REQUEST FOR PROPOSALS
FOR
In-Home Recovery Program – One Award for Two Sites

Publication Date: May 31, 2023

Response Deadline: July 12, 2023, by 12:00 P.M.

Funding of $709,905.00 Available

There will be an Optional Virtual Conference on June 14, 2023, at 10:00 A.M.

The link to register for the conference is: https://www.zoomgov.com/j/1604684613

Christine Norbut Beyer, MSW
Commissioner

The Department of Children and Families (DCF) is the agency dedicated to ensuring all New Jersey residents are safe, healthy, and connected. To that end, DCF announces to potential respondents its intention to award a new contract.

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Section I - General Information

A. Pre-Response Submission Information:

There will be an **Optional Virtual Conference** for all respondents held on **June 14, 2023, from 10:00 A.M. to 12:00 P.M.**

Join ZoomGov Meeting
https://www.zoomgov.com/j/1604684613

Meeting ID: 160 468 4613
One tap mobile
+16692545252,,1604684613# US (San Jose)
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Respondents may not contact DCF directly, in person, or by telephone, concerning this RFP. Questions may be sent in advance of the response deadline via email to DCF.ASKRFP@dcf.nj.gov.

Technical inquiries about forms, documents, and format may be requested at any time prior to the response deadline, but **questions about the content of the response must be requested by 12 P.M. on June 15, 2023.** Questions should be asked in consecutive order, from beginning to end, following the organization of the RFP and reference the page number and section number to which it relates. All inquiries submitted should reference the program name appearing on the first page of this RFP. Written inquiries will be answered and posted on the DCF website as a written addendum to this RFP at:
https://nj.gov/dcf/providers/notices/requests/

B. Summary Program Description:

DCF Children's System of Care (CSOC) announces its intent to award a contract for the purpose of providing the In-Home Recovery Program (IHRP), a family-based recovery program serving adults, families, and young children.

DCF is a family and child-serving agency, working to assist New Jersey families in becoming or remaining safe, healthy, and connected. The goals of the IHRP are to improve outcomes for parents who have a substance use disorder (SUD) who are referred to the IHRP by the DCF Division of Child Protection and Permanency (CPP), in conjunction with the Child Protection Substance Abuse Initiative (CPSAI) and are actively parenting a child under six (6) years old. This program will expand the service array for these families through the following strategies:

- overseeing the provision of a specific evidence supported, trauma-informed in-home substance use disorder treatment program as proposed by the respondent;
- partnering with CPP to ensure successful program implementation and service utilization;
- partnering with Montclair State University to support program efficacy with training and reflective supervision of program staff;
- partnering with Rutgers University to evaluate the implementation of the program, including post-intervention changes on parental substance use and involvement with child protective services.

DCF will fund one (1) award for the implementation of two (2) teams serving two (2) CPP local offices (one team per local office) within the same county or CPP service area managed by one agency. Each team will serve a caseload of twelve (12) families at any one time and serve a minimum of twenty-four (24) families in total over a twelve (12) month period, with a total of forty-eight (48) families served across both teams over a twelve (12) month period. beginning on July 1, 2023, for a twelve (12) month budget not to exceed $709,905.00.

Respondents may propose to serve one of the following office configurations:

1. Two Union County Local Offices
2. Two Camden County Local Offices
3. Two Gloucester County Local Offices
4. Two Cumberland County Local Offices
5. Salem Local Office and One Cumberland County Local Office
6. Salem Local Office and One Gloucester County Local Office
7. One Cumberland County Local Office and One Gloucester County Local Office.

CPP will determine the specific Local Offices to be served in the approved configuration.

An important objective of the IHRP is to demonstrate the effectiveness of a proposed trauma-informed in-home treatment model for families involved with CPP who have a parent with a SUD, needing treatment, and a child under the age of six (6) years old. Outcome measures will include parental substance use, child placement at discharge, and a family's repeat involvement with child protective services.

C. Funding Information:

All funding is subject to appropriation. The continuation of funding is contingent upon the availability of funds and resources in future fiscal years.

This is a competitive process. Respondents are on notice that no annual increases will be considered as part of this contract to salaries, fringe, or benefits in future negotiations or contracts, unless approved by the State legislature for all contracting entities.

It is anticipated that approximately $709,905 will fund one (1) resulting contract.

The funds support the first year of a contract subject to renewal. Funds awarded under this program may not be used to supplant or duplicate existing funding.

The intended funding period for the contract is: July 1, 2023, to June 30, 2024. The funds available are to be budgeted to cover the expenses incurred during the contract term. DCF will not reimburse expenses incurred prior to the effective date of the contract except for approved start-up costs.

Additional funding to pay for permitted start-up costs is not available.

DCF may approve for reimbursement the start-up costs respondents propose in their budgets for the first year of the contract using the funds available in the annual contract ceiling. A justification and summary of the anticipated costs required to begin program operations must be entered into the final column of the Proposed Budget Form found at:
https://www.nj.gov/dcf/providers/contracting/forms/ The completed form must be submitted as a document included in PDF 2: Section III - *Documents to be Submitted with This Response, subsection A. Documents to be Submitted in Support of This Response.* All start-up costs are subject to contract negotiations and DCF approval.

Matching funds are not required.

Responses that demonstrate the leveraging of other financial resources are encouraged.

D. Respondent Eligibility Requirements:

Respondents must be in good standing with all State and Federal agencies with which they have an existing grant or contractual relationship and in compliance with all terms and conditions of those grants and contracts.

Respondents must not be suspended, terminated, or barred for deficiencies in performance of any award, and if applicable, all past issues must be resolved as demonstrated by written documentation.

DCF will not accept, receive, or consider a response from those under a corrective action plan in process with DCF or any other New Jersey State agency or authority.

Respondents must be fiscally viable and be able to comply with the contracting rules and regulations set forth in the DCF Contract Policy and Information Manual (CPIM) found at: DCF | Contracting Policy Manuals (nj.gov).

Where required, all respondents must hold current State licenses.

Respondents that are not governmental entities must have a governing body that provides oversight as is legally required in accordance with how the entity was formed, such as a board of directors for corporations, or the managing partners of a Limited Liability Corporation (LLC)/Partnership, or the members of the responsible governing body of a county or municipality.

Respondents must have the capability to uphold all administrative and operating standards as outlined in this RFP.

[OPTIONAL:] Provide any special or restricted eligibility requirements that should replace the following standard eligibility requirements:

Respondents must be business entities that are duly registered to conduct business within the State of New Jersey, for profit or non-profit corporations, partnerships, limited liability companies, etc. or institutions of higher education located within the State of New Jersey.

Respondents must be business entities that are duly registered to conduct business within the State of New Jersey, for profit or non-profit corporations, partnerships, limited liability companies, etc.

Respondents must be New Jersey–based SUD treatment and mental health providers serving adults, families, and/or children and must have an office(s) in New Jersey.

Respondents must be either:

- licensed SUD treatment programs with experience providing mental health services to caregivers involved with CPP; or
- licensed mental health agencies with experience providing SUD services to caregivers involved with CPP,

AND must be**:**

- able to staff at least one (1) team (one (1) parent/child clinician, one (1) substance use clinician, and one (1) family support specialist) with person(s) who are bilingual in English and one other common language in the proposed service area.

Preference will be given to substance use disorder and mental health treatment providers with experience and qualifications in the following areas:

- utilizing an electronic health record
- experience serving families and/or having an office(s) in Union, Cumberland, Gloucester, Salem, and/or Camden County
- working with young children utilizing an infant mental health approach
- implementing an evidence-based, healing-centered SUD treatment model
- working with DCF, including providing services to families involved with DCF CPP
- two (2) teams able to provide bilingual services in English and one other common language in the proposed service area

Respondents awarded a contract should achieve full operational census within ninety (90) days of award, or the award may be rescinded. Extensions may be available by way of written request to DCF.

Awardees are required to collaborate with Montclair State University (MSU) (for training, technical assistance, and reflective supervision) within thirty (30) days of contract award.

E. Response Submission Instructions:

All responses must be delivered ONLINE on the due date by 12:00 P.M. Responses received after 12:00 P.M. on July 13, 2023 will not be considered.

To submit online, respondent must complete an Authorized Organization Representative (AOR) form. The completed AOR form must be signed and

dated by the Chief Executive Officer or designated alternate and sent to DCF.ASKRFP@dcf.nj.gov

Authorized Organization Representative (AOR)
Form: https://www.nj.gov/dcf/providers/notices/requests/AOR.docx

Registered AOR forms must be received not less than five (5) business days prior to the date the response is due. Upon receipt of the completed AOR, DCF will grant the Respondent permission to proceed and provide instructions for the submission of the response. DCF recommends not waiting until the due date to submit your AOR forms in case there are technical difficulties during your submission.

F. Required PDF Content of the Response:

Submit in response to this RFP separate PDF documents labeled as follows:

PDF 1: *Section II - Required Performance and Staffing Deliverables* ending with a Signed Statement of Acceptance

PDF 2: *Section III - Documents to be Submitted with This Response, subsection A. Organizational Documents Prerequisite to a DCF Contract Award to be Submitted with the Response*

PDF 3: *Section III – Documents to Submitted with This Response, subsection B. Additional Documents to be Submitted in Support of This Response*

PDF 4: *Section IV - Respondent's Narrative Responses, subsections A. Community and Organizational Fit; B. Organizational Capacity; C. Organizational Supports; D. Vignette Response.*

Section II - Required Performance and Staffing Deliverables

NOTE: After reviewing the required deliverables listed below, respondents must sign the statement at the bottom of this Section II to signify acceptance of all of them.

(SUBMIT A COMPLETE COPY OF THE CONTENT OF SECTION II, ENDING WITH YOUR SIGNED STATEMENT OF ACCEPTANCE, AS A SINGLE PDF DOCUMENT. THIS WILL BE THE FIRST PDF SUBMISSION IN YOUR RESPONSE PACKET AND IS TO BE LABELED AS: *PDF 1: SECTION II - REQUIRED PERFORMANCE AND STAFFING DELIVERABLES*.)

A. **Subject Matter - The below describes the needs the awarded respondent must address in this program, the goals it must meet, and its prevention focus.**

1) **The need for this program as indicated by data regarding the health and human services issues and parent and community perceptions is:**

In 2020, 26.3% of NJDCF-involved children experienced a substance abuse caregiver risk factor and 12.4% had an alcohol abuse risk factor.[1] According to DCPP placement data, 12% of young children (children aged 0–3) who entered care in New Jersey between 2016 and 2019 and experienced reentry within twelve (12) months of reunification had a caregiver with a substance use issue.[2] As of July 1, 2022, 27% of the DCPP's families with children aged 0–3 receiving in-home services also had a caregiver with a substance use issue.[3] Meeting the needs of individuals with a substance use disorder in Union, Cumberland, Gloucester, Salem and Camden counties in New Jersey has become more challenging as the service landscape and, subsequently, access to intervention changes. FY22 CPSAI data for DCPP Local Offices in those counties is outlined below.

