Safe, Healthy, and Connected

DCF'S FIVE-YEAR IV-E PREVENTION STRATEGY

TABLE OF CONTENTS

EXECUTIVE SUMMARY 3

SECTION 1. INTRODUCTION 5

SECTION 2. DEVELOPING DCF'S PREVENTION STRATEGY: THE INFORMATION-GATHERING PROCESS 8

SECTION 3. DCF'S PREVENTION STRATEGY 15

Consultation and Coordination 16

SECTION 4. TITLE IV-E PREVENTION SERVICE DESCRIPTION AND OVERSIGHT 17

Title IV-E Prevention Services Selection Process 17

Title IV-E Prevention Services Description 19

Implementation of Title IV-E Prevention Services 21

SECTION 5. TITLE IV-E PREVENTION SERVICES EVALUATION STRATEGY AND WAIVER REQUEST 25

Compelling Evidence for Effectiveness of Evidence-Based Programs and Waiver Justification 26

Brief Strategic Family Therapy 26

Motivational Interviewing. 28

Intercept. 30

Sobriety Treatment and Recovery Teams (START). 31

Positive Parenting Program (Triple P)- Group. 32

Positive Parenting Program (Triple P)- Standard. 33

DCF's Continuous Quality Improvement Strategy 34

CoQI Teams & Improvement Cycles. 34

Model-Specific Fidelity Monitoring, Outcome Monitoring, and CoQI Processes 37

Brief Strategic Family Therapy. 37

Intercept. 38

Motivational Interviewing. 39

START. 40

Positive Parenting Program (Triple P)- Group. 41

Positive Parenting Program (Triple P) - Standard. 42

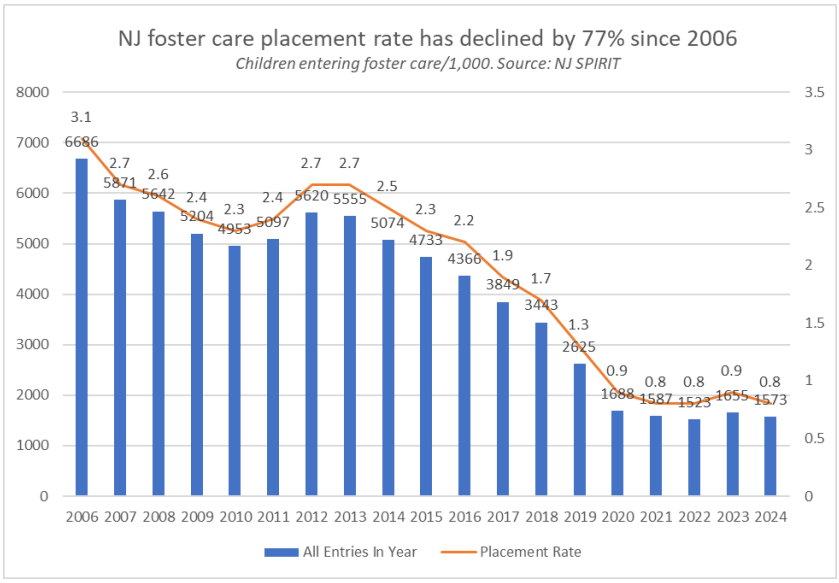
Evaluation Plan for Triple P (Standard) and Triple P (Group) Programs 43

SECTION 6. CHILD AND FAMILY ELIGIBILITY FOR TITLE IV-E PREVENTION SERVICES PROGRAM 50

New Jersey Prevention Candidacy 50

Support for New Jersey's Prevention Candidate Categories 51
Identifying Prevention Candidates and Pregnant and Parenting Youth in Foster Care and Developing Prevention Plans 56
SECTION 7. MONITORING SAFETY OF CHILDREN WHO RECEIVE TITLE IV-E PREVENTION SERVICES 60
Caseload Management 63
SECTION 8. CHILD WELFARE WORKFORCE SUPPORT AND TRAINING 64
Curricula and Course Content 64
Infrastructure to Support Training 66
Additional Workforce Supports 67
ATTACHMENT A. STATE ASSURANCE OF TRAUMA-INFORMED SERVICE-DELIVERY 70
ATTACHMENT B. STATE REQUEST FOR WAIVER OF EVALUATION REQUIREMENT FOR A WELL-SUPPORTED PRACTICE 72
ATTACHMENT C. STATE TITLE IV-E PREVENTION PROGRAM REPORTING ASSURANCE 76

EXECUTIVE SUMMARY



Every day in New Jersey, nearly 3,000 children are living in foster care. While the foster care census is the lowest on record— the result of a comprehensive deployment of strong prevention strategies over the last 20 years—decades of research have demonstrated the significant and often negative impact that foster care placement has on children's health, mental health and life course. New Jersey's child welfare system, nationally recognized for its steady and comprehensive reform, has reached a critically important stage in its development. In order to advance further in reducing incidents of maltreatment and foster care placement, the system itself must evolve.

The New Jersey Department of Children and Families (DCF) is the state's cabinet level agency dedicated to ensuring the safety, well-being and success of New Jersey's children, youth, families, and communities. Since its creation in 2006, DCF has stabilized, grown and developed the infrastructure needed to take on the challenges of—and to take advantage of the opportunities associated with—serving children and families in the 21st century.

DCF's strategic plan, which was finalized in 2019, is rooted in the vision that every New Jersey resident be or become safe, healthy, and connected. Among other transformational goals, DCF's strategic plan includes prevention. In advance of setting forth details related to the requirements of the Family First Prevention Services Act, DCF highlights the following principles:

1. Prevention, generally, and DCF's vision of a broader family strengthening system, more specifically, are collaborative, all-of-state efforts. Successful prevention depends both on efforts led by DCF, as well as those in which DCF exists *as a partner*. Prevention efforts include those by DCF, its sister agencies, provider agencies, educational partners, law enforcement, healthcare partners, and many more. Together, these collaborative efforts have the potential to offer a very powerful network of support to New Jersey's children and families.
2. New Jersey has long invested in programming aimed at reducing rates of child maltreatment and increasing family protective factors, as well as services and supports to preserve families and reduce the need for foster care placement as a

safety intervention. Prior to the current administration, and well before the enactment of the Family First Prevention Services Act in 2018, DCF developed an extensive and effective prevention network, inclusive of 57 Family Success Centers, three statewide home-visiting models, a Children's System of Care dedicated to the mental and behavioral health of children and youth, child assault prevention programs, school-based youth programming, numerous evidence-based interventions, and more. Through these efforts, as well as evolving child protection policies, New Jersey has the lowest rate of foster care placement in the country.[1] A comprehensive information gathering process, detailed later in the plan underscores that, for New Jersey to further meet the needs of children and families, it is necessary to add new services and resources to its prevention service array, improve the Department's and providers' capacity to provide quality services and to improve collaboration across major public sectors. DCF views the Family First Prevention Services Act as an exciting opportunity for New Jersey to expand and improve its existing prevention system.

3. It is critical to offer a full array of prevention services to families involved with the child protection system, as well as families *outside* of the child protection system. DCF currently offers prevention services to both populations and intends to similarly offer Title IV-E prevention services to both populations. Furthermore, DCF intends to bolster programming and resource offerings to families in the latter population category, i.e., creating a new statewide, upstream Family Preservation Service for children and families who are not involved in the child protection system.

4. DCF recognizes that concrete supports are a necessary component of any serious prevention strategy. DCF will continue to rely on the concrete supports provided through our sister state agencies, as well as to provide concrete supports through its Division of Child Protection and Permanency and provider agency networks whenever and wherever possible. While the Family First Prevention Services Act does not permit federal financial participation for concrete family supports at this time, DCF is hopeful that federal partners will further consider the evidence in this area and drive towards the inclusion of concrete supports in later iterations of the Title IV-E Prevention Services Clearinghouse.

Like DCF's strategic plan, this five-year plan rests on an assessment of New Jersey's current operations, programs, and practices with research on best practices. It relies on science and data. It is the culmination of time and insights from many— those internal to state government and DCF, as well as countless stakeholders and constituents. DCF looks forward to working with federal, state, and local partners to realize the plan's strategies and goals.

[1] New Jersey's rate of foster care placement per 1,000 children has declined to less than one-third of its 2014 level (2.5 per 1,000 in 2014, compared to 0.8 per 1,000 in 2021). New Jersey Child Welfare Data Hub Placement Rates | Data Hub (rutgers.edu). See also, United States Department of Health and Human Services Children's Bureau (ACF, ACYF). *Child Welfare Outcomes 2019: Report to Congress.* Accessed from: Child Welfare Outcomes 2019: Report to Congress | The Administration for Children and Families (hhs.gov)

SECTION 1. INTRODUCTION

In 2006, the New Jersey Department of Children and Families (DCF) was created as a cabinet level agency to have a greater focus on supporting and strengthening New Jersey's children and families. In the years since its creation, DCF's mandate has expanded well beyond the welfare and protection of children to include: design and delivery of New Jersey's public behavioral health care system for children and families, provision of public services for children with intellectual and developmental disabilities (I/DD) and their families, specialized educational programming, support services aimed at promoting success of transition aged youth, the administration of a network of community-based services focused on strengthening families and preventing and interrupting child maltreatment, and services and programming to prevent intimate partner violence and to assist with re/entering the workforce as head of household for this vast constituency across New Jersey.

Divisions and Offices. Each month, DCF serves over 154,000 constituents through an array of direct family-centered programs and services and a network of providers. Portfolios relevant to the IV-E prevention services plan include:

- **Children's System of Care.** CSOC serves children and adolescents with emotional and behavioral health care challenges and their families; children with I/DD and their families; and children with substance use challenges and their families. Core services include: 24/7/365 access to request services; mobile response and stabilization services, care management, intensive in-community treatment, applied behavior analysis, individual and family support services, treatment homes, residential treatment, and family support organizations.

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

- **Division of Family and Community Partnership.** FCP promotes the health, well-being, and personal safety of New Jersey's children and families. It works with parents, caregivers, organizations, and communities to ensure an effective network of proven support services, public education, and community advocacy to prevent maltreatment. FCP is responsible for the management of New Jersey's kinship navigator programs, Family Success Centers, school-linked services, early childhood services, in-home services that promote safety and

keep children and families together, reunification services, and housing programs, in addition to multiple statewide partnerships to promote strong families and communities.

Core Infrastructure Components. These programmatic divisions are supported by an array of operational and business offices. Over the last 16 years, the Department has stabilized, grown, and developed the infrastructure needed to take on the challenges of—and take advantage of the opportunities associated with—serving individuals, children and families in the 21st century. DCF's infrastructure is continuously evaluated to ensure best-in-class approaches to service delivery and design are utilized to support work that achieves our vision. Core infrastructure components include:

- **Workforce.** DCF's strongest asset is its staff. DCF employs over 6,600 employees, including investigators, caseworkers, inspectors, regulators, trainers, evaluators, researchers, attorneys, analysts, and administrators. DCF works hard to ensure that its staff are safe and well in the workplace.

- **Training.** DCF's Office of Training and Professional Development (OTPD) coordinates and oversees training for the Department and manages certificate programs and partnerships with New Jersey schools of social work. OTPD delivers training directly and through two statewide training partnerships. The New Jersey Child Welfare Training Partnership provides pre-service, foundational, and elective training to staff in CP&P. A partnership with Rutgers University Behavioral Health Care provides training and professional development for the network of service providers operating within the CSOC. DCF also invests in higher education for the child welfare workforce, partnering with schools of social work to recruit and train Bachelor of Social Work degree candidates for employment at DCF, and to assist staff in obtaining a Master of Social Work degree while employed at DCF. DCF offers in-house certificate programs for staff, i.e., the Violence Against Women Certificate program, the Substance Use Disorder Fellowship program, etc.

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

- **Financial Management.** DCF continually looks to be good stewards of state and federal revenue, managing innovative and financially responsible programs.

- **Facilities and Equipment.** DCF maintains one Central Office, 46 CP&P local offices, nine CP&P area offices, thirteen schools, and a state-of-the art training and professional development center. DCF's fleet of vehicles supports staff to undertake investigations, inspections, and casework and service activities. DCF's information technology and telephonic infrastructure allow staff to maximize efficiency and effectiveness of their work through both mobile and office-based technological supports.

- **Data Infrastructure.** DCF uses data to inform policy and programming, strengthen standard operating procedures, maintain focus on continuous quality improvement (CQI) and tell the stories of constituents across New Jersey. DCF maintains NJ SPIRIT, New Jersey's comprehensive child welfare information system (CCWIS), and contracts for the development and maintenance of CYBER, the electronic information system used by CSOC. Additionally, DCF maintains program-specific data systems and is in the process of developing consistent data collection methods for services delivered through other parts of its contracted service network. DCF utilizes state-of-the-art reporting tools, such as SafeMeasures, to put workload management reports directly into the hands of child welfare staff. Outcome data is routinely made available to the public through the New Jersey Child Welfare Data Hub [2] and monthly publications of performance and descriptive reports are available on DCF's website.[3]

- **Policy Development.** DCF maintains clear, concise and accessible policies. The entire DCF policy manual is available to the public and is accessible online.[4]

- **Continuous Quality Improvement Infrastructure.** DCF employs systems that support its ability to self-monitor performance, assess outcomes achieved, analyze practice, and self-correct.

[2] https://njchilddata.rutgers.edu/
[3] https://www.state.nj.us/dcf/
[4] https://www.nj.gov/dcf/policy_manuals/toc.shtml

SECTION 2. DEVELOPING DCF'S PREVENTION STRATEGY: THE INFORMATION-GATHERING PROCESS

Following the passage of the Family First Prevention Services Act in 2018, early efforts of the executive leadership team focused on development of the strategic plan described in the previous section, and on understanding the strengths and challenges of the existing child welfare system in New Jersey, including gaps in the then-available service array. Recognizing the opportunity presented by the Act, DCF's prevention services strategy and service array were assessed during this process. The components of this examination, which are detailed below, included the following activities, amongst others:

- Commissioner's listening tour,
- Series of regional and virtual forums,
- Meta-analysis of existing needs assessments,
- Statewide Human Service Advisory Council (HSAC) needs assessment, and
- Review of Department administrative data.

Commissioner's Listening Tour. Beginning in 2018, Commissioner Beyer embarked on a listening tour with youth, families, and individuals engaged in DCF's programs and services to hear about their lived experiences with DCF and its provider network. During the tour, she met with over 550 constituents in 22 locations across 15 counties. Findings from these sessions were summarized by the Rutgers University, School for Social Work, Institute for Families and made public.[5]

Among other themes, the listening tour underscored the value of prevention services, especially concrete parenting skills for caregivers and in-home services. Participants highlighted DCF's Keeping Families Together (KFT) program, as a particularly valuable service. Worker accessibility was named as a critical component of successful interventions, whereas housing and transportation were named as typical barriers to family success. Specific service gaps were identified in the areas of:

- Early childhood mental health
- Trauma-informed services
- Improved support for emotional and behavioral health care
- Step-down and wraparound services
- Support for siblings
- Improved services for individuals with autism
- Improved services for transitioning to adulthood
- Improved post-adoption services
- Improved service coordination and integration
- Improved training courses for caregivers

[5] https://www.nj.gov/dcf/news/reportsnewsletters/dcfreportsnewsletters/ListeningTourReport.pdf

Regional Forums. In Fall 2018, DCF convened three regional forums, one each in the northern, central, and southern regions of the state. During these forums, DCF described its emerging focus on prevention and family strengthening, and administered a survey to over 200 stakeholders, including DCF staff, attorneys for children and parents, service providers, advocates, and others, to hear varying perspectives on achieving DCF's vision. This survey identified that the most frequent needs for families are for health care, education support and family services, and highlighted the need for collaboration with systems outside of child welfare: health care, housing, and general social services. In response to a stop/ start/ continue prompt about actions the Department should take to act on the vision, the following were the most common responses:

Figure 1: Fall 2018 Regional Forum Feedback

What DCF should "start" doing	What DCF should "stop" doing	What DCF should "continue" doing
• Collaborate • Provide housing and housing support • Increase communication • Listen to more families/have humility • Community engagement	• Being overly restrictive with kinship homes • Using punitive approaches • Working in silos • Setting unrealistic expectations • Giving every family the same "cookie cutter" plan	• Collaboration and relationship building • Research/implement evidence-based services • Educate/train staff members • Advocating for families • Support • Prevention/proactive approaches

Synthesis of existing needs assessments. In March and April 2019, DCF conducted a meta-synthesis of DCF-related, existing needs assessments to gain a more comprehensive understanding of the challenges and needs of families in New Jersey. DCF reviewed administrative child welfare data from the CP&P CCWIS, NJ SPIRIT, and multiple unique needs assessments representing the voices of over 2,000 youth, caregivers, DCF staff, external stakeholders (e.g., advocates, providers, etc.) and a range of other perspectives as indicated below:

Figure 2: 2019 Needs Assessment Meta-Synthesis Inputs

Data Source	CP&P Staff	Parents/ Caregivers	Youth	Resource Parents	DCF Staff (non-CP&P)	Other Stakeholders
2017 Prevention Plan	√	√			√	√
CFSR Summary	√	√				
Contract Report from Local Interviews	√					
Domestic Violence Needs Assessment						√
Listening Tour		√	√	√		
NJCYC Strategic Plan						√
Regional Forum						√
Rutgers University Needs Assessment	√	√		√	√	√

The synthesis sought to triangulate common themes across needs assessments with quantitative information from DCF's administrative data. Among children served both in- and out-of-home, the most common challenges were caregiver substance use (out-of-home: 74%; in-home: 44%) and caregiver mental health issues (out-of-home: 66%; in-home: 29%). Domestic violence, housing instability, financial issues, and child mental health challenges affected over one-third of children in out-of-home placement. The majority of children in out-of-home placement (83%) experienced co-occurring challenges compared to just under half (42%) of children served in their own homes. Concrete supports were frequently identified as a challenge across all stakeholder groups and included housing, transportation, childcare, healthcare assistance/insurance, financial assistance, and employment assistance. Of note, the challenges identified varied by the type of respondent (e.g., a parent, Department staff, external stakeholders, etc.); professionals most often identified a need for additional professional services, whereas constituents most often described a need for parent skill development and concrete supports. Findings are summarized in Figure 3, below.

Figure 3: 2019 Needs Assessment Synthesis Service Themes

	Parent/ Caregiver Voice	CP&P Staff Voice	Community Voice
Caregiver Mental Health			
Caregiver Substance Use			
Child Mental Health			
Child Substance Use			
Domestic Violence			
Parenting Skills			
Lack of Concrete Supports			

Key:

- Theme was common across most/all needs assessments reviewed.
- Theme was represented in approximately half of the needs assessments reviewed.
- Theme was present in less than half of the needs assessments reviewed.

The synthesis also illuminated cross-cutting needs related to systems and delivery of services. As a means of organizing this feedback, DCF adopted the United Nations' rights-based Availability, Accessibility, Acceptability, Quality (AAAQ) framework.[6] Originally developed for the healthcare sector, the AAAQ framework is recognized as a tool for understanding and analyzing quality of service delivery across fields.[7] Service delivery needs fell under the four domains of the framework, including *availability* (e.g., targeted services for special populations), *accessibility* (e.g., flexible service hours), *acceptability* (e.g., trauma-informed and culturally appropriate services), and *quality* (e.g., evidence-

[6] World Health Organization. "The Right to Health." Fact Sheet. Accessed from: Microsoft Word - Right to health-factsheet Aug14.doc (ohchr.org)

[7] United Nations International Children's Emergency Fund (UNICEF). "Availability, Accessibility, Acceptability, and Quality Framework. A Tool to Identify Potential Barriers to Accessing Services in Humanitarian Settings." Accessed from: AAAQ-framework-Nov-2019-WEB.pdf (gbvguidelines.org)

based programming.) Systems needs included enhanced communication and data sharing across systems and a "one-stop-shop" model, where caregivers can receive support for a variety of challenges in one place rather than working with multiple providers and organizations to meet their needs. Using this lens, DCF identified the following needs related to service delivery:

Figure 4: 2019 Needs Assessment Synthesis AAAQ Themes

Domain	Definition[8]	Identified Needs
Availability	Sufficient existing services and programs (e.g., quantity, facilities, type, etc.) available to support those in need.	Targeted services for subpopulations that the available evidence suggest require adapted approaches to health and social service; e.g., children of domestic violence survivors, children and adults with disabilities, and youth transitioning into adulthood. Early child and infant mental health Visitation slots
Accessibility	Anyone is able to easily access supports/services (i.e., afford, get to, apply for, etc.) without discrimination.	Evening and weekend hours Increased in-home services B Services in close geographic proximity to families' homes
Acceptability	Supports/services are respectful of people and communities.	Trauma-informed services Non-judgmental, strengths-based approach Workers with specialized knowledge and training in DV and substance use Inclusion of youth/parent voice in service design and delivery Individualized services
Quality	Facilities that provide supports/ service are of good quality (e.g., clean, well-supplied), and staff are well-trained, knowledgeable and provide good customer service.	Evidence-based programs and promising practices Shorter wait times Lower staff caseloads Lower staff turnover Quality assurance processes and evaluation

DCF/Human Service Advisory Council (HSAC) Statewide Needs Assessment. HSACs are DCF-funded, statutorily mandated, county-based planning, advisory and advocacy organizations dedicated to meeting the human service needs of the county.[9] They seek to facilitate, coordinate, and enhance the delivery of social services through collaborative relationships within the county and among the counties, and with private and state agencies. During 2019-2020, DCF, through the HSACs, completed a statewide needs assessment to attain county-specific qualitative information related to family and youth needs and barriers to meeting those needs. At the conclusion of the data collection, DCF engaged Rutgers University, School of Social Work, Institute for Families to complete a statewide synthesis of the findings from each county, summarizing priority need areas, barriers to addressing those needs, impacted subpopulations, successes and progress, and recommendations for action. Each of the county reports, as well as the statewide synthesis, were made public, and, in August 2021, DCF and Rutgers University

[8] Ibid.
[9] N.J.A.C. 10:2, et. seq.

held a public forum to disseminate findings to stakeholders throughout the state.[10] Despite substantial differences in demographics, population density, income level, industries and more, New Jersey's 21 counties largely identified the same needs and barriers: housing, mental/behavioral health care for adults and children and substance use services. Similarly, the counties also generally identified the same, often compounding, barriers to access available services: lack of awareness of services, transportation, waitlists and stigma.

