STRATEGY BRIEF

STRONG FAMILIES

How did New Jersey **safely reduce the number of children in congregate care?**

Every child deserves a safe and stable family. When children must be removed from their families, it is the responsibility of the child protection agency to ensure that they are placed in the most nurturing and least restrictive settings possible. Congregate care — whether small group homes, larger residential care facilities, or psychiatric hospitals — should be used for the treatment of complex physical and behavioral health needs, not for meeting the general placement needs of children in out-of-home care.

In response to multiple requests from child welfare leaders, child advocates, and jurisdictional partners seeking to better understand how different states have safely reduced their reliance on congregate care, Casey Family Programs conducted in-depth interviews with a number of jurisdictions. This jurisdictional snapshot provides a summary of conversations with **New Jersey's Department of Children and Families**[1] regarding the strategies implemented to achieve a 45% reduction in the use of congregate care from 2009 to 2016. It includes background information and context about New Jersey's child welfare system, key strategies, relevant outcomes as a result of the strategies employed, and the lessons learned or tips for other jurisdictions seeking to reduce their reliance on congregate care.

casey family programs

Agency background

New Jersey's Department of Children and Families (DCF) is a stand-alone agency composed of a number of divisions, including Child Protection and Permanency (CPP, New Jersey's child protection agency) and the Children's Systems of Care (CSOC, which manages behavioral health, substance abuse treatment, and developmental disability services for the state). CPP and CSOC work together closely to ensure that children and youth receive flexible, family- and community-based services to address their behavioral and mental health needs.

Key strategies

The significant decrease in New Jersey's congregate care usage has not been the result of a single program or policy. Rather, the approach has been multifaceted and iterative, highlights of which are provided below.

Case practice model

The reduction of congregate care placements for children in foster care has been driven in large part by the core commitments and expectations outlined in the **agency's practice model**, including its commitment to:[2]

- Support families in creating family teams, so that their natural family and community networks can help the family develop and manage customized family plans matched to their current situation.
- Make diligent efforts to identify, evaluate, and consider relatives for placement, consistent with child safety and well-being. Preference and available supports should be provided for relative placement.
- Place children in family settings that can be expected to become the child's permanent placement if necessary, unless another placement is temporarily needed for therapeutic reasons.
- Make every effort to place children within the community or county of their parents' residence unless the reason for the location of the placement outside the community or county is to help the child achieve his/her goals.
- When a child is placed into foster care, placement selection will take into account the location of the child's school; the agency strives to avoid the child having to change schools as the result of placement.

These guiding principles are emphasized and operationalized through policy, supervision, training, and case planning and conferencing tools such as the Case Practice Guide. Now, when children cannot remain safely with their families and must be placed in out-of-home care, they almost always are placed in family homes, reflecting DCF's philosophy of "**first placement, best placement**." According to CPP leadership, it is now "extremely, extremely rare for a child's placement to ever be in a group care setting."

Prioritizing relatives, family friends, and communities

When children must be removed from their homes to ensure their safety, **relative placements are always preferred and prioritized**, as are family friends and neighbors in the community. DCF provides staff with clear policy guidance and related strategies to support this guiding principle. Investigators have the ability to place children with relatives in emergency situations, and the agency can initiate **same-day presumptive eligibility for relative caregivers**.

Matching and preparation of children and families

If a relative placement is not available, staff utilize a **matching tool** included in the agency's statewide automated child welfare information system (SACWIS) that allows a child's characteristics to be matched with those of available foster homes. DCF provides clear resource home selection guidance to staff, as well as a range of key considerations and steps to support a trauma-informed removal and placement process: Removal of a Child; Preparations

for Placement; and Day of Placement. Evening and weekend staff are provided with a list of all available placements in their catchment area; they make calls at the beginning of a shift to develop relationships with resource parents, and again after placing a child, to offer support and help mediate or troubleshoot any initial issues. All caseworkers are required to visit children within five days of a new placement, but staff also call the day after placement to provide support to both the child and the caregiver over the phone.