County	# referrals for SUD assessment submitted to CPSAI	% referred individuals assessed for SUD service needs	% assessed individuals recommended for SUD treatment	% individuals enrolled in treatment following recommendation
Union	365	64%	39%	60%
Cumberland	280	47%	86%	44%
Gloucester	391	63%	67%	49%
Salem	108	57%	90%	47%
Camden	762	64%	76%	41%

The needs of parents who use substances and the potential impact on their young children are well documented.[4,5] One of the most challenging responsibilities for a Child Protective Services (CPS) social worker is weighing the developmental needs of a child against the risk associated with parental substance use in determining whether the child needs to be removed. Historically, child protection has focused primarily on the physical safety of children without taking

[1] U.S. Department of Health & Human Services, Administration for Children and Families, Children's Bureau. (2022). Child Maltreatment 2020. Available from https://www.acf.hhs.gov/cb/report/child-maltreatment-2020

[2] State of New Jersey Department of Children and Families. (January 2023). Rutgers Data Portal and DMR Risk Factor Algorithm.

[3] State of New Jersey Department of Children and Families. (2022). DMR M-5/Risk Dataset as of 7/1/2022.

[4] Seay, K.D., & Kohl, P.L., 2015. The comorbid and individual impacts of maternal depression and substance dependence on parenting and child behavior problems. *Journal of Family Violence*, *30*(7):.899–910.

[5] Whitaker, R.C., Orzol, S.M., & Kahn, R.S., 2006. Maternal mental health, substance use, and domestic violence in the year after delivery and subsequent behavior problems in children at age 3 years. *Archives of General Psychiatry*, *63*(5): 551–560.

into consideration the need to balance that with psychological safety and well-being. Children removed due to parental substance use typically remain in foster care longer and are less likely to be reunified than children removed for other reasons.[6,7] In fact, for many children, foster care placement has not resulted in positive outcomes.[8,9] Additionally, the child's placement outside of the home might have an unintended negative impact on the mother's recovery process and sense of well-being and therefore an impact on successful reunification. Some mothers may increase substance use to manage the loss experienced from removal and their sense of being judged as a less-than-competent parent. Diminished motivation to participate in treatment after a child is removed may lead to an increase in adverse life events.[10]

Child welfare knowledge and case practice have evolved to recognize that parent and child do not need to be separated for a parent to achieve substance use recovery and for the child to remain safe.

NJDCF intends to partner with a Respondent to embark on a multipronged, two-generation, trauma-informed initiative to support parental SUD recovery, healthy attachment, family stability, and positive child development. The initiative is composed of three (3) components:

1) Implementation and provision of the Respondent's proposed well-supported or evidence-based, healing-centered in-home substance use disorder treatment program model

2) Training, technical assistance, and reflective supervision funded by NJDCF and provided by Montclair State University

3) Evaluation funded by NJDCF and provided by Rutgers University

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[6] Lloyd, M.H., Akin, B.A., & Brook, J., 2017. Parental drug use and permanency for young children in foster care: A competing risks analysis of reunification, guardianship, and adoption. *Children and Youth Services Review*, *77*: 177–187.
[7] Vanderploeg, J.J., Connell, C.M., Caron, C., Saunders, L., Katz, K.H., & Kraemer Tebes, J., 2007. The impact of parental alcohol or drug removals on foster care placement experiences: A matched comparison group study. *Child Maltreatment*, *12*(2): 125–136.
[8] Villodas, M.T., Litrownik, A.J., Newton, R.R., & Davis, I.P., 2015. Long-term placement trajectories of children who were maltreated and entered the child welfare system at an early age: Consequences for physical and behavioral well-being. *Journal of Pediatric Psychology*, *41*(1):
46–54.
[9] Weiler, L.M., Garrido, E.F., & Taussig, H.N., 2016. Well-Being of Children in the Foster Care System. In M.R. Korin (Ed.), *Health Promotion for Children and Adolescents* (pp. 371–388). New York, NY: Springer.
371–388.
[10] Donohue, B., Azrin, N.H., Bradshaw, K., Van Hasselt, V.B., Cross, C.L., Urgelles, J., Romero,V., Hill, H.H., & Allen, D.N., 2014. A controlled evaluation of family behavior therapy in concurrent child neglect and drug abuse. *Journal of Consulting and Clinical Psychology*, *82*(4): 706. [10] Nicholson, J., Finkelstein, N., Williams, V., Thom, J., Noether, C., & DeVilbiss, M., 2006. A comparison of mothers with co-occurring disorders and histories of violence living with or separated from minor children. *The Journal of Behavioral Health Services & Research*, *33*(2): 225–243.

NJDCF reviewed several program models designed to improve outcomes for caregivers of young children who are involved with child protection services and who suffer from substance use disorders. One of the most promising models NJDCF reviewed was developed and implemented in Connecticut. In 2006, the Connecticut State Department of Children and Families (CTDCF) recognized the need to address the dual challenges of parenting and achieving recovery if the child placement rate in Connecticut was to decrease. The CTDCF brought together faculty members from Johns Hopkins University (JHU), the University of Maryland, and the Yale Child Study Center (YCSC) to develop treatment that integrated contingency management SUD treatment with in-home, attachment-based parent-child therapy.

JHU's Reinforcement-Based Treatment (RBT)[11] is an evidence-based, comprehensive behavioral substance use treatment that incorporates interventions from the Community Reinforcement Plus Vouchers Approach,[12] relapse prevention,[13] and motivational interviewing.[14] The staff from JHU developed RBT in 1997. The conceptual foundation of RBT is based on operant conditioning. Positive reinforcement is the most effective means of producing behavior change. The RBT approach is to replace the reinforcement of substances with healthier alternative activities that are incompatible with substance use.

RBT was originally developed as a clinic-based treatment for clients diagnosed with opioid use disorder exiting detoxification programs in Baltimore, Maryland. Two (2) randomized controlled studies revealed that clients in RBT were more likely to be abstinent from substances, had longer treatment length of stay, and worked more days at three (3), six (6), and twelve (12) months post-admission to treatment than clients in standard community-based treatment programs.[15,16] RBT has been adapted to treat pregnant substance-using women and has achieved similar treatment outcomes.[17]

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[11] Tuten, L.M., Jones, H.E., Schaeffer, C.M., & Stitzer, M.L., 2012. *Reinforcement-based treatment for substance use disorders: A comprehensive behavioral approach*. American Psychological Association.

[12] Budney, A.J., & Higgins, S. T., 1998. *Therapy Manuals for Drug Addiction, Manual 2: A Community Reinforcement Plus Vouchers Approach:*
Treating Cocaine Addiction. Rockville, MD: National Institute on Drug Abuse.

[13] Irvin, J.E., Bowers, C.A., Dunn, M.E., & Wang, M.C., 1999. Efficacy of relapse prevention: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *67*, 563–570.

[14] Miller, W.R., & Rollnick, S., 2002. *Motivational Interviewing: Preparing People for Change, 2nd Ed*. New York: Guilford.

[15] Gruber, K., Chutuape, M.A., & Stitzer, M.L., 2000. Reinforcement-based intensive outpatient treatment for inner city opiate abusers: A shortterm evaluation. *Drug and Alcohol Dependence*, *57*(3), 211–223.

[16] Tuten, M., Defulio, A., Jones, H., & Stitzer, M., 2011. A randomized trial of reinforcement-based treatment and recovery housing. *Addiction, 107*(5), 973–982.

[17] Jones, H.E., O'Grady, K.E., & Tuten, M., 2011. Reinforcement-based treatment improves the maternal treatment and neonatal outcomes of pregnant patients enrolled in comprehensive care treatment. *The American Journal on Addictions*, *20*(3), 196–204.

The YCSC developed the Coordinated Intervention for Women and Infants (CIWI) program in 1990 with funding from the Abandoned Infants Assistance Act, administered by the Department of Health and Human Services. CIWI was an intensive, in-home, trauma-informed clinical service for women with a history of substance use who were pregnant or had an infant under the age of twelve (12) months. The principles of attachment theory guided the clinical work. Teams focused on the caregiver's ability to provide appropriate care, nurturing, and emotional availability to the child. Parents were asked to explore how their own experience being parented impacted their parenting behaviors. Staff utilized an infant mental health approach to assist mothers to focus on the needs and feelings of the child in the present moment. Data from 2004 to 2006 revealed that 63% of children lived with a biological parent at the time of discharge. The CIWI program ended in 2008.

YCSC, JHU, and CTDCF integrated RBT and CIWI into a new model, Family-Based Recovery (FBR),[18] which is based on two (2) foundational principles: attachment is critical to healthy development and substance use treatment works.

The FBR model was originally implemented in 2007 by six (6) community-based agencies. Each agency had one (1) FBR team; each team carried a caseload of twelve (12) families. In 2013, CTDCF expanded FBR statewide. There are currently seventeen (17) FBR teams providing this clinical in-home service.

YCSC continues to provide quality assurance oversight, training, and model fidelity with FBR Services. Data provided by FBR sites and analyzed by FBR Services reveals statistically significant changes in several pre-/post-intervention assessment scores for clients in the areas of depression, parenting stress, and parental bonding. Toxicology results show a steady increase in negative screens after the first fifteen (15) weeks in FBR, suggesting a primary goal of the project is being met. In Fiscal Year 2017–2018, 84% of children lived with a biological parent at discharge. FBR is currently undergoing a randomized control trial with funding from a social impact bond project in collaboration with Social Finance, LLC, CTDCF, and the University of Connecticut.

Awardees of this RFP will provide a model to support the New Jersey IHRP. While DCF has reviewed the model outlined above, other well-

[18] Hanson, K.E., Saul, D.H., Vanderploeg, J.J., Painter, M., & Adnopoz, J., 2015. Family-based recovery: An innovative in-home substance abuse treatment model for families with young children. *Child Welfare*, *94*(4), 161–183.

supported or evidence-based models that integrate caregiver substance use treatment and attachment-based therapeutic interventions may be proposed. Two (2) teams will be expected to perform the set of services outlined below. DCF will consider Respondents who successfully articulate the guidance provided in Section E: Activities.

2) **The goals to be met by this program are:** to improve outcomes for families who become known to CPP and children who are at risk of placement because of parental substance use.

B. Target Population - The below describes the characteristics and demographics the awarded respondent must ensure the program serves.

1) **Age:** Children 0 up to their 6th birthday, Adults
2) **Grade:** N/A
3) **Gender:** N/A
4) **Marital Status**: N/A
5) **Parenting Status:** Children must be residing in the home or be within 45 days of reunification with parent
6) **Will the program initiative serve children as well as their parent or caregiver?** Yes, children aged 0 up to their 6th birthday.
7) **DCF CP&P Status:** CP&P In Home Case
8) **Descriptors of the youth to be served:** Parent/Child Dyad
9) **Descriptors of the Family Members/Care Givers/Custodians required to be served by this program initiative:** DCPP involved caregivers with substance use disorders
10) **Other populations/descriptors targeted and served by this program initiative:**

The target population for the IHRP is CPP involved parent(s) who have a SUD, and a child under six (6) years old. Only one (1) child per family will be enrolled in the program. CPP will provide referrals of the target population to the provider agency. The parent(s) might have other children, but the youngest child under six (6) years of age will be the target of treatment. Service level approximates ASAM 2.1. The IHRP is considered an alternative to an intensive outpatient program (IOP) or, if clinically appropriate, a mother-child residential treatment program. Inter-partner violence and homelessness are not exclusionary criteria.

