



## DCF Needs Assessment 2016

### Report #2: Qualitative Findings

*Strengths and needs of children and youth at risk for entering out-of-home placement and those in out-of-home placement*



**Needs Assessment 2016**

Report #2: Qualitative Findings

Prepared for the

New Jersey Department of Children and Families,  
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Child Welfare and Well-Being Research Unit

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# Contents

- Executive Summary ..... 1**
  - Purpose ..... 1**
  - Summary of Key Activities..... 1**
  - Summary of Findings ..... 2**
  - Limitations of the Findings ..... 2**
  - Themes, Needs and Domains ..... 2**
  - Next Steps ..... 3**
- Introduction ..... 4**
  - Report Organization..... 5**
- About CP&P ..... 6**
  - What We Do ..... 6**
- Needs Assessment Overview ..... 6**
  - Work to Date ..... 6**
- Research Methods..... 8**
  - Methods..... 8**
  - Limitations of the Research..... 9**
  - Presentation of Findings ..... 9**
- Qualitative Findings ..... 11**
- Caregiver Substance Abuse ..... 11**
  - Caregiver Substance Abuse Overview ..... 11**
  - Need 1: Caregivers need immediate access to substance abuse services. .... 12**
  - Need 2: Caregivers need services that help them maintain their recovery over time.... 15**
  - ..... 17**
  - Caregiver Substance Abuse – Practice Context ..... 17**
- Caregiver Mental Health ..... 17**
  - Caregiver Mental Health Overview ..... 17**
  - Need 1: Caregivers need mental health services that address co-occurring issues. .... 18**
  - Need 2: Caregivers need access to quality mental health services. .... 19**

Caregiver Mental Health – Practice Context .....	21
<b>Domestic Violence.....</b>	<b>21</b>
Domestic Violence Overview .....	21
Need 1: Families impacted by domestic violence need a comprehensive service array. .....	22
Domestic Violence – Practice Context .....	25
<b>Child Mental Health .....</b>	<b>25</b>
Child Mental Health Overview.....	25
Needs 1: Children need consistent, individualized mental health services. ....	25
Need 2: Children need trauma-informed mental health services.....	27
Child Mental Health – Practice Context .....	28
<b>Poverty.....</b>	<b>29</b>
Poverty Overview .....	29
Need 1: Families need help meeting their children’s basic needs. ....	29
Need 2: Families need long-term safety net supports.....	31
Need 3: Families need transportation to access services. ....	33
Poverty – Practice Context .....	34
<b>Housing.....</b>	<b>35</b>
Housing Overview .....	35
Need 1: Low-income families need long-term housing assistance. ....	35
Need 2: Caregivers need stable housing when children are in an out-of-home placement.....	37
Housing – Practice Context .....	37
<b>Child Substance Abuse .....</b>	<b>38</b>
Child Substance Abuse Overview.....	38
Need 1: Children need appropriate substance abuse treatment services. ....	38
Need 2: Children with substance abuse issues need to be engaged in the treatment process.....	39
Child Substance Abuse – Practice Context .....	40
<b>Justice-Involved Children and Caregivers.....</b>	<b>40</b>

Justice-Involved Children & Caregivers Overview .....	40
Need 1: Dually-involved children need coordination between the juvenile justice and child welfare systems. ....	41
Need 2: Dually-involved caregivers have unique service needs. ....	42
Justice System Involved Children and Caregivers – Practice Context .....	43
Challenging Populations .....	44
Challenging Populations Overview.....	44
Multi-Need, Frequent-Contact Families .....	46
Multi-Need Families.....	46
Qualitative Analysis of Families with Multiple Need Domains .....	50
Need 1: Multi-need caregivers need help coping with complex life situations. ....	50
Need 2: DCF staff and contracted service providers need help coordinating fragmented, limited services to address complex family needs.....	51
Frequently-Encountered Families .....	53
Summary of Findings.....	58
Major Themes and Findings .....	58
Service Implications .....	61
Moving Forward.....	64
Appendix A – About CP&P .....	65
Appendix B – Qualitative Methods.....	74
Framework for Research .....	74
References .....	77

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# Executive Summary

## Purpose

This report presents interim findings from the New Jersey Department of Children and Families' (DCF) three-year, multi-phase needs assessment process identifying the strengths and needs of families with children in, or at risk for entering, out-of-home placement. DCF has partnered with the Child Welfare and Well-Being Research Unit at the Rutgers University School of Social Work to assist in this needs assessment process.

## Summary of Key Activities

The focus of this third phase of the needs assessment included the key activities and accomplishments summarized below.

- **Primary Data Collection.** During this phase of the project, the study team collected qualitative data about child and family needs through focus groups and interviews with internal and external stakeholders, including system-involved families.
- **Internal and External Workgroups.** The DCF internal workgroup continued to meet monthly and provide critical guidance to the needs assessment process, including identifying and developing categorizations for broad need domains and identifying sources of data for describing New Jersey's child and family service array. The external workgroup met once, and a core group of individuals, including contracted service providers and a member of a system-involved family, were identified to continue the external consultation for the needs assessment process.

These activities built upon two previous phases that included (1) a review of DCF reports and needs assessments from 2008 and 2014 to identify need domains for children in families involved with DCF and (2) a review of client-level data from New Jersey's case management system, New Jersey Statewide Protective Investigation, Reporting, and Information Tool (NJ SPIRIT) to define the mix of child and family needs for children both at risk for and already in out-of-home placement.

## Summary of Findings

This report focuses on findings from focus groups and interviews conducted with DCF staff, service providers and families of origin. The purpose of the study was to generate, from the personal experiences of DCF staff, service providers and parents, a broad yet nuanced understanding of the needs of children and families involved with DCF. The qualitative methods used to conduct the study are described more fully in Appendix B. At the most basic level, *themes* emerged through our analysis of the transcripts. These themes were then clustered into *needs* or broader statements that summarized commonalities among the themes.

## Limitations of the Findings

**A critical point to keep in mind when reading this report is that while quotes reveal the perceptions of the respondent, they may or may not reflect a universal reality. Thus, in keeping with the intent of this qualitative phase, findings should not be used to make generalizations about the broader population of children and families served by DCF.** Instead, this will inform the quantitative survey efforts to follow in the subsequent phase of the needs assessment in order to ensure we explore quantitatively the full range of diverse themes raised by the participants in this study.

## Themes, Needs and Domains

Table 1, below, presents key service implications for practice that emerged from this study. The first seven need domains examined (caregiver substance abuse, caregiver mental health, domestic violence, child mental health, poverty, housing or child substance abuse) were identified through prior archival data analysis. The remaining two need domains (justice involvement and challenging populations) were added to reflect findings that emerged through focus groups and interviews. The service implications coming from those need domains reflect needs that emerged across multiple domains.

**Table 1. Service Implications**

1. Co-occurring needs are common for both caregivers and children involved with DCF, and these intersecting multiple needs have accumulating effects for families.
2. Caregivers need long-term services, aftercare and follow-up services across need domains.
3. Caregivers need access to psychiatric service and trauma-informed mental health care. While this need was also evident for children, it was raised less frequently.
4. Access to services for caregivers and children may be uneven due to availability, transportation, eligibility requirements, and poverty.
5. Caseworkers and families need access to appropriate services when they are needed. This likely requires the support of a complex continuum of care.

## Next Steps

The innovations and transformation in practice that DCF has undertaken is evident in the broad appreciation by staff of the needs that families experience. There was a strong similarity in how staff and families viewed needs. This shared assessment of the needs families experience and the work that remains to be done speaks to the department's capacity to further address those identified needs. The independent evaluation team came away from dozens of focus groups and interviews, comprising of 170 stakeholders, with the sense that the Department cares deeply about the well-being of the children and families it serves. The focus groups and interviews underscored their diligent work in the face of many societal pressures including factors associated with poverty, homelessness, substance abuse and mental health problems. The staff, from administrators to front-line workers, seemed to have a sense of areas where more needed to be done to build on their existing efforts to enhance practice, and they took that mission seriously. **Yet it was also clear that, as in much of the country, greater societal investment in addressing these issues would ease the burden on DCF and similar organizations as they are increasingly called upon to deal with the consequences of problems that have both roots and solutions that extend beyond the scope of child welfare alone.**

These findings, along with findings from earlier needs assessment work, provide a structure to support the process as it moves forward. The next phase of work will focus on survey research based on the seven predetermined domains described above. Using these domains, questions will include needs, gaps, and successes that fall into those domains. Concurrently, a survey of contracted service providers will seek to quantify the number of service slots available to meet these needs, as well as any existing waitlists for services. The research team will continue working closely with the internal and external workgroups to examine questions including:

- What are child needs in out-of-home care and for those receiving in-home services?
- What are the needs of parents who have children in out-of-home care or who are receiving in-home services?
- From the perspective of their caseworkers, what are the needs of children and families receiving out-of-home care or in-home services?
- How are the perspectives about needs of various stakeholders similar or different?
- What is the availability of services and where are there waiting lists?

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# Introduction

The NJ Department of Children and Families (DCF) has implemented a three-year, multi-phase needs assessment process to identify the strengths and needs of families with children at risk for entering out-of-home foster care placement and those already in out-of-home placement. As part of the ongoing requirements under the Sustainability and Exit Plan (formerly the Modified Settlement Agreement) and the Department's commitment to operate as a learning organization, DCF is taking concrete steps to better understand the needs and service gaps for those children and families that are served. This has included partnering with leading child welfare scholars at the Child Welfare and Well-Being Research Unit and Institute for Families at Rutgers University School of Social Work to support the needs assessment process.

The first phase of the needs assessment was completed with a comprehensive review of DCF's prior reports and assessments of need from 2008 to 2014. The internal workgroup finalized this review to identify key need domains for children in families involved with DCF and published the report on the DCF website.

The second phase of the needs assessment was completed in March 2016 and identified pressing needs for children and families through a review of child abuse and neglect investigations and child welfare assessments completed from 2009-2013<sup>1</sup> by DCF's Child Protection and Permanency (CP&P) division. This helped to guide the focus of the needs assessment, whereby sources of client-level data were identified and analyzed to describe the needs of children and families. New Jersey's State Administered Child Welfare Information System, NJ-SPIRIT, DCF's client-level case management system, was used to construct need domains for children and families served from 2009-2013.

This current phase focused on qualitative data collected through focus groups and interviews with key stakeholders, staff, contracted service providers and families. Additional analysis of secondary data explored the needs of frequently-encountered families and those with multiple identified needs. The current report presents findings from this phase of the needs assessment.

The final phase of the needs assessment will include conducting surveys with families, staff and contracted service providers, as well as examining service gaps. This will be followed by prioritizing needs and goals.

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<sup>1</sup> All child welfare records used in this analysis between 1/1/2009 to 6/30/2011 are impacted by expunction. Any family with an unfounded allegation of abuse or neglect and no prior history of abuse or neglect is deleted from NJSPIRIT after three years if no subsequent allegation of abuse or neglect is found (See DCF Policy Manual CPP-III-E-2-100).

## Report Organization

This report emphasizes the activities of the third phase of the DCF needs assessment in the following sections:

**About CP&P:** This section provides an overview of the agency and its services. A more complete description of CP&P responsibilities and activities and a discussion of how families become involved with the state's child welfare system is included in Appendix A.

**Needs Assessment Overview:** This section provides a brief outline of the needs assessment process to date. It begins with a summary of findings from the first phase of the project and then describes the qualitative research that was the focus of the second phase. A detailed description of the research methods used to conduct the qualitative study is included in Appendix B.

**Research Methods:** This section of the report offers a high-level overview of the methods used to conduct the present study and includes a discussion of the strengths and limitations of the qualitative approach to inquiry. Analytic methods are described in detail and guidance on interpreting findings is offered.

**Qualitative Findings:** This section describes child and family needs in New Jersey based on qualitative data collected through focus groups and interviews with key stakeholders. Findings are grouped into 9 broad domains (caregiver substance abuse, caregiver mental health, domestic violence, child mental health, poverty, housing, child substance abuse, justice system-involved children and caregivers, and challenging populations). Each section includes a description of the need summaries that emerged through the analysis, as well as a discussion of the themes that contributed to each need summary.

**Multi-Need, Frequent-Contact Families:** This section examines in greater depth the needs and issues facing families with multiple identified needs and/or frequent contact with the child welfare system using a mix of archival data and findings from focus groups and interviews.

**Service Implications:** This section summarizes major themes and findings that emerged across domains and presents them in the context of implications for services.

**Next Steps:** Finally, the report identifies next steps for the DCF needs assessment process.

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# About CP&P

## What We Do

The Division of Child Protection and Permanency (CP&P) is a division of New Jersey's Department of Children and Families (DCF), the state's first comprehensive agency dedicated to ensuring the safety, well-being and success of children, youth, and families. Created in July 2006, DCF's vision is to ensure a better today and even a greater tomorrow for every individual the agency serves.

Formerly known as the Division of Youth and Family Services (DYFS), CP&P is the state's child protection and child welfare agency. Its mission is to ensure the safety, permanency and well-being of children and to support families.

CP&P is responsible for investigating allegations of child abuse and neglect and, if necessary, arranging for the child's protection and services to help the family. These tasks involve investigating reports of child maltreatment, providing out-of-home care for children when indicated, and collaborating with many community-based agencies to provide therapeutic services, counseling, parenting skills classes, substance abuse treatment, mental health care, and in-home services. When a child enters out-of-home placement, CP&P begins a concurrent planning process. This involves working with the family towards reunification while concurrently implementing a permanency back-up plan. In cases in which the family court supports the determination that a child cannot be safely returned home from foster care, CP&P will begin adoption planning. (See Appendix A for more detailed description.)

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# Needs Assessment Overview

## Work to Date

In the first phase of the needs assessment, DCF internal reports and assessments completed from 2008-2014 were reviewed to identify common need domains encountered across practice areas, including child maltreatment reporting, receipt of in-home services, and out-of-home placement. A common set of risk factors and service needs for children and families emerged from these reports and assessments. These needs were then examined and refined in NJ-SPIRIT data in the second phase resulting in seven need domains: caregiver mental health, caregiver substance abuse, child mental health, child substance abuse, poverty, housing, and domestic violence. For a detailed description of the research

methodology see the Needs Assessment Interim Report from March 2016 on the administrative data.<sup>2</sup>

Table 2 presents the identified needs of all children with reports between 2009 and 2013, as well as child and family needs separated by child protective services (CPS) reports and child welfare services (CWS) referrals. Caregiver substance abuse was the most commonly identified need for children overall (32%), as well as for children with CPS reports (36%). Fewer children with CWS referrals (14.0%) had caregiver substance abuse needs. Child mental health was the most frequently identified need for children with CWS referrals (22%), while 11% of children with CPS reports had mental health needs. Just over 22% of children overall, as well as 24% of children with CPS reports and 14% of children with CWS referrals, had caregiver mental health needs.

**Table 2. Percentage of children with identified needs for all CPS reports and CWS referrals, 2009-2013<sup>2</sup>.**

<b>Need Domain</b>	<b>All Reports %</b>	<b>Child Protective Services %</b>	<b>Child Welfare Services %</b>
<b>Caregiver Substance Abuse</b>	32.0	36.1	14.4
<b>Caregiver Mental Health</b>	22.2	24.1	14.0
<b>Domestic Violence</b>	14.4	16.2	6.4
<b>Child Mental Health</b>	12.7	10.6	21.7
<b>Family Poverty</b>	11.0	11.6	8.4
<b>Housing</b>	6.3	5.8	8.5
<b>Child Substance Abuse</b>	3.0	2.4	5.4

*Note: Percentages exceed 100%, as children and families may have multiple needs identified.*

This current phase of the needs assessment process relied on interviews and focus groups with DCF-involved families, DCF staff and contracted service providers to further explore these need domains, as well as identify other issues facing children and families involved with DCF. Findings from this phase of the work are the focus of this report.

Future efforts will include conducting a broader survey from which the needs can be generalized to the broader population of families served by DCF.

<sup>2</sup> [http://www.state.nj.us/dcf/childdata/protection/DCF.Needs.Assessment.Interim.Report\\_3.16.pdf](http://www.state.nj.us/dcf/childdata/protection/DCF.Needs.Assessment.Interim.Report_3.16.pdf)

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# Research Methods

## Methods

In order to identify the strengths and needs of families with children in, or at risk for entering, out-of-home placement, focus groups and interviews were conducted with DCF staff, service providers and parents/families of origin. Focus groups and interviews have the ability to generate important insights about key stakeholders' perceptions, attitudes, beliefs, and experiences that are not likely to be obtained through surveys. The following section provides a brief overview of the methods used during this phase of research.

To obtain a full picture of the strengths and needs of families with children in, or at risk for entering out-of-home placement, key stakeholder groups involved in every part of the child welfare system were identified by the research team and the internal workgroup at the Department of Children and Families. These groups are as follows: key administrators at the New Jersey Department of Children and Families; frontline investigators, caseworkers, and specialists involved in making placement decisions as well as in service delivery; specialty service providers in areas such as substance abuse and domestic violence; and families involved in some capacity with the agency. Through the inclusion of multiple and diverse perspectives, the researchers sought to ensure a broad and nuanced assessment.

Ultimately, 170 participants took part in this study. Parents from families of origin, DCF staff and service providers were among 144 participants who took part in one of the 17 focus groups that were conducted. The remaining data were collected through 26 individual interviews with parents, contracted service providers and senior DCF staff.

A semi-structured interview protocol was developed to elicit information from participants about the strengths, needs, gaps, and barriers related to the provision and/or receipt of services by the New Jersey Department of Children and Families. The interview protocols generally covered service needs, service gaps, and barriers to services. Interviews and focus groups were adapted slightly to reflect the role of the participant(s).

A priori categories were used to code and analyze the interview and focus group data. Once a codebook was developed, graduate level research assistants were trained on principles of coding and analysis by two qualitative methodologists. Procedures were established for systematic coding of the data, the addition of codes that emerged from data analysis, and for resolving divergent interpretations of the data. Specific details about the analysis process are included in Appendix B.

## Limitations of the Research

Qualitative research is valued for its ability to generate data to understand the lived experiences of subjects and the meanings attached to such experiences (Padgett, 2008). Qualitative researchers expect their findings to represent diverse perspectives, feelings, experiences and views of study participants (Altschuler, 1999; Grover, 2004; Mitchell & Kuczynski, 2010). This underlying assumption has important implications for how the findings from this study should be considered by readers. A few critical points to keep in mind when reading this report include:

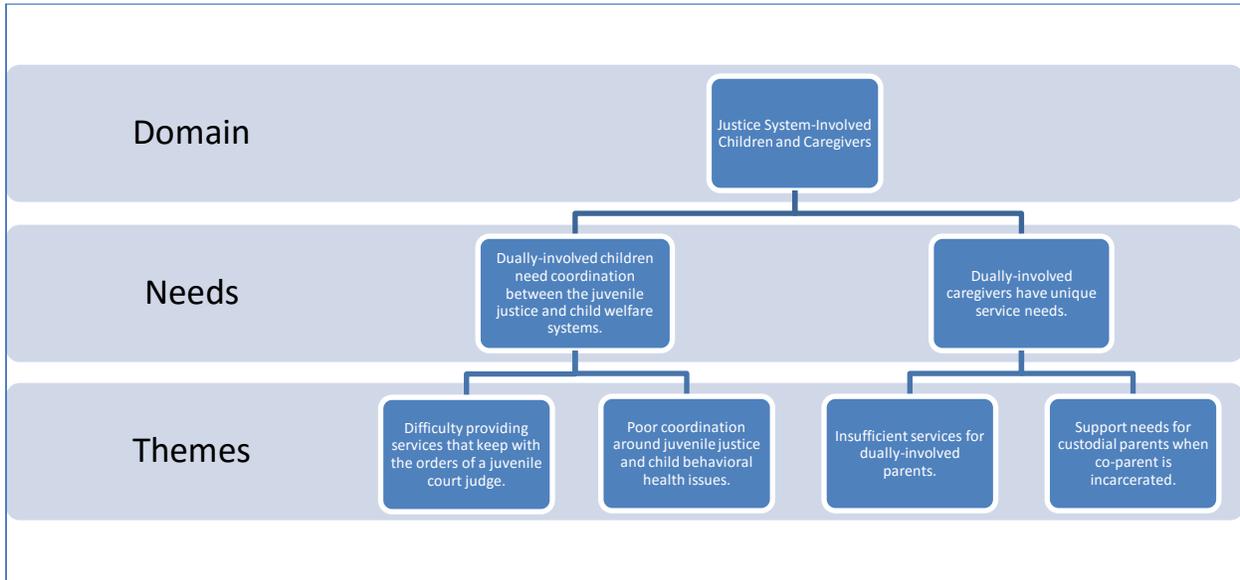
- Reflecting the study's qualitative approach, the findings in this report value and respect each subject's expertise on his or her interpretation of the needs of children and families involved with DCF. **Quotes, while edited lightly for readability, reflect the perceptions of the respondent, which may or may not reflect a universal reality. In some cases, comments made by subjects rely on dramatic language (for example, qualifiers such as "all" or "never") and clearly contradict a known reality.** In such cases, we have left quotes unchanged but included clarifying information in a footnote.
- The "thick descriptions" of a phenomena captured through this qualitative study are not quantified. **Hence, readers should not attempt to judge the frequency with which a theme was noted.** Keeping with the qualitative methodology, this approach respectfully values the diversity of opinions presented by subjects.
- Finally, the themes which emerged in this study are only reflective of the experiences and views of study participants. The involvement of different subjects in the study could potentially yield different results. **As a result, findings should not be used to make generalizations about the broader population of children and families involved with DCF.** This keeps with the intent of the study, which was to explore the needs of DCF-involved children and families through the personal experiences of DCF staff, service providers and parents.

