Prepared by Institute for Families at
Rutgers School of Social Work

Supportive Visitation Services Program Manual

NEW JERSEY DEPARTMENT OF
CHILDREN AND FAMILIES

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Acknowledgments

The Supportive Visitation Services (SVS) program model was developed by the New Jersey Department of Children and Families (NJ DCF). NJ DCF would like to thank a number of collaborative partners who contributed to the development of the SVS program model and implementation supports and who tested the model by participating in its pilots. The SVS program model would not be where it is today without the dedication, expertise and significant time of staff from DCF; implementing SVS provider agencies—Family Connections and Care Plus New Jersey; consultants; and SVS families.

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Finally, NJ DCF acknowledges the families themselves who participated in the SVS program pilots. It is with a commitment to creating interactions for families that grow stronger relationships, more confident parenting skills, and greater opportunities for healthy family functioning that this manual was developed.

[1] National Implementation Research Network at the Frank Porter Graham Child Development Institute. Available online at: https:nirn.fpg.unc.edu/.

Purpose, Organization, and Expectations of this Program Manual

PURPOSE

The purpose of the Supportive Visitation Services (SVS) Program Manual is to serve as a comprehensive resource that incorporates the frameworks, procedures, operational processes, and resources necessary for maintaining program fidelity to the Supportive Visitation Services model and carrying out service activities with consistency and excellence.

The SVS Program Manual outlines how to implement services according to the best practices captured in the practice profile. It is designed to standardize the delivery of services across SVS provider agencies. Standardization of service delivery also requires prudent judgment in working with the unique needs and circumstances of children and families. SVS programs should remain reasonably flexible to the discovery of improvements in and adaptations in service delivery that are not yet documented in the SVS Program Manual. Any improvements or adaptations must be discussed with DCF program staff so that they are documented and as appropriate considered for integration into the SVS Practice Profile and Manual.

ORGANIZATION

This manual is organized into four (4) main sections and an appendix:

Section 1. Introduction to the Supportive Visitation Services Program. This section offers history and background on how the program was developed. It also provides an overview of the SVS Logic Model highlighting the expected outcomes, services, and resources needed to implement the model.

Section 2. SVS Practice Model. This section focuses on the SVS Practice Profile—outlining the guiding principles and essential functions of the SVS Program Model. It describes the behavioral indicators that need to be present in order for the program to be successfully implemented by SVS staff.

Section 3. SVS Program Services. This section explores the SVS Program Model core service activities. It highlights the required SVS Practice Profile Essential Functions and program forms/tools necessary to conduct each activity.

Section 4. SVS Administrative Operations. This section focuses on administrative functions that lead to successful operation of the Supportive Visitation Services Program. It highlights core staff, recruitment, and selection processes and training and coaching opportunities. It also includes policies, procedures, forms and other tools, including the SVS Observation Fidelity Tool, which are necessary to implement an SVS program.

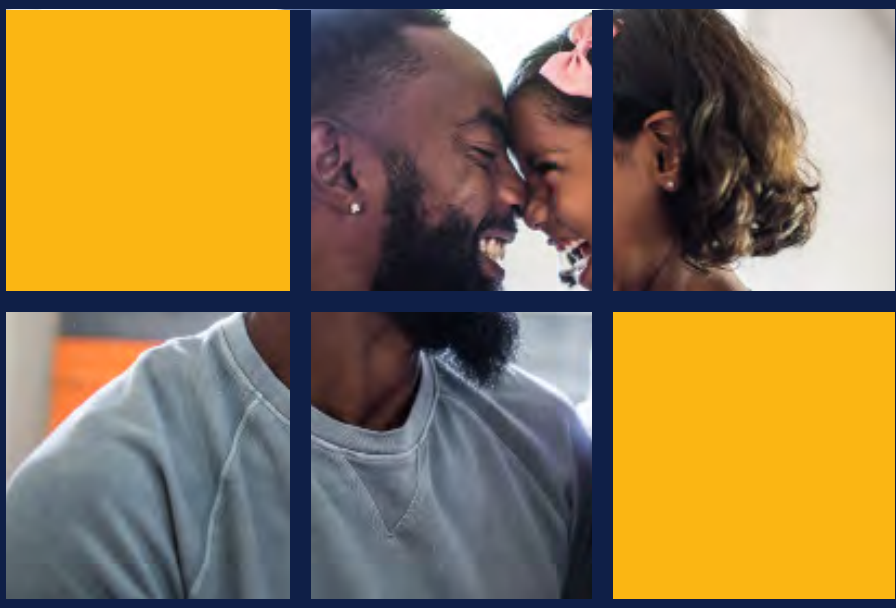
Appendix. The program manual also includes an appendix containing more detailed background information, standard program forms and/or relevant tools necessary to carry out the SVS Program Model.

EXPECTATIONS

Agencies who contract with NJ DCF to deliver the SVS Program Model for families in New Jersey are expected to use this SVS Program Manual as a guide for successful implementation and to achieve desired outcomes. It is critical that all providers adhere to the practice and service standards outlined in this manual to ensure SVS program fidelity, and ultimately, benefit from the successful outcomes enjoyed by children and families who participate in SVS programs and throughout the SVS provider network.

Section 1

Introduction to the Supportive Visitation Services Program



HISTORY AND BACKGROUND

The New Jersey Department of Children and Families (NJ DCF) is charged with serving and safeguarding the most vulnerable children and families in the state. The Department is committed to a vision where all New Jersey residents are safe, healthy, and connected. The values of Collaboration, Equity, Evidence, Family and Integrity, guide the work of the Department and serve as the professional compass for decisions large and small (State of New Jersey Department of Children and Families, 2013).

NJ DCF's Division of Child Protection and Permanency (DCP&P) works to ensure the safety, permanency, and well-being of children and to support families. DCP&P is responsible for investigating allegations of child abuse and neglect and, if necessary, arranging for the child's protection and the family's treatment. In September 2020, DCP&P received over 4,000 child protective services (CPS) reports (Beyer, 2020). The issues that challenge a family's ability to keep a child safe and free from harm are often very complex, requiring a variety of supports to meet the specific and highly individualized needs of families involved. In some of these instances, children are unable to safely remain in their homes, and they are placed into out-of-home settings, ideally with other members of the family who are close to the child. Nationally, there were approximately 437,000 children in foster care on the last day of 2016 (U.S. Department of Health and Human Services, 2019). In New Jersey, there were 3,833 children in out-of-home placement on or about September 30, 2020 (Beyer, 2020).

Children placed in an out-of-home placement benefit significantly from the opportunity to visit with parents, siblings, and/or interested relatives, and when it is in the best interest of the child, this visitation should be immediate and regular (Department of Children and Families, n.d.). Research indicates that parent-child visitation leads to:

- Increased likelihood of reunification. Children were almost ten times more likely to reunify with regular visits, as recommended by the court (Davis et al., 1996).
- Shorter lengths of stay in out-of-home placement. Children who do not visit with their family spend almost three times as much time in out-of-home placement (Mech, 1985).
- Decreased likelihood that the child will re-enter care (Farmer, 2006).
- Stronger parent-child attachments. Children with higher levels of attachment had few behavioral problems, were less likely to take psychiatric medication, and were less likely to be termed "developmentally delayed" (McWey & Mullis, 2004).

The visitation environment itself plays a crucial role in supporting positive family interactions (Haight, Black, Workman, et al., 2001). Research has shown that home-like and other supportive settings are preferable (Haight, Black, Mangelsdorf, et al., 2001), and NJ DCF policy reinforces these evidence-based practices by calling for quality, weekly visitation in the least restrictive, most comfortable setting possible (State of New Jersey Department of Children and Families, 2013). In order to achieve this goal, NJ DCF partners with a number of community providers to facilitate and support parent-child visits.

Historically, the Department contracted separately for visitation that was categorized as either "therapeutic" or "supervised." Therapeutic visitation refers to contact between non-custodial parents and their children in the presence or under the supervision of a fully accredited mental health professional who is actively involved in promoting some level of behavioral change in the parent-child relationship. Supervised visitation refers to contact between parents and their children who are in out-of-home placement that occurs in the presence of a specially trained professional who is actively involved in promoting change in parent-child relationships.

NJ DCF recognized that many children and families experiencing out-of-home placements benefit from the clinical support and interventions embedded in a therapeutic visitation model. However, NJ DCF also understood that a family's needs are likely to change over time, and that ideally, most families will require less frequent therapeutic support and more frequent supportive or unsupervised visits as they work toward reunification with their child. To preserve both commitments to children, NJ DCF sought to develop an innovative supportive visitation services model which blended both types of services. In 2015, this program model was piloted in three target counties: Morris, Sussex, and Passaic, and in 2017, NJ DCF expanded supportive visitation services to Essex County as well.

PROGRAM DEVELOPMENT APPROACH

With the goal of creating a well-defined, replicable supportive visitation services program model, NJ DCF and its contracted service providers tapped into the principles of implementation science. The field of implementation science provides frameworks that assess and support the design and implementation of interventions toward the achievement of targeted outcomes (Fixsen et al., 2015; Powell et al., 2015). For innovative programs that are informed by literature, but have yet to be rigorously evaluated, the practice must be defined, implementation supports (training, coaching, fidelity tool, etc.) must be developed to support the practice, and data collection and evaluation must be established to inform ongoing practice improvements. These fundamental steps are necessary before the targeted outcomes can be achieved. NJ DCF systematically utilized the National Implementation Research Network's Active Implementation Framework and accompanying tools to organize and carry out program development for SVS (Metz, 2016). For more information about how the Active Implementation Framework was used for SVS program development, please see Appendix A.

THE SVS PROGRAM MODEL

SVS is an innovative parent-child visitation model designed for DCP&P-involved families with children in out-of-home placement to maintain and strengthen familial interactions and facilitate permanency. Families with all DCP&P case goals can participate in the program.

Longer-term goals of the SVS program include:

- Family well-being
- Shorter lengths of stay in out-of-home placement
- Increased reunification
- Decreased maltreatment post-reunification
- Decreased re-entry into out-of-home placement

Shorter-term goals of the SVS program include:

- Increased parenting knowledge and practices
- Increased nurturing and attachments
- Increased family functioning/resilience
- Increased social supports

SVS offers supportive visitation services along a continuum to meet the unique needs of each family. The continuum includes a full range of visitation services from least restrictive supportive to more intensive therapeutic interventions. Families can receive one or more visitation type. The family's visitation supervision level is determined through assessment and collaborative visitation planning processes. Visits occur in the least restrictive setting that maintains participant safety. Visit locations may include the family's home, a relative or family friend's home, the resource parent's home, an in-community, family-friendly location or at the SVS provider's site. Families are reassessed at regular intervals to determine if families' goals have been met and if a different level of supervision is recommended. Aftercare services are available to families for up to six-months post-reunification to support the transition home and reduce the risk of re-entry. The family's DCP&P case must remain open for aftercare services to be provided. The SVS Program Model also includes transportation, documentation in NJSPIRIT (NJ DCF's Comprehensive Child Welfare Information System or CCWIS) and DCP&P and stakeholder collaboration.

Information about the SVS Logic Model can be found on page five and in Appendix B. The logic model highlights the vision, target population, resources needed, activities, and short- and long-term program outcomes for the SVS program.

In addition to the SVS Logic Model, NJ DCF and a subset of SVS providers developed the SVS Practice Profile. As a tool for operationalizing a program model, practice profiles outline guiding principles and essential functions so that the program becomes "teachable, learnable, and doable" for staff (Metz, 2016). More information on the SVS Practice Model can be found in Section 2 of this manual. The SVS Practice Profile can also be found in Appendix C.

NJ DCF SUPPORTIVE VISITATION SERVICES LOGIC MODEL

VISION: Each child placed by the Division of Child Protection and Permanency (DCP&P) in out-of-home placement shall have the opportunity to visit with parents, siblings, and interested relatives to maintain and strengthen familial interactions and work toward permanency.

NAME OF INITIATIVE: Supportive Visitation Services (SVS)

TARGET POPULATION: DCP&P-involved families with children in out-of-home placement who require visitation supervision due to visitation safety and/or risk factors.

RESOURCES:

STAFFING:
Program Leader, Therapeutic Visitation Specialist, Supportive Visitation Specialist, and Driver

VISIT LOCATION:
Home-like/family-friendly environments: Parent home, Family or friends' home, Resource home, In-Community settings, or Agency

COLLABORATIONS:
Family, DCP&P, and Other partners

DATABASES:
NJSPIRIT and Agency data system

ASSESSMENT AND EVALUATION:
Assessment and Evaluation Tools including Caregiver Survey and Continuous Quality Improvement Practices

ACTIVITIES:

ASSESSMENT AND PLANNING:

Referral—Receive referrals from DCP&P. Contact DCP&P caseworker within 24 hours of receiving referral to review and obtain additional information. Contact family within 48 hours of receiving referral to schedule an initial intake assessment.

Initial Intake Assessment—Complete a biopsychosocial assessment with parent and child, as appropriate, and SVS Caregiver Survey by a master's level visitation specialist. In-person, intake assessment to be scheduled within one week of receiving referral or at the family's first availability.

Pre-Visitation Plan Visits—Conduct visits as soon as possible and prior to the development of the family's SVS Visitation Plan which occurs during a Visitation Planning Meeting. These initial visits should occur in the least restrictive setting that ensures the safety of all participants. These visits can be determined based on existing visitation plans, if applicable, or court orders in consultation with DCP&P. These visits are part of the assessment process and observations from these visits are used to inform the family's visitation plan.

Visitation Planning Meeting—Facilitate meetings within one (1) month after initial intake assessment and every three (3) months thereafter. Meetings to include discussion of the family's visitation strengths and challenges, DCP&P case plan or service updates, and family and natural supports. The SVS Visitation Plan is to be developed utilizing assessment, observation, and collaboration with input from the family, DCP&P, and other partners as indicated. Plans to include Impact of Separation; Visitation Goals; Visitation Supervision Level; Visitation Location; Visitation Frequency and Duration; Visitation Participants; and Visitation Activities and What to Bring. Reassess the family at regular scheduled intervals (at least every three months) through a visitation planning meeting with family, DCP&P, and other partners as indicated. Determine if current visitation goals have been met and/or whether families would benefit from a different level of intervention/supervision. Update visitation plan as needed and administer SVS Caregiver Survey.

SUPPORTIVE VISITATION SERVICES:

Provide a continuum of visitation services to meet the unique needs of each family. Each visit to include a pre-visit meeting to discuss visitation goals and focus of visit and a post-visit debrief to process visit and plan for the next visit. Continuum of supportive visitation services may include Therapeutic Supervised Visits; Supportive Supervised Visits; Relative/Community Partner Supervised Visits; and Unsupervised Monitoring.

POST-REUNIFICATION SERVICES (AFTERCARE):

Provide supports to the family for up to six (6) months post-reunification. Interventions are based on family's need.

SYSTEMS COLLABORATION AND COORDINATION:

DCP&P—Engage in regular phone and in-person contact, participate in FTMs, provide written collaterals which includes progress notes and/or court reports, and document visits into NJS within five business days of each visit.

Transportation—Coordinates and/or transports children to and from visits. Transportation may also be provided to parents, if needed. Transportation may also be provided by resource parents, DCP&P staff, etc.

COACHING AND SUPERVISION:

Support the quality execution of the supportive visitation services model through staff coaching and supervision. Individual and/or group clinical supervision to be provided by licensed staff clinician through weekly meetings.

DATA COLLECTION AND REPORTING:

SVS Caregiver Survey—Administer electronic SVS Caregiver Survey at Initial Intake Assessment (baseline/within 30 days of enrollment), at every Visitation Planning Meeting (every three-month interval that the caregiver is enrolled in SVS) and within two weeks of discharge.

Monthly Service and Aggregate Reports—Submit monthly services and aggregate reports by the 1st Friday of each month. Monthly Service Report includes service, intake, and discharge data.

SHORT-TERM OUTCOMES:

- Increased parenting knowledge and practices
- Increased nurturing and attachment
- Increased family functioning/resilience
- Increased social supports

LONG-TERM OUTCOMES:

- Family Well-being
- Shorter lengths of stay in out-of-home placement
- Increased reunification
- Decreased maltreatment post-reunification
- Decreased re-entry into out-of-home placement

ASSUMPTION: RESEARCH INDICATES PARENT-CHILD VISITATION LEADS TO:

- Increased likelihood of reunification. Children were almost ten times more likely to reunify with regular visits, as recommended by the court (Davis et al., 1996).
- Shorter lengths of stay in out-of-home placement. Children who do not visit with their family spend almost three times as much time in out-of-home placement (Mech, 1985).
- Decreased likelihood that the child will re-enter care (Farmer, 2006).
- More secure attachments and better adjustment, exhibiting fewer behavioral problems (McWey & Mullis, 2004).

IMPLEMENTING AGENCIES

A list of SVS implementing agencies with program staff contact information is available online at DCF: Family and Community Partnerships (nj.gov/dcf/about/divisions/dfcp/).

Section 2
SVS Practice Model

SVS PRACTICE PROFILE

The SVS model comes to life in the SVS Practice Profile Appendix C). A practice profile is a tool for operationalizing an intervention so that staff, supervisors, and directors across implementing agencies have a clear understanding of the practice. Utilizing a practice profile helps create consistency in implementation across practitioners and agencies. A practice profile includes guiding principles and essential functions.

SVS GUIDING PRINCIPLES

Guiding principles are the philosophy, values, and principles that underlie the innovation. These guide the practitioner's decisions and ensure consistency, integrity, and sustainable effort across all practitioners (Fixsen et al., 2013; Metz et al., 2011).

There are seven (7) SVS Guiding Principles:

1. **Collaborative**—services are provided in partnership with families and communities.
2. **Supportive**—services are strength-based, trauma-informed, family-centered, and collaborative.
3. **Flexible**—services are based on evolving family needs and are enhanced or refined as needed.
4. **Family-driven**—services are based on family goals and schedules, underlying needs and child development considerations.
5. **Community-based, least restrictive**—services are provided in the least restrictive, safe setting, preferably the family's home or in the community.
6. **Promotes well-being**—services mitigate safety concerns, enhance family relationships, communication, and bonding by utilizing trauma-informed practices for parents, caregivers and children.
7. **Trauma-informed**—services address underlying trauma utilizing trauma-informed care.

SVS ESSENTIAL FUNCTIONS

Essential functions define the role of practitioners and inform activities within each phase of work. Essential functions provide a clear description of the features that must be present to say that the innovation is being used and to achieve outcomes ("essential functions" are sometimes called core components, active ingredients, or practice elements). Each Essential Function includes operational definitions describing the core activities associated with each essential function and allow the innovation to be "teachable, learnable, doable, and assessable" across a range of contexts (Fixsen et al., 2013; Metz et al., 2011; Metz, 2016).

There are six (6) SVS Essential Functions:

1. **Engaging**
2. **Assessing**
3. **Active Listening**
4. **Teaming**
5. **Therapeutic Intervening**
6. **Coaching**

ENGAGING

Establishing and maintaining relationships with family by building rapport through open communication, staff consistency, and involving the family, DCP&P, resource parents, service providers, and additional family members in all aspects of the visitation process.

The following behavioral indicators are expected best practices for engaging in SVS and should be demonstrated by staff in practice:

Initiates and maintains ongoing phone and in-person contact with family.

- Introduces self and program, discusses referral source, and answers any emergent questions, preferably in a phone call.
- Schedules appointments at time and place that is convenient for the family and confirms visits.
- Communicates in an open, honest, respectful, and culturally sensitive manner which may include:
  - Using a language that parents understand; communicating with the family using positive, everyday language;
  - Recognizing the parent as a partner in the process; and
  - Being respectful of the family's faith, culture, and existing family rituals.
- Discusses roles and responsibilities which may include:
  - Clearly explaining expectations, policies, and procedures of the program;
  - Clarifying time frames for working with the family
  - Informing the family of their rights and responsibilities.
- Always engages in a transition process when staff changes. Process should include internal case conferencing and discussion of transfer details with family, DCP&P, and relevant stakeholders.

Schedules and conducts visits in the least-restrictive setting while ensuring the safety of the child(ren).

- Understands visitation is a parental right and does not use visitation as a reward or punishment to the family if they miss or cancel a visit or visits.
- Ensures that visits are only used for family time/supporting the parent-child relationship.
- Ensures visits occur in a home-like, welcoming location. Visits at the family's home are preferred, if safe/suitable. The visit setting should be one in which families typically interact.
  - The order of priority for visits is to occur as follows: Family Home, Relative Home, Resource Home, Community Location, Provider/Partner Agency, or DCP&P
- Discusses with the family all options for visit locations during intake and collaborates with DCP&P and family to finalize visit location based on assessment and/or visitation-level criteria.
- Ensures that visitation location/setting is always tied to visit plan goals (parenting skills related to removal reason and child's safety).

ENGAGING (CONTINUED)

Ensures the environment for parent-child contact is safe, non-traumatizing, and promotes healthy attachment.

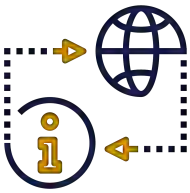
- Observes visitation location for safety and risk factors.
- Intervenes to establish or ensure safety as needed.

Always involves family in the process.

- Uses strengths-based, solutions-focused, family-centered, trauma-informed strategies to elicit family input.
- Incorporates family's ideas into planning processes and visitation services. Examples include: visit locations, frequency and duration of visits, participants, and activities.
- Creates opportunities for families to discuss feelings and reactions about removal, changes in visitation level, and DCP&P case goal.

Initiates and maintains ongoing phone and in-person contact with DCP&P and other stakeholders, as appropriate.

- Introduces self and program to DCP&P staff and stakeholders including resource parents, service providers, court/legal personnel and any additional family members, etc., and answers any emergent questions, preferably in a phone call.
- Actively seeks opportunities to engage in regular communication with DCP&P and other stakeholders by phone, in person, and/or written collateral contacts.
- Invites DCP&P staff and stakeholders, with family's consent, to participate in SVS provider-facilitated Visitation Planning Meetings at least quarterly and discusses their role and input in supporting the family.
- Educates stakeholders about the importance of visitation and family time.



ASSESSING

Using a process to collect information and use it to address the family's identified needs.

The following behavioral indicators are expected best practices for assessing in SVS and should be demonstrated by staff in practice:

Uses a process to gather information.

- Asks questions by phone and/or during in-person meetings with family, DCP&P workers, and other collateral providers. Inquiries about family history, goals, and ongoing and evolving needs to collect and confirm information.
- Reviews DCP&P referral form and contacts DCP&P worker for family and case-specific information.
- Gathers information from relevant sources. This may include information from: case records, the child's school reports, substance use evaluations, medical reports, mental health assessments, and any other relevant information to inform the assessment of the family.
- Inquires about the family's natural supports. Examples include maternal and paternal relatives, close friends, and community resources and supports.
- Observes family's interactions in initial pre-visitation plan visits and ongoing visits.

Fills out required assessment tools.

- Accurately completes and administers the following within the designated time frames:
  - Biopsychosocial assessment with parent and child.
  - Rose Wentz Matrix[2]; and
  - SVS Caregiver Survey at Initial Intake Assessment (baseline), at each Visitation Planning Meeting (every three-month interval), and at discharge

Synthesizes information and completes visitation plan.

- Discusses observations and assessments with parents and elicits feedback regarding parenting styles and behaviors.
- Incorporates gathered information from reviews, inquiry, observations, parent feedback and assessments in a visitation plan which includes recommendation of visitation level(s) and requirements for moving along the continuum from family's current level to less restrictive levels.

Updates the visitation plan at regular intervals.

- Reviews the visitation plan at least every three (3) months or as necessary to determine progress, update goals, and determine if it is appropriate to consider changes in supervision level, location, and setting.

[2]Available information on the Rose Wentz Matrix can be found online at http://www.wentztraining.com/products/tools.

ACTIVE LISTENING

Using communication techniques that encourage free dialogue and mutual understanding.

The following behavioral indicators are expected best practices for active listening in SVS and should be demonstrated by staff in practice:

Creates an environment that empowers family members, including parents, child, etc., to communicate their goals and needs.

- Encourages open dialogue by inquiring about the family's goals and needs during weekly debriefing and visits, and being receptive to feedback.
- Validates family's thoughts and feelings.
- Incorporates family's voice into the process.
- Uses a process to debrief with families (see Coaching essential function).
- Preps parent(s) for visitation planning meeting and supports parent(s) in advocating for themselves during the meeting.

Utilizes various interviewing and/or communication techniques.

- Addresses the family in ways that are consistent with their cultural expectations.
- Presents open-ended questions to encourage dialogue with a focus on potential solutions.
- Summarizes and reframes what is said to validate common understanding and encourage mutual dialogue.
- Recognizes non-verbal communication.
- Maintains good eye contact and posture.
- Takes notes, if needed, trying not to interrupt the flow of conversation.

TEAMING

Respectful and meaningful collaboration with families (and community partners) to achieve shared goals.

The following behavioral indicators are expected best practices for teaming in SVS and should be demonstrated by staff in practice:

Advocates for parents/families as necessary and supports them in advocating for themselves.

- Develops a plan with the family to identify steps they can take to meet their needs and/or steps staff can take to support the family. Follows up and revises plan as necessary.
- Links the family to community resources, formal and informal supports, and coordinates with DCP&P.
- Provides coaching to families to advocate for themselves through modeling self-advocacy, problem-solving, persistence, and supports them in navigating systems effectively.
- Encourages and supports family to maintain supplemental contact with children outside of visits, as appropriate. Examples may include: phone calls, emails, letters, social media, and attendance at events such as school conferences and medical appointments.

Collaborates with DCP&P and community partners.

- Shares relevant information from visits with DCP&P staff or other stakeholders as necessary.
- Involves community partners in planning meetings and considers their service recommendations, as appropriate, when completing the family's visitation plan.
- Defines clear roles for each member of the team including DCP&P and other collaborative staff so that all team members are working toward a common goal for the family.

Facilitates and/or attends meetings.

- Conducts visitation planning meetings which include:
  - discussing family's progress;
  - updating goals; and
  - determining if changes in supervision level, location, and setting are appropriate.
- Attends and actively participates in DCP&P case conferences, Family Team Meetings (FTMs), and/or other child and family meetings, as available.

THERAPEUTIC INTERVENING

Purposeful use of evidence-based/informed techniques intended to help families identify and process emotions and apply positive coping skills.

The following behavioral indicators are expected best practices for therapeutic intervening in SVS and should be demonstrated by staff in practice:

Promotes behavioral change through clinical interventions.

- Promotes parent-child attachment, emotional regulation, and demonstration of parental competencies and uses trauma-informed therapeutic approaches to assist and support family members.
- Uses clinical expertise to observe, document, and evaluate parent-child interactions.
- Addresses concerns and supports family goals with a focus on decreasing family conflict, improving communication, developing the parent's ability to identify and appropriately redirect the child's inappropriate behaviors, and decreasing the risk of abuse or neglect within the family.
- Directly intervenes with children and models parenting techniques and skills to promote healthy attachment and increased child wellbeing.
- Models for parents how to support children during transitions and assesses and normalizes child's responses to transitioning into and out of the visit.
- Provides feedback and positive reinforcement on parenting skills and interactions.
- Educates parents on child development.
- Observes how the parent responds to and uses information provided and aligns frequency of intervening to parental needs and skills.
- Empowers and allows parents to be the lead in caring for their children with support from the Visitation Specialist, as needed.

COACHING

Targeted instruction to parents about improving parenting skills, family dynamics, and other identified goals that support reunification.

The following behavioral indicators are expected best practices for coaching in SVS and should be demonstrated by staff in practice:

Enhances parental skills by goal setting, modeling, mentoring, reinforcement, and feedback and reflection.

- Empowers the parent(s) to be the lead in caring for their child(ren) during visits and utilize learned skills during their interactions.
- Helps families learn how their child's behavior is shaped by the adult's words, actions, and attitudes.
- Encourages and supports parents to incorporate and demonstrate skills they have learned or developed to meet the unique needs of their child(ren).
- Observes and intervenes or redirects parent with verbal reminders to cue learned parenting skills, when direct intervention by visitation specialist is not needed.
- Validates parents' and/or children's progress.
- Operates from a trauma-informed perspective.

Prepares for each visit with parent(s).

- Reviews goals and expectations of visits.
- Encourages the parent to plan activities for visit.
- Works with the family to address any fears, barriers, and parenting challenges.
- Explores potential problems and coaches parent(s) on strategies to use during visits.

Debriefs with parent(s) after each visit.

- Asks parents how they feel the visit went and allows parents to express their feelings and concerns.
- Comments favorably on some aspect of child's and parent's interaction in the visit.
- Makes suggestions for improvement as necessary.

Section 3
SVS Program Services

This section provides a detailed description of the SVS program services. It outlines the service activities delivered in the SVS program model and highlights the SVS Essential Functions necessary to facilitate successful delivery of each activity. It is critical that all providers are adhering to the service standards outlined in this section to ensure SVS program fidelity within their program and throughout the SVS provider network.

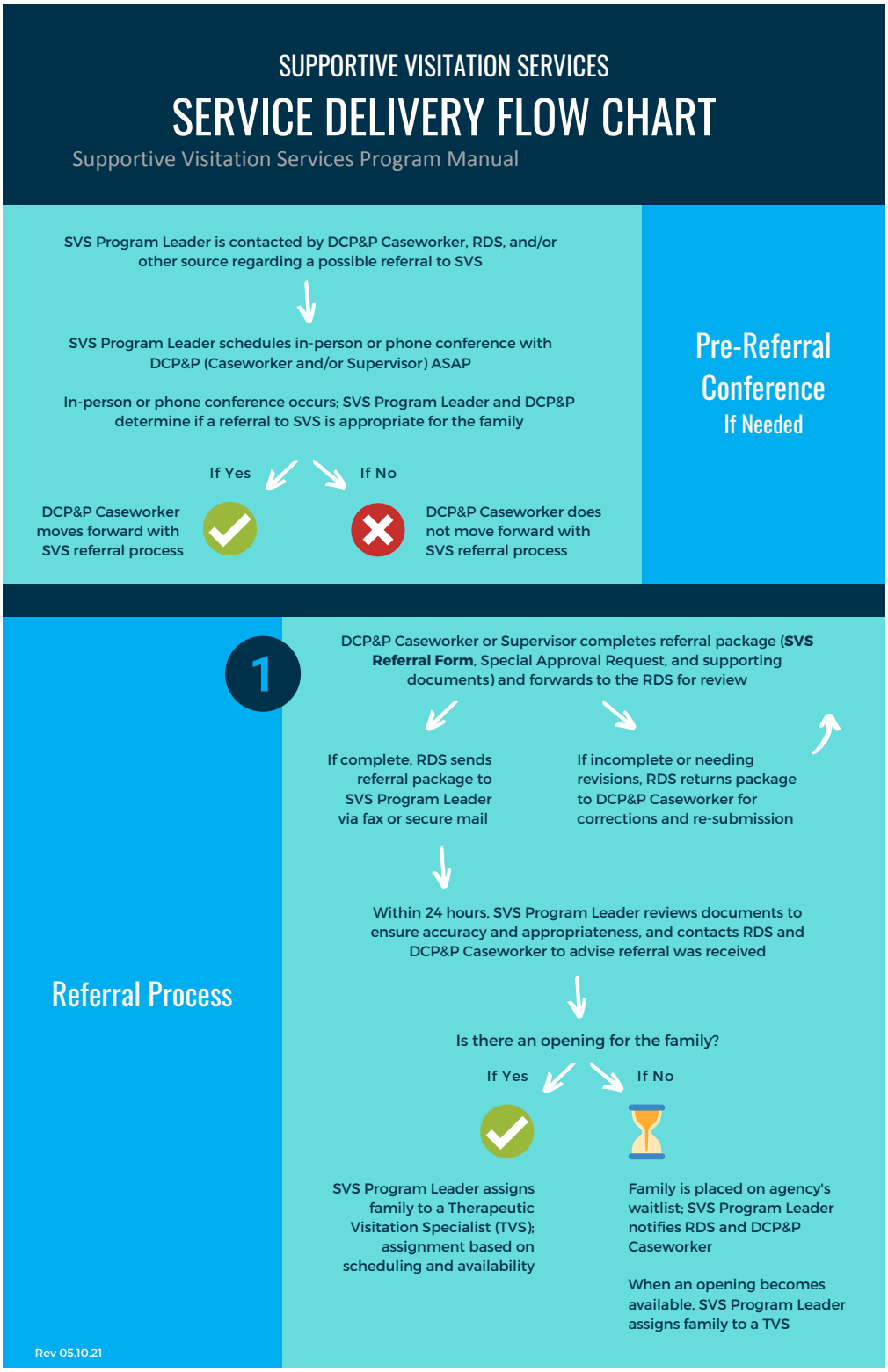
This section begins with a visual depiction of the SVS service delivery flowchart. For each step of the service delivery process, it highlights the actions staff need to take, the time lines for completion of tasks, and the forms that need to be completed during each step of the service delivery process.

