is done through supervisory review of the transitional and case plans.

In July 2011, the Child Health Unit began tracking engagement with young adults ages 18 -20. Nurse engagement includes an assessment of the young adult's ability to engage and navigate the health care system. The nurse provides the youth with ongoing health education and guidance to improve their ability to independently navigate the healthcare system once they leave the system of care.

FFY 15: In anticipation of the New Federal Health Care Law on January 1, 2014, and the responsibility for administering the requirement of extending Medicaid for eligible former foster youth to age 26, the OCS took the lead in designing the program and developing the plan for implementation. Efforts involved a high level degree of cooperation with various units within the DHS Division of Medical Assistance and Health Services (NJ's single state agency for Medicaid), as well as the DCF Office of Information Technology, the DCF Office of Adolescent Services, and CP&P. In March 2014, the OCS partnered with DCF OIT and DMAHS to auto-enroll all 18-21 year old consumers with an open DCPP placement or Medicaid-eligible support line in the **Medicaid Expansion for Young Adults, or MEYA** program. Each month the OCS authorizes the use of a "birthday batch" to convert any youth turning 18 or 21 with open

DCPP placement Medicaid to MEYA Medicaid extending coverage to age 26. OCS staff market the program through youth forums, website, and flyers, and educate service providers to outreach children who were not active in March 2014 but may still be eligible. OCS staff also work with partners to stay informed and educate on other available resources for young adults who are not eligible for MEYA. Through these coordinated efforts, the state has achieved 99% compliance with ensuring youth aging out of the Child Welfare system have access to medical coverage.

The Child Health Units continue to train DCP&P staff on recognizing pediatric health "red flags", using the enhanced **Pediatric Health and Red Flags Tool** developed in 2012 and completed in 2014. The final section of the tool, specific to Adolescents and Young Adults, was accepted in April 2014, and a training module on the Adolescent tool began in the Summer of 2014.

2015 APSR

Attachment C

Disaster Plan Update

June 30, 2015

Department of Children and Families (DCF)

DISASTER PREPAREDNESS PLAN

2015

January 2015

State of New Jersey

Office of Emergency Management

Department of Children and Families

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During the past Federal Fiscal Year as well as calendar year 2014, the state of New Jersey was not affected by a disaster. The following represents the DCF Disaster Preparedness Plan which emphasizes a comprehensive collaborative response following critical events or disaster.

Section 1.

Introductory Materials

Statement of Approval

The all hazards Department of Children and Families' (DCF) Disaster Preparedness Plan for the State of New Jersey is approved by the Office of the Chief of Staff DCF and by the Office of the Commissioner DCF.

This plan supersedes any prior emergency response plans.

___________________________________ _________________

Chief of Staff DCF Date

____________________________________ _________________

Commissioner DCF Date

Record of Distribution (Internal)

The All Hazards Department of Children and Families' (DCF) Disaster Preparedness Plan for the State of New Jersey will be distributed internally to all DCF Executive and Senior Managers as follows:

_______ The Commissioner,

_______ The Chief of Staff,

_______ The Deputy Commissioner,

_______ The Assistant Commissioner, Performance Management and Accountability,

_______ The Assistant Commissioner, Legal Regulatory and Legislative Affairs

_______ The Director of Administration,

_______ The Assistant Commissioner, Child Protection and Permanency,

_______ The Assistant Commissioner Family & Community Partnerships and the Division on Women

_______ The Director, Communications and Public Affairs,

_______ The Director, Children's System of Care,

_______ The Director, Office of Adolescent Services,

______ The Chief Administrator,

______ The Director, Office of Information Technology,

______ The Director, Office of Emergency Management,

______ The Administrator, State Central Registry,

______ The Director, Clinical Services

______ The Director, Strategic Development

Record of Distribution (External)

The All Hazards Department of Children and Families' (DCF) Disaster Preparedness Plan for the State of New Jersey will be distributed externally to the following persons/agencies:

_______ Office of the Commissioner, NJ Department of Human Services (DHS)

_______ Office of the Asst. Commissioner, NJDHS-Division of Mental Health Services (DMHS)

_______ Office of Facilities Management, NJDHS

_______ NJ Office of Emergency Management (NJOEM)

_______ NJ Office of Homeland Security & Preparedness (OHSP)

_______ NJDHS-DMHS Director, Disaster and Terrorism Branch

_______ Other Public and Private Emergency Response Organizations

_______ American Red Cross

_______ Salvation Army

_______ United Way

_______ ACF Region II

Record of Changes

The following table will record all changes to the All Hazards Department of Children and Families' Disaster Preparedness Plan after approval. These changes will be incorporated into the next revision of this plan.

Changes Made By:	**Page number**	**Date**
DCF OEM	Addition of COOP plan annex	January 2012
DCF OEM	9	6/5/08
DCF OEM Asst. Director	4,5	4/7/09
DCF OEM Asst. Director	1,8,9,11,14, 17, 18,19, 22,24,25,26, 27,28	4/13,14,15,16/ 09.1/2012
DCF OEM Asst. Director	1,2,8,11,15,24,25, 28	8/2/2012
DCF OEM	10,15,16,26	7/24/13
DCF OEM	7,11,20,21,27	2/7/14
DCF OEM	20, 25, 26	5/16/2014

Section 2.

Executive Summary

The Department of Children and Families (DCF) was established by legislation July 1, 2006. The DCF maintains approximately 78 work sites around the state.

As of December 2014, DCF served 90,724 children.

The need for formal planning and practice in anticipation of possible critical events in a system this size is apparent. Evacuation centers, transportation, education, staffing, and medical care are all services which would be required post-crisis. The need to practice drills for potential emergencies is necessary. In addition, post Hurricanes Katrina and Sandy, comprehensive emergency preparedness plans are necessary to ensure the safety and protection of the children, youth, women and families we serve.

The DCF Disaster Preparedness Plan, (DPP) based on the National Response Framework model, emphasizes a comprehensive collaborative response following a disaster. The plan will include the coordination and on-going provision of all DCF services and continuity of business operations. The DCF Office of Emergency Management has initiated and established connections with the NJ Office of Homeland Security & Preparedness (OHS&P), NJOEM, DOH, DMHS and DHS to ensure coordination.

The process for revising this plan will involve entities from all DCF components. Utilizing the National Incident Management System (NIMS) and Incident Command System (ICS) an all hazards approach, the plan will require the integration of the following 4 critical elements – (1) planning and preparedness, (2) mitigation, (3) response and (4) recovery.

Further planning efforts will be coordinated with state, county and local emergency management entities. Essential functions and notification and activation procedures will be identified. Activation of this plan may be for a localized event (one jurisdiction), regional (multiple-counties) or statewide catastrophic disaster.

The disaster plan and more specifically, the DCF Continuity of Operations Plan (COOP) will clearly delineate the delegations of authority, order of succession and the assignment of responsibility in the

event of an emergency. The COOP identifies the essential functions of the DCF as well as the essential employees who will sustain those functions thus ensuring adherence to planned activities in a coordinated manner to minimize disruption of operations. As a part of plan implementation, all DCF entities will participate in on-going training, drills and exercises.

This plan is intended to be a fluid, ever-changing document subject to annual review and revision based on identified areas requiring improvement. The DCF Office of Emergency Management will coordinate updates and maintenance of the plan and documents.

Section 3.

Mission Statement

It is the mission of the Department of Children and Families to, in partnership with New Jersey's communities, ensure the safety, well-being, and success of New Jersey's children and families. Through a holistic system of care, DCF seeks to ensure a better today and even a greater tomorrow for every individual we serve.

The mission of the Department of Children & Families Disaster Preparedness, Response and Recovery Plan is to ensure the resilience of that holistic system by providing a framework for organizational response to emergencies encompassing all hazards. By providing for an organized, efficient response to all conceivable hazards, the plan allows us to confidentially serve New Jersey's children, youth, women and families.

The goals of the plan are as follows:

- To provide structure to the efforts of DCF's varied components—including the Children's System of Care (CSOC), Family and Community Partnerships, Division on Women, Office of Adolescent Services, Performance Management and Accountability, Office of Education, the State Central Registry,, Child Protection and Permanency, The Office of Training and Professional Development, the Institutional Abuse Investigation Unit and the Office of Licensing—as they work towards a comprehensive model of business continuity.
- To utilize the Incident Command System and be National Incident Management System (NIMS) compliant.
- To support the continuous and uninterrupted provision of child protective services, child behavioral health services, services to child and youth with developmental disabilities, support

and services to homeless youth, and services to survivors of sexual assault and domestic violence, including shelters.

- To ensure continuity of operations for children and families and those that will need supports as a result of an emergency situation.
- To define DCF's role as an NJOEM identified support agency to NJDHS in their role as the state coordinating agency for ESF #6.[2]

[2] Emergency Support Functions (ESFs) are primary mechanisms at the operational level used to organize and provide assistance. (ESF) #6 – Mass Care, Emergency Assistance, Housing, and Human Services coordinates the delivery of mass care, emergency assistance, housing, and human services when local response and recovery needs exceed their capabilities

Section 4.

Purposes

- Enhance emergency management functions, responsibilities, policy and guidance.
- Support the actions of NJDHS regarding coordination of ESF#6 activities as requested.
- Ensure DCF business continuity and coordination with NJ Office of Homeland Security and Preparedness and NJ Office of Emergency Management.
- Provide immediate systematic and coordinated response and subsequent recovery from any unplanned interruption impacting normal standard operating procedures.
- Document strategies, resources and procedures that will be utilized to respond to any interruption of operations.
- Reduce possible impact of emergencies on business continuity/continuity of operations.
- Define assumptions and policies.
- Facilitate cooperative relationships for emergency response at the state, county and local level.
- Ensure the safety, well-being and success of children, youth, families and communities within established NJ OEM protocols, executive orders and state plans.
- Establish an interoperable communications system. Facilitate communication with DCF staff, Providers and families.
- Protect records and information systems.

Section 5.

Assumptions

The following planning assumptions can be made for DCF emergency response in a disaster -

- As directed in State of NJ Executive Order #5 (Governor Jon S. Corzine) DCF is required to cooperate with the Office of Homeland Security and Preparedness in response to any incident/disaster.
- As dictated in State of NJ Executive Order #50 (Acting Governor Richard J. Codey) all DCF senior staff and other staff members with emergency response responsibility shall have completed the NIMS Awareness Course: National Incident Management System (NIMS), An Introduction.
- DCF will act as a support agency to NJDHS regarding coordination of ESF#6 as requested.
- This plan is to be used to provide direction to the DCF response statewide, regionally or locally depending upon the scope and location of the incident/disaster.
- Incidents are typically managed at the lowest possible geographic, organizational and jurisdictional level.
- Each DCF worksite location shall have a completed site evacuation plan.
- Each DCF functional component shall have a designated order of succession.
- The plan supports the ongoing 24 hour operation of the State Centralized Registry (SCR) and call center. (1-877-NJABUSE)
- The plan supports the ongoing off hour's operation of the DCF Special Response Unit (SPRU) system.
- The plan supports the ongoing 24 hour operation of the State Domestic Violence hotline system.
- The plan supports the emergency provision of education services to all students of the DCF Office of Education.
- Documentation of the occurrence of an incident with the potential to disrupt or impact the functional operation of a DCF component will be completed.
- Emergency notification of implementation of a response to an incident/disaster will be provided.
- Preservation of essential case management records will be provided through the NJ SPIRIT system.
- Provision of emergency mental health services as required and requested as delineated in the Children's System of Care. (needs expansion here)
- The plan supports the ongoing operation of all DCF Administrative, Area and Local offices which remain safe, accessible and operational The plan provides for the use of all DCF facilities State owned and leased, on a flexible and extended hours of operation

- The plan provides for the use of flexible and extended work hours, including staggered shifts and alternate worksites,
- Agencies contracted, funded by and/or licensed by DCF are valuable partners.
- Volunteer organizations such as the American Red Cross, the Salvation Army and other agencies are valuable partners in the event of a disaster.

Section 6.

Disaster Definitions and Hazard Categories

Disaster Definition (FEDERAL)

An occurrence of such severity and magnitude that normally results in deaths, injuries and property damage and that cannot be managed through the routine procedures and resources of government. It requires immediate, coordinated, and effective response by multiple government and private sector organizations to meet human needs and speed recovery. (Federal Emergency Management Agency)

Any hurricane, tornado, storm, flood, high water, wind-driven water, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, drought, fire, explosion, or other catastrophe, natural or man-made, in any part of the United States that, in the determination of the President, causes a large-scale community incident and damage of sufficient severity and magnitude to warrant (under the Stafford Act)2 major disaster assistance, above and beyond emergency services by the Federal government, to supplement the efforts and resources of States, local governments and disaster relief organizations.

Disasters (hazards) can be categorized as natural, accidental, and manmade. Natural disasters can include hurricanes, floods, and tornadoes, certain categories of fires, earthquakes, and severe storms. Accidental disasters can include chemical spills, gas explosions, airplane crashes, automobile or boating accidents. Manmade disasters can include war, assault, sabotage, hostage situations, arson, murder and acts of terrorism that can be chemical, biological, nuclear/radiological, explosive, cyber, and may occur concurrently.

Although community incidents may be insufficient in scope or magnitude to activate a presidential declaration, they may still impact the affected community. A community incident damages the bonds linking people together and impairs the prevailing sense of community. This type of event strikes at the vulnerabilities of people who are going about their normal routines. An example of a community incident, that does not trigger a disaster declaration, could be a shooting in a public facility.

Disaster Definition (STATE)

The State of New Jersey defines a disaster as a community incident in New Jersey that in the determination of the Governor causes damage of sufficient severity and magnitude, to warrant activation of the State Emergency Operations Plan.

An event is considered traumatic if it is so stressful to many of those affected that, if the crisis was left unresolved, ongoing psychological disturbance would impair emotional, social, physical or vocational functioning.

The crisis is caused by the stresses of either a natural, accidental or manmade emergency/disaster the scope, nature and unexpectedness of which overwhelms normal defenses, social supports and sense of security.

2. The Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act) is a United States federal law designed to bring an orderly and systemic means of federal natural disaster assistance for state and local governments in carrying out their responsibilities to aid citizens. It created the system in place today by which a presidential disaster declaration of an emergency triggers financial and physical assistance through the Federal Emergency Management Agency (FEMA). The Act gives FEMA the responsibility for coordinating government-wide relief efforts.

To reduce the effect of emergency/disaster related stress on individuals, appropriate anticipatory guidance and crisis counseling must be provided as soon as possible following the event. Crisis counseling services should also be coordinated with the services of the first line public and private agencies responsible for the health and safety of New Jersey's citizens.

Additional Hazard-Specific Categories:

All of the following categories would be assessed in light of specific events of medium or high probability in the state. These events would vary from region to region –

- Air transportation incidents and serious transportation accidents
- Civil Disturbances/Contractual Disputes
- Coastal hazards
- Communicable Disease Outbreaks/Epidemics
- Drought
- Earthquake
- Fires and Explosions (structural, wildfires)
- Floods and flash floods (coastal inland)
- Forest fires and wildfires
- Hailstorms
- Hurricanes and Nor Easters
- Hazardous materials (any release of)
- Heat waves

- Nuclear power plant incidents
- Operational issues including government shutdown
- Technological Emergencies/Manmade accidents
- Terrorism
- Tornadoes and severe thunderstorms
- Unexpected utility failures
- Winter storms
- Structural collapses
- Active Shooter
- Bomb Threats

Categories of need would be examined in light of less probable but potentially more catastrophic events, such as the effects of bioterrorism or nuclear attack.

Terrorism:

Terrorism is the unlawful use of force or violence against people or property to intimidate a government or civilian population in the furthering of political or social objectives. The State of NJ is vulnerable to the effects of terrorist events in the form of chemical, biological, nuclear or cyber attack, weapons and firearms, fusion, weapons of mass destruction and animal disease. Potential targets include schools, shopping centers, healthcare facilities, airports, nuclear power plants, transportation infrastructure, metro chemicals, pharmaceuticals and major public events of various venues. Intentional contamination is also a factor via intentional contamination of agriculture and livestock by Foreign Animal Diseases (FAD's) The NJ Office of Emergency Management (NJ OEM) has noted potential terrorist targets in the State Emergency Operations Plan. The NJ OEM has also identified potential areas for the release of hazardous materials and biological agents. The priority of securing the safety of the children and families we serve will be inherent in protecting our critical infrastructure, key resources and assets. This will be accomplished by the establishment and maintenance of effective communication and coordination between DCF and the various state and private partners with the goal of a reduction in vulnerability and rapid recovery from a disaster. DCF/OEM will follow all command protocols and procedures designated by the NJ OEM in the event of a terrorist event.

<u>Section 7.</u>

DCF Organization and Operations

The Department of Children and Families (DCF) was created by legislation in July 2006 as the primary state Department for the provision and oversight of services to children and families, including child protection and permanency services, abuse and neglect prevention and strengthening family programs, child behavioral health and developmental disability services, services to displaced homemakers and survivors of domestic violence and sexual assault, and the licensing of child care centers, youth residential programs, partial care programs and adoption agencies. The Department is staffed by more than 6,000 employees, and provides services to nearly 100,000 child and adult clients each month.

DCF is composed of four Divisions—The Division of Child Protection and Permanency (CP&P), the Division of Children's System of Care (CSOC), The Division of Family and Community Partnerships (FCP), the Division on Women (DOW)—and many non-division administrative offices with oversight for areas such as Administration and Management, Information Technology, Adolescent Services, Legal and Legislative Affairs, Advocacy, Training and Professional Development, Communications and Licensing.

DCF maintains a 24 hour a day call center the State Centralized Registry (SCR) for the reporting of allegations of child abuse and neglect and contracts, licenses and/or funds a variety of child placement and child and family support services through many private agencies within this state and others.

Section 8.

Essential Services and Priorities During a Disaster

DCF's primary focus in the event of any declared disaster will be the preservation of capability to respond to emergency situations (i.e. allegations of ongoing child abuse or neglect) and the continuation of services to clients, with a primary focus on children in out of home placement and children or adults requiring essential services to ensure to safeguard their life, well-being or safety.

During a declared disaster, DCF will focus on the continuation of the following operations and services:

1. Child Protection response, including operation of the 24 hour State Central Registry Hotline for the reporting of child abuse and neglect allegations
2. Operation of the Domestic Violence Hotline
3. Monitoring of and support to children placed by CP&P in resources homes or residential placement settings or treatment programs, including worker visits to these placement settings
4. The uninterrupted provision of behavioral health and developmental disability services to CSOC clients.
5. The continuous operation of domestic violence shelters and other shelter facilities operated or licensed by DCF or a contracted provider
6. The evacuation or relocation of any facility or home providing care or support to DCF clients
7. Provision of services to homeless youth and youth at risk of homelessness
8. Preservation of communications systems to ensure ready communication between providers, parents, children and DCF officials.
9. Preservation of IT infrastructure and systems of record, and confidentiality of the same.

Child protection and permanency services necessitated by or otherwise arising from the occurrence of a declared disaster will be the responsibility of CP&P. This responsibility will be met by working cooperatively with the NJ Office of Emergency Management, the NJ Office of Homeland Security and other State departments, Divisions, Bureaus and offices. It will also be carried out in cooperation with and assisted by a variety of county and local offices of emergency response and many private and volunteer human services and emergency response agencies. DCF is identified as a support agency to NJDHS regarding the coordination of ESF#6 if necessary.

Coordination with other state and federal entities will be undertaken by the DCF Office of Emergency Management.

Section 9.

Phases of DCF Disaster Planning and Response

DCF's disaster response can be broken into three distinct phases:

1. The Planning and Preparedness Phase, which will include identification of essential functions, assessment, plan development and participation in exercises and drills.

2. The Response and Mobilization Phase, which will involve activation of the DCF emergency notification protocol as well as briefing, assignment and deployment of staff. Responses may involve:
    - the provision of assistance to local emergency response entities, support of agencies contracted to or licensed by DCF
    - accessing disaster mental health services
    - coordination of the movement of children
    - re-deployment of staff,
    - utilization of alternate work and/or expansion of work hours
    - utilization of residential facilities

3. The Recovery Phase, which will initiate upon DCF's return to normal operations. Continued access to disaster mental health services or a move to provision of long term crisis counseling may be required. An evaluation of planning, preparedness and response activities will be completed during this phase of the process.

Planning and Preparedness Phase

The planning and preparedness phase is critical to ensure the capability exists to continue essential functions and operations across a variety of potential emergencies or disasters. DCF OEM is responsible to assist in the development of unit or office specific plans to include – evaluation, compilation, technical assistance, and approval. These plans will be incorporated into the DCF overall plan. Preparedness objectives are as follows:

- Continued performance of essential functions and operations.
- The protection of individual and facility records and IT systems/information.

- Minimize operational disruption.
- Minimize the damage and loss of resources.
- Mitigate the effects of the emergency.
- Minimize the crisis response time.
- Efficient plan activation and continuity of operations.

The preparedness phase encompasses the time frame before a disaster and such preparedness will start as early as notifications are received. Preparedness activities include:

- Plan development.
- Identification of alternate work sites.
- Establishment of designations of authority and orders of succession.
- Establish interoperable communications.
- Identify and designate emergency relocation personnel.
- Ensure on-going staff training in disaster preparedness.
- Develop and update resource inventory and directory.
- Comprehensive review of plan with all staff
- Annual update and revisions of the plan.
- Educate all staff as to the need for personal preparedness.
- Establishment of memorandums of understanding and mutual aid agreements.
- Participation in trainings, exercises, drills, testing of plans.
- Communications preparedness messaging (Portal, DCF Emergency Hotline)

Mitigation actions reduce or eliminate long-term risk to DCF staff, children, families, facilities and environment from all hazards with a goal of maximized disaster resistance. DCF OEM will take proactive measures to identify, develop, implement and evaluate strategies to reduce Department wide vulnerability to all hazards by organizing resources, assessing risks, developing a mitigation plan, implementing the plan and monitoring progress.

