

## Discussion Points

### Department of Children and Families (General)

#### Key Performance Indicators

1. The Governor's FY 2016 Budget Recommendation includes several Key Performance Indicators for the DCF (pages D-32 and D-33) providing actual values for FY 2014 and revised/target values for FY 2015 and FY 2016. In several indicators, the target value for FY 2015 and FY 2016 is lower than the actual value for FY 2014 (e.g. *Abuse/Neglect reports assigned for investigation within three hours of initial report*, decreasing from 99.2% to 98.0%; *Adoptions finalized within nine months of a child being placed in an adoptive home*, decreasing from 98.2% to 93.0%; and *Children involved with a Care Management Organization who were maintained in their own homes/community*, decreasing from 83.0% to 80.0%).

- **Questions:** In cases where the DCF exceeds its targets, will targets be increased to encourage even greater performance? When targets are exceeded, to what extent are resources reallocated to other areas of budgetary or staffing needs?

#### **Response:**

DCF will adjust targets as appropriate, based on historic trend data and other dynamics. Performance in several of these key areas can be affected by various factors such as call volume, referral rates, number of children legally free and available for adoption and the number of children with intellectual and developmental disabilities that are transitioned to care management organizations. When evaluating the data utilized for the purpose of setting annual performance targets, DCF must consider many things that could affect its ability to reach the goals/milestones. All available data and potential operational impacts are carefully evaluated during this process. For some performance metrics, sustainability is important; to consistently meet the target over time which can be an indicator of quality of performance.

These indicators are only part of the information DCF considers when evaluating its budget needs. The budget is a dynamic document. DCF projections are adjusted based on historic utilization trends, number of children/youth receiving services, expenditure patterns, etc. DCF will 'track and adjust' based on many factors including the characteristics of youth in our care and services required. Projections are developed that align the appropriations needed to support programs and services for children and families anticipated for each fiscal year.

**Discussion Points (Cont'd)**

Superstorm Sandy Federal Funding

2. New Jersey received temporary supplemental funding under the federal Social Services Block Grant (SSBG) in order to provide enhanced social services to those affected by Superstorm Sandy. This funding expires by September 30, 2015, which will result in the reduction or termination of some contracts that were supported with this funding. As originally requested in the State’s request to the federal government,<sup>1</sup> the portion of this funding to be administered by DCF would be spent in the following program areas:

<b><u>Program</u></b>	<b><u>Original Allocation</u></b>
Preventing Child Abuse and Promoting Child Safety	\$11,201,600
Strengthening Families and Communities	\$5,580,000
Health Care Support and Education	\$2,647,500
Domestic Violence	\$3,994,000
Sexual Violence and Human Trafficking	\$4,446,000
Child Mental Health and Substance Abuse	\$9,550,000
Building Resiliency and Supporting Recovery through Supports for Schools and Students	\$5,803,000
Early Childhood	\$720,000
Administration	\$1,529,000
<b>Total</b>	<b>\$45,471,100</b>

- **Questions:** Please provide an updated table showing expenditures to date and expected final allocations and expenditures. What areas, if any, will the State continue to provide State-funded support when the federal supplemental funding is no longer available?

**Response:**

Please see chart and explanation below.

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<sup>1</sup> The application is available online at [http://www.state.nj.us/humanservices/home/New\\_Jersey\\_Supplemental\\_SSBG\\_Intended\\_Use\\_Plan.pdf](http://www.state.nj.us/humanservices/home/New_Jersey_Supplemental_SSBG_Intended_Use_Plan.pdf)

**Discussion Points (Cont'd)**

Program	Original Allocation	Current Allocation	Expenditures as of 3/31/15
Preventing Child Abuse and Promoting Child Safety	\$11,201,600	\$4,411,746	\$1,423,709
Strengthening Families and Communities	\$5,580,000	\$5,551,400	\$4,502,693
Health Care Support and Education	\$2,647,500	\$1,051,108	\$987,384
Domestic Violence	\$3,994,000	\$2,707,860	\$2,380,474
Sexual Violence and Human Trafficking	\$4,446,000	\$5,097,455	\$4,015,327
Child Mental Health and Substance Abuse	\$9,550,000	\$473,000	\$257,600
Building Resiliency and Supporting Recovery through Supports for Schools and Students	\$5,803,000	\$3,784,000	\$3,100,076
Early Childhood	\$720,000	\$720,000	\$690,000
Administration	\$1,529,000	\$1,528,470	\$270,489
<b>Total</b>	<b>\$45,471,100</b>	<b>\$25,325,039</b>	<b>\$17,627,751</b>

In the chart above, please note, the \$20,146,061 decrease from the original intended use plan represents a redirection of grant funds to the priority need of housing following extensive analysis of utilization trends, demand for services, and actual expenditures for the DCF initiatives. DCF, in conjunction with the two other grant recipients, agreed that this funding should be reallocated to address the priority need of housing for many survivors impacted by Superstorm Sandy. As a result, this funding was redirected to the Department of Human Services Sandy Homeowner and Rental Assistance Program (SHRAP) and the Housing and Mortgage Finance Agency's (HMFA) SSBG Rental Assistance Program to provide critical financial support to storm survivors.

DCF responded quickly to address the needs of residents hardest hit by, and suffering the greatest from, Superstorm Sandy. Thanks to this grant, we were able to expand many of our pre-existing services so that they could reach the greatest number of people in need as quickly as possible. We were able to expand access to about twenty different programs and services, from domestic violence and sexual violence services to displaced homemaker programs to Family Success Centers to substance use disorder treatment services to homeless youth outreach and more.

About two and a half years after the storm, some of the initial demand that necessitated expanding our pre-existing services and programs has lessened. Many of the vendor contracts supporting this expansion are now expiring.

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DCF is currently evaluating the programs and researching alternative potential funding sources, such as alternate federal grant funding. In the interim, it is important to note yet again that as many of these programs were expansions to serve anticipated increase in need, the majority of these services will still be available to those impacted by Superstorm Sandy as they are already a part of our regular service array. The Northern Monmouth Family Success Center also known as the Bayshore Family Success Center will be sustained utilizing existing resources.

We continue to be fully dedicated to addressing the needs of our state's women, children and families. And we will always seek ways to enhance services, provide service efficiently and effectively, and ensure a better today and an even greater tomorrow for every individual we serve.

### Provider Contracts

3. The FY 2015 Appropriations Act includes \$13.2 million for "Community Provider Contract Adjustments," within Interdepartmental Accounts (Appropriations Handbook page B-205). As of March 2015, this funding has not yet been distributed. A similar provision in the FY 2014 Appropriations Act was defunded in order to address a revenue shortfall at the end of that fiscal year, and the amounts that would have been distributed were not included in the contract base for subsequent fiscal years.

- **Questions: Is a contract adjustment expected to be distributed to DCF providers during FY 2015? Will this adjustment be included in the contract base for any renewals of the same contracts in FY 2016?**

### **Response:**

Yes, it is expected that these funds will be distributed to eligible DCF providers during FY 2015. This process is being coordinated through the Department of Treasury, Office of Management and Budget and with the Legislature. At this time, the FY 2016 budget does not include a recommended appropriation for continuation of this funding.

4. During the May 5, 2014 hearing of the Assembly Budget Committee on the DCF Budget, Chairman Schaer described a DCF service provider that received a significantly lower average per-capita reimbursement rate than the rate for other providers in the same

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category, on average, in an “apples-to-apples” comparison<sup>2</sup>. Commissioner Blake responded that such differences have arisen over time as new services have been created at different payment rates, and that no mechanism had existed to adjust existing contracts for the same service to match the reimbursement levels for a new provider. The commissioner further indicated that the department is working to set fixed rates for services and rebid the relevant contracts in order to eliminate these discrepancies, but that this process would take several years.

- **Questions:** In the past year, what contracted services have been rebid according to a uniform Statewide reimbursement rate or methodology? Has any specific category of service been identified as having a particularly broad range of reimbursement rates, which the department anticipates standardizing in the near future? Does standardizing rates help to improve access to services where they are needed?

### Response:

In 2014, the DCF Children’s System of Care (CSOC) rebid its Intensive Residential Treatment Services (IRTS) to standardize rates and deliverables for these services across the state. This process provides that IRTS programs deliver a consistent model of care for youth statewide.

In early 2015, contracts were awarded to the following providers for 50 beds statewide:

- North: Youth Consultation Services (YCS)
- Central: Carrier Clinic
- South: CFG Health Systems and Legacy Treatment Services

5. A study released by Rutgers University, Department of Labor Studies and Employment Relations in March 2014 entitled *Overlooking Oversight*<sup>3</sup> reported several problems with the State’s procedures for contracting with private vendors. The report’s general findings include the following:

- Oversight costs are typically not incorporated into contracts or the decision to contract, resulting in insufficient allocation of resources to oversight and, in some cases, the contracting out of services that could be more efficiently provided in-house.
- Contracts do not contain adequate performance requirements and standards, resulting in poor quality service provided to consumers.

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<sup>2</sup> Audio recording available at [http://www77/media/archive\\_audio2.asp?KEY=ABUB&SESSION=2014](http://www77/media/archive_audio2.asp?KEY=ABUB&SESSION=2014). The relevant discussion begins at approximately 1:02 into the recording.

<sup>3</sup> Available online at <http://smlr.rutgers.edu/news-events/new-study-review-of-njs-oversight-of-third-party-contractors>

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- A decline in the number of experienced contact managers and inadequate training and qualification or remaining contract managers, along with insufficient on-the-ground oversight capacity, generally as a result of attrition of experienced employees, results in an inability to effectively monitor vendors.
- **Questions:** For each major finding described above, as they pertain to contracting processes employed by the DCF, please indicate whether the report's findings are meritorious, and what steps the department is taking to address these problems.