This section also describes the SVS referral process, SVS program eligibility and the SVS intake process. It focuses on pre-visitation plan visits and defines the three (3) parts of successful visits. The pre-visit preparation and post-visit debriefs are vital for supporting caregivers in planning and adapting their parenting behaviors to be responsive to children's developmental and attachment needs. The section continues the focus of visit quality and describes the ongoing planning and assessing of visitation based on best practices.

It attends to the continuum of services of SVS programming from therapeutic to unsupervised visits. This section also describes post-reunification aftercare services. SVS programs and staff must work collaboratively with DCP&P, family, and community providers alike. The section highlights these key alliances and identifies some of the other services to which SVS programs refer to ensure that families' unique needs and challenges are addressed. Finally, this section describes the three primary program discharge outcomes.

Forms that are referenced but not shown in Section 3 can be found in the Appendix of the SVS Program Manual.

SVS SERVICE DELIVERY FLOWCHART (ALSO AVAILABLE IN APPENDIX D)



2

Initial Intake Assessment

Assigned TVS contacts DCP&P Caseworker via phone to clarify and/or gather additional information about the family, including caregiver(s) and child(ren)

2 Business Days

TVS contacts caregiver(s) via phone to schedule an initial intake assessment; assessment includes caregiver(s) and child(ren), if developmentally appropriate

Initial intake assessment occurs in-person

SVS Initial Intake Assessment is completed, location and frequency of initial (pre-visitation plan) visits are determined, and caregiver(s) availability for visits is obtained

7 Calendar Days or Earlier

Based on the initial intake assessment, family either continues with TVS or is assigned to a Supportive Visitation Specialist (SVS) to begin pre-visitation plan visits

Immediately following the initial intake assessment, the assigned visitation specialist schedules the family's initial visitation planning meeting (VPM) with the caregiver(s) and DCP&P caseworker; meeting details are shared with other meeting participants--which may include resource parents, caregivers, relatives, and other informal and formal supports, as needed

3

Initial Visits (Pre-Visitation Plan Visits)

Visitation specialist confirms child's schedule with resource parents

Based on caregiver(s) and child(ren)'s availability, visitation specialist schedules date and time for initial visits and communicates the schedule via phone or writing to caregiver(s), resource parent, DCP&P Caseworker, school, and/or other applicable parties

Visitation Specialist:

1. Conducts pre-visit prep meeting with caregiver(s) and child(ren), if needed
2. Confirms visits with caregiver(s) and resource parents by phone 24 hours in advance of each visit
3. Transports child(ren) and/or caregiver(s) to visit, if needed
4. Facilitates visit
5. Conducts post-visit debrief with caregiver(s) and, if needed, with child(ren)
6. Transports child(ren) and/or caregiver(s) from visit, if needed
7. Documents the family's visit in NJ SPIRIT within 5 business days of the visit and in applicable agency system(s)

Note: After the initial visit, visitation specialist contacts DCP&P Caseworker by phone to discuss how the visit went

Initial pre-visitation plan visits occur weekly, at minimum, until the VPM is held and the family's visitation plan is developed; a VPM should occur within 30 days of the family's initial intake assessment

4 Visitation Planning Meeting (VPM)

Caregiver(s) and visitation specialist determine who should participate in the VPM, and the visitation specialist extends invitations

Prior to the VPM, visitation specialist completes the **Rose Wentz Matrix*** and drafts the **SVS Family Visitation Plan**; documents are reviewed with the SVS Program Leader

VPM occurs with caregiver(s), visitation specialist, SVS Program Leader, DCP&P Caseworker, and invited participants

Visitation specialist facilitates the VPM and completes VPM forms, including the **SVS Family Visitation Plan**; the family's visitation plan outlines visitation supervision level, location, frequency, and duration

VPMs occur every 3 months, at minimum, or when a change in visitation plan is recommended

*Wentz, R. (2008). Visitation Planning Decision Matrix. Retrieved from http://wentztraining.com/docs/VisitPlanning.pdf

5 Ongoing Visits (Post-Visitation Plan Visits)

Visits begin based on the family's visitation plan.

Visitation supervision levels include:

- Therapeutic Supervised
- Supportive Supervised
- Relative and/or Community Partner Supervised
- Unsupervised Monitoring

Visitation Specialist:

1. Conducts pre-visit prep meeting with caregiver(s) and child(ren), if needed
2. Confirms visits with caregiver(s) and resource parents by phone 24 hours in advance of each visit
3. Transports child(ren) and/or caregiver(s) to visit, if needed
4. Facilitates visit
5. Conducts post-visit debrief with caregiver(s) and, if needed, with child(ren)
6. Transports child(ren) and/or caregiver(s) from visit, if needed
7. Documents the family's visit in NJ SPIRIT within 5 business days of the visit and in applicable agency system(s)

If changes are recommended to the family's visitation supervision level, a VPM should occur

Outcomes

Reunification Occurs: Family Participates in Aftercare	Reunification Occurs: Family Declines Aftercare	Other Permanent Outcome is Achieved (Adoption/KLG/etc.)	All Other Outcomes
• Aftercare services provided based on family's need • Services continue up to 6 months • Services closed if need no longer exists • Closing letter is sent to caregiver(s) and DCP&P Caseworker is notified	• Services end and family is discharged from program • Closing letter is sent to caregiver(s) and DCP&P Caseworker is notified	• Services end and family is discharged from program • Closing letter is sent to caregiver(s) and DCP&P Caseworker is notified	• Services end and family is discharged from program • Closing letter is sent to caregiver(s) and DCP&P Caseworker is notified

ESSENTIAL FUNCTIONS AND EXPECTED BEHAVIORAL INDICATORS FOR SERVICE ACTIVITIES

Each service activity described in this section includes a cover page outlining 1) the **SVS Service Activity** to be described, 2) **SVS Forms** required to be completed or administered for this activity, and 3) the **SVS Essential Functions** necessary to deliver this service activity.

FOR EXAMPLE:

1) **SVS Service Activity to be described**

SERVICE ACTIVITY

Service Activity Forms

- Engaging
- Assessing
- Active Listening
- Teaming
- Therapeutic Intervening
- Coaching

3) **SVS Essential Functions necessary to deliver this service activity**

2) **SVS Forms with links required to be completed or administered for this activity**

Following this cover page for each SVS Service Activity, there is a page detailing the SVS Essential Functions, and more specifically, the expected behavioral indicators necessary to perform the identified SVS Service Activity. These behavioral indicators describe what you need to do in practice for this activity.

REFERRAL PROCESS

SVS Referral Form

Engaging

Assessing

Active Listening

Teaming

Therapeutic Intervening

Coaching

ESSENTIAL FUNCTIONS AND EXPECTED BEHAVIORAL INDICATORS FOR REFERRAL PROCESS

Engaging

- Initiates and maintains ongoing phone and in-person contact with family
- Always involves family in the process
- Initiates and maintains ongoing phone and in-person contact with DCP&P and other stakeholders, as appropriate

Teaming

- Advocates for parents/families as necessary and supports them in advocating for themselves
- Collaborates with DCP&P and community partners
- Facilitates and/or attends meetings

Assessing

- Uses a process to gather information

Therapeutic Intervening

- Promotes behavioral change through clinical interventions

Active Listening

- Creates an environment that empowers family members, including parents, child, etc., to communicate their goals and needs
- Utilizes various interviewing and/or communication techniques

Coaching

- Enhances parental skills by goal setting, modeling, mentoring, reinforcement and feedback and reflection

REFERRAL PROCESS

The referral process includes program eligibility, pre-referral conferences, if needed, and referral.

SVS PROGRAM ELIGIBILITY

In order to be eligible for SVS services, a family must be actively involved with DCP&P and one or more children are in an out-of-home placement. SVS serves families with all case goals including reunification, adoption, and KLG. Supportive visitation services are designed for families who need supervision/support to facilitate parent-child relationships.

DCP&P Supervisors, in consultation with DCP&P caseworkers, are required to complete the DCF Parent-Child Visitation Planning Tool (Appendix E) for every DCP&P-involved family whose children enter out-of-home placement. The planning tool, completed for each parent-child relationship, recommends a visit supervision level, visit location and frequency, and duration of visits. If "Therapeutic Supervised Visitation by Contracted Visitation Provider or DCP&P" or "Supervised Visitation by Contracted Visitation Provider or DCP&P" is recommended and SVS is available in the county in which the family resides, SVS might be appropriate, and a referral can be made. All referrals for SVS services must come from DCP&P local office staff. Ideally the referral for SVS is made immediately after the removal of a child or children if possible, however it is not a requirement. A referral to SVS can be made at any point during the case, as long as the children are in custody of DCP&P.

SVS programming may not be appropriate if there is a current, restrictive contact order in place between visiting participants; the parent or child refuses to participate in visits, despite efforts to engage, regularly misses or does not show up for visits, or is unable to participate in visits; and/or if the parent or child had severe mental health, substance use, or other challenges that need to first be stabilized before safely participating in visitation services.

PRE-REFERRAL CONFERENCE

In some instances, it may be unclear if SVS is appropriate for a family and a pre-referral conference between the SVS program leaders and DCP&P staff may be necessary. It is not required. To set up a pre-referral conference with SVS, the DCP&P staff (Caseworker, Supervisor, RDS, etc.) contacts the SVS Program Lead to discuss details of the case and to decide if a referral to SVS is appropriate and what level of visitation might be needed.

REFERRAL

Once it is determined that the family is appropriate for SVS services, the DCP&P caseworker completes the SVS Referral Form (Appendix F) and DCP&P Special Authorization Request (SAR) in NJSPIRIT and submits them to the DCP&P Supervisor for approval. Following this, the referral packet which includes the 1) completed SVS Referral Form 2) Signed SAR, and 3) DCP&P Case Plan/Family Summary and supporting documents (verified complaint for custody, most recent court orders, prior mental health evaluations), if applicable, is given to the DCP&P Resource Development Specialist for final approval. The Resource Development Specialist forwards it directly to the SVS Program Leader electronically or by fax. Referrals can be sent to SVS at any day or time.

Once a referral is received by SVS, the SVS Program Leader reviews the referral and ensures the referral is complete (i.e., referral signed by DCP&P caseworker, Supervisor & Resource Development Specialist and completed without any areas left blank, the necessary documents are attached, the approved SAR has the correct rate/number of units, etc.) If the referral is incomplete, the SVS Program Leader will communicate with DCP&P staff about the missing or incorrect information and explain that the case cannot be assigned until everything is received.

When the completed referral is received, the SVS Program Leader emails the Resource Development Specialist and the DCP&P caseworker within 24 hours confirming the receipt of the referral and the status (i.e., case assigned or placed on wait list). If the program has an opening, the SVS Program Leader assigns the case to a Therapeutic Visitation Specialist who will schedule the initial intake assessment with the family. If there is not an opening at the time the referral is received, the case will be placed on the waitlist, and the DCP&P caseworker and family will be contacted by phone as soon as an opening becomes available. The SVS Program Leader is responsible for monitoring the waitlist and ensuring that each SVS Visitation Specialist has a full case load. Once SVS has an opening, the SVS Program Leader assigns the next case available from the waitlist.

In the event that there are no openings at the SVS program, the Resource Development Specialist will be notified by phone and/or email so that the DCP&P staff can determine whether the family should remain on a waitlist for this agency or the referral can be sent to another agency within the county, if available. In either case, the DCP&P caseworker is responsible for ensuring the family has visits until services can begin through an SVS Program.

INITIAL INTAKE ASSESSMENT

Engaging

Assessing

Active Listening

Teaming

ESSENTIAL FUNCTIONS AND EXPECTED BEHAVIORAL INDICATORS FOR INITIAL INTAKE ASSESSMENT

Engaging

- Initiates and maintains ongoing phone and in-person contact with family
- Ensures the environment for parent-child contact is safe, non-traumatizing, and promotes healthy attachment
- Always involves family in the process
- Initiates and maintains ongoing phone and in-person contact with DCP&P and other stakeholders, as appropriate

Active Listening

- Creates an environment that empowers family members, including parents, child, etc., to communicate their goals and needs
- Utilizes various interviewing and/or communication techniques

Assessing

- Uses a process to gather information
- Fills out required assessment tools
- Synthesizes information and completes visitation plan

Teaming

- Advocates for parents/families as necessary and supports them in advocating for themselves
- Collaborates with DCP&P and community partners
- Facilitates and/or attends meetings

INITIAL INTAKE ASSESSMENT

The Initial Intake Assessment process begins with a Therapeutic Visitation Specialist receiving a case from the SVS Program Leader. The Therapeutic Visitation Specialist calls the DCP&P Caseworker within two (2) business days to gather information that is pertinent to visitation, such as:

- Reason for DCP&P involvement
- What led to the removal
- Current visitation schedule and progress with visits thus far

Once this conversation has taken place, the Therapeutic Visitation Specialist calls the visiting parent within two (2) business days to schedule the Initial Intake Assessment. The Initial Intake Assessments should occur within one week of receiving the referral or at the family's first availability. At minimum, the Initial Intake Assessment includes the Therapeutic Visitation Specialist and the visiting parent(s). Children may also be included depending on their age. If DCP&P seeks to participate they may, but it is not a requirement.

During this Initial Intake Assessment, the Therapeutic Visitation Specialist introduces themselves and the program, and explains SVS services. The Therapeutic Visitation Specialist allows the family time to tell their story and gather any information the parent(s) would like to share at that time. The Therapeutic Visitation Specialist completes all necessary intake paperwork including the biopsychosocial assessment, HIPAA paperwork, agency handbook, and the SVS Caregiver Survey (Appendix G).

Providers are expected to complete a biopsychosocial assessment during the Initial Intake Assessment that includes, at minimum, current and historical information in the following areas:

- a description, in the family's words, of events that led to DCP&P involvement and current areas of concern
- family and community supports including family structure, assets, and strengths
- family and child development and education
- history of trauma, abuse, and/or loss and out-of-home placements
- medical including physical health and medication
- behavioral and mental health including services currently or formerly in use
- substance use and treatment
- current status including symptoms, thought processes, orientation, memory, insight, judgment, appearance, mood, affect, etc.

From the information gathered during the biopsychosocial assessment, a clinical impression is created to identify strengths, challenges, motivation, and potential clinical goals. These goals should be further developed in the visitation planning meetings and outlined in the family's visitation plan.

Additionally, during the Initial Intake Assessment, visit planning occurs for the initial, pre-visitation plan visits. The family is asked whom they would like in the visits, where they would like visits to occur, what activities they would like to occur at visits, what parenting skills or other areas they would like to work on, and when the family is available for visits.

Lastly, during the Initial Intake Assessment, caregivers must complete the SVS Caregiver Survey to submit baseline evaluation responses to NJ DCF. For more information, please refer to "SVS Caregiver Survey" in Section 4 of this manual.

Based on the information gathered from DCP&P during referral, from the family during Initial Intake Assessments, and the results of the Parent-Child Visitation Planning tool, the Therapeutic Visitation Specialist determines the level of visitation that is most appropriate for this family (i.e., supportive or therapeutic) for the pre-visitation plan visits. The parents' availability and scheduling for visits is also discussed during this intake. After the intake has been held with the visiting parent(s), the Therapeutic Visitation Specialist will also introduce the program to the resource parent and child (if age-appropriate) via phone.

The Therapeutic Visitation Specialist facilitates the initial visits and may determine that the Supportive level of visitation is more appropriate for the family than the Therapeutic level. In that case, a Supportive Visitation Specialist is assigned, and all parties are notified. Prior to the transition, a collaborative visit is held with both Visitation Specialists present to increase comfort for the family.

Immediately following the completed Initial Intake Assessment, the assigned SVS Visitation Specialist schedules the family's initial Visitation Planning Meeting (VPM) with the caregiver(s) and DCP&P Caseworker. Once confirmed, the meeting details are shared with other meeting participants. For more information, please refer to "Visitation Planning Meeting" in Section 3 of this manual.

PRE-VISITATION PLAN VISITS

Engaging

Assessing

Active Listening

Teaming

Therapeutic Intervening

Coaching

ESSENTIAL FUNCTIONS AND EXPECTED BEHAVIORAL INDICATORS FOR PRE-VISITATION PLAN VISITS

Engaging

- Initiates and maintains ongoing phone and in-person contact with family
- Schedules and conducts visits in the least-restrictive setting while ensuring the safety of the child(ren)
- Ensures the environment for parent-child contact is safe, non-traumatizing, and promotes healthy attachment
- Always involves family in the process
- Initiates and maintains ongoing phone and in-person contact with DCP&P and other stakeholders, as appropriate

Teaming

- Advocates for parents/families as necessary and supports them in advocating for themselves
- Collaborates with DCP&P and community partners
- Facilitates and/or attends meetings

Assessing

- Uses a process to gather information

Therapeutic Intervening

- Promotes behavioral change through clinical interventions

Active Listening

- Creates an environment that empowers family members, including parents, child, etc., to communicate their goals and needs
- Utilizes various interviewing and/or communication techniques

Coaching

- Enhances parental skills by goal setting, modeling, mentoring, reinforcement and feedback and reflection
- Prepares for each visit with parent(s)
- Debriefs with parent(s) after each visit

PRE-VISITATION PLAN VISITS

During the Intake Assessment Visit information about the parents' availability and schedule is gathered. With that information the Visitation Specialist calls the resource parent to inform them of the parents' availability for visits and to discuss the child(ren)'s schedule. If the availability of the visiting parent and child aligns, the Visitation Specialist will schedule the first visit during this phone call and then follow up with the parent to confirm it has been scheduled. Should the availabilities between the visiting parent and child(ren) not align, the Visitation Specialist will make additional phone calls to the visiting parent to discuss other scheduling options. Once the availability between the child(ren) and visiting parent coincides, the first parent-child visit and transportation arrangements are scheduled. If necessary, the Visitation Specialist will also coordinate with other parties that might be involved (e.g., schools, day cares, after cares, camp, etc.) to confirm transportation/pick-up/drop-off information.

The day before the first visit, the Visitation Specialist will call the resource parent and visiting parent to confirm the upcoming scheduled visit. Before the visit occurs, the Visitation Specialist consults with the parent and child to prepare family for the first visit. Preparation can occur in a planned meeting, on the phone, or during transport to the visit. Parents can be picked up first to allow for discussion time en route to pick up children. Parent preparation should conclude before the child is picked up and enters the vehicle.

The Visitation Specialist transports the child and/or parent to the visit location. The visit occurs for a minimum of two hours or for the duration that was previously arranged during the coordination process.

Following the visit, the Visitation Specialist will conduct a parent and/or child post-visit debrief to process the session and then provide the drop-off transportation for the child(ren) and/or parent(s). Debriefing can occur while transporting the parent and child, or by dropping off the child first to have some time in the vehicle with the parent.

The Visitation Specialist will call the DCP&P Caseworker by the next business day to provide an update about how the first visit went. The Visitation Specialist will also document the visit in NJSPIRIT, NJ DCF's Comprehensive Child Welfare Information System, within five (5) business days and in the agency's internal system, as required. These visits will continue for the next 2–4 weeks, until the first Visitation Planning Meeting occurs, and the family's formal visitation plan is developed. During this time, the Visitation Specialist is building a relationship with the family and gathering information through observations that will inform their visitation plan and be presented during the Visitation Planning Meeting.

Pre-visit consults with the parent(s) and the child(ren), when age appropriate, should involve discussions around planned activities, supplies to bring to the visit, and planning for anticipated challenges such as responding to children's emotions and behaviors.

Visit debriefing should involve an exchange of reflections on the visit and feedback. Debriefs should begin with engaging the parent(s) to elicit their thoughts about how the visit went, including self-reflection on their own parenting behaviors and responses. The Visitation Specialist should offer behaviorally specific observations and strengths-based feedback. The Visitation Specialist should ask the parent(s) what they would like to do the same or different during the next visit. Solution-focused questions can also be used to help engage the parent(s) in planning for strategies to address visitation challenges.

COMPONENTS OF SUCCESSFUL VISITS

The practice of visitation is a planned and purposeful process that involves intentional stages to ensure that family time is a quality experience.

There are three (3) primary parts of the visitation process:

1. The pre-visit preparation: a planning stage before the visit.
2. The visit: the stage that consists of family time.
3. The post-visit debrief: a stage of debriefing after a visit.

The pre-visit preparation

The planning for visitation happens in several important ways. Group meetings, such as Visitation Planning Meetings (VPM) held by SVS, are where visitation plans are developed and details such as time, location, participants, and transportation are discussed and arranged. Family Team Meetings with DCP&P are another collaborative group setting where visitation preparation can occur. Visitation planning also occurs on a regular basis, one-on-one, with parents, and children when age appropriate. This planning stage, individually and in VPMs, should always include input from the parent, and ideally the child, about the activities planned, supplies to bring to the visit, and how they will spend their quality family time together. The preparation time before a visit is an important time with parents to discuss anticipation of any behavioral or emotional challenges that could arise and to plan strategies to address those challenges.

Preparation can occur in a planned meeting with parents, on the phone, or while transporting to the visit, as parents can be picked up first to allow for discussion time en route to pick up children.

The planning stage may also involve the resource parent. Plans with the resource parent should be made regarding their communication with parents and items needed to bring to the visit for the children. There should be clarity about what will be supplied by the parent or the resource parent, such as change of clothes or bottles/snacks. The resource parent should have a means to share information about any medical, educational, emotional, and behavioral updates about the children. This can happen through direct communication or in a shared journal. Plans should also be made for how the resource parent will help the children process feelings and behaviors that occur after visitation.

The role of the Visitation Specialist should also be discussed before visits. The parent should understand if the Visitation Specialist will be actively coaching or observing, and under what circumstances the Visitation Specialist might intervene.

The visit

SVS visitation staff are required to contact visiting participants 24 hours in advance of the visit to confirm attendance. SVS visitation staff must initiate this contact. Once confirmed, a visit can occur.

The visit is the time that is reserved for the planned and purposeful activities and interactions between the parent and the child(ren) that are designed to meet the child's developmental and attachment needs. During visits, Visitation Specialists observe, and when appropriate, model and coach age-appropriate interactions with the parents and children. If the family is receiving therapeutic visitation services, there may be more intentional involvement and coaching with the Visitation Specialist. This will look different based on the needs, strengths, and culture of the family.

In the event that parents fail to attend regularly scheduled visits, efforts will be made to re-engage through continued outreach to parents and collaborative planning. Multiple failed appointments may result in the agency discharging the family from the SVS program.

The post-visit debrief

Visit debriefing is an important opportunity for reflection. This stage begins with the Visitation Specialist engaging parents to review and discuss their perceptions of how the visit went, including encouraging self-reflection of their own parenting behaviors and responses. The Visitation Specialist should engage parents to elicit their thoughts about strengths, challenges, and learning opportunities. The Visitation Specialist also gives strength-based, behaviorally specific feedback and makes suggestions for improvements, as necessary. The Visitation Specialist should ask the parent(s) what they would like to do the same or different during the next visit. Solution-focused questions can also be used to help engage the parent(s) in planning for strategies to address visitation challenges.

Debriefing should be practiced regularly and should be considered the closing stage of each visit. It can occur immediately after a visit or in a planned contact soon after the visit. If the Visitation Specialist is transporting both the child and parent, the child can be dropped off first to allow for discussion time between the Visitation Specialist and the parent.

NOTE: While the pre-visit preparation meeting and post-visit debrief must occur with the visiting caregiver, staff also meet with the child, depending on the child's age, before or after the visit to help them to transition back to their foster care placement and to process the visit that has occurred. Children, again depending on the child's age, may also be involved in the planning of visits when appropriate.

Transportation

Children are also supported through consistent transportation with the same staff member if the service is providing transportation. Involvement of resource parents in providing transportation is encouraged, as this provides collaboration and teamwork around the care of the child. Additional information can be found in "SVS Transportation" in Section 4 of this manual.

Documentation

Details of every visit must be recorded by the Visitation Specialist in NJSPIRIT within five (5) business days of each visit and in the agency's internal record system, if applicable. Additional information can be found in "SVS Documentation" in Section 4 of this manual.

VISITATION PLANNING MEETING

- Rose Wentz Matrix
- SVS Family Visitation Plan
- Visitation Planning Meeting Agenda and Forms

Engaging

Assessing

Active Listening

Teaming

ESSENTIAL FUNCTIONS AND EXPECTED BEHAVIORAL INDICATORS FOR VISITATION PLANNING MEETINGS

Engaging

- Initiates and maintains ongoing phone and in-person contact with family
- Ensures the environment for parent-child contact is safe, non-traumatizing, and promotes healthy attachment
- Always involves family in the process
- Initiates and maintains ongoing phone and in-person contact with DCP&P and other stakeholders, as appropriate

Active Listening

- Creates an environment that empowers family members, including parents, child, etc., to communicate their goals and needs
- Utilizes various interviewing and/or communication techniques

Assessing

- Uses a process to gather information
- Fills out required assessment tools
- Synthesizes information and completes visitation plan
- Updates the visitation plan at regular intervals

Teaming

- Advocates for parents/families as necessary and supports them in advocating for themselves
- Collaborates with DCP&P and community partners
- Facilitates and/or attends meetings

VISITATION PLANNING MEETING

A cornerstone of SVS services is the Visitation Planning Meeting, a collaborative meeting which includes visit participants and relevant stakeholders to finalize the family's visitation plan and provide a clear description of the services the family is receiving, and where the family is currently on the continuum of visitation services.

SVS FAMILY VISITATION PLAN

Visitation Planning Meetings are to be held within 30 days of the family's initial intake assessment and minimally every three (3) months thereafter, or sooner if needed. They are held at a location most convenient for and preferred by the visiting parent (e.g., family home, agency office, or DCP&P local office). Attendees at Visitation Planning Meetings consist of the Visitation Specialist, the parent(s), DCP&P Caseworker/Supervisor, the resource parent(s), and other natural supports.

During the initial stages of engagement in SVS services, the Visitation Specialist will work with the family to identify a date/time/location of the Visitation Planning Meeting. Just prior to the meeting, the Visitation Specialist will follow up with potential attendees to make sure all parties are still available.

Before the Visitation Planning Meeting, the Visitation Specialist completes the Rose Wentz Matrix[3] (Appendix H) and the DCF Parent-Child Visitation Planning Tool (Appendix E). After completing the Rose Wentz Matrix and the DCF Parent-Child Visitation Planning Tool and reviewing the results, the SVS Family Visitation Plan (Appendix I) is drafted, which is based on visit observations and input from and work with the family to date.

THE SVS FAMILY VISITATION PLAN INCLUDES:

Impact of Separation—This section includes a description how separation affects child development and the parent-child relationship.

Visitation Goals—Goals are developed and included in the visit plan based on visitation strengths and challenges, family need, and child development considerations. The plan clearly identifies requirements to move to a less restrictive visitation supervision level.

Visitation Supervision Level—Level of supervision along the continuum is based on assessment and the DCF Parent-Child Visitation Planning Tool (Appendix E) in collaboration with DCP&P and may change as the family's needs change over time.

Visitation Location—Visit location is based on assessment, DCF Parent-Child Visitation Planning Tool (Appendix E), and family's request. Visitation location should be in the least restrictive setting possible, including the family's home, kin or resource parent's homes, and/or in-community locations. Visits should only occur in the provider or DCP&P's office when visitation safety and/or risk factors exist.

[3]Available information on the Rose Wentz Matrix can be found online at http://www.wentztraining.com/products/tools.

Visitation Frequency and Duration—Visit frequency and duration are based on assessment, DCF Parent-Child Visitation Planning Tool (Appendix E), and family's request and availability. Visits should be as frequent and as long as possible, unless harmful to participants and/or requested otherwise. Children's age and development should be considered when determining visitation frequency and duration based on the following:

- Infants/Toddler—ages birth to five (5) years old are recommended to have shorter, more frequent visits
- Younger, school-aged children—ages six (6)–12 years old are recommended to have longer, more frequent visits
- Adolescent/young adults—ages 13–17 years old are recommended to have longer, less frequent visits.

Visitation Participants—This section details the names and relationships of family-requested visitation participants and identifies if they are DCP&P-approved. If identified individuals are not DCP&P-approved, this section should outline steps for approval.

Visitation Activities and What to Bring—This section details visitation activities, what caregivers should bring to visits, etc. It should include any cultural considerations, as appropriate.

Prior to the meeting, the SVS Program Leader reviews the family's visitation plan. The Visitation Specialist facilitates the meeting by following the SVS VPM Agenda and Forms (Appendix J) and reviews the Visitation Plan with the attendees at the meeting.

DURING THE VISITATION PLANNING MEETING, ATTENDEES ARE EXPECTED TO DISCUSS AND GIVE CONSIDERATION TO THE FOLLOWING:

Strengths of the Family—This section should highlight what is working well in visits focusing on attendance, relationships, bonding, parent-child interactions, parenting skills, and communication.

Visitation Challenges—This section should highlight what is not working well in visits and could be improved focusing on attendance, relationships, bonding, parent-child interactions, parenting skills, communication, etc.

DCP&P Case or Service Updates—This section describes progress toward case goals, recent court orders, and any additional service updates.

Family and Natural Supports—This section explores and identifies family supports to serve as potential visitation supervisors, if applicable, or to offer their homes as an option for visits.

The Visitation Plan is edited during the meeting to reflect any new information or changes discussed. Once the plan is finalized and agreed upon by all parties, all parties sign and are given a copy.

The Visitation Plan is to be reviewed again in three (3) months, or sooner if needed, during the next Visitation Planning Meeting. The next Visitation Planning Meeting will be scheduled at the end of the meeting.

CONTINUUM OF VISITAITON SERVICES

Engaging

Assessing

Active Listening

Teaming

Therapeutic Intervening

Coaching

ESSENTIAL FUNCTIONS AND EXPECTED BEHAVIORAL INDICATORS FOR CONTINUUM OF VISITATION SERVICES

Engaging

- Initiates and maintains ongoing phone and in-person contact with family
- Schedules and conducts visits in the least-restrictive setting while ensuring the safety of the child(ren)
- Ensures the environment for parent-child contact is safe, non-traumatizing, and promotes healthy attachment
- Always involves family in the process
- Initiates and maintains ongoing phone and in-person contact with DCP&P and other stakeholders, as appropriate

Teaming

- Advocates for parents/families as necessary and supports them in advocating for themselves
- Collaborates with DCP&P and community partners
- Facilitates and/or attends meetings

Assessing

- Uses a process to gather information

Therapeutic Intervening

- Promotes behavioral change through clinical interventions

Active Listening

- Creates an environment that empowers family members, including parents, child, etc., to communicate their goals and needs
- Utilizes various interviewing and/or communication techniques

Coaching

- Enhances parental skills by goal setting, modeling, mentoring, reinforcement and feedback and reflection
- Prepares for each visit with parent(s)
- Debriefs with parent(s) after each visit

CONTINUUM OF VISITATION SERVICES

SVS provides at least weekly visitation services along a continuum to meet the unique needs of each family. The continuum includes a full range of visitation services from least restrictive supportive to more intensive therapeutic interventions. Families can enter SVS anywhere on the visitation continuum and move along the continuum throughout their involvement with SVS. The family's visitation supervision level is determined through assessment and collaborative visitation planning processes. Families are reassessed at regular intervals to determine if their goals have been met and if a different level of supervision is recommended.

Families can receive one or more of the following visitation types:

- Therapeutic supervised visitation,
- Supportive supervised visitation,
- Relative/community partner supervised visitation and/or
- Unsupervised monitoring.