Resource family recruitment

New Jersey has been working to improve its array of resource families for many years. In order to reduce its reliance on congregate care, DCF also changed the way that it worked with resource parents, approaching them not as beds or placements, but as **valued, integral partners**. The state also invested considerable time and attention on targeting its recruitment efforts using strategies such as market segmentation, which involves looking at the broad population of potential resource families and dividing them into subsets that have common needs, interests, or characteristics and then designing and implementing strategies to target them. **DCF has been so successful in its recruitment efforts that now the current number of licensed foster homes is more than double the number of children requiring placement in out-of-home care (approximately 14,000 beds are available in licensed foster homes versus 6,600 children in care).**

Resource family support and retention

In addition to recruitment efforts, New Jersey adopted a new **family model of care** that included an extensive menu of support for foster, adoption, and kinship caregivers that has helped reduce the overall foster care population as well as dramatically reduce the number of children placed in congregate care.[3] In this model, resource families are provided with Parent Resources for Information, Development, and Education (PRIDE) and other preservice training, a comprehensive handbook, and other resources. The agency also funds a range of support services, multiple appreciation events, and ongoing training opportunities for foster, adoptive, and kinship families offered through the New Jersey Foster and Adoptive Family Services.

A resource worker and child health unit nurse are assigned to help support the caregiver and provide services to the child in the resource home. This paradigm of resource home support, articulated in the New Jersey Resource Family Retention Plan, is very intensive, with multiple staff working to secure as many community resources as possible to help keep children in these family-based settings. DCF also provides peer supports to resource parents through an active mentoring program and a peer support helpline staffed by veteran resource families and run by Rutgers University Behavioral Health Care Call Center. The agency implements an annual resource family survey to capture feedback from families regarding their experiences and needs to inform the agency's retention planning and activities for the coming year.

Creation of a Children's System of Care

In 2001, as a result of sustained advocacy by a parent caucus and children's advocates, New Jersey's governor mandated the creation of the Children's Initiative, which subsequently became the Children's System of Care. Historically, New Jersey's families had

> We've moved away from just filling a bed or finding a placement — we're looking for a family.
>
> — NEW JERSEY DEPARTMENT OF CHILDREN AND FAMILIES

to relinquish custody of their child in order to access critical behavioral health services; the Children's Initiative was created to allow families access to needed services without separating parents and children in the process.

CSOC is grounded in New Jersey's long-standing commitment to core principles for organizing and delivering services for children and families that support the dignity and integrity of children, families, and the communities in which they live. CSOC is designed to break down barriers between child-serving systems. It is not a mental health initiative; not a child welfare initiative; not a Medicaid initiative; not a juvenile justice initiative. It is a Children's Initiative and addresses the whole child in all aspects of family and community life, focusing on strengths that support community living and healthy social development for children and families.[3]

Universal behavioral health care

Today, CSOC has the flexibility and funding to ensure provision of the right services to children and families, at the right time, and in the right setting. CSOC has been effective in reducing the number of children entering foster care, especially those in need of behavioral health services when there is no concern for child abuse or neglect. CSOC provides a **strong continuum of behavioral health, developmental disability, and substance use treatment services**, offered in an array of settings, and available to all children and families in the state, regardless of geography, insurance, or income. Through care management and wraparound, in-home clinical and behavioral assistance, intensive community-based services, outpatient and partial care programs, afterschool and therapeutic nurseries, as well as crisis response services, the state has been able to significantly reduce the number of children in institutional care or accessing inpatient psychiatric treatment.[4] The implementation of CSOC also enabled the state to close its child psychiatric hospital and state-operated residential treatment centers, and bring children back from out-of-state facilities. Some of the core components of CSOC include:

Family support organizations

Family support organizations are state-based peer support organizations run by families being served by CSOC. Their approach allows the family to drive the individualized planning process and brings the youth's voice into the plan as well. They assist other system partners in the work of authentic youth and family engagement, critical to both preventing the need for congregate care as well as supporting the successful transition from congregate care back to the family and community, and reducing the need for subsequent episodes of care.

Mobile crisis response

One of the key services of the CSOC is the Mobile Response and Stabilization Services (MRSS) team, which is available statewide 24 hours a day, seven days a week to respond within one hour of a request for assistance or support. MRSS is open to all children and families in crisis, including birth, kinship, foster, and adoptive families. The mobile response team also can assess whether the child might need ongoing services, and can refer the child to other CSOC-supported services. Based on MRSS' success in stabilizing foster placements, DCF conducted a pilot study to evaluate the impact of providing MRSS to all new foster placements in a local area. The results were promising and the agency now deploys an MRSS worker to meet with every child entering foster care or in a new placement, as well as with the child's resource family, to provide support, mitigate the trauma of placement, and prevent placement disruption.