<u>Inclusion Criteria</u>

a. Parent
   i. The parent is a mother and/or father assessed by the CPSAI with a SUD diagnosis.

ii. The parent's CPSAI assessment result indicates that he/she may be served in an IOP level of care or higher, per ASAM criteria for Level 2.1 outpatient services. Individuals requiring residential withdrawal management are not eligible.

iii. The parent is not involved in any other treatment program (such as counseling and behavioral therapies for SUD treatment or Family Preservation Services) or is willing to discharge from the program to participate with the IHRP. Parents whose recovery is supported by medication, prescribed by a qualified health care professional, are expected to commence, or continue to receive these services.

iv. The parent is willing and able to engage in the treatment.

v. The parent is in a caregiving role to the child at least 50% of the time.

b. Child

i. The child is under six (6) years old.

ii. The child resides in the parent's home, or if the child is placed outside the home, there is a plan for reunification within thirty (30) to forty-five (45) days or less from the time of referral.

11) Does the program have **income eligibility** requirements? No.

C. Activities - The below describes the activities this program initiative requires of awarded respondents, inclusive of how the target population will be identified and served, the direct services and service modalities that will be provided to the target population, and the professional development and training that will be required of, and provided to, the staff delivering those services.

1) **The level of service increments for this program initiative:** individual in-home parent/child treatment interventions and group services delivered in the community
2) **The frequency of these increments to be tracked:** All treatment interventions and group services are to be documented for each encounter.
3) **Estimated Unduplicated Clients:** 12 parents per team served by 2 two teams, or 24 parents in total across both teams at all times.
4) **Estimated Unduplicated Families:** 48 families annually
5) **Is there a required referral process?** Yes
6) **The referral process for enabling the target population to obtain the services of this program initiative:**

Eligible parents will be identified and screened by CPP according to the criteria outlined in **Section II., subsection B. Target Population.** Prior to implementation of the IHRP, CPP and the contractor will collaborate to develop a process and plan for managing referrals.

- The respondent will not maintain a waiting list. The respondent will accept all referrals up to the number of families that can be assigned.
- Each of the two teams is required to treat a minimum of twelve (12) parents during the IHRP.
- Each team must successfully enroll 75% of all referred parents. “Enrolled” is defined as completion of an intake session and three subsequent home visits.
- Teams must complete the three phases of the IHRP, as described below, for at least 40% of enrolled participants. “Completion” is defined as the parent receiving a minimum of four months of IHRP treatment, having twelve (12) consecutive negative toxicology screens, having custody of the child, and completing one other co-constructed treatment goal.

7) **The rejection and termination parameters required for this program initiative:**

Exclusion Criteria

a. A parent whose psychiatric symptoms require immediate attention and stabilization prior to IHRP treatment.
b. A parent who requires medical withdrawal management in a residential or acute care setting.
c. A parent who is participating in a duplicate service and whose enrollment in IHRP would be overwhelming.

8) **The direct services and activities required for this program initiative:**

Intake Session

The intake session is scheduled by the IHRP team. The IHRP team and CPP caseworker attend the intake session at the parent’s home to review with the parent the reason for referral, targeted substance(s), safety agreements, and the treatment model. The parent may elect to consent for treatment, ask for a period of no more than twenty-four (24) to forty-eight (48) hours to consider treatment options, or decline IHRP treatment.

If the parent elects to enroll in the IHRP during the intake session, the parent will sign a consent form for treatment, complete a toxicology

screen with an IHRP staff person, sign a release of information to the CPP, and complete intake forms. Parents enrolled in Medically Assisted Treatment (MAT) at another agency will also sign consent for disclosure to/from the IHRP and the MAT provider. If a parent asks for a period of time to consider enrolling in the IHRP, the CPP caseworker will communicate with the client within the agreed-upon time frame and inform the IHRP staff. If the parent agrees to participate, the protocol outlined above for the intake session will be followed.

Team responsibilities include the following:

- Offer treatment sessions minimally from 8:00 a.m. to 7:00 p.m., Monday through Friday
- Able to offer flexibility in scheduling sessions outside of the above-noted hours to best meet the needs of the clients served
- Provide services fifty-two (52) weeks per year
- Provide 24/7 phone coverage for crisis intervention
- Provide treatment to each client for six (6) to nine (9) months depending on time of enrollment

The Three Phases of the IHRP

Assessment Phase

The IHRP team will meet with the parent three (3) times a week. The team will conduct a comprehensive evaluation of each parent and child participating in the IHRP, which will result in the formulation of a DSM-5 diagnosis for the parent and an individualized treatment plan. The evaluation will provide a clinical integration of the parent's medical, psychosocial, substance use, legal, educational, and treatment histories, as well as an assessment of the child's development and parent-child interaction and attachment style. The evaluation should be comprehensive enough to address the needs of the child and parent within the context of the family and social community. The team will complete Family Based Recovery measures and tools.

Recovery planning will be a critical part of the IHRP team's work with parents and the CPP. IHRP staff and the parents will develop a plan to be implemented at times when parents are experiencing strong cravings and are at high risk of relapse and/or are in crisis and need to ensure safety for themselves and their child(ren). The IHRP team will work with the parent to identify an alternative caregiver for the child if the parent chooses to use substances. The team will discuss with the parent how to manage a relapse if it should occur. The plan will be shared with the CPP.

Treatment Phase

The team conducts three (3) home visits a week for at least the first six (6) months of treatment. After six (6) months of treatment, the parent may be stepped down to two (2) visits a week.

Treatment consists of four (4) components:

1) Parent-Child Component

The IHRP will not utilize a parenting curriculum. The IHRP team will use naturally occurring parent-child interactions as opportunities for reflection and support. The purpose of each parent-child session is to observe the back and forth of communication between parent and child, how the parent interprets the child's cues, and how the parent and child deal with ruptures and misunderstandings. The parent-child clinician will conduct a session with the parent and child once a week in the home or in the community (e.g., pediatrician visit, library). The child might have siblings residing in the home. The IHRP recognizes that all children might need assessment, possible interventions, and advocacy with systems, and this is the domain of the parent-child clinician. The parent-child clinician will facilitate assessments and referrals to all children in the home as needed but will not be expected to provide treatment to all children in the household. The parent-child work will focus on the following:

- understanding of child development
- child and household safety
- child health/well-childcare
- understanding of and response to child cues and needs
- positive parent-child interactions for secure attachment
- consistency in household routines and arrangements for childcare

2) Substance Use Component

The substance use clinician will provide individual, trauma-informed psychotherapy in addition to substance use treatment for the parent. The IHRP will use tools and principles from Reinforcement-Based Treatment. Treatment goals are designed to replace the function (or purpose) of substance use for the individual. Experiencing the tangible benefits parents receive from being substance free-first and foremost, being able to parent their child-provides powerful motivation and focus to recovery. The substance use clinician will utilize a variety of tools to inform and guide the clinical work.

These include the following:

- Brief Substance Use Assessment (BSUA)
  This tool will be used by the clinician to assess how long a parent has used each substance and how much the parent has spent on substances in an average day. This tool provides valuable information for contracts and treatment goals. Every 90 days, the clinician and parent will complete a BSUA Follow-Up Tool.
- The Functional Assessment (FA)
  The FA will provide the clinician with critical information regarding the "function(s)" that substance use serves in the parent's life. It examines how substance use fits into the parent's daily routine; what people, places, events, and feelings are associated with use; and which substances are commonly paired together. By completing the FA, the clinician will obtain information that will guide the clinical work (contracts, treatment plan, psychiatric evaluation, and management).
- Graphs
  Family Based Recovery graphs are a cognitive-behavioral tool that keeps abstinence and abstinence-related goals tangible and salient to the parent.
- Contracts
  Contracts are written agreements between the IHRP team, and the parent designed to improve the likelihood that he/she will engage in a particular behavior.

3) <u>Psychiatric Evaluation and Pharmacotherapy</u>
   The psychiatrist/APRN will be available to conduct a psychiatric evaluation on all parents. The psychiatrist/APRN will provide pharmacotherapy and medication-assisted treatment (MAT) as needed. The psychiatrist/APRN will refer parents to an affiliated MAT provider as appropriate.

4) <u>Basic Needs Assessment and Support</u>
   Many IHRP parents need assistance with obtaining basic needs for themselves and their family. The IHRP recognizes that parents need to have many of their basic needs met in order to maintain recovery and parent their children in a competent manner. The team is expected to help with referrals, as needed, in the following areas: housing, health care, education, employment, utility bills, social services, energy assistance programs, Early Intervention Services, and child-care. Staff will assist parents with obtaining important documents (Social Security cards, birth certificates, driver's licenses, and Green Cards) as needed. The IHRP team

will transport parents to offices and appointments, when appropriate.

Transition Planning

The parent can be stepped down to Phase III, which consists of one (1) home visit a week, four (4) to six (6) weeks prior to discharge. The length of service in this phase will be based on the clinical needs of the parent and child. Discharge planning should be a collaborative endeavor between the parent, the IHRP, and the CPP caseworker. Prior to discharge, the recovery plan will be reviewed with the parent and updated as needed. A parent will be considered as successfully graduating from the IHRP if at the time of discharge the child lives with the parent, the parent has twelve (12) consecutive negative toxicology screens, and the parent has achieved one other co-constructed goal.

9) **The service modalities required for this program initiative are:**
a) Evidence Based Practice (EBP) modalities: N/A
b) DCF Program Service Names: In-Home Recovery Program
c) Other/Non-evidence-based practice service modalities:

Substance Testing

Toxicology testing is for clinical purposes only. All IHRP staff are required to conduct toxicology screens with clients. Parents will be asked to submit a sample for screening at every encounter. IHRP staff will observe the toxicology screen when the staff member is the same gender as the parent. The IHRP will utilize a combination of CLIA-waived rapid tests and chain-of-custody procedures for testing within a licensed clinical laboratory to screen for a minimum of 12 substances. Additional toxicology testing as required by CPP will be determined in consultation with the Local Offices. Breathalyzers will be used at each visit for parents who have a diagnosis of an alcohol use disorder. IHRP staff will randomly (at least twice a month) conduct breathalyzer tests on all other parents.

Vouchers

Contingency management therapy provides positive reinforcement for evidence of behavioral change. The IHRP provides a $10 gift card/voucher for each negative toxicology screen during the first phase of treatment. Vouchers are one incentive for recovery and are a means to jump-start recovery and engagement at the beginning of treatment. Parents earn up to $700 in vouchers for negative toxicology screens. The provider must have gift cards available to dispense at all times. It is expected that other non-monetary reinforcements for

recovery, such as improved health and family relationships, will be in place consistently by the time the client has received this amount. The parent will earn a $20 gift card for completion of all discharge measures. Providers are advised to ensure the costs of vouchers are included in the program budget.

Parent-Child Therapy Group

The Parent-Child Therapy Group is a weekly, two (2) hour group that provides the parent another form of positive reinforcement for recovery. Parents must have a negative toxicology screen on the day of group in order to attend. While the group is not mandatory, all parents will be asked to sample the parent-child therapy group at least once. Parents will be encouraged to bring their child to group. All IHRP staff members will attend the group. In addition to clinical group time, the parent-child therapy group will consist of parents, children, and staff sharing a meal together. Initially, while a core group is building, staff may need to provide a more structured format, using ice breakers, recovery-related games, or art therapy as tools to initiate topics for discussion. Whatever the topic or activity, a goal of the parent-child therapy group is for the conversation to ultimately link to issues of parenting and/or recovery. Depending on the age of the children and the activity and/or topic, children may remain with parents during the therapy portion of the group. At other times, it will be more appropriate for the children to move into another room under the supervision of a staff member.

Collaboration with DCF

The Department is a family and child serving agency, working to assist New Jersey families in being or becoming safe, healthy, and connected. Parents referred to IHRP by CPP are at risk for child maltreatment due to parental substance use. To ensure that children are safe and have minimal exposure to risk, the IHRP teams are expected to operationalize strengths-based principles and collaborate with CPP to ensure engagement of families, ongoing safety and risk assessment, and solution-based case planning. When requested, the IHRP teams will make joint home visits with CPP and participate in Family Team Meetings.