Therapeutic Supervised Visitation

Therapeutic Supervised Visitation is supervised by a Master's level Therapeutic Visitation Specialist (TVS) and is required when a significant level of intervention or clinical support is needed to facilitate positive parent-child interactions during visits. The TVS promotes parent-child attachment, emotional regulation, and demonstration of parent competencies, and uses trauma-informed therapeutic approaches to assist and support family members. For more information, please refer to expected behavioral indicators for "Therapeutic Intervening" in the SVS Practice Profile (Appendix C). Therapeutic Supervised Visitation could be indicated for high-risk safety concerns, such as sexual abuse, physical abuse, etc. Treatment goals related to improving parenting skills, attunement, and communication within the family are established and reviewed as a part of the therapeutic process. Pre-visit prep and post-visit debriefs with parents are specifically focused on planning activities for visits, processing feelings from visits, and reviewing progress toward treatment goals.

Supportive Supervised Visitation

Supportive Supervised Visitation is supervised by a Bachelor's level Supportive Visitation Specialist and provides a lower level of intervention and support. Interventions might include parent coaching or mentoring to support and/or reinforce clinical gains, without direct therapeutic or clinical intervention. For more information, please refer to expected behavioral indicators for "Coaching" in the SVS Practice Profile (Appendix C).

Relative/Community Partner Supervised Visitation

Relative/Community Partner Supervised Visitation is provided by willing, able, and DCP&P-approved family and/or community partners. Examples include relatives, friends, mentors, neighbors, teachers, faith-based leaders, counselors, etc. SVS serves as an occasional monitor for these visits, once monthly or more often if additional support is indicated by visitation participants, DCP&P, or SVS staff. SVS will conduct the initial and subsequent assessments and maintain contact with the family and those responsible for supervising the visits. SVS staff will observe a visit, and process with the parties before and after the scheduled monitored visit in a pre-visit prep and post-visit debrief meeting.

Unsupervised Monitoring

SVS will continue to support families who transition to unsupervised visits by serving as an occasional monitor. Once monthly, or more often as required, SVS staff will observe a visit, and process with the parties before and after the scheduled monitored visit in a pre-visit prep and post-visit debrief meeting. SVS will conduct the initial and subsequent assessments and maintain contact with the family regarding the visits.

Table 1 below summarizes the interventions provided by SVS visitation staff for each of the visitation and monitoring services provided in SVS programs.

Table 1. SVS Interventions for Visitation and Monitoring Services

	Therapeutic Supervised	Supportive Supervised	Relative/Community Partner Supervised Visit Monitoring	Unsupervised Visit Monitoring
Eligible Families	Significant level of intervention or clinical support is needed to facilitate positive parent-child interactions and ensure visit safety	Intervention and/or support is needed to ensure visit safety; no relatives or community partners are identified or willing, able, or DCP&P-approved to supervise	Intervention and/or support is needed to ensure visit safety; relatives or community partners are willing, able, and DCP&P-approved to supervise	No supervision is needed to ensure visit safety
Visit Supervisor	Master's level Therapeutic Visitation Specialist (TVS)	Bachelor's level Supportive Visitation Specialist	Willing, able, and DCP&P-approved family or community partners. SVS serves as an occasional monitor, once monthly or more often, as indicated.	No visit supervisor required. SVS serves as an occasional monitor, once monthly or more often, as indicated.
Description of Intervention	Promote parent-child attachment, emotional regulation, and demonstration of parent competencies, and uses trauma-informed therapeutic approaches to assist and support family members. Treatment goals related to improving parenting skills, attunement, and communication within the family are established and reviewed as a part of the therapeutic process.	Interventions might include parent coaching or mentoring to support and/or reinforce clinical gains, without direct therapeutic or clinical intervention.	Interventions might include parent coaching or mentoring to support and/or reinforce clinical gains, without direct therapeutic or clinical intervention.	No intervention needed during visits.

Additional information on the components of successful visits can be found in “Pre-Visitation Plan Visits” in Section 3 of this manual. Information on the mechanics of conducting visits is provided along with information on pre-visit prep, the visit, post-visit debriefing, transportation, and documentation. Each component must be included in all levels of visitation services.

Post-Reunification Support/Aftercare Services

At the time that reunification is determined, a VPM is held to discuss voluntary post-reunification/aftercare services. During the VPM, goals are created to guide aftercare services. SVS staff continue to collaborate with the family and DCP&P to develop an aftercare plan for ongoing services after the family has been stabilized in the home.

When a family has achieved reunification and is receiving aftercare, the most recent Visitation Specialist working with the family will then support the family through the transition by providing in-home aftercare services. The goal of aftercare services is to assist the family with the challenges of reunification and ultimately prevent repeat maltreatment and re-entry into out-of-home care. Initially, weekly home visits will be scheduled with the family. Visits will gradually decrease to bimonthly and then monthly as determined by the family’s needs and progress. Services may continue for up to six (6) months. An open, active DCP&P case is required for SVS to continue providing aftercare services to families.

In-home services include supportive coaching; the Visitation Specialist may work with the family around assistance in improving family dynamics, de-escalating crises, decreasing children’s acting-out behaviors, improving parenting skills, assessing long-term and concrete needs, and addressing other variables that can contribute to a family’s safe and lasting reunification.

Aftercare services also include providing appropriate referrals to other services and may include connecting the family with individual and/or family therapy, a parent support group, a parent education class, and other relevant community resources. Referrals are identified in collaboration with families. In some cases, the family may have the means to access services on their own. For example, a family may have their own health coverage for counseling services. In other cases, the referral is coordinated with DCP&P to connect families with DCF-contracted services.

The end of aftercare is determined in a case conference or preferably an FTM with SVS, DCP&P, and the family together. Aftercare services will also end when DCP&P determines that a child is not in danger and closes the family’s case. For more information, please refer to “Program Discharge” in Section 3.

Documentation of aftercare services consists of progress notes entered into the SVS program’s internal electronic documentation system.

COLLABORATION WITH DCP&P, FAMILIES AND COMMUNITY-BASED PROVIDERS

Engaging

Assessing

Active Listening

Teaming

ESSENTIAL FUNCTIONS AND EXPECTED BEHAVIORAL INDICATORS FOR COLLABORATION WITH DCP&P, FAMILIES AND COMMUNITY-BASED PROVIDERS

Engaging

- Initiates and maintains ongoing phone and in-person contact with family
- Always involves family in the process
- Initiates and maintains ongoing phone and in-person contact with DCP&P and other stakeholders, as appropriate

Active Listening

- Creates an environment that empowers family members, including parents, child, etc., to communicate their goals and needs
- Utilizes various interviewing and/or communication techniques

Assessing

- Uses a process to gather information

Teaming

- Advocates for parents/families as necessary and supports them in advocating for themselves
- Collaborates with DCP&P and community partners
- Facilitates and/or attends meetings

COLLABORATION WITH DCP&P, FAMILIES, AND COMMUNITY-BASED PROVIDERS

To help families be successful in meeting their goals, it is critical for service providers to proactively plan and collaborate with one another to positively impact service delivery. This involves planful collaboration of mutually agreed-upon goals and a clear understanding of which provider will assist the family in working toward identified goals, tasks, and service delivery activities. Including a large number of providers to assist a family is not always a good use of resources and can result in confusion for families, duplication of efforts, or an absence of a needed service. As such, planful collaboration is an important activity for SVS providers when working with DCP&P and other community agencies.

Families must be full participants in the identification of their needs, strengths, solutions, goals, and planning process. Various opportunities for collaboration with families, such as VPMs, DCP&P Family Team Meetings, and ongoing planning, meeting, and debriefing, make up SVS service delivery practices.

COLLABORATION WITH DCP&P

Case collaboration between SVS and DCP&P is critical to create and implement individualized plans to address unique family needs and to ensure effective service delivery. SVS and DCP&P work together with families toward shared goals.

Collaboration between SVS and DCP&P often begins before referral and continues until after the contact with the family. Formal points of collaboration between SVS and DCP&P include:

- Pre-Referral Conferences
- Referral
- Initial Intake Assessments
- Initial Visit Updates
- Visitation Planning Meetings
- Family Team Meetings
- Ongoing Visit Updates
- Aftercare Service Coordination and Updates
- Discharges

Initial and Ongoing Engagement

Initial engagement between DCP&P and SVS begins at the point that a representative, typically the DCP&P Caseworker, Supervisor, or RDS, contacts SVS regarding a possible referral. The referral triggers the first of several case conferences that occur between staff from both agencies. The first conference identifies the family's appropriateness for participation in the Supportive Visitation program.

DCP&P and SVS continue to work together throughout the duration of a family's involvement with SVS to meet the family goals. The DCP&P caseworker is included as a collaborator in the initial and ongoing Visitation Planning Meetings held by SVS.

Ongoing engagement also includes:

- Phone *C*alls: Serve as primary regular contact for DCP&P and SVS to case conference and review family progress and service needs. The number of phone calls vary by case but should occur at minimum monthly or more often, as indicated. If there is (or risk of) an incident/concern during a visit, SVS staff contact the DCP&P caseworker in addition to documenting in a progress note.

- Visit Documentation: Details from all visits are documented by SVS staff in a contact sheet in NJSPIRIT within five (5) business days of the visit.

- Written *C*ollateral *R*eports: These are letters describing family progress, service needs, and adherence to visitation plan. A written collateral report is sent to DCP&P for court every three months or at the request of the DCP&P case worker. For example, a written collateral report may be requested following overnight visitation.

Participation in Family Team Meetings

Family Team Meetings (FTMs) are generally held every three (3) months and are facilitated by DCP&P staff with families to build a team of functional supports that will assist the family in achieving their goals. Teaming is the process in which DCP&P and families plan together regarding the case situation and move the family toward permanency goals and attend to service needs. Attendees of Family Team Meetings are determined by families and consist of formal supports (i.e., SVS and other service providers) and informal supports (i.e., friends, family, resource parents, and other individuals from the family's identified network of support).

COLLABORATION WITH FAMILIES

SVS collaborates with families from the first contact until the decision to end services. Caregivers are partners with shared power in the process of change.

Families must have a voice in the processes and activities throughout their involvement in SVS service delivery. SVS partners with families in scheduling visits and Visitation Planning Meetings; assessing family strengths and needs; planning, conducting, and post-visit debriefing; determining that other community resources, supports, and services are needed; in Family Team Meetings that are held with DCP&P; and decisions about changing supervision levels, aftercare, and discharge.

Families also drive the ability for SVS to collaborate with other community providers, as consent is needed to share any family and case planning and progress information.

COLLABORATION WITH COMMUNITY PROVIDERS

With family consent, SVS communicates and coordinates with other community providers. SVS engages other family-identified supports or service providers that can be a part of Visitation Planning Meetings and DCP&P Family Team Meetings to ensure that all services are working toward the family's goal and that there is not duplication of services. Examples may include coordinating visits with an inpatient substance abuse service; incorporating lessons skills developed in parenting groups into visits with families; and/or having some of the children's services (such as Early Intervention) attend visits to help provide psychoeducation on the needs of the child to the parent.

RESOURCES FOR FAMILIES

From the time that families are initially connected to SVS, to the time of planning for aftercare, and finally a discharge of services, SVS programs assess the strengths and challenges faced by families. SVS programs work to ensure that families' unique needs are met and that they have access to a wide range of supportive services. SVS programs refer and connect the individuals and families they serve to organizations and resources that address specific needs, and promote wellness and stability within the family.

Some of the common resource referrals provided by SVS services include:

- Housing support
- Educational and occupational services
- Domestic violence services
- Medical care and treatment
- Mental health care
- Substance use/abuse treatment
- Legal services
- Early intervention
- Childcare
- Kinship programs
- Financial services
- Community wellness programs

PROGRAM DISCHARGE

While family visitation is understood as one of the most critical elements of family reunification, the length of time a family is involved with visitation services and the reason for discharge varies.

There are four (4) primary SVS program discharge outcomes. They include:

- Reunification occurs and the family participates in aftercare services
- Reunification occurs and the family declines aftercare
- Other permanent outcome is achieved
- All other outcomes

Reunification occurs and the family participates in aftercare:

Aftercare services are provided based on the family's needs and services can continue for up to six (6) months. Services are closed if the need no longer exists and a closing letter is sent to the caregiver(s) and the DCP&P Caseworker is notified.

Reunification occurs and the family declines aftercare:

If a family declines aftercare, SVS services end and family is discharged from program. Closing letter is sent to the caregiver(s) and DCP&P Caseworker is notified.

Other permanent outcome is achieved:

When an outcome is achieved that includes adoption/KLG/living with relatives, etc., SVS services end and family is discharged from program. A closing letter is sent to the caregiver(s) and DCP&P Caseworker is notified.

All other outcomes:

When no permanent outcome is achieved and/or SVS is no longer appropriate for the family, services end and family is discharged from program. A discharge from SVS may occur when parents are not consistently participating in the mandatory components of the program, such as their therapeutic supervised visitation or if parents do not attend for a significant amount of time. In the event that two consecutive visits are missed, a warning letter is to be initiated and discussed with the family that states that all future visits must be attended as scheduled. If efforts are made by the Visitation Specialist to re-engage the family and the parents choose not to take part in visitation as planned, SVS services will be terminated. Both parents and DCP&P Caseworkers will be notified in a Discharge Letter that the parent's lack of compliance with the program has resulted in discharge.

Section 4

SVS Administrative Operations

SVS STAFFING

SVS JOB DESCRIPTIONS

There are three (3) core SVS positions needed in order to deliver SVS services:

1. Program Leader
2. Therapeutic Visitation Specialist
3. Supportive Visitation Specialist

Job descriptions for core SVS positions align with the SVS Practice Profile's Guiding Principles and Essential Functions. SVS providers should use these job descriptions for recruitment, selection, and hiring processes and modify these position descriptions as applicable to meet agency's requirements and/or staffing needs.

Program Leader

An SVS Program Leader is responsible for day-to-day operations of agency's SVS Program; recruiting, selecting, coaching, supervising, and assessing therapeutic and supportive visitation specialists and drivers; collecting, overseeing quality of, and reporting SVS data; participating in various CQI activities; and attending meetings and delivering presentations. The SVS Program Leader is responsible for providing, or coordinating, clinical oversight and supervision of visitation staff.

Job description for Program Leader can be found in Appendix K.

Therapeutic Visitation Specialist

An SVS Therapeutic Visitation Specialist is responsible for supporting parent-child visitation for families in their homes or communities who require therapeutic intervention; completing biopsychological assessments, assessment tools, and visitation plans; documenting visits and completing reports; facilitating parent debriefings before and after visits and visitation planning meetings; transporting to children and/or parents; communicating with children, parents, relatives, resource parents, DCP&P, and/or other stakeholders by phone and in person; attending various meetings and trainings; and assessing families' service needs and linking them to appropriate community providers.

Job description for Therapeutic Visitation Specialist can be found in Appendix L.

Supportive Visitation Specialist

An SVS Supportive Visitation Specialist is responsible for supporting parent-child visitation for families in their homes or communities; completing and updating visitation plans; documenting visits and completing reports; facilitating parent debriefings before and after visits and visitation planning meetings; transporting children and/or parents; communicating with children, parents, relatives, resource parents, DCP&P, and/or other stakeholders by phone and in person; attending various meetings and trainings; and assessing families' service needs and linking them to appropriate community providers.

Job description for Supportive Visitation Specialist can be found in Appendix M.

SVS Driver, Optional SVS Position

Agencies may decide to utilize an SVS Driver. An SVS Driver is responsible for transporting children and/or parents to and from visitation locations; ensuring safety of passengers; maintaining vehicle; recording and maintaining applicable logs; communicating with visitation specialists, parents, resource parents, children, etc.; and attending applicable trainings.

Job description for SVS Driver can be found in Appendix N.

Additional SVS Staff, as needed

Additional staff may be required to carry-out program operations.

SVS INTERVIEW PROTOCOL

Significant efforts should be made by SVS implementing agencies to hire staff from within the communities being served by the program and whose race, ethnicity, and/or language reflect the individuals being served.

SVS uses a purposeful process for selecting and hiring SVS program staff with the required skills, abilities, and other characteristics to implement the SVS program model. The following interview materials should be reviewed by your agency's selection team and used as a guide when developing your agency's SVS selection protocol. The recommended SVS Interview Protocol includes:

- Initial Telephone Interview (Appendix O)
- Face-to-Face Interview (Appendix P)
- Behavioral Rehearsal/Role-Play (Appendix Q)
- Mock Case Study/Writing Sample (Appendix R)
- Candidate Scoring Rubric (Appendix S)

Two sets of interview questions are provided for use during initial phone screenings and face-to-face interviews with SVS candidates. These questions can be modified as needed if your team will not conduct two stages of interviews (phone and face-to-face) or for the specific position. Review the questions ahead of an interview and identify relevant questions, and customize as needed.

Mock case studies, scenarios, and behavioral rehearsal provide opportunities to assess candidates' skills beyond the interview questions. The team should decide which of these activities to use, and at which point during the selection process. The agreed-upon protocol should be used consistently with all candidates, and the team should use a standardized scoring rubric to assess each applicant.

All interviewing materials can be found in the Appendix O–S of this manual.

SVS TRAINING

Skills-based training is necessary to promote acquisition of skills and information needed to carry out program services and competencies. Training alone, however, is not sufficient to ensure successful application of knowledge and skills in practice. Supervision and on-the-job coaching are needed to reinforce skills and inspire staff confidence (National Implementation Research Network, n.d). SVS includes both staff and supervisor training and coaching to support successful delivery of program services.

All SVS staff are required to complete and utilize SVS trainings and developed coaching materials to promote competency in the SVS Practice Model; and to provide ongoing professional development for staff in areas relevant to their position.

NEW JERSEY SUPPORTIVE VISITATION SERVICES TRAINING FOR VISITATION SPECIALISTS & STAFF

An in-depth and interactive, asynchronous web-based training model is available to Supportive Visitation Services Staff to strengthen knowledge, skills, and competencies necessary to implement the SVS Program Model. The New Jersey Supportive Visitation Services Training for Visitation Specialists & Staff includes the following content:

- An Introduction to Supportive Visitation Services Program Model including SVS Logic Model and SVS Practice Profile
- Overview of SVS Service Delivery Processes and Continuum of Visitation Services
- Description of the SVS Essential Functions of Engaging, Assessing, Teaming, Active Listening, Coaching, and Therapeutic Intervening, and associated expected behavioral indicators for each

All SVS Staff are required to complete the New Jersey Supportive Visitation Services Training for Visitation Specialists & Staff.

NEW JERSEY SUPPORTIVE VISITATION SERVICES TRAINING FOR SUPERVISORS

An in-depth and interactive, asynchronous web-based training model is available to Supportive Visitation Services Program Leaders for program supervisors to explain and implement the knowledge and skills required in their role, and enhance the skills used to support their staffs' work with families.

The New Jersey Supportive Visitation Services Training for Supervisors consists of four main sections: the functions of a supervisor; supervisory skills; the supervisor-supervisee relationship; and self-care for the supervisor.

All SVS Program Leaders (and/or supervisors) are required to complete the New Jersey Supportive Visitation Services Training for Supervisors.

COACHING TRAINING COACHING TO THE PRACTICE MODEL: APPLYING THE CHILD WELFARE SKILLS-BASED COACHING FRAMEWORK TO SVS

The New Jersey Supportive Visitation Services Training for Supervisors is followed by the Coaching to the Practice Model: Applying the Child Welfare Skills-Based Coaching Framework to SVS training.

The Coaching to the Practice Model: Applying the Child Welfare Skills-Based Coaching Framework to SVS training provides an overview of coaching, and more specifically, the Child Welfare Skills-Based Model. Each module focuses on a stage of the model detailing the process, tools and strategies used during it.

The Child Welfare Skills-Based Coaching Model encourages self-reflection to help build identified practice skills. The model is cyclical and focuses on a process of learning and engaging to help the learner apply a specific skill.

All SVS Program Leaders (and/or supervisors) are required to complete the Coaching to the Practice Model: Applying the Child Welfare Skills-Based Coaching Framework to SVS training.

DCF GUIDE TO COACHING PRACTICE

A Guide to Coaching Practice was developed to compliment the Coaching to the Practice Model: Applying the Child Welfare Skills-Based Coaching Framework to SVS training. It's a practical guide outlining the process and providing tools to assist SVS Program Leaders in effectively using the Child Welfare Skills-Based Coaching Model in coaching sessions with their staff. Additional information on SVS coaching can be found later in this section.

SVS SUPERVISION

SVS Program Leaders provide supervision and clinical oversight to SVS staff. They are responsible for overseeing that staff deliver, and are supported in the delivery of, services as described in the SVS Logic Model and SVS Practice Profile to ensure program fidelity. Fidelity to the program is essential to ensure the SVS model is being implemented as intended, with the goal of producing positive program outcomes. Fidelity is measured in many ways for SVS programming—through data collection and reporting to assess whether service activities are being delivered as outlined and through use of a fidelity tool (SVS Observation Fidelity Tool) to measure the quality-of-service activities being delivered to ensure best practices are being followed. More information about the SVS data collection and reporting can be found later in this Section of the manual.

SVS OBSERVATION FIDELITY TOOL

The purpose of the SVS Observation Fidelity Tool (Appendix T) is to assess the quality and consistency with which SVS staff are implementing the SVS practice model. The SVS Observation Fidelity Tool is based on the SVS Essential Functions and observable behaviors outlined and described in the SVS Practice Profile. Program Leaders should use the tool to evaluate staff competencies in the SVS Essential Functions through direct observation. The tool highlights areas for SVS Program Leaders to focus their coaching to help improve staff knowledge, skills, and competencies.

SVS Program Leaders will use the tool during observation of a therapeutic or supportive visit or Visitation Planning Meeting. Program Leaders should use the SVS Observation Fidelity Tool with each visitation specialist (Therapeutic and/or Supervised) at least once every six (6) months. Scheduling of the observation should occur with the SVS Visitation Specialist and the family prior to the visit or meeting.

As the SVS Program Leader observes the visitation specialist's therapeutic visit, supportive visit, or Visitation Planning Meeting, she or he rates each activity on the SVS Observation Fidelity Tool using the rating criteria described below. If she or he is not certain about a rating during observation, the comment section can be used to take notes and to later confirm a rating and calculate scores. It is highly recommended that SVS Program Leaders use the electronic version of the SVS Observation Fidelity Tool to input and calculate scores.

Definitions or Rating Criteria:

Skill Exceeds Basic Standards (4)

The visitation staff goes beyond the basic standard required and performs skills easily and purposefully, consistently effective and sometimes exceptional. While she/he continuously strives to improve, there are no identified needs.

Skill Demonstrated (3)

The visitation staff demonstrates skill at a level that demonstrates s/he effectively and comfortably performs skill in most cases as opportunities arise. Areas for additional growth exist but visitation staff effectively works with families.

Beginning Evidence of Skill Demonstration (2)

The visitation staff demonstrates various behaviors related to the performance of the skill but needs additional opportunities to practice. He/she appears to understand the skill conceptually and offers beginning evidence in demonstrating it when opportunities arise. S/he is using primarily one (1) or two (2) techniques in an effort to demonstrate the skill and may not be able to use techniques in a consistent and purposeful manner.

More Development Needed to Demonstrate the Skill (1)

The visitation staff needs more knowledge and practice to demonstrate this skill. S/he may or may not have a conceptual understanding of the skill or recognize in hindsight how the skill might have been used in a specific practice situation.

N/A (N/A)

This rating is used when there are no opportunities to observe this behavior during the visit activity. For instance, if no emergent questions were brought up during a visit, the observer would select "N/A" for "Visitation specialist answers any emergent questions" in the Engaging section.

CLINICAL OVERSIGHT

SVS programs include therapeutic interventions and, therefore, must include clinical oversight and support. Clinical supervision in SVS programs must be provided by a fully licensed clinician, such as an LCSW or an LPC with proper education, training, and experience. Clinical supervision must be provided individually. In addition to individual supervision, group clinical supervision sessions can be utilized to enhance supervisory practice. Individual clinical supervision should be frequent and regular, and must occur at least weekly. Group clinical supervision may be provided through team meetings on regular or as-needed frequencies. During both individual and group clinical supervision sessions, cases are presented, reviewed, and reflected upon to ensure clinical interventions, and strategies are targeted to the family's needs, clinical best practices are adhered to, and families receive high-quality interventions.

SVS COACHING

In addition to training and supervision, SVS staff will receive regular and consistent coaching by SVS Program Leaders (and/or supervisors) as part of the SVS Program Model. Coaching is non-clinical, individualized, and aimed at developing awareness and at improving staff's knowledge, skills, and competencies in the SVS Practice Model. Coaching includes active listening, questioning, modeling, reflection, and feedback.

SVS Program Leaders (and/or supervisors) and visitation staff should work together to be prepared for pre-planned coaching sessions. During coaching sessions, SVS Program Leaders support staff to identify practice performance goals (using results of the SVS Observation Fidelity Tool and/or other practice assessment) and use collaborative coaching plans and tools to guide the process of facilitating and assessing the progress of practice development. SVS staff are also encouraged to identify practice performance goals and bring them to coaching sessions. The Child Welfare Skills-Based Coaching Model should be used during coaching sessions. SVS Program Leaders are introduced to the structure and tools for integrating coaching into their practice through the SVS Coaching for Program Leaders Training and the Guide to Coaching Practices.

SVS TRANSPORTATION

Transportation is an essential component of a visitation program. The SVS providers are responsible for ensuring children are transported to and from the visitation site. Transportation may be provided by any SVS staff (SVS Program Leader, Therapeutic Visitation Specialist, Supportive Visitation Specialist and/or driver), resource parents, parents, family members, DCP&P staff, etc. Transportation for the caregiver(s) may be provided and/or arranged by the SVS provider, as determined to be necessary, on a case-by-case basis by DCP&P. SVS providers shall not limit transportation to only in-county travel but should instead set reasonable limitations on transportation from DCP&P local offices.

SVS staff transporting children and/or caregivers must be licensed and insured to operate a vehicle in the State of New Jersey and abide by all highway and traffic safety regulations. The SVS provider is expected to maintain accurate and current records including drivers' information and vehicle fleet information (i.e., copies of driver's licenses; driver's abstract; vehicle insurance and inspection records). Vehicles should be equipped with proper car seats and other safety equipment as required by law.

SVS DOCUMENTATION

SVS providers are expected to provide consistent and accurate documentation of observations from each visit in the NJ DCF provider extension of NJSPIRIT, NJ DCF's Comprehensive Child Welfare Information System, within reasonable time frames, not to exceed five (5) business days. Training on the system can be provided to SVS providers by NJ DCF upon request. SVS providers are expected to minimally report the following: when and where the visit occurred, who attended the visit, and a description of relevant observations from the visit. The SVS provider is expected to notify DCP&P staff by phone in a timely manner when any significant events occur, or important information is learned by staff during visits. SVS providers are also responsible for providing DCP&P with written collateral reports for court every three (3) months or at the request of the DCP&P Caseworker.

Written collateral reports include a summary of all supervised contact with the family during that period. Reports include attendance (cancellations, re-scheduled appointments, failure to confirm or attend), tone and content of visits and interactions between parents and children, strengths and deficits evidenced during visits, and progress toward the family's visitation goals. There may also be a section for recommendations, if warranted.

CANCELLATION AND RESCHEDULING OF VISITS

SVS providers must have a clear policy regarding the cancellation and rescheduling of visits, including what each visit participant (parent, DCP&P, resource parent, provider agency) shall be expected to do in order to change or cancel a visit. The reason for cancellation must be documented and available for review. If a cancellation occurs, the service provider must establish a system to contact the DCP&P local offices in a timely manner in order to fill the vacancy, when possible. SVS providers must contact all visitation participants (parent, resource parent/child, etc.) in advance of the visit to confirm attendance. SVS providers must employ methods or strategies to engage parents and reduce cancellation and no-show rates.

TEMPORARY SUSPENSION OF VISITS

There are circumstances when visits may be placed on hold. A parent experiencing untreated, significant mental health and/or substance use/dependence issues may require inpatient treatment and temporarily be unavailable for visits until stabilized. During that time, SVS staff stay in contact with the treatment provider to determine when the parent is able to safely re-engage with SVS services.

VISIT SAFETY AND SECURITY

Safety of visitation participants is paramount. SVS providers must have clear procedures and protocols to ensure the safety of all visit participants, especially in very high-risk cases.

Procedures shall include safe exchanges and security during visits, if appropriate. Ground rules should be enforced, and intervention may be necessary to protect against physical and/or emotional harm. Visitation and waiting areas should be child-proofed and free of potential safety hazards.

SYSTEMS COLLABORATION AND NETWORKING

SYSTEMS COLLABORATION

Collaboration with other systems in the community is necessary to create a seamless and comprehensive system of care and support for individuals and families served by SVS.

Collaboration involves smooth and responsive referral efforts, ongoing telephone and electronic communication between programs, and face-to-face partnership in settings such as Family Team Meetings and Visitation Planning Meetings. Consent forms are necessary to permit family-specific written, verbal, and electronic communication between agencies within the system of support.

NETWORKING

SVS programs build and maintain connections with DCP&P and a network of community-based programs to create a system of support for families. Partnerships with other agencies and services help to ensure that the diverse needs of children and families are met and that culturally appropriate resources are accessible to the families being served. These collaborations are necessary to make sure that families' basic needs, as well as underlying needs, are addressed.

SVS programs should participate in events held by community-based providers, such as networking meetings and resource fairs to help educate the community about services provided by SVS programs.

Networking between SVS programs is an important activity that promotes sharing best practices, brainstorming solutions to common issues, and assisting one another in maintaining program model fidelity.

SVS DATA COLLECTION, REPORTING, AND CONTINUOUS QUALITY IMPROVEMENT

SVS providers are expected to participate in data collection, reporting, and continuous quality improvement processes to ensure high-quality service delivery and improved outcomes for families.

SVS EVALUATION

NJ DCF's Evaluation Plan for SVS is aimed at:

1. **Gaining insight:** the evaluation of the Supportive Visitation Services (SVS) program identifies the activities and elements of the model that define best practice in supportive visitation.
2. **Improving practice:** evaluation findings illuminate challenges and strengths of the model, will allow the model implementers to make mid course adjustments to improve practice, and provide data for continuous quality improvement and staff training.
3. **Assessing effects:** the evaluation assesses the extent to which intervention activities were implemented as planned and document the level of success in accomplishing program objectives.

SVS Evaluation Questions

The SVS Evaluation seeks to answer the following questions about the SVS model:

1. What are the characteristics of families enrolled in the Supportive Visitation Services program?
2. Was the SVS program implemented as intended?
    a. What was the process of identification and referral of families to the SVS program?
    b. Were all assessments and visitation plans completed within the expected time frames?
    c. Were visitation approaches implemented in alignment with the family's visitation plan?
    d. To what extent did providers implement pre- and post-visit meetings?
    e. Were visitation plans reviewed with the family to determine any changes in visitation level?
    f. Did reunified families receive aftercare services consistent with their transition needs?
    g. To what extent did families' level of supervision change along the continuum (therapeutic supervised, supportive supervised, relative/community partner supervised, unsupervised) over time?
3. What were the barriers and facilitators to the program achieving its objectives?
    a. What strategies were used to engage and involve families throughout the process?
    b. What strengths and challenges were experienced in the visit?
    c. How were systems collaborations formed and maintained in SVS?

4. To what extent did the program influence safety, permanency, and wellbeing for children and families?
    a. To what extent did parents' parenting knowledge and skills increase during their involvement in SVS?
    b. To what extent did parent-child attachment increase during families' involvement in SVS?
    c. To what extent did SVS improve families' child welfare outcomes?

5. What is the reach of the SVS program?
    a. What proportion of children participating in visitation in NJ do so through SVS programs?
    b. What are the differences between children who participate in an SVS program and those who do not?

Evaluation Stakeholders

The SVS program draws together a number of stakeholders who are teaming at different levels. Table 2 below summarizes the various stakeholders in the SVS program and their interests and role in the evaluation.

Table 2. Stakeholders' Interest and Involvement in the SVS Evaluation

Stakeholder	Interest or Perspective	Role in the Evaluation
NJ DCF Administration	Funds project	Receives results; makes program and policy decisions based on finding
DCP&P (Division of Child Protection & Permanency)	Referral partner; teaming	Receives results
SVS Providers	Service provider; model implementation	Collects and reports data on families; receives results; collaborates on interpreting findings; makes programmatic decisions based on finding
OSD (Office of Strategic Development)	Program management	Interprets findings; reviews evaluation reports and other inputs; makes programmatic decisions based on finding
ORER (Office of Research and Evaluation)	Oversees evaluation	Conducts evaluation; analyzes data; interprets and disseminates finding
SVS families	Program participants	Provides data; benefits from evidence-based program improvements; collaborates on interpreting findings

To answer the SVS evaluation questions, a variety of different data sources are used. These include DCF's administrative data and contact sheets, providers' service data collected through electronic health records, providers' rosters and progress notes, a caregiver survey to assess changes in protective factors and parenting skills over time, and a satisfaction survey with participating families.