Care management organizations

County-based, nonprofit care management organizations (CMOs) are responsible for face-to-face care management and comprehensive service planning for youth and their families with intense and/or complex needs. They coordinate the child family team (CFT) meetings, and implement individual service plans (ISPs) for each youth and

family using a wraparound approach to planning for each youth and a single point of accountability for services and supports needed to maintain stability.

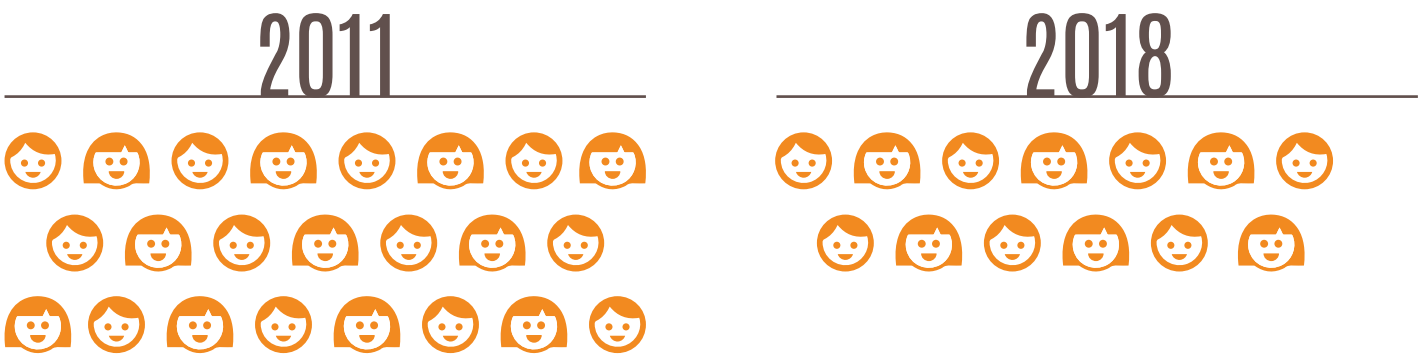
Critical to the reduction of congregate care, admission to CSOC's out-of-home treatment programs are informed by careful planning through child family teams led by CMOs. When the Child Protection and Permanency Division is involved with a family, they are a key partner of the CFT and planning process. Prior to requesting an out-of-home intervention, the CFT will meet to discuss the needs of the youth, develop a plan for the youth to return home as soon as possible, and obtain supervisory consultation and approval. During this process, the CFT must document that (a) the youth will benefit from treatment outside of the home, (b) the youth meets the clinical criteria for out-of-home treatment, (c) community treatment options are inadequate to meet the youth's needs, and (d) the family will have specific responsibilities during the time the youth is in out-of-home treatment. The family must be willing to attend CFT meetings, participate in therapeutic services, and interact with the youth regularly both in the program and at home. Once the CFT elects to pursue out-of-home treatment, the care manager handles the request and identifies options for specific programs within the needed level of care. The CFT discusses those options and assists the youth and family in choosing which provider will best meet the youth's needs. Once a provider is selected, the care manager coordinates with the provider and the family to schedule an admission and gather all required documentation.

Pre-placement planning and assessment
While there are certainly instances when a child must enter care on an emergency basis, in most situations out-of-home placements are informed by a careful planning and family engagement process. A Child Strengths and Needs Assessment is completed to identify the critical strengths and needs of any child who will be served by DCPP. The assessment provides information for the case plan, identifying the top three strengths and the top three needs of each child receiving services. It is used to (a) identify the child's critical needs in an objective format, (b) develop and plan effective service intervention, (c) monitor service referrals on behalf of the child, and (d) assess changes in a child's functioning over time, to evaluate the impact of services.