The IHRP team and CPP local and area office staff will work in close collaboration from the time of referral until the parent is discharged from the IHRP. The IHRP team will frequently communicate with the assigned CPP caseworker via phone and/or encrypted email (to ensure confidentiality) about the parent's progress and/or any concerns about the parent's functioning. The IHRP team will be required to notify the CPP caseworker when a parent relapses and

collaborate with the CPP to ensure the child's or children's safety. The CPP caseworker will likewise keep the IHRP team informed of any significant changes in the parent's case status.

The IHRP team, CPP staff, and parent will meet monthly to review progress toward goal achievement. The IHRP team will attend, when asked, any case planning meetings scheduled during the case episode, as well as child and family team meetings requested by the parent. In addition, the IHRP team, CPP caseworker, supervisor, and CPP/IHRP liaison will meet monthly in the CPP local office to review case progress.

CPP case closure for parents engaged in the IHRP shall be determined according to the CPP Case Closure in Cases with SUD Issues Policy, available at website below.

https://www.nj.gov/dcf/policy_manuals/CPP-III-C-8-00_issuance.shtml

Collaboration with Medication-Assisted Treatment Providers
IHRP clinicians and/or FSS will also collaborate with the parent's MAT provider, if applicable, and participate in case conferences telephonically or in person at least once a month.
Outreach

Since the IHRP is a home-based treatment, many of the barriers to accessing treatment are removed for IHRP parents. However, parents can avoid treatment by rescheduling frequently or not being home during scheduled home visits. Thus, the IHRP team will make multiple attempts to engage parents in treatment as outlined by the model. Staff may reach out via letter or phone call and attend scheduled sessions with the CPP caseworker.

Measures
IHRP clinicians utilize standardized measures to inform and guide treatment and identify and track symptoms over the course of the intervention. Measures are divided into three domains: parent, child, and parent-child relationship. Areas of focus in the three domains are as follows:

- parent: depression, anxiety, post-traumatic stress, and childhood trauma history
- child: development, resilience, behaviors, and trauma exposure

- parent-child relationship: parenting stress, parental reflective capacity, attachment styles, and parenting attitudes

Tools

A three-generation **genogram** provides a structure for obtaining family history and a preliminary understanding of the fit between the parent and the parent's family system. The genogram will be co-constructed by the parent-child clinician and the parent in the early stages of treatment and encourages a parent to think about the early influences of family and environment in terms of caregivers, stability, important relationships, mental and physical health, and substance use.

10) **The type of treatment sessions required for this program initiative are:** In-home dyadic treatment interventions

11) **The frequency of the treatment sessions required for this program initiative are:** three (3) home visits a week for at least the first six (6) months of treatment. After six (6) months of treatment, the parent may be stepped down to two (2) visits a week and then one (1) home visit a week, four (4) to six (6) weeks prior to discharge.

12) **Providers are required to communicate with Parent/Family/Youth Advisory Councils, or to incorporate the participation of the communities the providers serve in some other manner:** No

13) **The professional development through staff training, supervision, technical assistance meetings, continuing education, professional board participation, and site visits, required for this program initiative are:**

Staff Training and Reflective Supervision

DCF will contract with Montclair State University (MSU) to provide staff training, technical assistance, and reflective supervision. Awardees are required to collaborate with MSU within thirty (30) days of contract award and develop a concrete plan and timeline for staff training and reflective supervision as outlined below.

Introductory Training

MSU will provide an introductory training on the provision of in-home substance use treatment and Child-Parent Psychotherapy for the IHRP staff and DCF– CPP staff. The training, which will take place over a two (2) day period in a platform that considers the current

health and safety trends and guidelines present at the time of implementation, will introduce the basic constructs and techniques which inform the treatment program. Modules will address the theoretical framework, guiding programmatic principles, substance use treatment interventions and the provision of Child-Parent Psychotherapy.

Clinical Practice Seminar in Infant and Early Childhood Mental Health (IECMH) – one hundred (100) hours (two (2) hours/week/group for twelve (12) months)

The Clinical Practice in IECHM provides a necessary foundation for work with infants, young children, and their families. Attendees receive the equivalent of sixty (60) hours of training competencies towards the NJ-AIMH IMH Endorsement (www.nj-aimh.org/endorsement), including the areas of prenatal, infancy and early childhood development, the development of emotional and relational health, the power of relationships and interpersonal neurobiology, family and community systems, the influence of culture and context, assessment, intervention, and consultation strategies, evidence-informed clinical techniques, DC: 0-5 diagnostic system, Brazelton Touchpoints Approach, etc. Attendees also receive forty (40) hours of Reflective Supervision/Consultation by an Infant Mental Health Clinical Mentor (IMHM-C).

Two (2) certified consultants (one (1) parent/child, one (1) substance use) will provide weekly clinical consultation with IHRP teams. Total weekly phone time is 2.5 hours.

- The site supervisor will have one (1) thirty (30) minute call per week.
- Both team(s), including the supervisor, will participate in a two (2) hour virtual training/reflection supervision meeting each week.
- Both consultants will review in advance of the call clinical treatment notes, and model-specific tools and measures that have been administered.
- Consultants will be prepared to facilitate, and lead model-related discussions based on materials received.

Consultants will be available by email for questions that need to be addressed sooner than the consultation call.

Training in Child-Parent Psychotherapy – forty five (45) hours

Child-Parent Psychotherapy (https://childparentpsychotherapy.com/providers/training) is an evidence-based model of psychotherapy endorsed by the National

Child Traumatic Stress Network that is meant to support families with children under the age of six (6) who have experienced or witnessed a traumatic event. Training takes place over eighteen (18) months and is distributed over three (3) sessions that are separated by time, with the expectation that clinicians are working with cases during the time of training. The first learning session takes place over eighteen (18) hours. The second learning session is twelve (12) hours, and the third learning session is a final fifteen (15) hours.

Reflective Consultation in CPP practice – thirty six (36) hours concurrent with Professional Formation Communities in IECMH Clinical Practice (every other week 1-hr call)

Child-Parent Psychotherapy also necessitates the experience of reflective consultation about the clinicians' CPP practice. This takes place through two (2) one (1) hour meetings per week for the duration of the CPP training. At least 70% of the calls will need to be attended in order to complete the training.

Additional required training will include:

- The awardee is responsible for participating in the Nurtured Heart Approach (NHA) trainings and its implementation. NHA training will be provided by DCF CSOC staff and/or scheduled through CSOC Training and Technical Assistance: https://www.nj.gov/dcf/providers/csc/training/**https://www.nj.gov/dcf/providers/csc/training/**
- Identifying and reporting child abuse and neglect (Any incident that includes an allegation of child abuse and/or neglect must be immediately reported to the Division of Child Protection and Permanency (CPP) at 1-877-NJ ABUSE in compliance with N.J.S.A. 9:6-8.10)
- HIPAA: The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104-191, and regulations promulgated by the United States Department of Health and Human Services, forty-five (45) CFR Parts 160 and 164) was enacted to establish national standards for privacy and security in the handling of health-related information.
- 42 CFR Part 2 Confidentiality of SUD Patient Records training

D. Resources - The below describes the resources required of awarded respondents to ensure the service delivery area, management, and assessment of this program.

1) **The program initiative's service site is required to be located in:** County Specific (Union, Camden, Gloucester, Cumberland, Salem or adjacent County from eligible site locations; please see configurations as described in #2, below)

2) **The geographic area the program initiative is required to serve:** Respondents may propose to serve one of the following regional configurations:

1. Two Union County Local Offices
2. Two Camden County Local Offices
3. Two Gloucester County Local Offices
4. Two Cumberland County Local Offices
5. Salem Local Office and One Cumberland County Local Office
6. Salem Local Office and One Gloucester County Local Office
7. One Cumberland County Local Office and One Gloucester County Local Office.

CPP will determine the specific Local Offices to be served in the approved configuration.

3) **The program initiative's required service delivery location is:** Family Home and Community.

Access to Community Resources

As part of the proposed treatment model, the clinical team will provide information and assist clients to access available community resources to address basic needs, health care, family social opportunities, and medication-assisted treatment. Each grantee will be required to develop a Resource List that can be used by the clinical team when needs are identified, and linkages are required.

The Resource List may include, but does not have to be limited to, the following:

a. housing organizations
b. shelters (family and domestic violence)
c. pediatricians
d. MAT providers
e. parenting supports (e.g., Mommy and Me groups)
f. childcare organizations (e.g., Head Start and Early Head Start)
g. child development/health organizations (e.g., Birth to Three, Visiting Nurse Association)
h. food assistance (e.g., Supplemental Nutrition Assistance Program, Women, Infants and Children [WIC], food banks)
i. rental assistance programs
j. utility assistance
k. furniture assistance

l. clothing assistance
m. infant and child furniture/supplies assistance
n. code enforcement assistance
o. legal services
p. law and public safety
q. libraries

4) **The hours, days of week, and months of year this program initiative is required to operate:** Within the hours of 8:00 a.m. and 7:00 p.m. per day; Minimum of Five (5) days per week; Fifty-Two (52) weeks per year.

5) **Additional procedures for on call staff to meet the needs of those served twenty-four (24) hours a day, seven (7) days a week?** Yes (phone coverage for crisis intervention).

6) **Additional flexible hours, inclusive of non-traditional and weekend hours, to meet the needs of those served?** Yes

7) **The language services (if other than English) this program initiative is required to provide:** Respondents must be able to staff at least one (1) team (one (1) parent/child clinician, one (1) substance use clinician, and one (1) family support specialist) with person(s) who are bilingual in English and one other language that is common in the proposed service area. Preference will be given to respondents with two (2) teams able to provide bilingual services, or able to provide bilingual services in more than two (2) languages.

8) **The transportation this program initiative is required to provide:** Awardees are expected to provide or arrange transportation to parent-child sessions held outside of the home and/or group therapy sessions as needed to ensure parent participation; and the IHRP team will transport parents to offices and appointments in support of their basic needs, when appropriate.

9) **The staffing requirements for this program initiative, including the number of any required FTEs, ratio of staff to clients, shift requirements, supervision requirements, education, content knowledge, staff credentials, and certifications:**

Required Staff Duties/Responsibilities

NOTE: The respondent should have an awareness of the cultural needs of the families it proposes to serve. All members of at least one (1) of the two (2) teams (one (1) parent/child clinician, one (1) substance use clinician, and one (1) family support specialist) must

be bilingual in English and at least one other common language, and able to provide bilingual services that match the demographics of the proposed county or counties of service. Preference will be given to respondents with two teams able to provide bilingual services in English and the most common non-English language spoken in the proposed county(ies), and/or having a team(s) with capacity to provide services in more than two languages. The respondent may propose technology solutions to support service delivery in languages other than English.

The agency must have ***two (2)*** teams. The IHRP requires the following staff for model implementation:

IHRP clinical supervisor with oversight of both teams

- One (1) full-time licensed master's level clinician dedicated 50% to each team to provide clinical supervision and oversight for both teams.

Team members (for each team)

- Two (2) full-time licensed master's level clinicians for whom SUD disorder treatment is within their scope of practice (licensed clinical social worker [LCSW], licensed professional counselor [LPC], licensed psychologist, licensed marriage, and family therapist [LMFT] (4 full-time licensed master's level clinicians in total);
- One (1) full-time bachelor's level family support specialist (two full-time family support specialists in total), and
- One (1) part-time (.1FTE) psychiatrist or advanced practice registered nurse (APRN) for the parent(s) for the program in total.