## Presentation of Findings

Study findings are presented to make transparent the manner in which the research team moved through an inductive process to draw conclusions related to the needs of children and families involved with the Department. Analyzing qualitative data is a process of iterative reduction in which researchers move from specific observations (in this case, sentences in transcripts) to broader generalizations (in this report, themes, needs and domains) as they look for patterns that emerge. Figure 1 describes how this process was applied to this study.

At the most basic level, preliminary *themes* emerged through our analysis of the transcripts. These themes were then clustered into *needs* or broader statements that summarized commonalities among the themes. Finally, needs were related to one of seven pre-established *domains* (caregiver substance abuse, caregiver mental health, domestic

violence, child mental health, poverty, housing or child substance abuse). In some cases, the themes and need summaries suggested the creation of new domains including justice system involvement, and challenging populations.



**Figure 1. Analytic Process: Needs Related to Dually-Involved Children and Caregivers**

Because a number of similar themes emerged across multiple domains, the research team opted to include an additional level of analysis to examine these trends. Conceptually, these findings can be viewed as broad *service implications* for meeting the needs of children and families involved with the child welfare system. These are presented separately, in their own section of the report.

This analytic approach is reflected in how findings are presented throughout this report. First, findings are presented by domain. Within the section on each domain, we describe needs and related themes. Direct quotes from study participants were included to further represent the themes.

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# Qualitative Findings

The following section presents themes and needs that emerged from the focus group and interview data in relationship to 10 broader domains. Seven domains – caregiver substance abuse, caregiver mental health, domestic violence, child mental health, poverty, housing, and child substance abuse – reflect major child and family needs identified through earlier needs assessment efforts and are presented here in order of frequency from earlier record reviews from most to least frequent. The remaining two domains – justice-involved children and challenging populations – evolved directly from data collected for this study. (Findings related to multi-need, frequent-contact families draw upon additional analysis of archival data, as well as focus groups and interviews, and are presented in the next section of this report.)

## Caregiver Substance Abuse

### Caregiver Substance Abuse Overview

Almost one out of three reports received by DCF between 2009 and 2013 involved caregivers with an identified need related to substance abuse. During this time period, substance abuse was an identified need for 36.1% of child protective services reports and 14.4% of child welfare services referrals.

These New Jersey statistics reflect a national trend that suggests between 40% and 80% of families involved with the child protective services system are affected to some degree by substance use (Hines, Lemon, Wyatt, & Merdinger, 2004; Semidei, Radel, & Nolan, 2001; Young, Boles, & Otero, 2007). Parental substance abuse is a frequent reason that children enter foster care, accounting for an estimated 31% of all out-of-home placements nationally (Correia, 2013). Parents with addictions are also more likely than non-substance-abusing families to lose custody of their children (Frame, Berrick, & Brodowski, 2000; Jones, 2004; Marsh, Ryan, Choi, and Testa, 2006).

Drawing upon data collected through focus groups and interviews, this section explores needs related to caregiver substance abuse. The two broad needs that emerged from the data were:

- 1. Caregivers need immediate access to substance abuse services.**
- 2. Caregivers need services that help them maintain their recovery over time.**

## **Need 1: Caregivers need immediate access to substance abuse services.**

Respondents who described needs related to caregiver substance abuse reported that caregivers who are ready to engage in substance abuse treatment need immediate access to services that provide the appropriate level of care. The importance of readiness to engage in substance abuse treatment services is well-documented in the literature, as is the need to have services immediately available when a person is ready to seek treatment (Prochaska, DiClemente & Norcross, 1992; Hohman, 1998).

The following section explores the multiple ways this need was expressed by study participants.

**Identify caregiver substance abuse service needs early:** A few respondents indicated that identifying a caregiver's substance abuse need can be a lengthy process. This process hinges on both access to evaluations and relational factors between caregivers and caseworkers. One DCF respondent described challenges scheduling substance abuse evaluations and screenings, while a service provider reported that delays can also emerge when caregivers do not divulge substance abuse. This service provider noted that parents will often only divulge substance use if they feel a strong and supportive connection with their caseworker.

**Immediate Access to Substance Abuse Treatment is critical:** Once a caregiver has been identified as having a substance abuse need, several study participants indicated immediate access to appropriate treatment opportunities is a challenge and that waitlists for treatment services are common. Immediate access to treatment is critical because studies have shown that fewer than half of treatment-seeking substance abusers actually enter treatment after assessment (Donovan, Rosengren, Downey, Cox, & Sloan, 2001; Stark, Campbell, & Brinkerhoff, 1990). Further, longer waits for treatment have been associated with higher rates of pretreatment attrition (Festinger, Lamb, Kountz, Kirby, & Marlowe, 1995; Hser, Maglione, Polinsky, & Anglin, 1998; Kaplan & Johri, 2000). A study by Pollini, McCall, Mehta, Vlahov, & Strathdee (2006) found that almost 67% of treatment-seeking injection drug users never enrolled in services if they were placed on a waiting list rather than receiving immediate services.

Study participants who discussed substance abuse among caregivers felt that greater access to services was needed in light of observed increases in opiate abuse, including both prescription pill abuse and heroin use. These participant observations are in keeping with substance abuse treatment data collected by the New Jersey Department of Health, Division of Mental Health and Addiction Services (New Jersey Department of Human Services, 2016; New Jersey Department of Human Services, 2007). The number of treatment admissions statewide for heroin and other opiates increased nearly 46% between 2006 and 2015. In 2006, 22,053 treatment admissions statewide were for addiction to heroin and other opiates. By 2015, the most recent year for which data are available, the number of treatment admissions for heroin and other opiates increased to 32,093.

The following three quotes exemplify how this issue was expressed by study participants:

*“... we [treatment provider] keep their [caregiver] phone information and we always give out other places . . . if you need to get in tomorrow, we’re not going to be able to take you. . . They [caregivers] often disappear in that process because I only have eight beds and I don’t have openings very often. There’s not enough bed openings for that particular population, and they start using again. They disappear and then they don’t answer and then they miss their spot . . .”*  
[Service Provider]

*“You [caregiver] finally got to a point where you realize you need treatment and then the help just isn’t there, the support just isn’t there.”* [Service Provider]

*“... when they [caregivers] have [substance abuse] issues there is no facility to treat them. We have no substance abuse treatment centers or the ones that we have are full to capacity and there is a waiting list . . . maybe a month waiting list . . .”* [DCF Staff]

**Following detoxification caregivers need step-down treatment:** In line with the literature on experiences of substance users internationally, several participants highlighted a need for immediate access to step-down treatment services following detoxification. Respondents who were concerned with this need cited that if supports are not in place individuals are at a higher risk of overdose following detox as they are more biologically vulnerable to the dosages they took prior to detox (Walley, Krupitsky, Cheng, Quinn, Wulach, Coffin & Samet, 2015). These issues speak to the broader context of challenges presented by substance abuse problems and the need for greater societal investment in supportive and lasting treatment modalities to which child welfare systems can connect their families.

The following quote from a DCF staff member illustrates concerns about the limited availability of step-down services following detoxification:

*“They come to us asking for help and then we detox them, but then it’s nothing . . . Once they detox, they tend to overdose . . . they went and got detox and then there was nothing else for them and then they over-dosed...”* [DCF Staff]

**Services should address caregivers with co-occurring needs:** Co-occurring needs was an important topic outlined in the initial needs assessment report in March 2015, which found caregivers with concurrent mental health and substance abuse needs comprised 34.6% of families that presented to DCF with two identified needs between 2009 and 2013. Among families that presented to DCF with two identified needs between 2009 and 2013, 14.4%

experienced caregiver substance abuse and domestic violence needs, 6.3% experienced caregiver substance abuse and child mental health needs; and 6.1% experienced caregiver substance abuse and family poverty needs. These local findings reflect national data that shows slightly more than one-third of adults with substance use disorders also have a co-occurring mental health disorder (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, 2013). Similarly, Testa & Smith (2009) found that substance abuse problems often occur in conjunction with social isolation, poverty, unstable housing and domestic violence, all of which also contribute to child maltreatment.

Some respondents in this study reported a dearth of treatment opportunities for adults with co-occurring substance abuse and mental health issues. Relatedly, other respondents identified a need for community programs that address other situations often experienced by people with substance abuse disorders.

These concerns are reflected in the perceptions of service providers who participated in this study and work with substance abusing caregivers. Examples of statements made to the research team by contracted service providers include:

*“There’s just not enough services for our population. [Substance abuse and mental illness] . . . those two things are mainly the things that we’re dealing with.”*  
[Service Provider]

*“I’d say that all of our substance abuse population have some kind of mental health problem . . . just undetected . . .”* [Service Provider]

*“It’s mental illness but with a substance abuse component because they are mentally ill and are self-medicating with substances . . .”* [DCF Staff]

**Fathers with substance abuse may need inpatient services:** A few subjects noted a lack of services for single fathers with children. While New Jersey has expanded residential substance abuse programs that enable mothers in treatment to remain with their children, similar services are not readily available for single fathers.

*“Another issue that I’ve come across . . . is we have substance abusing fathers, who are the sole caregivers of their children. If they were women, and they needed inpatient [treatment] there are ‘Mommy and Me’ programs . . . but if they [single fathers] need inpatient treatment, there’s nowhere for them to go with their children.”* [DCF Staff]

**Identify real and perceived barriers that inhibit access to services:** Participants identified a number of barriers to enrolling caregivers into treatment services including the criminalization of substance abuse and resulting stigma, treatment co-payments and insurance coverage, agency operating hours and transportation. Illustrative quotes included:

*“Addiction is still a criminal thing, and it’s not considered a disease or a disorder or anything . . . addiction is still criminalized all around.” [DCF Staff]*

*“. . . I have a client recommended for certain level of treatment and they have to pay their way . . . you hear them saying I can’t afford the 20 bucks a session, I can’t afford the 30 bucks . . . and it’s the only thing stopping them from getting the counseling . . .” [DCF Staff]*

*“. . . there is a huge heroin epidemic going on around here . . . Trying to get a lot of services hooked up to immediately help families is very difficult. You finally get parents to agree to do it... and then they don’t have insurance or whatever the case is...it doesn’t work out. That’s a huge piece of it.” [DCF Staff]*

*“A lot of our families are working families . . . so the timing of the services...it is not always convenient. We want them to still work, so we need programs that would address those issues that occur at night or on the weekend.” [DCF Staff]*

## **Need 2: Caregivers need services that help them maintain their recovery over time.**

The high relapse rate following substance abuse treatment has been well documented (McLellan, A.T., Lewis, D.C., O’Brien, C.P., & Kleber, H.D., 2000). Increasingly, recovery from addiction is viewed as a non-linear process marked by periods of sobriety and relapse (Miller, Andrews, Wilbourne, & Bennett, 1998).

The following section explores the multiple ways that concerns about relapse prevention and recovery support services were expressed by study participants.

**Support caregivers in maintaining sobriety:** Maintaining sobriety following substance abuse treatment is a well-documented challenge (Huebner, Willauer & Posze, 2012). According to respondents, some caregivers underestimate the effort necessary to maintain their sobriety after completing a program and felt that currently available post-treatment services provide a critical support. Despite the existence of some post-treatment services, study participants highlighted ongoing existence of unmet need in this area in the state. For instance, some respondents noted that particular challenges arise when pre-existing stressors and relationship patterns return and when caregivers experience re-introduction to settings and networks of substance-using peers.

The quotes below illustrate the issues described by study subjects:

*“... [caregivers] want to change their life but when they get here [to recovery] they don’t really realize how hard that is.” [Service Provider]*

*“They finish the program and then they get their children. They get back all of these stressors . . . and then they relapse ... We end up going back and starting all over again.” [Service Provider]*

**Caregivers need assistance to prevent relapse and promote long-term recovery:**

Respondents reported struggling to prevent relapse and promote long-term recovery among caregivers. Service enhancements to help caregivers maintain recovery over time were spoken of as a priority by some, particularly in the context of federal timeline policy guiding permanency decisions. This theme reflects national research that suggests relapse rates for people treated for substance use disorders range from 40% to 60% (McLellan, Lewis, O’Brien, & Klebar, 2000). The quote provided below demonstrates such concerns:

*“Relapse prevention is a big thing . . . We get a lot of people who do well, get clean, are motivated...they want their children back. [Addiction] is bigger than they are . . . they relapse. So then what happens?” [Service Provider]*

**Establish positive supports through recovery programs:** Some study respondents noted that the presence of a good sponsor (through Alcoholics Anonymous or Narcotics Anonymous, for example) may facilitate a clients’ success after treatment. Other study participants, however, highlighted a practice paradox that seems to frustrate substance abuse professionals nationwide. These service providers explained that despite evidence of their effectiveness, these mutual support programs may also present risk of relapse for some, as they can be targeted by dealers at meetings. These varied responses are highlighted by the quotes below:

*“[Caregivers] need a life-long commitment too...a good NA sponsor; someone that they are held accountable to. . .” [DCF Staff]*

*“[NA/AA] becomes just a place for them to meet other dealers and pick up a new drug. . . clients will tell you . . . I can’t go to NA because that is where everybody sells.” [DCF Staff]*

### Caregiver Substance Abuse – Practice Context

1. As in much of the country, timeliness of service availability and alignment of that availability with timing of when caregivers are receptive to treatment, remains an ongoing challenge facing New Jersey.
2. Residential treatment services for single fathers raising children are scarce.
3. A remaining challenge will be to enhance services to help caregivers maintain their recovery over time. Efforts to aid caregivers in maintaining sobriety are also critical to reducing potential conflict with federal policy timelines guiding permanency decisions.

## Caregiver Mental Health

### Caregiver Mental Health Overview

Previous analysis of NJ-SPIRIT data found that 22.2% of all reports received between 2009 and 2013 were for children with an identified need related to their caregiver's mental health. During this time period, caregiver mental health was an identified need for 24.1% of child protective services reports and 14.0% of child welfare services referrals.

Research has documented high rates of mental health need among child welfare-involved caregivers in the U.S. and abroad (Burns, Mustillo, Farmer, Kolko, McCrae, & Libby, 2010; Westad & McConnell, 2012). Burns and colleagues (2010), for example, found that 40% of caregivers in a national sample of families involved with the child welfare system met the diagnostic criteria for depression. Among the broader population, an estimated one in six parents has a mental health problem (Hinden, Biebel, Nicholson, Henry, & Katz-Leavy, 2006).

Findings from focus groups and interviews elucidated factors that contribute to caregiver mental health needs and services for DCF clients. Two broad needs that emerged through the data were:

1. **Caregivers need mental health services that address co-occurring issues.**
2. **Caregivers need access to quality mental health services.**

## Need 1: Caregivers need mental health services that address co-occurring issues.

Given that the March 2015 interim needs assessment report found that more than one in five reports received between 2009 and 2013 involved a caregiver with an identified mental health need, it is notable that study participants tended to describe caregiver mental health challenges in relationship to co-occurring needs rather than as an isolated condition. In the vast majority of instances, caregiver mental health was discussed in the context of a complex and interdependent web of family challenges that commonly included substance abuse, poverty and domestic violence. The co-occurrence of mental health and substance abuse challenges is well documented in the literature (Choi & Ryan, 2006; Choi & Ryan, 2007). Relationships between mental health and substance abuse, social isolation, poverty, unstable housing and domestic violence have also been identified (Testa & Smith, 2009).

The following section explores the ways this need was expressed by study participants.

**Integrate services for co-occurring mental health, substance abuse, and domestic violence:** Several staff and provider participants discussed caregiver mental health, substance abuse, and domestic violence together. Two service providers, separately, called this combination “the trifecta.” At times, co-occurring domestic violence was characterized as a cause of caregiver mental illness, while substance abuse was described as a consequence (Martin, Kilgallen, Dee, Dawsen, & Campbell, 1998).

*“It’s... mental illness, substance abuse—domestic violence is a major challenge in all of our areas; and . . . it’s not just one factor, it’s a multitude. So it’s mental illness but with a substance abuse component because they [caregivers] are mentally ill and are self-medicating with substances, because it’s untreated. There’s domestic violence, a multitude of things. . .” [DCF Staff]*

*“Depression and anxiety are the two most common [caregiver mental health problems], although in our population we see a lot of bipolar. And also again it’s not uncommon if you really go into it deeply to find out that a lot of these people [substance abusing caregivers] had a mental health disorder and they were self-medicating. . .” [DCF Staff]*

**Identify and address caregiver trauma:** In several focus groups and interviews, participants linked caregivers’ mental health problems with exposure to trauma earlier in life that has gone untreated (Westfall, Nils, & Nemeroff, 2015). Some described how the prevalence of caregiver needs related to trauma influences their approach to service delivery.

*“I think that the underlying need for most of our moms that we see . . . overwhelmingly, is a need for trauma treatment because of their own—either sexual abuse, which is probably the biggest factor for our moms who are struggling with substance abuse, to the point where they can’t care for their children. More times than not there’s sexual abuse in their childhood that they’ve never been able to get adequate treatment for.” [DCF Staff]*

*“Well they’ve all experienced trauma, and they all—it’s a generalization, the vast majority have significant trauma, which runs anywhere from poverty, all kinds of abuse, neglect. So needless to say they come here not trusting people. So this is why we are very relationship focused; the whole underlying idea is to help them to gain some trust, which is foundational to all relationships. . .” [Service Provider]*

## **Need 2: Caregivers need access to quality mental health services.**

Study participants reported that caregivers with mental health concerns need timely access to quality mental health services. Respondents described an inadequate number of mental health providers, including psychiatrists, and an insufficient array of services. The Mental Health Association in New Jersey supports this perception in a recent policy statement indicating that anecdotal information suggests residents are having more difficulty linking with public and private services in a timely manner (Beauchamp & Johnston, n.d.). Additionally, the group reports an increase in the number of adults being screened for mental illness in hospitals, having been unable to access treatment elsewhere.

The following section explores the way this need was expressed by study participants.

**Caregivers need access to adult mental health providers:** While some study participants described the availability of strong existing services to address caregiver mental health needs, others indicated a need for additional providers.

*“It’s not just child psychiatrists, we have a shortage of adult psychiatrists to evaluate our clients too, and it’s because of the rate that the state pays them . . . We have families that wait . . . for a psychiatric [appointment], and they need it sooner to assist us in really completing our assessment and figuring out what we are going to do with the families.” [DCF Staff]*

*“There is a really big gap with mental health services in this community. There are not enough places that accept self-pay and Medicaid. And then also think about the additional layer of finding Spanish-speaking mental health services or any other language for that matter.” [Service Provider]*

*“So for a family that’s . . . feeling depressed or anxious, or whatever is going on, and wants to talk to someone right away, to say, ‘Well you have to wait, eight weeks for the first appointment,’ that’s significant.” [DCF Staff]*

While some, such as those above, talked of the needs for continued increases in adult mental health providers, one mother contrasted her positive recent experience with DCF to contacts she had in prior years when there had been fewer services available to her. This speaks to the progress we heard from staff and families to the increased attention to adult mental health over time.