DATA REPORTING

NJ DCF receives SVS data through various means including but not limited to:

- SVS Monthly Provider Data Reports (Appendix U)
- SVS Caregiver Survey (Appendix G)
- SVS Family Satisfaction Survey (Appendix V)

SVS evaluation data is collected on an ongoing basis with reporting occurring at multiple time points throughout each year. Table 3 describes the intervals for data collection and reporting associated with each type data.

Table 3. Collection and Reporting Schedule for SVS Data

Data	Responsible for Data Submission	Data Submission Frequency	Data Collection Method	DCF Data Synthesis and Reporting Frequency
Services Data • Visitations • Debriefs • Aftercare • New intakes • Discharges • Referrals	Provider	Monthly	Provider Report	Quarterly
SVS Caregiver Survey	Caregivers/ Provider	Intake, every three (3) months while enrolled in SVS, and Discharge	Survey	Biannually
Visit-Level Data • Visit locations • Visit participants	Provider	Ongoing	NJSPIRIT	Quarterly
Family/Child-level Data • Child welfare outcomes • Risk and demographic factors	DCP&P	Ongoing	NJSPIRIT	Annually
SVS Family Satisfaction Survey	Caregivers/ Providers	Biannually	Survey	Biannually

SVS Monthly Provider Data Reports

SVS providers are expected to share data monthly with NJ DCF for evaluation and continuous quality improvement (CQI) purposes. Monthly provider data reporting requirements and instructions can be found in Appendix U. NJ DCF analyzes this provider data and generates and shares monthly dashboards and quarterly reports with SVS implementing agencies for review, tracking, and reflection. Providers are expected to participate in quarterly CQI calls with NJ DCF program leads, NJ DCF contract administrators, and DCP&P area and local staff. During these calls, successes and areas where performance is below targets or outside typical ranges are identified and steps to improve performance are developed and implemented.

SVS Caregiver Survey

The SVS Caregiver Survey is a self-assessment questionnaire that incorporates the Protective Factors Survey (PFS-2) to assess protective factors, particularly nurturing and attachment, family functioning/resilience, and social supports; and the Parenting Skills Ladder to assess parenting knowledge and practices (Pratt et al., 2014). Additional information about the Protective Factors Survey (PFS-2), a product of the FRIENDS National Center in collaboration with the University of Kansas Center for Public Partnerships and Research, can be found at https://friendsnrc.org/evaluation/protective-factors-survey/.

Every caregiver who participates in SVS programming should complete an SVS Caregiver Survey (Appendix G) at enrollment, every three (3) months while in the program, and at discharge. SVS staff should utilize the initial intake assessment and visitation planning meetings to administer the survey. During the intake or Visitation Planning Meetings, SVS staff should give an internet-connected device to the caregiver to complete the survey. The survey is confidential, and responses come directly to NJ DCF. SVS staff should be available if the caregiver has questions or needs assistance to complete the survey. The survey is available in English and Spanish through SurveyMonkey. It takes about 10–15 minutes to complete.

SVS Family Satisfaction Survey

The SVS Family Satisfaction Survey (Appendix V) is a short, anonymous survey administered electronically to all active SVS participants twice per year. Modeled after the short form Client Satisfaction Inventory, the SVS Family Satisfaction Survey collects data on participants' experiences with the SVS program (McMurtry & Hudson, 2000). SVS Implementing Provider Agencies engage program participants to ensure survey completion by emailing them the link to the survey and also allowing participants to complete the survey using provided technology during program contacts (visits, visitation planning meetings, debriefs, etc.) in the identified reporting period. The survey is confidential, and responses are submitted directly to NJ DCF.

SVS Billing

Supportive Visitation Services is a fee-for-service program. Therefore, the assigned DCP&P caseworker is required to submit a Special Authorization Request (SAR) to authorize payments. A SAR must be signed by the DCP&P Supervisor and Casework Supervisor. Only one SAR is required for the family[4] and should be completed as follows by DCP&P:

- Use the youngest child, who is visiting, as the reference person.
- Estimate a minimum of 20 units per month/family for six (6) months. If circumstances are unique and more than typical visitation hours (2 hours/week) are being requested, DCP&P should contract the SVS program leader for a better estimation.
- Use the correct NJSPIRIT resource identification number for the contracted SVS provider.
- Use the correct NJSPIRIT service support line for Supervised and/or Therapeutic Visitation.

To ensure a seamless continuation of services, a SAR must be renewed at least every six (6) months. SVS providers will notify the family's DCP&P caseworker when a SAR is expiring or if monthly units will be exceeded. An active SAR needs to be in place for services to be provided.

SVS providers **may bill** for in-person SVS activities including initial intake assessments, supportive visits, pre-visit prep meetings and post-visit debriefs, visitation planning meetings, and aftercare services. SVS providers **may not** bill for transportation to and from visits, for documentation or communication, or for missed/cancelled visits (see "Additional Billing and Guidance" below). In this case, the SVS provider will be expected to provide support to the child to process his or her feelings from the missed visit. The SVS provider will determine the appropriate visit length depending on this process, which is variable. If multiple children are present and a parent does not show for a visit, the visit can continue to allow the children to maintain sibling connections.

The SVS rate is inclusive of direct and indirect costs that are required to deliver supportive visitation services and is based on an analysis of existing NJ DCF contracts for supervised and therapeutic visitation along with other data (salary metrics). It is NJ DCF's expectation that the awardee has capacity to deliver a continuum of services. NJ DCF anticipates that not all families will need to use all services. For example, some families may not require transportation for every visit, and not every visit for every family will require hands-on work with a therapist. SVS agencies can bill in 30-minute increments.

Continuation of DCF's funding for SVS programming is contingent upon the availability of funds in future fiscal years and agencies' contract compliance. Billing questions should be directed to the DCP&P Local Office billing clerk.

ADDITIONAL BILLING AND GUIDANCE

SVS providers may also bill for the following special circumstances:

No-Show Visits

The Parent/Caregiver—does not show up for a scheduled visit and did not cancel it prior to the child(ren) being transported to the visit location.

[4] If children are visiting with both their mother and father and they have different fathers, the DCP&P caseworker may need to complete multiple SARs for visitation services depending on the family's circumstances.

Without Siblings—SVS visitation specialists are encouraged to use time from the scheduled visitation to process the parent's absence with the child. The program can bill up to the nearest ½ hour, not to exceed one (1) hour, for time spent with the child processing. If the program spends 1–30 minutes with the child, it can bill for ½ an hour; if it spends 31 minutes or one (1) more with the child, it is capped at one (1) hour. It is billed at the standard SVS rate of $146.10/hour.

With Siblings—SVS visitation specialists are encouraged to use the scheduled visitation time to process with the children and for the siblings to visit. The program is able to bill for total time the siblings visited, inclusive of any time spent addressing the children's feelings in light of the parents' failure to appear. It is billed at the standard SVS rate of $146.10/hour. The SVS visitation specialist is required to separately document on the NJS contact note the amount of time spent processing the parents' failure to show up for the visit and the amount of time the children got to spend visiting one another.

With Family/Friends—SVS visitation specialists are encouraged to use the scheduled visitation time to process with the children and for the children and relatives, family friends, etc., to visit. The program is able to bill for the total time everyone visited, inclusive of any time spent addressing the children's feelings in light of the parents' missing the visit. It is billed at the standard SVS rate of $146.10/hour. The SVS Visitation Specialist is required to document on the NJSPIRIT contact note the amount of time spent processing the parents' failure to show up with the children and the amount of time the children got to spend visiting one another and their family, family friends, etc.

Request for Multiple Visitation Specialists—With approval from DCP&P, multiple SVS Visitation Specialists may be needed to participate in visits due to case circumstances (i.e., close supervision of parent or children is required, or family includes a large sibling group). The program can bill for each SVS Visitation Specialist's in-person visitation time. SVS Visitation Specialists should only enter one visitation contact note into NJSPIRIT. In circumstances where multiple SVS Visitation Specialists are involved with the family(ies), the program can only bill for one visitation planning meeting.

Request for Court Testimony—SVS Visitation Specialists, depending on case circumstances, may be required to testify in court. If Visitation Specialists are requested to testify by DCP&P, the program can bill at the rate of $146.10/hour for time spent prior to the hearing for participation in required meetings with the DAG and for time spent on the day of the hearing traveling to and from the courthouse and waiting and testifying in court.

SVS provider may reach out to their NJ DCF Program Lead for additional billing questions.

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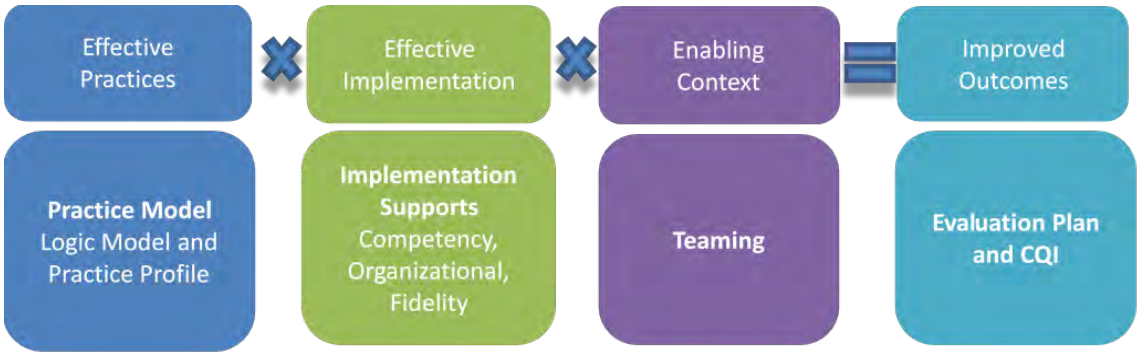
APPENDICES

Appendix A: SVS and the Active Implementation Framework

The National Implementation Research Network (NIRN)[1] summarized implementation science through the following formula which has now been adopted by the Department as its organizing framework for managing the complexities of implementing programming for children and families:

This formula demonstrates that improved outcomes for children and families can be achieved when effective practice, effective implementation supports, and an enabling context all coexist. These elements have a synergistic effect. Desired outcomes are only achieved through the interaction of all three factors.

NJ DCF systematically utilizes the Active Implementation Framework and accompanying tools to help organize and strengthen programming with families. The visual of NIRN's Active Implementation Formula[1]1 below illustrates the specific components that are needed to factor into this equation. Programming, whether new or existing, is assessed for the presence or absence of each factor component. When absent, that component is co-created through a teaming structure that includes stakeholders with the necessary expertise for that component.



Below is a description of each of the components of the Active Implementation formula:

Practice Model Logic Model and Practice Profile	For an intervention or practice to be effective, it must be well-defined by a logic model and practice profile. A logic model is a roadmap that describes what results one hopes to achieve by doing specified activities. A practice profile is a tool for operationalizing

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

	an intervention so that staff, supervisors, and directors in implementing agencies have a clear understanding of what they are expected to do when implementing the practice. A practice profile includes guiding principles and essential functions. Guiding principles are the philosophies, values and beliefs that inform specific interventions. Essential functions describe the practice elements and promote consistency across staff and providers[2]
Implementation Supports Competency, Organizational, Fidelity	To ensure that staff are prepared to implement the practice well, staff selection criteria (job descriptions and interview protocol), skill-based training, and follow up coaching to reinforce the training must be in place. In addition, organizational supports such as clear administrative processes, data collection/data systems to support decision-making, and processes for systems coordination are needed so that the context in which the program is being implemented can be established, and to ensure that the factors connected to the implementation are hospitable for the intervention to succeed.[3] [4]
Teaming	Multi-level teaming structures move programs, practices, and strategies from an idea to full implementation and ensure consistent internal and external communication within teams and between teams. Teams meet regularly, have dedicated appointments, and work in a structured way with agendas, meeting notes, following up on action items, timelines, work plans and project management.[5]
Evaluation Plan and CQI	Data is used to support program implementation, ensure intervention fidelity, and assess child & family outcomes. Continuous Quality Improvement (CQI) involves developing a process for identifying, collecting, and analyzing data that are useful to make decisions on improvement. This should be an ongoing process[6].

[2] Metz, A. (2016). *Practice Profiles: A Process for Capturing Evidence and Operationalizing Interventions.* Chapel Hill, NC: National Implementation Research Network, University of North Carolina. Available online at https://nirn.fpg.unc.edu/sites/nirn.fpg.unc.edu/files/resources/NIRN-Metz-WhitePaper-PracticeProfiles.pdf.

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[4] Metz, A., & Bartley, L. (2012). Active implementation frameworks for program success: How to use implementation science to improve outcomes for children. *Zero to Three Journal*, 32(4), 11-18.

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

A teaming structure was put into place to support the two-phase SVS model development approach.

In Phase 1, implementation teams focused on launching pilot programs and attending to operational challenges at the local and systems level; defining the model by creating the SVS Logic Model and Practice Profile; and setting up a data reporting structure to inform evaluation and CQI processes.

The SVS practice model has been developed by NJ DCF, in collaboration with staff from SVS implementing agencies, to provide best practices in visitation services for children and families in New Jersey. The SVS Practice Profile was vetted and tested with SVS visitation staff and families through multiple usability testing cycles to confirm alignment of the profile with current practice and understand feasibility of implementation. Testing consisted of observations, interviews and responses to follow-up forms.

In Phase 2, implementation teams focused on implementation supports by creating job descriptions and interview protocols, developing training and coaching and this program manual which includes standardized program forms and a fidelity tool. Team members include staff from SVS implementing agencies and NJ DCF (DCP&P area and local offices, Business Office/Contracting, Office of Strategic Development and Office of Research, Evaluation and Reporting).

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

Appendix B: NJ DCF SVS Logic Model

NJ DCF Supportive Visitation Services Logic Model

Vision: Each child placed by the Division of Child Protection and Permanency (DCP&P) in out-of-home placement shall have the opportunity to visit with parents, siblings and interested relatives to maintain and strengthen familial interactions and work toward permanency.

Name of Initiative: **Supportive Visitation Services (SVS)**

Target Population: DCP&P-involved families with children in out-of-home placement who require visitation supervision due to visitation safety and/or risk factors.

RESOURCES	ACTIVITIES	SHORT TERM OUTCOMES	LONG TERM OUTCOMES
Staffing: Program Leader, Therapeutic Visitation Specialist, Supportive Visitation Specialist, Driver **Visit Location:** Home-like/family friendly environments: Parent home, Family or friends' home, Resource home, In-Community settings, or Agency **Collaborations:** Family, DCP&P, and Other partners	**Assessment and Planning:** <u>Referral:</u> Receive referrals from DCP&P. Contact DCP&P caseworker within 24 hours of receiving referral to review and obtain additional information. Contact family within 48 hours of receiving referral to schedule an initial intake assessment. <u>Initial Intake Assessment</u> – Complete a biopsychosocial assessment with parent and child, as appropriate, and SVS Caregiver Survey by a master's level visitation specialist. In-person, intake assessment to be scheduled within one week of receiving referral or at the family's first availability. <u>Pre-Visitation Plan Visits</u> – Conduct visits as soon as possible and prior to the development of the family's SVS Visitation Plan which occurs during a Visitation Planning Meeting. These initial visits should occur in the least restrictive setting that ensures safety of all participants. These visits can be determined based on existing visitation plans, if applicable, or court orders in consultation with DCP&P. These visits are part of the assessment process and observations from these visits are used to inform the family's visitation plan. <u>Visitation Planning Meeting</u> – Facilitate meetings within one month after initial intake assessment and every 3 months thereafter. Meetings to include discussion of the family's visitation strengths and challenges, DCP&P case plan or service updates and family and natural supports. The SVS Visitation Plan is to be developed utilizing assessment, observation and collaboration with input from the family, DCP&P and other partners as indicated. Plans to include Impact of Separation; Visitation Goals; Visitation Supervision Level; Visitation Location; Visitation Frequency and Duration; Visitation Participants; and Visitation Activities and What to Bring. Reassess the family at regular scheduled intervals (at least every 3 months) through a visitation planning meeting with family, DCP&P and other partners as indicated. Determine if current visitation goals have been met and/or whether families would benefit from a different level of intervention/supervision. Update visitation plan as needed and administer the SVS Caregiver Survey. **Supportive Visitation Services:** Provide a continuum of visitation services to meet the unique needs of each family. Each visit to include a pre-visit meeting to discuss visitation goals and focus of visit and a post-visit debrief to process visit and plan for the next visit. Continuum of	Increased parenting knowledge and practices Increased nurturing and attachment Increased family functioning/ resilience Increased social supports	Safety Well-being Permanency Shorter lengths of stay in out-of-home placement Increased reunification Decreased maltreatment post-reunification Decreased re-entry into out-of-home placement

Database: NJ SPIRIT and Agency data system **Assessment and Evaluation:** Assessment and Evaluation Tools including Caregiver Survey and Continuous Quality Improvement Practices	supportive visitation services may include Therapeutic Supervised Visits; Supportive Supervised Visits; Relative/Community Partner Supervised Visits; and Unsupervised Monitoring. **Post-Reunification Services (Aftercare):** Provide supports to the family for up to six months post reunification. Interventions are based on family's need. **Systems Collaboration and Coordination:** DCP&P – Engage in regular phone and in-person contact, participate in FTMs, provide written collaterals which includes progress notes and/or court reports, and document visits into NJS within 5 business days of each visit. Transportation – Coordinates and/or transports children to and from visits. Transportation may also be provided to parents, if needed. Transportation may also be provided by resource parents, DCP&P staff, etc. **Coaching and Supervision:** Support the quality execution of the supportive visitation services model through staff coaching and supervision. Individual and/or group clinical supervision to be provided by licensed staff clinician through weekly meetings. **Data Collection and Reporting:** SVS Caregiver Survey – Administer electronic SVS Caregiver Survey at Initial Intake Assessment (baseline/within 30 days of enrollment), at every Visitation Planning Meeting (every 3-month interval that the caregiver is enrolled in SVS) and within two weeks of discharge. Monthly Service and Aggregate Reports – Submit monthly services and aggregate reports by the 1st Friday of each month. Monthly Service Report includes service, intake and discharge data.		
Assumption: Research indicates parent-child visitation leads to: • Increased likelihood for reunification. Children were almost ten times more likely to reunify with regular visits, as recommended by the court.[7] • Shorter lengths of stay in out-of-home placement. Children who do not visit with their family spend almost three times as much time in out-of-home placement.[8] • Decreased likelihood that the child will re-enter care.[9] • More secure attachments and better adjustment, exhibiting fewer behavioral problems.[10]			

[7] Davis, I., Landsverk, J., Newton, R. and Ganger, W. (1996). Parental visiting and foster care reunification. *Children and Youth Services Review, 18 (4/5),* 363-382.
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Appendix C: SVS Practice Profile

NEW JERSEY DEPARTMENT OF CHILDREN AND FAMILIES

Supportive Visitation Services (SVS)
Practice Profile

Guiding Principles	
Philosophies, values, or beliefs that programs have when working with families.	
Collaborative	Services are provided in partnership with families and communities.
Supportive	Services are strength-based, trauma-informed, family-centered, and collaborative.
Flexible	Services are based on evolving family needs and are enhanced or refined as needed.
Family-Driven	Services are based on family goals and schedules, underlying needs and child development considerations.
Community-Based, Least Restrictive	Services are provided in the least restrictive, safe setting, preferably the family's home or in the community.
Promotes Well-Being	Services mitigate safety concerns, enhance family relationships, communication, and bonding by utilizing trauma-informed practices for parents, caregivers and children.
Trauma-Informed	Services address underlying trauma utilizing trauma-informed care.

Essential Function		
Engaging *Establishing and maintaining relationships with family by building rapport through open communication, staff consistency, and involving family, DCP&P, resource parents, service providers and additional family members in all aspects of the visitation process*		
Expected	**Developmental**	**Unsatisfactory**
includes activities that exemplify practitioners who are able to generalize required skills and abilities to wide range of settings and contexts	*includes activities that exemplify practitioners who are able to implement required skills and abilities, but in a more limited range of contexts and settings*	*includes activities that exemplify practitioners who are not yet able to implement required skills or abilities in any context.*
• **Initiates and maintains ongoing phone and in-person contact with family.** o Introduces self and program, discusses referral source and answers any emergent questions, preferably in a phone call. o Schedules appointments at time and place that is convenient for the family and confirms visits. o Communicates in an open, honest, respectful and culturally sensitive manner which may include: • Using a language that parents understand; communicating with the family using positive, everyday language; [7] • Recognizing the parent as a partner in the process; and [7] • Being respectful of the family's faith, culture and existing family rituals. [15] o Discusses roles and responsibilities which may include: • Clearly explaining expectations, policies and procedures of the program; [6,7] • Clarifying time frames for working with the family [4,5,7] • Informing the family of their rights and responsibilities. [7] o Always engages in a transition process when staff changes. Process should include internal case conferencing and discussion of transfer details with family, DCP&P and relevant stakeholders.	• **Contacts family on a limited or sporadic basis.** o Provides a limited description of program and/or does not fully discuss referral source or answer any emergent questions. o Schedules appointments at a time and place that is convenient for the family but does not consistently confirm visits. o Sometimes communicates in a manner that is not open, honest, respectful and/or culturally sensitive. o Provides a limited explanation of roles and responsibilities, program expectations, policies and procedures. o Typically engages in transition process when staff changes but seldomly conferences cases internally or discusses transfer with family, DCP&P and relevant stakeholders.	• **Rarely maintains regular contact with family.** o Does not introduce program, discuss referral source and/or answer any emergent questions prior to intake assessment. o Schedules appointments at a time and place that is not convenient for the family. Does not confirm visits in advance. o Does not communicate in a manner that is open, honest, respectful and/or culturally sensitive. o Does not discuss or clearly explain roles and responsibilities, program expectations, policies and procedures. o Rarely engages in transition process when staff changes and does not conference cases internally or fails to discuss transfer details with family, DCP&P and relevant stakeholders.
• **Schedules and conducts visits in the least restrictive setting while ensuring the safety of the child(ren).** o Understands visitation is a parental right and does not use visitation as a reward or punishment to the family if they miss or cancel a visit or visits. [3,12] o Ensures that visits are only used for family time/supporting the parent-child relationship. [3] o Ensures visits occur in a home-like, welcoming location. Visits at the family's home are preferred, if safe/suitable. The visit setting should be one in which families typically interact. • The order of priority for visits to occur as follows: Family Home, Relative Home, Resource Home, Community Location, Provider/Partner Agency, or DCP&P. o Discusses with the family all options for visit locations during intake and collaborates with DCP&P and family to finalize visit location based on assessment and/or visitation-level criteria. o Ensures that visitation location/setting is always tied to visit plan goals (parenting skills related to removal reason and child's safety). [4,9,12,15,16]	• **Schedules and conducts visits in settings that may not be least restrictive.** o Sometimes uses visitation as a reward or punishment to the family if visits are missed or canceled. o Sometimes uses time during visits for activities unrelated to family time/supporting the parent-child relationship. o Inconsistently ensures visits occur in a home-like, welcoming location. Misses opportunities to hold visits in the family's home when it is safe/suitable. Visit settings are not always one in which families typically interact. o May not discuss all visit location options with the family and does not routinely collaborate with DCP&P and family to finalize visit location based on assessment and/or visitation-level criteria. o Inconsistently ties visit plan goals to visitation location/setting.	• **Seldomly or never conducts visits in the least-restrictive setting.** o Uses visitation as a reward or punishment to the family if visits are missed or canceled. o Does not ensure visits are only used for family time/supporting the parent-child relationship. o Does not ensure visits occur in a home-like, welcoming location. Does not conduct visits in the family's home when it is safe/suitable. Visits occur in a setting where families may not typically interact. o Does not discuss all options for visit locations with the family or collaborate with DCP&P and family to finalize visit location. o Does not tie visit plan goals with visitation location/setting.

Essential Function		
Engaging *Establishing and maintaining relationships with family by building rapport through open communication, staff consistency, and involving family, DCP&P, resource parents, service providers and additional family members in all aspects of the visitation process*		
Expected	**Developmental**	**Unsatisfactory**
includes activities that exemplify practitioners who are able to generalize required skills and abilities to wide range of settings and contexts	*includes activities that exemplify practitioners who are able to implement required skills and abilities, but in a more limited range of contexts and settings*	*includes activities that exemplify practitioners who are not yet able to implement required skills or abilities in any context.*
• **Ensures the environment for parent-child contact is safe, non-traumatizing, and promotes healthy attachment.** [16] o Observes visitation location for safety and risk factors. [4,7,15] o Intervenes to establish or ensure safety as needed.	o Inconsistently ensures the environment for parent-child contact is safe, non-traumatizing, and promotes healthy attachment. o Infrequently observes visitation location for safety and risk factors. o Misses opportunities to intervene and ensure safety.	o Does not ensure the environment for parent-child contact is safe, non-traumatizing, and promotes healthy attachment.
• **Always involves family in the process.** o Uses strengths-based, solutions-focused, family centered, trauma informed strategies to elicit family input. [2,6,7,11,13,15] o Incorporates family's ideas into planning processes and visitation services. Examples include: visit locations, frequency and duration of visits, participants, and activities. [2,7,15] o Creates opportunities for families to discuss feelings and reactions about removal, changes in visitation level and DCP&P case goal.	• **Sometimes involves family in the process.** o Sometimes uses strengths-based, solutions-focused, family-centered, or trauma-informed strategies to elicit family input. o Inconsistently incorporates family's ideas into planning processes and visitation services. o Infrequently creates or misses opportunities for families to discuss feelings and reactions about removal, changes in visitation level and DCP&P case goal.	• **Infrequently or never involves family in the process.** o Rarely or never elicits family input. o Does not incorporate family's ideas into planning processes and visitation services. o Does not create opportunities for families to discuss feelings and reactions about removal, changes in visitation level and DCP&P case goal.
• **Initiates and maintains ongoing phone and in-person contact with DCP&P and other stakeholders, as appropriate.** o Introduces self and program to DCP&P staff and stakeholders including resource parents, service providers, court/legal personnel and any additional family members, etc. and answers any emergent questions, preferably in a phone call o Actively seeks opportunities to engage in regular communication with DCP&P and other stakeholders by phone, in person and/or written collateral contacts. o Invites DCP&P staff and stakeholders, with family's consent, to participate in SVS provider-facilitated Visitation Planning Meetings at least quarterly and discusses their role and input in supporting the family. [2,6,7,15] o Educates stakeholders about the importance of visitation and family time. [3]	• **Inconsistently initiates and maintains phone and in-person contact with DCP&P and relevant stakeholders.** o Provides a superficial description of program and/or does not fully answer any emergent questions. o Misses opportunities to engage in communication with DCP&P and other stakeholders. o Inconsistently invites DCP&P staff and relevant stakeholders to SVS provider-facilitated Visitation Planning Meetings. Does not always clarify their role and input in supporting the family. o Misses opportunities to educate stakeholders about the importance of visitation.	o **Does not routinely initiate and maintain ongoing phone and in-person contact with DCP&P and relevant stakeholders.** o Does not introduce program to DCP&P staff and relevant stakeholders and/or is not responsive to emergent questions. o Does not actively seek opportunities to communicate with service partners. o Does not invite DCP&P staff and relevant stakeholders to SVS provider-facilitated Visitation Planning Meetings. Does not clarify their role and input in supporting the family. o Does not educate stakeholder about the importance of visitation.

Essential Function		
Assessing *Using a process to collect information and use it to address immediate and underlying issues families may be experiencing*		
Expected	**Developmental**	**Unsatisfactory**
includes activities that exemplify practitioners who are able to generalize required skills and abilities to wide range of settings and contexts	*includes activities that exemplify practitioners who are able to implement required skills and abilities, but in a more limited range of contexts and settings*	*includes activities that exemplify practitioners who are not yet able to implement required skills or abilities in any context.*
• **Uses a process to gather information.** o Asks questions by phone and/or during in person meetings with family, DCP&P workers and other collateral providers. Inquires about family history, goals, and ongoing and evolving needs to collect and confirm information. o Reviews DCP&P referral form and contacts DCP&P worker for family and case specific information o Gathers information from relevant sources. This may include information from: case records, the child's school reports, substance use evaluations, medical reports, mental health assessments, and any other relevant information to inform the assessment of the family. [6,7] o Inquires about the family's natural supports. Examples include maternal and paternal relatives, close friends, and community resources and supports. [3,7,10,13] o Observes family's interactions in initial pre-visitation plan visits and ongoing visits.	• **Gathers information on some but not all families served.** o Gathers basic, but not comprehensive, data on families from a limited number of data sources. o Gathers information which may address families' immediate but not underlying issues.	• **Does not gather information on families served.**
• **Fills out required assessment tools.** o Accurately completes or administers the following within the designated timeframes: • Bio-psychosocial assessment with parent and child; • Rose Wentz Matrix[11]; and • SVS Caregiver Survey at Initial Intake Assessment (baseline), at each Visitation Planning Meeting (every 3-month interval), and at discharge.	• **Fills out some but not all of the required assessment tools.** o Completes tools but not within the designated timeframes. o Inaccurately or only partially completes tools.	• **Does not fill out required assessment tools.**
• **Synthesizes information and completes visitation plan.** o Discusses observations and assessments with parents and elicits feedback regarding parenting styles and behaviors. o Incorporates gathered information from reviews, inquiry, observations, parent feedback and assessments in a visitation plan which includes recommendation of visitation level(s) and requirements for moving along the continuum from family's current level to less restrictive levels. [15]	• **Includes basic information about the family in the visitation plan but not include a comprehensive understanding of the families' immediate and underlying needs.** o Does not consistently discuss assessment findings with parents. o Includes recommended visitation level in the visitation plan but does not outline requirements for moving to less restrictive levels.	• **Does not include required components in the visitation plan.** o Does not discuss assessment findings with parents. o Creates a visitation plan that is not informed by data or an assessment process.
• **Updates the visitation plan at regular intervals.** o Reviews the visitation plan at least every 3 months or as necessary to determine progress, update goals, and determine if it is appropriate to consider changes in supervision level, location, and setting. [4,15]	• **Reviews and updates the visitation plan sporadically.** o Reviews of the visitation plan are not comprehensive.	• **Does not review or update the initial visitation plan.**

[11] Available information on the Rose Wentz Matrix can be found online at http://www.wentztraining.com/products/tools.

Essential Function		
Active Listening *Using communication techniques that encourage free dialogue and mutual understanding*		
Expected	**Developmental**	**Unsatisfactory**
includes activities that exemplify practitioners who are able to generalize required skills and abilities to wide range of settings and contexts	*includes activities that exemplify practitioners who are able to implement required skills and abilities, but in a more limited range of contexts and settings*	*includes activities that exemplify practitioners who are not yet able to implement required skills or abilities in any context.*
• **Creates an environment that empowers family members, including parents, child, etc., to communicate their goals and needs.** o Encourages open dialogue by inquiring about the family's goals and needs during weekly debriefings and visits and being receptive to feedback. [6,7,15] o Validates family's thoughts and feelings. [6,7,15] o Incorporates family's voice into process. o Uses a process to debrief with families (see Coaching essential function). o Preps parent(s) for visitation planning meeting and supports parent(s) in advocating for themselves during the meeting.	• **Inconsistently creates an environment that empowers family members, including parents, child, etc., to communicate their goals and needs.** o Encourages open dialogue by inquiring about the family's goals and needs during weekly debriefings and visits but may not always be receptive to feedback. o Sometimes validates family's thoughts and feelings. o Inconsistently incorporates family's voice into process. o Does not always use a process to debrief with families *(see Coaching essential function)*. o May prep parent(s) for visitation planning meeting but often advocates for the parent(s) during the meeting rather than supporting the parent(s) in self-advocacy.	• **Does not create an environment that empowers family members, including parents, child, etc., to communicate their goals and needs.** o Does not encourage open dialogue and rarely inquires about the family's goals and needs during weekly debriefings and visits and being receptive to feedback. o Does not actively validate family's thoughts and feelings. o Family's voice is mostly absent in the process. o Does not use any identifiable process to debrief with families. o Does not prep parent(s) for visitation planning meetings. o Implicitly or explicitly discourages parent(s) from advocating for themselves during the visitation planning meeting.
• **Utilizes various interviewing and/or communication techniques.** o Addresses the family in ways that are consistent with their cultural expectations. [7,15] o Presents open ended questions to encourage dialogue with a focus on potential solutions. [3,7] o Summarizes and reframes what is said to validate common understanding and encourage mutual dialogue. [1,7,15] o Recognizes non-verbal communication. o Maintains good eye contact and posture. o Takes notes, if needed, trying not to interrupt flow of conversation.	• **Utilizes a limited number of interviewing and/or communication techniques.** o Sometimes addresses the family in ways that are consistent with their cultural expectations. o Sometimes uses closed-ended questions when open-ended questions are more appropriate. o Misses opportunities for solutions-focused dialogue. o Sometimes summarizes and reframes what is said by the family. o Recognizes some, but not all, non-verbal communication. Is sometimes distracted during conversation. o Sometimes maintains good eye contact and posture. o Does not always take notes when needed. o May interrupt the flow of conversation to ask follow-up questions.	• **Rarely utilizes interviewing and/or communication techniques.** o Does not take cultural expectations into account when addressing families. May interact with families in a culturally insensitive manner. o Presents mostly closed-ended questions thus inhibiting solution-focused dialogue. o Rarely summarizes and reframes what is said by the family. o Is not attuned to non-verbal communication. o Rarely maintains good eye contact and posture; appears distracted. o Does not take notes when needed. o Often interrupts the flow of conversation.