Review of state child welfare data and Department administrative data.

New Jersey has long invested in programming aimed at reducing rates of child maltreatment and increasing family protective factors, as well as services and supports to preserve families and reduce the need for foster care placement as a safety intervention. Given the purpose of the Family First Prevention Services Act is "to provide enhanced support to children and families and prevent foster care placements," P.L. 115-123, DCF notes important trends in administrative data related to foster care placements:

- Over the last seven years, New Jersey's rate of foster care placement per 1,000 children has declined to less than one-third of its 2014 level (2.5 per 1,000 in 2014, compared to 0.8 per 1,000 in 2024).[11] Today, New Jersey has the lowest rate of foster care placement in the country.[12][13]
- Placement rates vary by age.
    - New Jersey's placement rate for infants under the age of one is over four times higher than the placement rate for any other age group (3.7.2 per 1,000, compared to 0.5 – 0.8 per 1,000).[14]
    - In 2024, 52% of children entering foster care were aged 5 years or younger and 24% were infants under the age of one.[15]
- Too many children experience foster care more than once. Between 2014 and 2024, about 80% of children entering foster care are doing so for the first time; consistently, 20% are entering for the second time or greater.[16]

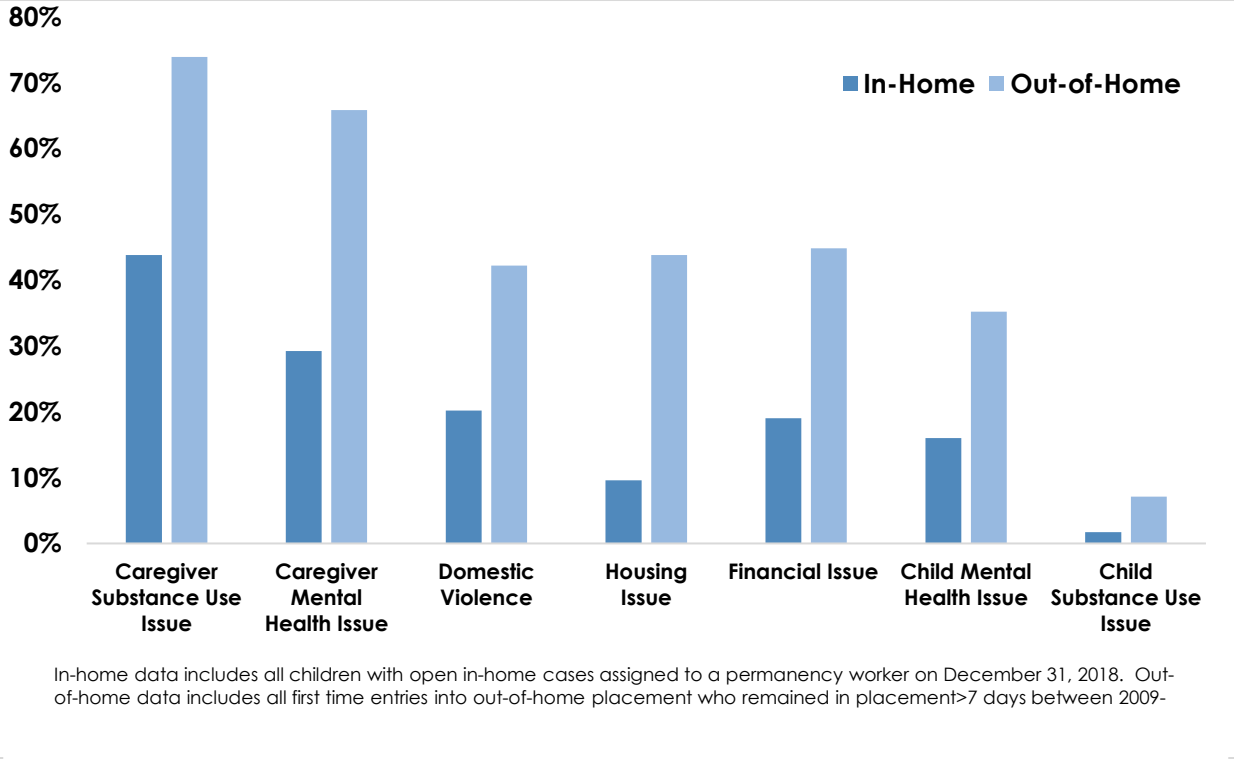
DCF examined its administrative data, looking at documented family circumstances that were most prevalent amongst families with open child protection cases. DCF found that caregiver substance use and mental health issues were highly prevalent in families in which a child had been placed into foster care, and that domestic violence, housing

[10] All county and statewide findings, as well as additional information about the needs assessment process, are publicly available at: DCF | DCF/HSAC County Needs Assessment (nj.gov).
[11] New Jersey Child Welfare Data Hub Placement Rates | Data Hub (rutgers.edu)
[12] United States Department of Health and Human Services Children's Bureau (ACF, ACYF). *Child Welfare Outcomes 2019: Report to Congress.* Accessed from: Child Welfare Outcomes 2019: Report to Congress | The Administration for Children and Families (hhs.gov)

[14] New Jersey Child Welfare Data Hub. Accessed from: Placement Rates | Data Hub (rutgers.edu)
[15] New Jersey Child Welfare Data Hub. Accessed from: Children Entering Out of Home Placement | Data Hub (rutgers.edu)
[16] New Jersey Child Welfare Data Hub. Accessed from: Children Entering Out of Home Placement | Data Hub (rutgers.edu)

issues and poverty were documented in nearly half of those families. Children's mental health and substance use issues were less prevalent, though still significant. Findings are summarized in Figure 5, below. During the Spring 2019 regional forums, DCF shared the results of these analyses with Departmental leaders, providers, advocates, attorneys, judicial stakeholders and others.

Figure 5: Child and Family Challenges Present in Families with Child Protection Involvement



In-home data includes all children with open in-home cases assigned to a permanency worker on December 31, 2018. Out-of-home data includes all first time entries into out-of-home placement who remained in placement>7 days between 2009-

New Jersey Task Force on Child Abuse and Neglect Prevention Plan. The New Jersey Task Force on Child Abuse and Neglect (NJTFCAN)[17] studies and develops recommendations regarding the most effective means of improving the quality and scope of child protective and preventative services provided or supported by state government, including a review of the practices and policies utilized by DCF's CP&P and FCP. The Task Force in comprised of volunteer members who are broadly representative of the community, ranging from child protection and law enforcement to advocates for children and parents. In 2021, the NJTFCAN released the 2022-2025 NJTFCAN statewide prevention plan.[18] As a part of this information-gathering process, DCF incorporated the priorities and strategies for the prevention of maltreatment included within the plan.

[17] DCF | New Jersey Task Force on Child Abuse and Neglect (NJTFCAN)
[18] https://nj.gov/dca/library/spotlight/2022-2025_NJ_Statewide_Prevention_Plan.pdf

Taken together, the information gathered during this process suggested that, in order for New Jersey to better meet the needs of children and their families, it is necessary to add new services to the current service array, to improve the existing services, to further develop the Department's and provider's capacity to provide quality services, and to improve collaboration across major public sectors. More specifically, there are needs for:

- Additional concrete supports, such as housing and financial and employment assistance, as well as increased and improved capacity in specific social services, such as mental health and substance use disorder treatment for youth and adults, post-adoption services, and more,
- Additional evidence-based services,
- Holistic services for youth and families with complex needs and families with infants,
- Trauma-informed, individualized approaches to service provision,
- Removal of barriers to getting help, such as transportation challenges and lack of service awareness,
- Improved system coordination, communication and collaboration, and
- Increased youth and parent voice and community engagement.

SECTION 3. DCF'S PREVENTION STRATEGY

DCF's strategic plan, outlined above, includes primary prevention as a transformational goal. Given the Department's scope, the Department's prevention goal extends beyond efforts to prevent child maltreatment and maltreatment-related injuries and deaths; it encompasses efforts to prevent death or injury related to child and adolescent behavioral health, as well as efforts to prevent harm in the context of sexual and intimate partner violence. While this Family First Prevention Services five-year plan will predominantly focus on prevention efforts related to child maltreatment, we recognize that, given the breadth of DCF's scope and charge, New Jersey's efforts to prevent child maltreatment and foster care placement are inextricably linked to the broader Departmental prevention strategy.

Recognizing both the strengths and limitations of New Jersey's existing prevention system and informed by the findings from the information gathering process, DCF devised a prevention strategy oriented towards achieving goals in three domains: (1) identity, (2) process, and (3) program. Throughout this section, DCF describes major initiatives and activities that are built, in progress, or planned to achieve goals in each of these domains.

Figure 6: Identity, Process, and Program Goals

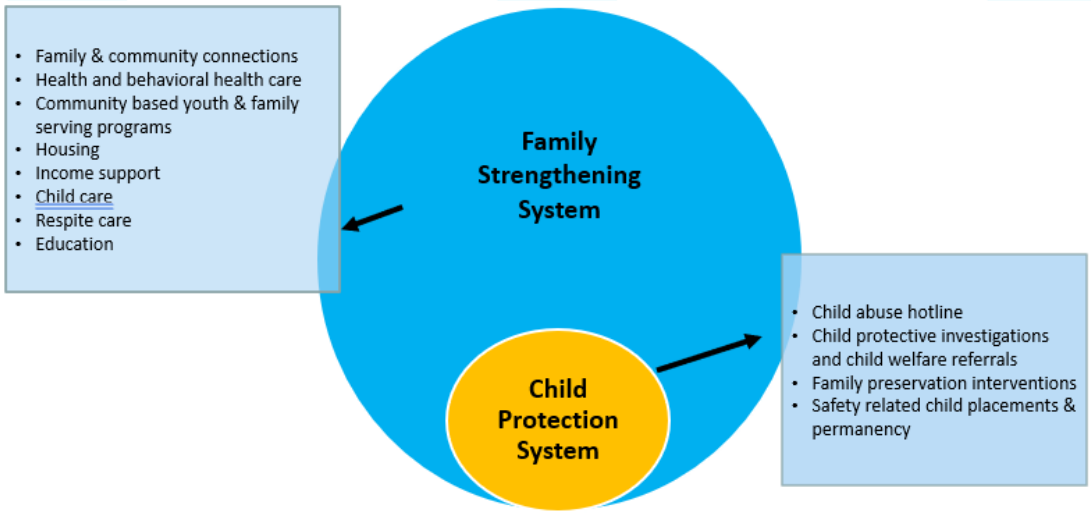
A. Identity Goals	Shift the Department's identity from a system with a predominant focus on traditional child protection services with peripheral family strengthening efforts to a system with a predominant focus on family strengthening efforts with traditional child protection services utilized only as a targeted intervention.
B. Process Goals	1. Creation of Departmental infrastructure to ensure high quality implementation of all purchased services – from innovative practices to evidence-based models, and 2. Strengthened stakeholder collaboration and state and local level public and community partnership to ensure that appropriate help is available to families at ideal times, in the right locations, and in the appropriate manner.
C. Program Goals	1. Prevention of child maltreatment and maltreatment related fatalities, 2. Prevention of unnecessary use of the child protection system to address family system challenges that can safely be addressed through health, social service, and community programming, 3. Prevention of the use of non-kin foster care as a safety intervention, and 4. Prevention of re-entry into foster care.

A. Identity Goals

Most broadly, DCF's prevention strategy focuses on departmental identity, reflecting a necessary shift from a system with a predominant focus on traditional child protection services with peripheral family strengthening efforts to a system with a predominant focus on family strengthening efforts with traditional child protection services utilized only as a targeted intervention. DCF's prevention strategy envisions a future with (1) a greatly

reduced, and safely reduced, child protection system and (2) a greatly enhanced family strengthening system.

Figure 7: DCF's Vision of a Family Strengthening System:



Consultation and Coordination

Pre-print Section 4

The Family First Prevention Services Act requires that Title IV-E agencies engage with other state agencies responsible for administering health programs, including mental health and substance abuse prevention and treatment services, and with public and private agencies with experience in administering child and family services, including community-based organizations, to foster a continuum of care for children. (Section 471(e)(5). As is described in Section 2, "Developing DCF's Prevention Strategy: The Information Gathering Process," DCF values and utilizes partnership and collaboration with state, public and private agencies throughout the family strengthening system to advance a powerful network of services and supports for children and families.

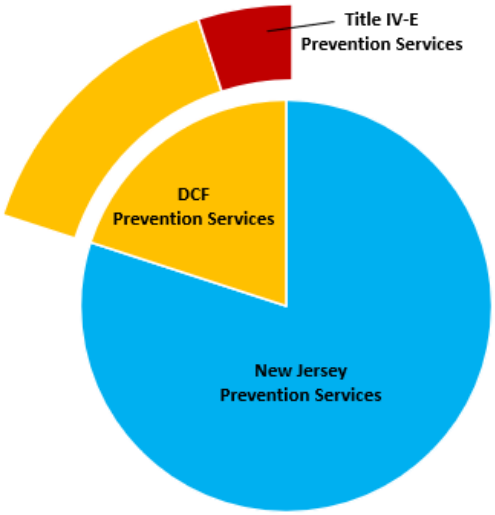
As the State's Title IV-B and Title IV-E lead agency, DCF ensures coordination of plans, strategies and provision of the contracted prevention services for children and families included within the Title IV-B and Title IV-E plans. Further coordination is made possible through DCF's role as lead agency for various federal grants, such as the Community-Based Child Abuse Prevention grant, Children's Justice Act grant, and more. For additional information regarding DCF's Title IV-B and IV-E programming, see DCF's Child and Family Services Program Report and Annual Programs and Services Plans.[19]

[19] https://www.nj.gov/dcf/childdata/njfederal/

SECTION 4. TITLE IV-E PREVENTION SERVICE DESCRIPTION AND OVERSIGHT

PRE-PRINT SECTION 1

Figure 27. New Jersey Prevention



As described in Section 3, "DCF's Prevention Strategy," the efforts that contribute to the prevention of child maltreatment, as well as the prevention of foster care placement in New Jersey, are comprehensive, encompassing policies and programs financed and managed across multiple state agencies. The extensive information gathering process, detailed in Section 2, "Developing DCF's Prevention Strategy: The Information Gathering Process," allowed DCF staff, constituents with lived experience, providers, advocates, attorneys, and other stakeholders at the state and local level to guide DCF's prioritization of programs for development and refinement. Utilizing findings from that process, DCF devised the detailed prevention strategy inclusive of identity, process and program goals, described above. The Family First Prevention Services Act allows states to claim reimbursement for certain mental health and substance use prevention and treatment services provided by qualified clinicians and in-home parent skill-based programs. (Section 471(e)(1)). The programs must be rated and approved by the Title IV-E Prevention Services Clearinghouse.[20] (Section 476(d)(2)). DCF views the Family First Prevention Services Act as an opportunity to work toward achievement of the previously described prevention strategy, strengthening specific programs within its service array with evidence-based models that meet the needs of those who both utilize and provide prevention services.

In this section, DCF provides a description and implementation plan for the subset of New Jersey's prevention services that DCF intends to add to its current service array and for which DCF proposes to seek reimbursement through Title IV-E and the Family First Prevention Services Act.

Title IV-E Prevention Services Selection Process

In addition to the information gathering process described previously, DCF undertook a comprehensive review of the core services across the Department, assessing the extent to which each service had identified target outcomes, a well-defined program model, implementation supports for providers (i.e., job description, training, coaching, fidelity

[20] Home | Title IV-E Prevention Services Clearinghouse (hhs.gov)

tool, manual, etc.), data collection mechanisms and processes to assess service outcomes and ongoing quality improvement. Comparing the existing service array to the needs and priorities expressed by stakeholders via the information gathering process previously described, DCF assessed the impact and feasibility of potential new programming and/or improvements to existing programming, as well as programmatic and operational staffing resource availability. Next, DCF used a collaborative model exploration process, utilizing an analysis tool adapted from the National Implementation Research Network (NIRN) Hexagon Discussion Analysis Tool[21] and "A Discussion Tool: Questions to ask the model developer" developed by Chapin Hall.[22] The tool was used to examine evidence, usability, supports, need, fit and capacity of various evidence-based models.[23] Through this process, DCF identified specific evidence-based models that best fit the needs of New Jersey constituents and determined which of those approaches would be eligible for claiming via the Family First Prevention Services Act.

In December 2022, prior to finalization of this plan, DCF broadly shared its prevention vision and strategies, including the identified Title IV-E prevention services, via webinar and concept paper released for public comment. Stakeholders and members of the public were invited to submit comment. After the period for public comment, DCF considered all feedback in the finalization of this plan.

[21] Metz, A. & Louison, L. (2018) The Hexagon Tool: Exploring Context. Chapel Hill, NC: National Implementation Research Network, Frank Porter Graham Child Development Institute, University of North Carolina at Chapel Hill. Based on Kiser, Zabel, Zachik, & Smith (2007) and Blase, Kiser & Van Dyke (2013). Available online at: NIRN Hexagon Discussion Analysis Tool_September2020_1.pdf (unc.edu).

[22] Chapin Hall (2020). A Discussion Tool: Questions to ask the model developer. University of Chicago. Developed in consultation with Casey Family Programs.

[24] Powell, B. J., Beidas, R. S., Lewis, C. C., Aarons, G. A., McMillen, J. C., Proctor, E. K., & Mandell, D. S. (2015). Methods to improve the selection and tailoring of implementation strategies. The journal of behavioral health services & research, 1-18. See also, Fixsen, D., Blase, K., Metz, A., & Van Dyke, M. (2015). Implementation science. In J. D. Wright (Ed.), International encyclopedia of the social and behavioral sciences (2nd ed., Vol. 11, pp. 695-702). Amsterdam: Elsevier.

Title IV-E Prevention Services Description

The following models from the Title IV-E Prevention Services Clearinghouse have the potential to supplement or enhance DCF's existing prevention initiatives.

Figure 8. Title IV-E Prevention Services

Service Description	Model Target Population	New Jersey Target Population and Prevention Candidacy Category
Brief Strategic Family Therapy (BSFT)		
BSFT is an intervention that uses a structured family systems approach for families with children from aged six to 17 years old, who display or are at risk for developing problem behaviors, including substance use, conduct problems, and delinquency. This intervention is usually provided in 12 to 16 weekly sessions in homes, clinics, community centers or health agencies. BSFT includes three intervention elements (establishment of relationships, observation and working in the present) to support family transformation that support healthy rather than problematic interactions. In the Title IV-E Prevention Services Clearinghouse, BSFT is rated as well-supported and is categorized as an intervention for mental health, substance use and parenting skills. • Manual: Szapocznik, J. Hervis, O., & Schwartz, S. (2003). *Brief Strategic Family Therapy for adolescent drug abuse* (NIH Pub. No. 03-4751). National Institute on Drug Abuse.	BSFT is designed for families with children or adolescents, ages 6 to 17 years, that display or are at risk for developing problem behaviors, including drug use and dependency, antisocial peer associations, bullying, or truancy.	New Jersey families with children or adolescents, ages 6 to 17 years, that display or are at risk for developing problem behaviors, including drug use and dependency, antisocial peer associations, bullying, or truancy. This includes Prevention Candidacy categories A, C, H and J, among others.
Motivational Interviewing		
MI is an evidenced-based and client-centered counseling approach that promotes change in behavior and helps individuals address and resolve issues related to ambivalence to change. It is a conversational approach that motivates individuals by supporting them in navigating the five stages of change: pre-contemplation, contemplation, preparation, action, and maintenance. MI uses various clinical methods to help individuals recognize the need to change their behavior and to highlight the possibility of being able to change their behavior. This approach is usually provided prior to or with other types of therapy or programs in one to three sessions that range from 30 to 50 minutes. In the Title IV-E Prevention Services Clearinghouse, Motivational Interviewing is rated as well-supported and categorized as an intervention for substance use. Consistent with other jurisdictions, DCF intends to utilize MI as a foundational, cross-cutting EBP across various service lines within our preventive services spectrum. • Manual: Miller, W. R., & Rollnick, S. (2012). *Motivational Interviewing: Helping people change* (3rd ed.). Guilford Press.	MI can be used to promote behavior change with a range of target populations and for a variety of problem areas.	New Jersey families with children or youth, ages 0-17, who have high needs or risks, who could benefit from crisis stabilization, support and/or prevention services. Examples of needs or risks may include: imminent risk of child removal, homelessness or housing instability, substance abuse disorders, medical/mental health disorders, domestic violence, developmental disability (child), trauma history, drug-related arrest or overdose, discharge from incarceration, or inpatient treatment facilities. This includes Prevention Candidacy categories A, B, D, F, G, I and L, among others.
Intercept		
Intercept® provides intensive in-home mental health services to children and youth from birth to 18 years of age who are in out-of-home place or at risk for entry or re-entry into out-of-home placement. Intercept offers prevention services to children and their families as an effort to reduce foster care placements. In addition, reunification services are provided to children in out-of-home placements and their families to reduce time in placement. Family Intervention Specialists work with children and their families offering individualized services to address needs. They provide support in school or legal meetings and 24-hour on-call crisis support. In the Title IV-E Prevention Services Clearinghouse, Intercept is rated as well-supported and categorized as an intervention for parenting skills. • Manual: Goldsmith, T. (Ed.). (2007). *Youth Villages clinical protocols treatment manual*. Youth Villages.	Intercept is designed to serve children from birth to age 18 that are at risk of entry or re-entry into out-of-home placements (e.g., foster care, residential facilities, or group homes) or who are currently in out-of-home placements. Intercept is designed to serve children who have emotional and behavioral problems or have experienced abuse and/or neglect.	New Jersey children from birth to age 18 that are at risk of entry or re-entry into out-of-home placements (e.g., foster care, residential facilities, or group homes) or that are currently in out-of-home placements. New Jersey children that have emotional and behavioral problems or have experienced abuse and/or neglect. This includes Prevention Candidacy categories A, B, C, F, G, H, I J and L, among others.
Positive Parenting Program (Triple P) Level 4- Standard		