*“I am a hoarder, and it was deemed an unsafe environment for my children, which I knew because I was reaching out for help... this time around it is different... there were services available for me. [Agency] is now involved and they have done amazing things both physically and therapeutically...” [Parent]*

**Caregivers need effective adult mental health services:** Some study participants highlighted the need for enhancements in quality and effectiveness of some existing mental health services targeting adults in the state. Respondents expressed concerns about the availability of professionals (largely psychologists and psychiatrists) to conduct evaluations to diagnose mental health issues and recommend treatment. Others were concerned about treatment that does not extend beyond dispensing medication.

*“And there are not enough services for [adults], and the services that there are, the people [who] work in those services are overwhelmed. They’re underpaid, overworked . . . there’s a rare client that we get that has an extensive mental health history that is getting the services that they need. We have people who have extensive mental health history that get their medication prescribed 3 to 5 months at a clinic and don’t meet with anybody. I don’t know how that’s possible...” [DCF Staff]*

*“We can’t accurately diagnose because we don’t have the services in the area or we don’t have good quality evaluators. So we might think something is wrong and we send people to one evaluator and they say one thing, then we send them to someone else and they say something completely different.” [DCF Staff]*

### Caregiver Mental Health – Practice Context

1. Caregiver mental health problems among DCF-served families are often associated with other needs including substance abuse and domestic violence.
2. Trauma histories may exacerbate caregivers' mental health problems and complicate treatment engagement and adherence strategies.
3. DCF staff and contracted service providers generally describe the need for enhanced quality adult mental health services willing to work with system-involved caregivers, in order to address waitlists and reliance on those who offer inadequate treatment in the absence of better options.

## Domestic Violence

### Domestic Violence Overview

Previous analysis of NJ-SPIRIT identified domestic violence in 14.4% of all reports received between 2009 and 2013. During this time period, domestic violence was an identified need for 16.2% of child protective services reports and 6.4% of child welfare services referrals. Nationally, nearly 30 million children in the United States will be exposed to family violence before the age of 18, with 30 to 60 percent of these youth becoming involved, to some extent, with the child welfare system (Hamby, Finkelhor, Turner & Ormrod, 2011). Data from the National Child Abuse and Neglect Data System found that 27.4% of child maltreatment victims in 34 states had a risk factor related to domestic violence (U.S. Department of Health and Human Services, 2015).

Findings from focus groups and interviews identified family support, impacts of domestic violence on children, treatment programs for batterers and long-term, wrap-around services to be among the needs for families experiencing domestic violence. Domestic violence is also described in other sections of this report as co-occurring with substance abuse, mental health, housing and financial needs.

Drawing upon data collected through focus groups and interviews, this section explores needs related to domestic violence. The overall need that emerged from the data was:

- 1. Families impacted by domestic violence need a comprehensive service array.**

## **Need 1: Families impacted by domestic violence need a comprehensive service array.**

Respondents reported the need for positive support for victims of domestic violence, and a parallel effort for batterer intervention. Participants specifically described the need for long-term services that are trauma-informed and reflect this inter-generational challenge.

The following section explores the ways this issue was articulated by study participants.

**Victims need positive support:** Study respondents noted that caregivers experiencing domestic violence often, for a variety of reasons, lack support from other family members. This concern is grounded in research that has found family support serves as a protective factor for domestic violence victims, contributing to higher self-esteem, better mental health and a greater likelihood that the victim would leave the abuser (Jewkes, 2000; Coker, Smith, Thompson, Mckeown, Bethea, & Davis, 2004).

Relatedly, some respondents described domestic violence as an intergenerational issue among many families involved with DCF. As a result, domestic violence can become a normalized aspect of family relationships. While some studies support the concept of intergenerational domestic violence (Pollak, 2004), others have identified the relationship is mediated by the extent to which parents display a broader antisocial disposition (Simons, Wu, Johnson, & Conger, 1995).

**Perpetrators need intervention services to change behavior:** Respondents also discussed a lack of treatment and intervention programs to help batterers change their behaviors. Studies suggest such programs can be helpful in addressing domestic violence issues (Babcock, Green & Robie, 2004). Some respondents indicated that other services offered to domestic violence perpetrators – such as substance abuse and mental health treatment – are inadequate in addressing domestic violence behaviors on their own.

Quotes illustrating the need for batterer’s intervention programs include:

*“We don’t have a wealth of domestic violence services in particular for batterers, so what we wind up treating the victim and the batterer goes onto another family and batters...” [DCF Staff]*

*“The lack of offender programs we have in [County]. We have a real need for that service.” [DCF Staff]*

*“...batterers services for the perpetrators, that is a really big need. There are limited services for batterers . . . Judges refer them for anger management, and that’s not the appropriate intervention for domestic violence . . .” [Parent]*

**Children need trauma informed services:** Study participants reported that children who are exposed to domestic violence experience trauma and require specialized services (Evans, Davides, DiLillo, 2008).

Respondents discussed how exposure to domestic violence and separation from a parent contribute to a demand for trauma-focused services for children. This need reflects an abundance of literature that links exposure to domestic violence with negative consequences for children. Kilpatrick & Williams (1997) found that exposure to domestic violence can be a significant predictor of post-traumatic stress disorder in youth. Wolfe and colleagues (2003) linked witnessing domestic violence with negative outcomes related to children's social, emotional, behavioral and cognitive development, as well as health functioning. Other studies linked child exposure to domestic violence with behavior problems, including conduct disorder (Kitzmann, Gaylord, Holt, & Kenny, 2003; Meltzer, Doos, Vostanis, Ford, & Goodman, 2009).

*“How does a resource parent or even a family member for that matter, if it is a kinship placement, deal with not only this child who has been removed from their home and all of the trauma that happens there but the extra layer of DV that makes things super complicated?” [Service Provider]*

*“They did provide services, like therapy services . . . One of my children was having a hard time dealing with the fact that his dad wasn't in the house so they got me hooked up with some programs that got a therapist that comes in once a week to talk with him.” [Parent]*

**Families need services that specifically target intergenerational family violence:** One impact of domestic violence on families involved with DCF, according to respondents, is that they may lack a strong family support system because of incidental consequences with family members and intergenerational domestic violence. This theme speaks to the complex and increased vulnerability of those with family violence histories for both perpetration and for subsequent victimization. Quotes indicating this theme include:

*“So what I have found here is intergenerational, that you have deep roots in these communities, seven, eight, nine generations, and breaking the cycle is really hard.” [Service Provider]*

*“... He [son] is practicing what his dad has done to me in the past . . . The way my husband used to abuse me, he's doing the same thing. So for example, [son] doesn't respect women or girls because his dad does not, does not respect anybody, especially the women.” [Parent]*

*“Many of the people we see have difficult history as children themselves... unresolved issues of sexual abuse, domestic violence.” [DCF Staff]*

*“We all have support groups that help us through the hard times. I always worry about families, because they come from ... [intergenerational issues] ... If you don’t know differently, how do you do differently?” [DCF Staff]*

**Victims need long-term wrap-around services:** Several respondents felt that services for domestic violence victims lacked a needed long-term, holistic focus. Some respondents also identified issues related to service availability and waiting lists in some areas. Practitioners and scholars in this area have echoed this need, calling for comprehensive, long-term and wrap-around services to address the complex issues victims face (Hague & Bridge, 2008; Goodman & Epstein, 2008; Krug, Mercy, Dahlberg, & Zwi, 2002; Dichter, & Rhodes, 2011).

In discussing DV services, informants reported that many programs were too short-term. Further, services were felt to be lacking a needed holistic perspective. A service provider noted:

*“...What we have seen change is that women need long-term [services]. It can’t be 30-60-90 days, it has to be . . . a two-year wrap-around program that provides lots and lots of supportive services.” [Service Provider]*

**Families need services available in their community:** Several respondents described challenges of finding services for families experiencing domestic violence. In some cases, service availability appears to be related to a lack of clinicians to work with the population. In other locations, facility space (residential programs) appears to be an issue.

*“I just have to add, with domestic violence, I’ve seen a lot of that. Even when we try and refer families to one particular agency there is a waiting list of a couple of months because they don’t have enough clinicians.” [DCF Work]*

*“. . . When we have to move the families . . . there is nothing here in the county. Every time that we call the county they don’t have a space... We have to transport the mother, because she had a little job, to the place that she works. Twice...we move them from the environment, the area that they know, because we don’t have the services. The domestic violence shelter, they never have a space, basically...for the families”. [DCF Worker]*

*“I believe there should be a campaign or something going on where ... you have the opportunity to call up and say ‘I need help’ and not having it held against you or being blamed or on your record...”[Parent]*

### **Domestic Violence – Practice Context**

1. All workers (not just DCF staff) engaging with families experiencing domestic violence must understand the complexity of domestic violence and approach families with appropriate sensitivity and empathy.
2. More services are needed to help batterer's make lasting changes to their behavior.
3. Trauma-informed services must be available to children who witness DV.
4. Longer-term, wrap-around services would be helpful in supporting DV victims.

## **Child Mental Health**

### **Child Mental Health Overview**

Close to 13% of all reports received by DCF between 2009 and 2013 involved children with an identified need related to child mental health. During this time, child mental health was an identified need in 10.6% of child protective services reports and 21.7% of child welfare services reports. Nationally, an estimated 50% of children and youth involved with the child welfare system experience mental health problems (Stagman & Cooper, 2010).

Drawing on data collected through focus groups and interviews, this section explores needs related to child mental health. The main needs that emerged from the data were:

- 1. Children need consistent, individualized mental health services.**
- 2. Children need trauma-informed mental health services.**

### **Needs 1: Children need consistent, individualized mental health services.**

Respondents reported the need for timely access to services that provide an appropriate level of care to meet a child's individualized mental health needs. Nationally, the level of unmet need for mental health services for all children and adolescents ranges from 51% to 81% (Ginsberg, n.d.). Participants specifically described needs for more child psychiatrists, consistency in mental health service provision, and treatment options targeted to specific conditions.

The following section explores the multiple ways this need was expressed by study participants.

**Children need accessible child psychiatrists:** A number of respondents reported a significant shortage of child psychiatrists in the state, which was described as a barrier to providing critical evaluative and psychiatric services to children with mental health needs. This concern is consistent with a recognized shortage of child psychiatrists nationally (Thomas & Holzer, 2006).

*“I have the luxury of being in a very populated area...when somebody rings a bell there is a program for them; except child psychiatry . . . The lack of child psychiatry causes such a backlog... It has ripple effects into every avenue of the behavioral and mental health system ... I don't know the last time I heard shorter than a six-month wait to see a child psychiatrist . . .” [DCF Staff]*

*“We have one full-time child psychiatrist in the county and she does not take Medicaid... So almost every child psychiatrist is going to be out of county and there's no public transportation to out of county...unless you want to take three different buses and spend 3 or 4 hours getting there if you can manage it.” [DCF Staff]*

**Provide continuity of mental health services for children:** Reflective of national child welfare challenges (Marsh, Cay, Angell, Andrews, & Curry, 2012), some respondents reported that children needed greater consistency in the mental health services that they received. One respondent described the communication challenges and delays faced when children are sent to multiple providers and agencies for evaluations and recommended a “*comprehensive diagnostic center*” where providers could work together in establishing the needs of and treatment plan for each child. Another respondent described how frequent changes in service providers made it difficult for children to establish relationships of trust with therapists, an impression consistent with the research relating to children’s development of relationships with therapists.

**Children with unique mental health needs require specialized service options:** Although participants indicated that standard mental health services for children are often available, some respondents indicated that specialized mental health services for children with unique mental health needs were often difficult to find. Some respondents specifically noted difficulty finding mental health services for children who have experienced sexual abuse trauma, children with severe behavioral issues, and children requiring residential placement.

*“ . . . there’s not a lot of places to refer children who have sex abuse in their histories... so what I have said is, ‘I’m going to start small. I’ll get a 10 hour a week counselor whose got experience in this and hopefully see how that goes’... So for now, that position, according to the prosecutor’s office, we can be flooded. They had 40 in the last 3 months. 40 cases and they had nowhere to refer them.”*  
[Service Provider]

*“I’ve seen for children who have fire setting or sexually acting out [symptoms] we have a pretty difficult time, well the CMO has a pretty difficult time, finding placements for them, appropriate placements for them.”* [DCF Staff]

Although services may be limited at times, one parent described significant improvement in their experience of child mental health service provision by DCF over the past decade:

*“Like with my daughter, she’s 22 now. But when she was 11 she tried killing herself. And they would not help me out at all. I had to take her down to [name of hospital] and admit her myself down to a program down there to get her help; she’s bipolar. . . so when my son starting showing signs of having problems and I called the crisis center, and they came in and stuff, I was like wow you guys are here this quick? I was like wow where were you guys 15 years ago. And it was totally different...”* [Parent]

## **Need 2: Children need trauma-informed mental health services.**

Respondents who described needs related to children’s mental health discussed a need for trauma-informed services to support children who are involved with the child welfare system. In addition to being victims of abuse or neglect, these children are also often exposed to domestic violence, caregiver substance abuse and other issues that can result in trauma.

The following section explores the ways this need was described by study participants.

**Ensure mental health services are trauma informed:** Reflecting the literature regarding children’s experiences nationally, several respondents reported that children involved with CP&P often encountered circumstances triggering a need for trauma-informed mental health services. According to the federal Substance Abuse and Mental Health Services Administration, trauma-informed approaches recognize the widespread impact of trauma on individuals including the signs and symptoms in which it manifests, respond by integrating knowledge about trauma into all aspects of services, and actively attempt to avoid re-traumatization (Substance Abuse and Mental Health Services Administration, 2015).

Respondents described issues relating to the experiences of children, as well as the availability of trauma-related mental health services.

*“...my son ended up being diagnosed with PTSD, he also has autism with it...the school wasn’t complying with what we were asking for him and they had to call CP&P on us because he was missing school because of it.” [Parent]*

*“They’ve been sexually abused. They’ve been separated from their parents. They’ve had traumatic experiences, some of them horrific traumatic experiences . . .” [DCF Staff]*

*“I think because of all that unaddressed trauma . . . we notice it for young people that may be doing well here academically, but there’s such a sense of loss and connection... they’re in continual grief . . .” [DCF Staff]*

*“ . . . they [children] need that emotional piece because when they come in they act out, and they’ve been traumatized by that separation. And so we’re actually really starting to become more focused on what can we do for the child and the trauma that they’ve experienced and the attachment trauma they’ve had . . .” [Service Provider]*

### **Child Mental Health – Practice Context**

1. A shortage of child psychiatrists in the state, reflecting a national shortfall, makes it difficult for children to get the evaluative and other psychiatric services that they need.
2. Children with mental health needs often have a history of trauma, and additional services may be needed to supplement existing trauma-informed services.
3. Inconsistency in mental health service provision may interfere with children’s evaluations and progress.
4. Services targeted to address specific mental health needs may be needed to supplement existing children’s mental health services.

# Poverty

## Poverty Overview

According to previous analysis of NJ-SPIRIT data, approximately 11% of all CP&P reports between 2009 and 2013 involved issues of family poverty. During this time period, poverty was an identified need for 11.6% of child protective services reports and 8.4% of referrals for child welfare services.

Poverty is often associated with child abuse and neglect, but is also frequently related to other issues facing CP&P involved families, including caregiver mental health, caregiver substance abuse, and domestic violence (Walsh, 2010). According to data presented later in this report, family poverty was a common need among families presenting with a combination of multiple complex needs. Poverty among families involved with child protective services has also been linked with unemployment and a variety of material hardships (Geen, Kortenkamp, & Stagner, 2001; Shook, 1999).

Drawing upon data collected through focus groups and interviews, this section explores needs related to poverty experienced by children and families involved with DCF. Three broad needs that emerged from the data were:

- 1. Families need help meeting their children's basic needs.**
- 2. Families need access to long-term safety net supports.**
- 3. Families need transportation to access services.**

### **Need 1: Families need help meeting their children's basic needs.**

In describing the impact of poverty on families involved with DCF, several respondents described how poor families struggle to meet many of their children's basic needs. These issues are widely noted in the literature on poverty and child welfare system involvement.

Several respondents identified a connection between poverty and involvement with the child welfare system, reporting that poor families may be perceived as neglecting their children when they cannot make ends meet.

The following two quotes describe this situation:

*"...It's poverty that's leading . . . families to come on our radar. Not always, I mean there's obviously neglect and abuse, but sometimes the situation that is being viewed as neglect are really a poverty issue that has kind of spiraled out of control." [DCF Staff]*

*“Well a lot of my permanency cases, the underlying issue is poverty. It seems if these folks can get certain basic needs met, they can get over their hump and continue.” [DCF Staff]*

**Families in poverty need assistance with food, housing and payments for utilities:**

Respondents identified low-wage work as a primary contributor to family poverty and the related challenges parents face providing for their children. According to study informants, these families have trouble meeting basic day-to-day needs. Research has linked low wages to a number of family concerns including low marriage rates, increased divorce rates, family instability, challenges accessing child care and other basic needs, and poor health (Yarrow, 2015).

According to respondents, food insecurity is a frequent issue for children living in poverty. Poverty also contributes to challenges in obtaining and maintaining housing, as well as paying utility bills. This challenge is reflected in research indicating that housing issues may bring families deeper into child welfare, if unaddressed (Cohen-Schlanger, Fitzpatrick, Hulchanski, & Raphael, 1995).

The following section explores the multiple ways this need was expressed by study participants.

*“...Most minimum wage jobs don’t offer 40 hours a week, so again you do the math, it’s almost impossible.” [DCF Staff]*

*“...children are not getting their needs met . . . families are struggling to feed their children.” [DCF Staff]*

*“Just the other day, the office, this office got a referral from a Family Success Center about a family who needed help with utility bills.” [DCF Staff]*

*“... there are agencies that help with security deposits, the rental assistance, but they’re constantly out of funds because the need is so high.” [DCF Staff]*

*“... we are seeing a huge increase with homelessness and food stamps, and all of those different sources are running out or they are not qualifying and it’s like the pyramid with those basic needs are not met.” [DCF Staff]*

**Families in poverty need support during financial crises:** Some respondents described this population as being susceptible to financial instability because relatively minor financial setbacks can become a major crisis. In addition, study subjects reported that this situation is exacerbated because low-wage positions often do not offer sufficient hours for a family to

escape poverty. Finally, some respondents reported that housing costs contribute heavily to the lack of financial security among low-wage earners.

Quotes illustrating this feedback included:

*“...there are times where families come because they’re in crisis, because something just happened. Their light just got shut off for whatever reason. They don’t have food because someone lost their job or there was a death in the family.” [Service Provider]*

*“...When you have to pay 50% of your income toward housing you’re left with little left to be able to care take your children so it’s always a struggle for caregivers in the county...” [Parent]*

**Link formerly-incarcerated parents to employment/training programs:** Some respondents reported that while some formerly-incarcerated parents are able to obtain low-wage work, many have difficulty finding any type of employment contributing to poverty-related issues for their families.

*“...[some of] our parents have criminal backgrounds and they come back into the world and have no real services for them. I have a client now who, he had some charges, so now many of the places he wants to apply, they won’t hire him. He has to go through the process of trying to see if he can expunge his record. I gave him all of that information, but you know definitely poverty and criminal history is a big...is one of the biggest issues we have as well.” [DCF Staff]*

## **Need 2: Families need long-term safety net supports.**

Respondents who described needs related to poverty reported that stricter enforcement of TANF time limits and the short-term focus of many programs that support poor families has left many DCF-involved families without access to needed long-term safety net supports. These concerns are echoed by advocates who contend that altering tax codes, offering subsidized jobs programs, expanding child care subsidies, increasing SNAP benefits and expanding housing subsidies would introduce financial stability into the lives of poor families (Children’s Defense Fund, 2015).

The following section explores the multiple ways this need was expressed by study participants.

**Some families in poverty need money management skills:** Some respondents discussed the challenges poor families face managing their money. In particular, it was noted that some families may not have a future-oriented budgeting approach.