The IHRP clinical supervisor with oversight of both teams will be a licensed clinician (e.g., a master's or doctoral level behavioral health professional) with at least five years' experience providing clinical and/or substance use services to children and families. Prior supervisory experience is required. This individual will be responsible for the following activities:

- Oversee the IHRP and its staff
- Provide weekly reflective supervision to the team
- Ensure treatment follows the FBR model and tools and measures are complete and timely
- Develop a strong collaborative relationship with the DCF CPP local office's IHRP liaison

- Review all referrals to determine eligibility
- Attend CPP reviews to guide team around discussion topics
- Submit monthly reports that meet CPP criteria for clients' progress toward treatment goals to CPP staff
- Oversee data collection and provide data to the IHRP evaluator
- Provide direct clinical care at the weekly parent-child outpatient therapy group and in the home when needed due to clinical acuity or staff absence
- Attend required trainings
- Participate in technical assistance meetings and calls

The clinicians (two (2) on each team, total of four (4)) will be master's level behavioral health professionals for whom SUD treatment is within their scope of practice. Clinicians may include licensed clinical social workers, licensed professional counselors, licensed psychologists, or licensed marriage and family therapists who are qualified to practice independently in New Jersey. Each clinician will be cross-trained and will act as the parent/child clinician for six (6) clients and the individual/substance use clinician for six (6) clients. The two (2) clinician roles are as follows:

Individual/Substance Use

- Deliver treatment that targets parental recovery and psychological well-being
- Conduct toxicology screens using oral or other methods that do not require urine sample collection
- Breathalyzers will be used at each visit for parents who have a diagnosis of an alcohol use disorder. IHRP staff will randomly (at least twice a month) conduct breathalyzer tests on parents that have a diagnosis for any other substance use disorder.
- Utilize FBR tools to inform and guide treatment
- Use FBR-specific abstinence-related tracking tools, such as graphing
- Provide individual psychotherapy to address comorbid mental health issues
- Co-construct treatment goals related to recovery, relapse, relapse prevention, education, employment, healthy relationships, family communication, and/or legal issues
- Refer client to medication-assisted treatment (MAT) as appropriate
- Collaborate with other systems to coordinate care to support the client and child, including with the MAT provider as needed
- Co-facilitate weekly parent-child therapy group

- Attend required trainings
- Submit all required data to supervisor and evaluator
- Participate in technical assistance meetings and calls

Parent-Child

- Deliver treatment to facilitate positive parent-child interactions and optimal child development
- Promote reflective capacity utilizing an infant mental health approach
- Conduct developmental screenings
- Address safe sleep and other safety issues
- Focus on the client's relationship with the child and the systems that interact with the child
- Conduct toxicology screens using oral or other methods that do not require urine sample collection

10) **The legislation and regulations relevant to this specific program, including any licensing regulations:** Treatment services must be delivered by independently licensed clinicians for whom substance use and mental health treatment are in their professional scope of practice.

11) **The availability for electronic, telephone, or in-person conferencing this program initiative requires:**
The IHRP team and DCPP local and area office staff will work in close collaboration from the time of referral until the parent is discharged from the IHRP. The IHRP team will frequently communicate with the assigned DCPP caseworker via phone and/or encrypted email (to ensure confidentiality) about the parent's progress and/or any concerns about the parent's functioning. The IHRP team, DCPP staff, and parent will meet monthly to review progress toward goal achievement. The IHRP team will attend, when asked, any case planning meetings scheduled during the case episode, as well as child and family team meetings requested by the parent. In addition, the IHRP team, DCPP caseworker, supervisor, and DCPP/IHRP liaison will meet monthly in the DCPP local office to review case progress. IHRP clinicians and/or FSS will also collaborate with the parent's MAT provider, if applicable, and participate in case conferences telephonically or in person at least once a month.

12) **The required partnerships/collaborations with stakeholders that will contribute to the success of this initiative:**
IHRP clinicians and/or FSS will collaborate with the parent's MAT provider, if applicable, and participate in case conferences telephonically or in person at least once a month.

13) **The data collection systems this program initiative requires:**

Toxicology Screens
- Negative, Positive, and Missing data
- Reason for Missing Screens
- MAT status

Qualitative Data:
- Client Admission interview
- Discharge Interview
    - Collect client experiences, expectations for treatment, engagement, ideas about parenting and recovery
- Staff Interview

Child Welfare Data:
Annual data pull using client SPIRIT IDs for the following:
- Re-Reports
- Substantiated Re-reports
- Removals
- Reunifications
- number of clients who start with Safety Protection Plans, when these plans are lifted, and when they are reinstated (or newly instituted).

For Staff:
The following scales are a part of the staff survey that is taken by staff:
- Evidence Based Practice Attitude Scale (EBPAS)
- Secondary Traumatic Stress Scale (STSS)
- Questions about Attitudes about Substance use Disorders (SUD)
- Attitudes Related to Trauma Informed Care Scale (ARTIC)
- Rejection Sensitivity RS-Adult Questionnaire (A-RSQ)
- Implementation Scales
- Brief Attachment Scales
- Job Ability, Job Satisfaction, Supervisor and Agency Support, Emotional Control over Work Duties, Job Feedback, and Organizational Attachment Scales
- Leadership Commitment, Agency Goals, Vision and Resources, and Capability & Staffing Scales

For Program:
- Intervention Fidelity by Team
- Intervention Fidelity as Organization

14) **The assessment and evaluation tools this program initiative require:**

The provider will be required to collaborate with Rutgers University to implement the following assessment and evaluation tools.

Timeline of Clinical Assessments for Clients				
Measure	**Intake (Baseline)**	**6-Month Reassessment**	**Discharge**	**3-Months Post Discharge**
Brief Substance Use Assessment	X	X	X	X
Functional Assessment	X			
Feedback Report	X			
GAD-7 (Parent Anxiety)	X	X	X	X
PHQ-9 (Parent Depression)	X	X	X	X
UCLA-PTSD (Parent Trauma)	X	X	X	X
AAPI (Parenting Attitudes and Behaviors)	X	X	X	X
PSI (Parenting stress)	X	X	X	X
PRFQ (Parental Reflective Functioning)	X	X	X	X
DECA – all ages (child socio-emotional development)	X	X	X	X
ASQ (child development)	X	X	X	X
PFS-2 (family needs, risk, and protective factors, demographics)	X		X	
ECR (Parent relational attachment)	X			
CTQ (parent childhood trauma)	X			

E. Outcomes - The below describes the evaluations, outcomes, information technology, data collection, and reporting required of respondents for this program.

1) **The evaluations required for this program initiative:**

Program Evaluation

The Program also includes a separate evaluation component. If the evaluation demonstrates evidence of clinical effectiveness and

positive child welfare outcomes, including decreased costs for foster care, a case could be made to the State of New Jersey for more widespread support of an in-home treatment model that addresses parental substance use and the parent-child dyadic relationship. Requirements for IHRP teams for the program evaluation are detailed below.

Provide Data for the Project Evaluations

More detailed information about data requirements for the separately funded evaluation will be shared with teams during the training and technical assistance sessions. Measures are used to inform and guide the clinical work in addition to providing valuable data for program evaluation. Measures are divided into three domains: parent, child, and parent/child relationship. Areas of focus in the three (3) domains are as follows:

- parent: depression, anxiety, post-traumatic stress, and childhood trauma history
- child: development, resilience, behaviors, and trauma exposure
- parent-child relationship: parenting stress, parental reflective capacity, attachment styles, and parenting attitudes.

2) **The outcomes required of this program initiative**

a) Short Term Outcomes:

- Parent Outcomes
  - Parents demonstrate abstinence
  - Parents display/exhibit a positive perception of their child
  - Parents are connected to additional treatment services, as needed
  - Parents identify and access a sober support network, as needed
- Child Outcomes
  - Children experience fewer incidents of maltreatment
  - Children remain with biological family
  - Children are placed in appropriate kinship care if needed
  - Children's development is tracked, referrals/interventions provided as needed

b) Mid Term Outcomes:

- Parent Outcomes
  - Parents have lower levels of stress
  - Parents have fewer depressive symptoms
  - Parents are more financially stable
  - Parents have increase job readiness skills, if applicable

- Child Outcomes
    - Children’s development is tracked, referrals/interventions provided as needed

c) Long Term Outcomes:

- Parent Outcomes
    - Parents retain custody of their children
    - Parents do not put their children at risk because of substance use
    - Parents are better attuned to their child’s needs
- Child Outcomes
    - Children live in safe and stable home environments
    - Children have enhanced well-being and increased protective factors
    - Children have more secure attachment to parent

3) **Required use of databases:** Describe the Information Technology Systems required for the Operation and Performance Monitoring of this program initiative

The provider will be required to collaborate with Rutgers University to collect information that Rutgers will store and analyze for IHRP. Rutgers will use the following data systems:

- Salesforce (collect, store, client, child welfare, toxicology, program data)
- Qualtrics (collect, store, staff data)
- HIPPA compliant Box Folder (store de-identified client, staff, and program data, de-identified client interview data and staff interview data, quarterly reports, infographics)
- Tableau (in development with SPARK learning) to input and visualize client and program data so that programs will be able to see it in real time.

These systems:

- Are HIPPA compliant (for all client data)
    - Qualitrics is not, but only anonymous staff data is collected
- Work with DCF for an annual data pull

4) **Reporting requirements:** Describe the documents and reports required for data collection, reporting, and ongoing quality improvement for this program initiative

The provider will be required to collaborate with Rutgers University in ongoing quality improvement activities. This involves participating in quarterly and annual meetings with IHRP staff and DCF leadership where findings are discussed, CQI goals are identified, and program

processes and procedures are adjusted. Rutgers uses the following documents and reports for data collection and reporting:

- Quarterly Reports
- Infographics of Data
- Tableau to visualize and track all client and program data.

F. Signature Statement of Acceptance:

By my signature below, I hereby certify that I have read, understand, accept, and will comply with all the terms and conditions of providing services described above as *Required Performance and Staffing Deliverables* and any referenced documents. I understand that the failure to abide by the terms of this statement is a basis for DCF's termination of my contract to provide these services. I have the necessary authority to execute this agreement between my organization and DCF.

Name:

Signature:

Title:

Date:

Organization:

Federal ID No.:

Charitable Registration No.:

Unique Entity ID #:

Contact Person:

Title:

Phone:

Email:

Mailing Address:

[Optional when RFP includes multiple regions and/or target populations add the ability to select or indicate region and/or target population requested]

Section III - Documents to be Submitted with This Response

In addition to the Signature Statement of Acceptance of the Required Performance and Staffing Deliverables, DCF requests respondents to submit the following documents with each response. Respondents must organize the documents submitted in the same order as presented below under one (1) of the two (2) corresponding title headings: A. *Organizational Documents Prerequisite to a DCF Contract Award to be Submitted with This Response* and B. Additional Documents *to be Submitted in Support of This Response*. **Each of these two (2) sections must be submitted as a separate PDF, which would be the second and third PDF submission in your response packet.**

A. Organizational Documents Prerequisite to a DCF Contract Award Requested to be Submitted with this Response:

(THIS WILL BE THE SECOND PDF SUBMISSION IN YOUR RESPONSE PACKET AND IS TO BE LABELED AS: *PDF 2: SECTION III - DOCUMENTS TO BE SUBMITTED WITH THIS RESPONSE, SUBSECTION A. ORGANIZATIONAL DOCUMENTS PREREQUISITE TO A DCF CONTRACT AWARD.)*

1) A description of how your **Accounting** System has the capability to record financial transactions by funding source, to produce funding source documentation, authorization to support all expenditures, and timesheets which detail by funding source how the employee spent their time, invoices, etc.