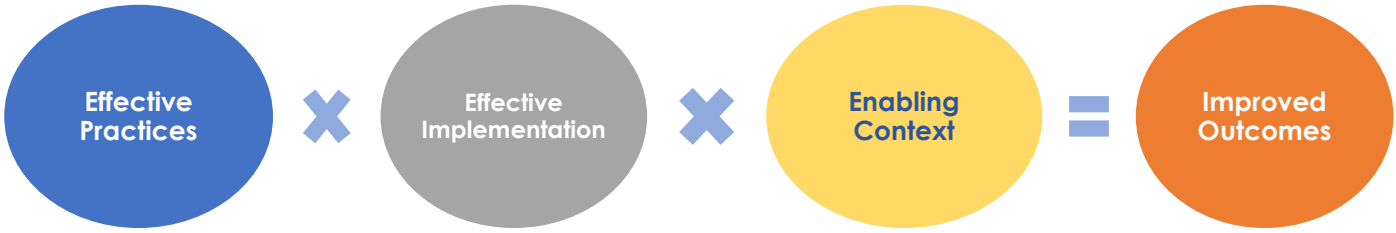
Triple P (Standard) is a parenting intervention for families with concerns about their child's moderate to severe behavioral problem. As part of Triple P (Standard), parents engage in one-on-one sessions with a practitioner. Sessions focus on promoting child development, managing misbehavior and implementing planned activities and routines to encourage independent child play. In the Title IV-E Prevention Services Clearinghouse, Triple P (Standard) is rated as promising and is categorized as an intervention for mental health. • Manual: Sanders, M. R., Markie-Dadds, C., & Turner, K. M. T. (2013). *Practitioner's manual for Standard Triple P (2nd ed.)*. Triple P International Pty Ltd.	Triple P (Standard) serves families with children up to 12 years of age that exhibit behavior problems or emotional difficulties.	New Jersey families with children up to 12 years of age and, in particular, parents that are interested in promoting their child's development or who are concerned about their child's behavioral problems. This includes Prevention Candidacy category A, among others.
Triple P Level 4- Group		
Triple P (Group) is a group-based parenting and family support system and intervention. It is a treatment and prevention program that addresses behavioral and emotional issues in children and youth. It provides realistic approaches for parents and families who want or need assistance in understanding and support child development and have concerns about behavior issues with their child. Participants can participate in group sessions that focus on topics that range from child development, behavior management, and positive parenting. Parents receive specific feedback that allows them to measure their progress and support around setting individual goals for themselves. Practitioners then provide individual feedback on progress using positive parenting strategies and goal setting. In the Title IV-E Prevention Services Clearinghouse, Triple P (Group) is rated as promising and is categorized as an intervention for mental health. • Manual: Turner, K. M. T., Markie-Dadds, C., & Sanders, M. R. (2010). *Facilitator's manual for Group Triple P (3rd ed.)*. Triple P International Pty Ltd.	Triple P (Group) services families with children up to 12 years of age. It targets parents that are interested in promoting their child's development or that are concerned about their child's behavioral problems.	New Jersey families with children up to 12 years of age and, in particular, parents that are interested in promoting their child's development or that are concerned about their child's behavioral problems. This includes Prevention Candidacy category A, among others.
Sobriety Treatment and Recovery Teams (START)		
START serves families involved with the child welfare system with at least one child aged 5 or younger and one parent diagnosed with a SUD. START is a family-centered model where families are part of team and have a voice in treatment decision-making and case planning processes. The model recruits, engages and keep parents in SUD treatment while simultaneously keeping their children safe. START has several primary goals and objectives, such as preventing out-of-home placement, increasing permanency, improving family stability, SUD recovery and child safety and well-being. Family teams assess progress and coordinate care across systems for families. Families also receive peer support from START family mentors. START intervention includes various activities, including intensive SUD recovery services, parenting and life skills coaching, child protective services case management and individual, group and/or family counseling. In the Title IV-E Prevention Services Clearinghouse, START is rated as supported and categorized as an intervention for substance use and parenting skills. • Manual: Willauer, T., Posze, L., & Huebner, R. A. (Eds.). (2018). *The Sobriety Treatment and Recovery Teams (START) model: Implementation manual*. Children and Family Futures.	START is designed to serve families involved in the child welfare system with at least one child, age 5 or younger and one parent diagnosed with a substance use disorder.	New Jersey families involved in the child welfare system with at least one child, age 5 or younger and one parent diagnosed with a substance use disorder. This includes Prevention Candidacy categories A and I, among others.

Note Regarding Other Title IV-E Prevention Services: In addition to the Title IV-E prevention services include in this plan and described above, DCF's current prevention services array includes a number of other evidence-based interventions that are included in the Title IV-E Prevention Services Clearinghouse with a rating of Well-Supported, Supported or Promising, including Functional Family Therapy, Healthy Families America, Multisystemic Therapy, Nurse-Family Partnership, Parents as Teachers, and Trauma-Focused Cognitive Behavioral Therapy. At the time of development of this plan, many of these interventions are funded through other federal sources, i.e., the Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program, Medicaid, etc. DCF will ongoingly explore opportunities to leverage the Family First Prevention Services Act for expansion of prevention services. Should DCF determine that the Family First Prevention Services Act provides further opportunity, DCF will submit an amended 5-year prevention plan.

Implementation of Title IV-E Prevention Services

Recognizing the importance of attending to implementation to achieve positive outcomes, DCF's programmatic and operational offices will, together, provide the infrastructure required for successful and sustainable implementation of the Title IV-E prevention services included in this plan. A description of the DCF's framework to achieve successful and sustainable implementation follows.

Figure 9. Active Implementation Formula



The field of implementation science provides frameworks to help assess and support the design and implementation of interventions for outcome achievement.[24]DCF utilizes the Active Implementation Formula and Implementation Stages developed by NIRN as its organizing approach to manage the complexities of implementation for high quality program development. [25] The Active Implementation Formula demonstrates that improved program outcomes for children and families can be achieved when there is an effective practice, effective implementation supports, and an enabling context. These elements have a synergistic effect with desired outcomes achieved through the interaction of all three factors. More detailed descriptions of the subcomponents of the Active Implementation Formula follow.

[24] Powell, B. J., Beidas, R. S., Lewis, C. C., Aarons, G. A., McMillen, J. C., Proctor, E. K., & Mandell, D. S. (2015). Methods to improve the selection and tailoring of implementation strategies. The journal of behavioral health services & research, 1-18. See also, Fixsen, D., Blase, K., Metz, A., & Van Dyke, M. (2015). Implementation science. In J. D. Wright (Ed.), International encyclopedia of the social and behavioral sciences (2nd ed., Vol. 11, pp. 695-702). Amsterdam: Elsevier.

[25] Metz, A., Bartley, L., Maltry, M. (2017). Supporting the Sustainable Use of Research Evidence in Child Welfare Services, An Implementation Science and Service Provider Informed Blueprint for the Integration of Evidence Based/Evidence Informed Practices into NJ Child Welfare System. The National Implementation Research Network.

Figure 10. Subcomponents of the Active Implementation Formula

Effective Practices	For an intervention or practice to be effective, it must be well-defined. Interventions should have clear outcomes and defined service activities and practices so that staff have a clear understanding of the program and practice model.[26]
Effective Implementation	To ensure that staff are prepared to implement the practice as it is intended job descriptions and interview protocol, skill-based training, follow up coaching to reinforce the training, and performance/fidelity assessments must be in place. In addition to supporting staff, organizational supports such as administrative procedures, plans for systems coordination, data collection processes and data collection mechanisms to support monitoring, evaluation and ongoing CQI are needed.[27] These implementation supports should be documented in a manual.
Enabling Context	Multi-level teaming structures are necessary to move programs, practices, and strategies from an idea to full implementation and to ensure consistent, linked internal and external communication within teams and between teams. [28] Monitoring, evaluation, and CQI should be used to ensure programs are implemented as intended, outcomes are achieved, and processes are in place for improvement.[29]

DCF uses a stage-based approach to guide, sequence, and implement the activities outlined in the Active Implementation Formula. The implementation of these activities requires "multiple decisions, actions, and corrections to change the structures and conditions necessary to implement and sustain new practices and programs successfully. These required decisions and actions are accomplished through a set of Implementation Stages." [30] There are four implementation stages: exploration, installation, initial implementation and full implementation. DCF utilizes teaming structures, comprised of groups or individuals with the necessary and varied expertise to support the implementation activity, to attend to implementation activities and link communication to ensure high quality program development.

In the Exploration Stage, the need for the program is established. A Model Exploration Team identifies program needs and targeted outcomes, explores and recommends program models, and identifies finances. After model selection and prior to model launch, the Installation Stage begins. During this stage, DCF establishes a State Level Implementation Team, consisting of participants from programmatic offices, operational offices, model developers, external consultants, and implementing agencies, to ensure the necessary implementation supports are in place to initiate the new practice and to support continued implementation. The State Level Implementation Team attends to staff competency supports (e.g., hiring practices, training, coaching to reinforce skills in

[26] Metz, A., Bartley, L., Blase, K., & Fixsen, D. (2011). A guide to developing practice profiles. Chapel Hill, NC: National Implementation Research Network, University of North Carolina. Available online at http://nirn.fpg.unc.edu/sites/nirn.fpg.unc.edu/files/resources/NIRN- Metz-WhitePaper-PracticeProfiles.pdf

[27] Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). Implementation research: A synthesis of the literature. Tampa, FL: Louis de la Parte Florida Mental Health Institute, University of South Florida. See also: Metz, A., & Bartley, L. (2012). Active implementation frameworks for program success: How to use implementation science to improve outcomes for children. Zero to Three Journal, 32(4), 11-18.

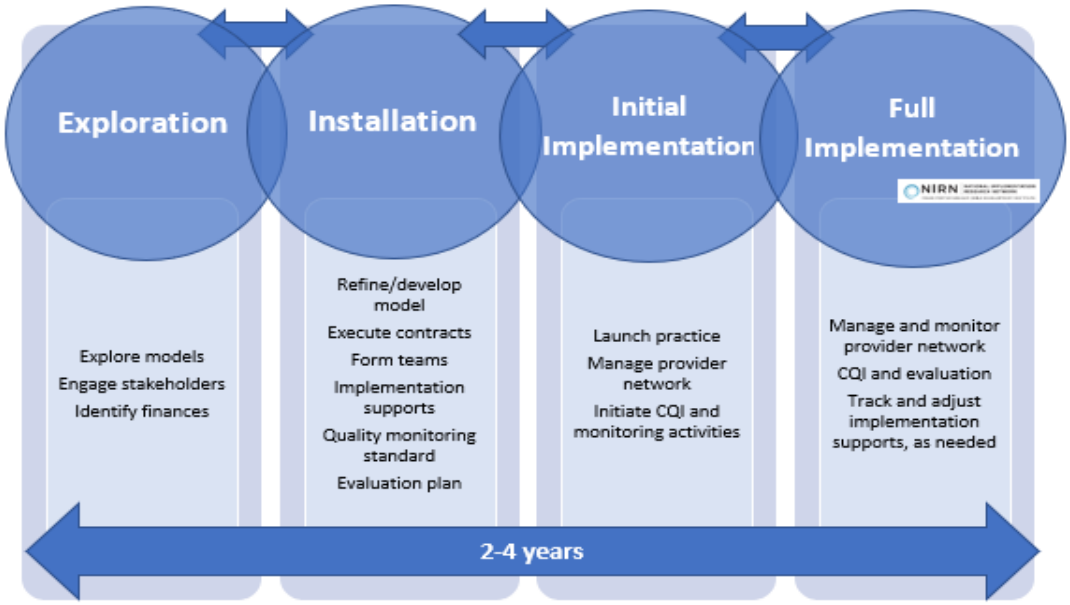
[28] Metz, A., Bartley, L., Ball, H., Wilson, D., Naoom, S., & Redmond, P. (2015). Active implementation frameworks for successful service delivery: Catawba County Child Wellbeing Project. Research on Social Work Practice, 25, 415-422.

[29] Metz, A., Bartley, L. & Maltry, M. (2017). DCF Evidence-Based Practice Blueprint Provider Workshop (2017). Based on work of the National Implementation Research Network (NIRN) and Metz, A., Bartley, L. & Louison, L. (2013-2016).

[30] State Implementation and Scaling-up of Evidence-based Practices Center. Activity Implementation Hub [MOOC]. National Implementation Research Network. University of North Carolina at Chapel Hill. Available online at https://nirn.fpg.unc.edu/ai-hub.

practice, performance/fidelity assessments, etc.), organizational supports (e.g., policies and procedures, data collection mechanisms, monitoring, evaluation and CQI plans, etc.), procurement and contracting. If a selected model does not have the necessary implementation supports, the State Level Implementation Team plans for the refinement or development of the needed supports. The Initial Implementation Stage begins when providers launch the practice. In this stage, the State Level Implementation Team remains in place and a Local Level Implementation Team is launched. In addition to managing the provider network, DCF launches the practice, coaching for providers, monitoring, continuous quality improvement and evaluation activities. The Full Implementation Stage occurs when provider staff are consistently delivering the practice as intended.[31] While the State and Local Level Implementation Teams meet at reduced frequencies, efforts related to training, coaching, data collection, monitoring, evaluation and CQI efforts continue. Ultimately, outcomes are achieved, and findings are disseminated.

Figure 11. Implementation Stages



As is described in Section 3, "DCF's Prevention Strategy," DCF has a rich infrastructure to support collaborative program selection, design, implementation, data collection, monitoring, evaluation and ongoing CQI through this implementation framework. DCF's programmatic offices, including CP&P, CSOC, FCP and DOW, and operational offices, including OSD, Office of Monitoring, Office of Applied Research and Evaluation, the Office of Data Management and Reporting, Office of Quality, OTPD and OIT, will, together, provide the expertise and infrastructure required for successful and sustainable implementation of the Title IV-E prevention services described in this plan. DCF's plans related to Continuous Quality Improvement, fidelity monitoring and evaluation are

[31] Fixsen, D. L., Blase, K. A., Timbers, G. D., & Wolf, M. M. (2001). In search of program implementation: 792 replications of the Teaching Family Model. In G. A. Bernfeld, D. P. Farrington, & A. W. Leschied (Eds.), *Offender rehabilitation in practice: Implementing and evaluating effective programs* (pp. 149–166). John Wiley & Sons Ltd.

included in Section 5, "Title IV-E Prevention Services Evaluation Strategy and Waiver Request."

Trauma Informed Service Delivery

DCF commits that each Title IV-E prevention service included in this plan will be delivered in a way that involves understanding, recognizing, and responding to the effects of all types of trauma and in accordance with recognized principles of a trauma-informed approach and trauma-specific interventions to address trauma's consequences and facilitate healing. See Attachment A, State Assurance of Trauma-Informed Service Delivery.

SECTION 5. TITLE IV-E PREVENTION SERVICES EVALUATION STRATEGY AND WAIVER REQUEST

Pre-print Section 1 and Section 2

The Family First Prevention Services Act requires that states include a well-designed and rigorous evaluation strategy for each Title IV-E prevention service included in their prevention plan. (Section 471(e)(5)(C)(i)). If the state provides compelling evidence of the effectiveness of "well-supported" services and meets CQI requirements, the Children's Bureau may waive this requirement. (Section 471(e)(5)(C)(ii)). DCF seeks a waiver for three of the Title IV-E prevention services included in this plan: Brief Strategic Family Therapy (BSFT), Motivational Interviewing (MI), and Intercept. For MI, DCF requests a waiver for use as a foundational, cross-cutting intervention. DCF commits to undertaking rigorous evaluations of the Positive Parenting Program (Triple P)- Standard, the Positive Parenting Program (Triple P)- Group, and the Sobriety Treatment and Recovery Teams (START) through a two-phase approach. All services will be continuously monitored to ensure fidelity to the practice model, determine outcomes achieved and ensure that data informs ongoing quality improvement efforts.

In this section, DCF outlines evidence of the effectiveness of each identified Title IV-E prevention service, describes DCF's CQI framework and processes and sets forth evaluation plans for models rated as less than well-supported. Detailed quality improvement plans will be developed closely with model developers and service providers once DCF concludes procurement of both. Should any material changes evolve, DCF will submit an amended version of this plan.

Figure 12. DCF's Evaluation and CQI Commitments

Evidence-Based Program	Clearinghouse Rating	Rigorous Evaluation	Continuous Quality Improvement	Evaluation Waiver Requested
Brief Strategic Family Therapy (BSFT)	Well-Supported		X	X
Motivational Interviewing (MI)	Well-Supported		X	X
Intercept	Well-Supported		X	X
Sobriety Treatment and Recovery Teams (START)	Supported	X	X	
Triple P (Standard)	Promising	X	X	
Triple P (Group)	Promising	X	X	

Compelling Evidence for Effectiveness of Evidence-Based Programs and Waiver Justification

As stated in section 471(e)(5)(C)(ii) of the Family First Prevention Services Act, the Children's Bureau may waive evaluation requirements for programs rated as "well-supported" by the Title IV-E Prevention Services Clearinghouse if a state (1) provides compelling evidence of program effectiveness, and (2) employs CQI of the program in accordance with Section 471(e)(5)(B)(iii)(II). New Jersey is seeking a waiver of evaluation for the BSFT, MI and Intercept programs, which are each deemed "well-supported" by the Title IV-E Prevention Services Clearinghouse. See Attachment B, State Request for Waiver of Evaluation Requirement for a Well-Supported Practice. Evidence to support the effectiveness of these well-supported programs, along with the START, Triple P (Standard) and Triple P (Group) programs, is reviewed below.

Brief Strategic Family Therapy.

Rated as a "well-supported" program by the Title IV-E Prevention Services Clearinghouse, studies have found that BSFT is an effective program for treating youth, aged 6-17 years old, experiencing, or at risk for experiencing, a substance use disorder, conduct problems or general delinquency. This aligns with DCF's target population for this intervention. See Table 1, above. Per the Clearinghouse, "[BSFT] is rated as a well-supported practice because at least two studies with non-overlapping samples carried out in usual care or practice settings achieved a rating of moderate or high on design and execution and demonstrated favorable effects in a target outcome domain. At least one of the studies demonstrated a sustained favorable effect of at least 12 months beyond the end of treatment on at least one target outcome." For BSFT, five studies were reviewed in depth with one rated high quality. A summary of findings is detailed in Figure 13, below.

BSFT is a proven program for improving child behavioral and emotional functioning and reducing child delinquent behavior. In one study, children who received BSFT showed improved behavioral and emotional functioning by demonstrating lower scores on externalizing behaviors, including issues with truancy, at follow-up (IRR = 0.70, 95% CI [0.53, 0.92]) compared to a comparison group.[32] Another study showed a reduction in police-related delinquent behaviors among youth, including reductions in both lifetime (IRR = 0.68, 95% CI [0.57, 0.81]) and past year (IRR = 0.54, 95% CI [0.40, 0.71]) arrests, as well as lifetime (IRR=0.63, 95% CI [0.49, 0.81]) and past year (IRR = 0.70, 95% CI [0.53, 0.92]) incarcerations.[33] BSFT has also been successful at reducing youth substance use and improving family functioning. In a 2011 study, the median number of days of self-reported drug use was significantly higher among youth who received treatment as usual compared to BSFT and BSFT was more effective in engaging and retaining family members in treatment and improving parent reported family functioning.[34]

---

[32] Horigian, V. E., Feaster, D. J., Brincks, A., Robbins, M. S., Perez, M. A., & Szapocznik, J. (2015b). The effects of Brief Strategic Family Therapy (BSFT) on parent substance use and the association between parent and adolescent substance use. Addictive Behaviors, 42, 44-50. doi:10.1016/j.addbeh.2014.10.024

[33] Horigian, V. E., Feaster, D. J., Brincks, A., Robbins, M. S., Perez, M. A., & Szapocznik, J. (2015b). The effects of Brief Strategic Family Therapy (BSFT) on parent substance use and the association between parent and adolescent substance use. Addictive Behaviors, 42, 44-50. doi:10.1016/j.addbeh.2014.10.024

[34] Robbins, M. S., Feaster, D. J., Horigian, V. E., Rohrbaugh, M., Shoham, V., Bachrach, K., Miller, M., Burlew, K. A., Hodgkins, C., Carrion, I., Vandermark, N., Schindler, E., Werstlein, R., & Szapocznik, J. (2011). Brief Strategic Family Therapy versus

Favorable outcomes have also been found in the domain of adult well-being with reductions in parent/caregiver substance use and improvement in overall family functioning. One study demonstrated a reduction in reported alcohol use between baseline and 12-month follow-up by parents/caregivers who participated in BSFT ($\chi 2(1) = 4.46$, $p = .04$).[35] Another study demonstrated significant improvements in overall family functioning.[2]

Figure 14. BSFT Outcomes and Findings

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child well-being: behavioral and emotional functioning	-0.06 -2	1 (5)	327	Favorable:1 No effect: 3 Unfavorable:1
Child well-being: substance use	-0.13 -5	1 (17)	420	Favorable: 0 No effect: 17 Unfavorable: 0
Child well-being: delinquent behavior	0.31 12	1 (4)	261	Favorable: 4 No effect: 0 Unfavorable: 0
Adult well-being: parent/caregiver substance use	Not calculated	1 (2)	481	Favorable: 1 No effect:1 Unfavorable: 0
Adult well-being: family functioning	0.06 2	2 (8)	455	Favorable: 1 No effect: 7 Unfavorable: 0

treatment as usual: Results of a multisite randomized trial for substance using adolescents. Journal of Consulting and Clinical Psychology, 79(6), 713–727.

[35] Horigian, V. E., Feaster, D. J., Robbins, M. S., Brincks, A. M., Ucha, J., Rohrbaugh, M. J., Shoham, V., Bachrach, K., Miller, M., Burlew, A. K., Hodgkins, C. C., Carrion, I. S., Silverstein, M., Werstlein, R., & Szapocznik, J. (2015). A cross-sectional assessment of the long term effects of brief strategic family therapy for adolescent substance use. The American journal on addictions, 24(7), 637–645.