*“ . . . A lot of them come from families that have addiction problems... the skills that they have learned have been carried on so... [need help] budgeting their money, or prioritizing how they spend their monies....” [DCF Staff]*

*And so it's really trying to help families . . . part of it is revitalizing a certain part of the city and so within that revitalization project, this is trying to help families to be more established financially and more stable by taking households and bringing them through a yearlong curriculum. They get a savings account. They learn how to budget. They learn how to save. They learn how to set goals and they're working together with a family coach to really try to boost them and help them out.” [DCF Staff]*

**Families in poverty need long-term access to public assistance benefits:** A number of informants reported that county boards of social services are adhering more strictly to eligibility limits for TANF and other public assistance benefits in recent years. Respondents said that families that reach the five-year time limit for public cash assistance benefits may also come to the attention of CP&P when other community programs fail to fill the gap. Subjects also discussed the challenges they see families face trying to access public benefits and described scenarios in which parents lose access to needed services if their children live with a relative or in foster care for a period of time.

Quotes illustrating this theme include:

*“I have situations where a mom is working, a single mom is working (and) trying to go to school... she's using these services, but because she started college classes (and) working nights, she can't find daycare for her kid... so she sends the kid to go live with a family member for a couple months until she can get steady. Social services assistance says 'well you don't have a kid, you're not getting any services'.” [DCF Staff]*

*“A lot of these families are reaching the five-year mark, which is what they get for assistance. And even the (Service Provider) and the other agencies that can provide some sort of monetary assistance don't have it, so it ends up coming to us for either assistance, placement, or whatever else.” [DCF Staff]*

### **Need 3: Families need transportation to access services.**

Many low-income families cannot afford to own a car and rely on public transportation to access services and supports. Many respondents noted that transportation was a significant issue for these families. In 2014, 11.7% of New Jersey residents did not have access to a vehicle, compared to 9.1% of the entire U.S. population (U.S. Census Bureau, 2014). Lack of access to a vehicle was most pronounced among the state's foreign-born, non-citizen residents with 25.7% not having access to a vehicle.

The following section explores the multiple ways this need was expressed by study participants.

**Need access to transportation, particularly in rural communities:** Respondents reported the greatest challenges are among families that do not own a car. Public transportation systems in the less populated areas of the state were often described as being impractical. The complexity of taking multiple modes of public transportation with young children was identified as an issue by several respondents. Finally, respondents reported that transportation is more broadly problematic when some specialized services are not available within the county.

The quotes from focus group and interview respondents provided below illustrate this theme:

*"I can't say enough about the housing and the transportation and the childcare barriers that people run into. . ."* [DCF Staff]

*"Our county just did their needs assessment, the top priorities were, as usual, transportation, mental health, psychiatric care . . . So it's not just our population that is saying this, it's our community."* [DCF Staff]

*"...we have families who have to take two or three buses just to get to their destination, which is very much unfortunate. In a car . . . it may take you 20 minutes. It takes them two hours because of the bus routes."* [DCF Staff]

*"typically folks don't have a car, so it's relying on either public transportation and in some of our more rural parts of the state it could be taking two to three buses. People can take an all day trip, just . . . to get a service and then come home."* [DCF Staff]

*"[Medicaid transport] is very unreliable and so they're missing appointments. We're trying to quickly catch them up to their doctor's appointment, their child's appointment. It's really lacking out there for them to be able to get to appointments . . ."* [DCF Staff]

**Need help navigating the public transportation system:** A few respondents reported that in addition to arranging transportation and providing rides to help families access services, they also try to teach families to use public transit if available.

*“There’s buses and things like that but the system isn’t the most user friendly so it’s difficult for families to get where they need to go. I mean they do it. How they do it, I’m not always sure but one of the things that we see a lot of is families are very resilient... Families and parents when they know that they need to get their kids something, they will find a way, so it’s usually just trying to help them navigate and then they’re on it.” [DCF Staff]*

### **Poverty – Practice Context**

1. Low-wage work is a significant contributor to poverty among families involved with DCF. Services are needed to help low-wage earners move into better jobs, which will reduce their vulnerability to financial problems.
2. Longer-term access to public safety net programs is needed to help ensure that poor families can meet the basic needs of their children.
3. Transportation presents multiple barriers for poor families, particularly those living in the state’s more rural regions.

# Housing

## Housing Overview

Previous analysis of NJ-SPIRIT data found that 6.3% of all reports received between 2009 and 2013 were for children with an identified need related to housing. During this time period, housing was an identified need for 5.8% of child protective services reports and 8.5% of child welfare services referrals. Studies have found a strong link between homelessness and housing issues and involvement with the child welfare system (Courtney, McMurtry, & Zinn, 2004; Dhillon, 2005).

Drawing upon data collected through focus groups and interviews, this section explores needs related to housing. Two broad needs that emerged from the data were:

1. **Low-income families need long-term housing assistance.**
2. **Caregivers need stable housing when children are in an out-of-home placement.**

### **Need 1: Low-income families need long-term housing assistance.**

Respondents described the high burden of housing costs on low-income families, as explored above (see Poverty section). The following section further explores the ways this need was expressed by study participants.

**New Jersey has a high cost of living and housing is unaffordable for some families:** The high cost of living in New Jersey, according to respondents, leaves low-income families particularly vulnerable to housing instability.

*“I think that’s a New Jersey problem . . . I think it is expensive to live in New Jersey period, for any one of us, and I think when you have lower-income people who are living in a state that is very expensive to live in, this kind of exasperates [sic] their problems even more.” [DCF Staff]*

*“I mean even if everyone’s working in a family they may not have enough to get the security deposit together, and have enough to get adequate space . . . if they’re a family of four or whatever they are. I mean it’s expensive to get an apartment in this state...” [Service Provider]*

*“You go to parts of Jersey City. There are families paying three, four or five thousand dollars rent while we have families with an income of \$360 trying to pay or make it and get a home with that same amount ...” [DCF Staff]*

**Need public assistance programs that provide long-term solutions to safe, affordable housing:**

Respondents identified the high cost of living in New Jersey, inadequate housing and other supports for the working poor, enforcement of TANF time limits, and inadequate shelter capacity as factors that contribute to housing needs among families served by CP&P.

Rules and cutbacks in public assistance programs, both for housing and other services, further complicate housing issues. This trend is reflected in the national literature on housing (Phinney, Danziger, Pollack & Seefeldt, 2007).

*“...With welfare you only qualify for housing for a certain amount of years, I think it’s five years. I think you need to qualify for TANF (Temporary Assistance for Needy Families) to be eligible for housing, because you’re only allowed five years on TANF and then once you exhaust your five years, like where do you go from there? Section 8 has a waiting list that’s like five years or something like that.” [DCF Staff]*

*“The Board of Social Services is enforcing what their rules have always been and it’s statewide now so the Division is seeing a lot more homelessness cases. The Board of Social Services is telling the clients, at least in my county, to call us for help because they are not going to get them help.” As another respondent said about TANF limits: “There is no going around it, there is no amendment. There is no extension. There is just nothing.” [DCF Staff]*

*“We see a lot of undocumented families and sometimes it is really difficult trying to get them assistance with rent . . . sometimes they may have a child that was born here . . . that would help us for them to get food stamps, but it is really difficult. I see the struggle . . . that is something that we see a lot in our area is undocumented families. Sometimes we open services . . . so that we can pay for services, because they don’t have insurance, they are not able to pay on their own. That is definitely a big issue in our area.” [DCF Staff]*

**Fathers and pregnant teens need available shelters:** There are gaps related to shelter space for specific populations, including single fathers and pregnant teens. While not specific to the population served by DCF, New Jersey’s 2016 Point-In-Time Count of the Homeless (Monarch Housing Associates, 2016) found that the “unsheltered homeless” (defined as people whose primary nighttime residence is a public or private place not designed for or ordinarily used as a regular sleeping accommodation, such as a car, park, or abandoned building) increased 54.9% between 2014 and 2016. During the same time period, the overall homeless population declined by nearly 25%. The 1,327 unsheltered households counted in 2016 included 26 (2%)

families with at least one adult and one child. This was an increase of seven families from 2015.

*“ . . . we get a lot of those calls, we have shelters that take women or families but few that take fathers with children.” [DCF Staff]*

## **Need 2: Caregivers need stable housing when children are in an out-of-home placement.**

A second theme that emerged related to housing focused on the need for stable housing to allow children who have been in an out-of-home placement to return home (Cohen-Schlanger, Fitzpatrick, Hulchanski, & Raphael, 1995).

The following section explores the ways this need was expressed by study participants.

**Families need stable housing to support reunification:** Several respondents indicated that at times reunification can be delayed due to housing issues. Nationally, families that are nearing reunification often have unmet housing needs. Ironically, not having custody of their children often compromises a parent’s housing stability (Marcenko, Lyons & Courtney 2011).

*“I think one thing that we really need ... is some type of reunification program for housing.” [DCF Staff]*

*“...When it’s time to reunify we have these children who are ready, because they have gone through all of the services, and then you have these parents that have done everything that we have asked for them to do for reunification, but that barrier is now housing.” [DCF Staff]*

*“ . . .[It’s a] huge issue in our county. It’s something that we try to talk to different social service agencies about and there is no solution. It’s definitely a huge need in many of those cases where reunification is a barrier because there is no housing.” [DCF Staff]*

### **Housing – Practice Context**

1. Housing is a significant issue, particularly for low-income families.
2. Few programs are available to provide long-term assistance to help low-income families with housing costs.
3. Some parents lose housing or housing assistance when their children enter foster care. The loss of housing may be a barrier to reunification for these same families.

# Child Substance Abuse

## Child Substance Abuse Overview

Fewer than 5% of all reports received by DCF between 2009 and 2013 involved children with an identified need relating to child substance abuse. During this time period, child substance abuse was an identified need in 2.4% of child protective services reports and 5.4% of child welfare services referrals (Weinberg et al., 1998).

Although child substance abuse was among the less frequently identified needs for DCF involved families, a number of respondents discussed issues relating to child substance abuse. Findings from focus groups and interviews identified co-occurrence of substance abuse and other child needs, as well as the availability and use of services, to be among the issues affecting children and families with child substance abuse related needs.

Drawing upon data collected through the focus groups and interviews, this section explores needs related to child substance abuse. The two broad needs that emerged from the data were:

- 1. Children need appropriate substance abuse treatment services.**
- 2. Children with substance abuse issues need to be engaged in the treatment process**

### **Need 1: Children need appropriate substance abuse treatment services.**

Several respondents who described needs related to child substance abuse reported that children need access to substance abuse services that provide the appropriate level of care.

The following summary explores the ways this need was expressed by study participants.

#### **Ensure availability of a continuum of treatment services for children and adolescents:**

Some respondents reported a general shortfall of a continuum of services for children and adolescents with substance abuse needs, including detox programs and inpatient and outpatient treatment, but also a focus on more long-term treatment options for adolescents. Research has shown that this shortage, also identified by some respondents, could complicate the efforts of caseworkers to obtain appropriate services and placements for children (Simms, et al., 2000).

“We are starting to see more substance abusing in children . . . [and] teens and we are holding them in hospitals waiting for beds at [Organization] or other facilities that we can try and get them at, but we are running into no beds, no placements or we can’t put them in a resource home, because there might be other children there... or they don’t know how to handle a substance abusing teen...” [DCF Staff]

**Treatment must provide options that address co-occurring needs:** Several respondents described child substance abuse as frequently co-occurring with other child needs, particularly mental health and behavioral needs. This is reflective of the literature showing high levels of co-occurring mental health needs among children who engage in substance use (Center for Behavioral Health Statistics and Quality, 2015). According to data presented later in this report, children with co-occurring substance abuse and mental health needs accounted for 3.3% of families that presented to DCF with two identified needs between 2009 and 2013. Some of respondents reported that this population of children requires more targeted treatment options than are currently available.

*“A lot of kids use marijuana recreationally, but now they’re using marijuana infused with prescription pills or prescription other medicine . . . which leads up into what can be diagnosed as a mental health issue, because of their behaviors . . . people fall through the cracks, especially adolescents.” [DCF Staff]*

One respondent described the shift from focusing on child substance abuse as a stand-alone issue to a co-occurring one:

*“In the substance use world, what we’ve done is we’re moving into the co-occurring model, rather than just a substance use model... So we’ve kind of forced that hand in a certain regard, for instances all our residential program for substance use we’ve converted to co-occurring and we support the agencies by raising their rates and adding clinical staff for example.” [Service Provider]*

## **Need 2: Children with substance abuse issues need to be engaged in the treatment process.**

**Youth need to be motivated to use substance abuse services:** Some respondents suggested that substance abuse services for children and adolescents are available, but may be underutilized. Researchers have identified stigma, as well as other issues, as barriers to service use for youth (Battjes, et al., 2003). One potential obstacle to the utilization of these services cited, was that, for many children substance abuse services are voluntary rather than mandated.

*“PerformCare has a level in which they can service them and the clients still need to accept it, we can’t force, we can’t force them, they actually have to consent to treatment . . . unless they’re under JJC [Juvenile Justice Commission] but we don’t have the same type of leverage, like we do on an adult. So, it binds our hands that much more.” [DCF Staff]*

### Child Substance Abuse – Practice Context

1. Child substance abuse often co-occurs with other issues, such as mental health and behavioral needs.
2. While some respondents indicated a lack of child substance abuse services, other qualitative data suggests that some available services may be underutilized.

## Justice-Involved Children and Caregivers

### Justice-Involved Children & Caregivers Overview

In focus groups and interviews with DCF staff, contracted service providers and families, several respondents expounded upon the unique needs of children and caregivers who were involved with the justice system. While research has clearly identified a population of youth who are involved in both the juvenile justice and child welfare systems, few efforts have attempted to quantify the frequency with which this crossover occurs, largely due to the difficulty obtaining data from both systems. Ryan & Testa (2005) estimated that delinquency rates are approximately 47% greater for youth associated with at least one substantiated report of maltreatment.

While data are available about the number of children involved with the child welfare system who have an incarcerated parent, existing estimates of the size of this population are likely too small (Child Welfare Information Gateway, 2015). In 2013, nearly 20,000 children nationwide entered foster care due to parental incarceration, accounting for 8% of all children who entered care that year (Child Welfare Information Gateway, 2015). This total does not include cases in which a child involved with the child welfare system remains in their home, cases in which a parent is incarcerated just before or any time after a child is removed from the home, and cases in which the incarcerated parent was not the child's primary caretaker at the time of the child's removal.

This section explores needs of children and families who are concurrently involved with the justice and child welfare systems. Two broad needs evidenced in the data were:

1. **Dually-involved children need coordination between the juvenile justice and child welfare systems.**
2. **Dually-involved caregivers have unique service needs.**

## **Need 1: Dually-involved children need coordination between the juvenile justice and child welfare systems.**

Respondents who described needs related to dually-involved children reported challenges between systems that impact placements and result in inappropriate services for children with behavioral health needs. Such concerns were reflected in a report by the Center for Juvenile Justice Reform (Herz et al., 2012). The report identified a number of challenges related to serving crossover youth including lack of a coordinated response, ineffective service delivery, lack of engagement by educational and behavioral health systems, failure to recognize the impact of trauma on behavior, and inadequate attention to permanency and transition to adulthood.

The following section explores the multiple ways this need was expressed by study participants.

### **Children involved with juvenile justice systems need appropriate placement options:**

Some respondents highlighted that it is problematic for DCF to provide placements and services to children that juvenile court judges decide should not be detained.

*“It comes up when they [courts] . . . don’t want to detain them, and they [courts] want us [DCF] to place them in our foster homes. That is problematic.” [DCF Staff]*

*“The court doesn’t know what to do with them . . . they [children] are one point off [from meeting the criteria for admission to a detention center] so it’s ‘Okay, we’ll send them back home and have the division put in these services.’ Also, they [dually-involved youth] can’t be alone with this child or they can’t be alone with this one. Now you have mom that has to go to work and she is like ‘What can you guys do to help me with a babysitter?’ Then we are sitting here trying to get all of these issues resolved.” [DCF Staff]*

### **Systems need to coordinate to appropriately address child behavioral health issues:**

Several issues were identified related to juvenile justice and child mental health. A DCF staff member reported that school staff sometimes address children’s behavioral health issues inappropriately, leading to unnecessary police involvement. A service provider reported that the juvenile justice systems and child behavioral health systems need better coordination.

*“Ok, he was not behaving, the school had to do something . . . they call the police, when a child is misbehaving in a school... This is not a criminal child; they are just having behavioral problems. Somebody needs to speak to him or her.” [DCF Staff]*

*“... if a kid [is] coming out of juvenile justice, and they happen to [need] behavioral health care – those systems don’t always work together well. . . They have two different rules and regulations going on.” [Service Provider]*

## **Need 2: Dually-involved caregivers have unique service needs.**

Focus groups and interviews with DCF staff, contracted service providers, and DCF-involved families, provided a number of identifiable challenges relating to parents with criminal justice system contact. One contracted service provider reported that approximately half of clients in an adult program had probation requirements from the criminal justice system.

Themes from the qualitative data included a lack of sufficient services for parents with criminal justice histories and the impact of the stress of one parent’s incarceration on the parent remaining with the children.

The following section explores the ways this need was expressed by study participants.

**Dually-involved parents need to be engaged with planning and provided services:** A respondent suggested improving outreach efforts to engage with parents who are serving a prison sentence.

*“He’s been convicted of something and he’s going to be in there for quite a few years, and we’re not putting services... This is a perfect time to get this guy engaged.” [DCF Staff]*

Other respondents indicated that formerly-incarcerated parents need help expunging prior records, which would help them obtain employment and housing.

*“Expungement is a big thing. A lot of our young men don’t know what they can expunge, so they can get a job. They can get into housing because that felony has been expunged. That kind of educational piece. Again, I’m not expecting us to be able to do the things . . . but to have those partnerships – to know that when I send or refer to someone that they’re going to work on that piece.” [DCF Staff]*

**Custodial parents need additional supports when co-parents are incarcerated:** The qualitative data suggests that the incarceration of one parent can lead to significant stress for the parent remaining in the home with the child or children. This theme is reflected in the literature about parental incarceration and child welfare system involvement (Denby, 2012;

Nesmith & Ruhland, 2011). As one parent in this situation described, supportive services for the custodial parent can be quite useful.

*“I am doing it [parenting] by myself. Why? Because my husband is incarcerated...even though it is harder for me...it’s a little bit more stressing...”*  
[Parent]

*“The issue that one parent may be incarcerated, so there’s a very important figure out of a kid’s life...Putting a lot of pressure on a single parent who already has a lot of stuff to deal with.”* [DCF Staff]

*“I was pregnant, my husband was in jail, and I was by myself. I was really doing it by myself. I got to a point that. . . I was like, ‘Let’s just give up, not doing anything more’ . . . But, when DYFS<sup>3</sup> came in and everything . . . they were like, ‘You need any help?’ I was like, ‘Yes I need a lot of help...’”* [Parent]

#### **Justice System Involved Children and Caregivers – Practice Context**

1. As in communities across the country, the child welfare system is at times called upon to provide services for adjudicated youth.
2. Children who need mental health services to address behavioral issues are at times reported to police rather than connected with services.
3. Additional services for criminal justice-involved caregivers, both in the community and those currently incarcerated, may benefit DCF families.
4. The incarceration of one parent may be a significant source of stress for the parent who remains with the child or children, and the custodial parent may need additional support.

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<sup>3</sup> A number of respondents referred to the Division of Child Protection and Permanency by its former name, Division of Youth and Family Services/DYFS.

# Challenging Populations

## Challenging Populations Overview

Several populations were identified as being especially challenging to serve across several need domains, including low-income families (Martin & Citrin, 2014), rural populations (Child Welfare Information Gateway, 2012), and undocumented immigrants (Child Welfare Information Gateway, 2015a).

Drawing upon data collected through focus groups and interviews, this section explores needs related to serving these populations. One broad need that emerged from the data was:

### **Need 1: Caseworkers need help finding services for several difficult-to-serve populations.**

Parents described challenges in serving low-income populations, rural populations, and undocumented residents. The following section explores the ways this need was expressed.

**Need long-term solutions to address needs of low-income residents:** In their discussions about poverty, housing and transportation, study participants highlighted the need for long-term solutions for the state's poorest residents. Participants described public assistance programs as short-term in nature. In some cases, caregivers are not capable of entering the workforce due to their own mental health issues, cognitive limitations or caregiving responsibilities. For populations that are able to work, participants reported that services needed to maintain financial stability are often reduced or eliminated once a family's income becomes too high. Finally, participants indicated that low-income residents often lack access to a car hindering their access to services.