### Response:

It is important to note that the department has taken affirmative steps over the last few years to strengthen its contracting processes. Please see below in response to allegations:

- **Oversight Costs typically not incorporated into contracts or contract out services provided more efficiently "in house"**

The Division of Child Protection and Permanency's (CP&P) Third Party Social Services contracts provide services directly to children and families served by CP&P for which there is either no "in-house" capacity or additional capacity is needed, including but not limited to:

- Medical, mental, and behavioral health evaluations or therapy
  - DCF has published rates that it uses for many of its CP&P vendor contracts for medical, mental, and behavioral health evaluations/counseling.
- Substance Abuse evaluations/therapy
- Family Preservation Services
- Supervised Visitation
- **DCF's performance requirements**
  - DCF, and previously as DHS, has focused on developing standardized performance measures
    - In 2009, DCF implemented measures
    - In 2012, DCF convened focus groups to develop program measures for the following contract programs:
      - School-Based Youth Services (High School only)
      - Therapeutic Visitation
      - Supervised Visitation
      - Adolescent Transitional Housing

## Discussion Points (Cont'd)

- Adolescent Life Skills
  - Partial Care/Partial Hospitalization
  - PALS (Peace: A Learned Solution)
  - Project Myself
  - Court Appointed Special Advocates (CASA)
- DCF's Office of Quality infusing Logic Models into program service design
- DCF's Office of Strategic Development is focused on performance-based contracting and shifting the service array to be responsive to the changing needs of the women, children, youth and families we serve.
- **Contract Monitoring and Staff**
  - In 2011, DCF issued a formal approach for monitoring Third Party Contracts (excluding individual providers)
    - Includes document review and on-site visits
    - Process anticipates collaborative program review by DCF staff: contracting; program leads; Institutional Abuse Investigation Unit (IAIU) and the Office Of Licensing (OOL) as needed
  - Office of Grants Management and Auditing
    - Each year, solicits feedback from DCF units to inform its plan for auditing DCF contracted providers
  - Business Office/Local Office/Area Office meetings
    - Regularly scheduled meetings between Business Offices and Local Office/Area Office staff to review and discuss any contract concerns
  - DCF has a number of additional mechanisms in place to gather stakeholder feedback:
    - Regular Commissioner meetings with Stakeholders
    - Needs Assessment
    - Resource Directory
    - DCF Office of Advocacy
    - CP&P Qualitative Review
    - Family Team Meetings
    - Family Support Organizations
    - DCF funds research to evaluate DCF funded projects

## Discussion Points (Cont'd)

- Accredited Agencies regularly solicit consumer feedback to inform their program
- Staff Competency
  - Office of Contract Administration (OCA) developed training curriculum for Business Office Staff
    - All staff trained on Closeout process in August 2013 with refresher course in 2014
    - OCA created Assistant Director position- key focus on developing and implementing training curriculum specific to contract administration.
- Staffing Capacity
  - The Office of Contract Administration has staff needed to manage DCF's contracts.

6. The Rutgers report described in discussion point #5 above includes a "case study" of the Division of Child Protection & Permanency. The report describes a system in which individual caseworkers are the primary State employees in a position to assess the quality of the services being provided to clients. However, caseworkers are not informed of the terms of providers' contracts or any individuals who might be precluded from providing services under a contract for a particular reason. According to the report, this could potentially permit a vendor to subcontract work to a provider with a track record of endangering children. In such a scenario, the caseworker would be the only State employee to know that the disqualified provider was providing a service, but would not know that the use of that provider was a violation of the vendor's contract. The report also notes that there is no institutional mechanism for caseworkers to communicate to the contracting unit any quality issues they see with particular providers. Because of the multitude of caseworkers, a contractor can provide poor services to dozens of clients with no repercussions, even though many caseworkers are aware of the poor quality of their work.

- **Questions: What mechanisms are in place to ensure that vendors do not subcontract with providers who are ineligible to provide certain services? What formal and informal mechanisms exist to identify service providers that are eligible, but demonstrate poor performance? What corrective measures does the department take in such instances?**

### Response:

DCF has no record of Rutgers contacting it to participate in its overall review of the State's contracting practices nor those specific to DCF.

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- Existing DCF policy requires contractors to submit any sub-contracts to DCF for review and approval
- Beginning in FY2015, DCF has strengthened its policies on how to adequately document a provider is in "good standing":
  - Confirming a provider's DUNS number is in active status and the provider is not barred from doing business with the federal government (SAMS.gov)
  - Checking Treasury's (NJ) debarment website to see whether provider is barred from contracting with any State agency
  - Requiring providers to submit a signed Certification of Debarment with RFP submissions and for FY16, requiring providers submit a signed Certification with contract renewal packages.

### Formal and Informal Contract Monitoring

- DCF has a number of formal and informal mechanisms to monitor a provider's performance
  - In 2011, DCF issued a formal approach for monitoring Third Party Contracts (excluding individual providers)
    - Includes document review and on-site visits
    - Process anticipates collaborative program review by DCF staff: contracting; program leads; IAIU/OOL as needed
  - Office of Grants Management and Auditing
    - Each year, solicits feedback from DCF units to inform its plan for auditing DCF contracted providers
  - Business Office/Local Office/Area Office meetings
    - Regularly scheduled meetings between Business Offices and Local Office/Area Office staff to review and discuss any contract concerns
  - DCF has a number of additional mechanisms in place to gather stakeholder feedback:
    - Regular Commissioner meetings with Stakeholders
    - Needs Assessment
    - Resource Directory
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    - CP&P Qualitative Review
    - Family Team Meetings
    - Family Support Organizations
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### Corrective Action for Poorly Performing Providers:

- Where client safety is not a presenting factor, DCF utilizes a number of strategies to support its providers, including but not limited to:
  - Convening joint contract/Division/provider meeting to understand barriers to delivering contracted services
  - Provide technical assistance
  - Linking underperforming providers with high performing providers to provide technical assistance/guidance/tips
  - Referring providers to outside entities that provide technical assistance to non-profits
- If client safety is predominate concern, DCF may stop referrals and depending on nature of program, require provider to take additional steps to ensure safety of clients who can't be immediately transitioned to another provider
- If DCF initiates Corrective Action, provider is required to submit a plan detailing its approach to remedy program deficiencies to DCF for approval and to submit progress reports on a regular basis to demonstrate continued progress.

### Office of Licensing

7. The DCF is responsible for the licensure and regulation of child care centers, youth and residential programs, resource family homes, and adoption agencies. According to a report by Advocates of Children of New Jersey released in December 2013,<sup>4</sup> DCF had a staff of 38 inspectors responsible for oversight of approximately 4,000 child care centers Statewide. A February 2015 press release from the same organization indicates that the DCF recently hired 16 additional licensing inspectors.

- **Questions: How many staff are currently employed in the Office of Licensing? Of these, how many are responsible for inspections of licensed facilities and programs? How will the additional staff improve the performance of the office?**

### Response:

**The Office of Child Care and Youth Residential Licensing** currently employs a total of 101 employees. The staffing compliment includes 1 Director and 1 Secretarial Assistant that reports to the Director, additional staff is assigned as follows:

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<sup>4</sup> Available online at [http://acnj.org/downloads/2013\\_12\\_01\\_kidscountchildcarereport.pdf](http://acnj.org/downloads/2013_12_01_kidscountchildcarereport.pdf).

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**Youth Residential Licensing:** 1 Assistant Chief, 3 Child Care Quality Assurance Supervisors, 2 Clerical Staff, 20 Inspection Staff (includes 1 vacancy)

**Child Care Licensing:** 1 Assistant Chief, 2 Professional staff, 7 Child Care Quality Assurance Supervisors, 50 Inspection Staff (includes 1 vacancy), 1 Application Unit Supervisor, 8 Application Unit Staff and 4 Clerical Staff.

As part of an effort to reduce the ratio of Child Care Centers to each Child Care inspector and to increase the frequency of inspections in Child Care Licensing, a total of 20 additional positions were approved. The Office of Licensing (OOL) is working to fill all of these positions and to fully train the inspection staff to be active in the field. Once all staff is fully in place and trained, the ratio of inspectors to centers will change from 1:112 to 1:75. This will support quality inspections and allow inspectors to provide more technical assistance to Child Care Center Providers.

8. Prospective employees in a child care center are required to submit to a child abuse record investigation check and a criminal record history background check. Until these checks are completed, the employing child care center does not know if its employee has a history that would disqualify him or her from employment at the center, and the employee is not permitted to be left unsupervised with children. According to testimony submitted to the Senate Budget and Appropriations Committee by the New Jersey Child Care Association,<sup>5</sup> child abuse record investigation checks are conducted manually by DCF staff, and typically take several months – in some cases up to nine months – to be completed and returned to the child care center.

- **Questions: What is the process for conducting a child abuse record investigation for child care employees? What is the average time it takes to conduct a check and return its findings to the requestor? Does the department plan to improve the process, either by adding staff or automating some part of the process?**

### Response:

#### CARI Checks

In 2014, a total of 38,486 CARI applications were received and processed. The process for conducting a child abuse record information (CARI) check for a potential employee of a child care center begins by the applicant completing the standard form and submitting it to the Department of Treasury for processing the \$10 fee. The Department of Treasury then forwards the completed application to the DCF-CARI unit. This unit then conducts a search of its records for substantiated incidents of child abuse and/or neglect in the Department's

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<sup>5</sup> Available online at [http://www.njleg.state.nj.us/legislativepub/budget\\_2016/031015/Galante\\_L.pdf](http://www.njleg.state.nj.us/legislativepub/budget_2016/031015/Galante_L.pdf).

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electronic database. After the search is completed, the form is stamped with the results and mailed back to the requesting Child Care Center.