Motivational Interviewing.

MI is rated as a "well-supported" practice on the Title IV-E Prevention Services Clearinghouse. By reducing substance use among parents/caregivers and improving their overall mental, physical, and emotional wellbeing, MI seeks to improve child well-being and prevent entry into foster care. Per the Clearinghouse, "MI is rated as a well-supported practice because at least two studies with non-overlapping samples carried out in usual care or practice settings achieved a moderate or high [rating] on design and execution and demonstrated favorable effects in a target outcome domain. At least one of the studies demonstrated a sustained favorable effect of at least 12 months beyond the end of treatment on at least one target outcome."[36] For MI, 30 studies were reviewed in depth by the Clearinghouse with 13 rated high quality. A summary of findings is detailed in Figure 15, below.

A large body of evidence indicates that MI is effective in increasing treatment adherence and reducing drug and alcohol use in diverse populations, including parents/caregivers, which aligns with DCF's target population for this intervention. See Table 1, above. The Clearinghouse review indicates that MI demonstrated favorable, statistically significant impacts on parent/caregiver substance use in multiple high and medium rated studies and thus shows compelling evidence of effectiveness for this outcome.[37,38,39,40,41] For example, a study focused on alcohol use interventions in trauma centers found that the MI treatment group decreased their weekly alcohol consumption by 49% over the comparison group for a period of 11 months following treatment.[42] A meta-analysis of randomized controlled trials of MI found the practice's aggregate effect size on alcohol consumption was .18 (95% CI: 0.07,0.29) when compared to no treatment and .43 (95% CI: 0.17, 0.70) when compared to another substance use intervention.[43]

More specifically, research has demonstrated the effectiveness of MI in the child welfare context. In a 2018 literature review that explored the use of MI in child welfare, 12 of 16 articles reviewed suggested that MI improves parenting skills, parent/child mental health, and retention in services while reducing substance use and recidivism within the child welfare system.[44]

---

[36] Administration for Children and Families. *Title IV-E Prevention Services Clearinghouse*. Accessed from: https://preventionservices.acf.hhs.gov/

[37] Carey, K. B., Carey, M. P., Maisto, S. A., & Henson, J. M. (2006). Brief motivational interventions for heavy college drinkers: A randomized control trial. Journal of Consulting and Clinical Psychology, 74(5), 943-954. doi: 10.1037/0022-006X.74.5.943

[38] Field, C., Walters, S., Marti, C. N., Jun, J., Foreman, M., & Brown, C. (2014). A multisite randomized controlled trial of brief intervention to reduce drinking in the trauma care setting: How brief is brief? Annals Of Surgery, 259(5), 873-880. doi:10.1097/SLA.0000000000000339

[39] Rendall-Mkosi, K., Morojele, N., London, L., Moodley, S., Singh, C., & Girdler-Brown, B. (2013). A randomized controlled trial of motivational interviewing to prevent risk for an alcohol-exposed pregnancy in the Western Cape, South Africa. Addiction, 108(4), 725-732. doi:http://dx.doi.org/10.1111/add.12081

[40] Saitz, R., Palfai, T. P. A., Cheng, D. M., Alford, D. P., Bernstein, J. A., Lloyd-Travaglini, C. A., . . . Samet, J. H. (2014). Screening and brief intervention for drug use in primary care: The ASPIRE randomized clinical trial. JAMA, 312(5), 502-513. doi:http://dx.doi.org/10.1001/jama.2014.7862

[41] Gentilello, L. M., Rivara, F. P., Donovan, D. M., Jurkovich, G. J., Daranciang, E., Dunn, C. W., . . . Ries, R. R. (1999). Alcohol interventions in a trauma center as a means of reducing the risk of injury recurrence. Annals Of Surgery, 230(4), 473-480.

[42] Gentilello, L. M., Rivara, F. P., Donovan, D. M., Jurkovich, G. J., Daranciang, E., Dunn, C. W., . . . Ries, R. R. (1999). Alcohol interventions in a trauma center as a means of reducing the risk of injury recurrence. Annals Of Surgery, 230(4), 473-480.

[43] Vasilaki, E. I., Hosier, S. G., & Cox, W. M. (2006). The efficacy of motivational Interviewing as a brief intervention for excessive drinking: A meta-analytic review. Alcohol and Alcoholism, 41(3), 328-335. https://doi.org/10.1093/alcalc/agl016

[44] Shah, A., Jeffries, S., Cheatham, L., Hasenbein, W., Creel, M., Nelson-Gardell, D. & White-Chapman, N. (2018). Partnering with Parents: Reviewing the Evidence for Motivational Interviewing in Child Welfare. Family in Society: The Journal of Contemporary Social Services, 100(10). https://doi.org/10.1177/1044389418803455

Figure 15. Motivational Interviewing Outcomes and Findings

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child well-being: substance use	-0.01 0	5 (33)	1634	Favorable: 0 No effect: 33 Unfavorable: 0
Adult well- being: parent/caregiver mental or emotional health	0.00 0	3 (5)	1464	Favorable: 0 No effect: 5 Unfavorable: 0
Adult well-being: parent/caregiver substance use	0.16 6	15 (109)	6066	Favorable: 16 No effect: 91 Unfavorable: 2
Adult well-being: parent/caregiver criminal behavior	-0.01 0	2 (7)	1610	Favorable: 0 No effect: 7 Unfavorable: 0
Adult well-being: family functioning	0.10 4	1 (1)	777	Favorable: 0 No effect: 1 Unfavorable: 0
Adult well-being: parent/caregiver physical health	0.00 0	4 (10)	2158	Favorable: 0 No effect: 10 Unfavorable: 0
Adult well-being: economic and housing stability	-0.02 0	1 (1)	777	Favorable: 0 No effect: 1 Unfavorable: 0

Intercept.

Intercept is rated as a "well-supported" program on the Title IV-E Prevention Services Clearinghouse. Among families with children who are at risk of either entry or re-entry into foster care, a target population for this model in New Jersey, see Table 1, above, Intercept has been shown to prevent a foster care placement. Among children already in foster care, another target population for this model in New Jersey, the intervention aims to reduce time to reunification. Per the Clearinghouse, "Intercept is rated as a well-supported practice because at least two studies with nonoverlapping samples carried out in usual care or practice settings achieved a rating of moderate or high on design and execution and demonstrated favorable effects in a target outcome domain. At least one of the studies demonstrated a sustained favorable effect of at least 12 months beyond the end of treatment on at least one target outcome."[45] The Clearinghouse reviewed two studies in-depth with both rated moderate quality. Figure 16, below, provides a summary of findings from the review. Intercept demonstrated favorable, statistically significant impacts on child permanency, as evidenced by a reduction in out-of-home placements and an increase in planned permanent exits.

In a study conducted by Chapin Hall, Intercept was shown to reduce out-of-home placement by 53% following a maltreatment investigation.[46] In Chapin Hall's follow-up evaluation with a non-overlapping population of youth, the risk of placement was 37% lower among children referred to Intercept than children in the comparison group. The effect of Intercept was sustained 6 and 12 months after Intercept services ended.[47] In another study by Chapin Hall, the odds of achieving permanency were found to be 24% higher for the Intercept group compared to a matched comparison group.[48]

Figure 16. Intercept Outcomes and Findings

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child permanency: out-of-home placement	0.40 15	2 (2)	91778	Favorable:2 No effect: 0 Unfavorable: 0
Child permanency: planned permanent exits	0.13 5	1 (1)	4029	Favorable: 1 No effect: 0 Unfavorable: 0

[45] Administration for Children and Families. Title IV-E Prevention Services Clearinghouse. Accessed from: https://preventionservices.acf.hhs.gov/

[46] Huhr, S., & Wulczyn, F. (2020). Do intensive in-home services prevent placement?: A case study of Youth Villages' Intercept® program. The Center for State Child Welfare Data. https://fcda.chapinhall.org/wp-content/uploads/2019/10/YV-Intercept-Results-1-8-2020-final.pdf

[47] Huhr, S. & Wulczyn, F. (2021). The Impact of Youth Village's Intercept Program on Placement Prevention: A Second Look. Accessed from: https://fcda.chapinhall.org/wp-content/uploads/2021/08/YV-Prevention-Final-8.13.2021.pdf

[48] Huhr, S., & Wulczyn, F. (2020b). Do intensive in-home services promote permanency?: A case study of Youth Villages' Intercept® program. The Center for State Child Welfare Data. https://fcda.chapinhall.org/wp-content/uploads/2020/09/Permanency-YVIntercept-final-982020.pdf

Sobriety Treatment and Recovery Teams (START).

START is currently rated as a "supported" program on the Title IV-E Prevention Services Clearinghouse. By encouraging parental substance use recovery and improving family stability and self-sufficiency, the model aims to prevent placement of children in foster care and promote child safety, wellbeing and permanency. Per the Clearinghouse, "START is rated as a supported practice because at least one study carried out in a usual care or practice setting achieved a rating of moderate or high on design and execution and demonstrated a sustained favorable effect of at least 6 months beyond the end of treatment on at least one target outcome".[49] For START, three studies were reviewed by the Clearinghouse in depth with two rated moderate quality and one rated low quality. A summary of findings from the review is detailed in Figure 17, below.

Studies show that START has produced favorable effects on child permanency and out-of-home placements. In a 2012 impact study, children in the START intervention group entered out-of-home care at a rate of 21% compared to 42% in a matched comparison group (Effect size: 0.23).[50] In a 2015 study of families receiving child welfare services, which is DCF's target population for this intervention, see Table 1, above, there was significantly less recurrence of maltreatment among families who received START 6 months post treatment, and less reentry into foster care 12 months post treatment (matched comparison, 13.2%; intervention, 0%) compared to a matched comparison group.[51] Additionally, adding START into existing treatment plans was found to be more effective in helping Child Protective Services-involved parents achieve sobriety than a single modality of treatment alone (66.3% of mothers in START plus another treatment modality, 37% of mothers with only one treatment modality).[52]

Figure 17. START Outcomes and Findings

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child safety: child welfare administrative reports	-0.10 -4	2 (6)	2228	Favorable: 0 No effect: 5 Unfavorable: 1
Child permanency: out-of-home placement	0.33 13	2 (8)	3086	Favorable: 4 No effect: 4 Unfavorable: 0

[49] Administration for Children and Families. Title IV-E Prevention Services Clearinghouse. Accessed from: https://preventionservices.acf.hhs.gov/

[50] Huebner, R. A., Willauer, T., & Posze, L. (2012). The impact of Sobriety Treatment and Recovery Teams (START) on family outcomes. Families in Society, 93(3), 196-203. https://doi.org/http://dx.doi.org/10.1606/1044-3894.4223

[51] Hall, M. T., Huebner, R. A., Sears, J. S., Posze, L., Willauer, T., & Oliver, J. (2015). Sobriety Treatment and Recovery Teams in rural Appalachia: Implementation and outcomes. Child Welfare, 94(4), 119-138.

[52] Huebner, R. A., Willauer, T., & Posze, L. (2012). The impact of Sobriety Treatment and Recovery Teams (START) on family outcomes. Families in Society Journal of Contemporary Social Services, 93(3), 196–203. https://doi.org/10.1606%2F1044-3894.4223

Positive Parenting Program (Triple P)- Group.

Triple P (Group) is rated as "promising" by the Title IV-E Prevention Services Clearinghouse.[53] Triple P (Group) focuses its service delivery on group sessions where practitioners communicate positive parenting strategies for addressing misbehavior in children. Per the Clearinghouse, "Triple P – Positive Parenting Program – Group (Level 4) is rated as a promising practice because at least one study achieved a rating of moderate or high on study design and execution and demonstrated a favorable effect on a target outcome." [54] For Triple P (Group), 18 studies were reviewed by the Clearinghouse in terms of their extent of evidence, with two rated high quality, 5 rated moderate quality, and 5 rated low quality. A summary of findings from the review is detailed in Figure 18, below.

Evidence from the below studies demonstrates that Triple P (Group) has had positive outcomes on child behavioral and emotional well-being, as well as on adults' positive parenting skills and overall mental health. In a 2013 study examining the effectiveness of the Triple P (Group), findings demonstrated that, when compared with a matched comparison group, parents who received Triple P (Group) reported significantly lower rates of child behavior problems, parental stress, dysfunctional discipline style and overall parental conflict, with all effects maintained six months after program completion.[55] In a randomized controlled trial of Triple P (Group) among families who had children aged 6-10 with a psychiatric Attention Deficit Hyperactivity Disorder diagnosis, results indicated a significant improvement across all outcome categories in the treatment group. [56]

Figure 18. Triple P (Group) Outcomes and Findings

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child well-being: behavioral and emotional functioning	0.19 7	6 (16)	615	Favorable: 4 No effect: 11 Unfavorable:1
Child well-being: social functioning	0.10 4	1 (2)	288	Favorable: 0 No effect: 2 Unfavorable: 0
Adult well-being: positive parenting practices	0.36 14	6 (14)	591	Favorable: 11 No effect: 3 Unfavorable: 0

[53] Administration for Children and Families. Title IV-E Prevention Services Clearinghouse. Accessed from: https://preventionservices.acf.hhs.gov/

[54] Administration for Children and Families. Title IV-E Prevention Services Clearinghouse. Accessed from: https://preventionservices.acf.hhs.gov/

[55] Leung, C., Fan, A., & Sanders, M. R. (2013). The effectiveness of a Group Triple P with Chinese parents who have a child with developmental disabilities: a randomized controlled trial. Research in developmental disabilities, 34(3), 976–984. https://doi.org/10.1016/j.ridd.2012.11.023

[56] Aghebati, A., Gharraee, B., Hakim Shoshtari, M., & Gohari, M. R. (2014). Triple p-positive parenting program for mothers of ADHD children. Iranian journal of psychiatry and behavioral sciences, 8(1), 59–65.

Adult well-being: parent/caregiver mental or emotional health	0.59 22	4 (12)	191	Favorable: 4 No effect: 8 Unfavorable: 0
Adult well-being: family functioning	0.24 9	2 (3)	120	Favorable: 0 No effect: 3 Unfavorable: 0

Positive Parenting Program (Triple P)- Standard.

Triple P (Standard) is rated as "promising" by the Title IV-E Prevention Services Clearinghouse.[57]

Triple P (Standard) focuses its service delivery on one-on-one sessions between parents and practitioners. Per the Clearinghouse, "Triple P – Positive Parenting Program – Standard (Level 4) is rated as a promising practice because at least one study achieved a rating of moderate or high on study design and execution and demonstrated a favorable effect on a target outcome."[58] For Triple P (Standard), two studies were eligible for review by the Clearinghouse in terms of their extent of evidence, with one rated moderate quality and one rated low quality. A summary of findings from the review is detailed in Figure 19, below.

Evidence for Triple P (Standard) has shown favorable outcomes in the domains of child behavioral and emotional functioning, as well as positive parenting practices and caregiver mental health.[59, 60]

Figure 19. Triple P (Standard) Outcomes and Findings

Outcome	Effect Size and Implied Percentile Effect	N of Studies (Findings)	N of Participants	Summary of Findings
Child well-being: behavioral and emotional functioning	0.51 19	1 (3)	136	Favorable: 2 No effect: 1 Unfavorable: 0
Adult well-being: positive parenting practices	0.41 15	1 (3)	136	Favorable: 2 No effect: 1 Unfavorable: 0
Adult well-being: parent/caregiver mental or emotional health	0.26 10	1 (8)	136	Favorable: 1 No effect: 7 Unfavorable: 0

[57] Administration for Children and Families. Title IV-E Prevention Services Clearinghouse. Accessed from: https://preventionservices.acf.hhs.gov/

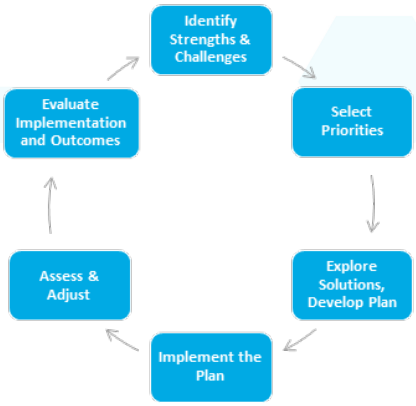
[58] Administration for Children and Families. Title IV-E Prevention Services Clearinghouse. Accessed from: https://preventionservices.acf.hhs.gov/

[59] Bor, W., Sanders, M. R., & Markie-Dadds, C. (2002). The effects of the Triple P-Positive Parenting Program on preschool children with co-occurring disruptive behavior and attentional/hyperactive difficulties. Journal of Abnormal Child Psychology, 30(6), 571-587.

[60] Sanders, M. R., Markie-Dadds, C., Tully, L. A., & Bor, W. (2000). The Triple P-Positive Parenting Program: A comparison of enhanced, standard, and self-directed behavioral family intervention for parents of children with early onset conduct problems. Journal of Consulting and Clinical Psychology, 68(4), 624-640. https://doi.org/10.1037/0022-006X.68.4.624

DCF's Continuous Quality Improvement Strategy

Figure 20. DCF's CoQI Framework



To ensure that implementation of each Title IV-E prevention service is supported by a systematic quality improvement process that utilizes data, evidence and best-practices in decision-making, DCF will leverage its agency-wide CoQI framework. As described in Section 3, "DCF's Prevention Strategy," DCF's CoQI framework utilizes qualitative and quantitative data to assess performance, develop improvement plans and manage change across the programs and provider agencies providing direct services to New Jersey's children and families. Rooted in CQI best practices and improvement science, the framework targets ongoing program improvement through a six-stage cyclical process that includes: identifying strengths and challenges; selecting improvement priorities; exploring solutions and developing an improvement plan; implementing the improvement plan; assessing progress then adjusting the plan as needed; and evaluating implementation and outcomes.

CoQI Teams & Improvement Cycles.

Teaming and collaborative problem-solving are at the foundation of DCF's approach to CoQI. DCF's CoQI framework brings together teams, which consists of DCF programmatic and operational staff, provider agency staff, model developers and technical assistance providers, around regular collaboration touchpoints to review progress and address barriers towards program and provider-specific improvement goals. Teams will be organized around periodic CoQI cycles and more frequent "rapid" CoQI cycles for Title IV-E prevention services as described below. To see this approach applied within CP&P and for additional detail, see CP&P's CoQI description brief.[61]

- **Periodic CoQI Cycles.** Periodic CoQI cycles will be designed to evaluate and improve the performance of DCF programs. They bring together all provider agencies administering a given program to review implementation and outcomes, and to collaboratively develop a shared improvement plan with program-level goals. This process is monitored on an ongoing basis by the DCF program lead and Office of Quality team lead.
    - ***Team:*** Each evidence-based program will have a periodic cycle CoQI team responsible for reviewing data and managing a periodic cycle CoQI improvement planning process. The team will include, but not be limited to, the DCF programmatic division lead, DCF program lead, DCF Office of Quality team lead, DCF OSD implementation lead, provider agency staff, and model developers/technical assistance providers, as applicable.

[61] https://www.nj.gov/dcf/childdata/exitplan/2023-CoQI.Description.pdf

- ***Data inputs:*** The data inputs for the periodic CoQI cycles will focus on quality of services, program reach, compliance, competence and goal achievement. Depending on the evidence-based program and its stage of implementation, data may be generated through DCF's Office of Monitoring, Office of Applied Research & Evaluation or the model developer with measures derived from the data inputs listed below. As required by the Family First Prevention Services Act, DCF will track and evaluate foster care placement status among each child who receives Title IV-E prevention services.[62] Data inputs include: monitoring scorecard (service quality), key performance indicators (compliance and reach), fidelity data (competence/compliance), and outcome data (goal achievement).
- ***Outputs:*** Tangible outputs from the periodic CoQI Cycle will include (1) a program-level improvement plan with specific, measurable, attainable, relevant, and time-bound goals and (2) agreed upon provider-level activities focused on supporting the overall programmatic goals.
- ***Touchpoints:*** Periodic cycle CoQI teams will meet at regular intervals during the improvement cycle. The first meeting will be focused on a "strengths and challenges analysis" in which data is collaboratively reviewed to identify a programmatic priority to develop an improvement plan. In interim meetings, the team will review program-level progress towards achieving identified goals. In the final meeting, the team will review programmatic data to determine whether the specified goals were achieved. If the goals were achieved, the periodic cycle CoQI Team will identify a new priority for the next cycle. If one or more performance goals were not achieved, the team will establish new activities or revise the existing activities for the next cycle.

- **Rapid CoQI Cycles.** Rapid CoQI cycles are designed to evaluate and improve the performance of specific provider agencies implementing DCF programs on a more frequent basis. The rapid CoQI cycle will focus on implementation of the program at the provider-level. Data feeds into an improvement process in which time-limited goals and action steps are generated to support rapid performance improvement. This process will be monitored by a DCF program lead and provider agency lead.
  - ***Team:*** For each provider agency implementing an evidence-based program, there will be a unique rapid cycle CoQI team responsible for reviewing data and managing the rapid cycle improvement plans specific to that agency. The team will include, but not be limited to, DCF program lead, provider agency staff, and model developers/technical assistance providers, as applicable.
  - ***Data inputs:*** The data inputs for the rapid CoQI cycles will focus on the context in which programs are implemented (e.g., referrals, staffing, etc.), the provider agency's compliance with key performance indicators and the competence of provider agency staff to implement the model.

[62] Children's Bureau. June 2022. Revised Technical Bulletin #1. Accessed from: https://www.acf.hhs.gov/sites/default/files/documents/cb/technical-bulletin-revision_0.pdf

Depending on the program and its stage of implementation, data may be generated through DCF's Office of Monitoring, Office of Applied Research & Evaluation, Office of Data Management and Reporting or the model developer with measures derived from the following data inputs: caseloads, staffing, referrals (context), key performance indicators (compliance/context), and fidelity data (competence/compliance).

