

Statement of
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Court-appointed Monitor for
Charlie and Nadine H. v. Christie

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Good afternoon. I am pleased to provide the court with an update of the State's progress in meeting the requirements of the Charlie and Nadine H. v. Christie Modified Settlement Agreement (MSA). I am Judith Meltzer, Deputy Director of the Center for the Study of Social Policy and the Court-appointed Monitor. With me are Kristen Weber, Martha Raimon, and Dan Torres, who are part of the Center's monitoring team.

This Monitoring Report covers the State's progress in meeting commitments of the Modified Settlement Agreement for the period between July 1 and December 31, 2010. This is the ninth Monitoring Report under the MSA, and provides additional information on Phase II performance benchmarks and the results – or outcomes – of the State's interventions in the lives of New Jersey's children and families.

In producing this report, we independently verified data provided by DCF and also obtained information from stakeholders throughout the State, including contracted service providers, youth, relatives and birth parents, advocacy organizations, and judicial officers. We spoke to a sample of caseworkers from across the State to verify caseload data. In February 2011 we conducted a record review of a sample of child abuse and neglect investigations to assess the comprehensiveness and quality of investigations practice. We will issue a supplemental report on investigations this summer, which will detail the findings and recommendations from that case record review.

Attached to the report as an Appendix is a supplemental report with the findings and recommendations from the Adolescent Case Record Review conducted last period on the status of youth aged 18-21 who had been in foster care and exited care between January 1 and June 30, 2010.

As is supported by the data in the report, there has been significant performance improvement since the reform work began under the Modified Settlement Agreement almost five years ago. ***While the final outcomes and expectations of the MSA are not fully met in significant areas as outlined in the report, there is substantial evidence that New Jersey's child welfare system is more adequately resourced, better staffed and better managed, and overall, doing a better job protecting and supporting New Jersey's children and families.*** This finding is especially important right now because as the Court is aware, the ability of DYFS and its partners to protect New Jersey's children

has been under intense public and press scrutiny as a result of the tragic death of Christiana Glenn in May and the severe neglect and abuse of her siblings.

As Monitor, DCF is to inform us of all cases that involve child deaths or near deaths in which there is suspected abuse or neglect. When we have questions about prior DYFS involvement or there is a question of whether DYFS should have intervened, my staff or I request and review case records. We have done so in the case involving Christiana Glenn and her siblings and I want to briefly share our preliminary observations and findings. First, DCF leaders have been forthcoming and open to our inquiries and have provided quick and full access to all of the records we requested. Last week, we reviewed all of the relevant DYFS records from the family's involvement with DYFS in 2006 and 2008. On Thursday evening, June 9, we learned for the first time that DYFS' ongoing internal review uncovered a call to the Hotline in May 2011 about these children that they had not previously discovered because it was inadequately documented and not linked to the case. We have not reviewed that report or the tape recording of that Hotline call nor have we yet reviewed any records from the Essex County Court on their independent custody case involving this family. We intend to do so as soon as those records are available for review.

Our review to date found that in January and April, 2008, DYFS staff conducted appropriate and adequate investigations and at that time, reached defensible conclusions. In the last investigation and case closing in April 2008, the DYSF worker appropriately interviewed the children and the caregiver, contacted a neighbor (the only neighbor in the building where the family resided), requested and received reports on the children from their pediatricians and the day care providers where the children were enrolled. There was no interview of the person who made the report since the report was made anonymously. In April of 2008, none of the activities and behaviors that were associated with the children's abuse and Christiana's death were observable by the DYFS worker, nor reported to the DYFS worker by the neighbor, the day care providers or the pediatrician. We will need to look closely at the 2011 call to SCR to determine what breakdowns occurred, the responsibility for the lack of response to that call, and the lessons that can be learned for the future.

There are several other observations that I have already communicated to DCF leaders and wish to share based on our preliminary review. First, when DYFS first came in contact with Christiana's mother in 2006, she was a struggling parent who may have benefited from additional services and supports. Although the abuse and neglect allegations were properly not founded, DYFS did attempt to help her and provide voluntary services for almost a year. Looking back, one would have hoped for improved ability to engage a struggling mother in services at a point before abuse and neglect occurs. One would have also hoped that on case closing, the family could have been linked to a community-based provider, such as a Family Success Center, to support her with the challenges of raising three young children as a single parent. This engagement with DYFS or a community-based provider is, of course, voluntary and requires both an orientation to comprehensive assessment and family support and a skill set that the Department has been working to improve since 2006. This is one of the reasons that the

intensive work that is ongoing on case practice model implementation is so important to continue.