2) **Affirmative Action Certificate:** Issued after the renewal form [AA302] is sent to Treasury with payment.
   Note: The AA302 is only applicable to new startup agencies and may only be submitted during Year One (1). Agencies previously contracted through DCF are required to submit an Affirmative Action Certificate.
   Website: https://www.state.nj.us/treasury/contract_compliance/

3) **Agency By-Laws** -or- Management **Operating Agreement** if a Limited Liability Corporation (LLC) or Partnership

4) Statement of **Assurances** signed and dated.
   Website: https://www.nj.gov/dcf/providers/notices/requests/#2
   Form:
   https://www.nj.gov/dcf/providers/notices/Statement.of.Assurance.doc

5) **Attestation Form for Public Law P.L. 2021, c.1** - Complete, sign and date as the provider.

Form: Attestation.Form.To.Be.Completed.by.Providers.Covered.by.Public.Law.2021c.1.-6.7.21.pdf (nj.gov)

6) Dated List of Names, Titles, Emails, Phone Numbers, Addresses and Terms of either the **Board of Directors** of a corporation, or the **Managing Partners** of a Limited Liability Corporation (LLC)/Partnership, or the **members** of the responsible governing body of a county or municipality.

7) For Profit: **NJ Business Registration Certificate** with the Division of Revenue (see instructions for applicability to your organization).
Website: https://www.nj.gov/treasury/revenue/busregcert.shtml

8) **Business Associate Agreement/HIPAA** - Sign and date as the Business Associate.
Form: https://www.nj.gov/dcf/providers/contracting/forms/HIPAA.docx

9) For Profit: **Chapter 51/Executive Order 117** Vendor Certification and Disclosure of Political Contributions (See instructions for applicability to your organization). Website: https://www.nj.gov/treasury/purchase/forms.shtml

10) **Conflict of Interest Policy** (Respondent should submit its own policy, **not** a signed copy of the DCF model form found at the end of the following DCF policy.)
https://www.nj.gov/dcf/documents/contract/manuals/CPIM_p8_conflict.pdf

11) All **Corrective action plans or reviews** completed by DCF (inclusive of DCF Licensing, Divisions and Offices) or other State entities within the last two (2) years. If applicable, a copy of the corrective action plan should be provided and any other pertinent information that will explain or clarify the respondent's position.

    If not applicable, the respondent is to **include a signed written statement** that it has never been under any Corrective Actions or reviews. Respondents are on notice that DCF may consider all materials in our records concerning audits, reviews, or corrective active plans as part of the review process. Respondents subject to a Corrective Action not yet completed are not eligible to apply.

12) Certification Regarding **Debarment**
Form:https://www.nj.gov/dcf/documents/contract/forms/Cert.Debarment.pdf

13) Disclosure **of Investigations & Other Actions Involving Respondent**
Form:
https://www.nj.gov/treasury/purchase/forms/DisclosureofInvestigations.pdf

14) **Disclosure of Investment Activities in Iran**

Form:
https://www.nj.gov/treasury/purchase/forms/DisclosureofInvestmentActivitiesinIran.pdf

15) **Disclosure of Ownership (Ownership Disclosure Form) THIS FORM MUST BE SUBMITTED WITH THE RESPONSE OR THE RESPONSE WILL BE NON-RESPONSIVE**
Form:
https://www.nj.gov/treasury/purchase/forms/OwnershipDisclosure.pdf
The Ownership Disclosure form must be completed and returned by non-profit and for-profit corporations, partnerships, and limited liability companies. The failure of a **for-profit** corporation, partnership, or limited liability company to complete the form prior to submitting it with the response **shall result in rejection of the response**.

16) **Disclosure of Prohibited Activities in Russia and Belarus**
Form:
https://www.state.nj.us/treasury/administration/pdf/DisclosureofProhibitedActivitesinRussiaBelarus.pdf

17) **Source Disclosure Form (Disclosure of Source Location of Services Performed Outside the United States)**
Form:
http://www.state.nj.us/treasury/purchase/forms/SourceDisclosureCertification.pdf

18) Document showing **Unique Entity ID (SAM)** Number
Website: https://sam.gov/content/duns-uei

19) Certificate **of Incorporation**
Website: https://www.nj.gov/treasury/revenue

20) **Notice of Standard Contract Requirements, Processes, and Policies**
Sign and date as the provider
Form: Notice.of.Standard.Contract.Requirements.pdf (nj.gov)

21) **Organizational Chart of respondent -** Ensure chart includes the agency name, current date, and the allocation of personnel among each of the agency's DCF programs with their position titles and names.

22) **Prevent Child Abuse New Jersey's (PCA-NJ) Safe-Child standards -** A brief description (no more than two (2) pages double spaced) of the ways in which respondent’s operations (policies and/or practices) mirror these standards. The document should include the agency name & current date. The Standards are available at: “Sexual Abuse Safe-Child Standards” (state.nj.us)

23) **Standard Language Document (SLD) (or Individual Provider Agreement or Department Agreement with another State Entity as designated by DCF.)**
Sign and date as the provider
Form:
https://www.nj.gov/dcf/documents/contract/forms/StandardLanguage.doc

24) **System for Award Management** (**SAM)** Submit a printout showing active status and the expiration date. Available free of charge.
Website: https://sam.gov/content/home
Helpline:1-866-606-8220

25) **Tax Exempt Organization Certificate** (ST-5) -or- **IRS Determination Letter** 501(c)(3)
Website: https://www.nj.gov/treasury/taxation/exemptintro.shtml

26) **Tax Forms: Submit a copy of the most recent full tax return**
Non-Profit: Form 990 Return of Organization Exempt from Income Tax
or- For Profit: Form 1120 US Corporation Income Tax Return -or-
LLCs: Applicable Tax Form and may delete/redact any SSN or personal information
Note: Store subsequent tax returns on site for submission to DCF upon request.

27) **Trauma Informed and Cultural Inclusivity Practices -** Submit written policies describing the incorporation of these practices into your provision of services.

B. Additional Documents to be Submitted in Support of This Response

(THIS WILL BE THE THIRD PDF SUBMISSION IN YOUR RESPONSE PACKET AND IS TO BE LABELED AS: *PDF 3: SECTION III – DOCUMENTS TO BE SUBMITTED WITH THIS RESPONSE, SUBSECTION B. ADDITIONAL DOCUMENTS TO BE SUBMITTED IN SUPPORT OF THIS RESPONSE*.)

1) A completed **Proposed Budget Form** documenting all costs associated with operating the program. If DCF is allowing funding requests for **start-up costs**, document these separately in the final column of the Proposed Budget Form. This form is found at:
https://www.nj.gov/dcf/providers/contracting/forms/

2) A completed **Budget Narrative** is required for the proposed program that: a) clearly articulates budget items, including a description of miscellaneous expenses or "other" items; b) describes how funding will be used to meet the project goals, responsibilities, and requirements; and c) references the

costs associated with the completion of the project as entered in the Proposed Budget Form found at: https://www.nj.gov/dcf/providers/contracting/forms/. When DCF allows funding requests for start-up costs, include in the Budget Narrative a detailed summary of, and justification for, any one-time program implementation costs documented in the final column of the Proposed Budget Form.

3) An **Implementation Plan** for the program that includes a detailed timeline for implementing the proposed services, or some other detailed weekly description of your action steps in preparing to provide the services and to become fully operational.

4) **Letter(s) of Collaboration** specific to a service to demonstrate commitment to the program.

5) Three (3) **Letter(s) of Support** from community organizations with which you already partner. Letters from any New Jersey State employees are prohibited.

6) **Price Quotes** for specially required equipment or software

7) **Proposed Respondent Organizational Chart** for the program services required by this response that includes the respondent's name and the date created.

8) **Proposed Subcontracts/Consultant Agreements/ Memorandum of Understanding** to be used for the provision of contract services.

9) A **Training Curricula Table of Contents** for the current and proposed staff consistent with the requirements described and certified to in the Activities Requirements) of the Required Performance and Staffing Deliverables of this RFP.

Section IV - Respondent's Narrative Responses

Respondents who sign the above Statement of Acceptance to provide services in accordance with the *Required Performance and Staffing Deliverables* additionally must submit a narrative response to every question below. A response will be evaluated and scored as indicated on each of the following three Narrative Sections: A. Community and Organizational Fit; B. Organizational Capacity; C. Organizational Supports, and D. Vignette Response. Respondents must organize the Narrative Response sections submitted in the same order as presented below and under each of the three corresponding title headings.

There is a 35-page limitation for the narrative response. The narrative should be double-spaced with margins of one (1) inch on the top and bottom and one (1) inch on the left and right. Narrative Sections of the responses should be double-spaced with margins of one (1) inch on the top and bottom and one (1) inch on the left and right. The font shall be no smaller than twelve (12) points in Arial or Times New Roman.

(ALL four (4) OF THESE SECTIONS MUST BE SUBMITTED AS A SINGLE PDF DOCUMENT, WHICH WOULD BE THE FOURTH PDF SUBMISSION IN YOUR RESPONSE PACKET AND IS TO BE LABELED AS: *PDF 4 – SECTION IV: RESPONDENT'S NARRATIVE RESPONSES, SUBSECTIONS A. COMMUNITY AND ORGANIZATIONAL FIT; B. ORGANIZATIONAL CAPACITY; C. ORGANIZATIONAL SUPPORTS and D. Vignette Response*.)

A. Community and Organizational Fit (20 Points)

Community and Organizational fit refers to respondent's alignment with the specified community and state priorities, family and community values, culture and history, and other interventions and initiatives.

1) Describe how this initiative is consistent with your organization's mission, vision, and priorities.

2) Describe how this initiative fits with existing initiatives/programming in your organization.

3) Describe any existing services and programs that are categorized as well supported, supported, or promising as per the California Evidence-Based Clearinghouse for Child Welfare definition(s) (CEBC). https://www.cebc4cw.org/

4) Describe how this initiative is consistent with your organization's experience working with the target (or similar) populations required to be served by this initiative.

5) Describe how you will meet the geographic area requirements of this program initiative.

6) Provide a concise summary of the In-Home Recovery Program your organization proposes to implement. It should explain how the proposed model will meet the needs of the required target population and achieve the required outcomes.

B. Organizational Capacity (50 Points)

Organizational Capacity refers to the respondent's ability to meet and sustain the specified minimum requirements financially and structurally.

1) Describe how the organization's leadership is knowledgeable about and in support of this initiative. Include how the requirements of this initiative will be met through your governance and management structure, including the roles of senior executives and governing body (Board of Directors, Managing Partners, or the members of the responsible governing body of a county or municipality). Do leaders have the diverse skills and perspectives representative of the community being served?

2) Does the organization currently employ or have access to staff that meet the staffing requirements for this initiative as described and certified to in the Resources/Staff Requirements section of the *Required Performance and Staffing Deliverables* of this RFP. If so, describe.

3) Does staff have a cultural and language match with the population they serve, as well as relationships in the community? If so, describe.