Response and Mobilization Phase

Response actions will be taken immediately before, during or after an emergency occurs to ensure effective maintenance of essential functions. Specific response activities based upon the function referenced will be identified as part of a unit, facility, office or agency specific disaster response plan as well as those activities identified for the DCF in its overall disaster response plan. DCF activities will be delineated in the Organization and Assignment of Responsibility portion of this plan. Actions to be taken by entities participating in the DCF response will be delineated in plans developed by those entities, some of which may be appended to this plan.

Response activities include:

- Development of an Action Plan outlining the flow of activation and how the Department would continue to operate.
- Notification and activation.
- Confirm or establish communication capabilities and test communication links.
- Assessment of workforce and workplace availability.
- Manage and/or coordinate the response.
- Manage Emergency Support Function #6 support agency responsibility.
- Deployment of personnel.
- Initiation of alternate facility process, as needed.
- Deploy transportation resources, as needed.
- Implement internal/external communications protocol.
- Evaluate performance and back up of IT systems.
- Documentation of response actions taken.
- Document response costs. Document for Federal reimbursement (include picture documentation)
- Implement public information protocol.
- Implement staff support protocols.

Recovery Phase

Integration of response and recovery activity is the desired state of affairs as recovery from an event begins. Implementation of a comprehensive disaster recovery and business resumption strategy will initiate a return to minimum operating standards. Additional activities will be identified which can hasten return to normal and encourage improved levels of operations. Establishment of short and long term recovery goals and objectives must be accomplished.

Short-term recovery goals may include:

- Continue provision of essential services to all affected.
- Establish priorities for reinstatement of various systems and operations.
- Establish timeframes for acceptable reinstatement of system and operational levels.
- Identification of resources necessary to restore operations.

- Continue established communication and staff support protocols.
- Application for Federal assistance via Federal grants.

Long-term recovery goals may include:

- Strategic planning and mitigation including how we change our processes.
- Management and coordination of recovery activities.
- Assess response and recovery costs.
- Develop and implement mitigation goals/activities.
- Debrief and capture lessons learned.
- Staff recognition.
- Build new system with improved response and strengthened infrastructure.

<u>Section 10.</u>

Organization and Assignment of Responsibilities

Administration

The DCF table of organization reflects a direct reporting relationship between the Office of the Commissioner and the following components; the Office of the Chief of Staff, Deputy Commissioner, Assistant Commissioner Performance Management and Accountability, Adolescent Services, Assistant Commissioner, Child Protection and Permanency, Children's System of Care, Assistant Commissioner Family and Community Partnerships, Division on Women. In the event of an emergency requiring activation of the State EOC, this leadership team will organize and respond from the Commissioner's conference room on the 4th floor 20 West State Street or via conference call. Unless specifically called to the State EOC, the Commissioner will lead efforts to maintain essential functions of the DCF and will be provided ongoing information relative to response efforts and any NJOEM requirements of the DCF. Information will be provided by the DCF/OEM personnel assigned to the State EOC.

Residential Services

Agency Providers: Disaster preparedness, response and recovery for agency operated residential programs licensed, contracted and/or funded by DCF will be provided as outlined in the agency wide emergency response plan and agency site specific emergency response plans in cooperation with the DCF and county and local emergency response entities as per contract requirements.

Resource Family Homes: Disaster preparedness, response and recovery for DCF Resource Family Homes will be provided in accordance with the DCF Manual of Requirements for Resource Family Parents in cooperation with county and local emergency response entities. It will further be carried out as indicated in the DCF Resource Family Disaster Plan completed and maintained by the Resource Family Home.

Any event impacting a large area of the state and requiring the movement of large numbers of children under the care and supervision of the DCF will result in a DCF system wide assessment to determine the existence of any vacant residential beds which may be utilized in the disaster response effort. An event of this size and scope may also see DCF active in its role as a support agency to NJDHS for ESF#6.

All child residents of resource family homes shall receive age appropriate instruction in how to evacuate the home safely in the event of fire or other emergency.

It is the responsibility of the caregivers with whom a child resides at the time of an event to care for that child until such time as an appropriate alternate site and /or caregiver(s) are identified. It is also the caregiver's responsibility to assure that each child is provided with documentation of identity as well as any medical information, school records, immunization records, court orders and physician and agency contact information, if available. If it becomes necessary to transfer care of a child, it is imperative that the child continue to receive food, clothing, medication (if needed) and emotional support and supervision.

If the size, nature or location of an event is significant enough that any residential facility cannot continue to serve the children residing there, on site, the facility caregiver should immediately implement a use of alternate facility process. Alternate facility process for residential services can include the following choices of a course of action:

- Use of emergency shelters.
- Use of an alternate site vacancy within the same agency.
- Use of an alternate site vacancy, outside the current agency.
- Use of family or relative care giver, DCF approved.
- Resource family re-location.
- Use of alternate resource family.
- Temporary, emergency hotel residence.

It is incumbent upon the caregiver to communicate any change in location of residence to the DCF through SCR. It is the obligation of the caregiver to seek out information pertaining to DCF Operations during the tenure of the event via the DCF webpage, DCF correspondence, media or newspapers.

Any information received relative to a change in residence for a child receiving services from DCF will be entered into the State Automated Child Welfare Information System (SACWIS) per DCF/CP&P protocol as soon as possible.

Should the use of emergency shelter be the only available alternative to residential services for any child or family receiving services from the DCF, the DCF will seek to provide support services to these individuals as appropriate and available for the duration of the event or until alternate residential accommodations can be provided.

For those children receiving residential services outside the state of NJ but funded by DCF, disaster response, if needed, will be provided through the national Emergency Management Assistance Compact (EMAC).

Education Services

The Office of Education (OOE) provides intensive 12-month educational services to children and young adults age 3 through 21. These services are provided at 16 DCF Regional Schools. Disaster preparedness, response and recovery will be provided based upon the Manual of Regional School Safety Plans and the individual school safety plan developed at each campus. All related activities will be conducted in cooperation with the DCF Office of Emergency Management and County and local emergency response entities.

Each of the regional schools will as part of preparedness and planning identify a school safety team. Each of the regional schools will also identify an alternate location for the provision of safe haven to their students in the event of a short term event which requires the use of an alternate facility process. Incidents which result in a facility being unavailable for use for any extended period of time will require the implementation of alternate facility process. Alternate facility process for the DCF Office of Education can include the following:

- Use of an alternate DCF/OOE facility.
- Use of a NJ DHS facility based upon memorandum of understanding.
- Use of an alternate private facility based upon lease agreement.

The DCF OOE maintains a fleet of 159 vehicles, of this 155 vehicles are school buses, a portion of which are parked at various OOE campuses. The OOE also employs a staff of part-time CDL drivers at each campus. Utilization of this transportation resource for disaster response will be as indicated in the transportation service portion of this plan.

Human Resource Services

The DCF Office of Human Resources DCF/OHR will be an important provider of essential services in all areas of disaster preparedness, response and recovery. The maintenance of an experienced, trained and informed workforce is a key component of DCF's level of preparedness. Provisions for the hiring of new employees and the training of all employees in the event of a disaster will be as designated in DCF/OHR policy and procedure.

Provision for the maintenance of timekeeping and payroll services will be as indicated in DCF/OHR policy and procedure. The DCF/OHR will work cooperatively with the NJ Civil Service Commission and NJ Department of the Treasury in pursuit of these goals.

The Office of Human Resources will partner with the DCF/OEM and the DCF Office of Communications to provide for accurate and timely workforce notification relative to any disaster and as indicated in the DCF Emergency Notification Protocol.

The DCF/OHR will coordinate with the DCF/OEM and designated employee bargaining units on the development of any memorandums of understanding, side letters of agreement or concessions required by the establishment or alternate work sites, work rules or flexible and extended work hours necessitated by any event or occurrence.

DCF/OEM, DCF/OHR and the DCF Office of Training and Professional Development will cooperate in the development and implementation of a disaster preparedness, response and recovery curriculum. This curriculum will include elements of the National Incident Management System (NIMS), the Incident Command System (ICS) and other information critical to and current in the field of emergency management.

DCF/OEM will identify, coordinate and track the completion of all federal and state required disaster preparedness training for those employees designated.

The DCF/OEM will provide information and otherwise encourage the personal preparation of all DCF employees for disaster or disaster related situations. The DCF/OEM recognizes the reality that a personally prepared workforce will be better equipped to assist in the DCF response to any disaster if they themselves and those close to them are prepared. In that regard the DCF will look to develop and implement policy and procedure which will assist in the maintenance of a "disaster ready" workforce.

Office of Emergency Management Services

The DCF/OEM under the supervision and direction of the DCF Director of Administration will serve in the role of DCF liaison to the NJ Office of Homeland Security and Preparedness, the NJ Office of Emergency Management, the Domestic Security Preparedness Task Force, the Domestic Security Preparedness Planning Group, Federal Emergency Management Agency and to all other State Departments as well as county, local and agency offices of emergency management. DCF/OEM will assume this role for the purpose of assisting in guiding preparedness, response and recovery activities and resources relative to the provision of all child protection and welfare services either locally or on a statewide basis.

DCF/OEM is responsible for DCF plan development, implementation, training and revision. DCF/OEM will participate in regular drills and exercises of various type and size for the purpose of maintenance of an appropriate level of preparedness.

Child Protection and Permanency Services

The provision of child protection and welfare services requires the continuity of operations of the DCF State Central Registry (SCR) Child Abuse Hotline, the CP&P Area and CP&P Local offices and the Institutional Abuse Investigations Unit. Office, unit and/or building specific plans for the continuity of operations are in place at each work location. These plans specify contact persons, site coordinators, relocation coordinators, alternate worksites, numbers of employees and other information critical to maintaining the provision of these essential services to the children and families of the state of NJ.

Behavioral Health and Developmental Disability Services

The DCF recognizes the critical need for the ongoing provision of behavioral health and developmental disability services to children and youth. Services provide to clients under the auspices of CSOC are provided by contracted providers, and the need for plans to ensure the continuity of those services will be included in associated contracts and memoranda of agreement.

The state's contracted care coordinator, PerformCare, will ensure that systems are in place to allow for the preservation of records and continuation of payment to service providers.

Sexual Assault Services and Domestic Violence Shelters and Services

The occurrence of a declared disaster does not eliminate the need for domestic violence shelters or services, or sexual assault services provided through the Division on Women. Contracted providers and grant recipients will ensure that continuity of operations and relocation plans are in place.

Section 11.

Administration, Logistics and Legal

Any and all agreements and understandings entered into for the purchase, lease or otherwise use of equipment and/or services will be in accordance with the provisions of state law. The DCF will establish and adhere to the administrative controls necessary to manage expenditure of funds relative to disaster preparedness, response and recovery. DCF will provide for accountability and justification for all disaster related expenditures. DCF will provide for the timely submission of any documentation required to obtain federal reimbursement when available and in accordance with established federal program guidelines.

The DCF will adhere to all federal, state and department specific reporting guidelines and requirements in the event of any disaster. Back up and preservation of client records and case files is provided for in the State Automated Child Welfare Information System (SACWIS).

The information and technology (IT) infrastructure is a key element to the DCF operations. It is of the utmost importance that identified critical information systems are maintained and backed up. Information includes files, documents, computer software and databases required to carry out mission essential functions. IT shall provide the capability to back-up and restore both file and application servers in the event of an emergency.

IT employs offsite storage of all back-up tapes and utilizes the State of NJ Office of Information Technology hub facility for NJ Spirit. In the event of total destruction or loss of access to the50 East State Street building, key personnel could be provided remote access to the server. NJSPIRIT disaster recovery is located at a secured off site location. Phone equipment and back-up tapes are located at 50 East State Street

Section 12.

Plan Development and Maintenance

The DCF/OEM as directed by the Director of Administration DCF has the overall responsibility for planning and management of DCF resources as necessary in assuring emergency preparedness, response and recovery. Each functional component of DCF shares in the responsibility for development and maintenance of appropriate planning documents that address responsibilities assigned in the department plan.

The DCF/OEM will maintain and update the DCF All Hazards Disaster Preparedness Plan as required. Functional components within the DCF may recommend changes and will provide information relative to capability changes and/or emerging needs which may impact their emergency management responsibilities.

DCF functional components have the responsibility for maintaining unit, facility or site specific plans annexed to the DCF All Hazards Disaster Preparedness Plan. This may include the standard operating procedures, notification lists and resource data which ensure a prompt and effective response to emergencies.

The DCF/OEM will coordinate an annual review of the DCF All Hazards Disaster Preparedness Plan with functional component representatives of the DCF. The DCF/OEM will oversee all review and revision efforts to assure appropriate update based upon lessons learned during actual occurrences and exercises, and other changes in organization, technology, responsibility and/or capability.

The DCF/OEM will recommend and issue changes to the DCF All Hazards Disaster Preparedness Plan as authorized by the Office of the Chief of Staff DCF and the Office of the Commissioner DCF. The DCF/OEM will assure appropriate distribution of the DCF All Hazards Disaster Preparedness Plan and all of its functional annexes within the DCF and to other State departments and agencies as appropriate and as recommended by the NJ State Police Office of Emergency Management.

The DCF/OEM will ensure participation in any relevant exercises by one or all functional components of the DCF at least annually. The DCF/OEM and DCF functional components as required will also participate in statewide exercises in emergency response as requested by the NJ State Police Office of Emergency Management.

Section 13.

DCF Direction and Control

In concert with the assumption that emergency response to all incidents is typically best managed at the lowest jurisdictional, organizational or geographic level, DCF will most often serve in a support role relative to disaster response. It is only in those incidents which are exclusive to the Department of Children and Families (DCF) that DCF/OEM will take the lead in management of the response.

During the majority of emergency operations, state, county and local emergency responders will remain to the extent possible, under the established management and supervisory control of their parent organizations. Key officials with the responsibility for executing direction and control of multi-agency response and recovery operations within defined areas are identified in local, county and state plans.

DCF will implement plans to maintain essential functions relative to the well-being and success of New Jersey's children and families including child protection and welfare services for the entire state and will coordinate otherwise with the NJ State Police Office of Emergency Management in support of their response to all incidents requiring the activation of the State Emergency Operations Center (EOC).

Section 14.

Notification and Activation

DCF emergency notifications of any type and activation of the DCF Disaster Preparedness Plan in response to any occurrence requiring it will be provided by the DCF/OEM.

Information relative to staff reporting requirements, work location availability and alternate work locations and hours will be posted to the DCF website (http://www.state.nj.us/dcf/) and messaged via alerts and the 1-855-653-2336 employee hotline.

Use of established phone trees or chains of communication where available and established in operational or geographically defined work units is encouraged.

Section 15.

Resource Management

The goal of effective resource management is to ensure that DCF has the organizational structure and processes to locate, obtain and distribute necessary resources in the event of an emergency. DCF resources would include personnel, professional expertise, facilities, communications equipment, computer hardware and software, training curriculums and facilities; and vehicles. An emergency alert notification contact roster for DCF executive management will be maintained by the DCF OEM. In the event that new equipment is required, DCF would request deployment of emergency equipment from our regular vendors.

Access to resources from out of state or provision of resources for an out of state incident will be as defined in the Emergency Management Assistance Compact (EMAC) or thru FEMA via Emergency Response Team Advanced (ERT-A) located at the EOC.

Section 16.

Communications

To the extent permitted by the incident which has occurred communications within DCF will continue to utilize existing and operational land line telephones, mobile/cell phones, Smart Phones, and personal or laptop computers. Use of these devices will be contingent on the availability of current network services.

The DCF/OEM has also established a DCF emergency radio communications system connecting all DCF worksites by the assignment of portable 800Mhz Motorola radios to each site. The system is tested monthly and is activated in part or in whole when the ability to communicate or to communicate safely via other means is no longer available. The system is an interoperable system which is monitored by the NJ State Police and the NJ Human Services Police Department.

Section 17.

Public Information

All provision of disaster related information to the public for DCF will be coordinated through the DCF Office of Communications, The Office of the DCF Chief of Staff, the Office of the Commissioner (DCF) and the Office of the Governor. For a disaster requiring the activation of the State Emergency Operations Center (EOC), all releases of information will be the responsibility of a joint public information center at the state level.

In the event that a joint public information center is activated by the State EOC, the DCF Office of Communications will serve as the DCF liaison to that entity as noted in ESF #15 the public information officer would report to the Joint Information Center (JIC).

Section 18.

Transportation

Particular attention must be given to individuals who lack the capacity to provide or otherwise arrange transportation for themselves and for children in their care. In response to this need the DCF may look to utilize the fleet of vehicles which it maintains in the most efficient and equitable fashion in response to any event which calls for the movement of children under DCF supervision and to assure continued provision of child protection and welfare services throughout the state.

Facility, local, county or regional events may require the emergency re-allocation of a portion of the DCF fleet to or from an affected area depending upon the nature of the incident. For example flooding of a particular area may require that a portion of the fleet be relocated to higher ground. A disaster requiring activation of the State Emergency Operations Plan may require the re-allocation of the DCF fleet or portions of it to the NJ State Police Office of Emergency Management.

DCF will maintain a fleet of 2389 vehicles. It is expected that 2072 of these vehicles will support child protection and welfare services throughout the state and that 230 of these vehicles will support ancillary services including institutional investigations, residential services, information and technology services, licensing, adoption services, facilities management, training and revenue development. The Office of Education (OOE) utilizes 159 vehicles, 155 of which are buses used to transport children to the various regional school campuses operated by OOE and other educational programs

Section 19.

Evacuation

The DCF/OEM will ensure that all DCF operated facilities and programs have plans in place for the safe evacuation of staff and children from disaster affected areas to non-affected areas as a component of their facility/home disaster plan. Incorporated in the plans will also be provision of designated alternate sites and coordination of acceptance at specified sites. Plans will also address the need for the continuation of services at alternate sites. Caretakers are expected to contact DCF with information relative to the location to which they have relocated at the earliest possible date.

Exclusive of emergency evacuation of a facility for a fire or other reason (drill or otherwise), activation of evacuation plans will be triggered locally upon request or direction from Local, County or State Emergency Management authorities. Staff will receive instructions and trainings regarding the evacuation process.

Section 20.

Health and Medical

DCF is working collaboratively with the NJOEM and the NJDOH to improve the state of preparedness which DCF has as it pertains to health and medical services. Provision of disaster mental health services will be as indicated previously in section 8 of this document and as prescribed by the Children's System of Care. DCF caseworkers and other staff will seek to provide support to those individuals under their care and supervision at a local level and through the existing network of health care professionals in the community. DCF will continue to access the services provided by the Comprehensive Health Evaluations for Children exam sites where services were not impacted or impeded by the event and/or utilize existing emergency protocols for critical care via public health and hospital infrastructure. I n the event of a declaration of a state or federal disaster the DCF will seek to provide for medical and health related services to those individuals under its care and supervision at the direction of the NJOEM and/or the NJDOH.

Section 21.

Mass Care

Mass care consists of all activities to provide for all basic needs for those displaced by a disaster. This includes shelter, food, first aid, and relief supplies following a catastrophic event. DCF/OEM will implement procedures for providing or requesting mass care for personnel and children impacted by a disaster or emergency. Any event impacting a large area of the state and requiring the movement of large numbers of children under the care and supervision of the DCF will see implementation of the alternate facility process discussed in the residential services portion of this plan.

Section 22.

Continuity of Operations

The occurrence of a disaster of any size could impede the ability of the DCF to provide the essential services to the children of a portion of or the entire state of NJ. In response to this potentiality the DCF/OEM works with the various DCF organizational units and agencies in the development and maintenance of local continuity of government and continuity of operations plans. Lines of succession in the DCF are outlined in the DCF Orders of Succession. Delegations of authority for DCF functional components are as indicated in the school safety plans, CP&P emergency preparedness and response plans and office contingency plans on file in the DCF/OEM. Lines of succession and delegations of authority for agencies or facilities licensed by, contracted to or funded by must be defined in unit, facility, site or agency specific plans. Emergency action steps and the alternate facility process are delineated in organization and assignment of responsibilities specifically in the various essential services sections. Protection of government resources is addressed in the resource management portion of this plan. The protection of vital records is described in section 9. Administration, logistics and legal.

The DCF OEM has developed a separate Continuity of Operations (COOP) Plan to provide guidance in ensuring the execution of mission essential functions critical to the provision of ensuring the safety, well-being and success of children, youth, families and communities.

Section 23.

Glossary of Terms

All Hazards – anything that is potentially dangerous or harmful and often the root cause of an unwanted outcome.

Recovery- The development, coordination and execution of service and site restoration plans for impacted entities and the reconstitution of operations and services. Identify needs and resources, promote restoration of normal operations, incorporate mitigation measures and identify lessons learned.

Response- all activities that address the short-term direct effects of an incident. Activities can occur immediately before, during or directly after an emergency or disaster. Includes the execution of emergency operation plans to minimize unfavorable outcomes.

Catastrophic incident- any natural or man-made incident including terrorism, that results in extraordinary levels of mass casualties, damage or disruption severely affecting the infrastructure and operational functions.

Critical infrastructure – Vital systems and assets that the destruction or incapacity of such systems and assets would have a debilitating impact of functional operations and service provision.

Evacuation- An organized, supervised dispersal or removal of personnel and children/families from potentially dangerous areas and their reception and care to safe areas.