The following quotes illustrate how this theme was expressed by study participants:

*"...[families] no longer qualified for the benefits because they're making too much money...to qualify for Medicaid, or rental assistance or anything, but they're not making enough money to subsist." [DCF Staff]*

*"...oftentimes, if they [families] don't have access to healthcare...or food, and children aren't going to school, and they're truant...and it's because the family doesn't have a fixed address, or they don't have a way to get the child to school...that is a poverty thing..." [DCF Staff]*

*"...so the housing is ridiculous. People pay more than 50% of their income toward housing, so it's the greatest challenge...When you have to pay 50% of your income toward housing you're left with little...to [take care of] your children."*

*So it's always a struggle for caregivers..." [DCF Staff]*

**Rural populations need support for accessing services:** The unique service needs of people living in rural areas of the state were identified across multiple domains. Comments by study participants mostly reflected concerns about the challenge that rural residents face in accessing services. Exemplary quotes include:

*"...transportation becomes a much greater issue for the more rural..." [DCF Staff]*

*"...and the amount of services that are available compared to what's available down here, it's worse than night and day. In reference to transportation, hospitals, schools, just public resources in general. It's just not as much available as it is in other areas." [DCF Staff]*

*"...there's very few bus routes. People are basically living out in the woods, or the blueberry fields. And there's no way for them to access public transportation. There's no way at all for them to get to some of their services." [DCF Staff]*

**Undocumented immigrants need available services:** Challenges related to serving undocumented immigrants were voiced by study participants across multiple domains. This population is typically unable to access public assistance programs to address poverty and housing issues. In addition, this group often has limited access to health care services (due both to lack of insurance and language barriers) confounding access to substance abuse and mental health treatment. Finally, the language diversity of this population makes it difficult to find culturally-appropriate services (Earner & Izle, 2007).

*"New Jersey wants all children to be insured . . . Parents [in undocumented families] are not financially able to pay . . . for them to be at the doctor's office every so often." [Service Provider]*

*"So you're talking caregivers . . . who came to this country but are unable to obtain reasonable employment because they don't have any documentation, so they're working for two, three dollars an hour washing dishes, in the back room of a restaurant. You have their children they're not eligible for community-based services because they don't have any documentation, and even some of our programs and services they're not eligible for because they're not documented. Like for example a housing voucher, which is a federally funded voucher, they're not eligible for. And they're probably the most needy." [DCF Staff]*

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# Multi-Need, Frequent-Contact Families

## Multi-Need Families

An important finding of this analysis is that many children and families experience a combination of multiple needs. Close to a third (28%) of children had more than one identified individual or family need domain, with 18% having 2 need domains and 10% having 3 or more identified need domains. Multiple needs for most children included caregiver substance abuse and/or caregiver mental health needs. Notably, among children with 2 identified needs, a combination of caregiver mental health and caregiver substance abuse was the most common, with more than one third (35%) of children in the 2-need category having this need combination (see Table 3 for the ten most frequent combinations of needs for those with 2 needs). Moreover, either caregiver substance abuse or caregiver mental health was 1 of the 2 needs present in 8 of the 10 most frequently reported needs combinations. Caregiver substance abuse with domestic violence was the second most frequent combination, accounting for 14% of children with 2 identified needs. Children with 3 or more needs often experienced a combination of caregiver mental health and/or caregiver substance abuse along with domestic violence (19%), family poverty (12%), or child mental health (9%) needs (see Table 4 for the ten most frequent combinations of needs for those with 3 needs).

**Table 3. Most frequent need combinations for families presenting with two identified need domains from 2009-2013.**

Need Combination	n (%)
Caregiver Mental Health, Caregiver Substance Abuse	32,109 (34.6)
Caregiver Substance Abuse, Domestic Violence	13,370 (14.4)
Caregiver Mental Health, Child Mental Health	6,287 (6.8)
Child Mental Health, Caregiver Substance Abuse	5,806 (6.3)
Caregiver Substance Abuse, Family Poverty	5,631 (6.1)
Caregiver Mental Health, Domestic Violence	5,408 (5.8)
Family Poverty, Housing	4,708 (5.1)
Caregiver Mental Health, Family Poverty	3,494 (3.8)
Child Mental Health, Child Substance Abuse	3,109 (3.3)
Family Poverty, Domestic Violence	2,660 (2.9)

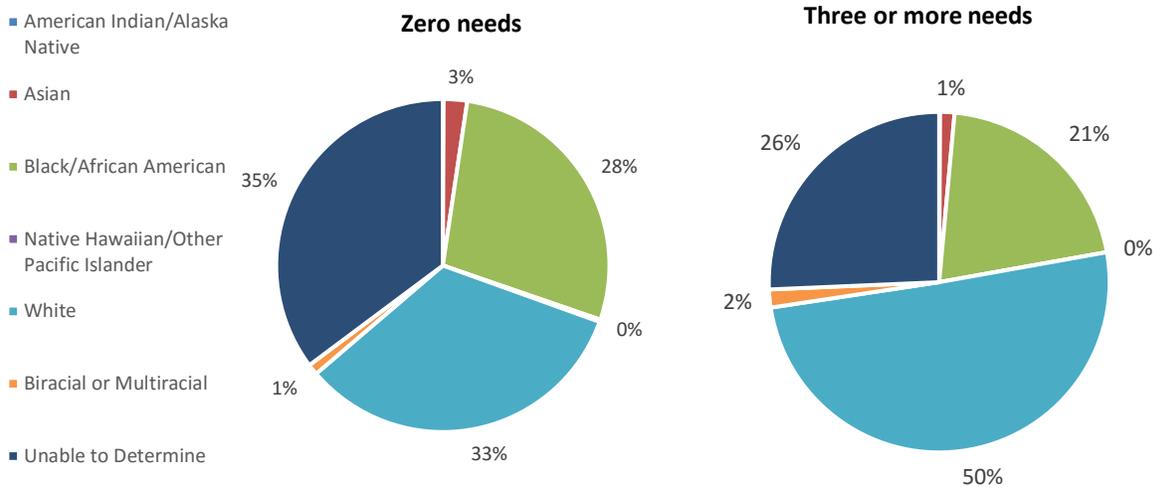
It is important to recognize that needs frequently occur in combinations, with substance abuse and mental health occurring most frequently among these combinations. This is particularly important as a window into family functioning, considering the role of caregiver substance abuse and caregiver mental health as needs directly proximal to parenting capacity. These needs are also associated with accumulating risk and need across more distal socioeconomic needs such as poverty and housing.

**Table 4. Most frequent need combinations for families presenting with three identified need domains from 2009-2013.**

<b>Need Combination</b>	<b>n (%)</b>
Caregiver Mental Health, Caregiver Substance Abuse, Domestic Violence (DV)	10,140 (18.7)
Caregiver Mental Health, Caregiver Substance Abuse, Family Poverty	6,520 (12.0)
Caregiver Mental Health, Caregiver Substance Abuse, Child Mental Health	4,708 (8.7)
Caregiver Mental Health, Caregiver Substance Abuse, Family Poverty, DV	3,287 (6.1)
Caregiver Mental Health, Caregiver Substance Abuse, Family Poverty, Housing	2,819 (5.2)
Caregiver Substance Abuse, Family Poverty, DV	2,317 (4.3)
Caregiver Substance Abuse, Family Poverty, Housing	1,969 (3.6)
Caregiver Mental Health, Family Poverty, Housing	1,591 (2.9)
Caregiver Mental Health, Caregiver Substance Abuse, Housing	1,459 (2.7)
Caregiver Mental Health, Family Poverty, DV	1,454 (2.7)

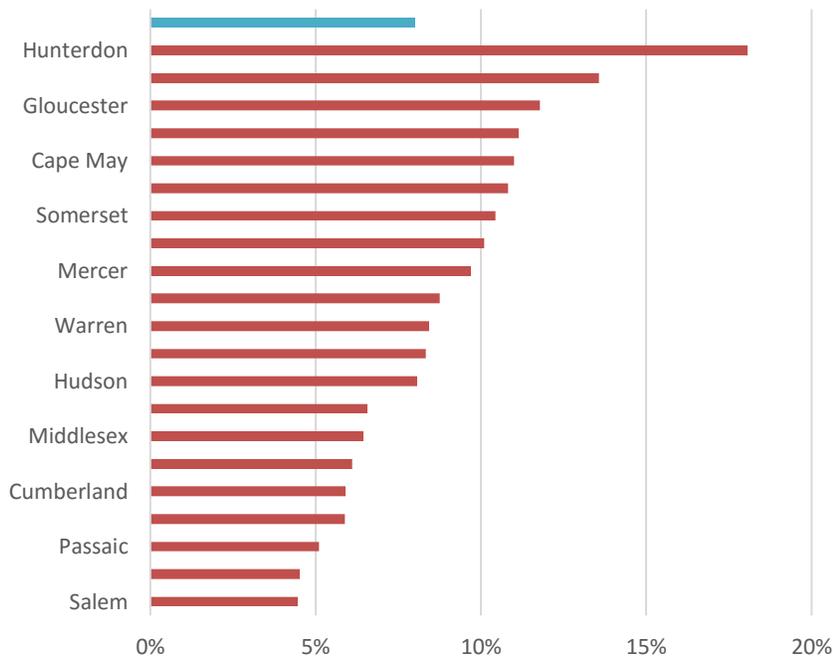
To build on these findings from the March 2016 report, additional analyses were conducted to understand issues related to multiple need families. Here, these analyses have been extended to better describe the children and families who present to DCF with multiple needs. Again, the cohort of children reported for the first time in 2009 was used to obtain representative data.

Half of the children encountered for the first time in 2009 (49%) had zero needs identified at the first report. Compared to these children, who had a mean age of 7.79 years when first encountered, those with three or more needs at that time were somewhat younger (6.43 years). Figure 2 compares the racial composition of these two groups, children with zero identified needs and children with three or more. Compared to children with no needs identified at the first report, children with three or more needs identified were more likely to be white and less likely to be black or have their race listed as “Unable to determine.”



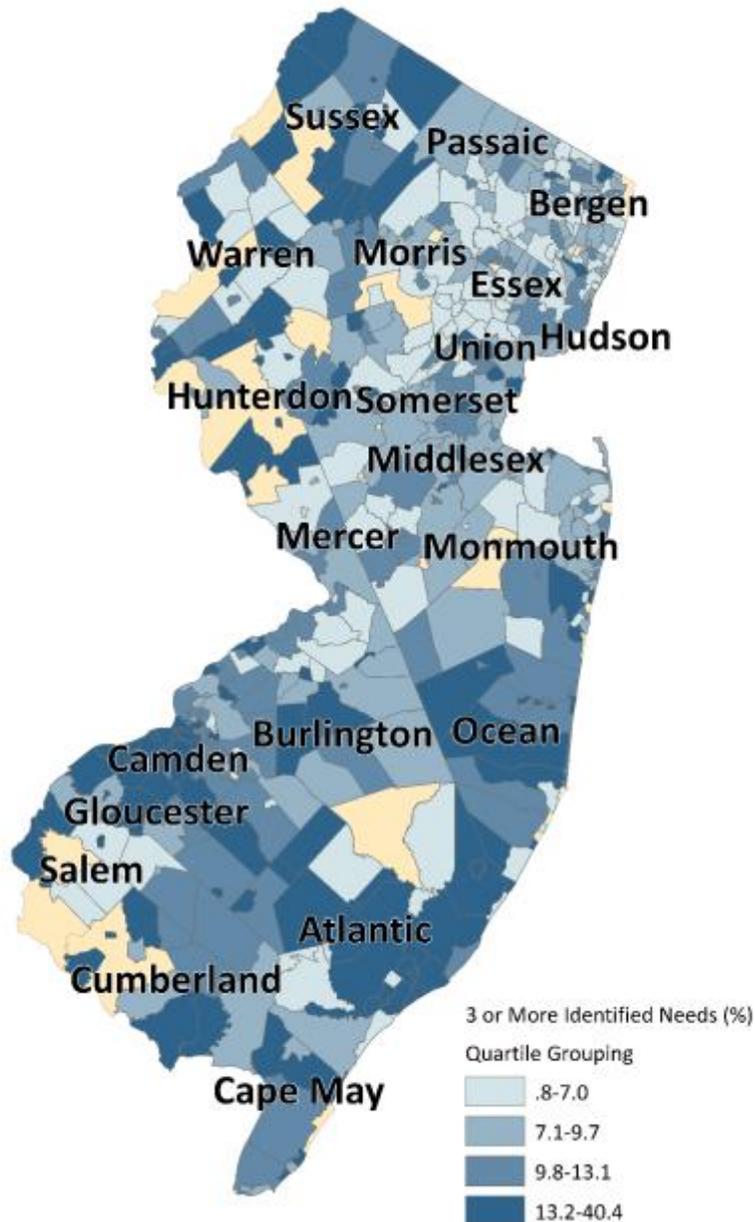
**Figure 2. Race of children with zero and three or more needs at the time of first report.**

Figure 3 below illustrates the share of each county's families reported for the first time in 2009 and found to have three or more needs. Hunterdon County has the largest percentage of multiple-need families (18%), though it should be noted that the county received the fewest reports in the state, by far. Sussex, Gloucester, Ocean, Cape May, Camden, Somerset, Monmouth, Mercer, and Atlantic also surpassed the state's percentage of multiple-need families.



**Figure 3. Percentage of families with three or more needs identified at first report.**

When the data are examined at the level of townships, it becomes clear that there is substantial within-county variation in the distribution of these especially high-need families. Figure 4, on the following page, illustrates the proportion of DCF-served families with three or more needs by township, ranked and presented in quartiles. The darkest areas represent those with the greatest density of families with three or more needs identified. Even in highly-rural counties, like Sussex, there are townships falling in the highest-density quartile as others are in the bottom quartile.



**Figure 4. Percentage of families with three or more identified needs, by municipality**

## Qualitative Analysis of Families with Multiple Need Domains

High levels of co-occurring needs among families involved with child welfare and child protection systems have been well documented across the U.S. (Vig, Chintz & Shulman, 2005; Marsh, Ryan, Choi, & Testa, 2005). In focus groups and interviews with a sample of New Jersey's DCF-involved families, DCF staff, and service providers, participants highlighted the challenges associated with compounding needs for caregivers and their children. Two overarching needs emerged in the analysis:

1. **Multi-need caregivers need help coping with complex life situations.**
2. **DCF staff and contracted service providers need help coordinating fragmented, limited services to address complex family needs.**

### Need 1: Multi-need caregivers need help coping with complex life situations.

Participants described how challenges accumulate, both within families and across generations.

**Multi-need families require comprehensive assessment:** Although families may be reported to DCF for a specific need, other needs often surface during the course of the investigation and case. Often these needs are concrete and linked with financial stress. A staff member described a common trajectory:

*“A lot of our families... may get involved for domestic violence or substance abuse but then [we hear], ‘I have an eleven-thousand-dollar gas bill that is going to be shut off next week, because I haven’t paid it... I can’t pay for it, because I have been paying for counseling services for my son, because you guys [DCF] told me I had to continue with this or I have to pay for my IOP [intensive outpatient] and I can’t buy food from [the store]; I use the pantries and they won’t let me come back.’ It’s just compounded...compounded.” [DCF Staff]*

**Multi-need caregivers require services that promote coping mechanisms:** One concern was how this high level of stress can overburden caregivers, diminishing the quality of care they are able to provide.

*“I have seen incidents where parents have been a little abusive toward their kids, not because they mean too but because of the underlying issue with the children and with life. And you can have such a stressful job and you come home and your kids make it stressful for you, you know you want to punch your boss in the face but you can’t do that, you need your job, but your kid pushes you....” [Parent]*

*“... I don’t think it’s that they don’t want to be there [caring for children]. I think that because of all the other needs that they have to go to work, so you’re going to work to just support, minimally support, the household and as a result their kids are left at home. Not because they want to leave them home but because they have to leave them home.” [DCF Staff]*

**Services need to address the impact of trauma on a family:** DCF staff and external service providers acknowledged that many caregivers in families with multiple needs are coping with their own histories of trauma, exacerbating the stress they experience. Trauma was identified as a common problem for substance abusing caregivers, and one that can adversely affect caregivers’ relationships with helping professionals.

*“I’d say that all of our substance abuse population have some kind of mental health problem and I think that I would even say, I think it goes even higher than substance abuse; . . . because you see the . . . hidden trauma that hasn’t been tapped into yet and so it affects their functioning in some way.” [DCF Staff]*

*“Well they’ve all [substance abusing caregivers] experienced trauma, and . . . it’s a generalization, the vast majority have significant trauma . . . which runs anywhere from poverty, all kinds of abuse, neglect, so needless to say they come here [service providing agency] not trusting people. So this is why we are very relationship focused. The whole underlying idea is to help them to gain some trust, which is foundational to all relationships.” [Service Provider]*

**Need 2: DCF staff and contracted service providers need help coordinating fragmented, limited services to address complex family needs.**

Families with multiple needs are likely to be receiving services from multiple providers, each of which may have its own focus, philosophy, and approach. This reality challenges efforts to address these needs comprehensively and in a coordinated manner.

**Need for intensive coordination and communication among service providers and staff:**

Agencies working with caregivers and children facing complex needs are challenged by the array of service providers working with these families. Some participants described the struggle to coordinate services when there are many agencies tasked with addressing needs.

*“...if everyone is sitting around the table and having a conversation, not only are we all going to learn from one another but we are also going to have a well-rounded assessment and . . . it’s going to eliminate some of that worker bias because every worker has their own biases and personal experiences...”*  
[Service Provider]

**Increase availability of services for children and caregivers with mild and moderate disability needs:**

Families may face multiple challenges, but individual needs may not rise to the threshold of severity required to receive services. A senior DCF staff member described how families falling short of eligibility requirements struggle:

*“We have a number of young people that [Don’t meet the criteria set by the Department of Developmental Disabilities]... Like, someone that’s in the borderline range of IQ that will not meet the criteria, and so they’re on a second grade level, they can’t really afford to work . . . developmentally they’re not able to support themselves or maintain a household. And where do they go for housing? Or where do they go for their service needs? Because they fall through the cracks.”* [DCF Staff]

**Families need post service stability:** Even as services may support a caregiver through a particularly challenging time, families with multiple needs may struggle to maintain stability when services are terminated. As described earlier (see the section on Substance Abuse), this is particularly problematic for caregivers in recovery following substance abuse treatment.

*“...[When services terminate,] it’s a time when they’re really susceptible to . . . either relapsing or going back to problematic behaviors. Because now they are faced with all these needs. And while they are here [they are] taken care of, but then they transition and there’s all this added stress.”* [Service Provider]

*“They [substance abusing caregivers] go back to being sober for 6 months, they have no housing, they have nothing, and they relapse; because they have no one to continue relapse prevention. It’s just such a circle that you go around.”*  
[DCF Staff]

Caseworkers may develop strategies to support families that struggle with multiple needs, even after case closure. During focus group with caregivers, we heard of the efforts of many workers who demonstrated their high degree of commitment to the ongoing well-being of families. One parent, for example, described his caseworker's efforts to remain in contact if it was necessary to address needs before they escalate.