4) Describe how your Agency plans to fulfill staffing requirements not currently in place by hiring staff, consultants, sub-grantees and/or volunteers who will perform the proposed service activities.

5) Are there designated staff with capacity to collect and use data to inform ongoing monitoring and improvement of the program or practice? If so, describe.

6) What administrative practices must be developed and/or refined to support the initiative/program/practice? What administrative policies and procedures must be adjusted to support the work of the staff and others to implement the program or practice?

7) Describe how the requirements of this initiative will be met through your existing collaborations, partnerships and collaborative efforts with other communities and systems.

8) Describe how the requirements of this initiative will be met through your membership in professional advisory boards.

9) Describe how the requirements of this initiative will be implemented through the existing or anticipated community partners listed and certified to in the resources section and the collaborative activities listed and certified to in the activities section of the *Required Performance and Staffing Deliverables* of this RFP.

10) Describe how the requirements of this initiative will be met through your plans for program accessibility that include, at a minimum, the following details: site description, safety considerations, and transportation options for those served.

11) Describe how the requirements of this initiative will be met through your strategies for identifying and engaging the target population and for maintaining their participation in services in accordance with service recipients' need(s).

12) Describe how you will ensure that patients who are clinically indicated for MAT will receive this service. Describe how you will partner with the prescriber to ensure continuity of care.

13) Describe past or present experience in serving families involved with the CPP including how collaboration and communication are and expect to be accomplished. Provide retention rates (if available) from prior initiatives. Describe challenges and successes previously experienced with other programs to engage and retain other target populations in home-based services.

14) Describe any existing partnerships or new collaborations that you plan to develop to help address families' access to basic needs and community resources.

15) Describe how the requirements of this initiative will be met through your commitment to cultural competency and diversity and plans to ensure needs of various and diverse cultures within the target community will be met in a manner consistent with the Law Against Discrimination (N.J.S.A. 10:51 et seq.).

16) Describe any fees for services, sliding fee schedules, and waivers.

17) Describe how the organization will meet current DCF guidance for in-home and community-based programs in response to Covid19: DCF | UPDATED January 20, 2023: COVID-19 Resources for Contracted Providers (nj.gov).

18) Describe the decision making and referral process when referrals to other levels of SUD care are needed.

19) Demonstrate experience with, understanding of, and integration of issues of trauma in adults and how it will be integrated into the treatment plan. Articulate how both explicit and implicit trauma will be addressed within the context of staff support and assessment/treatment.

C. Organizational Supports (20 Points)

Organizational Supports refers to the respondent's access to Expert Assistance, Staffing, Training, Coaching & Supervision.

1) Describe how your organization will support this initiative with required/ necessary training, coaching, supervision. Describe your organization's process to evaluate staff performance.

2) Describe how your organization will support the staff implementing this initiative by leveraging the resources of providers; communities; and other stake holders.

3) Describe how your organization will support the requirements of this initiative for collection, maintenance, and analysis of data. Will this require use of or changes to existing monitoring and reporting systems?

4) Describe how this initiative will be supported by your use of the data after it is analyzed and reported to evaluate program performance.

5) Describe how this initiative will be supported by your quality assurance and performance improvement processes, including the meaningful role of those to be served.

6) Describe how this initiative will be supported by your willingness to engage in participatory, collaborative evaluation planning with DCF to improve and finalize outcome indicators.

7) Describe your plan to accomplish the following:
    - ensure the staff participate in the required training when scheduled
    - ensure that staff have dedicated time to participate in the required additional training and support activities
    - address cultural competence and language barriers to treatment
    - recruit, hire, and train new staff in the event of staff turnover

D. Responses to Case Vignettes (10 Points)

Read the following five (5) vignettes and questions, select two (2) and develop a maximum one (1) page response to the questions for each of the two (2) vignettes.

<u>Case Vignettes</u>

1) Pauline is a 29-year-old mother. She has given birth to three children. She had her first child when she was 16 and placed the child up for adoption. She had her second child at age 22 and transferred guardianship to her mother soon

after birth. Pauline visits her every weekend. Pauline relapsed on heroin and cocaine several times during her third pregnancy. The hospital referred her to the Division of Child Protection and Permanency (DCP&P) after her daughter Hope was born. DCP&P referred Pauline and Hope to your program. Pauline appears very excited to have another chance to be a mother. She has expressed feeling anxious, saying she is not sure what to do with an infant as she has never taken care of one by herself. She is very worried DCP&P will take Hope away from her. Pauline has been meeting with your program regularly. In the sixth week of treatment, Pauline's urine toxicology screen is positive for heroin. Pauline becomes animated and tearful, saying, "Your test is wrong! I have not used anything!" Pauline says she is tired of people coming into her house all the time and asks you to leave.

What is your formulation of Pauline's behavior?
How do you respond to her during this session?
How would you define successful discharge for this family?

2) Carmen is a 35-year-old mother. Carmen lives with her husband, Steven. He works a full-time construction job and is very supportive of Carmen. She just gave birth to their first child, Alex. He was born eight weeks premature and had some minor respiratory issues at the delivery. At the time of birth, Carmen and Alex were positive for THC. They have been referred by DCP&P to your treatment program. During sessions, Carmen talks about Alex being her "miracle baby" as she did not think she could have children. She holds Alex during each session, looks at him often, and talks to him quietly when he is awake. She appears very attuned to his cues and is timely in responding. When Steven or other family members ask to hold the baby, she declines, saying, "He likes being with his mother." Her family laughs and talks about how Carmen is always holding Alex even at night when she could be sleeping.

How do you understand Carmen's wanting to hold her child? How might you learn more about this?
How would you define successful discharge for this family?

3) Melany is a 22-year-old mother. She has two children: Matt, Jr., age four months, and Margo, age 4. Melany and her children reside with her mother, who works two jobs and is not home much. Melany tested positive for oxycodone and cocaine throughout her pregnancy with Matt, Jr. She began using with her boyfriend, Matt, Jr.'s father, at the age of 19. She tested positive throughout her pregnancy and was referred to CP&P after Matt, Jr.'s birth. After DCP&P became involved, Melany began medication-assisted treatment and is now in your program to focus on cocaine use. During home visits, Melany sits on the couch holding Matt, Jr. and watching Margo play around the room. There are toys available to her children, though many are not appropriate for Margo's age or developmental phase. While Margo plays, Melany talks about her tumultuous relationship with Matt, Jr.'s father. When Margo moves toward

Melany, she engages a protective stance with Matt, Jr. and points out a toy for Margo to play with, then continues talking. At one point, Margo knocks over Melany's drink while trying to get up on the couch next her mother. Melany quickly jumps up, and screams at Margo to go sit on the stairs, saying "How many times have I told you to watch what you're doing? Now sit there." Margo sits quietly on the stairs for the rest of the session.

What is Melany's understanding of physical and emotional development?
How do you understand Margo's behavior?
How might you respond to this situation?
How would you define successful discharge for this family?

4) Angel is a 25-year-old mother. She has a 3-year-old son named Adam. She is in your treatment program for marijuana use. Angel started smoking marijuana when she was 13 years old and never thought she would be able to stop. Most of her family members and friends smoke marijuana. She was beyond excited when she had her first negative toxicology screen after three months in your program. Angel expresses ambivalence about her abstinence; she is very proud of herself for meeting her goal of abstinence, yet she has complained of increased irritability and difficulty sleeping, symptoms she feels are due to not smoking marijuana. During a session with Angel, you are sitting outside with her and Adam, talking on their front porch. Adam is riding a scooter that is intended for an older child, and he falls and scrapes his knee. He sits on the sidewalk in front of the house and is crying, rubbing his knee. Adam looks at you and Angel on the porch and reaches his hands out. Angel remains seated on the porch and says, "He'll be fine. He needs to learn to be tough in this world," and she continues talking to you.

What is your hypothesis about Angel's response to her child? What is your intervention?
How would you define successful discharge for this family?

5) Chris is a 20-year-old father. He lives with his partner, Cherie, and their child, Neveah, who is 8 months old. Neveah is their first child. Both Chris and Cherie use marijuana and cocaine. Chris, Cherie, and Neveah are living in Cherie's mother's apartment until they can save money for their own. Both Chris and Cherie have been referred for treatment, but Cherie declined, saying she would rather go to a different program. Chris agreed to start treatment in your in-home program. During the first three weeks of treatment, Chris canceled 4 out of 12 of his sessions. When asked about the canceled sessions, he stated that he had forgotten he had to work and could not meet. One time when you met with Chris in the home, Cherie was in the other room talking on the phone, and you overhear her say, "Chris's stupid program is here." The next time you went to see Chris, Neveah's grandmother answered the door and informed you that he "just left." No one answers the door when you attempt your second scheduled

session that week. You have called Chris twice since then, and he has not returned your call.

What is your formulation of Chris's behavior? What are your next steps with Chris? How would you define successful discharge for this family?

Section V - Response Screening and Review Process

A. Response Screening for Eligibility, Conformity, and Completeness:

DCF will conduct a preliminary review of each response to determine whether it is eligible for evaluation or immediate rejection in accordance with the following criteria:

1) The response was received prior to the stated deadline.

2) The Statement of Acceptance is signed by the person with the necessary authority to execute the agreement.

3) The response is complete in its entirety, including all documents required to be submitted in support of the response listed in Section III. A. and the organizational documents prerequisite to a contract award listed in Section III. B. If any of these documents are missing from the response, DCF may provide an email notice to the respondent after the response is submitted. Respondents will have up to five (5) business days after notice from DCF to provide the missing documentation, except those documents, such as the Ownership Disclosure Form, required by the Rapplicable law to be submitted with the response. If the documents are not then timely submitted in response to that notice, the response may be rejected as non-responsive.

4) The response conforms to the specifications set forth in the RFP.

Failure to meet the criteria outlined above, constitutes grounds for rejection of the response.

Responses meeting the initial screening requirements of the RFP will be distributed to the Evaluation Committee for its review and recommendations.

B. Response Review Process

The Department convenes an Evaluation Committee in accordance with existing regulation and policy to review all responses. All voting and advisory reviewers complete a conflict-of-interest form. Those individuals with conflicts or with the appearance of a conflict are disqualified from participation in the review process. The voting members of the Evaluation Committee will review responses,

deliberate as a group, and recommend final funding decisions.

The Department reserves the right to reject any response when circumstances indicate that it is in its best interest to do so. The Department's best interests in this context include, but are not limited to, the State's loss of funding, inability of the respondent to provide adequate services, respondent's lack of good standing with the Department, and indication or allegation of misrepresentation of information or non-compliance with any State contracts, policies and procedures, or State or Federal laws and regulations.

A response to an RFP may result in a contract award if the Evaluation Committee concludes the respondent will comply with all requirements as demonstrated by submitting the specified documentation and signing the Statement of Acceptance. All respondents are required to provide all the requested documentation, to confirm their ability to meet or exceed all the compulsory requirements, to provide services consistent with the scope of services delineated, and to comply with the service implementation and payment processes described. In addition, a response to an RFP will be evaluated and scored by the Evaluation Committee based on the quality, completeness, and accuracy of each of the three Narrative Sections: A. Community and Organizational Fit; B. Organizational Capacity; and C. Organizational Supports. A response earning the highest score may result in a contract award. The narrative must be organized appropriately and address the key concepts outlined in the RFP. The quality and completeness of the required documents may impact the score of the Narrative Sections to which they relate.

All respondents will be notified in writing of the Department's intent to award a contract.