In total, the process takes approximately one month. Additional time may be required in limited circumstances where archived paper files are needed to augment the information in the database or if there is a pending administrative appeal or other litigation.

DCF has improved the CARI process significantly. In December 2013, the CARI unit had a backlog of 20,000 applications at which time significant delays were occurring. The backlog has since been resolved following the Department's actions in "right-sizing" the unit and streamlining the process.

### Revenue Estimates

9. In FY 2014, DCF contract recoveries totaled \$17.4 million. For FY 2015, the Governor's FY 2015 Budget Recommendation originally anticipated \$18.5 million in DCF contract recoveries, but that estimate was revised down to \$14.1 million in the FY 2015 Appropriations Act. The Governor's FY 2016 Budget Recommendation anticipates \$14.5 million in DCF contract recoveries in FY 2015 and FY 2016 (page C-3), a slight increase over the previous estimate for FY 2015.

In response to FY 2015 OLS Discussion Point #4, the department indicated that, at that time, a similar anticipated decrease in contract recoveries from FY 2014 to FY 2015 was driven by specific details of certain contracts that are difficult to predict (such as staff vacancies, close out dates, and timing of audits.) The department also indicated that, as additional third party contract providers are moved into the fee-for-service platform, particularly within the Children's System of Care, there will be fewer recoveries from cost-related contracts.

- **Question: What accounts for the reduced amount of contract recoveries in FY 2015 compared to FY 2014?**

### **Response:**

As explained in the department's response in FY 2015, as DCF moves more contracted services to a fee-for-service structure, there will be fewer recoveries from third party contracts. Additionally, as noted previously, many variables affect the department's ability to predict a timeline for finalizing contract close-outs and receipt of any recoveries. The projected reduction in contract recoveries indicates that the department has structured state funds in its contracts more appropriately; negating the need to recover the funds after the contract has ended. While there will always be some amount of recoveries generated, the objective is to minimize the amount due going forward. These projections reflect our best estimate at this time.

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10. In FY 2014, federal revenue for foster care and adoption assistance under Title IV-E of the Social Security Act increased approximately \$15.5 million from the amount received in FY 2013, from \$143.0 million in FY 2013 (page C-17 of the Governor's FY 2015 Budget Recommendation) to \$158.5 million in FY 2014. Schedule 2 of the Governor's FY 2016 Budget Recommendation estimates slightly less revenue in FY 2015 and FY 2016 of \$154.5 million and \$157.5 million, respectively (page C-12).

- **Questions: How was DCF able to so dramatically increase federal IV-E revenues in FY 2014 compared to FY 2013? What explains the modest decline in anticipated revenues in FY 2015 and FY 2016, compared to FY 2014?**

### Response:

Basically these increases and decreases can be attributed to the timing of collections of prior year adjusting grant awards, ongoing adjustments during the claiming process and variable statistics utilized in quarterly cost allocation plans.

- The increase between FY13 & FY14 is primarily attributed to the normal claiming cycle's timing differential of \$8.6M in FY13 IV-E Revenue earned in FY13 but received and available to be utilized to offset costs in FY14. The remaining amount is additional FY14 IV-E revenue earned in excess of the original appropriation and can be explained, in part, by an increase in DCF's Fringe Benefit Rate (resulting from an increased Treasury Composite Fringe Benefit Rate).
- DCF is continuously working at "right-sizing" its IV-E revenue forecasts to bring our appropriations in line with projections and negate the effects the normal claiming cycles timing differential has between fiscal years as these do not necessarily translate into an "increase in revenue" so much as they do an "availability of funds".
- The forecasted decrease in IV-E revenue for FY15 is solely due to a reduction in DCF's federally approved FY14 Fringe Benefit rate of 48.90% to a forecasted 46.14% in FY15. A lower fringe benefit rate translates into lower fringe benefits costs in the Cost Allocation Plan (CAP), resulting in a reduction in IV-E revenue associated with administrative costs overall.

## **Child Protection and Permanency (CP&P)**

### Federal Monitor's Report

11. The Center for the Study of Social Policy (CSSP) serves as the independent Federal Monitor to assess DCF's compliance with the Modified Settlement Agreement requiring improvements to the State's child welfare system. The 15<sup>th</sup> monitoring report (evaluating

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the January – June 2014 period) was published January 9, 2015.<sup>6</sup> The report found that DCF met 19 performance measures, partially met 8 additional measures, and has substantially failed to meet 16 measures during the January to July 2014 reporting period. (Including measures that were not assessed during that period, DCF has met a total of 21 measures, partially met 10 measures, and failed to meet 22 measures.) The report notes that DCF has been able to maintain performance for nearly all previously met performance measures. The table below compares this performance to previous reporting periods.

<b>DCF Performance Targets Met, Partially Met, or Not Met Over Recent Reporting Periods</b>			
<b>Status of MSA Performance Measures</b>	<b>Reporting Period 13 (July 2012-March 2013)</b>	<b>Reporting Period 14 (April 2013 – December 2013)</b>	<b>Reporting Period 15 (January 2014 – July 2014)</b>
<b>Met</b>	21	23	19
<b>Partially Met</b>	8	7	8
<b>Not Met</b>	23	23	16
<b>Total assessed</b>	52	53	43
<i>Not assessed</i>	1	0	10

Across the 23 measures that were not met, the January 2015 monitoring report highlighted certain areas that needed particular attention, including, but not limited to:

- *Investigation of Alleged Abuse and Neglect* – The monitor notes that the State Central Registry continues to operate professionally, efficiently, and effectively. However, investigations caseloads have risen above compliance levels, which may have a deleterious impact on workers' ability to conduct timely and quality investigations.
- *Implementation of the Case Practice Model* – The report praises DCF's improvement in case practice performance in holding initial and quarterly Family Team Meetings, and its strategy of holding bi-weekly conferences among DCF leadership, Area Directors, and their Local Office managers. However, the report notes that certain ratings such as engagement with parents and family teamwork remain below levels expected by the Modified Settlement Agreement.
- *Timely Permanency through Reunification, Adoption, or Legal Guardianship* – With the exception of performance on finalizing adoptions within nine months of an adoptive placement, DCF's performance in most measures related to meeting permanency goals and discharging children to permanency (i.e., reunification with family, legal guardianship, or adoption) has remained the same or declined and does not meet the acceptable standards.

<sup>6</sup> Available online at <http://www.state.nj.us/dcf/about/welfare/federal/>.

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- *Health and Mental Health Care for Children in Out-of-Home Placement* – The report is generally positive in this area, but the one continued challenge is ensuring that resource parents receive a child’s health passport within five days of placement. Performance on this measure is 62 percent, well below the final target of 95 percent. However, in 98 percent of cases, the health passport was provided to resource parents within 30 days of a child entering out-of-home care.
- *Services to Older Youth* – The percentage of youth between the ages of 14 and 18 for whom Independent Living Assessments were completed dropped slightly below the MSA target of 95 percent this monitoring period. Also, 70 percent of older youth cases reviewed using the QR protocol were rated acceptable on services to older youth, below the MSA target of 90 percent. Moderate declines in performance for required services and supports to youth exiting care without achieving permanency were noted as well.
- **Questions: What specific actions has the department taken to address each of the above areas of concern in the current fiscal year? What specific increases or redeployments of staff, funds, or other resources have been implemented, if any, to address these concerns? What additional actions are planned for FY 2016, with what impact on staff, funds, or other resources? If available, please provide updated performance data for the MSA performance measures associated with each of the above areas.**

### Response:

#### Investigation of Alleged Abuse and Neglect

CP&P Area Directors and Local Office Managers use bi-monthly phone conference calls to look at Key Performance Indicators (KPI) in their respective offices; which includes looking at intake levels, caseload size, and overdue investigations. Several areas (Camden and Hudson) have put a great deal of focus on completing investigations and have shown a reduction in overdue investigations. Area Directors and Local Office Managers have realigned staff in the local offices to meet operational demands – increased Intake levels. Additional staff were added to Monmouth, Atlantic and Passaic counties. In addition, Area Impact Teams were moved to the local offices that were experiencing abnormally high Intake levels (example: October 2014 Ocean South received 278 referrals and the Intake Team was assigned to support that local office)

In December 2013, 1,421 investigations (32.6%) were over 60 days; in December 2014, 952 investigations (21.1%) were over 60 days.

#### Implementation of the Case Practice Model

There are several case practice pilots being conducted across the state to address engagement with parents and family teamwork functionality. There is a Case Practice Liaison

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(CPLs) assigned to each of the 9 areas in the state. The CPLs work in collaboration with each other, local office and area office leadership, case practice specialists, and Area Quality Coordinators to address areas of case practice that need improvement. In Camden there was an FTM expansion pilot in the Fall of 2014. Master Coaches were used to engage families on initial FTMs. Master Coaches modeled engagement skills and critical thinking skills for supervisors and caseworkers. Camden experienced an increase in the number of initial FTMs held in October and November and a decrease in the number of FTMs declined by family members. We are exploring other counties in the state where we will implement an FTM expansion pilot in the near future.