Essential Function		
Teaming *Respectful and meaningful collaboration with families (and community partners) to achieve shared goals.*		
Expected	**Developmental**	**Unsatisfactory**
includes activities that exemplify practitioners who are able to generalize required skills and abilities to wide range of settings and contexts	*includes activities that exemplify practitioners who are able to implement required skills and abilities, but in a more limited range of contexts and settings*	*includes activities that exemplify practitioners who are not yet able to implement required skills or abilities in any context.*
• **Advocates for parents/families as necessary and supports them in advocating for themselves.** o Develops a plan with the family to identify steps they can take to meet their needs and/or steps staff can take to support the family. Follows up and revises plan as necessary. o Links the family to community resources, formal and informal supports, and coordinates with DCP&P. [7,15] o Coaches families to advocate for themselves through modeling self-advocacy, problem-solving, persistence and supports them in navigating systems effectively. [7] o Encourages and supports family to maintain supplemental contact with children outside of visits, as appropriate. Examples may include: phone calls, emails, letters, social media and attendance at events such as school conferences and medical appointments. [3,5,15,16]	• **Advocates for parents/families when needed but not does typically support them in advocating for themselves.** o May develop a plan to meet family's needs but it is not comprehensive or lacks detail regarding steps the family can take to meet their needs and/or steps staff can take to support the family. Does not regularly follow up and revise plan when needed. o Misses opportunities to link the family to community resources, formal and informal supports, and/or infrequently coordinates with DCP&P. o Seldomly coaches families to advocate for themselves. o Infrequently encourages family to maintain supplemental contact with children outside of visits, as appropriate. May provide inadequate support to facilitate supplemental contact.	• **Generally does not advocate for parents/families when needed or support them in advocating for themselves.** o Does not develop a plan with the family to identify steps they can take to meet their needs and/or steps staff can take to support the family. Fails to follow up and/or revise plan despite a need to do so. o Does not link the family to community resources, formal and informal supports, and/or coordinate with DCP&P. o Does not coach family to advocate for themselves. o Does not encourage or discourages family from maintaining supplemental contact with children outside of visits.
• **Collaborates with DCP&P and community partners.** o Shares relevant information from visits with DCP&P staff or other stakeholders as necessary. o Involves community partners in planning meetings and considers their service recommendations, as appropriate, when completing the family's visitation plan. o Defines clear roles for each member of the team including DCP&P and other collaborative staff so that all team members are working towards a common goal for the family. [7,8,12,15]	• **Usually collaborates with DCP&P and community partners.** o Inconsistently shares relevant information from visits to DCP&P staff and/or other stakeholders as necessary. o Involves minimal community partners in planning meetings and/or does not fully consider their service recommendations. o Sometimes there is confusion about team member roles.	• **Rarely collaborates with DCP&P and community partners.** o Does not share relevant information from visits. o Does not involve community partners in planning meetings and/or consider their service recommendations. o Does not define clear roles for each member of the team.
• **Facilitates and/or attends meetings.** o Conducts visitation planning meetings which include: • discussing family's progress; • updating goals; and • determining if changes in supervision level, location, and setting are appropriate. [2,10,15] o Attends and actively participates in DCP&P case conferences, Family Team Meetings (FTMs), and/or other child and family meetings as available.	• **Facilitates and/or attends some meetings.** o Conducts visitation planning meetings. However, they may be superficial and only cover some of the following topics: • discussing family's progress; • updating goals; and/or • determining if changes in supervision level, location, and setting are appropriate. o Inconsistently attends and/or does not actively participate in DCP&P case conferencing, FTMs and/or other child and family meetings.	• **Rarely facilitates and/or attends meetings.** o Does not routinely conduct visitation planning meetings. o Does not attend DCP&P case conferencing, FTMs and/or other child and family meetings.

Essential Function		
<u>Therapeutic Intervening</u> *Purposeful use of evidence based/informed techniques intended to help families identify and process emotions and apply positive coping skills.*		
Expected	**Developmental**	**Unsatisfactory**
includes activities that exemplify practitioners who are able to generalize required skills and abilities to wide range of settings and contexts	*includes activities that exemplify practitioners who are able to implement required skills and abilities, but in a more limited range of contexts and settings*	*includes activities that exemplify practitioners who are not yet able to implement required skills or abilities in any context.*
• **Promotes behavioral change through clinical interventions.** o Promotes parent-child attachment, emotional regulation and demonstration of parental competencies and uses trauma-informed therapeutic approaches to assist and support family members. o Uses clinical expertise to observe, document and evaluate parent-child interactions. [4,12] o Addresses concerns and supports family goals with a focus on decreasing family conflict, improving communication, developing the parent's ability to identify and appropriately redirect child's inappropriate behaviors and decreasing the risk of abuse or neglect within the family. o Directly intervenes with children and models parenting techniques and skills to promote healthy attachment and increased child wellbeing. [4,14] o Models for parents how to support children during transitions and assesses and normalizes child's responses to transitioning into and out of the visit. o Provides feedback and positive reinforcement on parenting skills and interactions. [1,7,15,16] o Educates parents on child development o Observes how the parent responds to and uses information provided and aligns frequency of intervening to parental needs and skills. [5,7,13,15] o Empowers and allows parents to be the lead in caring for their children with support from the Visitation Specialist, as needed.	• **Inconsistently uses clinical interventions to promote behavioral change.** o Misses opportunities to promote parent-child attachment, emotional regulation and demonstration of parental competencies and does not regularly utilize a trauma-informed therapeutic approach to assist and support family members. o Demonstrates limited use of clinical expertise when observing, documenting and evaluating parent-child interactions. o Recognizes family's concerns but does not fully support family's goals. o Misses opportunities to intervene with children and model parenting techniques and skills. o Provides little guidance to parents on how to support children during transitions and offers limited information about child's normal responses to transitioning into and out of the visit. o Provides minimal feedback, feedback that is negative and critical, or misses opportunities to provide positive reinforcement on parenting skills and interactions. o Provides limited information to parents on child development. o Observes how the parent responds to and uses information provided but ineffectively aligns frequency of intervening to parental needs and skills. o Allows parents to be the lead in caring for their children but provides minimal support and encouragement.	• **Rarely uses clinical interventions to promote behavioral change.** o Does not promote parent-child attachment, emotional regulation and demonstration of parental competencies and does not demonstrate use of a trauma-informed therapeutic approach to assist and support family members. o Lacks clinical expertise when observing, documenting and evaluating parent-child interactions. o Does not recognize or support family goals. o Does not intervene with children or model parenting techniques and skills when necessary. o Does not model for parents how to support children during transitions and does not assess or normalize child's responses to transitioning into and out of the visit. o Does not provide strengths-based feedback or positive reinforcement on parenting skills and interactions. o Does not educate parents or lacks knowledge on child development. o Does not observe how the parent responds to and uses information provided. o Does not empower parents to be the lead in caring for their children during visits.

Essential Function		
Coaching *Targeted instruction to parents about improving parenting skills, family dynamics and other identified goals that support reunification or other permanent placement discharge.*		
Expected	**Developmental**	**Unsatisfactory**
includes activities that exemplify practitioners who are able to generalize required skills and abilities to wide range of settings and contexts	*includes activities that exemplify practitioners who are able to implement required skills and abilities, but in a more limited range of contexts and settings*	*includes activities that exemplify practitioners who are not yet able to implement required skills or abilities in any context.*
• **Enhances parental skills by goal setting, modeling, mentoring, reinforcement and feedback and reflection.** o Empowers the parent(s) to be the lead in caring for their child(ren) during visits and utilize learned skills during their interactions. [2] o Helps families learn how their child's behavior is shaped by the adult's words, actions and attitudes. [2] o Encourages and supports parents to incorporate and demonstrate skills they have learned or developed to meet the unique needs of their child(ren). [2] o Observes and intervenes or redirects parent with verbal reminders to cue learned parenting skills, when direct intervention by visitation specialist is not needed. [2,7,15] o Validates parents' and/or children's progress. o Operates from a trauma-informed perspective.	• **Enhances parental skills by goal setting but does little or no modeling and mentoring to reinforce learned skills.** o Often takes the lead in visits and infrequently empowers the parent(s) to be the lead in caring for their child(ren) o Misses opportunities to remind parents of their learned skills during their interactions with their child(ren). o Does not consistently help families learn how their child's behavior is shaped by the adult's words, actions and attitudes. o Provides minimal encouragement and support to parents to incorporate and demonstrate skills they have learned or developed to meet the unique needs of their child(ren). o Uses direct interventions instead of redirecting parents with verbal reminders to cue learned parenting skills. o Occasionally provides feedback/validation of parent's and/or children's progress o Demonstrates some use of a trauma-informed perspective but does not consistently incorporate trauma-informed principles into interactions with the family.	• **Seldomly set goals, model, mentor or reinforce to enhance parental skills.** o Does not empower the parent(s) to be the lead in caring for their child(ren) during visits and does not encourage parents to utilize learned skills during their interactions. o Allows adult's words, actions and attitudes to negatively affect child behaviors. o Does not encourage and support parents to incorporate and demonstrate skills they have learned or developed to meet the unique needs of their child(ren). o Does not provide intervention or redirection to parents to cue learned parenting skills when needed or does so when unnecessary. o Focuses on parents' and/or children's setbacks and issues rather than validating progress. o Does not incorporate a trauma-informed perspective into interactions with the family.
• **Prepares for each visit with parent(s).** o Reviews goals and expectations of visits. [2,6] o Encourages the parent to plan activities for visit. o Works with the family to address any fears, barriers, and parenting challenges. [10] o Explores potential problems and coaches parent(s) on strategies to use during visits. [6]	• **Prepares for some visits with parent(s).** o Does not clearly communicate goals and expectations of visits when preparing for visits with parents. o Plans activities for visit without parental input. o Identifies family's fears, barriers, and parenting challenges but does not effectively work with the family to resolve them. o Explores potential problems that may arise during visits but does not provide strategies for parent(s) to use to resolve them.	• **Rarely prepares for visits with parent(s).** o Does not consider goals and expectations when preparing for the visits. o No or minimal preparation for visit activities. o Does not discuss fears, barriers, and/or parenting challenges with parent(s). o Does not explore potential problems that may arise during visits.
• **Debriefs with parent(s) after each visit.** o Asks parents how they feel the visit went and allows parents to express their feelings and concerns. [6] o Comments favorably on some aspect of child's and parent's interaction in the visit. [10] o Makes suggestions for improvement as necessary. [2,6,9,10,13]	• **Debriefs with parent(s) after some visits.** o Inconsistently creates opportunities for parents to describe how they feel the visit went and to describe their feelings and concerns. o Only offers positive feedback to the parent and/or child after some visits. o Misses opportunities to make suggestions for improvement when beneficial or necessary.	• **Rarely debriefs with parent(s) after each visit.** o Does not ask parents how they feel the visit went or allow parents time and space to express feelings and concerns. o Does not provide any positive feedback on parent-child interactions during the visit. o Does not offer suggestions for improvement when necessary.

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Appendix D: SVS Service Delivery Flowchart

SUPPORTIVE VISITATION SERVICES

SERVICE DELIVERY FLOW CHART

Pre-Referral Conference If Needed

SVS Program Leader is contacted by DCP&P Caseworker, RDS, and/or other source regarding a possible referral to SVS

SVS Program Leader schedules in-person or phone conference with DCP&P (Caseworker and/or Supervisor) ASAP

In-person or phone conference occurs; SVS Program Leader and DCP&P determine if a referral to SVS is appropriate for the family

If Yes

DCP&P Caseworker moves forward with SVS referral process

If No

DCP&P Caseworker does not move forward with SVS referral process

Referral Process

1

DCP&P Caseworker or Supervisor completes referral package (**SVS Referral Form**, Special Approval Request, and supporting documents) and forwards to the RDS for review

If complete, RDS sends referral package to SVS Program Leader via fax or secure mail

If incomplete or needing revisions, RDS returns package to DCP&P Caseworker for corrections and re-submission

Within 24 hours, SVS Program Leader reviews documents to ensure accuracy and appropriateness, and contacts RDS and DCP&P Caseworker to advise referral was received

Is there an opening for the family?

If Yes

SVS Program Leader assigns family to a Therapeutic Visitation Specialist (TVS); assignment based on scheduling and availability

If No

Family is placed on agency's waitlist; SVS Program Leader notifies RDS and DCP&P Caseworker

When an opening becomes available, SVS Program Leader assigns family to a TVS

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NEW JERSEY DEPARTMENT OF CHILDREN AND FAMILIES

RUTGERS School of Social Work INSTITUTE FOR FAMILIES

Initial Intake Assessment

2

Assigned TVS contacts DCP&P Caseworker via phone to clarify and/or gather additional information about the family, including caregiver(s) and child(ren)

↓

TVS contacts caregiver(s) via phone to schedule an initial intake assessment; assessment includes caregiver(s) and child(ren), if developmentally appropriate

↓

Initial intake assessment occurs in-person

SVS Initial Intake Assessment is completed, location and frequency of initial (pre-visitation plan) visits are determined, and caregiver(s) availability for visits is obtained

2 Business Days

7 Calendar Days or Earlier

↓

Based on the initial intake assessment, family either continues with TVS or is assigned to a Supportive Visitation Specialist (SVS) to begin pre-visitation plan visits

↓

Immediately following the initial intake assessment, the assigned visitation specialist schedules the family's initial visitation planning meeting (VPM) with the caregiver(s) and DCP&P caseworker; meeting details are shared with other meeting participants--which may include resource parents, caregivers, relatives, and other informal and formal supports, as needed

Initial Visits
(Pre-Visitation Plan Visits)

3

Visitation specialist confirms child's schedule with resource parents

↓

Based on caregiver(s) and child(ren)'s availability, visitation specialist schedules date and time for initial visits and communicates the schedule via phone or writing to caregiver(s), resource parent, DCP&P Caseworker, school, and/or other applicable parties

↓

Visitation Specialist:

1. Conducts pre-visit prep meeting with caregiver(s) and child(ren), if needed
2. Confirms visits with caregiver(s) and resource parents by phone 24 hours in advance of each visit
3. Transports child(ren) and/or caregiver(s) to visit, if needed
4. Facilitates visit
5. Conducts post-visit debrief with caregiver(s) and, if needed, with child(ren)
6. Transports child(ren) and/or caregiver(s) from visit, if needed
7. Documents the family's visit in NJ SPIRIT within 5 business days of the visit and in applicable agency system(s)

↓

Note: After the initial visit, visitation specialist contacts DCP&P Caseworker by phone to discuss how the visit went

Initial pre-visitation plan visits occur weekly, at minimum, until the VPM is held and the family's visitation plan is developed; a VPM should occur within 30 days of the family's initial intake assessment

Visitation Planning Meeting (VPM)

4

Caregiver(s) and visitation specialist determine who should participate in the VPM, and the visitation specialist extends invitations

Prior to the VPM, visitation specialist completes the **Rose Wentz Matrix*** and drafts the **SVS Family Visitation Plan**; documents are reviewed with the SVS Program Leader

VPM occurs with caregiver(s), visitation specialist, SVS Program Leader, DCP&P Caseworker, and invited participants

Visitation specialist facilitates the VPM and completes VPM forms, including the **SVS Family Visitation Plan**; the family's visitation plan outlines visitation supervision level, location, frequency, and duration

VPMs occur every 3 months, at minimum, or when a change in visitation plan is recommended

*Wentz, R. (2008). Visitation Planning Decision Matrix. Retrieved from http://wentztraining.com/docs/VisitPlanning.pdf

Ongoing Visits (Post-Visitation Plan Visits)

5

Visits begin based on the family's visitation plan.

Visitation supervision levels include:

- Therapeutic Supervised
- Supportive Supervised
- Relative and/or Community Partner Supervised
- Unsupervised Monitoring

Visitation Specialist:

1. Conducts pre-visit prep meeting with caregiver(s) and child(ren), if needed
2. Confirms visits with caregiver(s) and resource parents by phone 24 hours in advance of each visit
3. Transports child(ren) and/or caregiver(s) to visit, if needed
4. Facilitates visit
5. Conducts post-visit debrief with caregiver(s) and, if needed, with child(ren)
6. Transports child(ren) and/or caregiver(s) from visit, if needed
7. Documents the family's visit in NJ SPIRIT within 5 business days of the visit and in applicable agency system(s)

If changes are recommended to the family's visitation supervision level, a VPM should occur

Outcomes

Reunification Occurs: Family Participates in Aftercare

- Aftercare services provided based on family's need
- Services continue up to 6 months
- Services closed if need no longer exists
- Closing letter is sent to caregiver(s) and DCP&P Caseworker is notified

Reunification Occurs: Family Declines Aftercare

- Services end and family is discharged from program
- Closing letter is sent to caregiver(s) and DCP&P Caseworker is notified

Other Permanent Outcome is Achieved (Adoption/KLG/etc.)

- Services end and family is discharged from program
- Closing letter is sent to caregiver(s) and DCP&P Caseworker is notified

All Other Outcomes

- Services end and family is discharged from program
- Closing letter is sent to caregiver(s) and DCP&P Caseworker is notified

Appendix E: DCF Parent-Child Visitation Planning Tool

New Jersey Department of Children and Families

PARENT-CHILD VISITATION PLANNING TOOL

INSTRUCTIONS

Purpose: This tool should be used to determine CP&P's recommendation for the visitation plan which includes visit supervision level, visit location, and visit frequency and duration.

Who is the tool used for? This tool should be completed for each parent-child relationship, separately. Note: If parents and/or children are visiting together, the more restrictive visitation supervision and location recommendation should be used to ensure safety and the visit frequency and duration should be adjusted accordingly to accommodate different recommended visitation schedules (For example, the visit supervision recommendation for one sibling, a 17 year old, is unsupervised and the visit supervision for another sibling, an infant, is supervised. If the siblings are visiting with their parent together, the visit should be supervised.)

Who completes the tool? CP&P supervisors and caseworkers should complete the tool together and may consult with a DAG as needed.

When is the tool completed? 1. Initial assessment – This tool should be completed when a decision for a child to enter out-of-home placement has been made; and 2. Monthly reassessment – The tool should be completed during all future monthly supervisory case conferences for families with a child in out-of-home placement.

How is the plan documented? Supervisors must document each visitation plan detail as identified below in a NJS contact sheet describing their monthly supervisory case conference for the family.

Use the process below to determine recommendations for the parent-child visitation plan:

1. VISIT SUPERVISION

Use the decision tree on reverse side to recommend the visit supervision level for each identified parent-child relationship. Document the supervision level in the monthly supervisory contact sheet in NJS and include any applicable, required supporting documentation.

RECOMMENDATIONS

UNSUPERVISED Visitation

No visitation supervisor is required as unsupervised visits should be explored. Per DCF Policy, **most visits will be unsupervised.**

SUPERVISED Visitation by Kin or Unrelated Resource Parent

Relatives, family friends or resource parents should be explored as visit supervisors until it is safe and appropriate for the family to have unsupervised visits.

SUPERVISED Visitation by Contracted Visitation Provider or CP&P

A contracted visitation provider or CP&P is recommended to supervise parent-child interactions during visits until it is safe and appropriate to move to a less restrictive visit supervision level (ex. Unsupervised or supervised by relatives, family friends or resource parents).

THERAPEUTIC SUPERVISED Visitation by Contracted Visitation Provider or CP&P

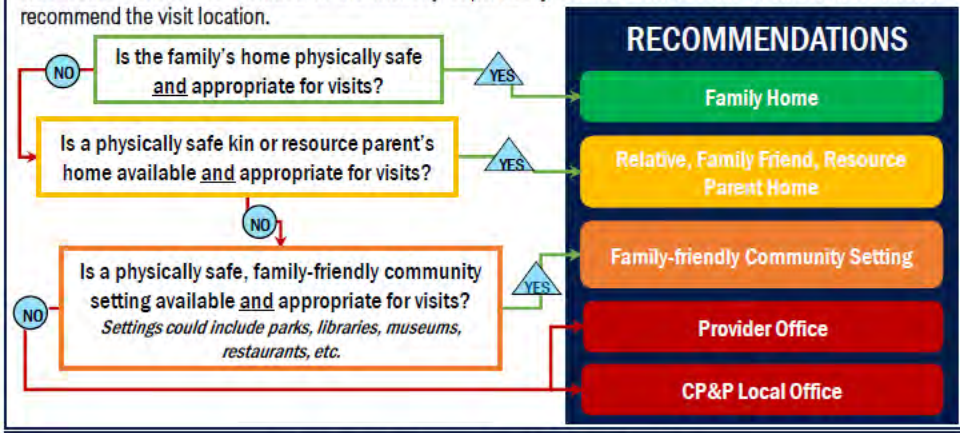
A contracted therapeutic visitation provider or CP&P is recommended to supervise parent-child interactions to address behavioral, developmental, relational, or safety needs in visits until it is safe and appropriate to move to a less restrictive visit supervision level (ex. Unsupervised or supervised by relatives, family friends or resource parents).

NO Visitation

Discuss if visits should occur.

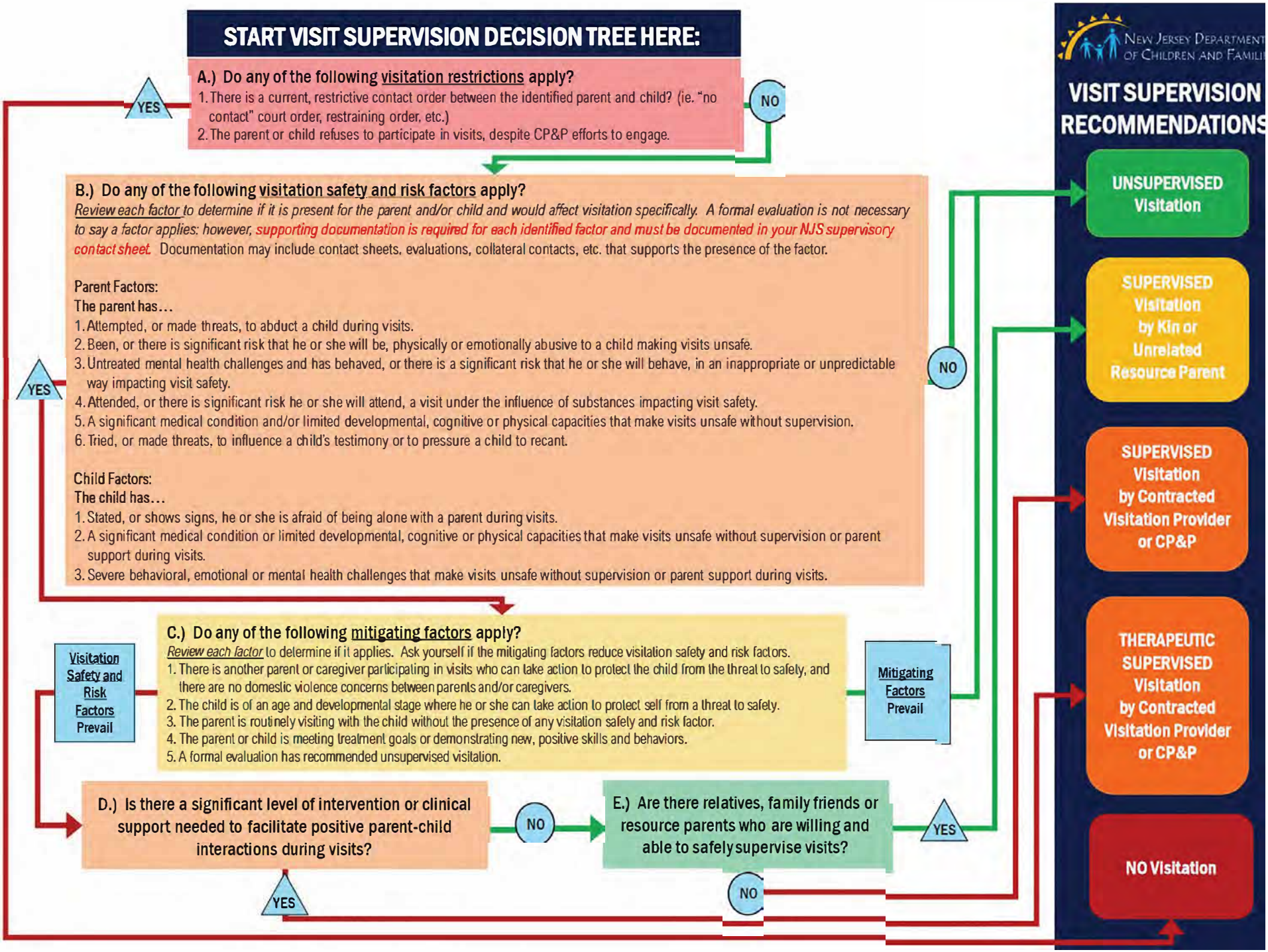
2. VISIT LOCATION

Visits must take place in the least restrictive, most comfortable setting possible. Decisions about visit location should be made in partnership with the family. Visits should occur in the family's home unless it is physically unsafe or requested otherwise. Visits should *only* take place in a CP&P local office or provider office setting when significant visitation safety and risk factors exist making other locations inappropriate. Justification for visit location should be included in the monthly supervisory contact note. **Use the decision tree below to recommend the visit location.**



3. VISIT FREQUENCY AND DURATION

Visits should be frequent and for as long as possible, unless harmful to participants and/or requested otherwise. Decisions should be made in partnership with the family and documented in the monthly supervisory contact note. At minimum, visits should occur weekly but as families move towards reunification, longer, and eventually, overnight visits should be explored. **Use the decision tree below for considering visit frequency and duration.**


START VISIT SUPERVISION DECISION TREE HERE:
A.) Do any of the following visitation restrictions apply?
1. There is a current, restrictive contact order between the identified parent and child? (ie. "no contact" court order, restraining order, etc.)
2. The parent or child refuses to participate in visits, despite CP&P efforts to engage.
YES
NO
B.) Do any of the following visitation safety and risk factors apply?
Review each factor to determine if it is present for the parent and/or child and would affect visitation specifically. A formal evaluation is not necessary to say a factor applies: however, supporting documentation is required for each identified factor and must be documented in your NJS supervisory contact sheet. Documentation may include contact sheets, evaluations, collateral contacts, etc. that supports the presence of the factor.
Parent Factors:
The parent has…
1. Attempted, or made threats, to abduct a child during visits.
2. Been, or there is significant risk that he or she will be, physically or emotionally abusive to a child making visits unsafe.
3. Untreated mental health challenges and has behaved, or there is a significant risk that he or she will behave, in an inappropriate or unpredictable way impacting visit safety.
4. Attended, or there is significant risk he or she will attend, a visit under the influence of substances impacting visit safety.
5. A significant medical condition and/or limited developmental, cognitive or physical capacities that make visits unsafe without supervision.
6. Tried, or made threats, to influence a child's testimony or to pressure a child to recant.
Child Factors:
The child has…
1. Stated, or shows signs, he or she is afraid of being alone with a parent during visits.
2. A significant medical condition or limited developmental, cognitive or physical capacities that make visits unsafe without supervision or parent support during visits.
3. Severe behavioral, emotional or mental health challenges that make visits unsafe without supervision or parent support during visits.
YES
NO
C.) Do any of the following mitigating factors apply?
Review each factor to determine if it applies. Ask yourself if the mitigating factors reduce visitation safety and risk factors.
1. There is another parent or caregiver participating in visits who can take action to protect the child from the threat to safely, and there are no domestic violence concerns between parents and/or caregivers.
2. The child is of an age and developmental stage where he or she can take action to protect self from a threat to safety.
3. The parent is routinely visiting with the child without the presence of any visitation safety and risk factor.
4. The parent or child is meeting treatment goals or demonstrating new, positive skills and behaviors.
5. A formal evaluation has recommended unsupervised visitation.
Visitation Safety and Risk Factors Prevail
Mitigating Factors Prevail
D.) Is there a significant level of intervention or clinical support needed to facilitate positive parent-child interactions during visits?
NO
YES
E.) Are there relatives, family friends or resource parents who are willing and able to safely supervise visits?
YES
NO
New Jersey Department of Children and Families
VISIT SUPERVISION RECOMMENDATIONS
UNSUPERVISED Visitation
SUPERVISED Visitation by Kin or Unrelated Resource Parent
SUPERVISED Visitation by Contracted Visitation Provider or CP&P
THERAPEUTIC SUPERVISED Visitation by Contracted Visitation Provider or CP&P
NO Visitation

Appendix F: SVS Referral Form

NEW JERSEY DEPARTMENT OF CHILDREN AND FAMILIES – SUPPORTIVE VISITATION SERVICES
OVERVIEW AND INSTRUCTIONS

What is Supportive Visitation Services (SVS)?

SVS is an innovative visitation model that offers supportive visitation services along a continuum to meet the unique needs of each family. The continuum includes a full range of visitation services from least restrictive supportive to more intensive therapeutic interventions. Families can receive one or more visitation type. The family's visitation supervision level is determined through assessment and collaborative visitation planning processes. Visits occur in the least restrictive setting that maintains participant safety. Visit locations may include the family's home, a relative or family friend's home, the resource parent's home, an in-community, family-friendly location or at the SVS provider's site. Families are reassessed at regular intervals to determine if families' goals have been met and if a different level of supervision is recommended. Aftercare services are available to families for up to 6-months post-reunification to support the transition home and reduce the risk of re-entry. The family's DCP&P case must remain open for aftercare services to be provided. SVS also includes transportation, NJS documentation and DCP&P and stakeholder collaboration.

Who is eligible for SVS?

SVS can be provided to DCP&P-involved families with children in out-of-home placement in Essex, Morris, Passaic or Sussex Counties who require supportive visitation services. Families with all DCP&P case goals can participate.

How do I make a referral to SVS?

1. Complete SVS referral form and checklist and signature page.
2. Complete SAR signed by supervisor and casework supervisor. Only one SAR is required for the family and should be completed:
    - Using the youngest child, who is visiting, as the reference person
    - Estimating a minimum of 20 units per month/family for 6 months. If circumstances are unique and more than typical visitation hours (2 hours/week) are being requested, please contact SVS program manager for a better estimation.
    - Using the correct resource information:
        - CARE PLUS NJ INC = NJS ResourceID: 10001396
        - FAMILY CONNECTIONS, INC = NJS ResourceID: 10001188
    - Using the correct support line for Supervised and/or Therapeutic Visitation, $146.10/hour:
        - SVS Essex – Care Plus = Supportive Visitation Serviccs Essex (K100)
        - SVS Essex – Family Connections = Reconnections Supported Visitation Essex
        - SVS Morris/Sussex – Family Connections = ReConnections Supported Visitation Morri
        - SVS Passaic – Family Connections = ReConnections Supported Visitation Passa
3. Securely email or fax SVS referral form, checklist and signature page, and documents to the SVS Program Leader.