Routine reviews and information-sharing
Ongoing, team-based reviews are an integral part of assessing the appropriateness of the level of care. Every 90 days, a new care plan is created for each child, which includes the youth's updated strengths and needs as well as an updated treatment plan. There are also joint care review meetings to help determine whether a higher level placement may still be needed or whether the youth is ready to "step down" to a lower level of care. New Jersey also uses a **single record** whereby all providers can document their work with the child and family to ensure ongoing and timely information-sharing and collaboration.

Workforce redeployment
As DCF dramatically reduced the number of children in placement it did not simultaneously shrink staff capacity. By maintaining a robust workforce in spite of a smaller number of children in care, the agency was able to significantly reduce caseloads and workloads, ensuring that staff have the time to meaningfully engage children and families, and focus their efforts on preventing placements, reducing placement moves, achieving timely permanency, and delivering post permanency supports to prevent re-entry to care. DCF was also able to redeploy a portion of the workforce to create after-hours and resource home support positions.

45% DECREASE
IN RELIANCE ON CONGREGATE CARE



OVER 50% REDUCTION

In 2009, there were approximately 8,000 children in foster care, with approximately 12% (985) placed in congregate care settings.

By 2016, following the investment of the strategies outlined above, only 7% (455) of the 6,600 children in care were placed in congregate care settings.[5]

Outcomes

By developing a robust array of services in-state, in combination with careful planning, New Jersey was also able to reduce the number of children in out-of-state behavioral health facilities from more than 300 to three in just five years (2007-2012), in keeping with the state's commitment to keep children as close to home as possible.[4]

Lessons learned

The system of care approach, made available to all families regardless of geography, income, or child welfare involvement, provides children and families with the services they need and helps prevent children from entering care as a result of behavioral health crises. When placement into care is necessary, **investing in a rich menu of support for resource families** (kinship, foster, adoptive) is key to reducing reliance on congregate care and improving timeliness to permanency. Positioning care management organizations to monitor, advocate, and support the youth and family during residential treatment, and to help families prepare for the child's transition home, is important.

Engaging residential providers in setting a shared goal of reducing the use of congregate care has been collaborative, as they have been supported with a different structure that includes ongoing assessment and determination of continuing need for this intensity of service. With the advent of the system of care philosophy and structure, DCF's community partners were more willing to collaborate as the conversations **shifted to family driven, youth guided, community based, culturally competent, and strengths based conversations with the collective goal to improve outcomes for children**. Shifting the language from "placement" to "treatment" was significant to help child welfare staff understand why and when the congregate care setting would be accessed. In addition, the dialogue from "we need fewer group homes" to "we need something different" was also critical to the early stages of these reforms. Providers who were able to adjust and meet the new service needs are still operating today. New Jersey also found it important to **engage and train legislators and the judiciary** as to why children need to be in family settings, with the right services, rather than placed in shelters. Education on when it was appropriate to utilize residential care settings was also an important strategy. Focusing only on placement stability can move children off the path to permanency. Children's well-being *and* the **urgency of their permanency needs** must be high priority.

To learn more, see related resources at Casey.org/New-Jersey-reduce-congregate-care

1 Interviews with Elizabeth Manley, SOC assistant commissioner, New Jersey Department of Children and Families, November 14, 2017, and Lisa von Pier, CPP assistant commissioner, Betsy Sunder, CPP deputy director, and Michelle Adams, CPP deputy director, New Jersey Department of Children and Families, December 15, 2017.

2 New Jersey Department of Children & Families. (2007; rev 2015). *Case Practice Model*. Retrieved from http://www.nj.gov/dcf/about/welfare/case/DCF_CasePracticeModel.pdf

3 US Government Accountability Office. (2015). *FOSTER CARE: HHS could do more to support states' efforts to keep children in family-based care* (GAO-16-85). Washington, DC: Author. Retrieved from https://www.gao.gov/products/GAO-16-85

4 New Jersey Department of Children and Families. (2017). *The role of mobile response in transforming children's behavioral health: The NJ experience*. Retrieved from https://zapdoc.tips/the-role-of-mobile-response-in-transforming-children-s-behav.html

5 Rutgers University Child Welfare Data Hub. (2018). *Children in Placement (Point in time)*. Retrieved from https://njchilddata.rutgers.edu/portal/children-placement-reports

P 800.228.3559
P 206.282.7300
F 206.282.3555

casey.org | KMResources@casey.org