- A "Back 2 Basics" pilot is underway in Salem and Cumberland County. An expert worked with leadership in the Area and Local Offices and with the CPLs from Salem and Atlantic on modeling and coaching staff around engaging family members and family teamwork. In this pilot, Local Office staff identifies challenging and difficult cases and then the CPL will review the family's history with the CP&P staff and then meet with the family (as needed). The CPLs are able to model for staff how to engage families under difficult situations and how to use family history when working with the family.
- A Protective Factors pilot to strengthen families with infants and young children is underway in Essex County. Over 300 staff have been trained on the Protective Factors model. A hybrid of this pilot is being created for rollout in Camden in the next few months. Seven of the nine 9 CPLs are certified trainers for Protective Factors. In this pilot, a multidisciplinary team of internal and external partners will participate in CP&P case conferences on selected cases; the goal will be to collectively brainstorm on best strategy to engage the family and help them build a formal/informal support team.
- The CPLs conduct workshops to improve case practice across the state; the following workshops have been held during the past few months: Two hour Protective Factors training in all local offices in Hunterdon/Sussex/Middlesex/Warren and planned for Monmouth/Ocean, Monmouth North training "Checking in with the Model", Middlesex "Fidelity of the Process", Middlesex Coastal "Formation and Function", Union Central "Supervisor Skill Building", Passaic North "Adaptive Leadership", Gloucester East "Engaging Parents with Mental Health Issues".
- Master Coach Forums were held in the southern counties on March 27th and northern counties on April 2nd - these forums are used to enhance the skills of Master Coaches on ways to improve case practice – specifically around engaging families and team formation and functionality. The Master Coaches take the knowledge and skills back to their local offices.

## Discussion Points (Cont'd)

### Timely Permanency through Reunification, Adoption, or Legal Guardianship

DCF has approached issues that affect timely permanency in several ways. Complex family challenges around mental health and substance abuse have impacted on timely permanency; i.e. inability to stabilize parent/caretaker for extended periods (ex. Individuals with addiction challenges that relapse after lengthy periods of sobriety). CP&P has identified the need to work with families around relapse prevention and a family's plans if relapse occurs.

Also, DCF is working with its court partners to manage scheduling delays, concerns regarding judicial extensions for reunification and to address CP&P recommendations regarding custody that can affect safety, permanency and well-being, all of which can impact timely permanency for children.

Further, DCF will address service gaps that may be a barrier to a parent's ability to access appropriate care that could be needed to move toward permanency goals. CP&P is working on strategies to develop methods to recruit adoptive homes for children and youth in medical/residential settings where termination of parental rights (TPR) has not been granted because the child is not in an adoptive home and an adoptive home cannot be recruited because the child is not legally free.

A Resource Family retention leadership kick-off event was held in March which focused on collaboration of units within the CP&P and efforts of increased teaming with resource parents around permanency, stability and well-being of youth in placement. These efforts will assist with a goal of improving permanency for the child.

Area Child Specific Recruiters are now under the direct assignment of Adoption Operations. This has allowed us to intensify efforts to identify youth without a committed family earlier in their placement. By doing so we anticipate that there will be less of a delay in achieving permanency as concurrent committed homes are secured earlier for this population. Adoption Operations has been able to expand its capacity to do child specific recruitment work with youth identified as not having a committed adoptive family by having the Area Child Specific Recruiters assigned to the operation. Due to these efforts, we are able to service approximately 260 more youth.

Intensive efforts are in place through a Federal Grant to focus on some of CP&P's "longest waiting children and youth". In addition to strategizing on enhancing child specific recruitment, specialized training has been developed and is being offered to resource parents who have either accepted or expressed an interest in adopting older, more challenging youth.

## Discussion Points (Cont'd)

### Health and Mental Health Care for Children in Out-of-Home Placement

As noted in the question, DCF's performance is strong throughout this realm. The exception noted in the question – the provision of Health Passports to resource parents within five days is not being met because, if met, the standard would irresponsibly place speed over quality. This is acknowledged in the monitoring reports through the publication of thirty day data. The health passport is a comprehensive and complex medical document intended to contain all of a child's significant medical information gathered from multiple health care providers over the life a child. Health care information necessary for a child's immediate-term care is provided to resource parents directly from Child Health Unit nurses upon placement.

### Services to Older Youth

Over the last fiscal year DCF restructured and enhanced the transition plan in order to promote improved practices regarding assessing and goal setting with youth. The new transition plan now called the Transitional Plan for YOUth Success (TPYS) was launched in September 2014. In order to prepare staff to use this new planning tool, training was created that covered the TPYS and also incorporated the importance of completing the Independent Living Assessment (ILA). To date there have been over 20 trainings held and over 300 staff trained. In addition, the new TPYS is now in NJ Spirit so we can more readily collect data, track compliance, and monitor practice with youth. Additionally, DCF will be launching an enhanced and updated training regarding the ILAs. The pilot training is in early April with a full training roll out by June, 2015. Finally, there are efforts underway to create a new and enhanced adolescent services website so workers and youth can more readily identify resources that will ultimately assist with identifying the most appropriate supports and services needed to achieve their goals. All of these efforts are being managed within the current budget.

DCF plans to continue the TPYS and ILA trainings in FY 2016. In addition, in FY 16 DCF will be launching a Youth Thrive training for staff and stakeholders in order to better understand adolescent development, neuroscience, youth resilience, social connections, and a variety of youth competencies to promote appropriate engagement, assessment, and planning as they transition to adulthood.

## Discussion Points (Cont'd)

### Court Appointed Special Advocates

12. The Governor's FY 2016 Budget Recommendation includes \$1.15 million for Court Appointed Special Advocates (CASA) (page D-40). This recommendation would discontinue the additional \$850,000 that was included in the FY 2015 Appropriations Act pursuant to a Legislative budget resolution. According to the department, this money primarily funds training of volunteer special advocates, who assist children and families involved in the family courts system. These training expenses (but not other expenses incurred by CASA) can generate a partial federal reimbursement under Title IV-E of the Social Security Act, according to a complex methodology.<sup>7</sup> During discussions in the FY 2015 budget process, DCF estimated that the CASA appropriation, as it was being used by CASA at that time, was earning approximately 30 to 40 cents of federal reimbursement on each dollar of State expenditure.

- **Questions: How is the additional funding in FY 2015 being spent? How will the recommended reduction in FY 2016 affect CASA operations and ability to provide services to clients? What proportion of CASA's total budget does the State appropriation represent?**

### **Response:**

CASA does not charge General and Administrative (G&A) costs to its contract with DCF; therefore CASA is not required to submit a total agency budget to DCF. CASA is best positioned to advise the proportion of its total budget represented by the State appropriation and the impact of any funding adjustments on its operations.

DCF's contract with CASA supports two program components: Advocacy and Training. In the FY15 contract, CASA used the additional \$850,000 as follows:

### **Advocacy**

- Increased this component's reimbursable ceiling by \$130,235, from \$78,500 (FY14) to \$208,735 (FY15).
- CASA charged additional portion of salary costs for Executive Director and Associate Director to DCF contract (approximately \$38,000 more than charged to contract in FY14)
- CASA created new position- Quality Review Coordinator (\$40,000)
- CASA charged new position – Social Media/Communications (\$12,500)
- CASA charged a data upgrade (approximately \$54,000)

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<sup>7</sup> The DCF provided a detailed explanation of this methodology in its written response to questions from the Assembly Budget Committee during the FY 2015 budget process, available at [http://www.njleg.state.nj.us/legislativepub/budget\\_2015/DCF\\_response.pdf](http://www.njleg.state.nj.us/legislativepub/budget_2015/DCF_response.pdf).

## Discussion Points (Cont'd)

### Training

- Increased this component's reimbursable ceiling by \$719,765, from \$1,071,500 (FY14) to \$1,791,265 (FY15)
- CASA charged additional portion of salary costs for Executive Director and Associate Director to DCF contract (approximately \$7,200 more than charged to FY14 contract)
- CASA increased grants to County CASA programs by about \$582,500
  - Atlantic/Cape May: increase of \$93,000 (all amounts rounded)
  - Bergen County: \$30,300
  - Mercer/Burlington: \$42,900
  - Camden: \$49,900
  - Cumberland/Gloucester/Salem: \$87,200
  - Essex: \$44,700
  - Hudson: \$8,800
  - Middlesex: \$36,800
  - Monmouth: \$30,650
  - Ocean: \$34,090
  - Morris/Sussex: \$28,250
  - Passaic: \$31,260
  - Somerset/Hunterdon/Warren: \$27,700
  - Union: \$36,700

### Mental Health and Substance Use Disorder Treatment for CP&P Parents

13. Many families involved with CP&P experience issues, conditions, and circumstances (either acute, chronic, or cumulative), such as a parent's mental health or substance abuse problem, that negatively impact their ability to ensure child safety and provide a stable home environment for their children. Appropriate treatment may help these families to improve their home environment and ultimately be removed from CP&P supervision more quickly. However, CP&P does not directly provide treatment to parents and cannot always ensure the availability of such treatment, though it does provide related support if a parent can get into a treatment program. (Substance use disorder treatment services are provided through the Department of Human Services, through Medicaid/NJ FamilyCare or the "Substance Use Disorder Treatment for DCP&P/Work-First Mothers" line item on page D-172.)

According to the Family Preservation Services program report for FY 2014,<sup>8</sup> a parent's mental health issue was identified as a significant stress factor in 41 percent of families in the program, and a parent's substance abuse was identified as a significant stress factor in 31 percent of families. Because this report only accounts for families served by Family

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<sup>8</sup> Available online at

[http://www.njleg.state.nj.us/opi/Reports to the Legislature/family preservation services fy2014.pdf](http://www.njleg.state.nj.us/opi/Reports%20to%20the%20Legislature/family%20preservation%20services%20fy2014.pdf).

## Discussion Points (Cont'd)

Preservation Services, which does not provide services to families currently experiencing domestic violence, these numbers may understate the percentage of all CP&P-involved families experiencing such problems.