C. Appeals

An appeal of a determination to reject a response as incomplete or unresponsive may be considered only to dispute whether the facts of a particular case are sufficient to meet the requirements for rejection and not to dispute the existence of any of the requirements.

An appeal of a determination not to award contract funding may be considered only if it is alleged that DCF has violated a statutory or regulatory provision in its review and evaluation process.

Pursuant to DCF policy P1.08, such appeals must be submitted in writing within ten (10) business days following the date on the Notice of Disqualification or Notice of Regret letter by emailing it to DCF.AHUAppeals@dcf.nj.gov and/or mailing it to:

Department of Children and Families
Office of Legal Affairs

Contract Appeals
50 East State Street 4th Floor
Trenton, NJ 08625

Section VI - Post Award Requirements

A. General Conditions of Contract Execution:

Respondents who receive notice of DCF's intent to award them a contract will be referred to the DCF Office of Contract Administration (OCA). As a condition of executing a contract, awardees must resolve with OCA any issues raised in the award letter or otherwise found to be need of clarification. If DCF finds after sending a notice of intent to award that the awardee is incapable of providing the services or has misrepresented any material fact or its ability to manage the program, the award may not proceed to contract execution. DCF determines the effective date of any contract, which is the date compensable services may begin.

A respondent awarded a contract shall be required to comply with the terms and conditions of the Department of Children and Families' contracting rules, regulations, and policies as set forth in the Standard Language Document, the Notice of Standard DCF Contract Requirements, the Contract Reimbursement Manual, and the Contract Policy and Information Manual. Awardees may review these items via the Internet at www.nj.gov/dcf/providers/contracting/manuals and https://www.state.nj.us/dcf/providers/contracting/forms/. Awardees also shall comply with all applicable State and Federal laws and statutes, assurances, certifications, and regulations regarding funding.

B. Organizational Documents Prerequisite to Contract Execution to be Submitted After Notice of Award:

The OCA contract administrator assigned to initiate and administer an awardee's contract will require the awardee to submit the following documents prior to finalizing the contract for funding:

Post-Award Documents Prerequisite to the Execution of All Contracts

1) **Acknowledgement of Receipt** of NJ State Policy and Procedures: Return the receipt to DCF Office of EEO/AA.
Form:https://www.nj.gov/dcf/documents/contract/forms/DiscriminationAcknowReceipt.pdf
Policy:https://www.nj.gov/dcf/documents/contract/forms/AntiDiscriminationPolicy.pdf

2) **Annual Report to Secretary of State** proof of filing.

Website: https://www.njportal.com/dor/annualreports

3) **Employee Fidelity Bond Certificate (**commercial blanket bond - crime/theft/dishonest acts)

   Bond must be at least 15% of the full dollar amount of all State of NJ contracts for the current year when the combined dollar amount exceeds $50,000. The $50,000 threshold includes fee-for-service reimbursements made via Medicaid. Not Applicable Note: Should state your agency will not exceed $50,000 in combined State of NJ contracts for the current year.

   Email To: OfficeOfContractAdministration@dcf.nj.gov and copy your contract administrator
   Policy:https://www.nj.gov/dcf/documents/contract/manuals/CPIM_p8_insurance.pdf

4) **Liability Insurance** (Declaration Page/Malpractice Insurance/Automobile Liability Insurance)
   Important: Policy must show:
   a. DCF as the certificate holder – NJDCF 50 E State Street, Floor 3, P.O. Box 717, Trenton, NJ 08625
   b. Language Stating DCF is "an additional insured"
   c. Commercial Liability Minimum Limits of $1,000,000 an occurrence, $3,000,000 aggregate
   d. Commercial Automobile Liability Insurance written to cover cars, vans or trucks, limits of liability for bodily injury and property damage should not be less than $2,000,000/occurrence.

   Email To: OfficeOfContractAdministration@dcf.nj.gov and copy your contract administrator
   Policy:https://www.nj.gov/dcf/documents/contract/manuals/CPIM_p8_insurance.pdf

5) Document showing **NJSTART** Vendor ID Number (NJ's eProcurement System) Website: https://www.njstart.gov/ Helpline: 609-341-3500 or - njstart@treas.nj.gov

6) **Standardized Board Resolution Form**
   Form:https://www.nj.gov/dcf/documents/contract/manuals/CPIM_p1_board.pdf

7) **Chapter 271/Vendor Certification and Political Contribution Disclosure Form**
   [2006 Federal Accountability & Transparency Act (FFATA)]
   Form:https://www.nj.gov/treasury/purchase/forms/CertandDisc2706.pdf

8) **Program Organizational Chart**

Should include agency name & current date

Post-Award Documents Prerequisite to the Execution of This Specific Contract

9) Copy of **Accreditation** (Joint Commission, COA, CARF, as applicable) Cancellation of accreditation must be reported Immediately.
10) **Annex A -** Sections 1.1, 1.3 (& 2.4 if not a CSOC OOH Contract).
    Note: Contract Administrators will provide any Annex A forms customized for programs when they are not available on the DCF public website. Website: https://www.nj.gov/dcf/providers/contracting/forms

11) **Annex B Budget Form -** Include Signed Cover Sheet
    Form: https://www.nj.gov/dcf/documents/contract/forms/AnnexB.xls
    Note: The Annex B Expense Summary Form is auto populated. Begin data input on Personnel Detail Tab.
    Website: https://www.nj.gov/dcf/providers/contracting/forms

12) **Certification Regarding Exemptions**
    Website: https://www.nj.gov/dcf/providers/contracting/forms

13) **Certification Regarding Reporting**
    Website: https://www.nj.gov/dcf/providers/contracting/forms

14) **Equipment Inventory** (of items purchased with DCF funds) Policy: https://www.nj.gov/dcf/documents/contract/manuals/CPIM_p4_equipment.pdf

15) **Schedule of Estimated Claims** (SEC) signed
    Form: Provided by contract administrator when applicable.

16) For Programs Hosting Youth, Adults, and Families or relying on Rent, Interest, or Depreciation in their program budget: current **Health/Fire Certificates**

17) For Programs Hosting Youth, Adults, and Families or when including Rent, Interest, or Depreciation in the program budget: copies of an executed **Lease, Mortgage** or **Deed.**

18) For Programs Hosting Youth, Adults, and Families or relying on Rent, Interest, or Depreciation in their program budget: current/continued **Certificate of Occupancy.**

19) **Professional Licenses and/or Certificates** currently effective related to job responsibilities.

20) **Subcontracts/Consultant Agreements/ Memorandum of Understanding** related to this contract for DCF review and approval.

C. Reporting Requirements for Awarded Respondents

Awarded Respondents are required to produce the following reports in accordance with the criteria set forth below, in addition to the reports specified above in this RFP related to the delivery and success of the program services.

1) **Audit** or **Financial Statement** (Certified by accountant or accounting firm.) A copy of the Audit must be submitted to DCF by all agencies expending over $100,000 in combined federal/state awards/contracts if cognizant with any department of the State of NJ. As noted in the Audit DCF Policy CON -I-A-7-7.6.2007 Audit Requirements, section 3.13 of the Standard Language Document, DCF also may request at any time in its sole discretion an audit/financial statement from agencies expending under $100,000 that are not cognizant with any department of the State of NJ. Note: Document should include copies of worksheets used to reconcile the department's Report of Expenditures (ROE) to the audited financial statements. (DCF Policy CON -I-A-7-7.6.2007 Audit Requirements)

   Awarded respondents are to submit the most recent audit or financial statement with the initial contract and then each subsequent one within 9 months of the end of each fiscal year.
   Policy:
   https://www.nj.gov/dcf/documents/contract/manuals/CPIM_p7_audit.pdf

2) **DCF Notification of Licensed Public Accountant Form** (NLPA)**-and-** copy of **Non-Expired Accountant's Certification**

   Awarded respondents must ensure DCF form is used, and 2 signatures are provided. Not required for agencies expending under $100,000 in combined federal/state awards or contracts. The $100,000 threshold includes fee-for-service reimbursements made via Medicaid. Also, the NLPA is a State of NJ form and need only list federal/state funds received via contracts with the State of NJ.

   Awarded respondents are to submit this form with each Audit, providing info related to the year subsequent to the audit.

   Not Applicable Note: Must state your agency will not exceed $100,000 in combined Federal/State awards or contracts.
   Form: https://www.nj.gov/dcf/providers/contracting/forms/NLPA.docx

3) Photocopies of Licensed Public Accountant firm's **license to practice**, and most recent **external quality control review** to be submitted with the NPLA.

4) **Reports of Expenditures (ROE)**:

A. Scheduled Payments Contract Component: To be submitted two times during the contract year: Interim (15 days from the end of the6th month, and Final (120 days after the end of the fiscal year); or in accordance with any separate DCF directive to file additional ROEs for specific contracted programs**. Quarterly ROEs must be submitted for contracted program budgets funded with federal grants.** The format for the ROE must match that of the Annex B budget form. **Note:** Must be prepared in accordance with the governing cost principles set forth in the DCF Contract Reimbursement Manual (CRM Section 6)

B. Fee for Service Contract Component: Not Required
Website: https://nj.gov/dcf/providers/contracting/forms/

5) **Level of Service (LOS) Reports**

Enter the cited DCF Standard Template Form for each month the number of youth, adults, and families served and ages of those receiving services, and the hours/days, county locations, etc. of those services, or record this data into another form, survey, or database that DCF agrees can serve to track LOS for the contracted program.
Website: https://www.nj.gov/dcf/providers/contracting/forms/

6) **Significant Events Reporting:**

Timely reports as events occur to include, but not be limited to, changes to: (1) Organizational Structure or Name [DCF.P1.09-2007]; (2) Executive and/or Program Leadership; (3) Names, titles, terms and addresses, of the Board of Directors; (4) Clinical Staff; (5) Subcontract/consultant agreements and the development or execution of new ones; (6) a FEIN; (7) Corporate Address; (8) Program Closures; (9) Program Site locations; (10) Site Accreditations (TJC,COA,CARF); (11) the contents of the submitted Standard Board Resolution Form; (12) Debarment and SAM status; and (13) the existence and status of Corrective Action Plans, Audits or Reviews by DCF (inclusive of DCF Licensing, Divisions and Offices) or other State entities.

Note: Agencies are under a continuing obligation, through the completion of any contract with the State of NJ, to renew expired forms filed with the NJ Department of the Treasury and to notify Treasury in writing of any changes to the information initially entered on these forms regarding: Investment Activities in Iran as per P.L. 2012, C.25; Investment Activities in Russia or Belarus as per P.L. P.L.2022, c.3; Disclosures of Investigations of the Vendor; Ownership Disclosure if for profit; Service Location Source Disclosure as per P. L. 2005, C.92; Political Contribution Disclosure as per P.L. 2005, C.271; Report of Charitable Organizations, and the Two-Year Chapter 51 Vendor Certification and Disclosure.
Policy:

https://nj.gov/dcf/documents/contract/manuals/CPIM_p1_events.pdf
Website:
https://www.state.nj.us/treasury/purchase/forms.shtml

D. Requirements for Awarded Respondents to Store Their Own Organizational Documents on Site to be Submitted to DCF Only Upon Request

1) Affirmative Action Policy/Plan

2) Copy of Most Recently Approved Board Minutes

3) Books, documents, papers, and records which are directly pertinent to this contract for the purposes of making audits, examinations, excerpts, and transcriptions, and to be produced for DCF upon request.

4) Personnel Manual & Employee Handbook (include staff job descriptions)

5) Procurement Policy