*"...he did constantly ask if there was any other issues, and nothing came up and we seemed to be handling it to the best of our ability. He did inform me . . . to keep his number and stay in touch and if there is any issue in the future to contact him and he will do his best to help out, whether helping out personally or push us in the right direction. That way . . . there wouldn't be a need for another open case, or another bigger issue, or an issue where someone will call and say, 'Hey listen, there is neglect on these kids' and whatnot. And for him just to still have his hand out there, and say, 'Hey if you need help, don't wait until it is too late, just call me and then we will figure it out'..." [Parent]*

## Frequently-Encountered Families

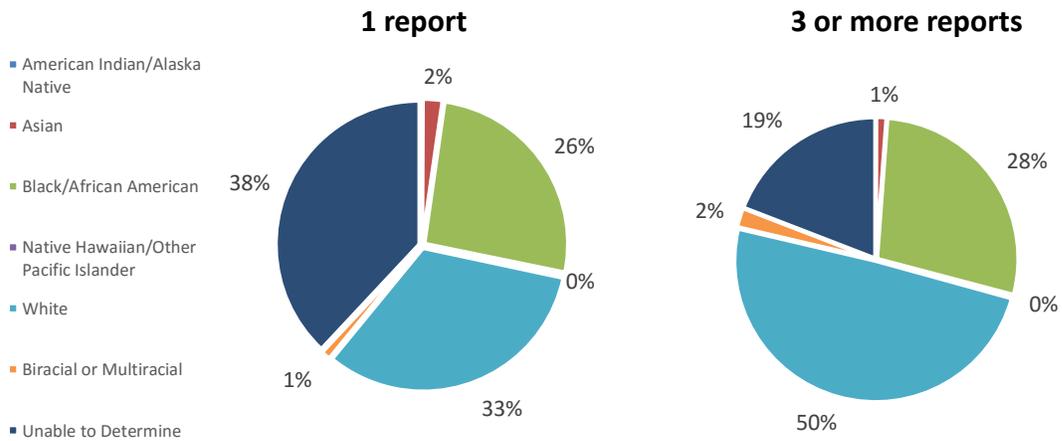
Extending analyses presented in the March 2016 Interim Report, characteristics of children and families with three or more reports to DCF within three years were explored. Records for a cohort of children whose first report to CP&P occurred in 2009 was extracted from NJ SPIRIT data. From this cohort, a subset of children who had three or more reports over the three-year period spanning 2009 to 2011 were examined. A specific goal of these preliminary analyses was to determine whether, at the time of the first report, families who will go on to repeatedly encounter CP&P are distinct in a distinguishable way from those who will only have one or two total encounters.

At their first report, frequently-encountered are likely to be significantly younger than their counterparts who are singly or doubly reported (Table 5). Children who go on to have three or more reports had a mean age of 5.99 years at the time of their first encounter, compared to a mean age of 7.93 for children with only one report.

**Table 5. Child's age (years) at 1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> report by total number of reports**

Total Number of Reports from 2009 to 2011						
	1 report		2 reports		3 or more reports	
	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.
<b>1<sup>st</sup> report age</b>	7.93	5.39	7.11	4.87	5.99	4.46
<b>2<sup>nd</sup> report age</b>			8.65	4.80	6.97	4.49
<b>3<sup>rd</sup> report age</b>					8.02	4.50

Figure 5 below shows the racial makeup of children with a single report from 2009 to 2011 and those with three or more reports.



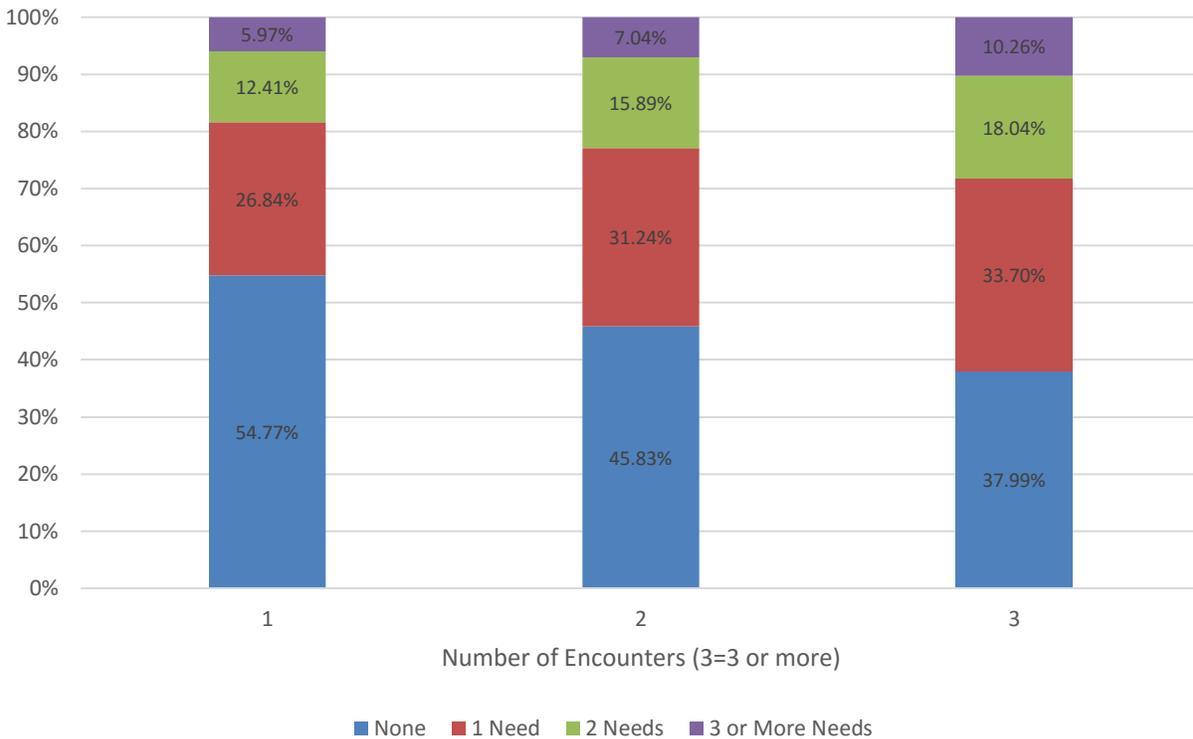
**Figure 5. Race of children with 1 report and 3 or more reports**

At the time of their first report to CP&P, children who go on to have three or more reports do not have substantively different identified needs from those children with only one or two reports over three years. As presented in the March 2016 interim report, frequently-encountered families are more likely to have needs identified over the course of their interaction with DCF (p. 26). This is true across all categories of need. However, when comparing the needs identified at the time of the first report for singly-reported families, doubly-reported families and families who go on to have three or more encounters, the differences are less stark. Table 6 lists the percentage of families in each of these categories with a given need identified at the time of the first report.

**Table 6. Percentage of children with each need domain present at their first report by three groups of children: those with only 1 report, those with 2 reports, and those with 3 or more reports from 2009 through 2011.**

	1 report	2 reports	3 or more reports
<b>Caregiver Mental Health</b>	14.79%	19.82%	23.13%
<b>Child Mental Health</b>	5.03%	6.45%	12.49%
<b>Caregiver Substance Abuse</b>	24.02%	27.34%	31.85%
<b>Child Substance Abuse</b>	1.61%	1.30%	1.60%
<b>Family Poverty</b>	9.20%	10.25%	11.26%
<b>Housing</b>	5.19%	4.72%	5.75%
<b>Domestic Violence</b>	11.69%	16.53%	20.38%

Likewise, the number of needs identified at the time of the first report differs only somewhat across groups. The number of needs at first report increases in a stepwise fashion with the number of total encounters (Figure 6). Surprisingly, most families with one encounter, two encounters, and three or more encounters have zero needs identified when first reported to DCF.

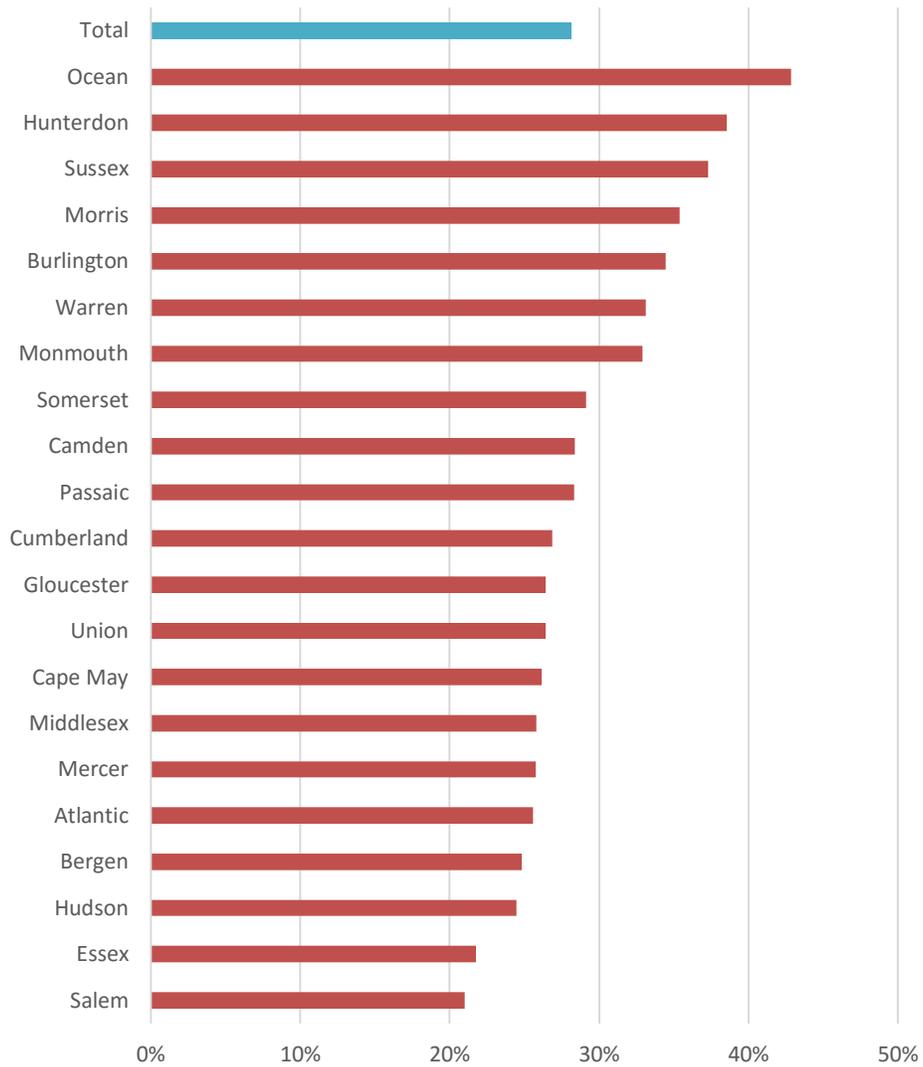


**Figure 6. Number of needs identified at first report for children with 1, 2, or 3+ encounters**

Overall, 28% of the cohort had three or more reports during the three-year period. Figure 7 illustrates the percentage of each county’s caseload of families with first reports in 2009 that went on to have three or more encounters with DCF. Ocean County saw the largest share frequently-encountered families, with 43% of its families reported for the first time in 2009 falling into this category. Seven other counties had a greater percentage of frequently-encountered families than the state overall: Hunterdon, Sussex, Morris, Burlington, Warren, Monmouth, and Somerset. These counties comprise a sizeable portion of the state’s rural population<sup>4</sup>, though further analyses are needed to determine whether a significant relationship between urban/rural

<sup>4</sup> New Jersey Department of Labor and Workforce Development ([http://lwd.dol.state.nj.us/labor/lpa/census/2kcensus/sf1/ur\\_pop.pdf](http://lwd.dol.state.nj.us/labor/lpa/census/2kcensus/sf1/ur_pop.pdf))

gradient and the density of frequently-encountered families exists.



**Figure 7. Percentage of county's families with first report in 2009 who had three or more reports before 2012**

# Summary of Findings

## Major Themes and Findings

The previous section of this report provided in-depth analysis of needs experienced by families involved with child welfare services. This section builds upon those findings by summarizing major themes and findings that emerged across domains and framing them in terms of implications for child welfare practice and services in New Jersey. Table 7, below, presents study findings by each major need domain.

**Table 7. Findings by Need Domain**

<b>Caregiver Substance Abuse</b>	
<i>Need</i>	<i>Themes</i>
1. Caregivers need immediate access to substance abuse services.	<ul style="list-style-type: none"> <li>• Delayed recognition of substance abuse</li> <li>• Limited treatment capacity</li> <li>• Limited availability of post-detox services</li> <li>• Limited treatment opportunities for needs that co-occur with substance abuse</li> <li>• Limited residential services for fathers with children</li> <li>• Barriers prohibit access to services</li> </ul>
2. Caregivers need services that help them maintain their recovery over time.	<ul style="list-style-type: none"> <li>• Challenges of maintaining sobriety</li> <li>• Need services to prevent relapse and promote long-term recovery</li> <li>• Informal supports may or may not be positive</li> </ul>
<b>Caregiver Mental Health</b>	
<i>Need</i>	<i>Themes</i>
1. Caregivers need mental health services that address co-occurring issues.	<ul style="list-style-type: none"> <li>• Mental health, substance abuse and domestic violence commonly co-occur</li> <li>• Caregiver trauma influences mental health needs</li> </ul>
2. Caregivers need access to quality mental health services.	<ul style="list-style-type: none"> <li>• Limited adult mental health providers</li> <li>• Poor quality services</li> </ul>

<b>Domestic Violence</b>	
<i>Need</i>	<i>Themes</i>
1. Victims need positive support.	<ul style="list-style-type: none"> <li>• Intergenerational family violence limits supports</li> </ul>
2. Both violence batterers and children exposed to domestic violence need services.	<ul style="list-style-type: none"> <li>• Exposure results in trauma, which must be addressed</li> <li>• Batterers need intervention services to change behavior</li> </ul>
3. Victims need long-term, wrap-around services.	<ul style="list-style-type: none"> <li>• Time limits impede service effectiveness</li> <li>• Availability of services is uneven</li> </ul>
<b>Child Mental Health</b>	
<i>Need</i>	<i>Themes</i>
1. Children need consistent, age-appropriate mental health services.	<ul style="list-style-type: none"> <li>• Insufficient number of child psychiatrists</li> <li>• Inconsistency in mental health service provision</li> <li>• Targeted service options for children with specific mental health needs.</li> </ul>
2. Children need trauma-informed mental health services.	<ul style="list-style-type: none"> <li>• Services to address trauma experienced by children</li> </ul>
<b>Poverty</b>	
<i>Need</i>	<i>Themes</i>
1. Caregivers need help moving out of low-wage jobs.	<ul style="list-style-type: none"> <li>• Vulnerability to financial crises</li> <li>• Formerly-incarcerated parents struggle to obtain work</li> </ul>
2. Poor families need help meeting their children's basic needs.	<ul style="list-style-type: none"> <li>• Unmet child needs contribute to DCF involvement</li> <li>• Need assistance with food, housing and payments for utilities</li> </ul>
3. Families need long-term safety net supports.	<ul style="list-style-type: none"> <li>• Need money management skills</li> <li>• Need long-term access to public assistance benefits</li> </ul>
4. Families need transportation to access services.	<ul style="list-style-type: none"> <li>• Barrier to accessing services, particularly in rural communities</li> <li>• Need help navigating the public transportation system</li> </ul>

<b>Housing</b>	
<i>Need</i>	<i>Themes</i>
1. Low-income families need long-term housing assistance.	<ul style="list-style-type: none"> <li>• Broad impacts of high cost of living in New Jersey</li> <li>• Limits on public assistance programs present barriers to safe, affordable housing.</li> <li>• Shelter space limited for some populations.</li> </ul>
2. Caregivers need stable housing even when children are in an out-of-home placement.	<ul style="list-style-type: none"> <li>• Families ready for reunification may experience housing challenges</li> </ul>
<b>Child Substance Abuse</b>	
<i>Need</i>	<i>Themes</i>
1. Children need appropriate substance abuse services.	<ul style="list-style-type: none"> <li>• Limited availability treatment services</li> <li>• Treatment options must address co-occurring needs</li> </ul>
2. Available child substance abuse services may be underutilized.	<ul style="list-style-type: none"> <li>• Stigma and other issues contribute to underutilization of substance abuse services by youth</li> </ul>
<b>Justice-Involved Children and Caregivers</b>	
<i>Need</i>	<i>Themes</i>
1. Dually-involved children need better coordination between the juvenile justice and child welfare systems.	<ul style="list-style-type: none"> <li>• Difficulty providing services that keep with the orders of a juvenile court judge</li> <li>• Poor coordination around juvenile justice and child behavioral health issues</li> </ul>
2. Dually-involved parents have unique service needs.	<ul style="list-style-type: none"> <li>• Insufficient services for dually-involved parents</li> <li>• Support needs for custodial parents when co-parent is incarcerated</li> </ul>
<b>Challenging Populations</b>	
<i>Need</i>	<i>Themes</i>
1. Caseworkers need help finding services for several difficult-to-serve populations.	<ul style="list-style-type: none"> <li>• Low-income families</li> <li>• Rural populations</li> <li>• Undocumented residents</li> </ul>
<b>Multi-Need, Frequently-Encountered Families</b>	
<i>Need</i>	<i>Themes</i>
1. Multi-need, frequently-encountered caregivers need help coping with complex situations.	<ul style="list-style-type: none"> <li>• Complex material needs</li> <li>• Taxed caregiver coping skills</li> <li>• Impact of trauma on other challenges</li> </ul>
2. DCF staff and contracted service providers need help knitting together fragmented, limited services to address complex family needs.	<ul style="list-style-type: none"> <li>• Need for intensive coordination and communication among providers and staff</li> <li>• Challenges of undocumented immigrants</li> <li>• Accumulation of sub-threshold needs</li> <li>• Termination of services and stability</li> <li>• Caseworker strategies to support families with multiple needs</li> </ul>

## Service Implications

### **1. Co-occurring needs are common for both caregivers and children involved with DCF, and these intersecting multiple needs have accumulating effects for families.**

Combinations of caregiver substance abuse, caregiver mental health and domestic violence were frequently discussed by study participants, with some referring to the co-occurrence of these needs as a “trifecta.” Participants also described families that struggled with multiple basic needs such as housing, poverty and/or transportation. In addition, caregiver substance abuse and caregiver mental health issues were frequently identified as contributing to this mix of basic needs.

Among children, study participants reported that substance abuse and mental health needs often coexist. Further, many asserted that most children served by the agency have experienced some level of trauma which needs specialized services.

### **2. Caregivers need long-term services, extended aftercare and/or follow-up services related to multiple need domains.**

Study participants often described the need for a long-term approach to helping DCF-involved families and children to provide clients with time and support to make lasting changes in their lives. For example, they described the need for recovery support and relapse prevention services to help caregivers who have completed treatment programs maintain their sobriety over time. Several respondents added a need for education on preventing overdose, which is an elevated risk after completing a treatment program.

Long-term approaches were also advocated by respondents when discussing housing supports. Several indicated that current practices focus on providing rental deposits, or paying utilities, but fail to help families to maintain housing over time. One respondent argued for extending wrap around services for victims of domestic violence up to two years.

### **3. Caregivers need access to psychiatric service and trauma-informed mental health care. While this need was also evident for children, it was raised less frequently.**

Study participants frequently spoke about the need for trauma-informed mental health services for both caregivers and children. Many associated caregiver substance abuse and mental health problems with prior trauma exposure. Leaving the trauma unaddressed, many argued, prohibits meaningful improvements for caregivers.

Respondents noted that DCF-involved children also have their own trauma histories. Exposure to substance abusing parents and domestic violence, among other things, can contribute to trauma among children served by the system. In addition, maltreatment or being removed from

their home can contribute to childhood trauma.

While some respondents indicated that trauma-informed services are increasingly available, many felt there were simply not enough practitioners skilled in using that approach. Additionally, they felt that psychiatric services for both adults and children were limited.

**4. Access to services for caregivers and children may be uneven due to availability, transportation, eligibility requirements, and poverty.**

Study participants described variation in the availability of services throughout the state. Many felt that some areas were better resourced than others. In some cases, this meant a greater variety of services were available. In other cases, this was described as having more providers from which to choose services. In general, participants reported that less-populated areas tended to have fewer service opportunities.

Even when services are available, transportation, eligibility requirements, and poverty may create access barriers for some caregivers and children. Public transportation can turn a short trip into an all-day outing, which is difficult for a single adult to negotiate, let alone a parent with several young children. Long travel times, participants said, also make people less likely to use services. Limited providers who accept Medicaid, as well as high co-pays, further restrict access to services for poor parents.

Provider agency policies and hours sometimes created barriers to access. For example, several respondents described agencies that conduct intakes on a “first-come, first-served” basis. This process, they contend, makes services much more accessible for families who have access to transportation regardless of their level of need. In addition, most ride services (such as Medicaid transport) will only schedule rides if a specific appointment time is available. Relatedly, a number of respondents described the difficulty in scheduling services for working families, who may not be available during an agency’s standard operating hours.

Other issues included waiting lists, difficult transitions to lower levels (step-down) of care, and the need for in-home services for those who can’t travel.

**5. Caseworkers and families need access to appropriate services when they are needed. This likely requires the support of a complex and complete continuum of care.**

Study participants described the need for immediate access to a continuum of services to help caregivers and children address the critical and complex issues that led to their involvement with DCF. Several described court-ordered services not being immediately available. Others focused on long waiting lists for services. Outpatient mental health services, several said, were easier to access when coming from an inpatient facility.