- **Questions: Please describe DCF's role in promoting appropriate mental health and substance abuse treatment for parents in families under CP&P supervision. What percentage of CP&P-involved families in which a mental health or substance abuse problem is identified is unable to access appropriate treatment?**

### Response:

DCF contracts with three regional agencies to provide statewide substance use disorder screening, assessment, evaluation, and referral to/coordination with treatment services for CP&P involved families for whom substance use poses a child safety risk. Child Protection Substance Abuse Initiative (CPSAI) services are delivered by qualified substance use disorder clinicians who are co-located in the CP&P local offices and function as a member of the child welfare case practice team. CP&P workers referred 21,699 biological parents and/or caregivers for a substance abuse assessment in calendar year 2014. 14,607 of individuals referred were assessed, and 4,692 individuals assessed were admitted to treatment. Approximately 10% of those who were assessed did not meet diagnostic criteria for a substance use disorder; all clients who meet diagnostic criteria receive a referral to a substance use disorder treatment program.

The major barrier is the parent's readiness for engaging in treatment and recovery. DCF is examining its current practices regarding substance use and co-occurring mental health disorders with CP&P families and is working to identify and implement evidence- and best-practice interventions, including motivational interviewing, to improve engagement in services and support improved outcomes for these families. DCF has also identified specific treatment service gaps in the southern part of the state, where there is no residential treatment for women with dependent children, and intends to issue an RFP to establish these services.

### Child Fatality and Near Fatality Review Board Findings

14. The 2013 report of the Child Fatality and Near Fatality Review Board (issued November 2014)<sup>9</sup> observes that CP&P's risk assessment and reassessment tool has not been consistently implemented, with particular concern in cases where an override exists without the use of the tool to inform that decision. The report indicates that the department is evaluating the appropriateness of the tool and the effectiveness of its implementation. The report recommends that a systematic, consistent, protocol should be created as a standard

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<sup>9</sup> Available online at [http://www.njleg.state.nj.us/opi/Reports to the Legislature/child fatality ar 2013.pdf](http://www.njleg.state.nj.us/opi/Reports%20to%20the%20Legislature/child_fatality_ar_2013.pdf).

## Discussion Points (Cont'd)

to determine how to make decisions when risk has been mitigated. During the period of evaluation, the board recommends that all cases in which risk is lowered be documented with the current available tools, and that there be a mechanism where multiple referrals, regardless of outcome, create an elevated degree of risk that cannot be overridden without dynamic and clear guidelines.

- **Question: What is the current status of the department's review of the risk assessment tool? What are the department's current policies with regard to documenting changes in the evaluated degree of risk? What are the current policies with regard to use of risk assessments in overriding a referral?**

### Response:

#### **Risk Assessment Policies and Practice**

Based on the recommendations of an internal DCF workgroup, DCF is currently engaged in efforts aimed at making the necessary revisions to New Jersey's SDM system and incorporate recent advances of the tools, including a validation study and enhancement of the family risk assessment and Reassessments tools. The goal of this project is to improve outcomes for children and families in New Jersey through improved decision making at the case and agency levels by a) Reducing subsequent harm to children and b) Expediting permanency for children who are removed from their homes. The validation study will inform the agency if the tools need to be amended to better predict risk factors.

The CP&P Risk Assessment is generated to identify families which have low, moderate, high, or very high probabilities of future child abuse or neglect. By completing this assessment, the caseworker obtains an objective appraisal of the likelihood that a family will maltreat their children in the next 18 to 24 months. The risk reassessment, combines items from the original risk assessment tool with additional items to evaluate a family's progress towards the case plan goals. This assessment is used to reassess risk and evaluate a family's progress toward fulfilling the case plan and achieving its case goals.

As it relates specifically to the override process, at the time of the initial risk assessment, an override may be applied by the worker and supervisor to increase the risk level in any case in which the risk level set by the assessment tool is too low, based on unique case circumstances the worker or supervisor believes warrant a higher risk level. This may occur when the worker is aware of conditions affecting risk that are not captured within the items on the risk assessment. It is important to note that with the risk assessment, the override may only increase the risk level, not decrease it.

The discretionary overrides are used mostly by permanency workers and their supervisors whenever unique case circumstances suggest that the risk score does not accurately portray the family's actual risk level. Unlike the initial risk assessment in which the risk level could only be increased, the risk reassessment permits the worker or supervisor to increase or

## Discussion Points (Cont'd)

decrease the risk level by one step because after a minimum of six months, the worker has acquired significant knowledge of the family. The worker is obligated to document the reason for the discretionary override and the override risk level needs to be indicated. Anytime a caseworker is recommending a discretionary override, supervisory review and consultation is required.

With cases where there are multiple referrals, the current risk assessment/reassessment tool would in fact elevate the risk score. However, as stated above, the discretionary override can be utilized as the caseworker in consultation with the supervisor would have that firsthand knowledge of the intricacies of the family's dynamics, growth since the initial concern and the progress towards safety and stability which they could objectively incorporate in the case planning.

As CP&P continues the work around re-evaluating the current tools, in the interim communication will be sent to all CP&P staff about the importance of supervisory consultation and oversight on any case situation requiring an override. Additionally, this memo will be reviewed with Area Directors at an Area Director meeting and with all Local Office Managers at a Statewide Manager's meeting.

15. The DCF has made available to Local Office staff through contracts a Clinical Consultant, whose role is to consult with staff when there are questions/concerns about a child's mental health status, treatment, diagnosis, or needs. The Child Fatality and Near Fatality Review Board report recommends the role of the Clinical Consultant be standardized to provide for better consistency Statewide, and it also recommends that DCF create performance standards for use when evaluating the effectiveness of the service.

- **Question: To what extent do Local Office Staff utilize the services of the Clinical Consultant? To what extent has the availability of the consultant improved the quality or efficiency of services provided to clients who may suffer from a mental health problem? How does the department assess the performance of the Clinical Consultant?**

### Response:

The Clinical Consultant (CC) is a consultant to the Child Protection and Permanency's Local Office Staff, Child Health Units and Team Leaders in the area of behavioral health care: diagnoses, developmental issues and red flags, treatment/intervention options, requests for and interpretation of clinical evaluations. If there is a current mental health/behavioral health crisis on the part of a child or an adult, the Clinical Consultant can help assess the situation and identify appropriate next steps. The Clinical Consultant is familiar with the mental health services for both children and adults in the local community and assist with links when necessary. Clinical consultants also work with the Children's Crisis Intervention Services

## Discussion Points (Cont'd)

(CCIS) units when needed. CC are provided with ongoing training and support from the DCF Children's System of Care (CSOC).

### Other

16. The Governor's FY 2016 Budget Recommendation discontinues a \$1.2 million appropriation for the Child Collaborative Mental Health Care Pilot Program (page D-39). This appropriation was added by a Legislative resolution to the FY 2015 Appropriations Act.

- **Questions:** Please describe the program that is funded by this appropriation. What services are provided, to what populations? Is the program supported by any funding other than the State appropriation? What information has been gathered in the pilot program that could inform the design of any future programs?

### **Response:**

The Collaborative Mental Health Care Pilot Program is designed to implement a best practice collaborative care model between primary care pediatricians (PCPs) and child mental health specialists in order to provide for the timely screening, assessment, diagnosis, and treatment of behavioral health disorders of children, youth, and young adults served in the pilot program. The program will provide universal screening of children, youth, and young adults for behavioral health disorders, timely access to psychiatric consultation for PCPs, timely patient access to direct psychiatric services, when indicated, and care coordination to support fluidity of referral, engagement with specialty care at the appropriate levels of care.

In State Fiscal Year 2015, \$1,200,000 in funding was allocated to DCF for this program in the legislatively approved budget. DCF initiated competitive bidding process for this initiative and issued a Request for Proposal (RFP) for the program on October 3, 2014. The RFP included a program evaluation requirement, with up to twenty percent of the available resources (\$240,000) dedicated to program evaluation activities. No additional funding has been made available for the project.

DCF has initiated contract negotiations with the responsive bidder, Meridian Hospitals Corporation. Working in partnership with Cooper University Health Care and the NJ Chapter of the Academy of American Pediatrics, the collaborative program will improve the capability of at least 40 pediatric primary care practices to screen, care manage, and improve access to

## Discussion Points (Cont'd)

care for approximately 240,000 children with suspected or identified mental health issues. Meridian and its partners will establish a "hub" behavioral health team in two regions in New Jersey: Monmouth/Ocean Counties and Camden/Burlington Counties. Each team will include a child and adolescent psychiatrist, a licensed clinical social worker care coordinator, and an administrative coordinator to implement this program. The program evaluation will be available at the conclusion of the one-year pilot program.

### Children's System of Care (CSOC)

#### Contracted Systems Administrator

17. The contract for the Contracted Systems Administrator for the CSOC (held by PerformCare since 2009)<sup>10</sup> is scheduled to expire in September 2015. (The contract was recently extended from an earlier expiration date in March 2015.) The Division of Purchase and Property released a Request for Information in November 2014 in order to gather information from vendors for the upcoming reprocurement of the contract<sup>11</sup>. As of March 2015, no RFP for its reprocurement has been released.

- **Question: What is the current schedule for the reprocurement of the Contracted Systems Administrator contract? How will the vendor's responsibilities under the new contract differ from the current contract?**

#### **Response:**

The contract for the Contracted Systems Administrator (CSA) has been extended, the RFP is currently being reviewed by the Division of Purchase and Property and CSOC believes it will be posted soon. The timeframe for implementation depends on when the RFP is posted, but CSOC has requested a 6 month transition if the current provider does not win the award. CSOC does not anticipate any significant changes to the contract.

#### Individual Transitions through State system of Developmental Disability services

18. Under the current structure of State programs, individuals with developmental disabilities in need of State-funded services move through programs administered by three different State departments as they age. Infants and toddlers receive services through the Early Intervention Program, administered by the Department of Health; children age 3 and older receive services through CSOC<sup>12</sup>; and adults receive services from the Division of Developmental Disabilities (DDD) in the Department of Human Services.