Note: To ensure a seamless continuation of services, a SAR must be renewed at least every 6 months. SVS providers will notify the family's DCP&P worker when a SAR is expiring or if monthly units will be exceeded. An active SAR needs to be in place for services to be provided.

What happens after I make an SVS referral?

The SVS Program Leader will review your referral and assign a supportive visitation specialist to the family. The specialist will contact you to review the referral and to get additional information about the family. The specialist will then contact the family to schedule an initial intake assessment to begin services. The SVS provider will invite you to participate in a Visitation Planning Meeting to create a visitation plan and determine visitation level.

Note: DCP&P is responsible for ensuring families receive visits until visitation services begin through the SVS program.

What if the family could benefit from additional services offered by the SVS provider agency?

Please contact the SVS provider agency directly if additional services are requested including parenting groups, etc. A separate SAR is required.

New Jersey Department of Children and Families – Supportive Visitation Services
Referral Form

Date:	_____	NJS Case ID#:			
DCP&P Case Manager:	_____		Office #:	_____	
Cell #:	_____	Email:	_____		@dcf.nj.gov
DCP&P Supervisor:	_____		Office #:	_____	
Cell #:	_____	Email:	_____		@dcf.nj.gov

Parents/Guardians*

Name:	_____	DOB:	_____	NJS Person ID#:	_____
Primary Language:	_____	Cell #:	_____	Home #:	_____
Address:	_____				
If no phone, please identify a primary contact:	_____			Contact #:	_____
Name:	_____	DOB:	_____	NJS Person ID#:	_____
Primary Language:	_____	Cell #:	_____	Home #:	_____
Address:	_____				
If no phone, please identify a primary contact:	_____			Contact #:	_____
☐ Parents require separate visits. Reason: _____					

*Please list additional parents/guardians on separate sheet, if applicable

Children*

Name:	_____	DOB:	_____	Male ☐ Female ☐	Allergies, meds or special needs? ☐
Resource Parent:	_____	Address:	_____		
Home #:	_____	Cell #:	_____	Work #:	_____
Name:	_____	DOB:	_____	Male ☐ Female ☐	Allergies, meds or special needs? ☐
Resource Parent:	_____	Address:	_____		
Home #:	_____	Cell #:	_____	Work #:	_____
Name:	_____	DOB:	_____	Male ☐ Female ☐	Allergies, meds or special needs? ☐
Resource Parent:	_____	Address:	_____		
Home #:	_____	Cell #:	_____	Work #:	_____
Name:	_____	DOB:	_____	Male ☐ Female ☐	Allergies, meds or special needs? ☐
Resource Parent:	_____	Address:	_____		
Home #:	_____	Cell #:	_____	Work #:	_____

*Please list additional children on separate sheet, if applicable

Lists Additional Adult(s) Who Will Visit	Relationship to Children	Home #	Cell #
_____	_____	_____	_____
_____	_____	_____	_____

DCP&P Case Information

List Agency, Provider or Program Currently Engaged with Family	Program Contact(s)	Contact #
_____	_____	_____
_____	_____	_____

Removal Date:	_____	Removal Reason:	_____
Next Court Date:	_____	Hearing Type:	_____

Case Goal: Reunification ☐ Adoption ☐ KLG ☐ Independent Living ☐ Other Long-Term Specialized Care ☐

☐	Safety concerns ☐ Worker safety concerns ☐ Domestic violence concerns ☐ Safety concerns of family home	☐	Communication ☐ Resource parents and parents/guardians have contact with each other ☐ Parents/guardians and children communicate outside visits
☐	Any additional relevant case information, please explain: _____		

NEW JERSEY DEPARTMENT OF CHILDREN AND FAMILIES – SUPPORTIVE VISITATION SERVICES
SIGNATURE PAGE

Documents	**Required Documents:**		Supporting Documents, if applicable:	
	☐	Completed SVS Referral Form	☐	Verified Complaint for custody
	☐	Signed Special Authorization Request (SAR)	☐	Most recent court orders
	☐	DCP&P Case Plan/Family Summary	☐	Prior mental health evaluations*
	*Please attach any psychological, psychiatric or other reports to help SVS staff develop family's visitation plan.			
DCP&P Local Office	☐	Essex Central Local Office	☐	Newark Center City Local Office
	☐	Essex North Local Office	☐	Newark Northeast Local Office
	☐	Essex South Local Office	☐	Newark South Local Office
	☐	Morris East Local Office	☐	Passaic Central Local Office
	☐	Morris West Local Office	☐	Passaic North Local Office
			☐	Sussex Local Office
SVS Programs	☐ **SVS Essex**			
	☐	Care Plus NJ, Inc.	NJS Resource ID: 10001396	
		SVS Program Leader: Lauren Walsh, LCSW laurenw@careplusnj.org Office: 201-797-2660 x 5675 Fax: 201-797-5025 *Essex Central, Essex North, Essex South, Newark Center City, Newark Northeast and Newark South LO*		
	☐	Family Connections, Inc.	NJS Resource ID: 10001188	
		SVS Program Leader: Joanna Audenried, LCSW jaudenried@familyconnectionsnj.org Cell: 973-650-6493 *Essex Central, Essex North, Essex South, Newark Center City, Newark Northeast and Newark South LO*		
	☐ **SVS Morris/Sussex and Passaic**			
	☐	Family Connections, Inc.	NJS Resource ID: 10001188	
		SVS Program Leader: Drew Nieuwenhuis, MS dnieuwenhuis@familyconnectionsnj.org Cell: 862-250-3629 *Morris East, Morris West, Passaic Central, Passaic North and Sussex LO*		
Required Signatures	By signing below, DCP&P allows SVS provider to transport minor children to and from visitation location.			
				____
	DCP&P Case Manager Signature			Date
				____
	DCP&P Supervisor Signature			Date
				____
	DCP&P RDS Signature			Date

Note: DCP&P is responsible for ensuring families visit until visitation services begin through the SVS program.

Appendix G: SVS Caregiver Survey and Administration Guidelines

NEW JERSEY DEPARTMENT OF CHILDREN AND FAMILIES

Supportive Visitation Services Caregiver Survey

Welcome to the SVS Caregiver Survey

Visitation Staff: Thank you for facilitating this process. Please complete the information below before turning over the survey to the client.

* 1. Visitation Staff Name

First and Last Name

* 2. Please complete the following client information

NJ Spirit Case ID

NJ Spirit Person ID

* 3. SVS Program Name

* 4. Survey Date

Date when survey is completed

Date

MM/DD/YYYY

* 5. Survey Interval

- Enrollment
- 6 months
- 12 months
- 18 months
- 24 months
- 30 months
- 36 months
- 42 months
- 48 months
- 54 months
- 60 months
- Discharge

SVS Staff Survey Script

<u>VISITATION STAFF: PLEASE READ THIS SCRIPT OUT LOUD TO THE CLIENT BEFORE TURNING OVER THE SURVEY.</u>

Thank you for your willingness to complete this short survey. The survey you are about to take will help us better understand the needs of the families we serve. We want to provide the best services that we can to all of our caregivers and families, and this is one way to help us keep on track.

The survey contains questions about your experiences as a caregiver and your outlook on life in general.

You will not lose services or be penalized in any way if you prefer not to complete the survey or prefer not to answer some of the questions.

All of the information that you share will be kept confidential. The services you receive will not be negatively affected by any answers that you give in this survey. Nobody from the SVS Program, including me, and nobody from DCP&P will see the answers you give on this survey. Your responses will go directly to the Office of Research, Evaluation and Reporting at DCF and will only be presented to us in summary with results from other clients.

The survey will take approximately 10 - 15 minutes to complete. When you are finished with the survey, you can let me know. If at any time you have questions about the survey, just let me know and I can help you.

Do you have any questions at this point?

<u>VISITATION STAFF: CLICK NEXT AND HAND OVER THE SURVEY TO THE CLIENT TO COMPLETE ON THEIR OWN.</u>

****
<u>POR FAVOR LEA ESTE GUIÓN AL CUIDADORES ANTES DEVOLVER LA ENCUESTA.</u>

Gracias por completar esta breve encuesta. La encuesta que vas a tomar nos ayudará a comprender mejor las necesidades de las familias a las que servimos. Queremos ofrecer los mejores servicios que podemos a todos nuestros cuidadores y familias, y esta es una manera de ayudarnos.

La encuesta contiene preguntas sobre sus experiencias como cuidador y su perspectiva de la vida en general.

No perderá servicios ni será penalizado si prefiere no completar la encuesta o prefiere no contestar

algunas de las preguntas.

Toda la información que compartas se mantendrá confidencial. Sus respuestas van directamente a la Oficina de Investigación, Evaluación y Reportes en El Departamento de Niños y Familias.

La encuesta solo tomará de 10 a 15 minutos para completar. Cuando hayas terminado con la encuesta, puedes avisarme. Si en algún momento tiene preguntas sobre la encuesta, déjame saber y puedo ayudarlo.

¿Tienes alguna pregunta en este momento?

PERSONAL DE VISITACIÓN: SELECCIONA “SIGUIENTE” Y ENTREGUE LA ENCUESTA A CUIDADOR PARA QUE LO PUEDA COMPLETAR SOLO.

Thank you for taking this survey. Please note that the Visitation Staff and CP&P will not have any access to your survey responses. Your responses will be kept confidential, and will only be used by the Research and Evaluation team for research purposes.

****

Gracias por completar esta encuesta. Tenga en cuenta que su respuestas serán mantenidas confidencial y sólo se usaran por la Oficina de Investigación, Evaluación y Reportes para evaluación.

6. In the past 6 months, have you interacted with your child in-person?
En los últimos 6 meses, ¿ha interactuado con su hijo en persona?

- ◯ Yes (Sí)
- ◯ No

This section asks about your parenting experiences and your general outlook on life. Please remember that this is not a test, so there are no right or wrong answers, and your responses are confidential. You should choose the answer that makes the most sense for you and your family.

If you need assistance completing the survey, please ask the visitation specialist.

You will notice that each question asks you to think about how much or how little each item reflects your life, or about how often you experience something. Please respond by marking the circle that best describes your situation. If you do not find an answer that fits perfectly, mark the one that comes closest.

For each of the following, mark the response that most closely matches how you feel.
****
Esta sección pregunta sobre sus experiencias como padre y su perspectiva general de la vida. Recuerde que esto no es un examen, no hay respuestas correctas o incorrectas. Sus respuestas son confidencial. Debe elegir las respuestas que hagan más sentido para usted y su familia.

Si necesitas asistencia para completar la encuesta, consulte el ó la especialista de visitas.

Se dará cuenta de que cada pregunta le pide que piense en cuánto o cuán poco cada elemento refleja su vida, o la frecuencia con que experiencias algo. Por favor responda marcando con un círculo lo que mejor describa su situación. Si no encuentras una respuesta que refleja perfectamente, marca la que más se acerque.

Por cada de los siguientes, marca la respuesta que más refleja lo que sientes.

7. The future looks good for our family. (El futuro se ve bien para nuestra familia).

Not at all like my life En absoluto no como mi vida	Not much like my life No mucho como mi vida	Somewhat like my life Algo parecido a mi vida	Quite a lot like my life Bastante parecido a mi vida	Just like my life Exactamente como mi vida
○	○	○	○	○

8. In my family, we take time to listen to each other. (En mi familia, tomamos el tiempo para escuchar).

Not at all like my life En absoluto no como mi vida	Not much like my life No mucho como mi vida	Somewhat like my life Algo parecido a mi vida	Quite a lot like my life Bastante parecido a mi vida	Just like my life Exactamente como mi vida
○	○	○	○	○

9. There are things we do as a family that are special just to us. (Hay cosas que hacemos como una familia que son especiales para nosotros).

Not at all like my life En absoluto no como mi vida	Not much like my life No mucho como mi vida	Somewhat like my life Algo parecido a mi vida	Quite a lot like my life Bastante parecido a mi vida	Just like my life Exactamente como mi vida
○	○	○	○	○

10. My child misbehaves just to upset me. (Mi hijo se comporta mal sólo para enojarme).

Not at all like my life En absoluto no como mi vida	Not much like my life No mucho como mi vida	Somewhat like my life Algo parecido a mi vida	Quite a lot like my life Bastante parecido a mi vida	Just like my life Exactamente como mi vida
○	○	○	○	○

11. I feel like I'm always telling my kids "no" or "stop." (Siento que siempre estoy diciéndome a mis hijos "no" o "détente").

Not at all like my life En absoluto no como mi vida	Not much like my life No mucho como mi vida	Somewhat like my life Algo parecido a mi vida	Quite a lot like my life Bastante parecido a mi vida	Just like my life Exactamente como mi vida
○	○	○	○	○

12. I have frequent power struggles with my kids. (Tengo frecuentes conflictos de autoridad con mis hijos).

Not at all like my life En absoluto no como mi vida	Not much like my life No mucho como mi vida	Somewhat like my life Algo parecido a mi vida	Quite a lot like my life Bastante parecido a mi vida	Just like my life Exactamente como mi vida
○	○	○	○	○

13. How I respond to my child depends on how I'm feeling. (Cómo respondo a mi hijo depende de en cómo me siento).

Not at all like my life En absoluto no como mi vida	Not much like my life No mucho como mi vida	Somewhat like my life Algo parecido a mi vida	Quite a lot like my life Bastante parecido a mi vida	Just like my life Exactamente como mi vida
○	○	○	○	○

14. I have people who believe in me. (Tengo personas que creen en mí).

Not at all like my life En absoluto no como mi vida	Not much like my life No mucho como mi vida	Somewhat like my life Algo parecido a mi vida	Quite a lot like my life Bastante parecido a mi vida	Just like my life Exactamente como mi vida
○	○	○	○	○

15. I have someone in my life who gives me advice, even when it's hard to hear. (Tengo alguien en mi vida que me da consejos, incluso cuando sea difícil de oír).

Not at all like my life En absoluto no como mi vida	Not much like my life No mucho como mi vida	Somewhat like my life Algo parecido a mi vida	Quite a lot like my life Bastante parecido a mi vida	Just like my life Exactamente como mi vida
○	○	○	○	○

16. When I am trying to work on achieving a goal, I have friends who will support me. (Cuando intento trabajar en mis metas, tengo amistades que me apoyan).

Not at all like my life En absoluto no como mi vida	Not much like my life No mucho como mi vida	Somewhat like my life Algo parecido a mi vida	Quite a lot like my life Bastante parecido a mi vida	Just like my life Exactamente como mi vida
○	○	○	○	○

17. When I need someone to look after my kids on short notice, I can find someone I trust. (Cuando necesito a alguien que cuida a mis hijos con poca anticipación, puedo encontrar a alguien en quien confío).

Not at all like my life En absoluto no como mi vida	Not much like my life No mucho como mi vida	Somewhat like my life Algo parecido a mi vida	Quite a lot like my life Bastante parecido a mi vida	Just like my life Exactamente como mi vida
○	○	○	○	○

18. I have people I trust to ask for advice about (check all that apply):
(Tengo personas en las que confío para pedir consejo sobre (Marque todas las que correspondan):

- ☐ Money/Bills/Budgeting
  Dinero/Cuentas/Presupuesto
- ☐ Relationships and/or My Love Life
  Mis Relaciones o mi vida amorosa
- ☐ Food/Nutrition
  Comida/Nutrición
- ☐ Stress, Anxiety, and/or Depression
  Estrés, Ansiedad, o Depresión
- ☐ Parenting/My Kids
  Como criar a mis hijos
- ☐ None of the above
  Ninguno de los anteriores

The following questions are about your experiences so far in this program. Your answers to these questions can help staff improve services for you and others like you, so it's important you answer honestly.
For each of the following, mark the response that most closely matches how you feel.
****

Las siguientes preguntas son acerca de sus experiencias hasta ahora en este programa. Sus respuestas a estas preguntas pueden ayudar al personal a mejorar los servicios para usted y otros cómo usted. Es importante que responda honestamente.

Para cada uno de los siguientes, marque la respuesta que más refleja cómo se siente.

19. I feel like staff here understand me. (Siento que el personal aquí me entiende).

Strongly agree Firmemente de acuerdo	Agree De acuerdo	Neither agree nor disagree No estoy de acuerdo ni estoy en desacuerdo	Disagree En desacuerdo	Strongly disagree Firmemente en desacuerdo
○	○	○	○	○

20. No one here seems to believe that I can change. (Nadie aquí cree que puedo cambiar).

Strongly agree Firmemente de acuerdo	Agree De acuerdo	Neither agree nor disagree No estoy de acuerdo ni estoy en desacuerdo	Disagree En desacuerdo	Strongly disagree Firmemente en desacuerdo
○	○	○	○	○

21. When I talk to people here about my problems, they just don't seem to understand. (Cuando hablo con la gente aquí sobre mis problemas, ellos no parecen entender).

Strongly agree Firmemente de acuerdo	Agree De acuerdo	Neither agree nor disagree No estoy de acuerdo ni estoy en desacuerdo	Disagree En desacuerdo	Strongly disagree Firmemente en desacuerdo
○	○	○	○	○

Sometimes it's hard for families to afford everything they need. For each of the following, check all that apply.

****

A veces es difícil para las familias pagar por todo lo que necesitan. Para cada uno de los siguientes, marque todos los que correspondan.

22. In the past month, were you unable to pay for: (check all that apply)
En el último mes, usted no ha podido pagar por: (marque todas las que correspondan):

- ☐ Rent or mortgage
  Renta o hipoteca
- ☐ Utilities or bills (electricity/gas/heat, cell phone, etc.)
  Utilidades o facturas (electricidad/gas/calefacción, teléfono celular, etc.)
- ☐ Groceries/food (including baby formula, diapers)
  Alimentos (incluyendo fórmula para bebés, pañales)
- ☐ Child care/daycare
  Cuidado de niños
- ☐ Medicine, medical expenses, or co-pays
  Medicina, gastos médicos o copagos
- ☐ Basic household or personal hygiene items
  Artículos básicos de higiene doméstica o personal
- ☐ Transportation (including gas, bus passes, shared rides)
  Transporte (incluyendo gas, pases de autobús, paseos compartidos)
- ☐ I was able to pay for all of these
  He podido pagar por todos estos

23. In the past year, have you: (check all that apply)
En el último año, usted ha: (marque todas las que correspondan)

- [ ] Delayed or not gotten medical or dental care
  Estado retrasado o no ha recibido cuidado médico o dental
- [ ] Been evicted from your home or apartment
  Sido desalojado de su casa o apartamento
- [ ] Lived at a shelter, in a hotel/motel, in an abandoned building, or in a vehicle
  Vivido en un refugio, en un hotel/motel, en un edificio abandonado o en un vehículo
- [ ] Moved in with other people, even temporarily, because you could not afford to pay rent, mortgage, or bills
  Mudado con otras personas, incluso temporalmente, debido al no poder pagar renta hipoteca o facturas
- [ ] Lost access to your regular transportation (e.g. vehicle totaled or repossessed)
  Perdido acceso a su transporte regular (por ejemplo, vehículo chocado o reposeído)
- [ ] Been unemployed when you really needed and wanted a job
  Estado sin trabajo
- [ ] None of these apply to me
  Ninguno de estos aplica

24. I have trouble affording what I need each month. (Es difícil pagar por lo que necesito cada mes).

Never Nunca	Rarely Rara la vez	Sometimes A veces	Often Casi Siempre	Almost always Siempre
○	○	○	○	○

25. I am able to afford the food I want to feed my family. (Puedo pagar por la comida que necesito para alimentar a mi familia).

Never Nunca	Rarely Rara la vez	Sometimes A veces	Often Casi Siempre	Almost always Siempre
○	○	○	○	○

Look at the Parenting Skills Ladder. Some people feel their skills in certain areas are low. Others see their skills as higher.

Think about where you are on the ladder NOW for each of the skills below.

Select the number (from 0 to 6) for where you are on the ladder in each of the skills below:

****

Mira a la escalera de habilidades como padres. Algunas personas sienten que sus habilidades en ciertas áreas son bajas. Otros ven sus habilidades como más alta.

Piense en dónde está en la escalera ahora para cada una de las habilidades de abajo.

Seleccione el número (de 0 a 6) para donde usted está en la escalera en cada una de las habilidades debajo.

Parenting Skills Ladder (La escalera de habilidades de crianza)

26. Know normal behavior for my child(ren)'s age level
Conocer el comportamiento normal para el nivel de edad de mi(s) hijo(s)

Low (Bajo)						High (Alto)
0	1	2	3	4	5	6
○	○	○	○	○	○	○

27. Show my child(ren) love and affection frequently
Mostrar amor y afecto a mi(s) hijo(s) con frecuencia

Low (Bajo)						High (Alto)
0	1	2	3	4	5	6
○	○	○	○	○	○	○

28. Listen to my child(ren) to understand their feelings
Escuchar a mi(s) hijo(s) para entender sus sentimientos

Low (Bajo)						High (Alto)
0	1	2	3	4	5	6
○	○	○	○	○	○	○

29. Help my child(ren) feel good about themselves
Ayudar a mi(s) hijo(s) a sentirse bien consigo mismo(s)

Low (Bajo)						High (Alto)
0	1	2	3	4	5	6
○	○	○	○	○	○	○

30. Set and stick to reasonable limits and rules
Establecer y mantener límites y reglas razonables

Low (Bajo)						High (Alto)
0	1	2	3	4	5	6
○	○	○	○	○	○	○

31. Know fun activities to help my child(ren) learn
Conocer actividades divertidas para ayudar a mi(s) hijo(s) a aprender

Low (Bajo)						High (Alto)
0	1	2	3	4	5	6
○	○	○	○	○	○	○

32. Find positive ways to guide and discipline my child(ren)
Encontrar formas positivas de guiar y disciplinar a mi(s) hijo(s)

Low (Bajo)						High (Alto)
0	1	2	3	4	5	6
○	○	○	○	○	○	○

33. Play with my child(ren) frequently
Jugar con mi(s) hijo(s) con frecuencia

Low (Bajo)						High (Alto)
0	1	2	3	4	5	6
○	○	○	○	○	○	○

34. Protect my child(ren) from unsafe situations
Proteger a mi(s) hijo(s) de situaciones inseguras

Low (Bajo)						High (Alto)
0	1	2	3	4	5	6
○	○	○	○	○	○	○

35. Talk with other parents to share experiences
Hablar con otros padres para compartir experiencias

Low (Bajo)						High (Alto)
0	1	2	3	4	5	6
○	○	○	○	○	○	○

36. Deal with the day-to-day stresses of parenting
Enfrentarme al estrés diario de la crianza

Low (Bajo)						High (Alto)
0	1	2	3	4	5	6
○	○	○	○	○	○	○

37. Understand my goals and values as a parent
Comprender mis metas y valores como padre/madre

Low (Bajo)						High (Alto)
0	1	2	3	4	5	6
○	○	○	○	○	○	○

* 38. Do you have a child between the ages of 3 and 8 years old? (¿Tienes un hijo entre 3 y 8 años de edad?)

- ◯ No
- ◯ Yes (Sí)

39. Now think about your child's behavior. If you have more than one child aged 3 to 8, choose one to think about.

Use the ladder to rate this child's skills (from 0 to 6) at this time. Rate your child's skills in these areas:

****

Ahora piense en el comportamiento de su hijo. Si usted tiene más de un niño de 3 a 8 años, elija uno para en cual pensar.

Use la escalera para calificar las habilidades de su niño (de 0 a 6) en este momento. Califica las habilidades de tu hijo en estas áreas:

Skills Ladder

40. Shows concern for others
Se preocupa por otros

Low (Bajo)						High (Alto)
0	1	2	3	4	5	6
○	○	○	○	○	○	○

41. Willing to follow limits and rules
Está dispuesto/a a seguir límites y reglas

Low (Bajo)						High (Alto)
0	1	2	3	4	5	6
○	○	○	○	○	○	○

42. Gets along with others
Se lleva bien con otros

Low (Bajo)						High (Alto)
0	1	2	3	4	5	6
○	○	○	○	○	○	○

THANK YOU FOR COMPLETING THIS SURVEY!
¡GRACIAS POR COMPLETAR ESTA ENCUESTA!

New Jersey Department of Children and Families

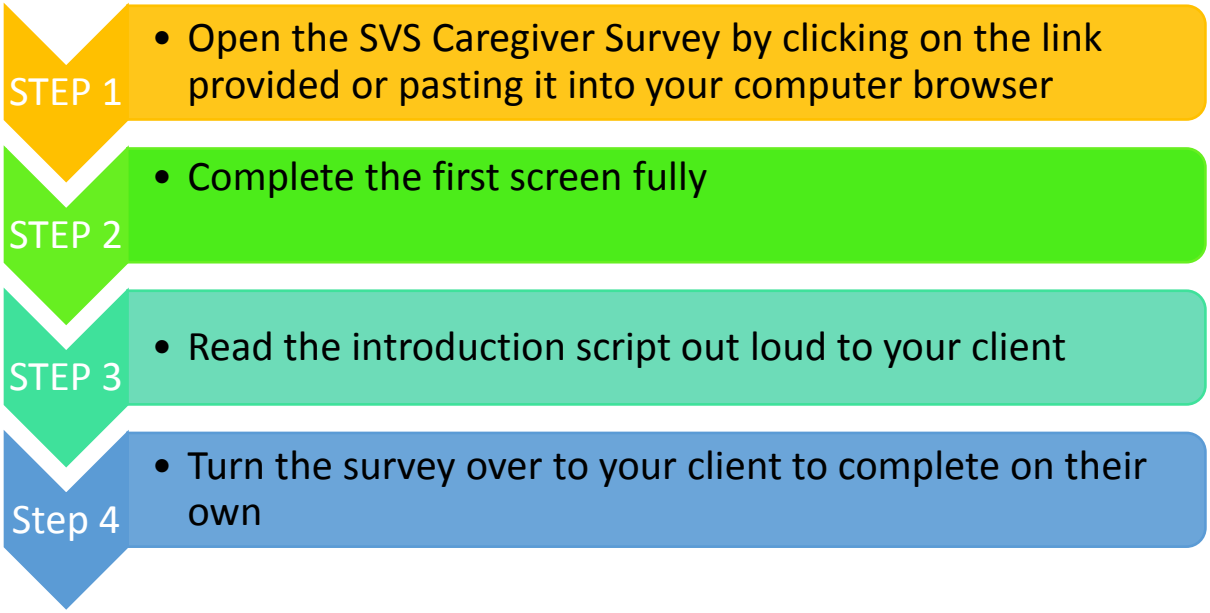
SVS CAREGIVER SURVEY

THE SVS CAREGIVER SURVEY ADMINISTRATION GUIDELINES

NEW JERSEY DEPARTMENT OF CHILDREN AND FAMILIES

INTRODUCTION

- The SVS Caregiver Survey is an electronic survey administered to SVS caregivers at the following time-points:
  - ✓ baseline (within 30 days of enrollment)
  - ✓ every 6-month interval that the caregiver is enrolled in SVS
  - ✓ Within 2 weeks of discharge
- The SVS Caregiver Survey should be administered on a desktop computer, laptop computer or tablet.
- Steps to follow in administering the SVS Caregiver Survey in SurveyMonkey



- Be available to the client in case any questions arise in the course of the survey completion process, while maintaining space for privacy.

WHAT TO BRING WITH YOU

- ✓ Laptop or tablet
- ✓ Link to the survey
- ✓ Caregiver's NJ SPIRIT Person ID AND NJ SPIRIT Case ID
- ✓ Caregiver survey Guidance Document

New Jersey Department of Children and Families

SVS CAREGIVER SURVEY SCRIPTS: INTRODUCTION

Please read out loud this introductory script to the client before the client begins the survey:

Thank you for your willingness to complete this short survey. The survey you are about to take will help us better understand the needs of the families we serve. We want to provide the best services that we can to all of our caregivers and families, and this is one way to help us keep on track.

The survey contains questions about your experiences as a caregiver and your outlook on life in general.

You will not lose services or be penalized in any way if you prefer not to complete the survey or prefer not to answer some of the questions.

All of the information that you share will be kept confidential. Your responses will go directly to the Office of Research, Evaluation and Reporting at the Department of Children and Families.

The survey will take approximately 10 - 15 minutes to complete. When you are finished with the survey, you can let me know. If at any time you have questions about the survey, just let me know and I can help you.

Do you have any questions at this point?

[Answer participant questions]

New Jersey Department of Children and Families

SVS CAREGIVER SURVEY SCRIPTS: INSTRUCTIONS

This script provides instructions on how to answer the questions in the first section (Qs7-18). The script is available in the client's section of the survey. However, you may consider reading this script out to the client if there are literacy concerns.

This section asks about your parenting experiences and your general outlook on life. Please remember that this is not a test, so there are no right or wrong answers, and your responses are confidential. You should choose the answer that makes the most sense for you and your family.

If you need assistance completing the survey, please ask me [the visitation specialist].

You will notice that each question asks you to think about how much or how little each item reflects your life, or about how often you experience something. Please respond by marking the circle that best describes your situation. If you do not find an answer that fits perfectly, mark the one that comes closest.

For each of the following, mark the response that most closely matches how you feel.

New Jersey Department of Children and Families

GUIDELINES FOR PROVIDING SURVEY ASSISTANCE TO CLIENTS

What should you do if a client does not understand the instructions on their own?

- Read out the instructions to the client without paraphrasing or rewording as this may lead to bias in the reponses.

What should you say if a client does not understand the question?

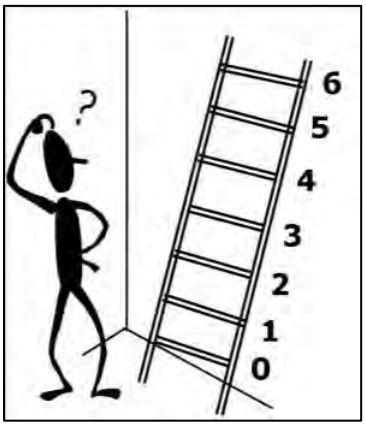
- Recommended response*: "I don't have any additional information. Just respond in a way that makes the most sense for you/your family/your life. There are no right or wrong answers."*

If the client continues to have difficulty in responding, they are permitted to skip the item.

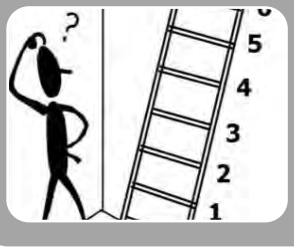
New Jersey Department of Children and Families

GUIDELINES FOR PROVIDING SURVEY ASSISTANCE TO CLIENTS

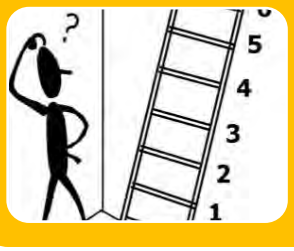
Using the Parenting Skills Ladder (Q26-37; Q40-42)



The Parenting Skills Ladder has a rating scale of 0 to 6, where 0 is the lowest score and 6 is the highest.



Caregivers are asked to rate their parenting knowledge and practice.



In Q40-42 caregivers rate their child's behavior. This child should be between ages 3-8.

Caregivers without children aged 3 or older are not required to respond to these items. The survey is designed to have them skip these items.

NEW JERSEY DEPARTMENT OF CHILDREN AND FAMILIES

References

Protective Factors Survey, 2nd Edition User Manual. (2018). FRIENDS National Center for Community-Based Child Abuse Prevention, Chapel Hill, NC. [Online]

Pratt, C., Katzev, A., Peters, C., Bowman, S., Rennekamp, D., & Sektnan, M. (2014). *Parenting Skills Ladder, Revised, Second Edition.* Oregon State University: Extension Family and Community Health.

Appendix H: Rose Wentz Matrix

Training Change

ROSE WENTZ

Planned, Purposeful and Progressive Visits
Developing Visit Plans: A Matrix of Best Practice Standards

- Parent child visits must be *planned* and are an intergal part of the *case planning* process:
  - The *primary purpose* of visits is to meet the child's developmental and attachment needs.
  - The *secondary purpose* is to teach, coach, and evalute the parenting skills necessary to ensure safety after reunification.
- Visits must *progress* from the first short and highly structured visits to overnight visits that occur in the parent's home without supervision in order to determine if a parent can maintain their new skills during normal and stressful family situaitons.