Several specific service needs were mentioned by participants including:

- Services for hoarders
- Batterer's intervention services
- PALS for adolescents
- Residential domestic violence programs that accept older male children
- Domestic violence shelter space
- Residential substance abuse treatment services for single fathers
- Recovery support/relapse prevention services
- Placements for some types of children (fire-setting, sexually-acting out)
- Counseling for children with sexual trauma
- Access to employment
- Stable, long-term housing
- Shelter space for single fathers with children
- Shelter space for pregnant teenagers

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## Moving Forward

The next phase of the needs assessment will build on the first three phases by using survey research to examine the extent to which a random sample of children and families experience service needs related to adult substance abuse, child substance abuse, adult mental health, child mental health, poverty, housing and domestic violence. The survey instruments are under development through engagement of the Rutgers team with the DCF internal working group. The survey methodology will be supplemented with a review of available DCF service array data in order to provide a broader context to the survey data regarding service need and utilization patterns. The Rutgers team will work with DCF partners to draw upon the provider agency contract data and other available service provision and utilization data to better understand the overlap of the distribution of services and need in the state.

Synthesized data from all four phases of the Needs Assessment, along with feedback from external stakeholders, will be used to identify trends and potential gaps between service needs and availability. This will be included in a final comprehensive report which will be a culmination of all four phases focusing on regional and statewide system issues, recommendations for change and subsequent tasks to mitigate these challenges.

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## Appendix A – About CP&P

The Division of Child Protection and Permanency (CP&P) is a division of New Jersey's Department of Children and Families (DCF), the state's first comprehensive agency dedicated to ensuring the safety, well-being and success of children, youth, and families. Formerly known as the Division of Youth and Family Services (DYFS), CP&P is the state's child protection and child welfare agency. Its mission is to ensure the safety, permanency and well-being of children and to support families.

### **How WE Do It**

The Child Abuse Hotline (State Central Registry) receives all reports of child abuse and neglect 24-hours a day, seven-days a week. Reports requiring a field response are forwarded to a CP&P Local Office for investigation. (After normal business hours, the hotline is linked with a statewide network of Special Response Units (SPRU) charged with the responsibility of responding to such reports.)

In cases in which a child has been harmed, or is at risk of harm, CP&P may petition family court to place the child in foster care. Foster homes are provided by caring individuals who have completed an extensive training and licensing program. CP&P's primary goal is to achieve reunification of the child with his or her birth parents. If the family court determines that a child cannot safely be returned home from foster care, CP&P will begin adoption planning.

CP&P also handles cases that are opened for child welfare services, which are services to assist a family in ensuring the basic health and welfare of their children in the absence of any child protection concerns. Typically, in these cases, a service need exists for the family, but there is insufficient risk to the child to justify a formal child protection investigation.

As part of its work, CP&P partners with many community-based agencies throughout the state to provide services to children and families such as:

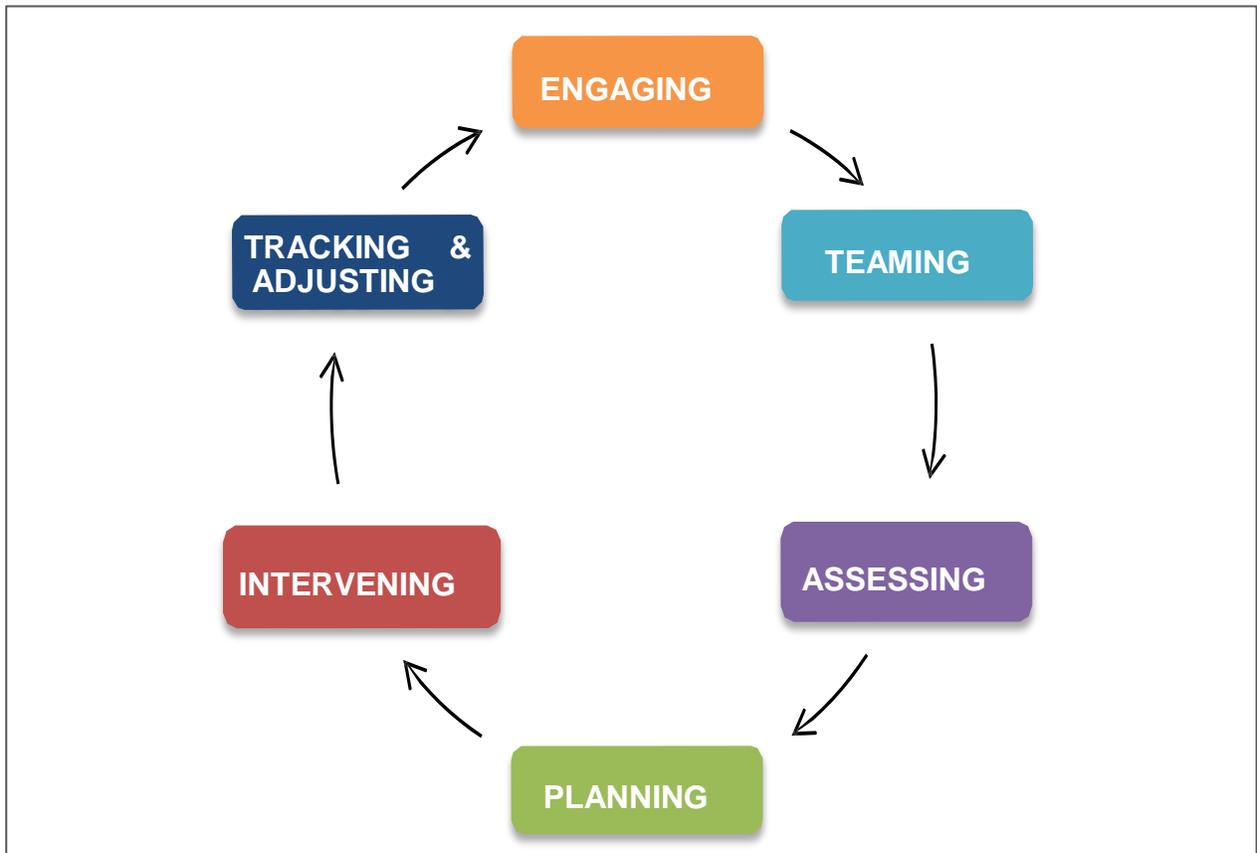
- Case management
- Family support services (parenting skills training, counseling, child care, etc.)
- Substance abuse treatment
- Domestic violence services
- Mental health services
- Foster care
- Adoption and kinship legal guardianship

The Department's Office of Clinical Services plays an important role in providing health services

to children in out-of-home placement. DCF worked with the Francois-Xavier Bagnoud Center at Rutgers University's School of Nursing to create the Child Health Units (CHU) in each CP&P local office. The CHU is staffed with a clinical nurse coordinator, nurse health care case managers, and staff assistants. Through this program, a nurse is assigned to every child in an out-of-home placement.

CP&P also provides services and supports to adolescents under supervision until their 21<sup>st</sup> birthday. Services assist youth to become self-sufficient as they transition to adulthood. Some of the services include life skills training, education, employment, financial assistance and housing.

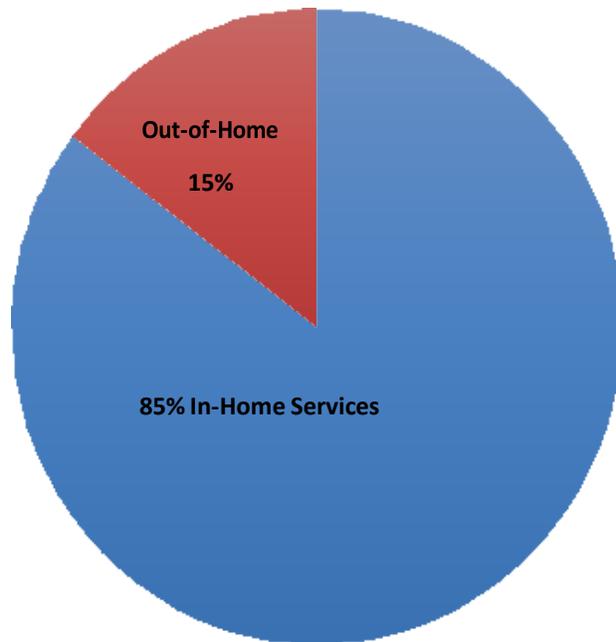
CP&P's work is guided by its Case Practice Model, which is a statement of best practices with guiding principles and expectations intended to improve outcomes for New Jersey's most vulnerable children and families. The Case Practice Model helps to establish clarity about how CP&P treats children and families and how families and their natural support networks are engaged in decisions affecting their safety and well-being. The key components of the case practice model include engaging, teaming, assessing, planning, intervening, and tracking and adjusting (Figure 8).



**Figure 8. New Jersey’s Case Practice Model**

## **WHO WE SERVE**

In addition to investigating allegations of child abuse and neglect, CP&P provides services that aim to ensure the safety and well-being of children and to help children and youth in out-of-home foster care achieve permanency. As of DCF’s quarterly demographics report from June 30, 2015, CP&P was actively delivering services to almost 51,000 children (Figure 9), either in their own homes (43,291) or in out-of-home placements (7,501). Reflecting CP&P’s commitment to keeping children and families together in the absence of a risk of harm, approximately 85% of children received services in their own homes.



**Figure 9. Proportion of children receiving In-Home and Out-of-Home Services as of June 30, 2015**

### **In-Home Population**

Children and youth receiving in-home services as of June 30, 2015 ranged in age from birth up to age 21 years. Nearly 40% of children being served in their own home are under the age of 5 years (18% are 2 years old or younger and 18% are 3-5 years old). Another almost 40% of children are school aged children ranging in age from 6-12 years (39%). Adolescents and older youth made up the rest of the in-home population, with 22% of children and youth between the ages of 13 and 17, and 3% ages 18 or older.

As of June 30, 2015, the percentages of males (50%) and females (50%) receiving in-home services were virtually identical. One third of the children and youth receiving in-home services were African American, while equal percentages of white (28%) and Hispanic (29%) children and youth received in-home services.

### **Out-of-Home Population**

As of June 30, 2015, almost half of children in placement were 5 years old or younger (26% were 2 years and younger and 19% were aged 3-5 years). The largest percentage of children in out-of-home placements were between the ages of 6 and 12 (31%). An additional 19% of youth were between 13 and 17 years of age, 6% of youth are 18 years and older.

The percentages of males (51%) and females (49%) in out-of-home placements were almost equal. More than forty percent of the children and youth in out-of-home placements were

identified as African American (42%). White children made up the second largest group of children in out-of-home placements (29%), followed by Hispanic (22%) children, and just 5% of children represent —Otherll racial groups such as Asian, Native American, Pacific Islander, etc. More than 90% of children reside in a family-based resource home (52% unrelated foster care, 39% kinship care). The remaining children and youth resided in either a group home/residential placements (7%) or were living independently (2%).

## **HOW DO FAMILIES BECOME INVOLVED WITH CP&P?**

Families generally become involved with CP&P in one of two ways. First, New Jersey's mandated reporter law requires every citizen to report suspected cases of child abuse or neglect to CP&P through NJ's Child Abuse Hotline (State Central Registry). These families are investigated by CP&P for a need of Child Protection Services (CPS) resulting from a CPS report generated by the Child Abuse Hotline. Second, families are assessed by CP&P for a need of Child Welfare Services (CWS) resulting from a CWS referral also generated by the Child Abuse Hotline when caregivers need support in ensuring the well-being of their children, even if there is no imminent risk of abuse or neglect to the child. The following provides information about the numbers of CPS reports and CWS referrals received by CP&P, as well as a brief overview of the CP&P process from initial report or referral to the hotline to case termination.

### **Sources of Reports and Referrals**

CPS reports and CWS referrals come from a number of sources, such as members of the community, family members, service professionals, schools, and law enforcement. Between June 1, 2014 through June 30, 2015, school staff initiated almost a quarter (22%) of the CPS reports and CWS referrals received by CP&P. After school, law enforcement (15%), healthcare providers (13%), and anonymous reporters (11%) were the next largest sources of calls to the Hotline.

### **Volume of Reports and Referrals**

During the first half of 2015, CP&P received a total of 38,318 CP&P CPS reports and CWS referrals. CPS reports accounted for more than three quarters (77.3%) of the total. In 2014, CP&P received a total of 74,411 reports and referrals, with 39,224 received between January and June. Similar to the data we have so far this year, CPS reports made up 77% of the total reports and referrals CP&P received in 2014.

### **CP&P Process from Hotline Call to Termination**

#### *Screening*

When a report of child abuse and neglect is received through the Child Abuse Hotline, the report is first screened as to whether it meets the statutory criteria for child abuse or neglect in New Jersey. For example, the report must involve a child under the age of 18. If the report does not meet this criteria, CP&P does not initiate a response. If the report meets the statutory criteria for abuse or neglect, the screener will categorize the report by type of abuse (i.e., physical

abuse, neglect, emotional abuse, or sexual abuse). The screener will also classify the report as either an initial report (i.e., the first report relating to this child and caregiver) or a subsequent report. The screener will then determine whether a report requires an immediate response or a response within 24 hours is sufficient.

Unlike CPS reports, with the exception of a court order, CWS referrals are voluntary. If CP&P accepts a CWS referral, field staff generally have 72 hours to initiate a response. However, a court order might require an earlier intervention.

#### *Initial Response*

The assigned child protection investigator must make a good faith effort to initiate an investigation through in-person contact with the child and family during the required time period. During the first contact with the child and family in a CPS report case, the investigator assesses the safety of the child using an evidence-based Structured Decision Making (SDM) tool. After the assessment, the child is classified as Safe, in need of a safety plan (child can remain in home with a Safety Plan in place), or Unsafe. Investigators continue to assess child safety throughout the case. During the initial response period, investigators will also conduct risk assessments, as well as assessments of strengths and service needs.

In CWS referral cases, investigators assess the child and family to determine if there are particular needs that should be met through CP&P rather than other child serving agencies. In the absence of a court order, service provision depends on caregiver consent.

#### *Substantiation Determination*

After investigating a CPS report, the child protection worker and his or her supervisor analyze the information collected during the investigation and make a finding as to whether or not the child is a victim of abuse or neglect. If the child is determined a victim, the CPS report is marked Substantiated. For the majority of the time period covered under this report, CP&P used a two-tier substantiation system, and CP&P reports were determined to be either Substantiated or Unfounded. As of April 1, 2013, CP&P employs a four-tier model, and reports are determined to be 1) Substantiated, 2) Established, 3) Not Established, or 4) Unfounded. In many cases, the four-tier system allows workers and supervisors to consider both aggravating and mitigating factors when deciding upon a substantiation category. Parents can appeal substantiations of abuse and neglect through the Office of Administrative Law. As CWS referrals do not involve abuse or neglect, these cases do not go through the substantiation process.

#### *Removal of Child and Court Process*

Although CP&P's goal is to preserve the child's family life, CP&P can remove a child from the child's home either 1) with a court order, or 2) when the child is in imminent danger and available CP&P or family resources will not eliminate this danger. If a child is removed without a court order, CP&P must inform the parent or legal guardian of the removal and the time and date of the court hearing to review the emergency removal.

During the first hearing, the court will determine whether CP&P has demonstrated that the child should be removed from the family home. If the court decides that the child can be cared for safely at home, the child will be returned home, with appropriate services, if needed. If the case proceeds, a fact finding hearing will be held, and the court will make a finding as to whether or not the child was abused or neglected. If the court finds abuse or neglect did happen, the court holds a disposition hearing, where a determination will be made as to what in-home or out-of-home services should be put in place. The court will hold review hearings following the disposition to monitor the progress of the family and the CP&P plan.

After a child has been in an out-of-home placement for 12 months, CP&P must request that the court hold a permanency hearing. If a child has been in an out-of-home placement for 15 of the last 22 months, with limited exceptions, CP&P must request a termination of parental rights hearing. If a child's parents' rights are terminated, the child can be adopted.

#### *Case Plan*

CP&P must prepare a case plan for families within 1) 30 days of a child entering out-of-home placement, or 2) within 60 days of a CP&P or CWS referral being referred for investigation or response. The child and family should be engaged in the creation of the case plan, and the plan should be strengths-based. The case plan should clearly lay out the steps that both CP&P and the family must take in order to reach the goals of the case plan, as well as the services and supports to be provided to the family. The case plan should be reviewed and changed every 6 months, as well as on an as needed basis.

#### *Permanency Planning*

CP&P requires that every child who enters an out-of-home placement receives permanency planning, with the goal of securing a permanent placement for the child as quickly as possible. CP&P caseworkers generally engage in concurrent permanency planning, i.e., the caseworker plans for reunification while also developing a plan for a secondary goal, such as adoption.

#### *Termination*

As services for child abuse or neglect are not always voluntary, CP&P is involved in the decision to terminate a CP&P report case. CP&P may terminate services in several circumstances, such as when 1) the child is safe and the case plan is complete, 2) a court orders termination of services, 3) the youth under supervision reaches the age of 21, or 4) the youth under supervision reaches the age of 18 and asks for his or her case to be closed.

**Table 8. Key Demographics and Findings.**

<b>Who We Serve</b>	
<p><b>In-Home</b></p> <ul style="list-style-type: none"> <li>• About 85% CP&amp;P children and youth</li> <li>• 50% male; 49% female</li> <li>• 34% are 5 years old and younger</li> <li>• 33% African American; 28% white; 28% Hispanic</li> </ul>	<p><b>Out-of-Home</b></p> <ul style="list-style-type: none"> <li>• About 15% of CP&amp;P children and youth</li> <li>• 50% male; 49% female</li> <li>• 44% are 5 years old and younger</li> <li>• 42% African American; 28% white; 22% Hispanic</li> <li>• Almost 90% in resource families or kinship care</li> </ul>
<b>Reports &amp; Substantiations</b>	
<p><b>CP&amp;P Reports/CWS Referrals</b></p> <ul style="list-style-type: none"> <li>• 38,313 reports/referrals in the first half of 2015</li> <li>• More than 3 out of 4 were reports of abuse or neglect</li> <li>• Close to one quarter came from school staff</li> </ul>	<p><b>Substantiation</b></p> <ul style="list-style-type: none"> <li>• In April 2015, 5% of CP&amp;P reports were substantiated; 7% Established; 61% Not Established; 27% Unfounded</li> </ul>

### **VOLUME OF CHILD PROTECTIVE AND CHILD WELFARE SERVICES, 2009-2013<sup>1</sup>**

Data on the overall volume of reports to Child Protective Services (CPS) and referrals for Child Welfare Services (CWS) were examined for 2009-2013 to understand whether New Jersey was experiencing changes in the number of reports received by its State Central Registry system. Table 6 presents the volume of CPS and CWS reports over the 2009-2013 period. Although there is substantial within-year variation in the monthly number of CPS and CWS reports, there was a general increase in the volume of these reports between 2009 and 2013, with an increase of 12% when 2013 is compared to 2009. This is part of a nationwide increase of 11% in the reporting of child abuse and neglect for the same period.

The overall 12% topline increase in combined CPS and CWS reports, however, disguises important variation in the increase between the two referral types. CPS reports only increased by 7% between 2009 and 2013, whereas CWS referrals were up 38% over that same period. CWS referrals thus increased as a proportion of total reports from 16% of the total in 2009 to over 20% in 2013.

In addition to one-time incidents that may have contributed to this trend, including Superstorm Sandy, high profile child fatalities, and the widely publicized arrest and trial of Jerry Sandusky in nearby Pennsylvania, the increase may also be attributed to more protracted socioeconomic factors, namely the economic downturn following the 2008 recession and rising unemployment. In New Jersey, unemployment grew sharply from 5% in January 2008 to 10% in October 2009, remaining above 9% until 2013. As more New Jersey families faced lengthy periods of economic uncertainty, requests for services and reports of suspected abuse or neglect may have been affected.

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# Appendix B – Qualitative Methods

## Framework for Research

In order to identify the strengths and needs of families with children in, or at risk for entering, out-of-home placement, focus groups and interviews were conducted by the Rutgers School of Social Work. Focus groups and interviews have the ability to generate important insights about key stakeholders' perceptions, attitudes, beliefs, and experiences that could not be obtained through survey data. This appendix details the qualitative methodology employed for data collection and analysis during this phase of research.