- ***Outputs:*** Tangible outputs from the rapid CoQI Cycle will include (1) a provider-level rapid improvement plan with specific, measurable, attainable, relevant, and time-bound goals and (2) agreed upon provider-level activities and timelines focused on supporting the specified goals.
- ***Touchpoints:*** Rapid cycle CoQI teams will meet more frequently depending on the evidence-based program and its stage of implementation. At the start of the rapid CoQI cycle, the team will collaboratively identify a metric that needs immediate attention for improvement and can be meaningfully improved through action taken at the provider-level. A time-limited improvement plan detailing who will do what and by when will be developed. At subsequent meetings, progress will be reviewed to track and adjust, and as goals are achieved or new trends requiring attention emerge, the implementation area of focus and resulting plan will shift.

Figure 21. CoQI Team Members and Roles

Team Member (as applicable)	**Role**	**Periodic CoQI Cycle**	**Rapid CoQI Cycle**
DCF programmatic division lead	Provides leadership for FCP, CSOC or CP&P.	X	
DCF program lead	Provides DCF oversight for network of providers implementing a given evidence-based program. Monitors periodic and rapid cycle improvement plans.	X	X
DCF Office of Quality team lead	Provides administrative oversight and facilitation of CoQI cycles. Monitors periodic cycle improvement plans.	X	
DCF OSD implementation lead	Oversees implementation activities and coordinates improvements/refines of implementation supports (training, coaching, etc.)	X	
DCF Office of Applied Research & Evaluation and Office of Monitoring	Provides technical expertise on the data inputs from the Monitoring Scorecard and the results of process and outcome evaluations.	X	
Provider agency staff	Oversees implementation of evidence-based program at the provider agency-level.	X	X
Model developer/technical assistance provider	Provides technical expertise for implementation and fidelity of the evidence-based model.	X	X

Model-Specific Fidelity Monitoring, Outcome Monitoring, and CoQI Processes

For each of the Title IV-E prevention service models included in this plan, DCF will leverage each program's existing fidelity measures to monitor ongoing fidelity to the practice during model implementation. DCF will continuously review fidelity adherence and program outcomes as part of the periodic and rapid CoQI cycles detailed above.

Brief Strategic Family Therapy.

A. **Fidelity Measurement.** Fidelity measurement and CQI are embedded in the BSFT model. Clinicians will be trained in BSFT following completion of a site readiness assessment that ensures the appropriate infrastructure exists to support implementation of the model. BSFT training consists of didactic exercises, video-recording analysis, and clinical case consultations. Fidelity for BSFT will be measured using the BSFT Adherence Certification Checklist, a standardized checklist used to rate a clinician's performance in implementing BSFT. BSFT Institute Faculty provides ratings once monthly per therapist, until such time that the provider develops their own BSFT Certified Onsite Supervisor. The Supervisor will then provide weekly fidelity ratings for each staff member implementing the model along with feedback and consultation. Once a clinician's mastery of BSFT is demonstrated, fidelity is monitored using the BSFT Adherence Certification Checklist in monthly to annual sessions. The therapist must obtain a rating of 3.5 or higher on the 5-point fidelity rating scale to maintain competent status in BSFT. Data from the BSFT Adherence Certification Checklist will be submitted to DCF and reviewed as part of our periodic and rapid CoQI cycles.

B. **Outcome measurement.** In New Jersey, and in alignment with the favorable outcomes assessed by the Title IV-E Prevention Services Clearinghouse, BSFT will be implemented with the goal of reducing delinquent behavior among youth and improving family functioning. Specific outcome measurement tools will be selected in partnership with the model developer during the initial implementation phase of the program and may include:
   - McMaster Family Assessment Device[63]: an assessment tool consisting of 7 scales that measure problem solving, communication, roles, affective responsiveness, affective involvement, behavior control and general functioning
   - Youth Self Report[64]: an adolescent self-report instrument designed to assesses the severity of 119 problem behavior and degree of functioning on three dimensions of Social Competence.
   - Structural Family Systems Rating[65]: a tool developed to assess changes in patterns of interaction in families with a youth with a behavioral problem.

---

[63] Epstein, N. B., Baldwin, L. M., & Bishop, D. S. (1983). The McMaster Family Assessment Device. Journal of Marital and Family Therapy, 9, 171-180. https://www.ntnu.no/c/document_library/get_file?uuid=cd377890-a31d-4692-a9b8-47c563844862&groupId=10293

[64] https://store.aseba.org/YOUTH-SELF-REPORT_11-18-50-per-Package/productinfo/501/

[65] Hervis, O.E., Szapocznik, J., Mitrani, V., Rio, A. & Kurtines, W. (1998). Structural Family Systems Ratings Scale. In J. Touliatos (Ed.) Handbook of Family Measurement Techniques (2nd edition), New York: Microfiche Publications

All outcome data will be collected by provider agencies and entered into a DCF data collection system.

Intercept.

The Intercept model is supported by a well-established CQI process developed by Youth Villages, the model developer, to ensure fidelity of implementation and achievement of key performance indicators. The Intercept CQI framework is based on three primary data inputs, detailed below, that will feed into DCF's periodic and rapid CoQI processes to inform ongoing program improvement efforts:

A. **Fidelity Measurement.** Fidelity will be measured via program model reviews and performance management.
   - **Program Model Reviews.** The program model review is Youth Villages' primary process for monitoring the implementation of the Intercept model. Annually in each location, Youth Villages gathers data through document review, customer surveys, staff surveys, interviews, and aggregate data pulled from electronic health records. This review generates scores that indicate areas of strength and opportunities for improvement to help ensure the program meets the expected outcomes. Following the identification of areas that need to be addressed, clinical and operational leadership work with the CoQI team to create a plan for additional monitoring and/or evaluation activities that will support implementation improvement.

   - **Performance Management.** Youth Villages, DCF and providers will regularly review key performance indicators, such as caseloads, staff retention, and rates of serious incidents.

B. **Outcome Measurement.** In New Jersey, and in alignment with the favorable outcomes assessed by the Title IV-E Prevention Services Clearinghouse, Intercept will be implemented with the goal of reducing out-of-home placement among youth. Data will be collected at admission, discharge and 12-months post-discharge. All youth who receive at least 60 days of service will be followed at all post-discharge points, regardless of status at discharge. Outcomes monitoring through Youth Village's GuideTree Information Management System for the Intercept program will include placement, custody, school status, negative involvement with the justice system, and out-of-home placements.

Motivational Interviewing.

A. **Fidelity Measurement.** Following training, an MI consultant will conduct two coding and feedback sessions with staff to ensure competency in MI skills. These sessions will be coded using one of the following: MI Treatment Integrity, MI Competency Assessment; MI Skills Code, or the MI Assessment Supervisory Tools for Enhancing Proficiency. The results will be used in small group coaching/skill building sessions to inform which practice areas or topics to focus on. These scores may be used to inform booster trainings, as needed. To monitor ongoing fidelity of MI implementation, DCF will use the Behavior Change Counseling Index (BECCI). The BECCI is an 11-item instrument that enables trainers and supervisors to observe staff implementing MI for effectiveness of delivery techniques, such as demonstrating emphatic listening, facilitating an exchange of ideas and encouraging topics about behavior change and personal reflection. Use of the BECCI is intended to increase practitioners' skills and standardization of practice and will also provide a measure of monitoring, allowing for identification of elements of the model that may need additional training or support.

B. **Outcome Measurement.** In New Jersey, and in alignment with the favorable outcomes assessed by the Title IV-E Prevention Services Clearinghouse, MI will be implemented with the goal of reducing caregiver substance use and, as a result of this, improving overall family stability and well-being. The primary outcomes DCF will monitor for MI will be caregiver substance use, family stability and family well-being. For MI implemented within Family Preservation Services, these outcomes will be assessed at entry and discharge from the program by provider agencies using the North Carolina Family Assessment Scale (NCFAS), or other appropriate measurement tool. The NCFAS is a valid and reliable instrument designed to assess family functioning in the domains of Environment, Parental Capabilities, Family Interactions, Family Safety, Child Well-Being, Social/Community Life, Self-Sufficiency, Family Health and Caregiver/Child Ambivalence. [66] Caregiver substance use is assessed under the "Parental Capabilities" domain. Results from the assessment for each family will be entered into an electronic data collection system.

   For MI implemented within the KFT program, caregiver substance use, family stability and family well-being will be measured either in the Arizona Self Sufficiency Matrix, Connecticut Supportive Housing Assessment and Acuity Index, or other appropriate measurement tool. The Self Sufficiency Matrix is designed to evaluation households' self-sufficiency across 18 different domains including caregiver substance use on a 5-point scale from "in crisis" to "empowered."[67] The Connecticut Supportive Housing Assessment and Acuity Index systematically assesses an individual's level of independence and support needs on a 4-point scale in areas related to housing stability, income and benefits, health and access to supportive services and resources. It also includes a discrete measure of substance use and related harm reduction strategies adopted by the caregiver. Results from the outcome assessment for each family will be entered by providers into a DCF-provided data collection system.

[66] Reed-Ashcraft, K., Kirk, R. S., & Fraser, M. W. (2001). The reliability and validity of the North Carolina family assessment scale. Research on Social Work Practice, 11(4), 503-520.
[67] https://www.mass.gov/doc/accs-self-sufficiency-matrix/download

START.

A. **Fidelity Measurement.** The START model incorporates a fidelity monitoring system implemented by the model developer to ensure ongoing fidelity of implementation. The fidelity monitoring system includes a fidelity review for each local jurisdiction implementing START and a certification review process. Results from both will be incorporated into DCF's periodic and rapid CoQI processes to inform ongoing program improvement efforts.

- **Fidelity Review.** Fidelity review for local jurisdictions occurs after approximately 12 months of service to families. The review includes a discussion-based process focused on assessment of current fidelity to each START Essential Component and Fidelity Standard. The fidelity review results in an updated implementation plan with the local jurisdiction.

- **Certification Review.** The certification review process occurs once full fidelity has been achieved. The process involves a self-assessment by the jurisdiction, a desk review of the self-assessment and supporting documentation and data, staff and community partner focus groups and parent interviews. Certification is valid for a three-year period with annual reports and check-ins.

- **Certification Review for State Infrastructure.** START is in the process of developing and piloting a certification review process for state infrastructure, which will allow states to provide their own ongoing training and technical assistance to sustain the model once they have reached full fidelity. DCF intends to undergo this additional review process once it is finalized by the model developer.

B. **Outcome Measurement.** In New Jersey, and in alignment with the favorable outcomes assessed by the Title IV-E Prevention Services Clearinghouse, START will be implemented with the goal of reducing out-of-home placement of children through reduced parental substance use. Data on participating caregivers will be collected at enrollment, discharge and at regular intervals through service delivery. Outcome data, including parental substance use treatment and recovery supports engagement, parental substance use, and out-of-home placements of children will be collected directly by providers and entered into a DCF data system. Specific measurement tools will be selected and finalized through discussion with the model developer.

Positive Parenting Program (Triple P)- Group.

A. **Fidelity Measurement.** Triple P (Group) incorporates a multi-level fidelity monitoring system to ensure ongoing fidelity of implementation. Fidelity of service delivery for Triple P (Group) is supported by a training course and a facilitator's manual, which involves an overview of guidelines for the successful implementation of Triple P (Group). Guidelines include specific instructions for properly identifying risk and protective factors within families, applying appropriate parenting strategies, and making referrals to services. There are also three fidelity monitoring processes, which are provided by the Triple P Implementation Framework and will be used by providers and DCF to support program delivery:

- **Accreditation of Practitioners.** The Accreditation of Practitioners form is designed to be completed simultaneously with provider training courses. This form is meant to aid in the establishment of a baseline competency across all practitioners, measuring facilitator's ability to implement the program as intended. It will also allow for tracking of staff who have successfully completed the required training.

- **Session Checklists.** Triple P (Group) has a session checklist which assists practitioners in implementing the model as intended. These checklists are integrated into the training protocol and are in all Triple P manuals. DCF intends to utilize these instruments as part of its formal, ongoing CoQI process.

- **Peer Support Networks.** Practitioners will receive ongoing feedback on cases from other trained Triple P providers through their participation in peer support networks.

B. **Outcome Measurement.** In New Jersey, and in alignment with the favorable outcomes assessed by the Title IV-E Prevention Services Clearinghouse, Triple P (Group) will be implemented with the goal of improving positive parenting practices and child behavioral and emotional functioning. Data on each participating parent/caregiver will be collected at enrollment and at discharge from the program. Outcome data will be collected and monitored through Triple P's Automated Score and Reporting Application (ASRA) , or another appropriate data system, and may include:

- **The Parenting Scale[68]:** a tool to measure dysfunctional discipline practices in parents of young children,

- **Strengths and Difficulties Questionnaire[69]:** a short, youth behavioral screening questionnaire,

- **Child Adjustment and Parenting Efficacy Scale[70]:** a parent-self report measure of child behavior problems, child emotional maladjustment and parent self-efficacy in managing specific child behaviors.

---

[68] Arnold, D. S., O'leary, S. G., Wolff, L. S., & Acker, M. M. (1993). The Parenting Scale: a measure of dysfunctional parenting in discipline situations. Psychological assessment, 5(2), 137.
[69] Vostanis, P. (2006). Strengths and Difficulties Questionnaire: research and clinical applications. Current Opinion in Psychiatry, 19(4), 367-372.
[70] Morawska, A., Sanders, M. R., Haslam, D., Filus, A., & Fletcher, R. (2014). Child adjustment and parent efficacy scale: Development and initial validation of a parent report measure. Australian psychologist, 49(4), 241-252.

Positive Parenting Program (Triple P) - Standard.

A. **Fidelity Measurement.** Triple P (Standard) incorporates a multi-level fidelity monitoring system to ensure ongoing fidelity of implementation. Fidelity of service delivery for Triple P (Standard) is supported by a training course and a facilitator's manual, which involves an overview of guidelines for the successful implementation of Triple P (Standard). Guidelines include specific instructions for properly identifying risk and protective factors within families, applying appropriate parenting strategies, and making referrals to services. There are also three fidelity monitoring processes, which are provided by the Triple P Implementation Framework and will be used by providers and DCF to support program delivery:

- **Accreditation of Practitioners.** The Accreditation of Practitioners form is designed to be completed simultaneously with provider training courses. This form is meant to aid in the establishment of a baseline competency across all practitioners, measuring facilitator's ability to implement the program as intended. It will also allow for tracking of staff that have successfully completed the required training.
- **Session Checklists.** Triple P-Standard has a session checklist which assists practitioners in implementing the model as intended. These checklists are integrated into the training protocol and are in all Triple P manuals. DCF intends to utilize these instruments as part of its formal, ongoing CoQI process.
- **Peer Support Networks.** Practitioners will receive ongoing feedback on cases from other trained Triple P providers through their participation in peer support networks.

B. **Outcome Measurement.** In New Jersey, and in alignment with the favorable outcomes assessed by the Title IV-E Prevention Services Clearinghouse, Triple P (Standard) will be implemented with the goal of improving positive parenting practices and child behavioral and emotional functioning. Data on each participating parent/caregiver will be collected at enrollment and at discharge from the program. Outcome data will be collected and monitored through Triple P's ASRA, or another appropriate data system, and may include:

- **The Parenting Scale**[71]**:** a tool to measure dysfunctional discipline practices in parents of young children,
- **Strengths and Difficulties Questionnaire**[72]**:** a short, youth behavioral screening questionnaire,
- **Child Adjustment and Parenting Efficacy Scale**[73]**:** a parent-self report measure of child behavior problems, child emotional maladjustment and parent self-efficacy in managing specific child behaviors, and/or
- **Parenting Stress Index, Short-Form**[74]**:** a parent self-report measure of parental distress, parent-child dysfunctional interaction and perceived difficulty of child.

---

[71] Arnold, D. S., O'leary, S. G., Wolff, L. S., & Acker, M. M. (1993). The Parenting Scale: a measure of dysfunctional parenting in discipline situations. Psychological assessment, 5(2), 137.
[72] Vostanis, P. (2006). Strengths and Difficulties Questionnaire: research and clinical applications. Current Opinion in Psychiatry, 19(4), 367-372.
[73] Morawska, A., Sanders, M. R., Haslam, D., Filus, A., & Fletcher, R. (2014). Child adjustment and parent efficacy scale: Development and initial validation of a parent report measure. Australian psychologist, 49(4), 241-252.
[74] Haskett, M. E., Ahern, L. S., Ward, C. S., & Allaire, J. C. (2006). Factor structure and validity of the parenting stress index-short form. *Journal of Clinical Child & Adolescent Psychology*, *35*(2), 302-312.

See the Evaluation Plan below for further detail on our proposed evaluation questions, data collection methods, measures, and analysis plan.

Evaluation Plan for Triple P (Standard) and Triple P (Group) Programs

Through its Office of Applied Research and Evaluation (ARE), DCF takes a collaborative, utilization-focused approach to evaluation that fully and ongoingly integrates stakeholders' voices at all levels.[75,76] ARE will manage the evaluations for the Triple P (Group), Triple P (Standard) and START programs through a two-phased approach. In this section, DCF includes evaluation plans for Triple P-Standard and Triple P- Group, which DCF identifies as Phase 1 Title IV-E prevention services. DCF will develop and submit an evaluation plan for START, which DCF identifies as a Phase 2 Title IV-E prevention service, at the time of implementation planning and via an amendment of this plan; DCF will not seek Title IV-E reimbursement for START services until such time as that plan amendment is approved.

To design the final evaluations for Triple P (Standard) and Triple P (Group), DCF will intentionally and meaningfully engage model developers, provider organizations, DCF staff and DCF leadership in co-developing the evaluation questions, measures and methods and identifying study limitations. The evaluation questions that DCF will seek to answer, evaluation procedures, measures, methods and limitations of DCF's evaluation approach are described below. Should the collaborative process described here lead to any substantial changes to this plan, DCF will submit an amendment to this plan.

Triple P (Standard) and Triple P (Group) are listed as "promising" practices on the Title IV-E Prevention Services Clearinghouse. Therefore, in addition to ongoing fidelity and outcome monitoring for the Triple P (Standard) and Triple P (Group) programs, DCF will implement rigorous evaluations while these models continue to be developed as well-supported evidence-based practices. Informed by the Children's Bureau's Evaluation Plan Development Tip Sheet[77] and the Title IV-Prevention Services Clearinghouse Handbook of Standards and Procedures[78], DCF will evaluate implementation, outcomes and, ultimately, the impact of these models. Figure 22 includes the evaluation questions DCF will prioritize for both the Triple P (Standard) and Triple P (Group) models.

[75] O'Sullivan, R. G. (2012). Collaborative evaluation within a framework of stakeholder-oriented evaluation approaches. Evaluation and program planning, 35(4), 518-522.
[76] Patton, M. Q. (2008). Utilization-focused evaluation. Sage publications.
[77] Administration for Children and Families. (August, 2019). Log No: ACYF-CB-IM-19-04: Evaluation Plan Development Tip Sheet.
[78] Wilson, S. J., Price, C. S., Kerns, S. E. U., Dastrup, S. D., & Brown, S. R. (2019). Title IV-E Prevention Services Clearinghouse Handbook of Standards and Procedures, version 1.0, OPRE Report # 2019-56, Washington, DC: Office of Planning, Research, and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services.

Figure 22. Triple P (Standard) and Triple P (Group) Priority Evaluation Questions

Implementation/ Process	1. To what degree did the program reach the intended target population? 2. To what extent was the program delivered with fidelity? 3. To what extent did families who participated in the program complete the program? 4. For what reasons do parents discharge early from the program? 5. To what extent are participating families satisfied with the program?
Outcomes	6. Did children's behavior improve during their parents' participation in the program? 7. Did parents' competence and confidence in promoting healthy development and managing behavioral issues improve during their participation in the program? 8. Did parenting stress decrease during parents' participation in the program? 9. To what extent do parents who participate in the program experience a re-referral, substantiated maltreatment and/or removal within 6, 12, and 24 months post-enrollment in the program? 10. Is there a significant difference in parents' outcomes based on the dose of the program received by participants? 11. Are there differences in participant outcomes based on their demographic characteristics and risk factors?
Impact	12. To what extent did the program reduce child welfare involvement among participating families (treatment) at 6, 12 and 24 months post-randomization compared to similar families who did not participate in the program (control)?

Evaluation Design. Triple P (Group) and Triple P (Standard) will be evaluated separately but utilize the same evaluation design and procedures. Evaluation questions 1 through 11 will be evaluated using a prospective, quantitative, single-group design that includes all parents who receive Triple P (Standard) and Triple P (Group) statewide. After sustained fidelity of implementation has been established and changes in short-term outcomes among participating families are observed, question 12 will be addressed using a randomized controlled trial (RCT) design to understand the causal impact of Triple P (Standard) and Triple P (Group) on New Jersey parents. A RCT design, largely considered the "gold standard" for measuring program effectiveness, will allow DCF to compare the trajectories of families who receive Triple P (Standard) or Triple P (Group) to those who receive services as usual.

Study Population. The study sample for evaluation questions 1 -11 will include all parents who enroll in Triple P (Standard) and Triple P (Group) and who consent to participate in DCF's evaluation of the program. The program intends to enroll approximately 350 parents in each program statewide per year. Because the two programs provide the same content- just through different formats - parents who participate in Triple P (Standard) will be automatically excluded from participation in Triple P (Group), and vice versa. Based on previous experiences evaluating DCF programs, DCF expects that over 75% of program participants will also consent to participate in the evaluation. Eligibility criteria for both programs include: 1) parent/caregiver with a child between the ages of 0-12; 2) open CPS case at enrollment and; 3) willingness to participate in the program.

The study sample for evaluation question 12 will include program participants plus a control group of CP&P-involved parents. DCF will identify and randomize eligible parents based on administrative records and information gathered from CP&P case workers. After screening parents for eligibility, DCF program staff will send the list of eligible parents

and the number of treatment slots needed to the evaluation team who will perform the random assignment. The evaluation team will send back to the program team the list of eligible parents with their group assignment (treatment or control). DCF program staff will then refer the treatment group parents to a Triple P provider whereas parents in the control group will only receive services as usual.