The matrix is developed based on the philosophy that the child will have a *safe* visit that is held at the most natural and home-like situation possible. Children and parents may feel *discomfort* before, during or after a visit. However, if the child is traumatized by the visit the case planning team should progressively change one element at a time until it is possible to have visits that do not traumatize the child. All children must have a Connection Plan for most children that will include face-to-face visits with the child's birth parents and others with whom the child has an emotional attachment. Children who are so traumatized that face-to-face contact is not possible may have contact through letters or phones. In some cases a child would be in treatment to address this trauma without any contact with the parent(s). In those cases just discontinuing any contact does not address the child's needs to heal from the trauma. The treatment service that addresses the parent/child relationship is the Connection Plan for that child.

If the child's visit plan has not been able to progress to successful and safe visits, no child should be reunited with his/her parent(s) in the following capacity:

- Overnight
- Unsupervised and testing that the child's safety plan works
- In the home where the child will live after reunification
- In situations that mimic when and how the maltreatment occurred, and
- With all the people who will live with the child (such as parent's boyfriends or roommates)

How to Use the Visit Tool

1. *The following matrix is to be used by professionals to develop and monitor visit plans that will support the goals of safety, permanency and well-being and meet the above standard for reunification.*

2. *The content is based on laws, research or best practice standards from: child welfare, court, Child and Family Service Reviews, child development, addiction, domestic violence, attachment theory, trauma impacts to children, impact of grief and loss and other supporting professional knowledge.*

3. *When developing a visit plan, most effective when planning is done in a team meeting approach, the first page of matrix (page 5) is used as the template.*

4. *The rows of the matrix list the <u>elements</u> that should be addressed in all visit plans:*
    a. Purpose
    b. Frequency
    c. Length
    d. Location
    e. Activities
    f. Supervision level
    g. Who attends
    h. Responsibilities (before, during and after a visit) and what can be brought to a visit
    i. Documentation (how this will be done and shared)

5. *The matrix is developed using the unique facts of the case. A summary of the best practice standards visit is added to the template to create a case unique set of information. The <u>factors</u> are selected from the following:*
    a. Child's developmental age and parenting skills related to encouraging attachment:
        i. Infants
        ii. Toddlers
        iii. Pre-schoolers
        iv. School age
        v. Adolescence
    b. The enhanced parenting skills based on the substantiated maltreatment:
        i. Neglect
        ii. Physical Abuse
        iii. Sex Abuse

   iv. Emotional Abuse
c. Time in Care (the permanency planning phase of the case):
   i. Initial placement visits
   ii. Reasonable / active effort visits
   iii. Final permanency planning decision evaluation visits
   iv. Post permanency visit planning
d. Family Culture:
   i. Siblings
   ii. Ethnicity and religion
   iii. Native American connections
   iv. Education stability
   v. Community
e. Other factors:
   i. Addiction
   ii. Mental illness
   iii. Domestic violence
   iv. Incarcerated or hospitalized parents
   v. Non-abusive parents
   vi. Special needs of the child or parent

6. *To use the matrix:*
   a. Choose all of the factors that relate to a child's case, i.e. child's age, type(s) of maltreatment that the child experienced, where in the permanency plan process the case is, family culture and any "other factors" that apply. Place the corresponding factor columns on the template.
   b. The case planning team then reviews each element of a plan across all the factors, such as frequency of visits, to determine the appropriate standard for that case.
   c. The first column, **Child Development**, takes precedent if there is conflict in best practice standards. Example: A child who requests a high level of supervision even after the parent has demonstrated safe parenting should be given that level of supervision until his/her fears or concerns can be addressed.
   d. Any time a case planning team determines that there are circumstances that requires a visit plan contain recommendations outside of the best practice standards, it is recommended that the team write a justification to support its decision. (These standards are based on evidence-based research. Your agency may make changes in these recommendations based on local policy and resources.)

7. Progressing the Visit Plan:
    a. After a successful, initial visit plan is developed, the tool is used to determine how to make progress. If the parent and child are doing well on visits, a progressive step is made. Progression is done by changing ONE of the elements of the visit plan; i.e. length, frequency, level of supervision, location, activities, at a time.
    b. These changes occur regularly to slowly move the visits towards mimicking the family's normal life that will test the family's ability to keep the child safe.
    c. If problems occur on the visits the progress is changed back to the last visit plan that was working where the child was not harmed or traumatized on the visit. It is not necessary, in most cases, to stop visits because of an incident.
    d. If a parent is making progress in treatment but no progress on visit than a case review is necessary to determine if the treatment, services are being effective. Similarly, a parent who is making progress in visits but not in treatment a case review should be done. Visits and treatment services should work together to help a family develop healthy attachments and the ability to ensure a child's safety and well-being.
    e. If a child is traumatized by visits or is stating s/he does not want to attend visits, the plan should be changed ONE element at a time until the visit is meeting the child's need. No child should be forced to attend visits that traumatize the child

8. Based on the visit plan, the *roles and responsibilities of all parties* are determined to ensure that the visit plan is successfully implemented. A chart on suggested responsibilities is included in the tool.

9. The final part of the tool is the Impact of Separation Chart. This chart helps guide visit planning based on common reactions children have to trauma, grief, loss and separation. Example: How do I prepare a parent that his/her infant may cling to strangers rather than go to the birth parent on the first visits? The case planning team selects the visit strategies that are appropriate for the child.

10. The tool is most effective when adapted to meet the local laws, standards, terminology and practices.

For more information about this tool, curricula and how it is being used in various locations contact Rose Wentz.
A sample of the tool and a visit plan using this tool is included in this document.

Developing a Visit Plan – Matrix Planning Form

	Child Developmental Needs & Parenting skills for bonding	Type of Maltreatment	Time in Care & Permanency Planning	Culture	Other Factors
Purpose					
Frequency / Length					
Location					
Activities					
Supervision level					
Who attends					
Responsibilities & what to have at visit					
Documentation					

Sample Visit Plan Based on the Visit Matrix

-- Jones Case Example

- ***Referral:*** A twenty month old child, Jeff, who was left unsupervised for over one hour. During that time the child left his bedroom and was found by a neighbor on a busy street a block away from the parents' home. The parent were found by the police to be asleep and appeared to be intoxicated. They stated that they thought their son was asleep and they believed he was not able to get out of his room by himself. This is the third similar referral for this family. The parents did not follow through with attending parenting classes as recommended by the previous worker.

- ***Strengths:*** Parents are married and employed, child and parents appear to have secure attachment, and the family has an extended family support system in the area, no prior referrals.

- ***Possible Underlying Causes / Risks*:** Lack of parenting knowledge and skills. Possible drug addiction by parents.

- ***Minimum Sufficient Level of Care/Enhanced Parental Capacity:*** Jeff will not be left out of the sight and sound distance of a capable person at any time. This person must be sober, able to check on Jeff regularly, keep him safe inside and outside of the home, call for additional help if needed and ensure that Jeff never "escapes" out of sight or sound distance. If Jeff demonstrates abilities to "escape" the parents will develop a safety plan and implement that plan. Example: If Jeff can open his bedroom door. The outside doors will be kept locked at all times to ensure he cannot reach the street. If Jeff is primarily "escaping" during the times the parents are asleep they must develop a system that would wake up a parent (or have a parent awake) during the time that Jeff is to be sleeping.

Visit Planning Decision Matrix – *Sample matrix for Jeff Jones case*

	Developmental Needs **TODDLER**	Type of Maltreatment **NEGLECT**	Time in Care **REASONABLE EFFORTS** ***1 TO 12 MONTHS****	Other Factors **DRUG ADDICTION**	**FAMILY CULTURE**
Pur-pose	Meet child's developmental needs & maintain connections	Assess, observe & teach safe parenting skills	Teach parenting skills & observe improved parenting	Protect child from inappropriate / unsafe parenting	Maintain & strengthen child's connection with culture, tradition and religion
Frequency & Length	2 to 4 per week 60 to 90 minutes Meets child's schedule	Long enough to practice parenting skills, approx. 1 hour. Increase time with increased skills of parents.	At least once a week At least one hour Increasing in length & frequency as family gets closer to reunification	As soon as possible – do not wait until parent is in treatment to begin visits. At time of day parent is least likely to be intoxicated.	If child does not have contact with cultural community through parent visits or caregiver this type of "visit" should be added to case plan
Location	Home or homelike environment; Community setting: parks, playgrounds, childcare, doctor appointments	Optimal: In parent's home unless location is unsafe. Home-like environment; foster or relative home, home-center	Birth family home whenever possible or home of relative & foster parents Community locations Agency office least desirable	Neutral location where drugs would not be available – as homelike as possible	In family or relative's home In community locations with cultural significance In language of the family
Activities	Parent meets child's needs; learning to do it himself – eating, dressing, toileting, play games, read, talk, sing, provide for safety at location	Practice the skills that lead to neglect: feeding, supervision, discipline. Learn to understand child's needs, feelings, abilities.	Modeling/teaching of parenting skills – see chart for suggestions Reactions to visits should be decreasing	Bonding & attachment activities especially for young children. Later activities that may be relapse triggers for parent.	Sharing family history, stories Teaching family traditions: holidays, cooking, games, hobbies, religious events and learning
Level of Supervision	Lack of communication & self-protection: supervision level should remain high until it is clear the child can communicate / parenting skills are demonstrated	Depends on level of neglect. Severe neglect requires high level of supervision until parent demonstrates improved skills, usually monitoring is enough	Decreasing level of supervision as parenting skills increase, level may vary depending on who attends	Therapeutic or supervision until treatment counselor approves UA does NOT indicate the level of safety or whether a visit should occur	Use family & people the family knows whenever possible to supervise visits & teach parenting skills, that person can speak the family's language
Who attends	Birth parents & siblings together or separate; Other key people with emotional attachment; Who child asks to see	Birth parent(s) or others in caregiver role, siblings. Later include entire family doing normal family activities	All the people the child would live with if reunification occurs. Sibling even if the child will not live with him/her, extended family, non-custodial parents	Non-addicted parent or other family support people can be observer of visit if s/he shows ability to make safe decisions; Have visit safety plan	Parents, siblings, extended family, fictive kin, anyone the family identifies as important in the child's life
Items for visit	Bring toys, diapers, food, & comfort items. Have adult who child feels safe with (could be foster parent) to help with all transitions.	Bring items to practice parenting skills: cooking, homework, toys, bathing, napping	Social worker should observe visit at least once every 2 months Clear case plan connection with visit activities, family involved in planning visit	No drugs or alcohol Set clear rules & enforce them – Relapse plan Everyone knows warning signs	Bring information, pictures, reading materials, & other items to teach family culture

Sample Visit Plan for Jeff Jones Based on the Visit Matrix:

Purpose:

1. To meet Jeff's needs to know that his parents love him and that he can count on them to be regularly available to him.
2. To demonstrate daily care skills while also ensuring Jeff's safety.

Length and Frequency:

Face to Face Contact: 3 times a week for one hour each time. The frequency and length of visits will be expanded by the agency caseworker as the parents demonstrate their abilities listed under activities.
Other contacts: Pictures of the family in the Jeff's bedroom, a call at 7:30pm each night for the parents to say goodnight to Jeff. Parents are encouraged to make tape recordings of them talking, reading, and singing that can be played for Jeff.

Location:

At least once a week Jeff will visit his parents in their home. The other times the parents will come to where Jeff is to minimize the amount of time he has to be in a car. This can include visits at the foster home, relative's home or other nearby locations. The family is involved in their local church. This church has agreed to pick up Jeff Sunday at 9am to bring him to their church. The parents are allowed to be with Jeff during the service. The church pastor has set up a transportation schedule and a person who will stay with Jeff so the parents and Jeff are not left alone.

Activities:

Bonding activities: The parents will spend time feeding, playing, clothing and other normal daily care
Parenting skills related to maltreatment: Initial – The parents will demonstrate the ability to meet Jeff's normal daily care needs. The parents will keep Jeff in sight and sound distance at all times. The parents will demonstrate the ability to anticipate Jeff's needs or actions that might cause him to "escape" or cause him harm. Examples: Give him boundaries for where he can play and keep him within the boundaries. Redirect him to safe activities when he starts to play in an unsafe way. Reward him for follow instructions. (If the parents attend a parenting class we will incorporate specific skills from the class into the visits.)

Supervision:

During the first weeks in care the Social Worker will be supervising the initial visits in order to learn more about how the parents supervise Jeff and if Jeff has any special needs or skills. Church members and foster parents will also monitor some of the bonding/family culture visits. Jeff can attend religious events when monitored by approved church members. Their role is to ensure Jeff's safety and model how to supervise a child of this age. At no time will the supervisor/monitor of the visit leave Jeff alone with his parents until the parents have consistently demonstrated their ability to supervise Jeff. As the parent's demonstrate their ability to keep Jeff in sight and sound distance the Social Worker can slowly allow the parents a few minutes of *observed* time. Example: Leaving the room but staying within hearing distance of Jeff.

The supervisor/monitor of the visit has the authority to provide suggestions and advice to the parents on how to supervise and parent Jeff. If the parents cannot or will not follow the supervisor's advice that visit may be stopped early. Examples that might lead to an early stop of a visit: Parents are intoxicated and cannot follow the visit rules or supervise Jeff. Parents are not interacting with Jeff even after reminders. Parents repeatedly place Jeff in potential danger and do not follow the advice of the supervisor/monitor of the visit. If the parents can complete suggested bonding activities but not practice supervision appropriately the visit should not be stopped early and the supervisor of the visit should provide/model the supervision that is needed.

Who should be Involved in the Visits:
Birth parents. Relatives or family friends that the parents identify. Church members.
The foster parents will begin to have visits at their home after the initial assessment is completed by the Social Worker. They will demonstrate how they supervise Jeff, sleeping arrangements, and other skills such as how to redirect a toddler.

What to Bring:
The parents will bring a snack or meal depending on the time of the visit. Meal schedules will be coordinated with the foster parents to ensure Jeff's schedule and diet is coordinate. Jeff has a favorite blanket that will be with him during visits. The supervisor of the visit needs to ensure he takes it with him and brings it back to the foster home. For each visit the parents will bring at least one item such as a book, toy, song, or items for a planned activity.

Documentation:
The supervisor of the visit will complete the visit document form. If there is a problem during the visit the supervisor of the visit will contact the social worker that day and provide a verbal report. Observers/monitors of visits are not required to do written reports but only provide verbal feedback when there is a problem or upon request from the Social Worker.

Impact of Separation:
Jeff has had trouble falling asleep during his first days in foster care. The birth parents will tell the Social Worker what his sleeping and napping schedule were when he was at home. They will also share if they have any bedtime routines such as reading books, saying prayers, keeping on a light, etc. The Social Worker will share that information with the foster parents and they will try to use the same schedule and do as many of these routines as possible.
On longer visits the birth parents will help Jeff take a nap by doing the same routines to help minimize the changes Jeff has to experience.
The foster parents will call the birth parents at 8pm each night. The parents and Jeff can talk for up to five minutes. Suggested activities: Read a book to Jeff; tell him that you love him, or other bedtimes routines.

Child Developmental Needs Factors

	Child Development/ Parenting skills INFANTS	Child Development/ Parenting skills TODDLERS	Child Development/ Parenting skills PRESCHOOL	Child Development/ Parenting skills GRADE SCHOOL	Child Development/ Parenting skills TEENS
Purpose	Meet child's developmental needs & maintain connections	Meet child's developmental needs & maintain connections	Meet child's developmental needs & maintain connections	Meet child's developmental needs & maintain connections	Meet child's developmental needs & maintain connections
Length	3 to 5 per week Long enough for parent to feed, change diapers, play – 60 minutes minimum; meets child's schedule	2 to 4 per week 60 to 90 minutes Meets child's schedule	2 to 4 per week 60 to 90 minutes Meets child's schedule	1 to 2 per week 1 to 3 hours Meets child's schedule	At least once a week 1 to 3 hours Meets child's schedule
Location	Home or home-like environment Allows for caring of baby Have items that calms baby; blanket, pacifier, toy Community, doctor appts.	Home or home-like environment Community setting: parks, playgrounds, childcare, doctor appts.	Home or home-like environment Community setting: parks, playgrounds, childcare, doctor appts.	Child helps to choose Home or home-like environment Where child already is: school, sports, park, restaurant, therapist, doctor	Teen helps to choose Where teen already is: school, sports, park, restaurant, mall, therapist, home of parent or caregiver, doctor
Activities	Parent meets child's needs: crying, eating, sleeping Play on floor or eye level Music, read book, talk to baby; Bonding activities	Parent meets child's needs: learning to do it herself – eating, dressing, toileting Play games, read, talk, sing Provide safety & supervision	Child chooses what to do *during* visit: which book to read, what toy to play with, what game Ask child about their life. Provide discipline.	Child helps to choose: what child likes to do; sports, games. What child must do: homework, chores. Ask child about his life. Provide discipline.	Teen helps to choose: what child likes to do, sports, games, shopping. What child must do: homework, chores. Ask child about her life. Discipline.
Supervision	Lack of communication & self protection means that supervision level should be higher than same situation with older children.	Lack of communication and self protection means that supervision level should be higher than same situation with older children.	Communication and self-care skills assessed to determine supervision level	Communication and self-care skills assessed to determine supervision level	Communication and self-care skills high enough for the teen to give input to level that is needed, i.e. youth is able to self-protect
Who attends	Birth parents & siblings together or separate, Other key people with emotional attachment	Birth parents & siblings together or separate, Other key people with emotional attachment Who child asks to see	Ask child who he wants to visit Birth parents & siblings together or separate, Other key people with emotional attachment	Ask child who he wants to visit Birth parents & siblings together or separate, Other key people with emotional attachment	Ask teen who he wants to visit Birth parents & siblings together or separate, Other key people with emotional attachment
Responsible	Bring food, toys, diapers & comfort items. Have adult who child feels safe with (could be foster parent) help with all transitions.	Bring toys, diapers, food, & comfort items. Have adult who child feels safe with (could be foster parent) help with all transitions.	Bring toys, diapers, food, & comfort items. Have adult who child feels safe with (could be foster parent) help with all transitions.	Bring toys, food, homework, & other items for session. Allow child time to adjust to transitions.	Bring food, homework, games & other items for session. Allow child time to adjust to transitions.

This document only contains the Developmental Needs Factor. Contact Rose Wentz regarding the entire tool.

Visits: ROLES AND RESPONSIBILITIES

	BEFORE	DURING	AFTER
CHILD'S PARENT(S)	• Ask about any rules/expectations s/he does not understand. Follow all the rules. • Find items to bring. • Arrange transportation. • Call as soon as possible if visit must be cancelled or you will be late. • Ask for help on how to handle your and the child's emotions that commonly occur during visits.	• Follow the rules. Come prepared. Come on time. Bring required items for visit and nothing else. Do not bring other people without permission. • Give child 100% of your attention. • No drugs or alcohol use at visit and do not come to visit intoxicated. • If you are having a mental health crisis ask for visit to be postponed.	• Listen for feedback and ask questions about how to improve. • State concerns to SW. • Provide suggestions for next visit. • Take care of yourself – visits are hard emotionally. • Talk to a friend, SW, or therapist to debrief visit.
SOCIAL WORKER (person responsible to develop visit plan)	• Place child in a home that is close and will support visits and family connections. • Place sibling together or ensure they have frequent visits. • Provide everyone with written visit plan. • Tell *parent(s)* of expectations and rules. • Help parent(s) prepare what to say to child, what to bring, what activities are allowed/expected. Do not expect that parent(s) knows how to perform parenting tasks and assume parent(s) will feel "unnatural" during visit – PREPARE the parent(s) to succeed. • Explain to *child* purpose of visit, safety rules, how long it will last, and returning to caregiver following visit. Practice what s/he may want to say to parent(s) • Arrange transportation and location. • Do not use visits as a reward or punishment.	• See Supervisor of visit responsibilities if you are also doing that task. • See Transporter of visit responsibilities if you are also doing that task. • Make visits a high caseload priority so that they occur.	• Apply sanctions to parents who break rules. Do not use visits as rewards or punishment. • Give the child's parent(s) feedback on their interactions, behaviors, parenting skills or other issues. Communicate in a strength-based manner. • Use Progressive Visit Planning to increase or decrease an item in the visit in order to meet the child's needs and to determine parenting skills. • Call and check with child and/or caregiver to see how the child is reacting to visits • Ask everyone about how to improve the visits
CHILD'S OUT-OF-HOME CAREGIVER	• Prepare child for the type of visit; talk about visit, how to handle emotions and the safety plan. • Pack clothes, food, medicine, comfort item or other items needed for visit • Say positive things to the child about visit and parents. • Transport child to visit. • Give information to SW and parent about child: anything that might affect the visit, i.e. school, illness, behaviors. • Support contact with siblings and others. • Do not use visits as reward or punishment for child's behavior. • Believe that family connections are essential.	• Have the visit in caregiver(s) (your) home. • Model or teach parenting skills to the child's parent. • Supervise or monitor visits – see supervisor of visits for more details • Help with transitions at beginning and the end of visits, especially if the child is emotionally attached to you or the child does not remember the family members who will be at the visit. • Be willing to meet with the child's parent(s) before and after the visit. Avoid "handing off" the child to a third party in order that you not meet the parent(s).	• Transport child back to your home. • Have routine that will comfort child, allow for emotions to be safely expressed. • Discuss "abnormal" reactions the child has to visits with the child's caseworker. • Document visits if you supervised visit or it occurred in your home. • Take care of yourself, the child, and your family - given your emotions.

	BEFORE	DURING	AFTER
CHILD/ YOUTH	• Tell adults what you prefer regarding visits; location, frequency, who attends, activities, safety. • Ask any questions you have about the visits • Tell adults if you are having feelings you cannot handle, are afraid, or need information.	• Have fun. • Be on time. • Follow the rules. • Use your safety plan, ask for help. Ask for visit to end if you feel unsafe.	• Tell adults if you have any questions, feelings, reactions, or concerns about the visit. • Tell adults what you think would make the visits better.
SUPERVISOR OF VISIT	• Must be willing and able to put child's best interest first. • Given the visit plan, have the skills required to implement the plan; to supervise, model parenting skills , assess, interactions, or observe. • Complete any training required to be a visit supervisor, especially for conducting high level of supervision for violent or unsafe parents.	• End visit if parent violates rules or if child indicates his/her safety is at risk. • Enforce all the rules of the visit (location, activities, people attending). • End visit if parent shows any signs of intoxication, mental illness or abusive behaviors. • Supervised/Observation supervisor: do not talk to others during the visit, do not get involved in activities even if asked, only intervene if safety issues occur. • Modeling/teaching supervisor: do provide direct modeling or teaching of parenting skills as determined by the case plan. Can give advice to parent during the visit. • Therapeutic supervisor: therapy, teaching parenting skills, family counseling, play therapy. • Take notes regarding visit. Send to SW ASAP. May be required to testify in court. • Watch the clock and be sure all 3 phases of a visit occur (saying hello, the activities, saying goodbye).	• If social worker has approved provide immediate feedback to parent – do this out of hearing of the child. • Document visit and send to appropriate people. • Call social worker or caregiver soon after the visit if there is a special need of the child or parent(s) that should be addressed immediately. • If approved, check with older children, out of hearing from the child's parent(s), as to the child's questions, reactions, or assessment of the visit.
TRANSPORTER	1. Be on time. 2. Safe driving and car seats. 3. Listen to child during the ride. 4. Provide reassurance. 5. Report any concerns immediately to social worker. 6. May be asked to provide information from caregiver to SW or child's parent(s).	• See Supervisor of visit responsibilities if you are also doing that task.	• Be on time. • Safe driving and car seats. • Listen to child during the ride but do not give advice. • Provide reassurance. • Report any concerns immediately to social worker. • May be asked to provide information to caregiver.

LEVELS OF SUPERVISION
-- A continuum to ensure safety while allowing the most normal family interactions possible

Therapeutic: Role modeling, therapy, and teaching occurs to improve the parenting skills or parent-child relationships. Conducted by trained mental health professional or other professional.

Supervised: Parent and child are in sight and sound distance of an objective person who can ensure the safety of the child and ensure that the visit plan is followed. The family is not allowed "alone" time unless specifically approved. Supervisor of visit must have appropriate training and skills.

Observed/Monitored: Objective party who maintains some level of contact during the visit to ensure visit plan is followed. This level of observation will vary depending on the plan. In the lowest level, the visit can occur in a public setting without a designated observer: school events, child's sports, or other activities, medical appointments, parks, restaurants, pro sport games, etc.

Unsupervised: Parent and child allowed time alone from one hour to overnight. Child and family have resources available during visit to call for help. A clear safety plan has been developed, tested and is known by all parties.

Sources for matrix:

- Hess, Peg McCartt and Kathleen Ohman Proch. Family Visiting in Out-of-Home Care: A Guide to Practice. Washington: Child
- Welfare League of America, 1988.

- Wright, Lois E. and Cynthia B. Seymour. Working with Children and Families Separated by Incarceration: A Handbook for Child
- Welfare Agencies. Washington: Child Welfare League of America, 2000.

- Rycus, Judith S., Ronald C. Hughes, and Norma Ginther. "Core 104 Separation and Placement in Child Protective Services: A Training
- Curriculum." Columbus: Institute for Human Services; Washington: Child Welfare League of America, 1988.

- Wright, Lois E. Toolbox No. 1: Using Visitation to Support Permanency. Washington, DC: Child Welfare League of America, 2001.

IMPACT OF SEPARATION CHART: *Sample of Content*

	Developmental Response Special Issues	Behaviors that may occur or how the may be impacted	Visit Strategies Social Worker, Birth Parent or Caregiving Parent needs to do to help child
TODDLER	Typical reactions by toddlers: fear, regression, fantasy, guilt, bewilderment, change in level of aggression, generalized emotional neediness, inability to enjoy play or using play to recreate the family.	• Toddler will test their "new world" to try & understand how it works. • Toddler behaviors such as temper tantrums will increase after being traumatized. • Workers, caregivers & parents often want to blame someone or interpret the behaviors as related to things besides the separation, i.e. XXX must not be a good parent of the child.	• Expect toddler to show behavioral signs of trauma and loss. • Do not blame adults or shame the toddler. • Provide structure, rules, consistency and stability for the toddler – minimize how many changes the toddler must have – make changes slowly • Reassure the toddler that she is loved. • Control behaviors that can cause harm to the toddler or others but do not overreact.
	The toddler needs dependable adults to help him/her cope.	• Child can turn to relative, substitute caregivers or a known and trusted worker for help & support during the placement process. • Child may cling to strangers to try and cope.	• Early & regular contact with parent or other who the toddler has emotional ties. • Do bonding activities. • Place siblings together and/or provide time for them to comfort each other. • Provide toddler with his favorite comfort item.
	The toddler is likely to have an inaccurate and distorted perception of the placement experience.	• Toddler may make up stories about abuse, what occurred, why it occurred, what is happening to him in care, etc. This can appear to be lying to others.	• Discuss reality and fantasy with the child. • Do not punish child for "telling lies".
	See people in extremes of all good or all bad	• Toddler may fear new caregiver or environment. • Toddler talks about people in extremes, i.e. My mommy is bad/good.	• Assure toddler s/he is safe with caregivers. • Inform parents and caregivers of these issues so they do not overreact to things he may tell them, e.g. "My new mommy is mean to me."
	Any placement of more than a few weeks is experienced as permanent.	• Without visits, the child may assume parents to be gone, dead or not coming back. • A toddler can complete the grief and loss cycle in a few weeks. A toddler believes what they see and experience, not what they are told.	• Do frequent visits, if not possible, have pictures, talk about the absent parent or have phone calls or audio tapes. • Prepare the parent for the toddler's behavior and lack of memory if visits have not occurred regularly. • Give the toddler a chance to remember or reestablish a connection with the parent at the beginning of a visit.

VISIT PLANNING DECISION MATRIX

Client: Amy Green, Child: Ruth Green, 2months

	Developmental Needs: INFANT	Type of Maltreatment: NEGLECT	Time in Care Initial Placement	Other Factors: SUBSTANCE DEPENDENCE	Family Culture
Purpose	Meet Ruth's developmental needs, maintain bond, and care for basic needs.	Assess parenting skills, model appropriate interactions.	Teach parenting skills, identify support system to aid in reunification.	Protect child from unsafe parenting/client maintains sobriety.	Maintain child's relationship with extended family/family traditions.
Frequency/Length	2-4 times per week, 60-90 minutes, meets parent/child schedule.	Increased visitation time once basic parenting is completed autonomously.	2 times per week during visitation.	ASAP	Extended family on visits 1x per month at minimum.
Location	Reunity House, Ms. Green's home, resource placement.	Parent's home/Reunity House.	Parent's home, foster parent's home, Reunity House.	Supervised, homelike environment.	Have child visits occur in family's home as frequently as possible.
Activities	Meet Ruth's basic needs ie: feeding, changing. Maintain bond with child by engaging child actively in everyday activities.	Meet child's needs and anticipate child's needs prior to their occurrence.	Basic infant care and parent-child bonding activities.	Attachment activities/ Basic parenting skills. Identify relapse triggers.	Family celebrations with child present.
Supervision level	Ongoing supervised visitation during assessment. Decreased supervision once goals are met.	Monitoring visitation for appropriateness.	Continue to decrease supervision based on goals met.	Supervised visitation	Supervised visitation.
Who Attends	Amy Green, Maternal grandmother, extended family one time per month, (biological father is incarcerated).	Ms. Green, MGM, Paternal Aunt, biological brother of child to prepare for change in placement.	All family members within Ms. Green's home.	Biological parents, extended family,	Biological parents, extended family, etc. (As specified by client).
Responsibilities & what to have at visit	Foster parent to supply personal comfort items for child (pacifier/blanket/car seat). Client to provide necessities: Diapers, formula, clothing.	Ms. Green bring items to practice parenting skills ie: bathing items, bottles, changing supplies.	Foster parent to supply comfort items for child. Client to provide necessities. Clinician to provide sensory toys.	No drugs/alcohol	Foster parent- comfort items. Client-necessities.
Documentation	Progress notes, Memos to ECR, treatment plan.	Progress notes, Memos to ECR, treatment plan.	Progress notes, Memos to ECR, treatment plan.	Progress notes, Memos to ECR, treatment plan.	Progress notes, Memos to ECR, treatment plan.

Visit Plan for Amy Green and Ruth Green

Purpose:

1. Ms. Green to meet Ruth's basic and developmental needs through visitations to plan for reunification.
2. Assess Ms. Green's parenting skills, assist her in identifying supports, keep child safe during visitations.

Length and Frequency:

Visitations will begin face to face two times per week for sixty minutes. The frequency and length of visitations will be expanded by social worker as the parent demonstrates abilities listed under activities. Other contacts: Ms. Green and foster parent currently communicate on a weekly basis over the phone; communication is to continue. Ms. Green is also to be notified by foster parent of all doctor appointments.

Location:

Visitations will initially take place at Reunity House Paterson. Once Ms. Green demonstrates the ability to care for her child's basic needs autonomously, visitations will take place at the foster home, within the community, and at the client's home (once a risk assessment is completed). In addition, the paternal aunt is currently being explored as a resource parent. Visitations may take place within the aunt's home once the Division completes assessment of the home.

Activities:

Bonding activities: Ms. Green will spend visitations caring for her daughter's basic needs by feeding, changing, clothing, bathing, and caring for any other needs autonomously. *Parenting skills related to substance dependence:* Ms. Green is to maintain a daily schedule which includes caring for her daughter's needs while abstaining from substance use.

Supervision:

Ms. Green will be supervised by social worker for the entirety of visitations initially. Once the assessment period is completed and safety concerns are ruled out, visitations may occur in other locations. Ms. Green may begin visitations within her home, the paternal aunt's home, and the maternal grandmother's home. Visitations will be initially monitored by social worker within the home settings. Once safety concerns are ruled out, visitations may be supervised by paternal aunt or foster mother based on where the visitation is taking place.

Who should be Involved in Visits:

Ms. Green and her supports are to be involved in visitations. (Mr. Thomas, Ruth's father is currently incarcerated). Ms. Thomas, the PGM, and Ms. Booker, Paternal Aunt. Ms. Green's biological family, who reside in Pennsylvania, may attend visitations at Ms. Green's request. The foster parents may attend visitations that take place within their home or at Ms. Green's request.

What to Bring:

Ms. Green is to provide necessities for Ruth which may include but is not limited to: Diapers, formula, clothing, etc. Foster parents are to provide personal and comfort items for child including but not limited to: Pacifier, blanket, car seat, etc. Social worker is to provide sensory toys and other items which may aid in developmentally appropriate play.