Second, this case demonstrates so clearly why DYFS, although legally responsible for the protection of children from abuse and neglect, cannot do this important job alone. Something happened in this family between 2008 and 2011 when Christiana died. It is imperative that DCF and DYFS reach out to community and neighborhood leaders to understand why neighbors, relatives and citizens are frequently reluctant to alert the child protection system when they have concerns. The obvious questions raised are what needs to change so that community views and experiences DCF and DYFS as helping partners in the goal of protecting children and how can DYFS improve the SCR and put in safeguards so that no case requiring investigation gets missed.

Third, the single largest reporter of suspected child abuse and neglect are schools and day care institutions which see children every day. In this case, the children were home schooled and thus far less visible to natural community protections. I believe the State should examine its laws and policies and practices on home schooling so that it is not possible for children to completely escape from public view.

Lastly, I am concerned that the negative press that has surrounded this case will be interpreted that the State's investments in improving its child welfare system are not worth it. In my view, nothing is further from the truth. DCF leadership has been vigilant in examining this tragedy in an effort to uncover when and if things went wrong and make corrections. The work of child protection is the most difficult and complex of human service work. The State has made demonstrable progress in many areas. This progress is not possible without the evident commitment, hard work and cooperation of DCF leaders, managers, frontline workers and supervisors and many partners in the courts, in private agencies and in the community. So while I will comment later on the things that remain to be accomplished, the problems that still exist and the challenges ahead, it is important that a tragedy involving a child, no matter how horrific, be used as a catalyst for further improvement and not overshadow the significant good work that occurs every day and the progress that New Jersey has legitimately made in the five years since I was asked to be the Monitor.

➤ ***First, the State has met or surpassed expectations in several key outcome areas:***

- Since the creation of the Child Health Units and assignment of nurses to children in out-of-home care, DCF has achieved substantial and sustained results related to health care outcomes including pre placement screening and child immunizations, medical and dental care and up-to date immunizations. As of December 2010, 86 percent of children age three or older who have been in out-of-home placement for at least six months received a semi-annual dental visit. Ninety-five percent of all children in out-of-home placement were current with their immunizations.

- Placement of children with families is now routine practice.

In December 2010, 86 percent of children were placed with families or in family-like settings as opposed to a group setting, meeting the final target for this outcome. DCF has met this standard for the past four monitoring periods, demonstrating sustained practice change and fidelity to an important principle of the Case Practice Model.

The practice of placing young children in shelters has been eliminated. No child under 13 was placed in a shelter for a full calendar year, meeting the final MSA target and demonstrating that DCF has ended the use of shelters for this population of young children.

- DCF recruited and licensed 836 new kin and non-kin Resource Family homes from July through December 2010, exceeding its yearly recruitment target by 185 homes. DCF currently has the capacity to serve more than twice the number of children than are currently in out of home placement. Forty-five percent of the 836 Resource Family homes licensed between July and December 2010 are kinship homes.

➤ ***Second, the State continues to strengthen its infrastructure and move forward to implement important practice reforms in the field.***

- DCF continued to meet or exceed all of the expectations in the MSA pertaining to training its workforce.
- Sixty percent (28 of 47) of DYFS local offices have now completed intensive “immersion” training on the Case Practice Model, with a target date of May 2012 to complete all local offices.

➤ ***Third, the State continues to improve permanency outcomes for children in care.***

- In the months between July and December 2010, between 79 to 92 percent of adoptions were finalized within nine months of the child’s placement in an adoptive home, meeting the MSA final target for adoption finalization.

These data demonstrate cooperation between DCF and New Jersey’s family courts to achieve timely permanency for children and families.

➤ ***Fourth, the number of children placed out-of-state for treatment has continued to dramatically decline.***

- As of December 1, 2010, 21 children were placed out-of-state in mental health treatment facilities, down from 44 as of December 2009. This is the lowest number since reporting began for the MSA. This positive trend is evidence of the

State implementing plans to provide more appropriate mental health treatment options for children within the state and nearer the children's homes.

Now I will discuss areas requiring further attention that are highlighted in the report and some of the challenges ahead. You will recognize many of the challenges identified in our last report remain as areas of further work, which is to be expected. As has been demonstrated in other child welfare systems across the country, lasting practice change is more analogous to righting a barge than a skiff: it takes time, commitment, leadership and teamwork. New Jersey's advantage is that its Governor and legislature support these important practice changes and have become DCF's partners in bringing about the improvements discussed in detail in this report. The State has launched significant efforts to create sustainable methods of diagnosing and implementing mid-course corrections, some of which have already resulted in improved performance, such as with Family Team Meetings, and we hope to see more progress in the areas identified below in the next monitoring period.

Overall, while the State continues to make progress, the areas highlighted below need additional focus and attention.