Data Collection Methods & Procedures. To answer the evaluation questions, DCF will collect data through several different methods. First, DCF is exploring a new electronic data system through which providers will enter data related to participant demographics and risk factors, service utilization, baseline and outcome assessment and model fidelity. For parent self-report measures and satisfaction data, DCF will design a separate parent survey that can be sent directly to program participants to complete via email or text. Participants who do not have access to the internet can complete the assessment using a laptop or other electronic device provided by the Triple P provider agency. Data on child welfare outcomes (e.g., re-referrals to CP&P, removals, substantiated/established maltreatments), child welfare history, family demographics (e.g., parent age, family structure) and additional family risk factors (e.g., caregiver substance use, domestic violence, caregiver mental health challenge) will be drawn directly from NJ SPIRIT, New Jersey's SACWIS system. Figure 23 includes additional detail on each data collection mechanism, including intervals for data collection.

Figure 23. Evaluation Measures, Data Sources and Data Collection Intervals for Triple P (Standard) and Triple P (Group)

Domain of Interest	Measure	Data Source	Collection Interval and Sample
Participant Characteristics	- Participant demographics - Participant risk factors	Programmatic data from providers	- Baseline - Program participants
Service Use	- Dose of services received - Length of service participation - Discharge reasons	Programmatic data from providers	- Ongoing during service delivery - Program participants
Fidelity Measurement	- Session checklists	Programmatic data from providers	- Ongoing during service delivery - Program Participants
Caregiver Satisfaction	- Parent's satisfaction with service delivery - Ability of service to meet parent's needs - Areas for improvement in service delivery	Parent Survey	- Discharge - Program Participants
Short-Term Outcomes	- Use of positive parenting practices - Parenting stress - Parenting confidence - Child behavioral and emotional functioning	Programmatic data from providers Parent Survey	- Baseline and Discharge - Program Participants
Participant Characteristics and Child Welfare History	- Family risk factors - Child welfare history - Family demographics	NJ SPIRIT	- After treatment and comparison groups are established, determine if baseline equivalence was achieved through randomization - Treatment and control group participants
Long-term Outcomes and Impact	- Re-referrals to the child welfare system - Substantiated/established maltreatments - Removals	NJ SPIRIT	- For all program participants: 6, 12 and 24 months post-enrollment - For treatment and control group participants: 6, 12 and 24 months post-randomization

Analysis Plan. To answer the evaluation questions about Triple P (Standard) and Triple P (Group), the evaluation team will use statistical methods, including descriptive statistics (means, frequencies, proportions), bivariate analyses, and, if needed, multi-variate analyses. DCF will conduct analyses separately for parents who participate in Triple P (Standard) versus Triple P (Group).

For the impact analysis (i.e., Randomized Controlled Trial), we will conduct an intent-to-treat (ITT) analysis, meaning we will compare outcomes among all eligible individuals randomized to the treatment group (regardless of whether they actually engage with Triple P) to all eligible individuals randomized to the control group.

We will consider a p-value of .05 for statistical significance. Figure 24 outlines each evaluation question, the associated measures, and proposed analytical methods.

Figure 24. Evaluation Questions, Measures and Analytical Methods for Triple P (Standard) and Triple P (Group)

Evaluation Question	Measures	Analytical Methods
1.To what degree did the program reach the intended target population?	• Participant demographics Participant risk factors	Descriptive statistics (means, proportions, frequencies)
2.To what extent was the program delivered with fidelity?	• Session checklists	Descriptive statistics (proportions, frequencies)
3.To what extent did families who participate in the program complete the program?	• Dose of services received • Length of services	Descriptive statistics (means, proportions)
4.For what reasons do parents discharge early from the program?	• Discharge reasons	Descriptive statistics (proportions, frequencies)
5.To what extent are participating families satisfied with the program?	• Parent/caregiver's satisfaction with service delivery (quality, acceptability, accessibility) • Ability of service to meet parent/caregiver's needs • Areas for improvement in service delivery (open-ended)	Descriptive statistics (means, proportions, frequencies) Thematic analysis of qualitative areas for improvement
6. To what extent do parents who participate in the program experience a re-referral, substantiated maltreatment and/or removal within 6, 12 and 24 months post-enrollment in the program?	• Re-referral to the child welfare system • Substantiated/established maltreatment • Removal	Descriptive statistics (proportions, frequencies)
7. Did parents' competence and confidence in promoting healthy development and managing behavioral issues improve during their participation in the program?	• Use of positive parenting practices • Parent's parenting confidence	Paired samples t-tests (continuous measures) or McNemar's Test (categorical measures) comparing pre-post measures
8. Did parenting stress decrease during parents' participation in the program?	• Parent/caregiver stress	Paired samples t-tests (continuous measures) or McNemar's Test (categorical measures) comparing pre-post measures
9. Did children's behavior improve during their parents' participation in the program?	• Child behavioral and emotional functioning	Paired samples t-tests (continuous measures) or McNemar's Test (categorical measures) comparing pre-post measures
10. Is there a significant difference in outcomes based on dose received?	• Dose of services received • Length of services received • Parent/caregiver stress • Child behavioral and emotional functioning • Use of positive parenting practices • Parent/caregiver parenting confidence • Re-referral to the child welfare system • Substantiated/established maltreatment • Removal	*For pre/post parent survey measures:* Paired samples t-tests or McNemar's Test comparing the differences in differences between pre-post outcome measures by length of stay in the service and number of sessions received. Multivariate logistic or linear regression adjusting for demographic and risk factors, if needed. *For child welfare involvement outcomes:* Chi-square test comparing proportion of parents who experienced each outcome based on length of services received and number of sessions received. Multivariate logistic regression adjusting for demographic and risk factors, if needed.
11. Are there differences in participant outcomes based on participant demographics and risk factors?	• Parent/caregiver stress • Child behavioral and emotional functioning • Use of positive parenting practices • Parent/caregiver parenting confidence • Re-referral to the child welfare system • Substantiated/established maltreatment • Removal • Participant demographics • Participant risk factors • Participant child welfare history	*For pre/post Measures:* Paired samples t-tests or McNemar's Test comparing the differences in differences between the pre-post outcome measures by participant demographic and risk factors. Multivariate logistic or linear regression analyses, adjusting for risk and demographic factors, if needed. *For child welfare involvement outcomes:* Chi-square test comparing proportions of parents who experienced each outcome by participant demographic and risk factors. Multivariate logistic regression analyses adjusting for risk and demographic factors as needed.
12.To what extent did the program reduce child welfare involvement among participating families (treatment) at 6, 12 and 24 months post-randomization compared to similar families who did not participate in the program (control)?	• Re-referral to the child welfare system • Substantiated/established maltreatment • Removal	Chi-square test comparing proportion of parents who experienced each child welfare outcome by treatment versus control group. If baseline equivalence is not achieved through the randomization process, we will conduct multivariate logistic regression analyses accounting for potential confounders (i.e., those variables that show a difference between treatment and control at the p=.05 level).

Ethical Considerations. The evaluation of Triple P (Standard) and Triple P (Group) will require approval by DCF's Research Review Committee prior to initiation.[79] Only participants who consent to participate in the evaluation will be included in the prospective evaluation of participants in the program using primary data collection. DCF will ask for a waiver of consent for analysis of NJ SPIRIT administrative data for both the treatment and control groups.

Limitations. We believe that DCF has a strong plan in place for understanding implementation, outcomes, and impact of Triple P (Standard) and Triple P (Group). The evaluation's randomized controlled trial design and time horizon for evaluating child welfare outcomes may position Triple P (Standard) and Triple P (Group) to move from "promising" to "supported" practices on the Clearinghouse, assuming the expected impacts are observed. However, there are some limitations to this evaluation. First, families who receive Triple P (Standard) and Triple P (Group) in New Jersey may also receive other services based on their needs. Thus, it may be challenging to attribute outcomes observed through pre-post analyses among the treatment group to participation in Triple P (Standard) or Triple P (Group) alone. Assuming treatment and control group parents all have access to the same "services as usual", the randomized controlled trial design should account for this in the impact analysis. Second, the evaluation does not use a control group for evaluation of short-term outcomes and relies on child welfare system involvement metrics as the key outcomes to establish program impact.

[79] https://www.nj.gov/dcf/childdata/research/

DCF's monitoring, evaluation and CoQI processes bring together data from varied sources to provide a comprehensive picture of both program and provider-level performance. Examples of some of these data sources include:

Monitoring Scorecard. The Monitoring Scorecard is an annual report card produced through DCF's Office of Monitoring that provides an independent assessment of the performance of providers operating in the DCF service network, along with the quality of services being delivered. Providers' performance is measured against DCF's quality standards, as well as programmatic standards derived from contracts, the program manual and best practices in the field. For additional information on the Office of Monitoring or DCF's quality standards, please see Section 3, "DCF's Prevention Strategy."

New DCF Data System. DCF is exploring a new data system to serve as the primary information system for many providers implementing models included in this plan. This data system will enable DCF to collect information for participants in programs, support program eligibility determination and program enrollment, collect information on service planning and delivery and, as applicable, collect fidelity and outcome data.

NJ SPIRIT. NJ SPIRIT is DCF's CCWIS. It is a comprehensive, automated case management tool that integrates various aspects of case practice in a single statewide system. NJ SPIRIT has several built-in validation tools to support data quality and meets federal requirements for a CCWIS.

Model Developer Data Systems. Some model developers have a data system available that will be utilized in implementation, evaluation and CoQI processes. For example, Youth Villages, the model developer, incorporates use of the GuideTree system into implementation of its Intercept model. The GuideTree system collects case-level data on youth enrolled in the Intercept model along with Key Performance Indicators to monitor provider performance. Triple P (Standard) and Triple P (Group) utilizes the Automatic Scoring and Reporting Application, a web-based data system, for data collection, analysis, and reporting at the practitioner, agency, network, and statewide levels. The system aggregates client and programmatic data.

DCF commits to report to the Administration for Children and Families any information and data as ACF may require with respect to the Title IV-E prevention program described in this plan, including information and data necessary to determine performance measures. See Attachment C, State Title IV-E Prevention Program Reporting Assurance.

SECTION 6. CHILD AND FAMILY ELIGIBILITY FOR TITLE IV-E PREVENTION SERVICES PROGRAM

Pre-print Section 9, Section 3 and Section 4

Pursuant to the Family First Prevention Services Act, states may claim Title IV-E prevention services provided to candidates for foster care, children in foster care who are pregnant or parenting, and the caregivers of children in either of these categories. (Section 471(e)(2)). Pursuant to Section 475(13), a child who is a "candidate for foster care" is defined as

> a child who is identified in a prevention plan … as being at imminent risk of entering foster care …, but can remain safely in the child's home or in a kinship placement as long as [specified services] that are necessary to prevent the entry of the child into foster care are provided. The term includes a child whose adoption or guardianship arrangement is at risk of disruption or dissolution that would result in foster care placement.

The Family First Prevention Services Act allows each state to define "candidate for foster care." This section includes New Jersey's definition of prevention candidate, summarizes the data and evidence that support the prevention candidacy categories, and describes the processes for identifying prevention candidates and pregnant and parenting youth in foster care.

New Jersey Prevention Candidacy

In New Jersey, a child is a "candidate for foster care" if the child is determined to be at imminent risk of entering foster care and is able to be remain safely in the child's home with provision of evidence-based mental health, substance use disorder or in-home parenting skills prevention services. Based on information gathering during the information gathering process, DCF's administrative data and literature, DCF determined that "candidates for foster care" includes both children who are involved with the child protection system (hereinafter "CP&P involved prevention candidates") and children without child protection system involvement (hereinafter "community prevention candidates"). In New Jersey, a child is at "imminent risk" for the purposes of the State's Family First Prevention Services Act prevention program if they meet any of the criteria included in Figure 25.

Figure 25. New Jersey's Family First Prevention Services Act "Imminent Risk" Criteria

A. Children in families who have accepted services from CP&P, except those in out-of-home placement
B. Children or youth who have exited out-of-home placement
C. Children who are chronically absent from school or preschool
D. Children of incarcerated parents
E. Trafficked youth
F. Children in families experiencing homelessness or housing instability
G. Children in families experiencing interpersonal violence
H. Youth involved with law enforcement or who have been charged with civil or criminal offenses
I. Children whose caregivers have a substance use disorder or mental health condition, medical condition or disability which affects parenting capacity
J. Children who experience substance use disorders and/or moderate to severe mental health conditions
K. Substance-exposed infants, regardless of whether substance exposure has been identified as abuse or neglect
L. Children in families impacted by physical violence or inappropriate sexual activity or contact.

Support for New Jersey's Prevention Candidate Categories

DCF analyzed available data and literature for each prevention candidate category. Support for inclusion of each prevention candidate category follows:

Children in families with an open in-home CP&P case: From 2016 – 2021, the number of children served in-home at a given point in time ranged from approximately 29,000 to 41,000 with less than 29,000 at any given point in time in 2021.[80] DCF estimates that 29,000 youth are included in this target population.

Children or youth who have previously exited out-of-home placement: Research consistently demonstrates that one of the strongest predictors of out-of-home placement in foster care among youth is the experience of a previous out-of-home placement.[81,82] Since 2016, 8.6% - 10.2% of children have re-entered care after exiting to permanency within New Jersey. From 2016 – 2021, the number of children exiting out-of-home placement in New Jersey in a given year[83] DCF estimates that 2,500 youth are included in this target population per year.

[80] Rutgers Institute for Families & NJ Department of Children and Families. NJ Child Welfare Data Hub. Accessed from: https://njchilddata.rutgers.edu/
[81] Jedwab, M. & Shaw, T.V. Predictors of re-entry into the foster care system: comparison of children with and without previous removal experience. Children & Youth Services Review. 2017; 82.
[82] Wulcyzn, F., Parolini, A., Schmits, F., Magruder, J. & Webster, D. Returning to Foster Care: Age and Other Risk Factors. Children and Youth Services Review. 2020; 116.
[83] Rutgers Institute for Families & NJ Department of Children and Families. NJ Child Welfare Data Hub. Accessed from: https://njchilddata.rutgers.edu/

Children whose caregivers have a substance use disorder, mental health condition or disability: Children who live with a parent who has a substance use disorder or mental health disorder are at heightened risk for child maltreatment and placement in foster care compared to other children.[84, 85] A 2017 study found that over a third of infants born to mothers with mental health disorders were reported to Child Protective Services within one year compared to only 4.4% of infants born to mothers with no documented mental health disorder. Among infants born to mothers with co-occurring mental health and substance use disorders, the rate of Child Protective Services reports during infancy was 5.69 times that of infants born to mothers without a mental health disorder. [86] DCF data indicate that over a third of caregivers served in-home and out-of-home are experiencing a current substance use issue; 34% of families served out-of-home and 21% served in home have a documented mental health issue.[87]

Research suggests that 12.3% of children live in households with at least one parent who has a substance use disorder and that 17-25% of children live in a household in which a parent has a mental health disorder. To account for cooccurrence[88], we estimate that approximately 420,800 (21%) of New Jersey children live in a household with a caregiver who has a mental health and/or substance use disorder.

Studies have found that parents with intellectual disabilities are disproportionately represented in the child welfare system. [89, 90] A 2011 study found that 27% of child maltreatment cases involved at least one parent with an intellectual disability.[91] In a 2021 study, the proportion was even higher: 21.7% of children born to a mother with an intellectual or developmental disability were the subject of a Child Protective Services report within one year and 35.8% within four years.[92] Research suggests that 4.5 per 10,000 live births are to mothers with I/DD.[93] DCF estimates that approximately 910 children and youth are in this candidacy population.

---

[84] Lipari, R.N. and Van Horn, S.L. (August 24, 2017). Children living with parents who have a substance use disorder. The CBHSQ Report. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD.

[85] Mullick, M., Miller, L.J. & Jacobsen, T. (2001). Insight into mental illness and child maltreatment risk among mothers with major psychiatric disorders. Psychiatry. Serv., 52, 488–492.

[86] Hammond, I., Eastman, A.L., Leventhal, J.M. & Putnam-Hornstein, E. (2017). Maternal Mental Health Disorders and Reports to Child Protective Services: A Birth Cohort Study. International Journal of Environmental Research and Public Health 14 (11), 1320.

[87] Point-in-time estimate from 3/30/20. Includes cases in which caregiver mental health issue or caregiver substance use issue was noted in the past 12 months.

[88] Children's Bureau. (2021). Parental Substance Use: A Primer for Child Welfare Professionals. Accessed from: https://www.childwelfare.gov/pubPDFs/parentalsubuse.pdf

[89] T. Booth, W. Booth, & D. McConnell. (2005). The prevalence and outcomes of care proceedings involving parents with learning difficulties in the family courts. Journal of Applied Research in Intellectual Disabilities, 18, pp. 7-17.

[90] D. McConnell, M. Feldman, M. Aunos, N. Prasad. (2011). Parental cognitive impairment and child maltreatment in Canada. Child Abuse and Neglect, 35 (8) (2011), pp. 621-632.

[91] D. McConnell, M. Feldman, M. Aunos, N. Prasad. (2011). Parental cognitive impairment and child maltreatment in Canada. Child Abuse and Neglect, 35 (8) (2011), pp. 621-632.

[92] Rebbe, R., Brown, S., Matter, R. & Mienko, J. (2021). Prevalence of Births and Interactions with Child Protective Services of Children Born to Mothers Diagnosed with an Intellectual and/or Developmental Disability. Maternal Child Health Journal 25(4): 626-634.

[93] Rebbe, R., Brown, S., Matter, R. & Mienko, J. (2021). Prevalence of Births and Interactions with Child Protective Services of Children Born to Mothers Diagnosed with an Intellectual and/or Developmental Disability. Maternal Child Health Journal 25(4): 626-634.

Children in families experiencing homelessness and housing instability: Parents and children who are homeless and unstably housed are at high risk for domestic violence, food insecurity, mental illness, substance abuse, and chronic physical illness.[94,95] Additionally, children who experience housing instability are more likely to be separated from family and experience out-of-home placements in foster care.[96] As part of a constellation of risk factors, housing instability may also heighten children's risk for maltreatment.[97] DCF data indicates that 7% of families served in-home and 17% of families served out-of-home are experiencing a current housing issue.[98] The 2022 New Jersey point-in-time count conducted by the New Jersey Housing and Mortgage Finance Agency identified 1,799 children under the age of 18 experiencing homelessness in New Jersey which included households in emergency shelters, transitional housing and unsheltered.[99] However, research suggests the count inclusive of youth with unstable housing is likely much higher with 6-10% of children experiencing homelessness or housing instability at any given time.[100] DCF estimates approximately 121,400 to 202,310 youth are in this candidacy population.

Children who are chronically absent from school or preschool: Chronic absenteeism, defined as missing 10% or more of total enrolled school days occurs in about 16% of children in kindergarten through twelfth grade in the United States.[101] During the 2020-21 school year, 13.1% of students in New Jersey (preschool through twelfth grade) were chronically absent. Of this over 170,000 students, over half were economically disadvantaged, and a quarter were enrolled in special education.[102] High rates of chronic absenteeism early on reduce the chance of reading proficiently by third grade, a key indicator for long term academic success. As children get older, chronic absenteeism increases risk of not graduating high school, not attending college and not achieving high rates of career success.[103] Greater, unexplained and problematic absences have been shown to be 4.1 times higher in children with substantiated maltreatment cases, as compared to children with no Child Protective Services involvement. Children with substantiated maltreatment

[94]Buckner, J.C. (2008). Understanding the Impact of Homelessness on Children: Challenges and Future Research Directions. American Behavioral Scientist 51 (6): 721-736.

[95] Grant, R., Gracy, D., Goldsmith, G., Shapiro, A. & I.E. Redlener. (2013). Twenty-five Years of Child and Family Homelessness: Where Are We Now? American Journal of Public Health 103 (Supl2): e1-e10.

[96] Cowal, K., Shinn, M. Weitzman, B.C., Stojanovic, D. and L. Labay. (2002). Mother-Child Separations among Homeless and Housed Families Receiving Public Assistance in New York City. American Journal of Community Psychology 30 (5): 711-30.

[97] Freisthler, B., Merritt, D.H., & LaScala, E.A. Understanding the Ecology of Child Maltreatment: A Review of the Literature and Directions for Future Research. Child Maltreatment 11(3): 263-80.

[98] Point-in-time estimate from 3/30/20. Includes cases in which housing instability was noted in the past 12 months.

[99] Monarch Housing Associates. (2022). NJ Counts: Point-in-Time Count of the Homeless. Accessed from: https://www.nj211.org/sites/default/files/documents/2022-10/New-Jersey-PIT-2022-Report-compressed.pdf

[100]Morton, M. H., Dworsky, A., & Samuels, G. M. (2017). Missed Opportunities: Youth Homelessness in America. National Estimates. Chapin Hall at the University of Chicago.

[101] US Department of Education. (2019). Chronic Absenteeism in the nation's schools: A hidden educational crisis. Chronic Absenteeism in the Nation's Schools (ed.gov).

[102]New Jersey Department of Education (April 2022) Absenteeism. NJ School Performance Report. Accessed from: https://rc.doe.state.nj.us/2020-2021/state/detail/climate?lang=EN.[102]

[103]Chen, P., & Rice, C. (2017). Showing Up Matters: The State of Chronic Absenteeism in New Jersey, 3rd Annual Report. Advocates for Children of New Jersey.

cases are also significantly more likely to display "chronic truancy".[104] DCF estimates that 178,280 children are included in this candidacy population.

Children in families experiencing interpersonal violence: Studies have found that in the United States, an estimated 1 in 15 children are exposed to intimate partner violence each year with 26% exposed before they reach the age of 18.[105] Studies show a strong correlation between interpersonal violence and child abuse, with approximately half of these situations involving direct child abuse.[106] A review of Child Protective Services cases from two states found that, in cases that resulted in the critical injury or death of a child, 41-43% involved interpersonal violence.[107] Among DCF cases, 17% of in-home cases and 13% of out-of-home cases have documented interpersonal violence in the past twelve months, likely a vast underestimate.[108]

In 2016, there were 63,420 interpersonal violence offenses reported by the police in New Jersey with children involved and/or present during 28% (17,758) of these offenses. Accounting for known under-reporting, DCF estimates roughly 120,000 children are included in this candidacy population.