Qualitative research is guided by sensitizing concepts that are deployed as orienting frameworks (Blumer, 1979). Such concepts are the starting points for all aspects of qualitative research (Corbin and Strauss, 2007). The sensitizing concepts framing this research were generated from several sources: (1) The first sensitizing concept emerged from the research goal, to identify the strengths and needs of families with children in or at risk for entering out-of-home placement. (2) Other sensitizing concepts were generated from insights obtained from the first phase of the needs assessment. (3) Finally information garnered from DCF internal reports and assessments completed between 2008-2014 ground the methodological approach. Taken together, these sources informed the sampling strategy, the development of the interview and focus-group protocols, and the analysis of the interview and focus group data.

### ***Sampling Strategy***

To obtain a full picture of the strengths and needs of families with children in, or at risk for entering out-of-home placement and those already in out-of-home placement, key stakeholder groups involved in every part of the child welfare system were identified by the research team and the internal workgroup at the Department of Children and Families. These groups are as follows: key administrators at the New Jersey Department of Children and Families, frontline caseworkers involved in making placement decisions as well as in service delivery, specialty service workers in areas such as nursing, domestic violence, and families involved in some capacity with the New Jersey Department of Children and Families. Through the inclusion of multiple and diverse perspectives, the researchers sought to ensure a comprehensive and representative assessment.

### ***Participant Recruitment***

Participants were recruited for the research in a variety of ways. How a participant was identified, referred, and contacted was determined by a person's relationship to the New Jersey Department of Children and Families. All study participants were identified by DCF and then referred to the research team. The research team then invited the identified person to

participate in the research using both email and telephone. Biological parents who participated in the study received a \$20 gift card. Incentives for participation were not offered to any other subjects.

### ***Development of Interview Protocol***

Using the research goal as a starting point, the interview protocol was developed to elicit information from participants about the strengths, needs, gaps, and barriers related to the provision and/or receipt of services by the New Jersey Department of Children and Families. The interview protocols generally covered service needs, service gaps, and barriers to services. Interviews and focus groups were adapted slightly to reflect the role of the participant.

In keeping with the principles of qualitative interviewing, interview questions were open-ended and designed to draw out participant responses about their behavior/experiences, opinions/values and knowledge. Interview prompts guided participants to give concrete examples to support their statements. The collection of accounts from a diverse set of stakeholders facilitates: 1) identification and description of the array of services available to children, youth, and their caregivers served by New Jersey's Department of Children and Families (DCF); (2) assessment of whether these services are adequately meeting the population's needs; and (3) exploration of the factors that impede or facilitate addressing those needs.

### ***Analysis of Data***

Following a deductive method for content analysis, *a priori* categories were used to code and analyze the interview and focus group data. Codes were determined based on a common set of risk factors and service needs for children and families identified during the first phase of research. These need domains, which were further compared, examined, and refined using the NJ SPIRIT data cover seven categories and include: caregiver mental health, caregiver substance abuse, child mental health, child substance abuse, poverty, housing, and domestic violence.

A codebook was developed focused around these primary need domains with additional attention to service needs, gaps, barriers, and strengths., To enhance theoretical sensitivity in understanding the data, a review of the literature was conducted to ensure the inclusion of all appropriate codes. The literature review suggested the addition of codes related to organizational and environmental constructs. This two- part process ensures that the maximum possible categories and themes have been collected.

Once the codebook was developed, graduate level Research Assistants were trained on principles of coding and analysis by two qualitative methodologists. Procedures were established for systematic coding of the data, the addition of codes that emerged from data analysis, and for resolving divergent interpretations of the data.

Research Assistants followed a consensus coding procedure, coding several transcripts

individually and then meeting as a group to review each code. Through this process, decision rules were constructed and criteria for coding was agreed upon between all Research Assistants. Once consensus was reached on the definitions and applications of codes, the next third of transcripts were coded by Research Assistants in teams to further ensure confirmability of the results. The final third of the transcripts were then coded individually. One of the qualitative methodologists on the team reviewed the first third of transcripts to check fidelity to the codebook. Once the initial coding was complete, the qualitative methodologist picked a random sample of transcripts to review for coding accuracy and reliability.

Interview transcripts were analyzed and coded individually. Interpretative analysis of the data consisted of axial coding, or the examination of relationships between categories. Specific attention was paid to phenomena that co-occurred, overlapped, or was inter-related in nature.

### ***Limitations of Data***

While interview data is valuable for understanding respondents' attitudes and beliefs as well as their perceptions of services, needs and barriers related to the provision of services by the Department of Children and Families, it is important to note that accounts are not an objective assessment of the events reported by participants.

# References

- Allen, A. D., Hyde, J., & Leslie, L.K. (2012). "I Don't Know What They Know": Knowledge Transfer in Mandated Referral from Child Welfare to Early Intervention. *Children and Youth Services Review, 34*(5), 1050-059.
- Babcock, J.C., Green, C.E., & Robie, C. (2004). Does Batterers' Treatment Work? A Meta-analytic Review of Domestic Violence Treatment. *Clinical Psychology Review, 23*(8), 1023-053.
- Battjes, R. J., Gordon, M. S., O'Grady, K. E., Kinlock, T. W., & Carswell, M. A. (2003). Factors that predict adolescent motivation for substance abuse treatment. *Journal of substance abuse treatment, 24*(3), 221-232.
- Beauchamp, C., & Johnston, B. (n.d.). Access to Mental Health Treatment. *Mental Health Association in New Jersey*. Government Affairs Department. Web.
- Blumer, M. (1979). Concepts in the Analysis of Qualitative Data. *The Sociological Review, 27*(4), 651-677. doi:10.1111/j.1467-954X.1979.tb00354.x
- Burns, B. J., Mustillo, S. A., Farmer, E. M. Z., Kolko, D. J., McCrae, J., Libby, A. M., & Webb, M. B. (2010). Caregiver depression, mental health service use, and child outcomes. *Child welfare, child well-being, new perspectives from the national survey of child and adolescent well-being, 351-379.*
- Center for Behavioral Health Statistics and Quality. (2015). Behavioral Health Trends in the U.S.: Results from the 2014 National Survey on Drug Use and Health. (HHS Publication No. SMA 15-4927, NJDUH Series H-50). Retrieved from <http://www.samhsa.gov/data>.
- Child Welfare Information Gateway. (2012). *Rural child welfare practice*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.
- Child Welfare Information Gateway. (2015). *Child welfare practice with families affected by parental incarceration*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.
- Child Welfare Information Gateway. (2015a). *Immigration and child welfare*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.
- Children's Defense Fund. (2015). *Ending Child Poverty Now*. Washington, DC: Author.

- Choi, S., & Ryan, J.P. (2006). Completing substance abuse treatment in child welfare: The role of co-occurring problems and primary drug of choice. *Child Maltreatment, 11*(4), 313-325.
- Choi, S., & Ryan, J.P. (2007). Co-occurring problems for substance abusing mothers in child welfare: Matching services to improve family reunification. *Children and Youth Services Review, 29*(11), 1395-1410.
- Cohen-Schlanger, M., Fitzpatrick, A., Hulchanski, J. D., & Raphael, D. (1995). Housing as a factor in admissions of children to temporary care: A survey. *Child Welfare, 74*(3), 547.
- Coker, A.L., Smith, P.H., Thompson, M.P., Mckeown, R.E., Bethea, L., & Davis, K.E. (2004). Social support protects against the negative effects of partner violence on mental health. *Journal of Women's Health & Gender-Based Medicine, 11*(5), 465-476.
- Corbin, J., & Strauss, A. (2007). Basics of qualitative research: Techniques and procedures for developing grounded theory (3rd ed.). Los Angeles: Sage.
- Correia, M. (2013). Substance abuse data in child welfare. *Casey Practice Digest: Substance Use Disorders in Families with Young Children*, Casey Family Programs, Issue 5.
- Courtney, M., McMurtry, S., & Zinn., A. (2004). Housing problems experienced by recipients of child welfare services. *Child Welfare, 83*, 389-392.
- Denby, R.W. (2012). Parental incarceration and kinship care: Caregiver experiences, child well-being, and permanency intentions. *Social Work in Public Health, 27*, 104-128.
- Dhillon, A. (2005). *Keeping families together and safe: A primer on the child protection-housing connection*. Washington, DC: Child Welfare League of America.
- Dichter, M. E., & Rhodes, K. V. (2011). Intimate partner violence survivors' unmet social service needs. *Journal of Social Service Research, 37*(5), 481-489.
- Donovan, D.M., Rosengren, D.B., Downey, L., Cox, G.B., & Sloan, K.L. (2001). Attrition prevention with individuals awaiting publicly funded drug treatment. *Addiction, 96*, 1149-1160.
- Earnar, I. (2007). Immigrant families and public child welfare: Barriers to services and approaches for change. *Child welfare, 86*(4), 63.
- Evans, S.E., Davies, C., & Dilillo, D. (2008). Exposure to Domestic Violence: A Meta-analysis of Child and Adolescent Outcomes. *Aggression and Violent Behavior, 13*(2), 131-40.

- Festinger, D.S., Lamb, R.J., Kountz, M.R., Kirby, K.C., & Marlowe, D. (1005). Pretreatment dropout as a function of treatment delay and client variables. *Addictive Behaviors*, *20*, 111-115.
- Frame, L., Berrick, J.D., & Brodowski, M.L. (2000). Understanding re-entry to out-of-home care for reunified infants. *Child Welfare*, *79*(4), 339-369.
- Geen, R., Kortenkamp, K., & Stagner, M. (2001). *Foster care experiences of long-term welfare recipients in California* (Working Paper), Washington, DC: Urban Institute.
- Ginsberg, A. (n.d.) The Mental and Behavioral Health Needs of Children & Adolescents. Retrieved from <https://www.apa.org/about/gr/issues/cvf/mental-behavioralneeds.pdf>.
- Goodman, L.A., & Epstein, D. (2008). Listening to Battered Women: A Survivor-Centered Approach to Advocacy, Mental Health, and Justice. Washington, DC: American Psychological Association.
- Hague, G., & Bridge, S. (2008). Inching forward on domestic violence: The 'co-ordinated community response' and putting it in practice in Cheshire. *Journal of Gender Studies*, *17*(3), 185-199.
- Hamby, S., Finkelhor, D., Turner, H., & Ormrod, R. (2011). Childrens exposure to intimate partner violence and other family violence. *Juvenile Justice Bulletin: National Survey of Childrens Exposure to Violence*. Washington, DC: U.S. Department of Justice.
- Herz, D., Lee, P., Lutz, L., Stewart, M., Tuell, J., & Wiig, J. (2012). Addressing the Needs of Multi-System Youth: Strengthening the Connection between Child Welfare and Juvenile Justice. Washington, DC: Center for Juvenile Justice Reform.
- Hinden, B.R., Biebel, K., Nicholson, J., Henry, A., & Katz-Leavy, J. (2006). A survey of programs for parents with mental illness and their families. *Health Services & Research*, *33*(1), 21-38.
- Hines, A.M., Lemon, K., Wyatt, P., & Merdinger, J. (2004). Factors related to the disproportionate involvement of children of color in the child welfare system: A review and emerging themes. *Children and Youth Services Review*, *26*, 507-527.
- Hohman, M.M. (1998). Motivational interviewing: An intervention tool for child welfare caseworkers working with substance-abusing parents. *Child Welfare*, *77*(3), 257-289.
- Hser, Y., Maglione, M., Polinsky, M.L., & Anglin, M.D. (1998), Predicting drug treatment entry among treatment-seeking individuals. *Journal of Substance Abuse Treatment*, *15*, 213-220.

- Huebner, R., Willauer, T., & Posze, L. (2012). The impact of Sobriety Treatment and Recovery Teams (START) on family outcomes. *Families in Society: The Journal of Contemporary Social Services*, 93(3), 196-203.
- Jewkes, R. (2002). Intimate partner violence: causes and prevention. *The Lancet*, 359(9315), 1423-1429.
- Jones, L. (2004). The prevalence and characteristics of substance abusers in a child protective service sample. *Journal of Social Work Practice in the Addictions*, 2, 33-50.
- Kaplan, E.H., & Johri, M. (2000). Treatment on demand: An operational model. *Health Care Management Science*, 3, 171-183.
- Kilpatrick, K.L., & Williams L.M. (1997). Post-traumatic stress disorder in child witnesses to domestic violence. *American Journal of Orthopsychiatry*, 27(4), 639-644.
- Kitzmann, K. M., Gaylord, N. K., Holt, A. R., & Kenny, E. D. (2003). Child witnesses to domestic violence: a meta-analytic review. *Journal of consulting and clinical psychology*, 71(2), 339.
- Krug, E.G., Mercy, J.A., Dahlberg, L.L., & Zwi, A.B. (2002). The world report on violence and health. *The Lancet*, 360(9339), 1083-1088.
- Maiter, S., Palmer, S., & Manji, S. (2006). Strengthening social worker-client relationships in child protective services addressing power imbalances and 'ruptured' relationships. *Qualitative Social Work*, 5(2), 161-186.
- Marcenko, M.O., Lyons, S.J., & Courtney, M. "Mothers' Experiences, Resources and Needs: The Context for Reunification." *Children and Youth Services Review* 33.3 (2011): 431-38. Web.
- Marsh, J. C., Angell, B., Andrews, C. M., & Curry, A. (2012). Client-provider relationship and treatment outcome: A systematic review of substance abuse, child welfare, and mental health services research. *Journal of the Society for Social Work and Research*, 3(4), 233-267.
- Marsh, J.C., Ryan, J.P., Choi, S., & Testa, M. (2006). Integrated services for families with multiple problems: Obstacles to family reunification. *Children and Youth Services Review*, 28, 1074-1087.
- Martin, M., & Citrin, A. (2014). *Prevent, Protect & Provide: How child welfare can better support low-income families*. Washington, DC: Center for the Study of Social Policy.

- Martin, S. L., Kilgallen, B., Dee, D. L., Dawson, S., & Campbell, J. (1998). Women in a prenatal care/substance abuse treatment program: Links between domestic violence and mental health. *Maternal and child health journal*, 2(2), 85-94.
- McLellan, A.T., Lewis, D.C., O'Brien, C.P., & Kleber, H.D. (2000). Drug dependence, a chronic medical illness: implications for treatment, insurance and outcomes evaluation. *JAMA*, 284(13), 1689-1695.
- Meltzer, H., Doos, L., Vostanis, P., Ford, T., & Goodman, R. (2009). The mental health of children who witness domestic violence. *Child & Family Social Work*, 14(4), 491-501.
- Miller, W., Andrews, N., Wilbourne, P., & Bennett, M. (1998). A wealth of alternatives: Effective treatments for alcohol problems. In W. Miller & N. Heather (Eds.), *Treating addictive behaviors* (2<sup>nd</sup> ed.). New York: Plenum.
- Monarch Housing Associates (2016). New Jersey's Point-In-Time Count of the Homeless. Monarch Housing Associates: Cranford, NJ.
- Nesmith, A., & Ruhland, E., (2011). Caregivers of children with incarcerated parents. *The Open Family Studies Journal*, 4, 105-116.
- New Jersey Department of Human Services, Division of Mental Health and Addiction Services, Office of Planning, Research, Evaluation and Prevention (2007). Substance Abuse Overview 2006. Trenton, NJ: Author.
- New Jersey Department of Human Services, Division of Mental Health and Addiction Services, Office of Planning, Research, Evaluation and Prevention (2016). Substance Abuse Overview 2015. Trenton, NJ: Author.
- Phinney, R., Danziger, S., Pollack, H.A., & Seefeldt, K. (2007). Housing Instability Among Current and Former Welfare Recipients. *American Journal of Public Health*, 97(5), 832-37.
- Pollak, R.A. (2004). An intergenerational model of domestic violence. *Journal of Population Economics*, 17(2), 311-329.
- Pollini, R. A., McCall, L., Mehta, S.H., Vlahov, D., & Strathdee, S.A. (2006). Non-fatal overdose and subsequent drug treatment among injection drug users. *Drug and Alcohol Dependence*, 83, 104-110.
- Prochaska, J.O., DiClemente, C.C., & Norcross, J.C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist*, 47, 1102-1114.

- Ryan, J.P., & Testa, M.F. (2005). Child maltreatment and juvenile delinquency: Investigating the role of placement and placement instability. *Children and Youth Services Review, 27*, 227-249.
- Semidei, J., Radel, L.F., & Nolan, C. (2001). Substance abuse and child welfare: Clear linkages and promising responses. *Child Welfare, 130*(2), 109-128.
- Shook, K. (1999). Does the loss of welfare income increase the risk of involvement with the child welfare system? *Children and Youth Services Review, 21*(9/10), 781-814.
- Simms, M. D., Dubowitz, H., & Szilagyi, M. A. (2000). Health care needs of children in the foster care system. *Pediatrics, 106*(Supplement 3), 909-918.
- Simons, R.L., Wu, C., Johnson, C., & Conger, R.D. (1995). A test of various perspectives on the intergenerational transmission of domestic violence. *Criminology, 33*(1), 141-172.
- Stagman, S., & Cooper, J.L. (2010). Children's Mental Health What every policymaker should know. Retrieved from [http://www.nccp.org/publications/pub\\_929.html](http://www.nccp.org/publications/pub_929.html).
- Stark, M.J., Campbell, B.K., & Brinkerhoff, C.V. (1990). "Hello, may we help you?" A study of attrition prevention at the time of the first contact with substance-abusing clients. *American Journal of Drug and Alcohol Abuse, 16*, 67-76.
- Substance Abuse and Mental Health Services Administration (2015). Trauma-Informed Approach and Trauma-Specific Interventions. Retrieved from <http://www.samhsa.gov/nctc/trauma-interventions>.
- Testa, M. & Smith, B. (2009). Prevention and drug treatment. *Future of Children, 19*(2), 147-168.
- Thomas, C. R., & Holzer, C. E. (2006). The continuing shortage of child and adolescent psychiatrists. *Journal of the American Academy of Child & Adolescent Psychiatry, 45*(9), 1023-1031.
- U.S. Census Bureau. (2014). American Communities Survey.
- U.S. Department of health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2015). *Child Maltreatment, 2013*.
- U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (2013). *Results from the 2012 National Survey on Drug Use and Health: Summary of national findings*. Rockville, MD: Author.

- Vig, S., Chinitz, S., & Shulman, L. (2005). Young children in foster care: multiple vulnerabilities and complex service needs. *Infants & Young Children, 18*(2), 147-160.
- Walley, A.Y., Krupitsky, E., Cheng, D.M., Quinn, E.K., Wulach, L., Coffin, P.O., & Samet, J.H. (2015). Fatal and nonfatal overdose after narcology hospital discharge among HIV-infected Russians. *Drug & Alcohol Dependence, 146*, e2-e33.
- Walsh, W.A. (2010). *Hard Times Made Harder: Struggling Caregivers and Child Neglect*. Durham, NH: Carsey Institute, University of New Hampshire.
- Weinberg, N. Z., Rahdert, E., Colliver, J. D., & Glantz, M. D. (1998). Adolescent substance abuse: a review of the past 10 years. *Journal of the American Academy of Child & Adolescent Psychiatry, 37*(3), 252-261.
- Westad, C., & McConnell, D. (2012). Child welfare involvement of mothers with mental health issues. *Community mental health journal, 48*(1), 29-37.
- Westfall, N. C., & Nemeroff, C. B. (2015). The Preeminence of Early Life Trauma as a Risk Factor for Worsened Long-Term Health Outcomes in Women. *Current psychiatry reports, 17*(11), 1-18.
- Wolfe, D.A., Crooks, C.V., Lee, V., McIntyre-Smith, A., & Jaffee, P.G. (2003). The effects of children's exposure to domestic violence: A meta-analysis and critique. *Clinical Child and Family Psychology Review, 6*(3), 171-187.
- Yarrow, A. (2015). How low wages hurt families and perpetuate poverty. Retrieved from <http://politicsofpoverty.oxfamamerica.org/2015/04/how-low-wages-hurt-families-and-perpetuate-poverty/>.
- Young, N.K., Boles, S.M., & Otero, C. (2007). Parental substance use and disorders and child maltreatment: Overlaps, gaps and opportunities. *Child Maltreatment, 12*(2), 137-149.