Hazard mitigation- Actions and activities directed toward eliminating or reducing the risk of disaster occurrence.

Incident- An occurrence or event, natural or man-made that requires an emergency response to protect life or property.

Interoperable communications-The ability of emergency responders to talk to one another via radio and other communication systems and exchange voice/and or data with one another on demand and in real time.

NJ Department of Children and Families
50 East State Street
Trenton NJ 08625

Continuity of Operations Plan
2015

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a. EXECUTIVE SUMMARY

The Department of Children and Families (DCF) was established by legislation July 1, 2006. The Department of Children and Families maintains 76 work sites around the state. This currently includes 9 Area and 45 Local Division of Child Protection and Permanency offices throughout the state and 16 Departmental operated regional schools. As of December 2014, 90,724 children received services from The Department of Children and Families and additional 13,016 families were served by the Division on Women.

The need for formal planning and practice in anticipation of possible critical events in a system this size is apparent. The Department of Children and Families has developed this Continuity of Operations Plan to ensure its ability to maintain operation of all essential functions identified for the provision of services to the children and families of New Jersey. The plan is a compilation of policy, procedures and delegations of authority. It identifies alternate facilities, processes for the provision of interoperable communications and the backup of vital records and data. The plan calls for participation in training, tests and exercises. It includes planning for devolution as well as reconstitution. In addition, post Hurricanes Katrina and Sandy, comprehensive emergency preparedness plans are necessary to ensure the safety and protection of the children, youth, women and families we serve.

The Department of Children and Families Continuity of Operations Plan (COOP) will delineate the delegations of authority, order of succession and the assignment of responsibility in the event of an emergency. The COOP identifies the essential functions of the Department of Children and Families as well as the essential employees who will sustain those functions thus ensuring adherence to planned activities in a coordinated manner to minimize disruption of operations. As a part of plan implementation, Department of Children and Families entities will participate in on-going training, drills and exercises as scheduled.

This plan is intended to be a fluid, ever-changing document subject to on-going review and revision based on identified areas requiring improvement. The Department of Children and Families Office of Emergency Management will coordinate updates and maintenance of the plan and relative documents.

A key element of planning is the identification of essential functions of the Department of Children and Families. Planning will also include the identification and training of staff as well as the identification of resources which will ensure success of the plan. Implementation of the plan will be initiated by the Department of Children and Families Office of the Chief of Staff, and the Office of the Commissioner.

b. INTRODUCTION

The Governor of NJ, Chris Christie, has identified Continuity of Operations Planning (COOP) as a priority for his administration. The NJ Office of Homeland Security and Preparedness (OHSP) has been identified as the lead agency in this effort. The Office of Homeland Security and Preparedness stated objective is to assure that each organization is prepared to react to a natural and/or man-made business interruption with or without notice. The Department of Children and Families is an organization who supports this objective and the responsible entity regarding the safety and well-being of children and families. The Department is staffed by over 6,784 employees. It is imperative that the Department of Children and Families develop a continuity of operations plan that will make sustainment of essential functions possible.

The importance of planning for the emergency support of The Department of Children and Families essential functions is highlighted by recent weather events such as; Post Tropical Cyclone Sandy in 2012, Tropical Storm Irene in August 2011, Blizzard of 2008, and the state government shut down in July 2006 The vulnerability of the population served by the Department of Children and Families makes planning and preparedness for an occurrence a clear priority.

c. PROMULGATION STATEMENT

It is the mission of the Department of Children and Families to partner with New Jersey's communities; The Department of Children and Families will ensure the safety, well-being, and success of New Jersey's children and families. Through a holistic system of care, DCF seeks to ensure a better today and even greater tomorrow for every individual we serve.To accomplish this mission, NJ Department of Children and Families must ensure its operations are performed efficiently with minimal disruption, especially during an emergency. This document provides planning and program guidance for implementing the NJ Department of Children and Families Continuity Plan to ensure the organization is capable of conducting its essential missions and functions under all threats and conditions.

Key NJ Department of Children and Families personnel under this plan are collectively known as Business Essential Employees. Upon plan activation, business essential staff will deploy to the Professional Center at DCF, 30 Van Dyke Avenue, New Brunswick. If the Professional Center is unavailable the Morris/Sussex/Passaic and Cumberland, Gloucester/Salem Area Offices will serve as alternate sites. Upon arrival, continuity personnel will establish an operational capability and perform essential functions within 12 hours from the time of the activation of the Continuity Plan, up to a 30-day period or until normal operations can be resumed.

- This plan is developed in accordance with guidance:
- National Continuity Policy Implementation Plan, dated August 2007;

- Continuity Guidance Circular 1 (CGC 1) ,
- Continuity Guidance for Non-Federal Entities (States, Territories, Tribal, and Local) Government Jurisdictions and Private Sector Organizations), dated January 21, 2009;
- Continuity Guidance Circular 2 (CGC 2), Continuity Guidance for Non-Federal Entities, dated July 22, 2010;
- New Jersey Governors Executive Order #5 and Executive Order #50; and other related Directives and guidance.

d. RECORD OF CHANGES

Document Change Table

Change Number	Section	Date of Change	Individual Making Change	Description of Change
1	Plan	8/19/2013	Robert Challender	Format Change
2	Executive summary	2/5/2014	Robert Challender	Update
3	Update entire plan	8/8/2014	Rachel Trautman/Robert Challender	update
4.	Assumption	9/11/2014	Robert Challender	Emergency Power
5	Entire plan	2/9/2015	Robert Challender	Plan update

e. RECORD OF DISTRIBUTION

RECORD OF DISTRIBUTION

Document Transmittal Record

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Date of Delivery	Number of Copies Delivered	Method of Delivery	Name, Title, and Organization of Receiver

DISTRIBUTION OF COOP PLAN			
Plan Recipient	Portion of Plan Distributed	Date of Distribution	Method of Distribution
Primary Distribution List			
DCF Commissioner	Entire Plan		
DCF Chief of Staff	Entire Plan		
DCF OEM staff	Entire Plan		
All Designated Essential COOP personnel	Entire Plan		
Alternate Facility staff	Entire Plan		
Secondary Distribution List			
Successors, Back-up Field Locations & Back-up Organizations	Entire Plan		
Other	Relevant Portions of Plan		
Regional or field locations of the	Relevant Portions of		

Department	Plan		
General Distribution List			
All Designated Non-essential Personnel	Plan Overview		

I. PURPOSE, SCOPE, SITUATIONS, AND ASSUMPTIONS

The Department of Children and Families Continuity of Operations Plan addresses a wide variety of potential threats, crises and emergencies that include natural as well as man-made disasters utilizing an all-hazards planning approach.

The Department of Children and Families/Office of Emergency Management is the entity designated by the Commissioner, Department of Children and Families to facilitate the implementation of a Continuity of Operations Plan in event of disaster

A. PURPOSE

The Department of Children and Families , Office of Emergency Management has developed this Continuity of Operations Plan to provide guidance to staff that will ensure the execution of essential functions in the event of a crisis on any scale that disrupts operations. The Department of Children and Families provides support services to children and families in New Jersey and disruption or cessation of these services could place the children and families of New Jersey at increased risk.

A Continuity of Operations Plan beyond being a good business practice is part of the fundamental mission of an agency as a responsible and reliable public entity and allows for the execution of mission essential functions. Continuity of operations planning must establish preparedness and response capability to any and all threats to operations and safety of all personnel. Government today faces numerous challenges from natural disasters to terrorism and must be prepared to maintain operations during any event.

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B. SCOPE

The Department of Children and Families Continuity of Operations Plan addresses a wide variety of potential threats, crises and emergencies that include natural as well as man-made disasters utilizing an all-hazards planning approach. This plan is applicable to the Department of Children and Families organization as a whole encompassing all facilities, schools, offices and other entities as noted. It applies to those activities identified as essential functions of The Department of Children and Families in this plan as well as

subordinate activities which support them. All personnel identified as essential to support these activities are considered to be within the scope of the plan.

Specifically, a Continuity of Operations Plan is designed to:

- Address all hazards, threats and circumstances when standard operations become overwhelmed.
- Present a management framework.
- Establishes operational procedures to sustain essential functions.
- Facilitate the return to normal operating conditions as soon as possible with a timely and orderly recovery.
- Ensure The Department of Children and Families is prepared to provide critical services in an environment that is threatened, diminished or incapacitated.
- Ensure plans are viable, operational and compatible with NJ OEM plans.
- The Department of Children and Families is ready to respond to disasters, recover and mitigate against any impact to operations.
- Ensure uninterrupted communications.
- Provide sufficient operational capabilities relative to the event.
- Protect essential facilities, equipment, records and assets.
- Minimize the loss of life, injury and property damage.
- Reduce the consequences of a disaster.
- Restore essential functions within 12 hours after activation and performing those functions for up to 30 days in accordance with applicable Federal and State guidance.
- Maintains a high level of preparedness and COOP must be ready for implementation without significant prior warning.
- Assure compliance with any legal and statutory requirements.

SITUATION OVERVIEW

It is the policy of the State of New Jersey to maintain a comprehensive and effective continuity capability. To that end, by continuing the performance of essential functions through a catastrophic emergency, The Department of Children and Families support the ability of the State of New Jersey Government to perform Essential Functions (EFs), continues State's Constitutional Government, and ensure that essential services are provided to the citizens of New Jersey. A comprehensive and integrated continuity capability will enhance the credibility of New Jersey's security posture and enable a more rapid and effective response to, and recovery from, an emergency. Further, continuity

planning should be based on the assumption that organizations will not receive warning of an impending emergency.

The NJ Department of Children and Families continuity facilities were selected following an all-hazards risk assessment of facilities for continuity operations use. This risk assessment addresses the following for each continuity facility:

- Identification of all hazards
- A vulnerability assessment to determine the effects of all hazards
- A formal analysis by management of acceptable risk
- Sufficient distance between each facility location or threatened area and other facilities or locations that are potential sources of disruptions or threats
- Sufficient levels of physical security required to protect against identified threats
- Sufficient levels of information security required to protect against identified threats

Further, the NJ Department of Children and Families has evaluated its daily operating facilities in accordance with inter-organization risk and safety standard operating procedures or applicable organization standards.

Planning Assumptions

This Continuity Plan is based on the following assumptions:

- An emergency condition may require the relocation of the NJ Department of Children and Families Business Essential Employees to the continuity facility at The Professional Center at DCF, 30 Van Dyke Avenue New Brunswick NJ.
- The Professional Center at DCF is a fully operational training and meeting Center and will support Essential Business Employees and the continuation of the NJ Department of Children and Families essential functions by available communications and information systems within 12 hours from the time the Continuity Plan is activated, for potentially up to a 30-day period or until normal operations can be resumed
- The NJ Department of Children and Families regional operations are unaffected and available to support actions directed by the Commissioner or a successor. However, in the event that Essential Business Employees deployment is not feasible due to the loss of personnel, the NJ Department of Children and Families will devolve to 30 Van Dyke Avenue New Brunswick NJ.
- Upon activation of COOP, Executive Mgmt. and designated staff may be relocated if necessary to The Professional Center at DCF, capable of supporting all essential functions and sustaining operations for a maximum of 30 days.
- The Alternate Relocation Facility will be based on the threat of the incident, risk assessments and execution timeframes.

- The majority of information systems may not be available upon initial COOP activation.
- Mobile, cell and radio communications capabilities will be utilized if available to ensure direction and control of COOP activation and/or relocation for purposes of interoperability.
- The declaration of an emergency requiring COOP activation may require the discontinuation of non-mission critical functions at the discretion of executive management.
- The generator will provide lighting for the State Centralize Reporting (SCR) Operations for 5 days.
- Vendor will be able to supply diesel fuel for the SCR generator.

OBJECTIVES

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- The NJ Department of Children and Families continuity objectives are listed below:
    1. Ensure essential functions can be performed, if applicable, under all conditions.
    2. Reduce the loss of life and minimize property damage and loss.
    3. Execute a successful order of succession with accompanying authorities in the event a disruption renders the organization's leadership unable, unavailable, or incapable of assuming and performing their authorities and responsibilities of office.
    4. Reduce or mitigate disruptions to operations.
    5. Ensure the NJ Department of Children and Families has facilities where it can continue to perform its essential functions, as appropriate, during a continuity event.
    6. Protect essential facilities, equipment, records, and other assets, in the event of a disruption.
    7. Achieve the organization's timely and orderly recovery and reconstitution from an emergency.
    8. Provision of a time-phased implementation of the COOP Plan to mitigate the effects of the emergency and curtail crisis response time.
    9. Identify and designate principals and support staff to be relocated.
    10. Facilitate decision-making for execution of the COOP and the subsequent performance of operations

11. Ensure and validate continuity readiness through a dynamic and integrated continuity Test, Training, and Exercise (TT&E) program and operational capability.
12. Install and Maintain emergency power source (Generator)

SECURITY AND PRIVACY STATEMENT

This document is For Official Use Only. Portions of the Plan contain information that raises personal privacy or other concerns, and those portions may be exempt from mandatory disclosure under the Freedom of Information Act (see 5 United States Code §552, 41 Code of Federal Regulations Part 105-60). It is to be controlled, stored, handled, transmitted, distributed, and disposed of in accordance with Civil Service Regulations and is not to be released without prior approval of the Commissioner, NJ Department of Children and Families to the public or other personnel who do not have a valid "need to know".

Distribution of the Continuity Plan in whole or part is limited to those personnel who need to know the information in order to successfully implement the plan.

The NJ Department of Children and Families Office of Emergency Management will distribute copies of the Continuity Plan on a need to know basis.

COOP PLAN DISTRIBUTION

The Department of Children and Families Office of Emergency Management will be responsible for the distribution of the COOP plan and ensure that plan information is in the hands of personnel that may need the information following an event which warrants consideration of activation of the COOP plan. Many essential COOP personnel will not require access to the entire plan, but only the portions relevant to their duties and responsibilities. A table will be utilized to record distribution of the COOP:

In addition, copies of the Plan will be distributed to other designated organizations as necessary to promote information sharing and facilitate a coordinated inter-organization continuity effort. Further distribution of the plan is not permitted without approval from the Chief of Staff. The NJ Department of Children and Families, Office of Emergency Management will distribute updated versions of the Continuity Plan annually or as critical changes occur.

f. CONCEPT OF OPERATIONS

PHASE I: READINESS AND PREPAREDNESS

The NJ Department of Children and Families will participate in the full spectrum of readiness and preparedness activities to ensure personnel can continue essential

functions in an all-hazard/threat environment. The NJ Department of Children and Families readiness activities are divided into two key areas:

- Organization readiness and preparedness
- Staff readiness and preparedness

Activation and Relocation

1. Decision Process

Upon receipt of notification that a disaster has occurred or is imminent, the Department of Children and Families, Office of Emergency Management will respond in accordance with this COOP Plan. Scope of activation will be dependent upon the nature, location and impact of the event. The Department of Children and Families/Office of Emergency Management as directed by the Office of the Commissioner, Chief of Staff or their successors will activate the COOP Plan. When the decision is made to activate the COOP Plan, the Department of Children and Families Office of Emergency Management will begin notification procedures.

Disasters or potential disasters may impact the capability of The Department of Children and Families to perform its mission essential functions from one or more locations. The locations impacted may provide similar essential functions or essential functions which are different. Because events are often geographically based, The Department of Children and Families could see an impact to several offices or facilities while not impacting all of The Department of Children and Families facilities locales.

An event which has statewide impact may require the activation of the COOP plan for the entire department. Activation of response to an event will be driven by the emergency presented and in concert with the emergency, contingency or COOP plan. Each site will maintain a specific plan that identifies facility and function specific staff designated as Essential Employees and a relocation facility.

In any of the above referenced scenarios, the Department of Children and Families Chief of Staff and or Successor in consultation with the Commissioner will direct the activation of the COOP by Department of Children and Families /Office of Emergency Management. The Department of Children and Families / Office of Emergency Management or alternate will notify Executive Management that the COOP plan is being activated. If access to The Department of Children and Families Central Office at 50 East State Street is not available due to the nature of the event, the pre-determined continuity facility will be activated according to the DCF/ Office of Emergency Management Contingency Plan for relocation of The Department of Children and Families Central Office personnel. The Department of Children and Families essential functions will be supported by the Business Essential Employees from the Professional Center at DCF (30 Van Dyke Ave. New Brunswick NJ.) The time frame to regain access to 50 East State Street will dictate the utilization time of the Professional Center at DCF. When 50 East State Street is deemed ready for occupancy, support of essential functions will be transitioned back to 50 East State Street.

Business Essential Employees will be assisted by staff from throughout the Department of Children and Families in support of The Department of Children and Families essential functions. The scope of impact of a disaster/event will determine the availability of each of the many Department of Children and Families worksites. Where necessary, The Professional Center at DCF as well as local Business Essential Employees may be activated. Upon activation, Business Essential Employees will be responsible for ensuring the continuation of essential functions of The Department of Children and Families within 12 hours of deployment. All Business Essential Employees will possess the knowledge, skills, abilities and resources to support identified essential functions until the continuity facility is staffed and operational. The Business Essential Employees at any department continuity facility worksite will be assisted by The Department of Children and Families staff from the permanent work location for the duration of any event/disaster impact in support of all The Department of Children and Families essential functions.

Organization Readiness and Preparedness

The NJ Department of Children and Families preparedness incorporates hazard/threat warning systems, which includes:

Alert, Notification and Implementation Process

Incidents can occur with or without warning and during working hours or non-working hours. If the threat or occurrence of an incident adversely impacts operations, the COOP plan will be activated in response to a wide range of disasters to include natural disasters, terrorist threats and technological disruptions and failures.

Emergency notifications will be provided via standard communication devices (phone, cell phone, e-mail and DCF internet page) and according to the Department of Children and Families Emergency Notification Protocol when communications capabilities are unaffected by the disaster event. If standard communication is impacted and therefore unavailable, the Department of Children and Families emergency radio system will be activated.

Warning Conditions

With Warning: In many instances, The Department of Children and Families will receive advance warning prior to an event. This would allow for the implementation of the COOP plan and an orderly alert and notification of The Department of Children and Families staff. Activation will be as directed by the Department of Children and Families Office of the Commissioner, Chief of Staff or successor to the Department of Children and Families/Office of Emergency Management. The deployment of the appropriate Business Essential Employees to their designated continuity facility, if required, will be determined by the nature and scope of the event.

Without Warning: When a disaster/event occurs without warning, the notification to The Department of Children and Families/ Office of Emergency Management will likely come from the NJOEM, County ,local OEM or from a facility, school or office within The Department of Children and Families.

Non-Working Hours: Business Essential Employees will be alerted and activated by The Department of Children and Families/Office of Emergency Management.

Working Hours: Notification will commence via the DCF office of Emergency Management. Once alert and notifications have been completed, The Department of Children and Families employees at sites not impacted will be expected to stand by for direction as to where and when to report. At those locations where relocation is required by the impact of an event, those employees identified as the Business Essential Employees members for that site will report and make the Professional Center at DCF operational. Non Business Essential Employees members at these sites should also await guidance relative to reporting times and locations.

Where impact requires that a worksite identified as a continuity facility for a neighboring work site be activated as such, the activation of a flexible work schedule reflected in the local contingency or COOP plan may be required. All Business Essential Employees and otherwise are requested to remain prepared, accessible and flexible.

Time Phased Implementation /Magnitude of Disaster Classification

The goal of a Time Phased Implementation is to ensure maximization of the preservation of life and property in the event of a natural or man-made disaster by making the most efficient use of available personnel, equipment, facilities and resources. This plans intention is to provide a flexible response to all-hazard environments. The degree of COOP implementation will depend on the type and magnitude of the disaster. The Disaster Magnitude classification will be a factor in determination of COOP execution.

Levels of disaster are characterized as follows:

Minor Disaster- A minor disaster is any disaster which requires the evacuation of or makes unavailable a Department of Children and Families school or office and is likely to last for duration of less than 72 hours. Business Essential Employees from the impacted location(s) will be directed to begin operations at the designated continuity facility.

Major Disaster- A major disaster is any disaster which requires the evacuation of or makes unavailable a school or office with a duration that will exceed 72 hours. Business Essential Employees from the impacted locations will be directed to begin operations at the designated continuity facility.

Catastrophic Disaster- A disaster which requires evacuation of or makes unavailable a The Department of Children and Families school or office for a duration is likely to last for an extended period of time. Business Essential Employees from the impacted locations will be directed to begin operations at the designated continuity facility.

Implementation activities include-

- Organize log(s) for tracking disaster activities.

ANNEX A: • Activate plans for coordination with NJ OEM and call into action The Department of Children and Families personnel as designated.

ANNEX B: • Identify exact location of disaster, damaged areas and the extent of services required, geographic scope of disaster, number and names of counties involved and number of children under The Department of Children and Families purview that are homeless, evacuated due to the disaster.

ANNEX C: • Report destruction/damage or impact to facilities, schools, local offices, etc.

- Identify the status of The Department of Children and Families personnel on location in impacted offices.

ANNEX D: • Identify status of essential services, including short-term and long-term needs of the affected, current basic services curtailed or destroyed and anticipated reinstatement of services.

ANNEX E: • Activate coordination with community resources for the implementation of emergency services.

ANNEX F: • Inform State Emergency Operations Center and other disaster agencies of availability of existing network resources suitable for disaster relief.

- Transportation resources, i.e. buses, vans, volunteer vehicles and drivers available for evacuation of children/families and other emergency transport.
- Provide Information to disaster victims on a 24 hour basis utilizing a designated Helpline 211 as available.