Children of incarcerated parents: Research suggests that about 40% of children who have been involved in the foster care system have also experienced parental incarceration at some point in their lifetime.[109] Ecological studies have shown that states with higher incarceration rates also tend to have higher foster care caseloads.[110] DCF estimates that 60,000 children are included in this candidacy population.

Children in families impacted by physical violence or inappropriate sexual activity or contact: Results from the National Crime Victimization Survey indicate that .44% of Americans (1 in 230) were victims of violent crime, including rape/sexual assault, robbery and aggravated assault, in 2019.[111] DCF estimates there are approximately 26,700 children in this candidacy population per year.

Children who have substance use disorders and/or a moderate to severe mental health condition: Substance use disorders are among the most frequently documented mental health issues among youth in out-of-home placement with prevalence rates two to five times higher than in youth with no foster care history.[112] Research suggests that 4.1% of youth aged 12-17 nationally have a substance use disorder[113] and DCF data indicate that 4% of

---

[104]Armfield, J. M., Gnanamanickam, E., Nguyen, H. T., Doidge, J. C., Brown, D. S., Preen, D. B., & Segal, L. (2020). School absenteeism associated with child protection system involvement, maltreatment type, and time in out-of-home care. Child maltreatment, 25(4), 433-445.

[105] Hamby, S., Finkelhor, D., Turner, H., & Ormrod, R. (2016). Children's Exposure to Intimate Partner Violence and Other Family Violence (2011).

[106] Lloyd M. Domestic Violence and Education: Examining the Impact of Domestic Violence on Young Children, Children, and Young People and the Potential Role of Schools. Front Psychol. 2018 Nov 13;9:2094. doi: 10.3389/fpsyg.2018.02094. PMID: 30483170; PMCID: PMC6243007.

[107]Spears, L. (2000). Building bridges between domestic violence organizations and child protective services. Child Welfare, 800, 537-2238.

[108] Point-in-time estimate from 3/30/20. Includes cases in which domestic violence was noted in the past 12 months.

[109] Turney, K., & Wildeman, C. (2017). Adverse childhood experiences among children placed in and adopted from foster care: Evidence from a nationally representative survey. Child Abuse & Neglect, 64, 117-129.

[110]Edwards, F. (2016). Saving children, controlling families: Punishment, redistribution, and child protection. American Sociological Review, 81(3), 575-595.

[111] US Department of Justice. (2020). Criminal Victimization, 2019. Accessed from: https://bjs.ojp.gov/content/pub/pdf/cv19.pdf

[112] Keller TE, Salazar AM, & Courtney ME. (2010). Prevalence and timing of diagnosable mental health, alcohol, and substance use problems among older adolescents in the child welfare system. Children and Youth Services Review 32:626–634.

[113] CDC. (2022). Data and Statistics on Children's Mental Health. Accessed from: https://www.cdc.gov/childrensmentalhealth/data.html

youth in out-of-home placement have a documented substance use issue[114], likely a vast underestimate. DCF estimates approximately 24,000 youth in this candidacy population.

Mental health disorders are common among children involved in the child welfare system with estimates suggesting that nearly half of youth involved with the system have a mental health disorder.[115] CDC analyses found that 37% of high school youth experienced poor mental health during the pandemic.[116] In New Jersey, data indicate that approximately 13% or 86,000 youth suffered from a major depressive episode in the past twelve months.[117] Fifty-nine percent of these youth (est. 42,000) did not receive any treatment. [118] DCF estimates that approximately 86,000 - 246,000 New Jersey youth are in this candidacy population.

Infants born substance-exposed: Prenatal substance exposure can lead to neurobehavioral impairments, including poor attention, reduced impulse control and poor behavior regulation among children, and research suggests this population of children is at risk for worse child welfare outcomes.[119] However, interventions exist that can reduce the harmful impacts of prenatal exposures on children and help caregivers effectively parent children.[120] In federal fiscal year 2020, 2,005 substance exposed newborns were reported to DCF.[121]

Youth involved with law enforcement or who have been charged with civil or criminal offenses: A 2021 study found that about two-thirds of youth in the juvenile justice system had been referred to Child Protective Services for maltreatment at least once in their lifetime.[122] Youth in foster care and the juvenile justice system are often impacted by similar risk factors, including trauma, substance use, mental health challenges and child maltreatment history.[123] As of March 2022, there were 277 youth currently involved with New Jersey's Juvenile Justice System.[124] Additionally, in 2020, approximately 373 New Jersey youth aged 10-17 were arrested for aggravated assault, 363 for robbery, 1,059 for larceny

---

[114] Point-in-time estimate from 3/30/20. Includes cases in which child substance use issue was noted in the past 12 months.
[115] Burns, B., Phillips, S., Wagner, R. et al. (2004). Mental Health Need and Access to Mental Health Services by Youths Involved with Child Welfare: A National Survey. J Am Acad Child Adolesc Psychiatry 43(8):960-70.
[116] CDC. (2022). https://www.cdc.gov/media/releases/2022/p0331-youth-mental-health-covid-19.html
[117] Mental Health America. (2022). Youth Data 2022. Accessed from: https://mhanational.org/issues/2022/mental-health-america-youth-data#two
[118] Mental Health America. (2022). Youth Data 2022. Accessed from: https://mhanational.org/issues/2022/mental-health-america-youth-data#two
[119] Richards, T., Bertrand, J., Newburg-Rinn, S., McCann, H., Morehouse, E. & Ingoldsby, E. (2020). Children prenatally exposed to alcohol and other drugs: what the literature tells us about child welfare information sources, policies and practices to identify and care for children. J Public Child Welf. 2020 October 23; 1(24). doi:10.1080/15548732.2020.1814478.
[120] Richards, T., Bertrand, J., Newburg-Rinn, S., McCann, H., Morehouse, E. & Ingoldsby, E. (2020). Children prenatally exposed to alcohol and other drugs: what the literature tells us about child welfare information sources, policies and practices to identify and care for children. J Public Child Welf. 2020 October 23; 1(24). doi:10.1080/15548732.2020.1814478.
[121] Administration for Children and Families (2020). Child Maltreatment 2020. Accessed from: https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2020.pdf
[122] Herz, D.C., Eastman, A.L., Putnam–Hornstein & J. McCroskey. (2021). Dual System Youth and their Pathways in Los Angeles County: A Replication of the OJJDP Dual System Youth Study. Child Abuse & Neglect Aug;118:105160. doi: 10.1016/j.chiabu.2021.105160.
[123] Youth.Gov. (2022). Juvenile Justice: Connections with Youth in the Child Welfare System. Accessed from: https://youth.gov/youth-topics/juvenile-justice/connections-youth-child-welfare-system#_ftn
[124] NJ Office of the Attorney General. (2022). Juvenile Demographics and Statistics. https://www.nj.gov/oag/jjc/stats/2022-0520-Juvenile-Demographics-and-Stats.pdf

theft, 2,007 for drug abuse and 464 for possession of weapons.[125] Accounting for overlap in arrests, DCF estimates that approximately 4,000 youth are in this candidacy population.

Trafficked Youth: Research suggests that children in out-of-home care are at high risk for experiencing human trafficking with studies showing that 50-90% of children who were victims of child sex trafficking had been involved at some point with child welfare services.[126] In 2021, there were 89 unique Child Protective Services reports and Child Welfare Services referrals with a human trafficking concern or allegation noted.

Figure 26. Estimated numbers of children in DCF's candidacy categories.

Candidacy Category	Statewide Estimate[127]	Unit
Children in families who have open in-home cases with CP&P	29,000	Children with open "in-home" CP&P cases point-in-time
Children who have previously exited out-of-home placement	2,500	New exits annually
Children whose caregivers have a substance use disorder, mental health condition or disability that negatively impacts parenting	421,710	Children point-in-time
Children in families experiencing homelessness and housing instability	121,400 - 202,310	Children point-in-time
Children chronically absent from school	178,280	Children annually
Children in families experiencing interpersonal violence	120,000	Children point-in-time
Children of incarcerated parents	60,000	Children point-in-time
Children in families impacted by physical violence or inappropriate sexual activity or contact.	26,700	Children point-in-time
Children who have substance use disorders	24,000	Children point-in-time
Children with moderate to severe mental health conditions	86,000 – 246,000	Children point-in-time
Infants born substance-exposed	2,005	Infants reported annually
Youth involved in the Juvenile Justice System	4,000	Youth point-in-time
Youth survivors of human trafficking	89	CPS referrals and CWS reports with human trafficking noted annually

Identifying Prevention Candidates and Pregnant and Parenting Youth in Foster Care and Developing Prevention Plans

The Family First Prevention Services Act requires that Title IV-E prevention services be specified in advance of service provision in an individualized prevention plan for that child. (Section 471(e)(4)). For prevention candidates, the child's prevention plan must identify the

[125] Office of Justice Programs. (2020). Law Enforcement & Juvenile Crime: Statistical Briefing Book. Accessed from: https://www.ojjdp.gov/ojstatbb/crime/qa05103.asp?qaDate=2020

[126] Children's Bureau. (2017). Human Trafficking and Child Welfare: A Guide for Child Welfare Agencies. Accessed from: https://www.childwelfare.gov/pubPDFs/trafficking_agencies.pdf

[127] Estimates are not mutually exclusive.

foster care prevention strategy for the child so that the child may remain safely at home, live temporarily with a kin caregiver until reunification can be safely achieved, or live permanently with a kin caregiver; and list the prevention services to be provided to or on behalf of the child to ensure the success of the prevention strategy. (Section 471(e)(4)(A)(i)). For pregnant and parenting foster youth, the youth's prevention plan must be included in the youth's foster care case plan, list the services to be provided to or on behalf of the youth to ensure that the youth is prepared (in the case of a pregnant foster youth) or able (in the case of a parenting foster youth) to be a parent; and describe the foster care prevention strategy for any child born to the youth. (Section 471(e)(4)(A)(ii)).

For CP&P involved prevention candidates and pregnant/parenting youth: CP&P caseworkers are required to develop an initial case plan with a CP&P family within 60 days of receipt of the underlying report of abuse or neglect or a need for services.[128] The CP&P case plan is a collaborative effort between the family, CP&P, and, at times, provider agencies and/or other supports designed to address and mitigate the underlying issues and needs of the family, particularly those of the children and youth who are the focus of the plan. The case plan outlines the responsibilities of both CP&P and the family in addressing these concerns while working towards the achievement of outcomes.[129] All CP&P case plans are documented and stored in NJ Spirit, DCF's CCWIS.

CP&P case planning is an ongoing process designed to empower the family and their support network by focusing on their strengths and building solutions.[130] A key aspect of this process is the development of consensus for change with the family. This involves working with the family to identify and agree upon what needs to be addressed to reduce risk and ensure safety. A well-crafted case plan is holistic, comprehensive, and tailored to the specific strengths and needs of the family. Family involvement in the case planning process increases the rate of successful goal achievement and results in reduction of risk of future maltreatment. Research suggests that families are more motivated to commit to the case plan when they agree with the concerns that need to be addressed and resolved and the goals of the case plan.

Upon the determination that a family will have an open case with CP&P, eligibility for Title IV-E prevention services is established as all families that have accepted CP&P services, except those in out-of-home placement, are included in DCF's candidacy population. Individualized prevention plans for each CP&P-involved prevention candidates or pregnant/parenting youth, inclusive of each of the elements required by the Family First Prevention Services Act, will be included in the family's CP&P case plan. As such, during the case planning process, the family's assigned CP&P caseworker will identify the appropriate

[128] CPP-III-B-1-100.pdf (nj.gov)
[129] CPP-III-B-1-100.pdf (nj.gov)
[130] Antle, B. F., Christensen, D. N., van Zyl, M. A., & Barbee, A. (2012). The impact of Solution Based Casework (SBC) practice model on federal outcomes in public child welfare. Child Abuse & Neglect, 36(4), 342–353. doi: 10.1016/j.chiabu.2011.10.009

candidacy category or categories, describe the prevention strategy, and identify the Title IV-E prevention services needed to mitigate identified risks and prevent removal. Staff from DCF's Title IV-E eligibility review unit will review this information to determine each child's eligibility.

CP&P will update the family's case plan, including the elements required by the Family First Prevention Services Act, every six months after the initial case plan until the time of case closure.[131] These periodic and consistent updates include a reexamination of the individualized prevention plan for each CP&P-involved prevention candidate or pregnant/parenting youth, irrespective of risk level. In other words, CP&P caseworkers will review and update the family's case plan, and more specifically the prevention plan of all CP&P prevention candidates, including candidates for which the risk of entering placement remains high despite CP&P's provision of prevention services, minimally every six months. Staff from DCF's Title IV-E eligibility review unit will undertake eligibility re-assessments as needed based on the circumstances of the case and, minimally, every 12 months, in accordance with legislation. Families that continue with Title IV-E prevention services past CP&P case closure will engage with provider agency staff for ongoing assessment of needs and case planning through the processes described below.

For community prevention candidates: Utilizing a trauma-informed, strength-based perspective and relying on families as experts, staff at provider agencies will conduct an assessment of a provider agency-involved family's risks, strengths and needs to inform case and goal planning and service matching. Families will lead the development of the service plan with guidance from the provider agency. DCF will work with provider agencies to build their capacity to use assessments as a resource in engaging families and co-creating individualized prevention plans that reflect families' perspective of their needs and measures of success.

Provider agency staff and the family will complete the service plan at the time of the family's enrollment into the service. Provider agency staff will document the assessment, goals and services in a service plan. Provider agencies will enter service plans for families receiving Title IV-E prevention services into a DCF data system.

Individualized prevention plans for each community prevention candidate, inclusive of each of the elements required by the Family First Prevention Services Act, will be included in service plans created by the provider agency. As such, during the service planning process, provider agency staff will identify the appropriate candidacy category or categories, describe the prevention strategy, and identify the Title IV-E prevention services needed to mitigate identified risks and prevent removal. As required by the Family First Prevention Services Act, DCF will be responsible for determination of each potential community prevention candidate's candidacy and, therefore, eligibility for Title IV-E

[131] Case planning may occur at any time during the life of the case when changes in circumstance impact case goals, family dynamics, etc. that warrant a change or new plan.

prevention services based on the information inputted into the DCF data system by provider agency staff. Staff from DCF's Title IV-E eligibility review unit will review the family's service plan, including each child's individualized prevention plan information, to determine each child's eligibility. The date that that review is complete will be the date that candidacy is established. Results of DCF's eligibility determination and the date of determination will be made available to the provider agency.

Provider agency staff will maintain frequent and regular contact with the families to support service provision, assess progress made and/or support needed adjustments to services. The family's service plan, including all individualized prevention plans, will be revisited every six months, or any time a new safety or risk factor is identified, or any time services are not having the intended result as reported by the service provider or family, or at conclusion of the service. In other words, provider staff will review and update the family's service plan, and more specifically the prevention plan of all community prevention candidates, including candidates whose risk of entering placement remains high despite engagement in prevention services, minimally every six months.

RESPONSIBILITIES OF DCF'S PROVIDER AGENCY NETWORK

DCF's network of provider agencies will provide services to families with and without involvement in the child protection system. Via ongoing partnership, as well as procurement and contracting processes, DCF will ensure that provider agencies approach the work using a trauma-informed, strength-based perspective that centers families as experts. When the family is not CP&P involved, provider agency staff will be expected to conduct assessment on all families referred for Title IV-E prevention services, including: (1) an evaluation of safety, 2) an assessment of risks, strengths, and needs to inform case planning and service matching, and 3) goal and service planning. DCF will partner with provider agencies to ensure access to a suite of options for periodic safety and risk assessment and individualized case planning that meets the requirements of the Family First Prevention Services Act and supports the provider efforts to improve family engagement.

SECTION 7. MONITORING SAFETY OF CHILDREN WHO RECEIVE TITLE IV-E PREVENTION SERVICES

Pre-print Section 3

The Family First Prevention Services Act requires that states monitor and oversee the safety of children who receive Title IV-E prevention services through (1) periodic risk assessments throughout the period in which prevention services are provided and (2) reexamination of the prevention plan for the child if risk remains high despite the provision of the services or programs. (Section 471(e)(5)(B)(ii)).

This section describes processes for periodic safety and risk assessments for CP&P involved prevention candidates and community prevention candidates. Information regarding the processes for reexamination of individualized prevention plans is included in Section 6, "Child and Family Eligibility for Title IV-E Prevention Services Program."

For CP&P involved prevention candidates: CP&P caseworkers are responsible for formally and informally assessing the safety and risk of all children involved with the agency, beginning immediately after the agency's initial contact with the family. Formal assessment requires use of validated Structured Decision Making®(SDM) tools and processes in alignment with DCF's case practice model. SDM tools are evidence and research-based tools that identify the key points in the life of a child welfare case and use structured assessments to improve the consistency and validity of each decision, promoting objective decision making informed by actuarial models. Decisions made by caseworkers during an investigation are related to child safety, including whether there is imminent risk of abuse or neglect, whether there is credible evidence that maltreatment has occurred, whether safety interventions are needed to protect children from harm, whether a child may remain safely in the care of the current caregivers, and whether the family's needs indicate that they would benefit from ongoing services.

CP&P caseworkers will use several SDM tools to make decisions related to Title IV-E prevention services candidates, including the Safety Assessment, the Risk Assessment, and the Risk Reassessment. Expectations and guidance related to caseworker use of each assessment are detailed in DCF policy and summarized below.[132]

- **Safety Assessment.** The Safety Assessment assists staff in determining whether any child is likely to be in immediate or imminent danger of serious harm that requires immediate safety intervention, as well as what specific safety intervention needs to be implemented or maintained to provide appropriate protection. Safety assessment results include safe, safe with a safety protection plan or unsafe such that removal is necessary. Safety assessments are required in all cases where an

[132] CP&P-III-B-6-600

investigation into abuse or neglect is warranted. They take place throughout the life of a case, beginning with the first face-to-face contact following a report of abuse or neglect. At a minimum, child safety must be formally reassessed every three months. Additional formal safety assessment is required if new information presents that changes the threats to safety or safety decisions, as well as before closing a case.

- **Family Risk Assessment.** The family risk assessment assists staff in assessing the likelihood that a family will become reinvolved in child protection services in the next 18 to 24 months. Family risk assessments are based on the conditions that exist at the time of assessment, as well as the prior history of the family. This assessment includes a neglect assessment index and an abuse assessment index. Determinations as to level of risk include low, moderate, high or very high. Only one household is assessed per risk assessment tool. If an incident or case involves two households, separate tools must be completed for each household. Risk assessments are completed for all families for which a child abuse or neglect investigation has been initiated and for non-custodial parents who are being provided reunification services. Risk is assessed throughout the life of the case and, at a minimum, every three months using the family risk reassessment, described below.

- **Family Risk Reassessment.** The family risk reassessment helps staff to evaluate the caregivers' progress toward attaining case goals. Family risk reassessments are based on information gathered for the initial risk assessment and the family's current progress. These assessments are completed for all families with ongoing services whose children remain in the home. Family risk reassessments are completed, at a minimum, every three months. Additionally, they are completed whenever circumstances in a case change such that reassessment is warranted (e.g., change in family dynamic or structure, new allegation of abuse or neglect, etc.) and no more than 30 days prior to case closure.

It is DCF's expectation that caseworkers also informally assess safety at every contact with a family. Policy requires CP&P caseworkers to make regular in-home, in-person, face-to-face visits with each child, youth/young adult, and his or her parent/caregiver for families in open case status. These contacts, commonly known as Minimum Visitation Requirements (MVR), are aimed at assuring that children and families receive the maximum benefit of CP&P support.[133] Amongst other goals related to the family's case plan, caseworkers use MVRs to assess whether each child is receiving appropriate care and is safe from harm. MVRs occur as frequently as feasible and necessary to implement all elements of the case plan and to achieve permanency. The schedule can range from once every week to monthly. When the child is living in his or her own home, the MVR schedule is determined by the Family Risk Assessment, described above. Caseworkers and supervisors are required to review MVR schedules at least once every six months.[134]

As another part of the informal assessment process, CP&P collects collaterals from system partners who provide a service to or are involved in the life of the child, youth/young adult,

[133] CPP-III-C-3-100 (1).pdf
[134] CPP-III-C-3-100 (1).pdf

or parent/caregiver.[135] These collaterals support caseworkers in ensuring each child's safety and overall well-being. CP&P might seek collaterals from teachers and school administrators, physicians, therapists, mentors, substance use counselors and more. Collateral information is collected throughout the life of the case and provides valuable insight into critical aspects of the family's life.

CP&P caseworkers are required to conference with various levels of supervisory staff throughout a family's involvement with the Division. Safety and risk are regular topics during supervisory conferences. Supervisory discussion and review of safety and risk determinations is embedded in various other policies. For example, when a family's risk level is elevated to high or very high, it is necessary to conference with higher levels of supervision, e.g., Casework Supervisors.[136] Additionally, caseworkers are required to consult with their supervisor before leaving a home during an initial face-to-face contact if he or she identifies one or more threats to safety.[137]

Caseworkers' assessments of safety and risk are considerations during case planning. As is described in Section 6, "Child and Family Eligibility for Title IV-E Prevention Services Program," caseworkers are required to develop an initial case plan with the family within 60 days of receipt of the underlying report of abuse or neglect or a need for services and to update the family's case plan every six months after the initial case plan until the time of case closure.[138, 139] As children's individualized prevention plans are included in families' case plans, CP&P caseworkers will, therefore, review and update the prevention plans of all CP&P-involved prevention candidates, including children that remain at high risk of entering foster care despite the provision of prevention services, minimally every six months. If goals and outcomes are not being achieved and there is no progress on identified risk areas, CP&P staff and the family will re-assess the appropriateness of services and consider new support resources and linkage to services.