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<sup>10</sup> Term contract # T-1932

<sup>11</sup> Available online at <http://www.nj.gov/treasury/purchase/notices/112814b.shtml>.

<sup>12</sup> This population was shifted from the Department of Human Services to DCF beginning in FY 2013.

## Discussion Points (Cont'd)

- **Questions:** How does DCF ensure continuity of care for children with developmental disabilities as they transition from the Early Intervention Program to receiving services through DCF? How does DCF ensure continuity of care for adults as they transition to services provided by DDD?

### Response:

Services can be provided through CSOC once the child has been determined eligible for DD services. Not all children receiving services from Early Intervention are eligible for DD services. The application for DDD Services can be made as early as age 18, even though services do not begin until age 21, which gives individuals and their families 3 years to complete the intake process.

Individuals receiving intensive services through CSOC and determined in need of these services to continue once the individual turns 21 are supported by care management entities in completing the Medicaid application that is required in order to be eligible for services through the Division of Developmental Disabilities (DDD). CSOC and/or its designated care management entities participate in discussion with DDD prior to the transition. Families are required to complete the assessment process to determine functional limitations. CSOC and DDD also hold "roundtable" planning meetings on each child who is receiving intensive supports from CSOC to ensure continuity of services.

Individuals who are not receiving intensive services at the time of transition are required to become eligible for Medicaid and abide by other requirements of DDD. CSOC works with the ARC of NJ and Community Access, Inc. on assisting families to understand the transition process. These organizations have been identified by DDD as the organizations to communicate the transition process to families, though DDD's Planning for Adult Life Project.

CSOC also collaborates regularly with DDD and works on any identified barriers to transition.

19. P.L.2014, c.78 (C.30:4-25.20 et seq.) requires the Division of Developmental Disabilities (DDD) in the Department of Human Services, in consultation with the CSOC, to develop a single process for determining eligibility from the two divisions for services for individuals with developmental disabilities, regardless of age, in any case in which the two divisions mutually determine that a single process is clinically appropriate. In response to FY 2015 OLS Discussion Point #18, DCF indicated that "It is unlikely that use of a single application beyond that already permitted under DDD's and CSOC's regulations [for individuals between the ages of 18 and 21] would result in any savings; on the contrary, it more likely would result in erroneously providing developmental disability services to adults who no longer meet the statutory eligibility criteria because of DDD's reliance on outdated information."

## Discussion Points (Cont'd)

- **Questions:** When is the single application process required by the law expected to be implemented? In what proportion of cases is it anticipated that a single application would be considered clinically inappropriate? Given the DCF's concerns about a single application cited above, how will the DDD and DCF ensure that individuals receive appropriate services based on up-to-date information on their functional limitations?

### Response:

This law was enacted in December 2014. Since that time, DCF has been working with DHS on developing a process. The department's concerns raised last year were resolved by the amendments made prior to passage.

### Transition of Addiction and Mental Health Services from DHS to DCF

20. Mental health and addiction services for youth under age 18 were shifted from DHS to DCF during FY 2013 and FY 2014. The DHS and DCF had also planned to transition most mental health and addiction services for youth aged 18-20 to DCF. However, in response to FY 2015 OLS Discussion Point #14, DCF indicated that DHS had been working to quantify the funding for the services to be transitioned to DCF, but that the Governor's FY 2015 Budget Recommendation did not reflect any transition.

- **Questions:** On what schedule do the DHS and DCF plan to transition mental health and addiction services for youth aged 18-20 from DHS to DCF? What services will be transferred, and what services will remain with DHS? Has the related funding for this population been quantified?

### Response:

DHS and DCF are working to transition outpatient and intensive outpatient services for individuals who are 18 to 20.99 to CSOC in January 2016. DHS and DCF will be working to coordinate residential treatment for individuals with substance use disorders who are 18 to 20 after DHS transitions to a fee for service model.

### Behavioral Health Needs Inventory

21. Pursuant to P.L.2009, c.243 (N.J.S.A.30:4-177.63), the Commissioner of Human Services and the Commissioner of Children and Families are required to report annually on the inventory, usage, and need for mental health services, and are required to assess whether services are available in each service area of the State in order to ensure timely access to appropriate behavioral health services for persons who are voluntarily admitted or involuntarily committed to inpatient facilities for persons with mental illness in the State, and

## Discussion Points (Cont'd)

for persons who need behavioral health services provided by outpatient and community-based programs that support the wellness and recovery for these persons<sup>13</sup>. These reports have not included a needs assessment for child behavioral health needs since they began in 2012. The reports explain that the DCF has not required the County Interagency Coordinating Councils to conduct County Needs Assessments, because, in 2013, the councils were focusing their efforts on integrating services that were being transitioned from DHS to DCF, and in 2014, they were coping with increased service needs in the aftermath of Superstorm Sandy.

- **Questions: In the absence of a formal needs assessment, how does the department determine how to prioritize resources, by geography and types of service? When will resources be available to conduct a formal needs assessment? Given the limitations of State and county staff resources, would it be prudent to contract with a third party (such as a private research organization or a university) to conduct a needs assessment?**

### Response:

CSOC utilizes all available data to make decisions regarding prioritizing resources. CSOC is working with the Technical Assistance center at Georgetown University on a Needs Assessment for the Children's Interagency Coordinating Councils (CIACC) in all 21 counties.

### Comprehensive Medicaid Waiver Programs

22. The Comprehensive Medicaid Waiver, approved by the federal government in October 2012, authorizes three new Medicaid/NJ FamilyCare programs that are operated by the DCF. In response to FY 2015 OLS Discussion Point #15, the department indicated the following:

- The Intellectual and Developmental Disabilities with Dual Mental Health Diagnosis (IDD/MI) program is intended to provide a menu of seven intensive in-home and out-of-home services for children and youth between the ages of 5 and 21 who meet an institutional level of care. DCF had planned to begin offering four of the seven services to upwards of 100 eligible youth through Medicaid/NJ FamilyCare approved providers by August 2014, at which point they would begin to claim a 50 percent federal match on those services. The remaining three services were anticipated to be procured through a public bidding process that would take up to eight months. Originally projected State savings of \$3.6 million had been deducted from the Governor's FY 2015 Recommended Budget for DCF, but were not realized in FY 2014.

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<sup>13</sup> The 2014 DCF report is available online at [http://www.njleg.state.nj.us/opi/Reports to the Legislature/behavioral health inventory 2014.pdf](http://www.njleg.state.nj.us/opi/Reports%20to%20the%20Legislature/behavioral%20health%20inventory%202014.pdf)

## Discussion Points (Cont'd)

- The Autism Spectrum Disorder (ASD) Pilot Program is designed to provide 200 children under 13 years of age who have been assessed and diagnosed with autism with two new services: behavioral consultative supports and individual behavior supports, and to remove existing limits on occupational therapy, physical therapy, and speech and language therapy. At the time of its response, DCF had identified 100 eligible children for whom they planned to begin authorizing services in April 2014. The remaining 100 children were expected to be phased in as they were identified as eligible. The total cost of the program was anticipated at \$7.5 million, with \$2 million being the federal share.
- The Children with Serious Emotional Disturbance (SED) program permits the State to claim a 50 percent federal match for certain behavioral services for eligible children that were previously provided at 100 percent State expense. At the time of the response, this included 4,200 children, with a State savings of \$14.8 million. DCF indicated that it planned to begin claiming on three additional services provided to eligible clients during FY 2015, and was working on the logistics of enrolling 799 additional children into Medicaid/NJ FamilyCare.
- **Questions: Please provide an update regarding the implementation of these programs. What is the current timeframe for full implementation of each of these programs (ID/DD-MI, ASD, and SED)? How many children will be served by each of the programs in FY 2015 and in FY 2016? For each program, what State savings due to offsetting federal revenues are currently expected in FY 2015, and in FY 2016?**

### Response:

Below is a chart with the current target dates for implementation of certain components of these waiver programs. Due to the complexities of service development for these programs, the target implementation dates for individual components are later than originally anticipated. Once a provider network is in place, DCF will be able to authorize the services to the youth shortly thereafter. The below chart represents when we expect to be able to bid for services and build network of qualified providers.

It is estimated that 200 youth will be served by the IDD/MI and ASD waiver initiatives. Currently there are 90 youth in the DD/MI waiver and 38 youth in the ASD waiver.

The DCF budget is adjusted based on the analysis of utilization trends. As these initiatives are phased-in, data is used to realign our budget for identified service needs and the appropriate state/federal match. Any growth or savings will be identified and tracked during this process.

**Discussion Points (Cont'd)**

Waiver Component	Services	Target Date
ID-DD/MI Pilot	Respite	Provider Network in place
	Intensive in Community Supports Habilitative	Provider Network in place
	Individual Supports	Provider network currently in process of being approved and operationalized
	Natural Supports	Service procurement anticipated July 2015
	Interpreter	Service procurement anticipated July 2016
	Non-Medical Transportation	Service procurement anticipated July 2016
ASD Pilot	Individual Behavioral Supports	Provider Network in place
	Behavioral Consultative Supports	Provider Network in place
SED	Transitional Youth Life Skills Building (16 & Over) Youth Support and Training (5-16 yr old)	Development of certification process for existing IIC providers to offer these additional services anticipated July 2015
	Non-Medical Transportation	Service procurement anticipated July 2016

Child Fatality and Near Fatality Review Board Recommendations

23. Children receiving behavioral health services through CSOC whose behaviors necessitate treatment in a secure facility can be referred to an inpatient psychiatric intermediate care facility by a Children’s Crisis Intervention Service. The 2013 report of the Child Fatality and Near Fatality Review Board (described in discussion point #14 above) recommends expansion of the availability of these services, and creating other means to admission, aside from referral by a Children’s Crisis Intervention Service.