Case Planning

New Jersey's Case Practice Model requires that a case plan be developed within 30 days of a child entering placement and updated regularly thereafter. In December 2010, 56 percent of children entering care had case plans developed within 30 days as is required. This performance is only slightly better than reported in the previous six months and continues to be a concern. The Case Practice Model depends upon quality case planning practices, and this low level of documented performance must improve.

Further, workers are also required to routinely review and adjust case plans to meet the needs of families. From July through December 2010, between 64 and 68 percent of case plans due each month were modified within the required six month timeframe. The fact that this measure has not shown improvement—and has actually slightly declined—since the last Monitoring Report is a serious deficiency.

New Jersey has begun to address its low performance on case planning in its ChildStat conferences, and we will be monitoring the results from that process.

Family Team Meetings

Family Team Meetings (FTMs) are a critical aspect of New Jersey's Case Practice Model. Through FTMs, workers engage families and partners in a coordinated effort to make change intended to result in safety, permanency and well-being for the family.

By June 30, 2010, DCF was required to hold an FTM prior to or within 30 days of a child entering foster care and at least once per quarter thereafter for 90 percent of families. While improved from last monitoring period, DCF still falls significantly short of the expectations both pre-removal and as part of the case-planning process. One reason for

the improved performance may be DCF's use of the diagnostic process referred to as ChildStat. DCF began holding ChildStat meetings in September 2010 to help determine where the challenges lie to improve FTM performance. We will continue to follow DCF's progress in examining barriers to performance on this measure.

Visits

- *Caseworker visits with children*

Data from this monitoring period show that of the 432 children who were in an initial or subsequent placement for two full months, 216 (50%) had documented visits with their caseworkers twice per month. While DCF's performance improved by seven percent over last monitoring period, it remains very far below the performance benchmark for this measure. The Monitor continues to be very concerned by this low performance given the importance of visitation by caseworkers during the first few months of placement to assess children and families' needs and to ensure stability.

In December 2010, 88 percent of children in out-of-home placement were visited by their caseworker in their placement at least once per month as required. This performance falls short of the June 2010 final target by 10 percent.

- *Caseworker visits with parents*

Data on caseworker visits to parents or other legally responsible family members when the permanency goal is reunification also remains troubling. In December 2010, 39 percent of parents or other responsible family members were visited by caseworkers twice per month as required. Also, in December 2010, 13 percent of children had four documented visits with their parents as required and an additional 22 percent of children had two or three visits with their parents during the month. Given that parent-child visitation is essential to successful reunification and a core component of the Case Practice Model; we are troubled about this level of performance. We expect that the Department's decision to include visitation in their ChildStat analysis will help to identify and begin to resolve barriers to improved performance.

Finally, the report discusses a few other areas requiring attention including the State's work to fully implement an ambitious case based quality review process; making sure that DYFS maintains full compliance on all caseload standards, and improving service delivery to older youth, particularly 18-21 year olds who have not achieved permanency.

Regarding caseloads, DYFS continued to meet a majority of the MSA caseload standards with the exception of Intake where although the overall office standard for intake workers was met, 87 percent of individual intake workers had caseloads that were at or below the standard.

Regarding older youth, we want to call your attention to the supplemental case review report that is included as an Appendix. Both we and DCF have recognized that expansion and improvement of services to this population is a high priority. DCF has made improvements in services to older youth over the past year, particularly in the area

of required independent living assessments and in moving to expand service options for older youth. However, more work is needed to fully meet the service needs of this population. In an effort to assess DYFS's performance in meeting the needs of older youth, the Monitor conducted a case record review of all youth ages 18-21 who exited from DYFS custody between January 1 and June 30, 2010. The Adolescent Case Record Review found many youth face significant struggles and require more focused attention from DCF and its partners. The review found that almost three quarter of the youth were connected to a caring adult on exit and also that:

- A significant portion of exiting youth do not have stable housing;
- Youth need help to stay in school and complete educational programs;
- There is under utilization of available scholarship programs for foster youth and
- Youth are not well connected to the workforce.
 - Forty percent of youth were neither employed nor in school at the time of exit; and
 - Sixty-eight percent of youth were unemployed at the time of exit from DYFS placement, and of those employed, 78 percent had part time jobs.

In conclusion, New Jersey has and continues to work to achieve child welfare system improvements and better outcomes for children and families. Children in foster care are receiving regular health care, there is a surplus of Resource Family homes, caseloads are manageable, and worker training is routine, to name a few. Building on these accomplishments, improving case practice, and not permitting difficult challenges to interrupt the progress it has made toward desired outcomes will be critically important in the next few years. I have confidence in DCF's leader and the commitment of the Governor and legislature, to these reforms. I hope that Christiana Glenn's death will not tarnish all the good work that is done by dedicated workers every day. We need to shine a spotlight on problems, face them openly and solve them, but we also intend to recognize accomplishments and good work where it occurs.