For community prevention candidates: For the community pathways population, provider agencies will, likewise, assess safety of children via formal and informal assessments. Provider agency casework staff will use validated tools to complete an initial and ongoing safety and risk assessments to best identify whether there is immediate or imminent danger to the child or youth. DCF will work with provider partners to determine the most appropriate instruments for safety and risk assessment for each service; selected tools will meet the requirements of the Family First Act and incorporate assessment characteristics in alignment with the Solution-Based Casework model. The frequency of assessments will be informed by the specific tool being administered, changes in family circumstances and other factors that influence case planning. Additionally, as a part of service delivery, provider agency staff will have regular contact with the family and will be expected to informally assess safety and risk during every interaction. During the service delivery process, should risks emerge, provider agencies will develop safety plans as needed and maintain ongoing

[135] CPP-II-C-5-1000, CP&P-II-C-5-175, CP&P-X-A-1-5.51, CP&P-X-A-1-5.50
[136] CPP-III-C-5-200
[137] CPP-III-B-6-600 (1).pdf
[138] CPP-III-B-1-100.pdf (nj.gov)
[139] Case planning may occur at any time during the life of the case when changes in circumstance impact case goals, family dynamics, etc. that warrant a change or new plan.

communication to ensure families receive the supports necessary to keep children safely at home.

Provider agency staff's assessments of safety and risk are considerations during service planning. As is described in Section 6, "Child and Family Eligibility for Title IV-E Prevention Services Program," provider agency staff will revisit the family's service plan, including all individualized prevention plans, every six months, or any time a new safety or risk factor is identified, or any time services are not having the intended result as reported by the service provider or family, or at conclusion of the service. If service outcomes are not being achieved and there is no progress on identified risk areas (as reported by the service provider or the family), the provider agency will re-assess the appropriateness of services and consider new support resources and linkage to services in close collaboration with the family. If a safety concern is noted, the provider agency will connect with DCF's State Central Registry (SCR) hotline for further evaluation.

Caseload Management

Pre-print Section 7

A critical component in monitoring and ensuring children are safe and free from risk of maltreatment is to ensure management workloads for those charged with these critical assessments. Codified in New Jersey statute and DCF policy, DCF requires strict maintenance of caseload standards for CP&P caseworkers.[140]

- Intake Unit. Caseworkers in intake units may be assigned no more than 8 new investigations per month. Total primary assignments may not exceed 12 families. Two secondary assignments may be added to increase maximum assign to 14 families.
- Permanency Unit. Caseworkers in permanency units may be assigned no more than 15 families inclusive of ten children in placement.
- Adoption Unit Caseworkers. Caseworkers in adoption units may be assigned no more than 15 children.

DCF will collaborate with Title IV-E prevention service provider agencies to determine requirements related to caseload size, type and range to ensure that all interventions are delivered as intended to youth and families. The following components will be considered to support decision-making about caseload specifications: staffing requirements as dictated by specific evidence-based models, staff competence and readiness (specifically for new field staff), complexity of needs identified among families being served, the overall landscape of staff resources, and additional staff activities. Provider agencies will be tasked to ensure appropriate caseloads are maintained both at the individual and agency level. New provider agencies will be tasked with describing caseload management strategies in Requests for Proposals. DCF will periodically review provider caseload data and use caseload data to support the Collaborative Quality Improvement process.

[140] P.L. 2022, 130; CP&P-III-C-5-400

SECTION 8. CHILD WELFARE WORKFORCE SUPPORT AND TRAINING

Pre-print Section 5 and Section 6

The Family First Prevention Services Act requires states to outline how they are supporting and enhancing a competent, skilled and professional child welfare workforce to deliver trauma-informed and evidence-based services, including ensuring that staff is qualified to provide services that are consistent with the evidence-based models selected and developing appropriate prevention plans. (Section 471(e)(5)(B)(vii)). In addition, States must provide training and support for staff to assess what children and their families need, connecting the families served, knowing how to access and deliver the trauma-informed and evidence-based services and overseeing and evaluating the continuing appropriateness of services. (Section 471(e)(5)(B)(viii)).

In this section, DCF describes its efforts to support, enhance and train staff working with families of CP&P involved prevention candidates and community prevention candidates. For additional information related to staff training, see DCF's 2024 APSR and Training Plan.[141]

Curricula and Course Content

Case Practice Model and Solution Based Casework™. DCF's enhanced Case Practice Model (CPM) emphasizes the foundational elements of the Family First Prevention Services Act, the critical importance of prevention, the need for effective and collaborative case planning and continuous and thorough assessment. All case-carrying CP&P staff are expected to rely on the tenets of DCF's enhanced CPM during all interactions with children and families. Staff training on the enhanced CPM, as well as associated practical observations and field practicum experience, begin during pre-service training and continue through foundational and on-going trainings described below.

SOLUTION BASED CASEWORK™ (SBC)

The SBC model is based on three tenants:

- developing a partnership with families that is collaborative rather than adversarial;
- defining problems based on difficult situations in the family's everyday life so that caseworkers can be as practical and useful to the family as possible; and
- focusing interventions on noticing and celebrating skills and routines that individuals and families use (behavioral change) to increase safety and reduce risk, rather than prior focus on service completion and compliance.

Case practice is organized into four milestones:

- building consensus with the family around their family and individual needs;
- developing outcomes
- action planning, and
- noticing and celebrating change.

[141] https://www.nj.gov/dcf/childdata/njfederal/

DCF's original CPM provides a standardized, strength-based, and family-centered framework to guide how CP&P staff work with children, youth/young adults, and families.[142] The model consists of six key functions: engagement of youth and families, working with family teams, ongoing and quality assessment, individualized planning, tracking and adjusting, and safe and sustained transition from DCF involvement. In alignment with the Family First Prevention Services Act, DCF's CPM emphasizes that children should remain at home with their families whenever possible. The principles of DCF's CPM dictate that DCF should provide families with the services that they need in order to keep children safe and at home in order to avoid the trauma of removal.

CP&P recently enhanced its CPM with the adoption of Solution-Based Casework™ (SBC). SBC is an evidenced-informed practice model that focuses on finding practical solutions to family and individual challenges by promoting positive change within the family system. SBC is designed to help caseworkers better understand the family system and develop plans for change that are grounded in the family's daily routine and their unique network of supports. It aims to help families identify and use naturally available resources to address the everyday challenges experienced. SBC is organized into four milestones which guide case practice: (1) building consensus with the family around their family and individual needs; (2) developing outcomes; (3) action planning; and (4) noticing and celebrating change. SBC action plans are essential to the achievement of outcomes as they provide a roadmap for families to follow as they work towards outcome achievement. SBC action plans address difficult or high-risk situations that may arise for the family and provide a plan for the family to effectively manage these situations. These action plans are not static. They are reviewed and revised regularly to ensure relevance and success in achieving the desired outcomes.

In 2021, all CP&P caseload-carrying staff engaged in formal SBC training. In 2022, caseworkers began using SBC with CP&P-involved families. DCF is implementing a staff certification process, a critical component of DCF's efforts to ensure staff proficiency and model fidelity. The certification process requires supervisory staff to observe and assess casework staff using the tenants of the framework and SBC engagement skills to work with families, to identify where additional training and support is needed and to certify those staff that are proficient in SBC. The process includes reviewing documentation, including the family discussion guide, case plan and action plans.

Child welfare new worker training: pre-service and foundation learning paths. DCF has structured a pre-service family and community engagement training program for new child welfare caseworkers that is completed over twelve months. Pre-service training includes core practice courses, such as SBC, Structured Decision Making™, child development, identifying abuse and neglect, making visits matter, and simulation. Training is enriched through field practicum experience in partnership with the new caseworker's Field Training Unit (FTU) supervisor and pre-service trainers. OTPD partners closely with CP&P's FTU supervisors to promote a strong peer network of support, resources, and technical assistance. This partnership and network help to ensure new workers are successful in the

[142] DCF_CasePracticeModel.pdf (nj.gov)

early part of their employment and prepared for family assignment. After pre-service training, new caseworkers complete several foundational trainings on topics, such as domestic violence, substance use disorders, the value of kinship, childhood sexual abuse, and ACEs. The pre-service and foundational trainings, which are required of all new CP&P caseworkers, ensure that new staff have the skills necessary to develop appropriate case plans (e.g., SBC courses) and assess safety and risk (e.g., courses on SDM tools, identifying abuse and neglect, making visits matter).

Ongoing in-service trainings. Caseload-carrying child welfare staff are required to complete continuing education training annually through a variety of required and elective trainings offered statewide. OTPD keeps field staff informed of elective trainings offered through the NJCWTP, CSOC trainings offered through Rutgers University, University Behavioral Healthcare, free trainings available in the community, and approved supplemental trainings requested by local field staff. These supplemental trainings include specialized topics, such as substance use disorders and ACES. OTPD's Family First Prevention Services e-learning and live sessions described in the "A New Era of Training and Workforce Development" section, below, will also be available to CP&P staff.

Supervisory training. Upon promotion, new child welfare supervisors are enrolled in a longstanding supervisory training. This training includes content related to general supervisory practice with supplemental presentations, such as employee relations, ethics, and the performance appraisal system.

Infrastructure to Support Training

Office of Training and Professional Development (OTPD). DCF's OTPD provides the DCF workforce with learning experiences that support their job functions and carry out DCF's vision and strategic goals. OTPD offers relevant learning experiences that use a variety of training modalities that are stakeholder driven, research-informed, consider current practice trends, address cross-department needs, and align with DCF values and core approaches. OTPD partners with DCF operational divisions and other key external stakeholders to continuously measure performance and competencies that ensure the transfer of learning objectives and behavior change. OTPD oversees the operations of DCF's Professional Center and Learning Management System to promote optimal learning experiences and streamlined processes for training enrollment, attendance, on-demand learning and to develop learning pathways. OPTD manages the new worker training, foundation learning paths, ongoing in-service trainings, the New Jersey Child Welfare Training Partnership (NJCWTP), and the educational partnerships described below.

Child welfare training and educational partnerships. New Jersey has an established NJCWTP, which includes DCF, the Rutgers University's School of Social Work, Institute for Families and Stockton University's Child Welfare Education Institute (CWEI). This Partnership supports DCF's Learning Management System, various and evolving instructional design deliverables, training delivery, specialized training certificate programs and supporting DCF with various workforce development needs. For over a decade, DCF has also partnered with Stockton University's CWEI, who leads the Baccalaureate Child Welfare Education

Program (BCWEP) and the Master's Child Welfare Education Program (MCWEP) program and convenes the BCWEP and MCWEP university consortia. These educational programs offer workforce development options for new and seasoned field staff. Through an agency-wide training subscription offered through New Jersey's Civil Service Commission (CSC), all DCF staff have access to CSC's Center for Learning and Improving Performance (CLIP) trainings. CLIP trainings include over 500 self-paced trainings on a variety of different topics, such as time management, project planning, supervision, leadership, and agenda setting.

Provider agency workforce development. To support high quality implementation and to ensure fidelity and long-term sustainability, the provider agency workforce will be trained and coached on the unique model requirements. DCF's Office of Strategic Development will serve as an intermediary to lead these coordination efforts with model developers, other training consultants, and programmatic offices to ensure provider agencies have access to capacity building and consultation opportunities that ensure the delivery of services as intended. It is DCF's expectation that provider agencies will ensure ongoing staff development, supervision and training and coaching opportunities such that all provider agency staff attain and maintain the skills and competencies necessary to develop and monitor the case planning and safety and risk assessment processes described in Section 6, "Child and Family Eligibility for Title IV-E Prevention Services Program," and Section 7, "Monitoring Safety of Children who Receive Title IV-E Prevention Services." DCF will utilize the procurement and contracting processes to outline clear guidelines regarding the recruitment, selection, hiring and staff competencies, and training necessary to deliver interventions and services as intended and with fidelity. DCF will ensure all newly developed Request for Proposals and contract language incorporates requirements associated with DCF's quality standards, fidelity monitoring, and data collection requirements, as well as training requirements associated with the Family First Prevention Services Act. Providers are also one expected audience of the OTPD's Family First Prevention Services e-learning and live sessions described in the "A New Era of Training and Workforce Development" section, below.

Additional Workforce Supports

Infrastructure of programmatic and operational offices. As is described in Section 3, "DCF's Prevention Strategy," DCF has developed a rich infrastructure of programmatic and operational offices. In addition to supporting program implementation, this infrastructure will support CP&P caseworkers and providers in service planning, linkage to appropriate services, provision of models to fidelity, and more. This infrastructure will support the business processes by which families are referred and meaningfully engaged in services. Beyond ensuring service development and availability, DCF will ensure that service delivery is planned and sequenced with families. This work will involve achieving consistent role clarity within several CP&P staff functions, enhancing collaboration between DCF programmatic and operational offices, and enhancing or creating procedures and practice guides to support decision making around service selection and sequencing.

Local coordination of specialized services. Families involved with CP&P often face multiple stressors, including medical and mental health challenges, substance use and domestic

violence. Responding to these challenges oftentimes requires specialized clinical skills and knowledge. When families' unique needs require an integrated service approach that includes both clinical and case management services, CP&P staff help to ensure families access appropriate supports and services by partnering with specialized consultants in assessment, planning and coordination of services. Each CP&P Local Office has access to the following specialized supports:

- **Resource Development Specialist (RDS).** RDSs help caseworkers identify service providers and make appropriate referrals. RDSs act as liaisons between CP&P local offices and community and system partners. They create positive and collaborative partnerships with community agencies to assist in the identification of available services and resources to meet clients' needs to achieve case goals. RDSs attend community events, conduct presentations and disseminate informational pamphlets to raise awareness about child abuse and neglect and CP&P. They also provide feedback to local office managers and DCF's Office of Contract Administration regarding service needs and available resources.

- **Child Health Unit (CHU) Nurses.** CHUs are staffed by nurses and staff assistants, who partner with CP&P, biological and resource parents, and medical providers, to ensure each child's medical and behavioral health care needs are met and to provide overall health care case management to address daily needs for each child in out-of-home placement.

- **Child Protection Substance Abuse Initiative (CPSAI).** CPSAI provides Certified Alcohol and Drug Counselors and counselor aides to support caseworkers in case planning when substance use is identified as a concern. They assess, refer, and engage clients in appropriate treatment to address their individual needs. CPSAI also offers peer recovery support services for clients during and after formal treatment. CPSAIs also provide training to CP&P staff on topics related to substance use disorders.

- **Care Management Organization Clinical Consultants.** Clinical consultants are licensed behavioral health professionals, who provide on-site consultation services to CP&P staff regarding children and youth with behavioral health concerns and intellectual and developmental challenges. Clinical consultants also review records and make recommendations regarding appropriate behavioral health interventions to improve and support each child in achieving positive outcomes.

- **Domestic Violence Liaisons (DVL).** DVLs are specially trained professionals with extensive knowledge of domestic violence and domestic violence support services. In cases with the co-occurrence of domestic violence, DVLs provide assessments, conducts case consultations with CP&P staff, and make service referrals for non-offending parents and the person who uses violence. They also team with and educate CP&P staff on the dynamics of domestic violence.

Office of Staff Health and Wellness. In 2019, DCF established the Office of Staff Health and Wellness to improve the health, safety and well-being of all DCF staff.[143] The Office's purpose is to engage staff in resources and supports that foster overall physical and emotional well-being, strong morale and a culture of inclusivity and empowerment. Highlights of DCF's efforts to prioritize the health and safety of staff include: putting in place robust security measures in all offices, launching a mindfulness toolkit for staff, introducing a voluntary Flex-time program, and launching a monthly Real Talk series, in which staff are interviewed about current and relevant issues impacting their emotional health.

A New Era of Training and Workforce Development

DCF's transformation into a 21st century child well-being system requires updated and flexible workforce development strategies to holistically engage staff in learning and growth across the Department. Over the next 3-5 years, DCF's existing training program will be enhanced to better align with DCF's transformation, as well as the strategic plans described in this plan. The current or planned workforce development and training initiatives described below seek to further support caseworkers in their assessment of child and family needs, provision of linkage to needed services and supports, and their ability to understand and deliver trauma-informed and healing centered practice in partnership with the community.

- **Updated pre-service training**. DCF and the NJCWTP are currently updating pre-service training. This updated learning path will more heavily integrate concepts of protective and promotive factors, self-reflective practice, staff wellness, trauma-informed care, healing centered approaches, and resiliency. There will be enhanced new worker assessments and skills application activities to support transfer of learning and Simulation activities will be offered throughout the duration of pre-service training.

- **Leadership and Supervisory Training.** DCF is currently designing a sustainable leadership program based on the National Child Welfare Workforce Institute's updated Leadership Competency Framework Model. This updated leadership program will prepare and resource DCF's senior leaders for agency transformation and succession planning. Through the partnership, DCF is also beginning a process to revamp the supervisory training into a supervisory learning pathway. Together, these updated supervisory training initiatives seek to provide all DCF supervisors with more relevant and comprehensive supervisory practice guidance and resources while developing more customized learning opportunities for the various supervisory functions within DCF.

- **Learning Management System.** Over the last decade, DCF has upgraded its Learning Management System (LMS), amongst other things, expanding it to include access for provider agencies (e.g., Family Preservation Services, Keeping Families Together providers, and more). Accessibility and functionality within the LMS will continue to be developed to meet ongoing training needs for various internal and external stakeholders, including those associated with Title IV-E prevention services evidence-based programs and practices.

OTPD anticipates the creation of an e-learning, with annual live sessions, to provide background information and progress updates related to the Family First Prevention Services Act. A version of this e-learning will also be available for our provider agencies with live session implementation progress updates provided by DCF's executive staff through ongoing "roadshows" and community forums.

[143] https://www.nj.gov/dcf/oshw.html

ATTACHMENT A. STATE ASSURANCE OF TRAUMA-INFORMED SERVICE-DELIVERY

State Assurance of Trauma-Informed Service-Delivery

Instructions: This Assurance may be used to satisfy requirements at section 471(e)(4)(B) of the Social Security Act (the Act), and will remain in effect on an ongoing basis. This Assurance must be re-submitted if there is a change in the state's five-year plan to include additional title IV-E prevention or family services or programs.

Consistent with the agency's five-year title IV-E prevention plan, section 471(e)(4)(B) of the Act requires the title IV-E agency to provide services or programs to or on behalf of a child under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma and in accordance with recognized principles of a trauma-informed approach and trauma-specific interventions to address trauma's consequences and facilitate healing.

The New Jersey Department of Children and Families (Name of State Agency) assures that in accordance with section 471(e)(4)(B) of the Act, each HHS approved title IV-E prevention or family service or program identified in the five-year plan is provided in accordance with a trauma-informed approach.

Signature: This assurance must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

Christine Norbut Beyer Digitally signed by Christine Norbut Beyer Date: 2024.04.11 10:29:11 -04'00'

(Date) (Signature and Title)

(CB Approval Date) (Signature, Associate Commissioner, Children's Bureau)

ATTACHMENT B. STATE REQUEST FOR WAIVER OF EVALUATION REQUIREMENT FOR A WELL-SUPPORTED PRACTICE

State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Instructions: This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.

The New Jersey Department of Children and Families (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Motivational Interviewing (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

Signature: This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

_____	Christine Norbut Beyer Digitally signed by Christine Norbut Beyer Date: 2024.04.11 10:30:58 -04'00'
(Date)	(Signature and Title)
_____	_____
(CB Approval Date)	(Signature, Associate Commissioner, Children's Bureau)

State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Instructions: This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.

The New Jersey Department of Children and Families (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Brief Strategic Family Therapy (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

Signature: This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

(Date)	Christine Norbut Beyer Digitally signed by Christine Norbut Beyer Date: 2024.04.11 10:29:44 -04'00' (Signature and Title)
(CB Approval Date)	(Signature, Associate Commissioner, Children's Bureau)

State Request for Waiver of Evaluation Requirement for a Well-Supported Practice

Instructions: This request must be used if a title IV-E agency seeks a waiver of section 471(e)(5)(B)(iii)(V) of the Social Security Act (the Act) for a well-supported practice, and will remain in effect on an ongoing basis. This waiver request must be re-submitted anytime there is a change to the information below.

Section 471(e)(5)(B)(iii)(V) of the Act requires each title IV-E agency to implement a well-designed and rigorous evaluation strategy for each program or service, which may include a cross-site evaluation approved by ACF. In accordance with section 471(e)(5)(C)(ii) of the Act, a title IV-E agency may request that ACF grant a waiver of the rigorous evaluation for a well-supported practice if the evidence of the effectiveness the practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements included in section 471(e)(5)(B)(iii)(II) of the Act with regard to the practice. The state title IV-E agency must demonstrate the effectiveness of the practice.

The state title IV-E agency must submit a separate request for each well-supported program or service for which the state is requesting a waiver under section 471(e)(5)(C)(ii) of the Act.

The New Jersey Department of Children and Families (Name of State Agency) requests a waiver of an evaluation of a well-supported practice in accordance with section 471(e)(5)(C)(ii) of the Act for Intercept (Name of Program/Service) and has included documentation assuring the evidence of the effectiveness of this well-supported practice is: 1) compelling and; 2) the state meets the continuous quality improvement requirements supporting this request.

Signature: This certification must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

_____	Christine Norbut Beyer Digitally signed by Christine Norbut Beyer Date: 2024.04.11 10:30:19 -04'00'
(Date)	(Signature and Title)
_____	_____
(CB Approval Date)	(Signature, Associate Commissioner, Children's Bureau)

ATTACHMENT C. STATE TITLE IV-E PREVENTION PROGRAM REPORTING ASSURANCE

State Title IV-E Prevention Program Reporting Assurance

Instructions: This Assurance may be used to satisfy requirements at section 471(e)(5)(B)(x) of the Social Security Act (the Act), and will remain in effect on an ongoing basis. This Assurance must be re-submitted if there is a change in the assurance below.

In accordance with section 471(e)(5)(B)(x) of the Act, the New Jersey Department of Children and Families, (Name of State Agency) is providing this assurance consistent with the five-year plan to report to the Secretary such information and data as the Secretary may require with respect to title IV-E prevention and family services and programs, including information and data necessary to determine the performance measures.

Signature: This assurance must be signed by the official with authority to sign the title IV-E plan, and submitted to the appropriate Children's Bureau Regional Office for approval.

	Christine Norbut Beyer Digitally signed by Christine Norbut Beyer Date: 2024.04.11 10:26:05 -04'00'
(Date)	(Signature and Title)
(CB Approval Date)	(Signature, Associate Commissioner, Children's Bureau)