- **Questions:** How are children in need of extended inpatient psychiatric care assessed for that need and able to access those services? Does the department believe availability of inpatient services is a problem for its clients, either on a Statewide level or in any specific county or region of the State? If so, what does the department view as the best solution(s) to this problem?

## Discussion Points (Cont'd)

### Response:

Children who are in need of inpatient care require a psychiatric screening at a designated screening center. The screening center determines if the individual needs to be admitted into a Children's Crisis Intervention Services (CCIS) bed. From the CCIS, the treatment team may determine that a youth needs continued stabilization in a secure facility. CSOC is constantly monitoring the need for more resources and does not believe at this time that the system is in need of more intermediate care beds. CSOC is currently monitoring the need for additional CCIS beds and if determined that there is a need, will work with the Department of Health to address this need.

24. The Child Fatality and Near Fatality Review Board also recommends that CSOC contact Child Protection & Permanency in cases where a child has severe mental health issues and has either voluntarily terminated or is non-compliant with their CSOC treatment services, thereby placing them at high risk.

- **Questions: In what cases, if any, does CSOC currently provide information to CP&P regarding a client's compliance with treatment? Does CSOC have a formal policy in place for such information sharing?**

### Response:

CSOC is a mandated reporter in regards to concerns about abuse and neglect, for which the youth is at high risk. If suspected that a youth is in danger due to the noncompliance of the caregiver, CSOC would initiate a report to the State Central Registry (Child Abuse/Neglect Hotline).

## **Family and Community Partnerships (FCP) and Division on Women**

25. Legislative budget resolutions included in the FY 2015 Appropriations Act added \$2.24 million for Women's Services over the FY 2014 appropriation. An associated language provision (Appropriations Handbook page B-19) requires that \$1.84 million be appropriated to the lead domestic violence agencies in the State and to the New Jersey Coalition for Battered Women to offset costs of providing core domestic violence services. The provision also allocates an additional \$0.4 million to the 21 county-based sexual violence service organizations and the New Jersey Coalition Against Sexual Assault to offset the costs of providing direct services for victims of sexual violence.

- **Questions: Please provide the total amount allocated in FY 2015 and recommended for FY 2016 for each of the following: (1) the lead domestic violence agencies in the State; (2) the New Jersey Coalition for Battered**

**Discussion Points (Cont'd)**

**Women; (3) the 21 county-based sexual violence service organizations; and (4) the New Jersey Coalition Against Sexual Assault? What portion of these amounts is for any services other than core domestic violence services and direct services for victims of sexual violence?**

**Response:**

Pursuant to the FY 15 budget language provision, each lead domestic violence (DV) service provider received \$76,000 and the New Jersey Coalition for Battered Women received \$92,000 during SFY15. Each sexual violence (SV) service provider received, \$18,181 and the NJCASA received \$18,181 for a total of \$400,000.

The funding added by the Legislature in FY15 specifically was used by the providers for both DV and SV to "off-set" the cost of administering the programs. Most DV providers utilized the funds for this purpose. A few utilized the funds to support salaries of staff which provide services to victims of DV. Most SV providers utilized funds to support salaries of staff providing direct services to victims of SV. A few utilized funds to off-set the costs of the agency.

26. Funding for the Division of Women is contained within the Governor's FY 2016 Budget Recommendation for the Family and Community Partnerships program class. In response to FY 2015 OLS Discussion Point #21, DCF provided the following disaggregated funding information for the Division on Women since its transfer to DCF from the Department of Community Affairs in FY 2013.

<i>Direct State Services</i>	DCA	DCF	DCF	DCF	
Program	FY 2012 Expended	FY 2013 Expended	FY 2014 Adjusted	FY 2015 Recomm.	Source
Address Confidentiality Program	\$93,000	\$93,000	\$93,000	\$93,000	State
Expenses of the New Jersey Commission on Women	\$0	\$7,000	\$7,000	\$7,000	State
Grants to Displaced Homemaker Centers	\$75,000	\$0	\$0	\$0	Other
Office on the Prevention of Violence Against Women	\$252,000	\$252,000	\$252,000	\$252,000	State
Rape Prevention and Education	\$89,728	\$2,000	\$2,000	\$2,000	Federal

**Discussion Points (Cont'd)**

Women's Programs (primarily salaries & wages)	\$470,000	\$470,000	\$470,000	\$470,000	State
<b>TOTAL DSS</b>	<b>\$979,728</b>	<b>\$824,000</b>	<b>\$824,000</b>	<b>\$824,000</b>	
<b>Grants-in-Aid</b>					
Grants to Displaced Homemaker Centers	\$1,130,000	\$1,130,000	\$1,130,000	\$1,130,000	State
Grants to Displaced Homemaker Centers	\$646,000	\$646,000	\$688,000	\$688,000	Other
Grants to Women's Shelters	\$25,000	\$25,000	\$25,000	\$25,000	State
Office on the Prevention of Violence Against Women	\$51,295	\$56,000	\$56,000	\$56,000	State
Rape Prevention	\$450,000	\$900,000	\$900,000	\$900,000	State
Rape Prevention	\$94,299	\$196,579	\$197,000	\$197,000	Federal
Rape Prevention and Education	\$920,663	\$915,772	\$916,000	\$916,000	Federal
Violence Against Women Act Sexual Assault Services Grant	\$214,583	\$326,215	\$334,250	\$335,000	Federal
Women's Referral Central	\$25,000	\$25,000	\$25,000	\$25,000	State
<b>TOTAL GIA</b>	<b>\$3,556,840</b>	<b>\$4,220,566</b>	<b>\$4,271,250</b>	<b>\$4,272,000</b>	
<b>GRAND TOTAL DSS and GIA</b>	<b>\$4,536,568</b>	<b>\$5,044,566</b>	<b>\$5,095,250</b>	<b>\$5,096,000</b>	

- **Question:** Please provide an updated chart displaying total gross FY 2014 expenditures, FY 2015 adjusted appropriations, and FY 2016 recommended appropriations for the Division on Women, disaggregating the funding amounts by funding category and funding source.

**Response:**

Please see updated chart below.

## Discussion Points (Cont'd)

New Jersey Department of Children and Families  
 Division on Women  
 FY 2013 - 2016

### Division on Women: Funding Transferred from DCA to DCF in FY 2013

Direct State Services	DCA	DCF	DCF	DCF	DCF	Source	Comments
	Transferred From DCA	FY2013 Expended	FY2014 Expended	FY2015 Adjusted	FY2016 Recommend		
Address Confidentiality Program	\$93,000	\$93,000	\$93,000	\$93,000	\$93,000	State	
Empower II	\$37,000	\$0	\$0	\$0	\$0	Federal	Grant ended prior to FY 13
Expenses of the New Jersey Commission on Women	\$7,000	\$7,000	\$7,000	\$7,000	\$7,000	State	
Grants to Displaced Homemaker Centers	\$75,000	\$0	\$0	\$0	\$0	Other	\$75,000 moved to Grants-in-Aid for services.
Office on the Prevention of Violence Against Women	\$252,000	\$252,000	\$252,000	\$252,000	\$252,000	State	
Rape Prevention and Education	\$100,000	\$2,000	\$2,000	\$2,000	\$2,000	Federal	Only \$2,000 is utilized for travel costs - remaining is in Grants-in-Aid for services. See below.
Women's Programs (primarily Salaries and Wages)	\$470,000	\$470,000	\$470,000	\$470,000	\$470,000	State	
<b>TOTAL DSS</b>	<b>\$1,034,000</b>	<b>\$824,000</b>	<b>\$824,000</b>	<b>\$824,000</b>	<b>\$824,000</b>		

Grants-in-Aid	DCA	DCF	DCF	DCF	DCF	Source	Comments
	Transferred From DCA	FY2013 Expended	FY2014 Expended	FY2015 Adjusted	FY2016 Recommend		
Empower II	\$63,000	\$0	\$0	\$0	\$0	Federal	Grant ended prior to FY 13
Grants to Displaced Homemaker Centers	\$1,130,000	\$1,130,000	\$1,130,000	\$1,130,000	\$1,130,000	State	
Grants to Displaced Homemaker Centers	\$613,000	\$646,000	\$688,000	\$688,000	\$688,000	Other	FY 15 reflects shift of \$75,000 DSS to GIA
Grants to Women's Shelters	\$25,000	\$25,000	\$25,000	\$25,000	\$25,000	State	
Office on the Prevention of Violence Against Women	\$56,000	\$56,000	\$56,000	\$56,000	\$56,000	State	
Rape Prevention	\$900,000	\$900,000	\$900,000	\$1,300,000	\$900,000	State	SFY 15 Legislative increase
Rape Prevention	\$210,000	\$196,579	\$196,579	\$196,579	\$196,579	Federal	FFY15 grant award not yet received. Estimates for FY15 and FY16 based on FY14
Rape Prevention and Education	\$980,000	\$915,772	\$747,944	\$827,193	\$827,193	Federal	FFY15 grant award is \$827,193. FY16 based on FY15.
Violence Against Women Act Sexual Assault Services Grant	\$325,000	\$326,215	\$334,250	\$368,957	\$368,957	Federal	FFY14 grant award linked to SFY 15. FY16 estimate based on FY15
Women's Referral Central	\$25,000	\$25,000	\$25,000	\$25,000	\$25,000	State	
Intimate Partner Violence (Safe Dates)	\$0	\$0	\$0	\$300,000	\$0	Federal	One-Time Funds available for FY15
<b>TOTAL GIA</b>	<b>\$4,327,000</b>	<b>\$4,220,566</b>	<b>\$4,102,773</b>	<b>\$4,916,729</b>	<b>\$4,216,729</b>		
<b>GRAND TOTAL DSS and GIA</b>	<b>\$5,361,000</b>	<b>\$5,044,566</b>	<b>\$4,926,773</b>	<b>\$5,740,729</b>	<b>\$5,040,729</b>		

27. In response to questions from both budget committees, Commissioner Blake indicated that the department has historically relied on spreadsheets and anecdotal evidence to target funding for women's services and domestic violence funding.<sup>14</sup> The commissioner also indicated that the department was in the process of developing a data system for women's services and domestic violence agencies that could allow more deliberate targeting, which could be available "a year from now."