Staff Readiness and Preparedness

The NJ Department of Children and Families personnel will prepare for a continuity event and plan in advance for what to do in an emergency. Recommendation will be made to personnel to develop a Family Support Plan to increase personal and family preparedness. The www.ready.gov website provides guidance for developing a Family Support Plan and includes a “Get Ready Now” pamphlet that explains the importance of planning and provides a template that can be tailored to meet family-specific planning requirements.

The NJ Department of Children and Families continuity personnel will be encouraged to create and maintain drive-away kits. Business Essential Employees can transport the kits

or pre-position the kits at the continuity facility. A typical drive-away kit should contain those items listed in the table below.

Drive-Away Kit

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Drive Away Kit	
• Identification and charge cards – Organization identification card – Driver's license – Organization travel card – Health insurance card – Personal charge card • Communication equipment – Pager/BlackBerry – Organization cell phone – Personal cell phone • Hand-carried vital records • Continuity Plan • Directions to continuity facility • Maps of surrounding area • Business and leisure clothing • Flashlight	• Business and personal contact numbers – Emergency phone numbers and addresses (relatives, medical doctor, pharmacist) • Toiletries • Chargers/extra batteries for phones, GPS, and laptop • Bottled water and non-perishable food (i.e., granola, dried fruit, etc.) • Medical needs – Insurance information – List of allergies/blood type – Hearing aids and extra batteries – Glasses and contact lenses – Extra pair of eyeglasses/contact lenses – Prescription drugs (30-day supply) – Over-the-counter medications, dietary supplements

In addition, the NJ Department of Children and Families will conduct the following continuity readiness and preparedness activities: Post readiness information on NJ Department of Children and Families Portal, send preparedness emails to staff.

Phase II. Activation and Relocation

Activation and Relocation

To ensure the ability to attain operational capability at continuity facilities and with minimal disruption to operations, The NJ Department of Children and Families will execute activation and relocation plans as described in the following sections.

1. Decision Process

Upon receipt of notification that a disaster has occurred or is imminent, The Department of Children and Families/ Office of Emergency Management will respond in accordance with the COOP Plan. Scope of activation will be dependent upon the nature, location and impact of the event. The Department of Children and Families/ Office of Emergency Management as directed by the Office of the Commissioner, Chief of Staff or their successors will activate the COOP Plan.. When the decision is made to activate the COOP Plan, the Department of Children and Families Office of Emergency Management will begin notification procedures.

An event which has statewide impact may require the activation of the COOP plan for the entire department. Activation of response to an event will be driven by the emergency presented and in concert with the facility, school or office emergency, contingency or COOP plan. Each site will maintain a specific plan that identifies facility and function specific staff designated as Business Essential Employees and an Alternate Relocation Facility (ARF).

In any of the above referenced scenarios, the Chief of Staff and or Successor in consultation with the Commissioner will direct the activation of the COOP by The Department of Children and Families/Office of Emergency Management. The Department of Children and Families/Office of Emergency Management or alternate will notify Executive Management and the Executive Management and designated Business Essential Employees that the COOP plan is being activated. If access to the Department of Children and Families Central Office at 50 East State Street is not available due to the nature of the event, the Professional Center at DCF will be activated according to the Department of Children and Families Contingency Plan for relocation of Department of Children and Families Central Office personnel based at 50 East State Street (Annex D). The Department of Children and Families essential functions will be supported by the Business Essential Employees from the ARF for as long as necessary. The time frame to regain access to 50 East State Street will dictate the utilization time of The Professional Center at DCF. When the 50 East State Street building is deemed ready for occupancy, support of essential functions will be transitioned back to 50 East State Street.

Business Essential Employees will be assisted by staff from throughout the Department of Children and Families in support of DCF essential functions. The scope of impact of a disaster/event will determine the availability of each of the many Department of Children and Families worksites. Where necessary, ARFs as well as local Business Essential Employees will be activated. Upon activation Business Essential Employees will be

responsible for ensuring the continuation of essential functions of The Department of Children and Families within 12 hours of deployment. All Business Essential Staff will possess the knowledge, skills, abilities and resources to support identified essential functions until the Continuity site is staffed and operational. The Business Essential Employees at any department Continuity worksite will be assisted by Department of Children and Families staff from the permanent work location for the duration of any event/disaster impact in support of all Department of Children and Families essential functions.

Decision Process Matrix

Based on the type and severity of the emergency situation, the NJ Department of Children and Families Continuity Plan may be activated by one of the following methods:

(1) The State Governor, Commissioner

(2) The Commissioner, or a designated successor, may initiate the Continuity Plan activation for the entire organization, based on an emergency or threat directed at the organization

(3) NJ Office of Emergency Management

Continuity Plan activation and relocation are scenario-driven processes that allow flexible and scalable responses to the full spectrum of all-hazards/threats that could disrupt operations with or without warning and during work or non-work hours. Continuity Plan activation will not be required for all emergencies or disruptions, since other actions may be more appropriate.

The decision to activate the NJ Department of Children and Families Continuity Plan and related actions will be tailored for the situation and based on projected or actual impact and whether or not there is warning. To support the decision-making process regarding plan activation, key organization personnel will use the decision matrix below to support that process.

Decision Matrix

Decision Matrix for Continuity Plan Implementation		
	Work Hours	Non-Work Hours
Event With Warning	• Is the threat aimed at the facility or surrounding area? • Is the threat aimed at organization personnel? • Are employees unsafe remaining in the facility and/or area? • Are other Areas of the State	• Is the threat aimed at the facility or surrounding area? • Is the threat aimed at organization personnel? • Who should be notified of the threat? • Is it safe for employees to return to work the next day?

Decision Matrix for Continuity Plan Implementation		
	Work Hours	Non-Work Hours
	Affected?	
Event Without Warning	• Is the facility affected? • Are personnel affected? Have personnel safely evacuated or are they sheltering-in-place? • What are instructions from first responders? • How soon must the organization be operational? • Is the Continuity Facility affected? • Is Generator operational	• Is the facility affected? • What are instructions from first responders? • How soon must the organization be operational? • Are roadways passable? • Has anyone inspected the continuity facility to ensure operational readiness? • Does vendor have diesel fuel for generator

As the decision authority, the Commissioner will be kept informed of the threat environment using all available means, including the NJ Department of Children and Families Emergency radios, cell phone, email, state notification systems, local operations and State and local reporting channels and news media. The Commissioner will evaluate all available information relating to:

(1) Direction and guidance from higher authorities
(2) The health and safety of personnel
(3) The ability to execute essential functions
(4) Changes in threat advisories
(5) Intelligence reports
(6) The potential or actual effects on communications systems, information systems, office facilities, and other vital equipment
(7) The expected duration of the emergency situation

(8) Alert and Notification Procedures

(9) The NJ Department of Children and Families will activate phone tree, Inter/Intra net portals and the Employee Emergency Hotline for communicating and coordinating activities with personnel before, during, and after a continuity event.

(10) Before an event, personnel in the NJ Department of Children and Families Office of Emergency Management will monitor advisory information, including the National Weather Center, National Hurricane Center, The Severe Weather Center, and The Regional Operations and Information Center. In the event normal operations are interrupted or an incident appears to be imminent, the NJ Department of Children and Families will take the following steps to communicate the organization's operating status with all staff:

- The Director of the Office Emergency Management or designated successor will notify Commissioner/Chief of Staff of the emergency requiring Continuity Plan activation
- The Office of Emergency Management will notify Director of Administration and Director of Facilities Support via Phone, Text, Email or Emergency Radio. The NJ Department of Children and Families personnel will notify family members, next of kin, and/or emergency contacts of Continuity Plan activation.

Upon the decision to activate the Continuity Plan, the NJ Department of Children and Families will notify all NJ Department of Children and Families personnel, as well as affected and interdependent entities with information regarding continuity activation and relocation status, operational and communications status, and the anticipated duration of relocation. These entities include but not limited to:

- Continuity facilities and on-site support staff with information regarding continuity activation, relocation status, and the anticipated duration of relocation.
- The NJ Department of Children and Families Operations Center located in the State Emergency Operations Center via the Director of The Office of Emergency Management /Assistant Director of Emergency Management and the NJ Office of Emergency Management and other applicable elements/entities with information regarding continuity activation and relocation status, the NJ Department of Children and Families continuity facility, operational and communication status, and the anticipated duration of relocation.
- All NJ Department of Children and Families employees with instructions and guidance regarding the continuity activation and relocation.
- NJ State Central Registry
- Special Response Unit
- Contracted Vendors/Providers
- Resource Families
- Domestic Violence Hotline

Relocation Process

Once the Continuity Plan is activated and personnel are notified, the NJ Department of Children and Families will relocate continuity personnel and vital records to the Professional Center at DCF. The NJ Department of Children and Families essential personnel will deploy/relocate to the Professional Center at DCF to perform the Departments essential functions and other continuity-related tasks. Directions to the continuity facility will be included as part of the Continuity Plan:

DRIVING DIRECTIONS

A) 50 E State St, Trenton, NJ 08608-1715 US

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1. Start out going north on N Broad St/US-206 N/US-1-BR N toward E Hanover St. (go 0.18 miles)
2. Turn right onto Perry St.
   - Perry St is just past Olive St
   - Broad Street Discount Furniture & Appliances is on the left
   - If you reach Allen St you've gone a little too far

   (go 0.33 miles)
3. Merge onto US-1 N toward Princeton/New York. (go 21.48 miles)
4. Take the RT-91/Jersey Ave exit toward New Brunswick. (go 0.38 miles)
5. Keep right at the fork to go on Jersey Ave/RT-91. (go 2 miles)
6. Turn left onto Van Dyke Ave.
   - Van Dyke Ave is 0.4 miles past Triangle Rd

   (go 0.38 miles)
7. 30 VAN DYKE AVE is on the left.
   - Your destination is just past Wright Pl

B) 30 Van Dyke Ave, New Brunswick, NJ 08901-3253 US

>> TOTAL ESTIMATED TIME: 34 minutes | DISTANCE: 24.75 miles

Emergency procedures during work hours with or without a warning will be implemented as follows:

- Designated Department of Children and Families Business essential personnel will depart to the designated continuity facility from the primary operating facility or current location.
- Non-Business essential personnel present at the primary operating facility or another location will receive instructions from the Director of Administration or designee. In most scenarios, non-continuity personnel will be directed to proceed to their homes or other NJ Department of Children and Families facilities to wait for further guidance.
- At the time of notification, if available, information will be provided regarding safety precautions and routes to use when leaving the primary operating facility.

Emergency procedures during non-working hours with or without a warning will be implemented as follows:

- Designated Business Essential Staff will deploy to the designated continuity facility from their current location.
- Business Essential Staff will depart to the assigned continuity facility from their current location.
- Non- Business Essential Staff will remain at their residence or other designated facility to wait for further instructions.

. Business Essential Employees will augment staff already assigned to the Professional Center. These activities will be coordinated by the Director of Administration or designee with the replacement staff on a case-by-case basis. Non- Business Essential Staff personnel will remain available to replace or augment continuity personnel, as required.

The Director of Administration will direct the NJ Department of Children and Families Business Essential Employees to move to another facility, duty station, or home until further notice.

In the event of an activation of the Continuity Plan, the NJ Department of Children and Families may need to procure necessary personnel, equipment, and supplies that are not already in place for continuity operations on an emergency basis.

PHASE III: CONTINUITY OPERATIONS

Upon activation of the Continuity Plan, the NJ Department of Children and Families will continue to operate at 50 East State Street until ordered to cease operations by the

Commissioner or Designee via phone, email or text. During that time, essential functions will transfer to The Professional Center at DCF. The NJ Department of Children and Families must ensure that the continuity plan can be operational within 12 hours of plan activation.

The designated Business Essential Employees will be first to arrive at the continuity facility to prepare the site for the arrival of additional personnel. Upon arrival at the Professional Center at DCF staff will:

- Ensure infrastructure systems, such as power and heating, ventilating, and air conditioning are functional.
- Prepare check-in duty stations.
- Address telephone inquiries from staff.
- Identify security issues.
- Address telephone inquiries from Families.

As Business Essential Employees arrive, the Director of Training/Designee will conduct in-processing to ensure accountability. In-processing procedures are conducted at The Professional Center at DCF and will include: Registering, receive copies of the building floor plan, receive Chain of Command and seating assignment. In addition, the office will identify all organization leadership available at the continuity facility.

Upon arrival at the Professional Center at DCF, NJ Department of Children and Families Business Essential Employees will:

- Report immediately to the front lobby for check-in and in-processing.
- Receive all applicable instructions and equipment.
- Report to their respective workspace as identified in floor plan or as otherwise notified during the activation process.
- Retrieve pre-positioned information and activate specialized systems or equipment.
- Monitor the status of NJ Department of Children and Families personnel and resources.
- Continue NJ Department of Children and Families mission essential functions.
- Prepare and disseminate instructions and reports, as required.
- Comply with any additional continuity reporting requirements with the NJ Department of Children and Families. Notify family members, next of kin, and emergency contacts of preferred contact methods and information.

Business Essential Employees will account for all NJ Department of Children and Families personnel. The NJ Department of Children and Families will use the following processes to account for all personnel:

- Call down telephone trees, The Department of Children and Families Emergency Information Hot line 1-855-653-2336, NJDCF Internet and intranet website, etc. Human Resources will attempt to communicate with personnel who are unaccounted for.

During continuity operations, the NJ Department of Children and Families may need to acquire additional necessary personnel, equipment, and supplies on an emergency basis to sustain operations for up to 30 days or until normal operations can be resumed.

Phase IV: Reconstitution Operations

Within 24hrs of an emergency relocation, the following individuals will initiate and coordinate operations to salvage, restore, and recover 50 East State Street after receiving approval from the appropriate State and local law enforcement and emergency services:

- Director of Facilities or designee will supervise all phases of the reconstitution process
- Each NJ Department of Children and Families Division will designate a reconstitution point-of-contact (POC) to work with the Office of Facilities Support and to update office personnel on developments regarding reconstitution and provide names of reconstitution POCs to Chief of Staff within 12 hours of the Continuity Plan activation.

During continuity operations, Director of Facilities Support, Treasury and the Landlord must determine the status of the 50 East State Street facility affected by the event. Upon obtaining the status of the facility, the Landlord, NJ Department of Children and Families/Department of Treasury will determine how much time is needed to repair 50 East State Street and/or acquire a new facility. This determination is made in conjunction with Commissioner/Chief of Staff. Should NJ Department of Children and Families decide to reoccupy the building after repairs Director of Facilities Support and Treasury have the responsibility in conjunction with the Landlord of supervising the repair process and must notify Chief of Staff of the status of repairs, including estimates of when the repairs will be completed.

Reconstitution will commence when the Commissioner or other authorized person ascertains that the emergency situation has ended and is unlikely to reoccur. These reconstitution plans are viable regardless of the level of disruption that originally prompted implementation of the Continuity Plan. Once the appropriate NJ Department of Children and Families authority has made this determination in coordination with other State, local and/or other applicable authorities, one or a combination of the following options may be implemented, depending on the situation:

- Continue to operate from the Professional Center at DCF.
- Reconstitute the 50 East State Street and begin an orderly return to the facility.

- Begin to establish a reconstituted Department in another facility or at another designated location.

Before relocating to 50 East State Street or another facility, the Director of Facilities Support will conduct appropriate security, safety, and health assessments to determine building suitability. In addition, the Facilities Director will verify that all systems, communications, and other required capabilities are available and operational and that the Department is fully capable of accomplishing all essential functions and operations at the new or restored primary operating facility.

Upon a decision by the Commissioner or other authorized person that 50 East State Street can be reoccupied or that NJ Department of Children and Families will be reestablished in a different facility:

- The NJ Department of Children and Families Business Essential staff must notify The Commissioner/designee with information regarding continuity activation and relocation status, The Professional Center at DCF, operational and communication status, and anticipated duration of relocation.
- The NJ Department of Children and Families shall submit a Continuity Status Reporting Form to the Chief Of Staff/Designee, only if it contains more information beyond what has been reported.
- The Office of Facilities Support will develop space allocation and facility requirements.
- The DCF office of Human Resources will notify all personnel that the emergency or threat of emergency has passed and actions required of personnel in the reconstitution process using phone tree, text and email.
- Treasury will coordinate with the NJ Department of Children and Families and/or other applicable facility management group to obtain office space for reconstitution if 50 East State Street is uninhabitable.
- Human Resources will develop procedures, as necessary, for restructuring staff.
- Upon instruction from the Office of the Commissioner and as directed by the Office of the Chief of Staff the Office of Human Resources will inform all personnel impacted, that the need for activation of the Department of Children and Families COOP Plan no longer exists. An orderly return to normal activity and facilities may require a phased approach if conditions dictate. The Director of Facilities Support will provide updates to the Office of the Chief of Staff Department of Children and Families as to the status of the reconstitution.
- An after action review will examine operations, effectiveness of plans and procedures and will identify areas requiring correction. A remedial action plan may also be developed. Implementation of the plan will be monitored by the Chief Of Staff or Designee.

Upon verification that the required capabilities are available and operational and that the NJ Department of Children and Families is fully capable of accomplishing all essential functions and operations at the new or restored facility, the Director of Administration will begin supervising a return of personnel, equipment, and documents to the primary operating facility or a move to a temporary or new permanent primary operating facility. The phase-down and return of personnel, functions, and equipment will follow the priority-based plan and schedule outlined below; the NJ Department of Children and Families will develop return plans based on the incident and facility within 12 hours of plan activation.

• Priority #	• Action/Activity	• Responsible POC
1.	• Verify electrical requirements are met Emergency Generator installed at 50 East State St.	• Facilities Support
2.	• Verify IT/Communications requirements are met	• Information and Technology
3.	• Essential records transferred	• Records Unit
4.	• Equipment check implemented	• Facilities Support
5.	• Return of security	• Facilities Support

The NJ Department of Children and Families will continue to operate at the Professional Center at DCF until ordered to cease operations by the Commissioner/Chief of Staff. At that time, essential functions will transfer to the 50 East State Street. The NJ Department of Children and Families has developed plans to instruct personnel on how to resume normal operations as outlined below; the NJ Department of Children and Families will develop resumption plans based on the incident and facility within 12 hours of plan activation.

The New Jersey Department of Children and Families will focus on conducting normal operations, shutting down operations at the Professional Center at DCF, and reviewing and evaluating the overall Reconstitution process by conducting an after-action review for the purpose of evaluating the effectiveness of the Reconstitution policy, plans, processes, and procedures. This phase focuses on reviewing and evaluating the overall Reconstitution process. Through this review, New Jersey Department of Children and Families will identify lessons learned, best practices, and improvement needs. This includes developing an After Action Report for the purposes of summarizing the reconstitution event, identifying opportunities to improve and enhance the organization's Continuity program, plans, and capabilities; and developing an approach to implementing

improvements, to include incorporating After Action Report into the overarching Corrective Action Plan.

The post-Reconstitution activities described below apply regardless of the Reconstitution level. Key activities performed during Phase II include, but are not limited to those noted below -

- Implement phase down plan.
- Conduct normal operations.
- Conduct post-reconstitution hot wash.
- Document and evaluate review findings.
- Develop After Action Report/; update Corrective Action Plan.
- Update/revise Reconstitution Plan.
- Review findings.
- Update plans.

The Records Unit will identify any records affected by the incident. In addition, the Records Unit will effectively transition or recover vital records and databases, as well as other records that had not been designated as vital records, using the plan outlined below; the NJ Department of Children and Families will develop vital records transition and recovery plans based on the incident and facility within 24 hours of plan activation.

Vital Files, Records Databases

Each Department of Children and Families component is responsible to identify emergency operating records, legal and financial documents essential to the continued functioning of the Department in the event The Department of Children and Families has to relocate to 50 East State Street. Back up of vital documents on disks or CD's should be routine. One of the Department of Children and Families COOP Plan objectives is to ensure the protection of vital records that are needed to support essential functions of the Department at the Continuity Facility

Categories of these types of vital records and databases may include:

Emergency Operating Records- Records essential to the continued function or Reconstitution of The Department of Children and Families during and after an emergency. Included are the emergency plans; orders of succession; delegations of authority; staffing assignments; and related records of a policy

Legal and Financial Rights Records- Vital records critical to carrying out the essential legal and financial functions and activities included are records having such value that their loss would significantly impair the conduct of essential agency functions, to the detriment of the legal or financial rights or entitlements of the organization. Examples: accounts, contracting and acquisition files; official personnel files, payroll.

An information memo will be developed for dissemination to all Department of Children and Families employees in regards to the duration of alternate operations, and pertinent information The Department of Children and Families Chief of Staff will approve the memos and direct distribution of the document to the relocated personnel and non-essential staff through appropriate media and other sources that are available.

When the continuity personnel, equipment, and documents are in place at the new facility or 50 East State Street, the remaining NJ Department of Children and Families staff at the continuity facility or devolution site will transfer essential functions, cease operations, and deploy to the new or restored primary operating facility. The Chief of Staff will oversee the orderly transition from the continuity facility of all NJ Department of Children and Families functions, personnel, equipment, and records to a new or restored primary operating facility.

The NJ Department of Children and Families will conduct an After Action Review once back in the primary operating facility or in a new facility. The Chief of Staff can initiate and designate entities responsible for completing the After Action Review. The After Action Review will address the effectiveness of the continuity plans and procedures, identify areas for improvement, document these in the NJ Department of Children and Families corrective action program (Correctives Action Plan), and then develop a remedial action plan as soon as possible after the reconstitution. Designated staff are responsible for documenting areas for improvement in the Corrective Action Plan and developing a remedial action plan. In addition, the After Action Review will identify which, if any, records were affected by the incident, and will work with the Records Unit to ensure an effective transition or recovery of vital records and databases and other records that had not been designated as vital records.