- **Questions:** What is the status of the formal data collection system described by the commissioner that was in development in 2014? Is the system in operation, or if not, when will it be operational? How will the formal data system be used in planning and allocation of funding?

<sup>14</sup> For the discussion in the Assembly Budget Committee, find the audio recording for May 5<sup>th</sup> at [http://www77/media/archive\\_audio2.asp?KEY=ABUB&SESSION=2014](http://www77/media/archive_audio2.asp?KEY=ABUB&SESSION=2014). The relevant discussion is approximately 46 minutes into the recording.

**Discussion Points (Cont'd)****Response:**

The Department has identified potential software programs as a service option and is in the final stages of identifying which software program as a service will best meet the needs of the Division of Family and Community Partnerships (FCP) and the Division on Women (DOW). Once the procurement process is completed DCF will start to integrate four of the programs from FCP and DOW.

**Education Services**

28. In response to FY 2015 OLS discussion point #22a, DCF provided the following data regarding the department's State-operated Regional Schools, locations, and enrollments. Students in the department-operated Regional Schools include those with severe cognitive, emotional and behavioral disabilities, as well as teen parents and other "at risk" youth.

<b>DCF Regional School</b>	<b>County</b>	<b>Student Enrollment (March 2014)</b>	<b>Infant/Toddler Enrollment (March 2014)</b>	<b>Maximum Student Capacity (March 2014)</b>
Atlantic Campus	Atlantic	29	21	42
Bergen Campus	Bergen	47	N/A	50
Burlington Campus	Burlington	29	24	35
Cape May Campus	Cape May	25	11	36
Cherry Hill Campus	Camden	61	N/A	61
Cumberland Campus	Cumberland	18	N/A	22
Essex Campus	Essex	29	N/A	40
Hudson Campus	Hudson	10	N/A	15
Mercer Campus	Mercer	34	22	38
Middlesex Campus	Middlesex	(closed in 2013)		
Monmouth Campus	Monmouth	18	14	23
Morris Campus	Morris	12	N/A	23
Ocean Campus	Ocean	30	N/A	35

**Discussion Points (Cont'd)**

Passaic Campus	Passaic	46	N/A	50
Union Campus	Union	25	N/A	30
Warren Campus	Warren	28	6	28
Wanaque Campus	Passaic	63	N/A	65
<b>TOTAL:</b>		<b>504</b>	<b>98</b>	<b>593</b>

- **Questions:** Please provide updated enrollment and capacity information for 2015. Does the department plan to close any additional regional schools, or make any other substantial changes, during FY 2016?

**Response:**

The chart below provides updated enrollment information for March 2015. Maximum student capacity is a current estimate based on building size, current staffing levels, age range requirements, transportation capacity, nursery capacity and typical student needs for each population. These numbers are subject to variation depending on the specific requirements of individual children whose level of service may be driven by an IEP (Individualized Education Program). For example, a student with severe cognitive disabilities must have a 1:3 staff-to-student ratio based on special education regulations. Behavioral health students may need intensive 1:1 behavioral or academic support. A school with a Project TEACH program must be able to accommodate the needs of both the school aged teen mom and her infant/toddler. Nurseries require a 1:4 staff-to-child ratio based on licensing requirements. All of these factors impact the maximum student capacity.

<b>DCF Regional School</b>	<b>County</b>	<b>Student Enrollment (March 2015)</b>	<b>Infant/ Toddler Enrollment (March 2015)</b>	<b>Maximum Student Capacity (March 2015)</b>
Atlantic Campus	Atlantic	39	15	42
Bergen Campus	Bergen	50	N/A	50
Burlington Campus	Burlington	23	18	35
Cape May Campus	Cape May	30	9	36

**Discussion Points (Cont'd)**

Cherry Hill Campus	Camden	52	N/A	60
Cumberland Campus	Cumberland	14	N/A	20
Essex Campus	Essex	26	N/A	35
Hudson Campus	Hudson	7	N/A	15
Mercer Campus	Mercer	22	15	38
Monmouth Campus	Monmouth	12	10	20
Morris Campus	Morris	14	N/A	20
Ocean Campus	Ocean	27	N/A	30
Passaic Campus	Passaic	40	N/A	45
Union Campus	Union	26	N/A	30
Warren Campus	Warren	13	4	20
Wanaque Campus	Passaic	66	N/A	65
<b>TOTAL:</b>		<b>461</b>	<b>71</b>	<b>561</b>

NOTE: The Morris Campus and Hudson Campus buildings are only partially utilized for instructional programs. The remaining space at Morris Campus is used as office space for the northern region child study team. The remaining space at Hudson Campus is used for family/child visitation, family team meetings and professional development classes conducted by the DCF Training Academy.

No Regional School closures are planned at this time for FY 2016.

**Safety and Security Services**

29. In addition to their role in patrolling State psychiatric hospitals and developmental centers) the Human Services Police Department provides escort and intervention services to the DCF. In November 2014, the Human Services Police was reorganized to eliminate a 25-member unit that had been dedicated to DCF child welfare workers, in an attempt to reduce the department's perennially high overtime costs. (In response to FY 2015 OLS Discussion Point #23, DCF indicated that the FY 2013 overtime expenditures for the Human Services Police assigned to DCF totaled \$795,414, and the FY 2014 overtime expenditures were projected to be \$716,117.) Instead of reporting to DCF offices, officers are now centrally stationed at the three State psychiatric hospitals, and are dispatched to escort DCF

## Discussion Points (Cont'd)

caseworkers when needed. According to press reports, all Human Services Police officers are now to be "cross trained" to serve in both institutional security and community escort roles.

- **Questions:** How does the new central dispatch system compare with the old system with respect to the availability of officers to provide escort services? Has the cross-training of officers been successful in ensuring that all officers dispatched to escort DCF caseworkers are appropriately trained to the needs of the role? How has the reorganization affected overtime costs?

### Response:

The role of the HSP officers is to assist CP&P caseworkers by providing police services in many situations, as appropriate. The new central dispatch system compares with the old system in that the same services to our staff will be provided, but now officers will be deployed from a regional location (North, Central, South). This model affords police services to all CP&P caseworkers as needed in appropriate situations. Prior to DHS implementing this new model, officers were located only in *some* of our local offices during the hours of 10am to 6pm (after 6 pm, overtime procedures were activated). It was these specific local offices that used these services.

Today, all local offices have the same access to HSP services, and service has been extended to 7 days a week, 24 hours per day. DHS is collecting data for several service categories such as field assists, removals, police information, attempt to locate juvenile, attempt to locate adult and transports. Early reports on the implementation of the new model indicate that the officers are appropriately trained and are responsive to the needs of the DCF Local Office staff. DHS has shared with DCF that this is a standard model employed by police forces and it is designed to increase safety and accountability. DHS and DCF maintain open lines of communication and assess issues related to the reorganization in an effort to identify and address concerns. As this model has only been in effect for a few months, DCF does not have trend data related to overtime costs.

30. Three days after the dissolution of the unit of the Human Services Police described in Discussion Point #29, a stabbing incident in a DCF office in Camden brought a heightened level of scrutiny to on-site security at child welfare offices. (Prior to the reorganization, the Human Services Police had not been stationed at the office for security, but were sometimes present when awaiting an escort assignment. According to union representatives, this police presence added to security. DCF has disputed this claim, observing that there are more offices than officers in the dedicated unit, and that these officers were meant to spend most of their time in the field rather than at the offices.) Shortly thereafter, DCF began to implement enhanced office security measures, which include arming the private security guards that were already present at the offices and providing them with metal detector

## Discussion Points (Cont'd)

wands, and reorganizing the layout of certain offices that had previously lacked any separation of the client waiting area from employees' work area.

- **Questions:** Please describe the security measures currently in place at the State's child welfare offices. Is any additional expansion of security measures still being implemented, and if so, on what schedule? What is the total cost of these measures?

### Response:

DCF has implemented several measures to enhance worker safety and improve workplace security. Additional measures are in development.

Workplace security measures that are currently in place include:

- Armed security guards with metal detection wands stationed at the point of visitor entry in all CP&P Local Offices.
- Security guard protocol was developed and distributed to all local offices;
- Safety materials and signs have been created and posted in all entry/waiting areas to deter unwanted behaviors.
- Increased outreach efforts with local law enforcement to cultivate more collaborative working relationships;
- Some building modifications are underway to improve visitation areas utilized by the public.

Enhanced worker safety measures underway include:

- Development of an electronic safety alert in NJ SPIRIT so workers can easily document and share safety concerns in electronic case records. (Implementation anticipated in June 2015)
- Pilot of panic button lanyards for use in interview rooms and on-site visits with clients is underway. These buttons signal to the armed security guard if assistance is needed.
- Evaluation of mobile tracking options such as GPS and other location identification systems.
- A DCF safety workgroup has been meeting to assess worker safety, research training initiatives and to review policies, protocols and procedures related to case practice and daily operations in the office and in the field.
- Revisions to several policies and procedures are underway as well as development of additional training courses related to safety issues encountered by the workforce.

**Discussion Points (Cont'd)**

The implementation of these enhanced safety and security measures is currently estimated to cost approximately \$2 million and will be supported with Title IV-E funds earned through our cost allocation process and budgeted to support these initiatives as well as a realignment of other current resources.