DEVOLUTION OF CONTROL AND DIRECTION

The NJ Department of Children and Families is prepared to transfer all of its essential functions and responsibilities to personnel at a different location should emergency events render leadership or staff unavailable to support the execution of NJ Department of Children and Families essential functions. If deployment of continuity personnel is not feasible due to the unavailability of personnel, temporary leadership of the NJ Department of Children and Families will devolve to Preselected Child Protection and Permanency Area Offices. The NJ Department of Children and Families devolution plan is located at The Office of Emergency Management 50 East State Street Trenton NJ.

Purpose:

This Devolution of Operations Plan supports overall Department of Children and Families Continuity of Operations (COOP) planning, and provides procedures, guidance, and organizational structure to ensure the continuation of Department of Children and Families essential functions in the event that Department of Children and Families is incapacitated and personnel are unavailable or incapable of deploying to the designated Alternate

Relocation Facility. In this situation, Department of Children and Families Executive Management, leadership responsibility and essential functions will devolve to the designated Child Protection and Permanency Area Office along with several other satellite and interagency offices.

Plan Organization:

The plan outlines the basic policies, definitions, and assumptions that form the framework for the plan.

The plan introduces concepts relevant to the development and execution of the Devolution of Operations Plan.

The plan assigns responsibilities to the respective Department of Children and Families organizations tasked with planning and implementing devolution.

Plan provides an operational overview of devolution implementation.

Plan addresses specific Devolution of Operations site support procedures and requirements.

The annexes and tables, serve to strengthen or expand upon information discussed in the plan and will further specify information as to the identification of Department of Children and Families essential functions, alternate relocation facilities, mission critical systems, contact persons based upon location and/or function and resource requirements.

The Office of Emergency Management maintains responsibility for ensuring the currency of the NJ Department of Children and Families devolution plan.

Objectives:

The Devolution of Operations Plan addresses a key component of Continuity of Operations (COOP) planning identified in Federal Preparedness Circular (FPC) 65, Federal Executive Branch Continuity of Operations (COOP), dated June 15, 2004, in the event that Devolution of Operations procedures are necessary. At a minimum, the plan will meet the following objectives:

1. Identify prioritized essential functions and determine necessary resources to facilitate their immediate and seamless transfer to a devolution site;

2. Include a roster identifying organization Point of Contact (POCs) at the designated devolution site with overall responsibility for the personnel who will perform essential functions and activities when the devolution option of COOP activates;

3. Identify the likely activation conditions (triggers) that would initiate or activate the Devolution of Operations Plan;

4. Specify how and when direction and control of agency operations will transfer to the devolution of operations site(s);

5. List necessary resources (people, equipment, and materials) to perform essential functions at the devolution site;

6. Establish reliable processes and procedures to acquire resources necessary to continue essential functions and sustain operations for extended periods; and

7. Establish capabilities to restore or reconstitute agency authorities to their pre-event status upon termination of devolution.

Applicability and Scope:

This plan applies to the functions, operations, and resources necessary to ensure the continuation of The Department of Children and Families Central Office if crisis, attack, or catastrophe renders DCF Executive Management personnel incapable or unavailable to sustain operational capability at The Department of Children and Families or the alternate relocation sites, the Professional Center at DCF 30 Van Dyke New Brunswick NJ. This plan is applicable to all Department of Children and Families components. DCF staff must be familiar with Devolution of Operations policies and procedures and their respective Devolution of Operations roles and responsibilities.

Assumptions:

This Devolution of Operations Plan is based on the following assumptions:

1. An unwarned catastrophic event or condition requires the relocation of The Department of Children and Families executive management responsibilities and essential functions to organizations outside of the existing DCF central office site and the designated alternate relocation facilities; the Professional Center at DCF 30 Van Dyke New Brunswick NJ. Department of Children and Families executive management personnel based in the state capital region are unavailable and incapable of relocation.

2. The facilities in the Devolution of Operations sites are unaffected and have been resourced to incrementally assume the essential functions of DCF Central Office until a reconstituted The Department of Children and Families Central Office can assume such responsibilities.

3. Essential functions at 50 East State Street site will temporarily transfer, if required, to the Professional Center at DCF 30 Van Dyke New Brunswick NJ until the Department of Children and Families can reconstitute.

4. Appropriate delegation provisions are in place to ensure the rapid and efficient transfer of legal and fiscal authority.

5. Significant changes to the Department of Children and Families statutory authority and/or responsibilities will necessitate a revision of this plan.

6. NJ Department of Children and Families will conduct and documents annual training of devolution staff and conducts exercises to ensure essential functions are capable of being performed during devolution. This documentation includes the dates of all TT&E events and names and titles of participating staff. The NJ Department of Children and Families devolution TT&E documentation will be maintained by The Office of Emergency Management and found at 50 East State Street Trenton NJ. Further, the NJ Department of Children and Families CAP supports the devolution program. The NJ Department of Children and Families CAP DCFOEM and CAP documentation will be found at 50West State Street Trenton NJ.

g. ORGANIZATION AND ASSIGNMENT OF RESPONSIBILITIES

Key staff positions within the NJ Department of Children and Families are to include individual continuity members, those identified in the orders of succession and delegation of authority, Essential Business Employees and others possess additional continuity responsibilities. The responsibilities of these key continuity personnel are delineated by Office of Human Resources.

Position	Responsibilities
Commissioner	• Provide strategic leadership and overarching policy direction for the continuity program • Implement the Continuity Plan when necessary, or when directed by a higher authority • Promulgate orders of succession and delegations of authority • Ensure adequate funding is available for emergency operations • Ensure all organization components participate in continuity exercises
Communications Manager	• Update telephone rosters monthly • Conduct alert and notification tests
Records Manager	• Review status of vital records, files, and databases
Training Manager	• Develop and lead Continuity training • Plan Continuity exercises
Business Essential Employees	• Be prepared to deploy and support organization essential functions in the event of Continuity Plan implementation • Provide current contact information to manager • Be familiar with continuity planning and know individual roles and responsibilities in the event of Continuity Plan activation • Participate in continuity training and exercises as directed

h. DIRECTION, CONTROL, AND COORDINATION

During activation of the Continuity Plan, the Commissioner maintains responsibility for control and direction of the NJ Department of Children and Families. Should the Commissioner become unavailable or incapacitated; the organization will follow the directions laid out in Annex OS, *Orders of Succession.*

i. DISASTER INTELLIGENCE

During a continuity event, the NJ Department of Children and Families will require the collection and dissemination of critical information. While specific incidents may create additional or specialized reporting requirements, the following table lists examples of the information that would be collected and reported regardless of incident type.

Information Element	Specific Requirement	Responsible Element	Deliverables	When Needed	Distribution
Personnel Accountability	Account for all Essential Business Employees and Non-Essential Business Employees Account for all contract personnel	Human Resources Division	Reports Briefings	Status updates hourly following Plan activation	
Operational Status	Percent of Essential Business Employees arrived at site Ability to conduct each essential function	Continuity Manager Division Representatives	Situation briefings Situation reports	No later than 6 hours after plan activation, then hourly	
Hazard Information	Threat details specific to the continuity facility	emergency operations center	Situation briefings Situation reports	Two times per day at shift change	

j. COMMUNICATIONS

The NJ Department of Children and Families has identified available and redundant critical communications systems that are located at the primary operating facility and continuity facility. Further, the NJ Department of Children and Families maintains fully capable continuity communications that support organization needs during all hazards/threats, to include pandemic and other related emergencies, and give full consideration to supporting social distancing operations.

All NJ Department of Children and Families necessary and required communications and IT capabilities should be operational within 12 hours of continuity activation.

k. BUDGETING AND ACQUISITION OF RESOURCES

The NJ Department of Children and Families acquires those resources and capabilities essential to continuity operations. Within the budget, the NJ Department of Children and Families allocates for continuity resources and capabilities in accordance with the Treasury Circulars and Policies and other applicable directives and provides for the acquisition of those resources necessary for continuity operations on an emergency basis for up to 30 days or until normal operations can be resumed.

As part of the budget process, the NJ Department of Children and Families Identifies, prioritize, and justify the allocation of budgetary resources. The NJ Department of Children and Families integrates the continuity budget with its long-term strategic plan and links the budget directly to objectives and metrics set forth in that plan. For those contracts vital to the support of organization essential functions, the NJ Department of Children and Families has ensured contractor statements of work include the provision to provide staffing, services, and resources during emergency conditions.

l. PLAN DEVELOPMENT AND MAINTENANCE

The NJ Department of Children and Families, Office of Emergency Management is responsible for maintaining the NJ Department of Children and Families Continuity Plan.

The Continuity Plan, NJ Department of Children and Families essential functions, and supporting activities, will be reviewed by the Office of Emergency Management and updated on an on-going basis from the date of publication as part of the maintenance of continuity plans and procedures. The Office of Emergency Management is responsible for the annual plan review and update. In addition, the plan will be updated or modified when there are significant organizational, procedural changes, or other events that impact continuity processes or procedures.

m. AUTHORITIES AND REFERENCES

Continuity of operations is a federal initiative required by Presidential directive to ensure that agencies are capable of continuing to perform their essential functions under a broad

range of circumstances. The Federal Department of Homeland Security (DHS) COOP Guidance Document of April 2004 provides the structure for formulation of a Continuity of Operations Plan, in accordance with Presidential Directive-67and the following-

Executive Orders:

- Executive Order 12148-Federal Emergency Management
- Executive Order 12472- Establishment of the National Communications System
- Executive Order 12656- Assignment of Emergency Preparedness Responsibilities
- Executive Order 13228- Establishing the Office of Homeland Security and Homeland Security Council
- Executive Order 13231- Critical Infrastructure Protection in the Information Age

Presidential Directives:

- Presidential Decision Directive 63 (Security of Infrastructure)
- Presidential Decision Directive 67 (Agencies must have COOP Plans)
- Homeland Security Presidential Directive-1 (Activity coordination)
- Homeland Security Presidential Directive – 3 (Warning levels)
- Homeland Security Presidential Directive #5 (HSPD#5)
- Homeland Security Presidential Directive #8 (HSPD#8)

Acts:

- Robert T. Stafford Disaster Relief and Emergency Assistance Act

State:

- State of NJ Executive Order # 50
- State of NJ Executive Order # 5
- ESF # 6 Mass Care

IDENTIFICATION OF MISSION ESSENTIAL FUNCTIONS (MEF)

The NJ Department of Children and Families has completed the MEF process to identify those functions that the NJ Department of Children and Families must continue.

New Jersey Essential Functions Table EF (attached Annex)

The NJ Department of Children and Families MEFs are based on its mission and role in support of the continued performance of State functions. Federal Preparedness Circular 65 defines essential functions as those that enable an organization to provide vital services, exercise civil authority, maintain the safety of the general public and sustain the industrial and economic base. It further states that an agencies business functions must be continued to provide for minimal to no disruption of the organization's operation.

Typically, essential functions are those that must be continued in all circumstances and that cannot suffer an interruption for longer than 12 hours. Functions must be prioritized according to the criticality of the function, the relationship of the function other organizational functions and the likely scenarios that would adversely impact the function.

The ability to continue an essential function is driven by the availability of trained personnel also referred to as human capital, vital records and data bases, supplies, equipment and systems. Planning for the support of essential functions must take into consideration the ability to implement this support at any time, to provide for full operational capability and to sustain this operation for thirty days.

Table EF is a summary listing of The Department of Children and Families essential functions, the unit responsible for the support of that function, a direct contact and the executive management representative with unit authority. The Department of Children and Families essential functions have been divided into three areas; Administrative activity, Life Safety activity and System Support activity.

Organization Mission Essential Functions

Organization MEFs are a limited set of their organizational functions that must be continued throughout, or resumed rapidly after, a disruption of normal activities. Using CGC 2 guidance, the NJ Department of Children and Families implemented the MEF identification process to identify and prioritize their organizational MEFs. Identification of Continuity Personnel

In order to continue its essential functions, the NJ Department of Children and Families has determined the staff positions necessary to relocate under Continuity Plan activation. A copy of the current roster is found at Human Resources. The Human Resources is responsible for maintaining roster currency and ensuring personnel are matched against needed positions.

Each Business Essential Employees is selected by the Human Resources based upon:

- The predetermined essential functions that must be performed, regardless of the operational status of the NJ Department of Children and Families primary operating facility
- The member's knowledge and expertise in performing these essential functions

- The member's ability to rapidly deploy to the relocation site in an emergency situation

Function	Title/ Position	Name	Telephone Numbers	Additional Information

n. Vital Records Management

"Vital records" refers to information systems and applications, electronic and hard copy documents, references, and records, to include classified or sensitive data, needed to support MEFs during a continuity event. The NJ Department of Children and Families has incorporated its vital records program into the overall continuity program, plans, and procedures.

The NJ Department of Children and Families vital records program incorporates into the overall continuity plan with a clear authority to include:

- Policies
- Authorities
- Procedures
- The written designation of the NJ Department of Children and Families vital records manager

Within 12 hours of activation, continuity personnel at the continuity facility for the NJ Department of Children and Families should have access to the appropriate media for accessing vital records, including:

- A local area network
- Electronic versions of vital records
- Supporting information systems and data
- Internal and external email and email archives
- Paper copies of vital records

Identifying Vital Records

The NJ Department of Children and Families has identified records vital to its operations, and has assigned responsibility for those records which includes a combination of continuity personnel and records management personnel.

NJ Department of Children and Families maintains a complete inventory of vital records, along with the locations of and instructions on accessing those records. This inventory will be maintained at a back-up/offsite location as designated to ensure continuity if the primary operating facility is damaged, destroyed, or unavailable.

DCF will develop and maintain a Vital records plan packet or collection including:

- A paper copy or electronic list of the NJ Department of Children and Families key organization personnel and continuity personnel with up-to-date telephone numbers
- A vital records inventory with the precise locations of vital records.

- Updates to the vital records.
- Necessary keys or access codes.
- Listing of the access requirements and sources of equipment necessary to access the records.
- The NJ Department of Children and Families continuity facility locations
- NJ Department of Treasury lists of records recovery experts and vendors.
- A copy of the NJ Department of Children and Families continuity plans.

For the above items, The Department of Children and Families is responsible for providing access requirements and lists of sources of equipment necessary to access the records (this may include hardware and software. Internet access, and/or dedicated telephone lines).

This packet will be reviewed annually with the date and names of the personnel conducting the review documented in writing to ensure that the information is current. A copy will be securely maintained at the NJ Department of Children and Families continuity facilities so it is easily accessible to appropriate personnel when needed.

Protecting Vital Records

The protection of vital records is essential to ensuring the records are available during a continuity event, thus enabling an organization to perform their MEFs. The NJ Department of Children and Families will conduct a vital records and database risk assessment to:

- Identify the risks involved if vital records are retained in their current locations and media, and the difficulty of reconstituting those records if they are destroyed
- Identify offsite storage locations and requirements
- Determine if alternative storage media are available
- Determine requirements to duplicate records and provide alternate storage locations to provide readily available vital records under all conditions

Appropriate protections for vital records will be provided and will include dispersing those records to other organization locations or storing those records offsite. Other protections include multiple redundant media for storage.

The responsibility of each Department of Children and Families component is to identify emergency operating records, legal and financial documents essential to the continued functioning of the Department in the event The Department of Children and Families has to relocate to an ARF. Back up of vital documents on disks or CD's should be routine. One of the Department of Children and Families COOP Plan objectives is to ensure the protection of vital records that are needed to support essential functions of the Department at the ARF.

Categories of these types of vital records and databases may include:

Emergency Operating Records- Records essential to the continued function or reconstitution of The Department of Children and Families during and after an emergency. Included are the emergency plans; orders of succession; delegations of authority; staffing assignments; and related records of a policy or procedural nature that provide The Department of Children and Families staff with guidance and information resources necessary for conducting operations and for resuming formal operations at its conclusion, Legal and Financial Rights Records-

Training and Maintenance

The NJ Department of Children and Families vital records program includes a training program conducted by the Training Academy for all staff, to include periodic briefings to managers about the vital records program and its relationship to their vital records and business needs. The NJ Department of Children and Families staff training focuses on identifying, inventorying, protecting, storing, accessing, and updating the vital records. Training records for vital records are maintained by the Training Academy and are found at 30 Van Dyke Avenue New Brunswick NJ

The NJ Department of Children and Families vital records program includes an review of the program to address new security issues, identify problem areas, update information, and incorporate any additional vital records generated by new agency programs or functions or by organizational changes to existing programs or functions. The review provides an opportunity to familiarize staff with all aspects of the vital records program. It is appropriate to conduct a review of the vital records program in conjunction with the NJ Department of Children and Families continuity exercises. At a minimum, NJ Department of Children and Families vital records are annually reviewed, rotated, or cycled so that the latest versions will be available.

The NJ Department of Children and Families will conduct testing, documented in the NJ Department of Children and Families testing records, of the capabilities for protecting classified and unclassified vital records and for providing access to them from the alternate facility.

o. Continuity Facilities Annex

Continuity Facility Information

The NJ Department of Children and Families] has designated continuity facilities as part of its Continuity Plan and has prepared continuity personnel for the possibility of unannounced relocation to the site(s) to continue performance of essential functions.

The **NJ Department of Children and Families** continuity facility is located at **30 Van Dyke, New Brunswick NJ** A map of the surrounding area, including directions and route from the 50 east State Street Trenton is located on page 22. Additional facility details are as follows:

(1) 30 Van Dyke Ave. New Brunswick is **leased** by the **NJ Department of Children and Families**

(2) **security will be provided by a contracted Vendor. Staff must have a DCF Identification badge to gain entry .**

(3) Robert Wood Johnson Medical Center is located close by.

(4) The area has local businesses to support the needs of employees located at the facility.

The Professional Center at DCF provides the following in sufficient quantities to sustain operations for up to 30 days or until normal business activities can be resumed:

(1) Space and equipment, including computer equipment and software. The continuity facility is able to accommodate 100 personnel. Facilities floor plans, equipment inventory, and other applicable documents are found at 30 Van Dyke Avenue, New Brunswick NJ.

(2) Capability to perform MEFs within 12 hours of plan activation for up to 30 days or until normal operations can be resumed.

(3) Reliable logistical support, services, and infrastructure systems. Consideration for health, safety, and security, of personnel.

(4) Interoperable communications for effective interaction

(5) Capabilities to access and use vital records.

(6) Systems and configurations that are used in daily activities. IT support at the continuity facility is Located at the Facility. Details on the systems and configurations are available at Office of Information Technology.

(7) Emergency/back-up power capability. Details on the power capability are available at the Office of Facilities Management.

Continuity Facility Logistics

The NJ Department of Children and Families continuity facilities will be prepared to achieve full operational capability within 12 hours of notification.

The NJ Department of Children and Families will maintain transportation support that describes procedures for no-warning and with-warning events.

- During a no-warning event, and continuity personnel are to be transported to the continuity facility via Private or State owned and Assigned vehicles.
- During a with-warning event, and continuity personnel are transported to the continuity facility via Private or State owned and Assigned vehicles.

Continuity Facility Orientation

The NJ Department of Children and Families shall regularly familiarize Business Essential Employees with its continuity facilities. The NJ Department of Children and Families shall accomplish this orientation through, orientation sessions at the site, and briefings.

Continuity Communications

The NJ Department of Children and Families has identified available and redundant critical communication systems at the continuity facility. Further, the NJ Department of Children and Families maintains fully capable continuity communications that could support organization needs during all hazards/threats, to include pandemic and other related emergencies, and give full consideration to supporting social distancing operations. These systems provide the ability to communicate within and outside the organization and are found at Office of Facilities Support Stuyvesant Road Ewing NJ.

Communication systems that support the essential functions.

Communication System	Support to Essential Function	Current Provider	Specification	Alternate Provider	Special Notes
Non-secure Phones	x	Verizon		ATT	
Secure Phones					
Fax Lines	x	Verizon			
Cellular Phones	x			ATT	
Satellite					
Pagers					
E-mail	x	NJ OIT server		OIT	
Internet Access	x	NJ OIT server		OIT	
Data Lines	x	NJ OIT server		OIT	
Two-way Radios	x	NJDCF Office of Emergency Management		NJ State Police/NJ DHS Police	

All NJ Department of Children and Families necessary and required communications and IT capabilities should be operational within 12 hours of activation.

The NJ Department of Children and Families possesses communications capabilities to support the organization's senior leadership while they are in transit to continuity facilities. These capabilities are maintained by the Office of Facilities Support and The Office of Emergency Management.

p. Leadership and Staff

ORDERS OF SUCCESSION

Pre-identifying orders of succession is critical to ensuring effective leadership during an emergency. In the event an incumbent is incapable or unavailable to fulfill essential duties, successors have been identified to ensure there is no lapse in essential decision-making authority. The NJ Department of Children and Families has identified successors for the positions of Commissioner, Chief of Staff, Executive Management and Managers.

A copy of these orders of succession is found at The Office of Emergency Management 50 East State Street Trenton NJ. The Office of Emergency Management is responsible for ensuring orders of succession are up-to-date. When changes occur, the Office of Emergency Management distributes the changes to Executive Management via e -mail or hard copy.

The NJ Department of Children and Families orders of succession are:

- At least three positions deep, where possible, ensuring sufficient depth to ensure the NJ Department of Children and Families ability to manage and direct its essential functions and operations
- Include devolution counterparts, where applicable
- Geographically dispersed, where feasible
- Described by positions or titles, rather than by names of individuals holding those offices
- Reviewed by the organization's legal department as changes occur
- Included as a vital record, with copies accessible and/or available at both the primary operating facility and continuity facilities at The Office of Emergency Management

Commissioner	*Chief of Staff*
	TBD
	TBA

Position	Designated Successors
Chief of Staff	Director of Admissions
	Director of IT

Position	Designated Successors
Assistant Commissioner Legal & Legislative Affairs	Director of the office of Policy and Regulatory Development
	Director Legislative affairs

Position	Designated Successors
Assistant Commissioner Performance Management and Accountability	Director of Quality
	Director of IAIU

Position	Designated Successors
Assistant Commissioner Family Community Partnership/ Division on Women	Deputy Director Family Community Partnership
	Program Supervisor, Division on Women

Position	Designated Successors
Chief Administrator	Assistant Director
	Assistant Director

Position	Designated Successors
Assistant Commissioner Child Protection and Permanency	Deputy Director
	Assistant Director

Position	Designated Successors

Position	Designated Successors
Director Children System of Care	Deputy Director
	Deputy Director

Position	Designated Successors
Director of Adolescent Services	Assistant Director
	Executive Assistant

Position	Designated Successors
Director Emergency Management	Assistant Director
	Director of Facilities Support

In the event of a change in leadership status, the NJ Department of Children and Families must notify the successors, as well as internal and external stakeholders. In the event the NJ Department of Children and Families leadership becomes unreachable or incapable of performing their authorized legal duties, roles, and responsibilities, The Department of Children and Families will initiate a notification of the next successor in line. The Commissioner or Designee will use the following procedures to notify internal and external stakeholders of the change in leadership: Email, Text, Phone, and Emergency Radios (internal)

The NJ Department of Children and Families training records document the annual successor training for all personnel who assume the authority and responsibility of the organization's leadership to include briefing successors to the position of the Commissioner on their responsibilities and duties as a successor. This training is reflected in the NJ Department of Children and Families training records located at The Professional Center at DCF 30 Van Dyke Avenue New Brunswick NJ.

DELEGATIONS OF AUTHORITY

Generally, the NJ Department of Children and Families pre-determined delegations of authority will take effect when normal channels of direction are disrupted and terminate

when these channels have resumed. Pre-determined delegations of authority may be particularly important in a devolution scenario.

The NJ Department of Children and Families has identified the following delegations of authority:

- Orderly succession of officials to the position of Commissioner in the case of the Commissioner's absence, a vacancy at that office, or the inability of the Commissioner to act during an emergency or national security emergency. The delegation of authority for the Commissioner is found in the Hazard Specific Appendices.

The NJ Department of Children and Families delegations of authorities are found at the continuity facility and at Office of Emergency Management

Are included as vital records

(1) Are written in accordance with applicable laws and organization policy ensuring that the organization's MEFs are performed
(2) Outline explicitly in a statement the authority of an official to re-delegate functions and activities, as appropriate
(3) Delineate the limits of and any exceptions to the authority and accountability for officials
(4) Define the circumstances, to include a devolution situation if applicable, under which delegations of authorities would take effect and would be terminated

The NJ Department of Children and Families has informed those officials who might be expected to assume authorities during a continuity situation. Further, the NJ Department of Children and Families has trained those officials who might be expected to assume authorities during a continuity situation at least annually for all pre-delegated authorities for making policy determinations and all levels using in Service Training.

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Human Capital/Continuity Personnel

People are critical to the operations of any organization. Selecting the right people for an organization's staff is vitally important, and this is especially true in a crisis situation. Leaders are needed to set priorities and keep focus. During a continuity event, Business Essential Employees will be activated by the NJ Department of Children and Families to perform assigned response duties. In respect to Business Essential Employees, the NJ Department of Children and Families has:

- Identified and designated those positions and personnel they judge to be critical to organization operations in any given emergency situation as

continuity personnel. A roster of Business Essential Employees is maintained by the Human Resources and is found at 50 East Stale Street.

- Identified and documented its Business Essential Employees possess the skills necessary to perform essential functions and supporting tasks. A roster of Business Essential Employees is maintained by Human Resources and is found at 50 East State Street.
- Officially informed all Business Essential Employees of their roles or designations by providing documentation in the form of a memo to ensure that Business Essential Employees know and accept their roles and responsibilities. Copies of this documentation is maintained by the Human Resources and found at 50 East State Street.
- Ensured Business Essential Employees participate in the organization's future continuity TT&E program. as reflected in training records. Training records are maintained by the Professional Center At DCF and found at 30 Van Dyke Avenue, New Brunswick NJ
- Provided guidance to Business Essential Employees on individual preparedness measures they should take to ensure response to a continuity event using Intra Net, Email. Copies of this guidance is maintained by The Office of Emergency Management and found at 50 East State Street Trenton NJ

All Staff

It is important that the NJ Department of Children and Families keeps all staff, especially individuals not identified as continuity personnel, informed and accounted for during a continuity event. The NJ Department of Children and Families has established procedures for contacting and accounting for employees in the event of an emergency, including operating status.

- The NJ Department of Children and Families employees are expected to remain in contact with their supervisors during any facility closure or relocation situation. Employees will be notified by text, email phones.
- The NJ Department of Children and Families ensures staff are aware of and familiar with Human Capital guidance in order to continue essential functions during an emergency. The NJ Department of Children and Families uses the following methods to increase awareness by utilizing a Department of Children and Families intranet website, employee orientation briefing emails.

Accounting for all personnel during a continuity event is of utmost importance. In order to account for all staff, NJ Department of Children and Families will utilize call trees, ECATs, Rosters. An event that requires the activation of the Continuity Plan may personally affect the NJ Department of Children and Families staff.

Human Capital Considerations

The NJ Department of Children and Families continuity program plans, and procedures incorporate existing organization-specific guidance and direction for human capital management, including guidance on pay, leave/time off, work scheduling, benefits, hiring, authorities, and flexibilities. Human Resource has the responsibility for the NJ Department of Children and Families Human Capital issues. A copy of these policies and guidance is found 50 East State Street Trenton NJ and NJ Civil Service Commission.

The NJ Department of Children and Families has developed organization-specific guidance and direction for continuity personnel on Human Capital issues. This guidance is integrated with Human Capital procedures for its facility, geographic region, and the Office of Personnel Management or similar organization. This guidance is maintained by the Human Resource Office and found at 50 East State Street Trenton NJ.

The NJ Department of Children and Families has issued continuity guidance for human capital on the following issues:

- Additional Staffing:
- Work Schedules and Leave/Time Off:
- Employee Assistance Program:
- Employees who may need assistance:
- Benefits:
- Premium and Annual Pay Limitations:

Further, the Human Resource Office communicates Human Capital guidance for emergencies (pay, leave/time off, staffing, work scheduling, benefits, hiring authorities and other human resources flexibilities) to managers in an effort to help continue essential functions during an emergency. The process for communicating this information is as follows: Civil Service Commission Policy/Procedures.

VI. Test, Training, and Exercises Program

The NJ Department of Children and Families will establish an effective TT&E program to support the organization's preparedness and validate the continuity capabilities, program, and ability to perform essential functions during any emergency. The testing, training, and exercising of continuity capabilities is essential to demonstrating, assessing, and improving the NJ Department of Children and Families ability to execute the continuity program, plans, and procedures.

- Training familiarizes continuity personnel with their roles and responsibilities in support of the performance of an organization's essential functions during a continuity event.
- Tests and exercises serve to assess, validate, or identify for subsequent correction, all components of continuity plans, policies, procedures, systems, and facilities used in response to a continuity event. Periodic testing also ensures that equipment and procedures are kept in a constant state of readiness.

In accordance with CGC 1 guidance, the NJ Department of Children and Families will perform TT&E events at regular intervals, as shown in the table below.

Continuity TT&E Requirements	Monthly	Quarterly	Annually	As Required
Test and validate equipment to ensure internal and external interoperability and viability of communications systems				x
Test alert, notification, and activation procedures for all continuity personnel				x
Test primary and back-up infrastructure systems and services at continuity facilities				x
Test capabilities to perform essential functions				x
Test plans for recovering vital records, critical information systems, services, and data				x
Test and exercise of required physical security capabilities at continuity facilities				x
Test internal and external interdependencies with respect to performance of essential functions				x
Train continuity personnel on roles and responsibilities				x
Conduct continuity awareness briefings or orientation for the entire workforce				x
Train organization's leadership on essential functions				x
Train personnel on all reconstitution plans and procedures				x

Continuity TT&E Requirements	Monthly	Quarterly	Annually	As Required
Allow opportunity for continuity personnel to demonstrate familiarity with continuity plans and procedures and demonstrate organization’s capability to continue essential functions				**x**
Conduct exercise that incorporates the deliberate and preplanned movement of continuity personnel to continuity facilities				**x**
Conduct assessment of organization’s continuity TT&E programs and continuity plans and programs				**x**
Report findings of all annual assessments.				**x**
Conduct successor training for all organization personnel who assume the authority and responsibility of the organization’s leadership if that leadership is incapacitated or becomes otherwise unavailable during a continuity situation				**x**
Train on the identification, protection, and ready availability of electronic and hardcopy documents, references, records, information systems, and data management software and equipment needed to support essential functions during a continuity situation for all staff involved in the vital records program				**x**
Test capabilities for protecting classified and unclassified vital records and for providing access to them from the continuity facility				**x**
Train on an organization’s devolution option for continuity, addressing how the organization will identify and conduct its essential functions during an increased threat situation or in the aftermath of a catastrophic emergency				**x**
Conduct personnel briefings on continuity plans that involve using or relocating to continuity facilities, existing facilities, or virtual offices				**x**

Continuity TT&E Requirements	Monthly	Quarterly	Annually	As Required
Allow opportunity to demonstrate intra- and interagency continuity communications capability				x
Allow opportunity to demonstrate back-up data and records required for supporting essential functions at continuity facilities are sufficient, complete, and current				x
Allow opportunity for continuity personnel to demonstrate their familiarity with the reconstitution procedures to transition from a continuity environment to normal activities				x
Allow opportunity for continuity personnel to demonstrate their familiarity with agency devolution procedures				x

The NJ Department of Children and Families will formally document and report all conducted continuity TT&E events, including the event date, type, and participants. Documentation also includes test results, feedback forms, participant questionnaires, and other documents resulting from the event. Continuity TT&E documentation for the NJ Department of Children and Families is to be managed by the Office of Emergency Management and is found at 50 East State Street Trenton NJ Further, the NJ Department of Children and Families will conduct a comprehensive debriefing after each exercise, which allows participants to identify systemic weaknesses in plans and procedures and recommend revisions to the organization's continuity plan.

The NJ Department of Children and Families will develop a CAP to assist in documenting, prioritizing, and resourcing continuity issues identified during TT&E activities, assessments, and emergency operations. The NJ Department of **Children and Families** CAP incorporate evaluations, AARs, and lessons learned from a cycle of events into the development and implementation of its CAP.

Capability	Observation	Recommendation	Corrective Action	Capability Element	Primary Responsible Office	Organization POC	Start Date	End Date
Planning				Planning	**NJ Department of Children and Families**			

HAZARD-SPECIFIC APPENDICES

IMPLEMENTING INSTRUCTIONS

- Emergency Notification Procedure
- and Essential Functions Checklist
- IT Checklist
- Emergency Equipment Checklist
- Delegations of Authority
- Orders of Succession

I. Implementing Instruction #1: Delegation of Authority

NJ Department of Children and Families

Delegation Number: Issue Date:

DELEGATION OF AUTHORITY

AND SUCCESSION FOR THE

Commissioner NJ Department of Children and Families

PURPOSE

This is a delegation of authority for the continuity of essential functions through the orderly succession of officials at the NJ Department of Children and Families to the Office of the Commissioner in case of the Commissioner's absence, a vacancy at that office, or the inability of the Commissioner to act during a disaster or national security emergency.

DELEGATION

I hereby delegate authority to the following officials, in the order listed below, to exercise the powers and perform the duties of the Commissioner, in case of my absence, inability to perform, or vacancy of the office and until that condition ceases.

1. Chief Of Staff

If this position is vacant, the next designated official in the order of succession may exercise all the powers, duties, authorities, rights, and functions of the Office of the Commissioner but may not perform any function or duty required to be performed exclusively by the office holder.

Eligibility for succession to the Office of the Commissioner shall be limited to officially assigned incumbents of the positions listed in the order of succession, above. Only officials specifically designated in the approved order of succession are eligible. Persons appointed on an acting basis, or on some other temporary basis, are ineligible to serve as a successor; therefore, the order of succession would fall to the next designated official in the approved order of succession.

AUTHORITIES

OFFICE OF PRIMARY INTEREST

The Office of the Commissioner is the office of primary interest in this delegation.

CANCELLATION

Commissioner

New Jersey Department of Children and Families

GLOSSARY

Activation – Once a continuity of operations plan has been implemented, whether in whole or in part, it is considered "activated."

Organization Head – The highest-ranking official of the primary occupant organization, or a successor or designee who has been selected by that official.

All-Hazards – The spectrum of all types of hazards including accidents, technological events, natural disasters, terrorist attacks, warfare, and chemical, biological including pandemic influenza, radiological, nuclear, or explosive events.

Alternate Facilities – Locations, other than the primary facility, used to carry out essential functions, particularly in a continuity event. "Alternate facilities" refers to not only other locations, but also nontraditional options such as working at home (teleworking), telecommuting, and mobile-office concepts.

Business Impact Analysis (BIA) – A method of identifying the effects of failing to perform a function or requirement.

Business Process Analysis (BPA) – A method of examining, identifying, and mapping the functional processes, workflows, activities, personnel expertise, systems, data, and facilities inherent in the execution of a function or requirement.

Communications – Voice, video, and data capabilities that enable the leadership and staff to conduct the mission essential functions of the organization. Robust communications help ensure that the leadership receives coordinated, integrated policy and operational advice and recommendations and will provide the ability for governments and the private sector to communicate internally and with other entities (including with other Federal agencies, State, territorial, tribal, and local governments, and the private sector) as necessary to perform their Mission Essential Functions (MEFs).

Continuity – An uninterrupted ability to provide services and support, while maintaining organizational viability, before, during, and after an event.

Continuity Facilities – Locations, other than the primary facility, used to carry out essential functions, particularly in a continuity situation. "Continuity facilities" refers to not only other locations, but also nontraditional options such as working at home (teleworking), telecommuting, and mobile-office concepts.

Continuity of Operations – An effort within individual agencies to ensure they can continue to perform their Mission Essential Functions and Primary Mission Essential Functions during a wide range of emergencies, including localized acts of nature, accidents, and technological or attack-related emergencies.

Continuity Event – Any event that causes an agency to relocate its operations to an alternate or other continuity site to assure continuance of its essential functions.

Continuity Personnel – Those personnel, both senior and core, who provide the leadership advice, recommendations, and functional support necessary to continue essential operations

Corrective Action Program – An organized method to document and track improvement actions for a program. The Corrective Action Program (CAP) system is a web-based tool that enables Federal, State, and local emergency response and homeland security officials to develop, prioritize, track, and analyze corrective actions following exercises or real world incidents. Users may enter data from a finalized After Action Report/Improvement Plan, track the progress of corrective action implementation, and analyze and report on trends in improvement plans.

Delegation of Authority – Identification, by position, of the authorities for making policy determinations and decisions at headquarters, field levels, and all other organizational locations. Generally, pre-determined delegations of authority will take effect when normal channels of direction have been disrupted and will lapse when these channels have been reestablished.

Devolution – The capability to transfer statutory authority and responsibility for essential functions from an agency's primary operating staff and facilities to other agency employees and facilities, and to sustain that operational capability for an extended period.

Essential Functions – The critical activities performed by organizations, especially after a disruption of normal activities. There are three categories of essential functions: National Essential Functions, Primary Mission Essential Functions, and Mission Essential Functions.

Facilities – Locations where an organization's leadership and staff operate. Leadership and staff may be co-located in one facility or dispersed across many locations and connected by communications systems. Facilities must be able to provide staff with survivable protection and must enable continued and endurable operations.

Interoperable Communications – Communications that provide the capability to perform essential functions, in conjunction with other organizations/entities, under all conditions.

Leadership – The senior decision makers who have been elected (e.g., the President, State governors) or designated to head a branch of government or other organization.

Memorandum of Agreement/Memorandum of Understanding – Written agreement between departments/agencies that require specific goods or services to be furnished or tasks to be accomplished by one organization in support of the other.

Mission Essential Functions – The limited set of agency-level government functions that must be continued throughout, or resumed rapidly after, a disruption of normal activities.

Orders of Succession – Provisions for the assumption by individuals of organization senior leadership positions during an emergency in the event that any of those officials are unavailable to execute their legal duties.

Primary Operating Facility – The site of an organization's normal, day-to-day operations; the location where the employee usually goes to work.

Reconstitution – The process by which surviving and/or replacement organization personnel resume normal operations from the original or replacement primary operating facility.

Risk Analysis – The process by which risks are identified and evaluated.

Risk Assessment – The identification and assessment of hazards.

Risk Management – The process of identifying, controlling, and minimizing the impact of events whose consequences are or may be unknown, or events that are fraught with uncertainty.

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Testing, Training, and Exercises – Measures to ensure that an agency's continuity plan is capable of supporting the continued execution of the agency's essential functions throughout the duration of a continuity situation.

Virtual Offices – An environment where employees are not collocated and rely exclusively on information technologies to interact and conduct their work across distance from multiple geographic locations.

Vital Records – Electronic and hardcopy documents, references, and records that are needed to support essential functions during a continuity situation. The two basic categories of vital records are (1) emergency operating records and (2) rights and interests records.

AUTHORITIES AND REFERENCES

1. **Executive Order 5.**
2. **Executive Order 50**
3. Directive 51/Homeland Security Presidential Directive 20, *National Continuity Policy*, dated May 9, 2007.
4. Continuity Guidance Circular 1, *Continuity Guidance for Non-Federal Entities (States, Territories, Tribal, and Local Government Jurisdictions and Private Sector Organizations)*, dated January 21, 2009.
5. Continuity Guidance Circular 2, *Continuity Guidance for Non-Federal Entities: Mission Essential Functions Identification Process (States, Territories, Tribes, and Local Government Jurisdictions),* dated July 22, 2010.
6. FEMA Comprehensive Preparedness Guide 101, *Developing and Maintaining State, Territorial, Tribal, and Local Government Emergency Plans*, dated March 2009.

ACRONYMNS

AAR	After Action Report
BIA	Business Impact Analysis
BPA	Business Process Analysis
CAP	Corrective Action Program
CGC	Continuity Guidance Circular
IT	Information Technology
MEF	Mission Essential Function
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
STTEF	State, Territorial, and Tribal Essential Function
TT&E	Test, Training, and Exercise

2015 APSR

Attachment D

Training Plan Update

June 30, 2015

Workforce Development

Office of Training and Professional Development

(NJ Child Welfare Training Academy)

Accomplishments

During the **10/1/2013 – 9/30/2014** CFSP period, the New Jersey Child Welfare Training Academy:

- As the size and scope of the training operation continued to evolve and grow, the New Jersey Child Welfare Training Academy operations were folded into a larger organization, The Office of Training and Professional Development.
- Continued to provide instruction in seven monitored training categories under the Modified Settlement Agreement. Ensured that all caseload carrying staff attended and passed competency in: pre-service; in-service; concurrent planning; case practice model modules 1 and 2; investigative and intake; new supervisory; and new adoption worker training programs. Those staff who did not achieve their training goals during any six-month monitored period, had either separated from service, were on a leave of absence or had other justifiable reasons for their delay. It should be noted that since this statistic has been monitored that it has always been at 100% compliance.
- Coordinated and tracked the delivery of training in foundational casework practices including instruction in: concurrent planning; mental illness; and domestic violence protocol, mental health screening tools, child passenger restraint, and child sex abuse.
- Developed and delivered in partnership with various state universities, coordinated and tracked the delivery of additional specialized in-service courses for caseload carrying staff. Achieved 100% compliance for all caseload carrying staff to receive 40 hours of in-service training per calendar year as required by the Modified Settlement Agreement (MSA) of 2006. This is another area where compliance has been at 100% since the beginning of the MSA.
- Continued to sponsor a Baccalaureate in Child Welfare Program (BCWEP) that provides graduates with a two-year post-graduation employment opportunity with DCF, and a child advocacy certificate program for DCF employees to enhance their child advocacy skills and knowledge.
- Continued the MSW program that enables staff to continue to work full-time while pursuing their advanced degree. It also provides opportunities for staff to deepen their perspectives on social work and child welfare, develop advanced clinical skills, and enhance their supervisory skills. Field placements are planned using the other departments of DCF wherever possible.
- Ensured that competency is now assessed in all MSA required courses, newly written/offered courses, and select University Partnership courses through the use of pre and post-tests, and

established training policy and procedures for individuals who do not reach a specified level of competency upon completion of the courses.

- Continued to use data gathered from the Pre and Post tests to assess training outcomes, adjusted the pre and post test questions, and as planning tools for future course development
- Continued to design and launch supervisory level courses to compliment existing courses that train workers in the areas of secondary trauma impact, case plan, and sex abuse.
- Created the "Master Supervisor" Certificate program which helps build a solid knowledge base of 10 courses designed to enhance and improve supervisory skills and aids in local office succession planning. During the review period over 100 supervisors have been nominated for and started taking courses towards their certificate.
- Continued to gather and analyze course evaluations to improve course content and trainer delivery. Qualitative information gathered was used to plan for new courses and modify existing courses.
- All new caseworkers now receive Genogram, Ecomap and child passenger restraint training in their pre-service training as well as presentation by community-based resources.
- The University Partnership and the Office of Training and Professional Development (NJCWTA) created over 47 new trainings that brought the total of available courses to over 120.

Over 57,099 staff was trained in 2,199 training sessions

- Continued operations in a 107,000 sq.ft. facility with over 36 modern classrooms ranging in capacity size from 20 to 306 students.
- Completed a training program for 47 Local Office Managers conducted by the National Network for Social Work Managers. This training enhances the capacity of the LOMs to lead their teams through impending challenges and opportunities. It ran over 18 months and had mentoring and capstone projects as key elements of the learning process.
- Continued to deliver "Focus on Supervision" training that teaches Casework supervisors to team with clinically based service providers to look at families and the issues they may have with a more clinical approach to problem solving.
- Improved office case planning skills with a Transfer of Learning (TOL) training that is customized to the individual needs of each Local Office.
- Our training facility in New Brunswick was chosen as the site for the 2016 National Staff Development and Training Association National conference.
- In our role as a national model for training and training delivery, we have supplied technical assistance to Louisiana, Ohio, New York City and State, Delaware, Connecticut, and Pennsylvania. We are also sending trainers to Wisconsin to trainer their trainers in our supervisory training and to Minnesota to train our Human Trafficking 1 & 2 courses.
- Broadened our understanding of data by creating and delivering a course called "Supervisors and Data"
- Launched 18 new courses
- Completed Training to all DCF staff in Human Trafficking 1 (Awareness) and planed for delivery of Human Trafficking 2 in January 2015

Program Description:

The New Jersey Child Welfare Training Academy (NJCWTA) was established under the 2004 New Jersey Child Welfare Reform Plan, "A New Beginning: The Future of Child Welfare in New Jersey." The Reform Plan and the succeeding July, 2006 Modified Settlement Agreement (MSA) called for new ways of working with families and social services partners. The NJCWTA is charged with ensuring that New Jersey's child welfare staff training programs focus on supporting the State's commitment to the State's child welfare system reform. The NJCWTA is assisted in carrying out its mission through a collaborative partnership with Rutgers, Montclair and Stockton Universities. Together these entities form the New Jersey Child Welfare Training Partnership (NJCWTP).

In 2013, the Training Academy functions, administration over the NJCWTP, and the management and development of the 30 Van Dyke avenue site were folded into a larger operation called The Office of Training and Professional Development (OTPD) .

Preamble:

The New Jersey Department of Children and Families Office of Training and Professional Development of which the Child Welfare Training Academy is a part, serves staff and organizational development in ways that reflect both the best practices of child welfare and the quality improvement processes of a dynamic learning organization.

Principles of the NJ Office of Training and Professional Development

- Training is designed and delivered so that all people who interact with the Department of Children and Families (families and staff) are treated with the empathy, respect and understanding that reflect best child welfare practices.
- Training development, from curriculum design to training delivery, is framed within a commitment that promotes life-long learning: we model the change that we seek to enhance with others inside and outside the agency.
- Training and staff development occur within a framework of practice that actively creates a professional learning community at all levels of the agency.
- Needs and skills of our organization are assessed on an ongoing, quality-driven basis so that the OTPD reliably and responsively meets the shifting demands and expectations of the child welfare community.
- The OTPD emphasizes a blended learning approach to curriculum and training development: multiple methods of instruction allow an adult workforce to maximize its learning potential.
- All DCF staff will have the knowledge, skills, abilities and attitudes to work appropriately with people based on their self-identification so that power imbalances are minimized and staff members actively seek out the strengths and capacities of the people with whom they work.

In pursuit of the above principles, we hold ourselves accountable to the highest standards of performance required of a learning organization.

New Jersey Child Welfare Staffing and Structure:

- Robert M. Ring serves as the Director of OTPD. Total number of staff is 31, which includes 20 trainers and supervisors, 5 managers and 6 administrative support staff.
- The NJCWTA staff is located at the following locations:
  - 4 Echelon Plaza, 201 Laurel Road, Voorhees (6 staff)
  - Primary site-30 Van Dyke Ave. New Brunswick (26 staff)
- The NJCWTA training locations are at the following locations:
  - 4 Echelon Plaza, 201 Laurel Road, Voorhees
  - Primary site- 30 Van Dyke Ave. New Brunswick

- Additionally, OTPD trainers travel statewide to ensure that training programs are made as accessible to DCF staff as possible and training frequently is provided at the local and area offices and/or other public and private locations that are close to field staff.

Training Programs:

- **Pre-Service (Family & Community Engagement):** Pre-Service training is 180 hours of training that includes training on intake, assessments, community resources, Genograms, child passenger restraint and the critical components of the case practice model. All workers are enrolled within two weeks of their start date. Competency exams are completed by all new case-carrying workers. The Pre-Service training curriculum is centered on the new case practice model that includes family and community engagement. The Pre-Service training consists of 31 classroom days and 24 field days dispersed throughout the curriculum. The Pre-Service training also includes simulation exercises that provide trainees with a realistic setting to conduct interviews with parents, medical staff, and other child welfare professionals. During the last review period we began piloting a revised version of this training that has on-line components that The allowable Title IV-E administrative functions this training activity addresses are: *Referral to services; Preparation for and participation in judicial determinations; Placement of the child; Development of the case plan; Case reviews; Case management and supervision.*
- **Concurrent Planning:** Through the School of Social Work at Rutgers University, DCP&P staff are trained in concurrent planning methods, which optimize caseworkers' skills and ability to simultaneously work toward family reunification while also ensuring timely adoption, if the courts so move. This course was recently revised and updated. The 18 hours of training are offered in a classroom setting. The allowable Title IV-E administrative functions this training activity addresses are: *Preparation for and participation in judicial determinations; Placement of the child; Development of the case plan; Case reviews; Case management and supervision; Recruitment and licensing of foster homes and institutions.*
- **Supervisory Practices in Child Welfare:** Supervisory Practices in Child Welfare was developed to train newly promoted employees. It offers 14 days of combined classroom and field Supervisory training followed by competency assessments. The training is divided into 3 modules which are

Self Management, People Management and Casework Management. The allowable Title IV-E administrative functions this training activity addresses are: *Development of the case plan; Case reviews; Case management and supervision.*

In-Service Foundation Courses: Immediately following their pre-service training, **26 days of** training for newly hired DCP&P employees are offered within their first year of service includes:

- *Case Practice Module 1: Engaging Families and Building Trust-Based Relationships* (3 Day Course)
  This introduction to the guiding principles of DCF Case Practice focuses on engagement skills as the initial step in this strengths-based, family-centered model of practice. Concepts and strategies promoting respect, genuineness, empathy, and trustworthiness will be presented and further discussed. Skills that foster trust-based relationships with children, families, and communities will be highlighted and practiced. In addition, tools and techniques to identify the needs and strengths of the family will be illustrated through case studies.

- *Case Practice Module 2: Making Visits Matter—Home Visiting to Improve Safety, Well-Being, Stability, and Permanence for Children and Families* (3 Day Course)
  Today's changing child welfare practices focus strongly on the relationships with the child, family, or substitute caregiver(s) as well as the family's informal and formal supports. Skills needed to make the visit effective for information gathering and decision making will be presented so that participants will be better able to define the family's needs, the potential of all team members, and the support of all involved systems. Learning how to use the principles of the practice model in getting to know each family will be a central point in this workshop. Methods to achieve the four outcomes (safety, permanency, well-being, and stability) will be further explored. Ways to connect/join with children, families, and their informal and formal support networks will be emphasized.

- *Child Sexual Abuse Training for Child Welfare Professionals: Module 1* (4 Day Course)
  This training prepares the child welfare professional for working with families in which children have been sexually abused. Module 1 offers days 1-2 (Course 31) and days 3-4 (Course 32) of this course to examine how participants' values, beliefs, and emotional responses can impact case practice; identify the facts and myths about child sexual abuse that are prevalent in our

society; and discuss the historical context of child sexual abuse and its influence on present day beliefs. Participants will also be able to identify the many systems involved in child sexual abuse cases and differentiate between the specific roles and resources they offer, discuss the indicators of child sexual abuse within the context of normal and problematic sexual behaviors, discuss the effects of child sexual abuse and recognize the need for specialized treatment, examine personal feelings and beliefs about the non-offending parent/adults in the family, and discuss the crisis of the disclosure and the impact on the family.

- *Child Sexual Abuse Training for Child Welfare Professionals: Module 2* Course # (4 Day Course)
  Module 2 offers days 1-2 (Course 33) and 3-4 (Course 34) of the child sexual abuse curriculum to guide the child welfare professional in exploring how personal values, culture, and gender impact issues surrounding child sexual abuse; recognizing implications within the context of domestic violence, language barriers, and immigration status; reviewing the immediate and long-term impact of sexual abuse on children; identifying effective treatment options and remediating treatment barriers; exploring the impact of sexual abuse on the non-offending parent and family members; helping workers recognize common characteristics and types of offenders; and exploring Meghan's Law and other components of the legal system. Participants will discuss specific investigative processes and interview procedures to utilize with children and family members while also learning about effects of vicarious trauma.

- *Concurrent Permanency Planning* is a three-day course that lays out the concepts and practice of permanency, beginning with an historical perspective of relevant legislation, the modified settlement agreement, and exploration of children's developmental needs. The specific permanency practice of concurrent permanency planning is then explored, including the concepts of prognostic assessment, diligent search, and full disclosure; and the emerging practices of birth parent/resource parent relationships and post-permanency communication. The training culminates with a module concentrating on permanency for youth beyond concurrent planning timelines.

- *Domestic Violence* (2 Day Course)
  Current information on domestic violence and applicable NJ laws to provide a framework for the basic assessment of risk and protective factors in families will be the focus of this workshop. Participants will learn about prevalence, correlates, dynamics, and common manifestations of domestic violence. The cycle of violence and the typical progression of an abusive relationship will be illustrated. Highlights of the workshop also include a discussion of the impact of culture on the experience of domestic violence, including culturally accepted behaviors and community responses. Techniques for assessing and responding to domestic violence will be explored, and laws of NJ that pertain to domestic violence will be clarified.

- *Domestic Violence Policy and the DCP&P Case Practice Protocol* (1 Day Course)
  This workshop is taught by a trainer and a domestic violence liaison. Supervisors will explore and discuss the Domestic Violence Protocol that guides DCP&P staff when responding to DV situations in families where child abuse/neglect is present. Assessment and management of DV cases will be the central focus of this workshop. The emphasis will be on promoting the use of available DV tools, remedies, and resources so DCP&P workers can effectively address DV issues in their caseloads. To conclude, methods will be presented that supervisors can use to assess and develop the domestic violence skills of staff

- *Mental Health Screening Tool* (1 Day Course)
  This workshop is for non-clinical staff to learn to use the Mental Health Screening Tool for children with mental health concerns. Presentations will address the tool in the context of the effects of trauma on children's mental and physical development. The impact of trauma on the brains of children in foster care and the long-term effects of trauma will be examined. Participants will have an opportunity to practice using the Mental Health Screening Tool on case examples

- *Mental Health* (1 Day Course)
  A basic overview of a variety of serious mental illnesses will start this workshop. Participants will learn to recognize "red flags" that may indicate an adult may not be able to safely and effectively care for a child because of a mental illness. Resources in the mental health system and how to use them to create a safety net will be highlighted. Participants will develop skills in helping the adult who is suffering from a mental illness to care for the child (ren) in a safer and more effective manner.

- *Substance Abuse 1: Understanding Substance Abuse and Child Welfare* (Day 1)
  The goal of this first module is to provide child welfare professionals with a contextual knowledge of the effects of substance use and/or abuse that may be experienced by parents involved in the child welfare system. This module discusses the importance of using a family-centered approach to identify and respond to the variety of needs experienced by the entire family. This module will also discuss the prevalence of substance use (alcohol and other drugs), mental health disorders, and many other issues that may coexist for child welfare-involved families. The prevalence of mental health and substance abuse in New Jersey and the differential impact of these issues from a gender and race/ethnicity perspective will be highlighted.

- *Substance Abuse 2: Substance Abuse Disorders, Treatment, and Recovery* (Day 2)
  The goals of this second module are to inform child welfare professionals about the substance use disorder, treatment, and recovery needs of child welfare-involved families that can be used in the context of home visitation and case management. This module provides an explanation of the treatment and recovery processes, and it discusses the specifics on how substance use disorders can affect the interpersonal relationships and family dynamics of the family involved with the child welfare system in the context of safety, permanency, and well-being of children

- *Substance Abuse 3: Mental Illness* (Day 3)
  This third module aims to increase the child welfare worker's recognition of the differences between mental health disorders and substance use disorders in adults; explain symptoms that warrant comprehensive screening and assessments; define the different models of treatment for co-occurring disorders; and identify how these disorders affect interpersonal relationships and family dynamics of the family involved with the child welfare system in the context of safety, permanency, and well-being of children.

- *Substance Abuse 4: Case Planning* (Day 4)
  The purpose of this fourth module is to make child welfare workers aware of the various ways in which children are impacted by their parents' substance use and/or mental disorders, including co-occurring disorders, from prenatal exposure through childhood and adolescent development. This module discusses the importance of screening and assessment for a child's own alcohol, drug, and mental disorders that may or may not be a result of their parents' personal issues. The importance of delivering culturally competent services and collaborating with other service providers in developing and monitoring case plan progress will also be emphasized. Participants will also be provided with techniques for gathering and incorporating information about an individual's or family's substance use, mental health, or co-occurring disorders and treatment into the case plan..

  The allowable Title IV-E administrative functions that this training activity addresses are: *Referral to services; Development of the case plan; Case reviews.*

- **First Responders in Child Welfare (Child Protective Services Intake):** The First Responders in Child Welfare training has been developed and incorporated into the Pre-Service program. The First Responders in Child Welfare training is also offered as a stand-alone training to existing intake case carrying staff. During 2012, this course was expanded to 3 modules or six days or 36 hours. First Responders in Child Welfare is a training program designed to enhance investigator's required skills in the areas of family engagement; communication/interviewing;

assessment; documentation and investigation. The allowable Title IV-E administrative functions this training activity addresses are: *Referral to services; Preparation for and participation in judicial determinations; Case management and supervision.*

- **SDM/Safety and Critical Thinking:** This is a 2 day in-service program focusing on safety assessments using structured decision-making, and the creation of safety plans. Training includes instruction on how to recognize and respond to safety issues, and procedures to follow to ensure the safety of the child(ren). A competency exam is administered at the end of the course. Title IV-E administrative functions this training activity addresses are: *Referral to services; Preparation for and participation in judicial determinations; Case management and supervision.*

- **Documentation for Child Welfare Professionals:** This two-day in-service program covers the fundamentals of grammar rules typically involved in documentation narratives, and instruction and practice in summary recording. The program teaches how to determine relevant content for case narratives, and how to capture it in writing with clarity, accuracy and conciseness. The allowable Title IV-E administrative functions this training activity addresses are: *Preparation for and participation in judicial determinations; Development of the case plan; Case reviews; Case management and supervision.*

- **Cultural Competency:** This two-day in-service program discusses the influences of culture, assumptions and biases on case practice, and what it means to be culturally competent. Instruction on the importance of cultural competence when working with the LGBTQI community is also provided. The allowable Title IV-E administrative functions this training activity addresses are: *Preparation for and participation in judicial determinations; Development of the case plan; Case management and supervision.*

- **SPRU Worker Training:** This three-day program provides instruction to Special Response Unit (SPRU) workers on policy and practice in responding to child protective services referrals during evenings, weekends and holidays. Instruction includes the use of internal agency policies on after-hours response. The allowable Title IV-E administrative functions this training activity addresses are: *Referral to services; Preparation for and participation in judicial determinations; Case management and supervision.*

- **NJ Spirit:** The New Jersey Child Welfare Training Academy trains new and seasoned workers on the automated case management tool that supports case carrying workers' child protection, foster care, and adoption practice work. Training includes instruction on how to navigate the computer system and how to develop and maintain automated records management, case planning, service planning and data tracking. Since January, 2009, more than 3,000 staff (3,294) received NJ Spirit training. The allowable Title IV-E administrative functions this training activity addresses are: *Referral to services; Preparation for and participation in judicial determinations; Placement of the child; Development of the case plan; Case reviews; Case management and*

supervision; Recruitment and licensing of foster homes and institutions; Rate setting; A proportionate share of related agency overhead. Costs related to data collection and reporting.

- **Adoption Subsidy Training:** This is a 3 hour workshop offered to all adoption staff to explore in detail at what is involved in meeting the requirements of the Adoption Subsidy Program. Presentation is focused on Adoption subsidy policy/procedures and skills related to pre-finalization approval through post-finalization case completion. The allowable Title IV-E administrative functions this training activity addresses are: *Preparation for and participation in judicial determinations; Placement of the child; Development of the case plan; Case management and supervision.*

- **Working With and Supporting Families:** This 3-day training focuses on introducing Assistant Family Service Worker staff (a.k.a. case aides) to the skills and concepts needed to effectively work with and support families involved with DCP&P. The allowable Title IV-E administrative functions this training activity addresses are: *Referral to services; Preparation for and participation in judicial determinations; Placement of the child; Development of the case plan; Case reviews; Case management and supervision.*

- **DCP&P Case Practice and the Domestic Violence Protocol:** This course will provide a brief review of domestic violence dynamics, as well as information on the Domestic Violence Protocol adopted by the agency in 2009. Instruction includes how to respond to families experiencing domestic violence, statutory requirements, DCF guiding principles and goals, the application of DV Protocol standards within the DCP&P Case Practice Model. The allowable Title IV-E administrative functions this training activity addresses are: *Referral to services; Preparation for and participation in judicial determinations; Placement of the child; Development of the case plan; Case reviews; Case management and supervision.*

- **Case Planning for Case Planning With Youth, Children and their Families**
  This interactive mandatory class has two components: an online class and two day classroom training. The online course informs caseworkers about the NJ Spirit enhancements to the Case Plan. In addition, everyone is to complete the online before attending the two classroom training.

  The purpose of the two day classroom training is to help staff continue to functionalize the skills learned during the Case Practice Model trainings. The revised Case Plan document was created to reflect ongoing efforts to relate to families, to address their underlying needs, and to share decision-making authority with them.

The classroom training will address the process that caseworkers, families, and youth follow in developing a Case Plan that captures the family's Case Goal and the incremental steps made during the life of the case.

In-class demonstrations will model how monthly visits and Family Team Meetings can be used as opportunities to create and update a family agreement. Participants will think about and prepare for each section of the Case Plan such as the Case Goal, Family Summary, Strengths and Needs, Family Agreement (new tab), Visitation, and Educational Stability. The allowable Title IV-E administrative functions this training activity addresses are: Placement of the child; Development of the case plan; Case reviews; Case management and supervision.

- **Immigration Training Day 1**
  The goal of this day one of a three day training (each day is an independent module) is to increase child welfare workers understanding of the importance of working together with indigenous family and community structures when serving refugee and immigrant children. Module 1 will offer an overview of Immigration and Child Welfare, which will include knowledge about the various statuses of immigrant families in this country and knowledge about national laws and state policy regarding immigrant

  and refugee families, their rights and applicable services.

In Addition the courses listed below reflect what trainings are available to staff during the training year:

Administrative Hearings

Adolescent Training Module 1: Positive Youth Development

Adolescent Training Module 2: Life-Long Connections—Permanency Planning for Adolescents

Adolescent Training Module 3: Life Skills Assessment

Adoption New Worker Training

Adoption of Older Children

Adoption Recruitment/Placement Supports

AFSW 2: Making Connections and Visits Matter

Aligning Our Values – Master Supervisor Certificate Course

Animal Abuse as a Risk Factor for Child Maltreatment and Family Violence

Application of Group Dynamics to Family Team Meetings

Art of Communication

Assessing Child Play and Behavior

Assessing Older Adults as Surrogate Caregivers: Module 1 of 3

Assessing Older Adults as Surrogate Caregivers: Module 2 of 3

Assessing Older Adults as Surrogate Caregivers: Module 3 of 3

Attachment-Focused Work with Adoptive Families

Autism, Asperger's, and Obsessive Compulsive Disorder (OCD)

Bringing the Protective Factors Framework to Families

Building Resiliency in Children: Why Some Bounce Back and Some Never Do

Car Seat Safety

Case Planning for Youth, Children, and Their Families – Classroom

Case Planning for Youth, Children, and Their Families – NJS Online

Case Practice Model and DCF Business Practices

Case Practice Module 1: Engaging Families and Building Trust-Based Relationships

Case Practice Module 2: Making Visits Matter

Case Practice Module 3: Facilitating the Family Team Meeting Process

Case Practice Module 4: Functional Assessment

Case Practice Module 5: Planning and Intervention

Case Practice Module 6: Supervising Case Practice in New Jersey

Celebrating Culture: Working with Latino Families

Child Abuse and Neglect Investigative Findings: Using the Four-Tier Model

Child Abuse and Neglect Investigative Findings: Using the Four-Tier Model (Executive Overview)

Child Abuse and Neglect Investigative Findings: Using the Four-Tier Model (Online Booster)

Child Protective Services and the Legal System

Child Sexual Abuse Training for Child Welfare Professionals: Module 1

Child Sexual Abuse Training for Child Welfare Professionals: Module 2

Child Traumatic Stress

Children and Eating Disorders

Children In Court (CIC): Document Search

Coaching the Challenge Employee – Master Supervisor Certificate Course

Compulsive Hoarding: Issues and Strategies

Conceptualizing Crisis Intervention When Working with Adoptive Families

Concurrent Permanency Planning

CPR (Cardiopulmonary Resuscitation) and First Aid

Creating a Meaningful Life Story: Advanced Lifebook Development

Critical Thinking for Ethical Practice in Public Child Welfare

CSOC – Introduction to Children's System of Care

Cultural Competency: Module 1 of 3

Cultural Competency: Module 2 of 3

Customer Service for Child Welfare Staff

Data Skills for Supervisors – Master Supervisor Certificate Course

DCF Manager Orientation

Defensive Driving: A Classroom-Based Course on Crash Avoidance

Difficult Conversations: A Survival Guide for Supervisors

Difficult Conversations: A Survival Guide for Workers

Disaster Preparedness/Emergency Response

Documentation for Child Welfare Professionals

Domestic Violence

Domestic Violence Training for Supervisors – Master Supervisor Certificate Course

Domestic Violence Certificate Program

Domestic Violence Policy and the DCP&P Case Practice Protocol

Engagement of Non-Residential Fathers

Engaging and Teaming with Families

Enhancing Adoptive Families' Support of LGBTQI Youth

Enhancing Visitation: A Caseworker's Guide to Improving Visit Quality for Children and Families

Equal Employment Opportunity/Affirmative Action

Everyone Has a Story

Excel Training: Beginner Level

Excel Training: Intermediate Level

Executive Leadership in Organizations Serving Children and Families

Executive Writing Skills

Factual Witness Training

Family Dynamics in Addiction

Family Preservation Services: New Worker Training, Day One

Family Preservation Services: New Worker Training, Day Two

Family Preservation Services: New Worker Training, Day Three

Family Preservation Services: New Worker Training, Day Four

Family Preservation Services: New Worker Training, Day Five

Family Preservation Services: New Worker Training, Day Six

Family Systems Theory

Fetal Alcohol Spectrum Disorder

First Responders for Supervisors – Master Supervisor Certificate Course

First Responders: Module 1

First Responders: Module 2

First Responders: Module 3

Focus on Supervision

Fostering Youth Participation in Court

Gang Identification, Trends, and the Psychology of Gang Members

Girls and Gangs

Handling Vicarious Traumatization: Supervisors Building Resiliency

Helping Caregivers Talk with Kids, Tweens, and Teens Openly and Honestly About Sexuality

Human Trafficking: Education and Awareness

Human Trafficking: Engaging and Interviewing Skills

Hybrid New Worker Training – Modules 8/9: Making Visits Matter

Infant Care Basics for Non-Parent Workers

Intervening with Batterers Training

Interviewing Children with Consideration of Their Development

Introduction to Supervision of Clerical and Administrative Support Staff

Introduction to Testifying in Court (Half Day)

Investigations in the Context of Four Tiers

Kinship Adoption

LGBTQI 101

Lifebook Work for Child Welfare Professionals

Managing Your Personal and Professional Boundaries

Mental Health Evaluations Used in Child Abuse/Neglect Proceedings

Mental Health Screening Tool

Mental Illness

Missing and Exploited Youth (formerly known as Youth Runaway Behavior)

Motivational Interviewing: Applying Motivational Enhancement Theory

New Worker Orientation: Welcome to DCF!

New Worker Pre-Service Training: Understanding Child Welfare in NJ (Module 1)

New Worker Pre-Service Training: Taking Care of Yourself (Module 2)

New Worker Pre-Service Training: Computer Applications (Module 3)

New Worker Pre-Service Training: The Self-Aware Practitioner (Module 4)

New Worker Pre-Service Training: Focusing on Families from Screening to Closing (Module 5)

New Worker Pre-Service Training: Computer Applications--Structured Decision Making and NJ SPIRIT (Mod 6)

New Worker Pre-Service Training: Child Development and Identifying Abuse and Neglect (Module 7)

New Worker Pre-Service Training: Engagement and Interpersonal Helping Skills (Module 8)

New Worker Pre-Service Training: Facilitating Change (Module 9)

New Worker Pre-Service Training: Simulation (Module 10)

NJ Parent Link

NJS Resource Facilitator Training

Non-Violent Crisis Intervention

Normal Sexual Development through the Child Welfare Lens

Office Of Licensing Inspectors Training

Office Of Licensing Simulation

Preparing Children for Adoption

Presentation Skills

PRIDE Excellence Training

Psychology of Adoption

Qualitative Review Training

Reunification: The Importance of Resource Parents

RFSW Recruiter – Only for Resource Family Support Workers

RFSW Simulation – For RFSW Supervisors

RFSW Trainer Workshop – For New RFSW Trainers

SAFE (Structured Analysis Family Evaluation)

SAFE Interviewing

SANS Securing the Human (Security Awareness Network Online Training)

Social Emotional Foundations of Early Learning: An Infant Mental Health Approach

Special Response Unit (SPRU) Training

Strategies for Working with LGBTQI Population and Families

Stress Management for the Child Welfare Worker

Structured Decision Making (SDM) and Critical Thinking

Student Bullying: What Caseworkers Need to Know & Do

Substance Abuse 1: Understanding Substance Abuse and Child Welfare

Substance Abuse 2: Substance Abuse Disorders, Treatment, and Recovery

Substance Abuse 3: Mental Illness

Substance Abuse 4: Case Planning

Supervising the Transfer of Learning (TOL) Process -M aster Supervisor Certificate Course

Supervising Workers on Family Reunification – Master Supervisor Certificate Course

Supervisors Building Workers' Resiliency – Master Supervisor Certificate Course

Supervisory Issues in Child Sexual Abuse – Master Supervisor Certificate Course

Supervisory Practice in Child Welfare – Module 1 of 3: Self-Management

Supervisory Practice in Child Welfare – Module 2 of 3: People Management

Supervisory Practice in Child Welfare – Module 3 of 3: Case Management

Technology Addiction

Testifying in Court

The Impact of Parental Incarceration on Children in the Child Welfare System

The Protective Factors Framework

Toddler Care Basics for Non-Parent Workers

Transgender 101

Trauma-Informed Response When Working with Adoptive Families

Understanding and Managing Personal Stress Reactions

Understanding and Responding to Exposure to Violence and Trauma Through the Eyes of Infants and Young Children

Understanding Gender Identity

Using Genograms and Ecomaps

What Every Caseworker Needs to Know About Education and Special Education for Children in the Child Welfare System

What Every Caseworker Needs to Know About Early Intervention and School Discipline for Children in the Child Welfare System

Worker Safety -

Working with Arab-American and Muslim Families

Working with Immigrant Families Module 1: Immigration and Child Welfare

Working with Immigrant Families Module 2: Providing Culturally Relevant Services

Working with Parents with Cognitive Challenges

Working with South Asian Families

Working with Veterans and Military Families

All totaled we now offer over 167 courses in our catalog.

Cost allocation methodology for Training Programs:

The cost allocation methodologies indicated below are based upon the types and activities of the staff trained rather than on the subject matter of the training. As a result, none of the training items will be chargeable in its entirety to Title IV-E.

- For those training items provided or taught by Child Welfare Training Academy (CWTA) state employed trainers or consultants hired by the Training Academy, the basis for allocation of CWTA salary and non-salary costs is a multifaceted process based on the following:

(1) The number of DCF staff trained by Training

Academy state employed trainers and contracted trainers during the current quarter, multiplied by the number of hours of training.

(2) The costs from step (1) assigned to DCF are then further allocated based on the number of DCF staff trained during the current quarter multiplied by the number of hours of training to the functions to which the trainees are assigned.

(3) If permanency workers are trained and costs are thus assigned to this functional group, the costs will be allocated to Title IV-E training and to numerous other non-Title IV-E programs based upon percentages derived from a Random Moment Study for the quarter.

(4) If Resource Family staff and/or local office Adoption Services workers are trained and costs are thus assigned to these functional groups, the costs will be allocated to Title IV-E Adoption Assistance, Title IV-E Foster Care, and Title IV-B CWS, based on the number of Title IV-E Foster Care, Title IV-E Adoption Assistance, and all other non-Title IV-E children who reside in foster care and adoptive placements under the supervision of the Division.

(5) If the local office Child Placement Review workers are trained and costs are thus assigned to this functional group, the costs will be charged to Title IV-E and Title IV-B based upon the number of Title IV-E and all other children in foster care at the end of the current quarter.

Workforce Development & Continuing Education Programs:

- **Child Welfare Training Partnership:** This initiative is lead by Rutgers University partnered with Montclair State University, and Richard Stockton University of New Jersey to provide immersion-style training sessions on the Case Practice Model (CPM) within the DCP&P Local Offices. Courses are offered at locations in the northern, central, and southern regions of the state. The Partnership features an extensive quality assurance program to facilitate the identification of

future training needs, assess trainee satisfaction with course offerings, and provide a feedback loop for continual course improvements. Evaluation efforts will focus on identifying changes in knowledge among training participants and other relevant practice-related outcomes, such as those included in the federal Child and Family Service Reviews. The first two modules of this model have been integrated into the Child Welfare Training Academy's foundation course structure and its competencies threaded throughout its other curricula. The FY '14 budget for this program was $3.5 million.

- **Baccalaureate Child Welfare Education Program, Stockton College:** The Baccalaureate Child Welfare Education Program (BCWEP) is a consortium of seven schools, headed by Stockton University with undergraduate programs in social work that enables students to earn their Bachelor of Social Work (BSW) degree. Students apply in their junior year of college to participate in the program which includes taking child welfare- specific classes in their senior year, completing an internship of more than 400 hours in local DCP&P offices and agreeing to work in the field of public child welfare at a local DCP&P office for a period of two years, post-graduation. The BCWEP program provides students with access to field instructors who offer competency-based field instruction in child welfare practice. These interns are provided a 12-day work readiness training program that is intended to expedite their ability to carry cases. 21 students who graduated in FY14 are currently working for DCF, and approximately 33 students will graduate in FY15. **The FY15 budget for this program is $743,379. In total 284 students or 10.8% of caseworkers are graduates of the BCWEP program.**

- **Montclair Child Advocacy Certification Program:** This is an 18-hour credit program for staff, Child Placement Review Board members, and Court Appointed Special Advocates (CASA) who want to volunteer to help children at risk of out-of-home placement or who are in foster care. The program covers the importance of the Family Court's role with respect to child placement; the Adoption of Safe Families Act; and how to negotiate community systems that impact on children and families already in or at risk of entering the child placement system. Approximately 40 DCF staff participate in this program annually. The FY'14 budget for this program was $114,207.

- **Montclair Adolescent Advocacy Certificate training Program:** This 15 post Bachelors credit hour course has been designed to provide students with a multidisciplinary understanding of the role

of the adolescent advocate as seen through the disciplines of law, sociology, psychology, as well as through the voice of youth in New Jersey. This unique perspective encompassing these areas of learning equips graduates with training that will enhance their case practice skills with adolescents and young adults. This program will be offered to 50 students, 25 in-class and 25 on-line learning. The FY13 Budget for this program is $267,000

- **Masters Child Welfare Education Program, (MCWEP):** The Masters Child Welfare Education Program (MCWEP) is a partnership among the New Jersey Department of Children and Families and a consortium of three New Jersey MSW programs—Monmouth University, Rutgers University, and Stockton University. Expanding on the Baccalaureate Child Welfare Education Program with Stockton University as the consortium's Lead Institution, its purpose is to offer current Division of Child Protection and Permanency supervisors the opportunity to strengthen their skills in clinical social work practice and supervision, obtain an advanced credential in social work (MSW), and ultimately to enhance the capacity of the Division to deliver the highest quality services to the vulnerable children and families that it serves. The program consists of three components: enrollment in one of three New Jersey part-time MSW programs, participation in the MCWEP Learning Community (consists of bimonthly online discussions and quarterly face-to-face seminars involving all participants), and enrollment in two MCWEP specific course electives – Leadership and Supervision in Child Welfare and Trauma-Informed Child Welfare Practice. MCWEP students attend classes and complete a minimum 900-hour internship experience at an agency outside of DCP&P throughout the course of the program. Participants agree to work one year for every year of attendance in an MSW program. There is a total of 74 MCWEP students participating in the program. As of May 2015, 12 students have graduated. **The total cost of the program for FY15 is $1,067,363**
  Below are the goals and expected outcomes of this program

- GOAL 1 To provide opportunities for supervisors currently employed at the DCP&P to obtain the graduate-level social work education
- Outcome 1.1 Currently employed supervisors will complete their MSW degrees within 2-4 years of enrollment in the program.
- Outcome 1.2 Curriculum for two new elective advanced-level courses will be developed and offered online for all enrolled students. Topics will include Leadership and Supervision in Child Welfare and Trauma-Informed Child Welfare Practice. Specific child welfare competencies will be taught throughout the course curriculum and in field assignments.
- Outcome 1.3 A competency-based Field Learning Plan will be developed to guide and assess field-based learning.
- GOAL 2 To strengthen systemic linkages among the three divisions of the Department of Children and Families by developing placements for participating DYFS supervisors directly in DCBH or DPCP, or in agencies contracted by these other two divisions.
- Outcome 2.1 All field instructors working with CWEI MSW students will have completed a field instructor training course, with specialized instruction on teaching students aspects of working with vulnerable children and families in related settings.
- Outcome 2.2 All field instructors working with CWEI MSW students throughout the state will be provided with liaison services (visits, consultation on student learning) by Graduate Program Academic Coordinators who understand the purpose of CWEI.

- GOAL 3 To assess the effectiveness of the project in preparing students for advanced social work practice and supervision within DCP&P
- Outcome 3.1 The effectiveness of project activities in meeting project goals and objectives will be measured:

Cost allocation methodology for Workforce Development and Continuing Education:

- Contract Training - costs identified to the NJ Child Welfare Training Partnership are as follows:

  (1) The number of DCF staff attending the training during the current quarter is identified.

  (2) The costs of the NJ Partnership for Child Welfare are allocated based on the number of trainees paid by the Division attending specific Partnership-sponsored training programs during the current quarter, to the functions to which the trainees are assigned.

  (3) If local office Permanency workers, Resource Family workers, Adoption workers, and/or child placement review workers are among those trained, the allocation procedure are the same as for items (3), (4), and (5) under Training Programs.

- Contract Training - costs identified to the Baccalaureate Child Welfare Education Program (BCWEEP) are as follows:

  (1) The individuals attending this program are not yet DCP&P employees; the costs of the program are allocated to all DCP&P functions based upon Division staff counts for the quarter.

  (2) Costs assigned to the specific types of workers mentioned under Training Programs in items (3), (4), and (5) will be allocated to Title IV-E training based upon the methodologies identified in those items.

The Years Ahead

The NJ Child Welfare Training Academy has been and will continue to work on the following initiatives during the five years that this plan is in effect.

- Continue to implement future phases of the Case Practice Model for all DCF caseload-carrying staff
- Expand curricula to meet the specific needs of new and seasoned workers; new curricula designs will include, but will not be limited to: risk assessment skills for investigators; case practice advocacy as it relates to LGBTQI adolescents; data reporting enhancements for supervisors; various new supervisory training courses for in-service work (e.g., supervising child sexual abuse

investigators; Special Response Unit supervisors, foster and adoptive services supervisors; and re-designing the pre-service program for all new caseworkers.

- Offer online training for experienced supervisors provided by the National Child Welfare Workforce Institute through a New Jersey Portal.
- Provide workers with blended training opportunities; i.e., combining web-based training with classroom instruction
- Provide additional simulation-style training earlier in the new worker training program and throughout other in-service trainings.
- Expand and update the Academy's web site development for reporting and tracking purposes.
- Provide local offices with immediate access to "just in time" training sessions through the development of liaisons between the local offices and Training Academy trainers.
- Provide more tools and processes for transfer of learning from the classroom to on-the-job application; and increase trainer time spent assisting local offices in assuring the transfer of learning.
- Continue to strengthen our university partnerships
- Develop more "Transfer of Learning" projects to enhance field performance

Priority Objectives:

- To revise and strengthen the Pre-Service and Foundation course progression offered to newly hired caseworkers to reflect the new caseworker competency model and the latest evidence based practice.
- Continued implementation of the Case Practice Model throughout DCF.
- Provide training for Local Office Managers and Area Office Directors.
- Development of a comprehensive evaluation and transfer of learning system to assess training outcomes.
- Further development of web based and distance learning training opportunities.
- Further development of simulation-based training.
- Development and implementation of specific and specialized training for supervisory casework staff.
- Development and implementation of specific and specialized training for staff members who work with and support resource families.
- Development and implementation of specific and specialized training for staff members who work with and support adolescents.
- Development and implementation of specific, specialized training for staff members who work with non-resident fathers and family members outside of the birth family (e.g., paramours)
- Initiate transfer of learning activities to compliment statewide mandatory trainings.
- Gather and use data to help drive course creation and modification
- Continue to develop transfer of learning models to support field activities

On-going Objectives:

- To ensure that all newly hired case carrying employees participate in the pre-service training that addresses the new case practice model and provides a comprehensive orientation to the Department of Children and Families.
- To expand the In-Service courses offered to seasoned caseworkers.

- To ensure that the concepts of the case practice model are continuously incorporated into all pre-service and in-service trainings.
- To ensure courses are periodically reviewed and updated, and reflect the latest evidence based practice.

***Future Goals*:**

- OTPD will continue to work all of the above-mentioned on-going objectives, as well as to continue to meet standards that are required in accordance with the Modified Settlement Agreement.
- Work cooperatively with other states in sharing available course material.
- Build bridges to other state agencies, particularly DHS, in an effort to partner our resources and deliverables.
- Sharply focus course creation on specific identified needs
- Begin to develop courses for other titles/jobs within the DCF framework
- Bring more community partners into our training network.
- Streamline data gathering operations
- Develop more tools to enhance learning at a Local Office level.
- Look to customize learning further to the individual needs of each class.

2015 APSR

Attachment E

Adolescent Service Grid

June 30, 2015

Adolescent Services

These services are available to adolescents who are or were in out-of-home care through CP&P. (Eligibility varies by program)

Service Type	Age	Geographic Areas Served	Estimated Numbers to be Served	Description
Permanency Services	14-21	Camden, Gloucester, Cumberland, Salem, Cape May, Atlantic, Burlington, Mercer, Bergen, Hudson, Essex, Passaic, and Union counties	70	Intensive permanency services to a limited number of older adolescents, who are at risk of aging out of the system with no caring connections in place. This service is available to youth in out of home care between the ages of 14 and 21.
Life Skills	14-21	Statewide	482 (515 -if we include per diem slots)	Instruction in daily living domains such as budgeting and financial management, communication, decision making, self-care, pregnancy prevention, and housing for youth in out of home placement between the ages of 14-21. Assistance in obtaining a high school diploma, career exploration, vocational training, job placement, and job retention are also included.
After Care	17.5-22	Statewide	146	Intensive case management and support services to young adults between the ages of 17.5 and 22 who are involved with DCF or those who are no longer involved.
Wraparound Funding	16-22	Statewide	450	Flexible funding available for those adolescents in an independent living skills, aftercare, or transitional living program and is available for youth/young adults between the ages of 16 and 22. It is emergency, short-term and goal based funding.
Housing	16-21	Statewide	370	Non-clinical housing options, accessed through the Adolescent Housing Hub that provide safe and stable housing with the ultimate goal of assisting youth to achieve self-sufficiency and a successful transition to adulthood. Youth are typically between the ages of 16 to 21 and often require life skills services, case management, and assistance with achieving educational and employment goals.
Youth Advocacy	14-22	Statewide	800	Through the Youth Advisory Boards, youth and young adults, ages 14-22, have an opportunity to provide input and feedback on adolescent programming and policy to DCF management and staff. They are youth driven forums that strive to empower youth in foster care and homeless youth to successfully transition into adulthood upon leaving the DCF system of care. In addition, they help young people gain and strengthen advocacy, leadership and professional skills.
NJ Foster Care Scholars (NJFCS) Program (ETV)	16-22	Statewide	350	Provides funding for eligible foster, adoptive, kinship, and homeless youth to pursue a post-secondary education at an accredited two-year or four-year college, university, trade or career school.
Project Myself	16-22	Statewide	400	Program designed to help recipients of NJFCS improve their academic performance, complete post-secondary

Service Type	Age	Geographic Areas Served	Estimated Numbers to be Served	Description
				education and develop essential life skills and competencies.
Mentoring	12-21	Salem, Cumberland, Gloucester, Camden, Mercer, Essex and Bergen, counties	124	The intent of these programs is to provide youth/young adults between the ages of 13-21 with a caring adult whose goal is to form a positive relationship. Mentoring is provided through a variety of ways and settings which include exposing the youth to recreational activities, assisting them in developing life skills, job shadowing and educational supports.
Outreach to At Risk Youth (OTARY)	10-18 (possibly 21)	Hudson, Passaic, Essex, Middlesex, Union, Mercer, Monmouth, Atlantic, Camden, and Cumberland counties.	1,000	Programs open to the community to prevent crime and gang involvement.
Summer Housing Internship Program (SHIP)	16-22	Statewide	40	Summer program for NJFCS recipients that provides housing, a paid internship, a 3 credit course and supplemental activities.
Summer Internship Program (SIP)	16-22	Statewide	20	Summer program for NJFCS recipients that provides, a paid internship, a 3 credit course and supplemental activities during the summer.
Youth Corps	16-25	Atlantic, Cape May, Camden, Cumberland, Essex, Hudson, Mercer, Middlesex, Monmouth, Passaic, Union, and Warren counties.	25	A year-round, voluntary program which engages young adults in full-time community service, training, and educational activities.
Medical Coverage	18-26	Statewide		Medicaid is available to youth/young adults who are in an out of home placement and with the recent adoption of the Affordable Care Act; young adults may be eligible to receive Medicaid until the age of 26.
Financial Assistance	16-21	Statewide	400	The Independent Living Stipend is available to eligible youth between the ages of 16 -21 who are in need of additional financial assistance as they transition to adulthood.