Documentation:

Social worker is to complete bi-weekly progress notes of visitations at this time. Once visitations are transferred to more liberal visitations occurring within paternal aunt/paternal grandmother/foster parent's home, social worker is responsible to reach out to the monitor of the visitations one time weekly to discuss visitation information.

Memos to ECR will be utilized to document any collateral contacts/any information that is collected outside of visitations. Treatment planning will be completed every three months or sooner based on need.

Impact of Separation:

Ruth is well connected with foster mother and father as she has lived with them since birth. Ms. Green's contact with her daughter shall be expanded as soon as assessment in completed that no safety concerns are present. In addition, Ruth was exposed to opiates and cocaine prior to birth. It is paramount that Ruth is not exposed to her mother while she is under the influence in order to avoid further safety concerns.

Appendix I: SVS Family Visitation Plan

SVS Family Visitation Plan

Family Name: _____ NJS#_____ Visit Start Date: _____

Today's Date: _____ Next VPM Date (Tentative): _____

Impact of Separation: *Describes how it affects the child development & parent -child relationship.*	
Visitation Goals: *Develop goals based on visitation strengths and challenges, family need and child development considerations. Clearly identify requirements to move to a less restrictive visitation supervision level*	
Visitation Supervision Level: ***Level of supervision along the continuum is based on assessment, in collaboration with DCP&P, and may change as the family's needs change over time.*** **The visitation continuum consists of: Therapeutic, Supportive, Relative/Community Supervised, Unsupervised, & Aftercare when reunified.*	

Visitation Location: *Detail family's request for visitation location. Visitation location should be in the least restrictive setting possible including the family's home, kin or resource parent's homes, in-community locations. Visits should only occur in the provider or DCP&P's office when visitation safety and/or risk factors exist.*	
Visitation Frequency and Duration: *Child's age and development should be considered when determining visitation frequency and duration*	
Visitation Participants: *Detail names and relationships of family-requested visitation participants. Identify if they are DCP&P-approved and outlines steps for approval.*	
Visitation Activities and What to Bring: *Detail visitation activities, what caregivers should bring, etc. Include any cultural considerations, as appropriate*	
Note about Visitation Documentation: Details from each visit will be documented in agency's electronic health records and DCF's NJS case recording system. Visitation planning meetings will occur at least every three months, and visitation plans will be provided to families after each meeting. Reports will also be sent to DCP&P and forwarded to the courts at least quarterly.	

Appendix J: SVS Visitation Planning Meeting (VPM) Agenda and Forms

SVS Visitation Planning Meeting (VPM) – Details and Agenda

Date:	
Time:	
Location:	
Participants:	
Caregivers:	
Children, if applicable:	
SVS Staff:	
DCP&P Staff:	
Kin:	
Resource Parents:	
Service Providers:	

Agenda:

1. Review current visitation plan, if applicable, focusing on impact of separation, visitation goals, visitation supervision level, visitation location and visitation frequency and duration.
2. Discuss visitation updates from SVS visitation specialist(s), family, DCP&P, service providers and family supports, if applicable. Updates include visitation strengths and challenges, DCP&P case and/or service updates and exploration of family and/or natural supports.
3. Develop and/or review and update proposed visitation plan which includes impact of separation, visitation goals, visitation supervision level, visitation location, visitation frequency and duration, visitation participants, visitation activities and what to bring and visitation documentation.

SVS Visitation Updates

Family Name: _____ NJS#_____ Visit Start Date: _____

Today's Date: _____ Next VPM Date (Tentative): _____

Visitation strengths: *Highlight what's working well in visits focusing on attendance, relationships, bonding, parent-child interactions, parenting skills, communication, etc.*	
Visitation challenges: *Highlight what isn't working well in visits and could be improved focusing on attendance, Relationships, bonding, parent-child interactions, parenting skills, communication, etc.*	
DCP&P case or service updates: *Describe progress towards case goals, recent court orders and any service updates*	
Family and natural supports: *Explore family supports for possible visitation supervisors, if applicable, or potential home-like visitation settings*	

SVS Family Visitation Plan

Family Name: _____ NJS#_____ Visit Start Date: _____

Today's Date: _____ Next VPM Date (Tentative): _____

Impact of Separation: *Describes how it affects the child development & parent -child relationship.*	
Visitation Goals: *Develop goals based on visitation strengths and challenges, family need and child development considerations. Clearly identify requirements to move to a less restrictive visitation supervision level*	
Visitation Supervision Level: ***Level of supervision along the continuum is based on assessment, in collaboration with DCP&P, and may change as the family's needs change over time.*** **The visitation continuum consists of: Therapeutic, Supportive, Relative/Community Supervised, Unsupervised, & Aftercare when reunified.*	
Visitation Location: *Detail family's request for visitation location. Visitation location should be in the least restrictive setting possible including the family's home, kin or resource parent's homes, in-community locations. Visits should only occur in the provider or CP&P's office when visitation safety and/or risk factors exist.*	
Visitation Frequency and Duration: *Child's age and development should be considered when determining visitation frequency and duration*	
Visitation Participants: *Detail names and relationships of family-requested visitation participants. Identify if they are DCP&P-approved and outlines steps for approval.*	
Visitation Activities and What to Bring: *Detail visitation activities, what caregivers should bring, etc. Include any cultural considerations, as appropriate*	
Note about Visitation Documentation: Details from each visit will be documented in agency's electronic health records and DCF's NJS case recording system. Visitation planning meetings will occur at least every three months, and visitation plans will be provided to families after each meeting. Reports will also be sent to DCP&P and forwarded to the courts at least quarterly.	

Name	Signature
Name	Signature
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Name	Signature

Appendix K: SVS Job Description - Program Leader

ABOUT SUPPORTIVE VISTATION SERVICES (SVS): Parent-child visitation services for CP&P-involved families with children in out-of-home placement to maintain and strengthen familial interactions and facilitate permanency. Services are provided in the least restrictive setting that maintains safety along a continuum of supervision based on family need. Core activities include ongoing assessment, visitation, aftercare (post-reunification support), transportation and documentation.

TITLE: Program Leader

DESCRIPTION: Responsible for day-to-day operations of agency's SVS Program; recruiting, selecting, coaching, supervising and assessing therapeutic and supportive visitation specialists and drivers; collecting and reporting SVS data; participating in various CQI activities; and attending meetings and delivering presentations.

ESSENTIAL DUTIES:

Engaging

- Initiates and maintains ongoing communication with families in a culturally sensitive manner utilizing a family's preferred language taking into consideration a family's faith and culture.
- Ensures the environment for parent-child contact is safe, non-traumatizing, and promotes healthy attachment.
- Initiates and maintains ongoing communication with DCP&P, other providers, and supports.

Assessing

- Uses a process to gather information which includes reviewing collateral information and inquiring about family's natural supports.

Active Listening

- Creates an environment that empowers family members, including parents, children, and caregivers to communicate their goals and needs.
- Utilizes various interviewing and/or communication techniques in a culturally competent manner.
- Recognizes non-verbal communication and maintains good eye contact and posture.

Teaming

- Advocates for parents/families as necessary and supports them in advocating for themselves.
- Links the family to community resources and formal and informal supports and coordinates with DCP&P.
- Collaborates with and shares relevant information with DCP&P staff, other providers, and supports.
- Facilitates visit planning meetings and participates in other relevant meetings.

Coaching

- Operates from a trauma-informed perspective.

POSITION STATUS: ___ *Full-time, minimum of __ hours/week*
___ *Part-time, __ of hours/week)*
___ *Other:* _____

REQUIREMENTS:

Education: Graduation from an accredited college or university with a master's degree in social work, counseling or other related area.

Experience: Minimum of five (5) years of work experience providing mental health services including at least two (2) years of experience providing mental health or other therapeutic services to children, adolescents and/or families. Minimum of two (2) years of supervisory experience. Experience working with diverse populations.

License: Required to possess a valid professional license and/or certification and a valid driver's license in good standing.

Required Knowledge, Skills and Abilities:

- Leadership skills with the ability to proactively recognize and solve problems.
- Organizational skills with the ability to manage numerous projects and people simultaneously.
- Outstanding human relations skills with the ability to function in a team environment and be fair, respectful, considerate and inclusive.
- Effective oral and written communication skills.
- Computer literate with proficiency and working knowledge of database and reporting tools such as Microsoft Word, Excel, Access, and PowerPoint.

Appendix L: SVS Job Description - Therapeutic Visitation Specialist

ABOUT SUPPORTIVE VISTATION SERVICES (SVS): Parent-child visitation services for CP&P-involved families with children in out-of-home placement to maintain and strengthen familial interactions and facilitate permanency. Services are provided in the least restrictive setting that maintains safety along a continuum of supervision based on family need. Core activities include ongoing assessment, visitation, aftercare (post-reunification support), transportation and documentation.

TITLE: Therapeutic Visitation Specialist

DESCRIPTION: Responsible for supporting parent-child visitation for families in their homes or communities who require therapeutic intervention; completing biopsychological assessments, assessment tools, and visitation plans; documenting visits and completing reports; facilitating parent debriefings before and after visits and visitation planning meetings; transporting to children and/or parents; communicating with children, parents, relatives, resource parents, DCP&P, and/or other stakeholders by phone and in person; attending various meetings and trainings; and assessing families' service needs and linking them to appropriate community providers.

ESSENTIAL DUTIES:

Engaging

- Initiates and maintains ongoing communication with families in a culturally sensitive manner utilizing a family's preferred language taking into consideration a family's faith and culture.
- Schedules and conducts visits in the least-restrictive, most home-like location (the first preference being within the family's home) while ensuring the safety of the children.
- Ensures the environment for parent-child contact is safe, non-traumatizing, and promotes healthy attachment.
- Uses strengths-based, solutions-focused, family centered, trauma informed strategies to elicit family input.
- Initiates and maintains ongoing communication with DCP&P, other providers, and supports.

Assessing

- Uses a process to gather information which includes reviewing collateral information and inquiring about family's natural supports.
- Completes required assessment tools including but not limited to bio-psychological assessments, Rose Wentz Matrix and SVS Caregiver Surveys and documents contacts with families in agency's progress notes and DCP&P contact sheets.
- Creates a visitation plan with active familial involvement and updates the plan at regular intervals.

Active Listening

- Creates an environment that empowers family members, including parents, children, and caregivers to communicate their goals and needs.
- Utilizes various interviewing and/or communication techniques in a culturally competent manner.
- Recognizes non-verbal communication and maintains good eye contact and posture.

Teaming

- Advocates for parents/families as necessary and supports them in advocating for themselves.

- Links the family to community resources and formal and informal supports and coordinates with DCP&P.
- Collaborates with and shares relevant information with DCP&P staff, other providers, and supports.
- Facilitates visit planning meetings and participates in other relevant meetings.

Therapeutic Intervening
- Uses clinical interventions and trauma informed approaches to promote behavioral change in caregivers and children through education, modeling, reinforcement, and empowerment.

Coaching
- Enhances parental skills by goal setting, modeling, mentoring, reinforcement and feedback and reflection through a trauma-informed perspective.
- Prepares for each visit with caregivers reviewing goals and expectations and encouraging them to be the lead in visit planning.
- Debriefs with caregivers after each visit to allow for processing and self-reflection and discussion of strengths and challenges.

POSITION STATUS: ___ *Full-time, minimum of __ hours/week*
___ *Part-time,__ of hours/week*
___ *Other: _____*

REQUIREMENTS:
Education: Graduation from an accredited college or university with a master's degree in social work, counseling or other related area.

Experience: Minimum of one (1) year of work experience with children and families, particularly families involved with the child welfare system and/or affected by trauma. Experience working with diverse populations.

License: Required to possess a valid professional license and/or certification and a driver's license valid in New Jersey.

Required Knowledge, Skills and Abilities:
- Organizational skills with the ability to manage numerous visiting families and systems of care simultaneously to promote best practices.
- Outstanding human relations skills and the ability to function autonomously and in a team environment.
- Effective oral and written communication skills.
- Effectively solve problems and communicate information, including the identification and communication of problems and/or issues with appropriate team and management staff.
- Knowledge of resources and/or services in the community for the target population.
- Knowledge of trauma and its effects on children and families.
- Knowledge of infant, child and adolescent stages of growth and development.
- Knowledge of and ability to use therapeutic approaches when working with children and families.
- Model, coach, support, and mentor parents on use of nurturing and safe parenting.

- Deliver and score assessment tools.
- Excellent computer skills with proficiency and working knowledge of database and reporting tools such as Microsoft Word, Excel, Access, and/or electronic health record systems.
- Safely operate a motor vehicle abiding by all applicable traffic laws.
- Ensure safety of all passengers through appropriate safety measures including use of seat belts, car and booster seats and/or child safety locks.
- Knowledge of county's local and highway roads.

Working Conditions:

- A flexible working schedule is required to accommodate families which includes night, weekends and/or holidays.
- A majority of working time is spent out of the office transporting children and/or parents to and from visits and observing visits in families' homes or in the community (parks, libraries, restaurants, jails, etc.).
- Work may include lifting individuals up to, or in excess of, 50 pounds, and performing work that requires frequent standing, siting, bending, reaching, squatting, kneeling, and moving.

Appendix M: SVS Job Description - Supportive Visitation Specialist

ABOUT SUPPORTIVE VISTATION SERVICES (SVS): Parent-child visitation services for CP&P-involved families with children in out-of-home placement to maintain and strengthen familial interactions and facilitate permanency. Services are provided in the least restrictive setting that maintains safety along a continuum of supervision based on family need. Core activities include ongoing assessment, visitation, aftercare (post-reunification support), transportation and documentation.

TITLE: Supportive Visitation Specialist

DESCRIPTION: Responsible for supporting parent-child visitation for families in their homes or communities; completing and updating visitation plans; documenting visits and completing reports; facilitating parent debriefings before and after visits and visitation planning meetings; transporting children and/or parents; communicating with children, parents, relatives, resource parents, DCP&P, and/or other stakeholders by phone and in person; attending various meetings and trainings; and assessing families' service needs and linking them to appropriate community providers.

ESSENTIAL DUTIES:

Engaging

- Initiates and maintains ongoing communication with families in a culturally sensitive manner utilizing a family's preferred language taking into consideration a family's faith and culture.
- Schedules and conducts visits in the least-restrictive, most home-like location (the first preference being within the family's home) while ensuring the safety of the children.
- Ensures the environment for parent-child contact is safe, non-traumatizing, and promotes healthy attachment.
- Uses strengths-based, solutions-focused, family centered, trauma informed strategies to elicit family input.
- Initiates and maintains ongoing communication with DCP&P, other providers, and supports.

Assessing

- Uses a process to gather information which includes reviewing collateral information and inquiring about family's natural supports.
- Completes required assessment tools including but not limited to bio-psychological assessments, Rose Wentz Matrix and SVS Caregiver Surveys and documents contacts with families in agency's progress notes and DCP&P contact sheets.
- Creates a visitation plan with active familial involvement and updates the plan at regular intervals.

Active Listening

- Creates an environment that empowers family members, including parents, children, and caregivers to communicate their goals and needs.
- Utilizes various interviewing and/or communication techniques in a culturally competent manner.
- Recognizes non-verbal communication and maintains good eye contact and posture.

Teaming

- Advocates for parents/families as necessary and supports them in advocating for themselves.
- Links the family to community resources and formal and informal supports and coordinates with DCP&P.

- Collaborates with and shares relevant information with DCP&P staff, other providers, and supports.
- Facilitates visit planning meetings and participates in other relevant meetings.

Coaching
- Enhances parental skills by goal setting, modeling, mentoring, reinforcement and feedback and reflection through a trauma-informed perspective.
- Prepares for each visit with caregivers reviewing goals and expectations and encouraging them to be the lead in visit planning.
- Debriefs with caregivers after each visit to allow for processing and self-reflection and discussion of strengths and challenges.

POSITION STATUS: ___ *Full-time, minimum of __ hours/week*
___ *Part-time, __ of hours/week*
___ *Other: _____*

REQUIREMENTS:
Education: Graduation from an accredited college or university with a bachelor's degree in social work, counseling or other related area.

Experience: Minimum of one (1) year of work experience with children and families, particularly families involved with the child welfare system and/or affected by trauma. Experience working with diverse populations.

License: Required to possess a driver's license valid in New Jersey.

Required Knowledge, Skills and Abilities:
- Organizational skills with the ability to manage numerous visiting families and systems of care simultaneously to promote best practices.
- Outstanding human relations skills and the ability to function autonomously and in a team environment.
- Effective oral and written communication skills.
- Effectively solve problems and communicate information, including the identification and communication of problems and/or issues with appropriate team and management staff.
- Knowledge of resources and/or services in the community for the target population.
- Knowledge of trauma and its effects on children and families.
- Knowledge of infant, child and adolescent stages of growth and development.
- Model, coach, support, and mentor parents on use of nurturing and safe parenting.
- Excellent computer skills with proficiency and working knowledge of database and reporting tools such as Microsoft Word, Excel, Access, and/or electronic health record systems.
- Safely operate a motor vehicle abiding by all applicable traffic laws.
- Ensure safety of all passengers through appropriate safety measures including use of seat belts, car and booster seats and/or child safety locks.
- Knowledge of county's local and highway roads.

Working Conditions:

- A flexible working schedule is required to accommodate families which includes night, weekends and/or holidays.
- A majority of working time is spent out of the office transporting children and/or parents to and from visits and observing visits in families' homes or in the community (parks, libraries, restaurants, jails, etc.).
- Work may include lifting individuals up to, or in excess of, 50 pounds, and performing work that requires frequent standing, siting, bending, reaching, squatting, kneeling, and moving.

Appendix N: SVS Job Description - Driver

ABOUT SUPPORTIVE VISTATION SERVICES (SVS): Parent-child visitation services for CP&P-involved families with children in out-of-home placement to maintain and strengthen familial interactions and facilitate permanency. Services are provided in the least restrictive setting that maintains safety along a continuum of supervision based on family need. Core activities include ongoing assessment, visitation, aftercare (post-reunification support), transportation and documentation.

TITLE: Driver

DESCRIPTION: Responsible for transporting children and/or parents to and from visitation locations; ensuring safety of passengers; maintaining vehicle; recording and maintaining applicable logs; communicating with visitation specialists, parents, resource parents, children, etc.; and attending applicable trainings.

ESSENTIAL DUTIES:

Engaging

- Initiates and maintains ongoing communication with families in a culturally sensitive manner utilizing a family's preferred language taking into consideration a family's faith and culture.
- Ensures the environment for parent-child contact is safe, non-traumatizing, and promotes healthy attachment.
- Initiates and maintains ongoing communication with DCP&P, other providers, and supports.

Active Listening

- Creates an environment that empowers family members, including parents, children, and caregivers to communicate their goals and needs.
- Utilizes various interviewing and/or communication techniques in a culturally competent manner.
- Recognizes non-verbal communication and maintains good eye contact and posture.

Teaming

- Advocates for parents/families as necessary and supports them in advocating for themselves.

Coaching

- Operates from a trauma-informed perspective.

POSITION STATUS: ___ *Full-time, minimum of __ hours/week*
___ *Part-time, __ of hours/week*
___ *Other:* _____

REQUIREMENTS:

Education: Graduation from high school with diploma or equivalent.

License: Required to possess a driver's license valid in New Jersey.

Required Knowledge, Skills and Abilities:

- Safely operate a motor vehicle abiding by all applicable traffic laws.
- Ensure safety of all passengers through appropriate safety measures including use of seat belts, car and booster seats and/or child safety locks.

- Knowledge of county's local and highway roads.
- Effective oral and written communication skills.
- Computer literacy with working knowledge of and proficiency in computer applications such as Microsoft Word, Outlook and Excel.

Working Conditions:

- A flexible working schedule is required to accommodate families which includes night, weekends and/or holidays.
- Work includes lifting individuals up to, or in excess of, 50 pounds, and performing work that requires frequent standing, siting, bending, reaching, squatting, kneeling, and moving.

Appendix O: Initial Telephone Interview

Initial Telephone Interview

Instructions for Interviewers:

1) Introduce Agency

2) Describe SVS and position, including work location (county and hours (nights, weekends, holidays, etc.) and salary range, benefits, etc.; verify licensing/certifications; let applicant know that her/his driver history abstract and background checks will be requested (including child abuse record inquiry – CARI)

3) Ask the candidate if after explaining a little more about the job and the requirements he or she is still interested in the position. If not, thank the candidate and end the interview. If yes, move on to the initial telephone interview questions below.

4) Ask the following initial telephone interview questions:

a) *What motivates you to work with families, particularly those involved with the child welfare/child protection system?*

b) *Tell me about your experience working with children and families. Do you have experience working with families involved with the child welfare/child protection system?*

c) *This position requires observing visits in families' homes – how do you feel about that? Is that something you feel you're able to do?*

d) *This position includes a significant amount of driving and requires transporting children and/or caregivers – how do you feel about that? Is that something you feel you're able to do?*

5) Let the candidate know if he or she is selected to move forward with the interview process, the next step is a face-to-face interview which would include a behavioral rehearsal (role play) and mock case study (writing sample) and ask if the candidate has any questions.

Appendix P: Face-to-Face Interview Questions

Face-to-Face Interview Questions

1. What is it about this job that attracts you? Please talk about what motivates you to work with families, particularly those involved with the child welfare/protection system.

2. What led you to apply for this position at this time? Describe your professional journey thus far and your future professional aspirations.

3. Describe how your past experience might help you in this position and make you a good fit.

4. What strengths do you feel you would bring to this position?

5. What areas do you think you may need support or professional development in for this position?

6. Tell me about your knowledge of the identified county.

7. What is your comfortability working in the community and in families' homes? Are there specific things you are not comfortable with? How will you handle that?

8. For Therapeutic Visitation Specialists, what clinical skills and interventions do you use, or will you use with the families you work with?

9. For Therapeutic Visitation Specialists, how do you continue to use clinical skills and/or adjust clinical interventions in the community or in families' homes?

10. What is your knowledge of child development and parenting skills and how will you use this knowledge to support visiting families?

11. Describe your organizational skills. How do you manage a busy schedule?

12. What qualities do you like to see in a supervisor and how do you like to be supervised?

13. How do you handle conflicts on the job (with coworkers, supervisors or families)? Describe a particular difficulty that you had on your last job and how you handled it.

14. Have you ever been asked to do something unethical or unprofessional? If so, describe the situation and how you handled it. If not, how would you handle that type of situation?

15. As you advocate on a family's behalf, how will you handle situations where other parties (DCP&P, resource parent, etc.) might have differing opinions about a family's best interests?

16. Is there anything else that you think would be important for us to know about you?

17. Do you have any questions for us?

Appendix Q: Behavioral Rehearsal/Role Play

Instructions for both Therapeutic and Supportive Visitation Specialist Positions:

Situation: A family, which includes two children, ages 8 and 10 years old, and their mother and father, is currently participating in supportive-level parent-child visitation. The family just had a two-hour visit in the community at a local park which is now ending. The children are visibly upset that the visit is ending, and the visitation specialist is trying to transition the children to the vehicle for transport to the resource family's home. The children's parents are yelling at the children due to their behaviors.

Roles: The candidate will play the role of Supportive Visitation Specialist. One interviewer will play the role of parent and one will play the role of child.

Instructions for Interviewers: Listen for ways the candidate supports the parents and children in this scenario and works with the family to plan for and avoid this type of scenario in future visits.

Listen for: Flexibility, Perspective Taking, Gathering Information and Diagnosis, Action Planning

Following the Role Play: The interviewers should ask the candidate to rate her/his performance during the role play activity and ask the candidate what he/she thought went well and areas he/she could have improved. Interviewers should listen to and consider how the candidate reflects on his/her performance and how that aligns with the interviewers' assessment. The interviewers should provide constructive feedback and ask the candidate what he/she might have done differently with the information offered. Interviewers should look for the candidate to be open and responsive to the feedback and be thoughtful about how he/she would have responded differently with the insight.

Appendix R: Mock Case Studies/Writing Sample

Mock Case Studies/Writing Sample

A. Instructions for Supportive Visitation Specialist Position:

Instructions to the Candidate: Based on the behavioral rehearsal/role play, please document your interactions with the family in a brief progress note.

Instructions for the Interviewer*:* Completed progress note should be a well-written, easily understandable description of the role play interactions.

Interviewers should review the completed progress note and focus on: Accuracy, Clarity, Conciseness, Coherence, and Spelling and Grammar.

B. Instructions for Therapeutic Visitation Specialist Position:

Instructions to the Therapeutic Visitation Specialist Candidate:
Based on the case study provided, please write a clinical impression/summary for the identified family. Candidates should "consider the range of information available, any interesting or troubling omissions or contradictions in the facts the CPS worker was able to gather, your case assessment, the subsequent service recommendations you would make, and any glaring deficiencies in the larger service and/or policy environment highlighted by this case,"[5]

Instructions for the Interviewer*:*
Interviewers should present one of the three (3) case studies included below to the candidate. After the candidate completes the clinical impression, the interviewers should review and score it based on whether it includes the following information: Demographics, Family Composition, Strengths, Presenting Problem, Trauma History, and Recommendations.

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Sample Case Studies (3) for Mock Case Study/Writing Sample

Real Cases Project: The Case Studies

ANDREA R. CASE STUDY[7]

Case Details

Borough: Queens
Type of Report: Initial
Date of Intake: 9/15/07
Source of Report: Hospital psychiatrist
Date of Initial Visit: 9/15/07
Date Source Contacted: 9/15/07

Current Allegation: Inadequate Guardianship

Household:
Mother, Andrea R., age 27
Son, Vincent, age 9

Other Family Members:
Father, John S., age 33
Sister, Elizabeth, age 29

Allegation: Psychiatrist from Elmhurst Hospital called saying the mother overdosed on Zoloft last night and was brought to the hospital at 6:30 A.M. She was accompanied by her 9 year old son, Vincent. She was admitted to the hospital but refused to give any information to assist in making a plan for Vincent.

Family Background

Andrea is a 27 year old Caucasian woman who lives with her 9 year old son, Vincent in a one bedroom apartment in Queens that is described as spacious and clean. She is unemployed and receives $23 daily in food stamps, $68.50 biweekly in cash, and $624 monthly for SSI due to Vincent's autism/chronic asthma. Vincent's father is 33 year old, and is unemployed. He receives SSI due to an accident that occurred when he was 14 and left him unable to use his arm. John provides Andrea with occasional financial support and is involved with Vincent, visiting him 3 times a month. Both Andrea and John report having positive experiences with each other.

Andrea has been hospitalized at least 3-4 times according to her sister. She has been diagnosed at different times with schizophrenia, bi-polar disorder, major depression, and epilepsy. She currently takes Zoloft and seizure medication.

Prior Investigations

There have been five prior reports dating from 2001 to January 2007 against this family. In January 2001 an anonymous source reported Andrea for corporal punishment, inadequate guardianship, and drug and alcohol misuse. It was noted that Vincent communicated by crying, yelling, and making loud noises. After investigation and evaluation of the boy by an early intervention program, he was referred to a specialized hospital program and the case was closed, unfounded.

In November of the same year allegations of inadequate guardianship, lacerations, welts and bruises were made against Vincent's father John. The allegation was first made by a police officer to whom Andrea complained after her son returned home from a visit with his father with a black and blue mark under his eye. A social worker at the hospital where his mother took him for treatment made the same allegation. The father claimed that the bruise resulted from Vincent falling off a bed and onto a toy. Andrea said that he had returned from other visits with bruises so she became suspicious. The doctor who saw Vincent at the hospital did not think the bruise could have occurred as a result of an accident, and that it had to be deliberately inflicted. However, after an extensive investigation including several home visits, and interviews with the boy, his father, his paternal grandmother, with whom John lives, the doctor, and Andrea, the worker concluded that he "did not obtain any evidence to confirm the allegations." The case was closed, unfounded.

In 2002 a social worker at the preschool Vincent was attending made allegations of inadequate guardianship and inadequate food, clothing, and shelter against Andrea. It was alleged that Vincent often seemed uncared for, goes to school without extra diapers, in clothes that are often dirty or stained, and misses a day of school a week. Also, Andrea has usually failed to call the school when he was ill. The precipitating event for the report to the State Central Registry was that a teacher had to put another child's pamper on Vincent because his mother had not sent any extras, and he was wearing the same diaper for 36 hours. Andrea claimed that the diaper incident resulted from miscommunication with a friend who assists her so she can attend school. She forgot to ask her friend to change her child, and she does not change his pamper when he returns from school. The worker concluded that Andrea lacked knowledge of the child's developmental needs and referred her to a preventive service agency for services. The case was indicated.

The next report was made in 2006 by Andrea's ex-boyfriend's mother, who alleged parental drug and alcohol misuse and inadequate food, clothing, and shelter. Andrea denied the allegations, but said she knew who made the report. She had been assaulted by her ex-boyfriend, he was arrested, and she obtained a full order of protection against him. The CPS worker spoke with the district attorney, a friend who corroborated the assault against her, and the AHRC where Vincent was receiving services. All supported Andrea's story so the case was closed, unfounded.

The most recent complaint was filed by a police officer in January 2007. He reported that Andrea had become irrational, displaying extremely abnormal and erratic behavior, walking in circles, running from room to room, and calling 911 while officers were still in the home. He thought Vincent was also displaying abnormal behaviors similar to his mother. They were both transported to a major hospital where Andrea remained for about 2 weeks. During that time his maternal aunt, Elizabeth, cared for Vincent. Andrea was released with a diagnosis of major depression with psychotic features and prescribed several medications. She was to be seen by a therapist at the hospital, so the case was closed, unfounded.

In addition to these reports, Andrea lived with her mother when at least 2 reports were made naming her and her siblings as maltreated. The allegations were educational neglect, lack of supervision, and inadequate guardianship. These complaints were filed when Andrea was 14 and 16. In both cases the sources complained Andrea's mother smoked crack, left the family alone when she went to buy drugs, and let Andrea and her sister be out on the street until late. In the later complaint it was also noted that different men were frequently seen going in and out of the house. Although both cases were indicated, it is unknown what services were provided.

Current Investigation

On 9/15 the source, Dr. H., a psychiatrist, told CPS that Andrea was brought to the hospital by EMS at 6:30 am that morning because she overdosed on Zoloft the night before. Andrea's son Vincent accompanied her to the hospital. Andrea took the medication in an attempt to kill herself because she was depressed, lonely, and overwhelmed, along with having conflict with both internal and external family members. Dr. H. also reported that Andrea was hospitalized for schizophrenia in January 2007 at another hospital. Andrea was described as being "alert, quiet, guarded and uncooperative," the latter because she failed to give the hospital staff any legitimate telephone numbers of resources for her son while she was being treated at the hospital. He asked that ACS make immediate plans for care of Vincent. The worker talked with Dr. H. about respite care as an alternative to foster care, but after consultation with a hospital administrator, it was decided that ACS should assume responsibility for Vincent.

The worker held a face-to-face interview that day at the hospital with the child, Vincent, a fourth-grader, who reported that he does well in school. During the interview, Vincent told the CPS that his mother was "nice and taking good care of him." He denied that his mother hit him and said that his mother would talk with him when he would do something bad. Vincent added that he had been helping his mother to clean the home since she was not feeling well. In reference to the suicide attempt, Vincent said that he saw his mother take medication, but did not know the reason. The interview concluded by Vincent telling the CPS that he helped his mother a lot and hoped that she would be better soon. The worker also attempted to interview Andrea: however, she did not appear coherent.

During the hospital visit, the worker again spoke with Dr. H., the source. He said that Andrea was admitted to the Emergency Unit for evaluation. He also told the worker that Vincent's maternal aunt, Elizabeth said that Andrea had been hospitalized over five times for psychiatric problems and that the family is concerned about Vincent's safety. According to Dr. H., the aunt did not feel that Vincent would be safe returning home to his mother until there was remarkable improvement in her mental condition.

On 9/16, Vincent was observed at the hospital and found to have no bruises or marks; he was removed to the Children's Center awaiting placement with a relative after the completion of an expedited home study. He was later placed with a voluntary foster care agency.

The CPS worker had a face-to-face interview with Vincent at the Children's Center on 9/17, during which Vincent said that he was home with his mother at the time of the incident. He said that he saw his mother drinking "black water", but he later said that it was "black pills." Vincent said that he was afraid his mother was going to turn into a monster, but he did not elaborate as to what he meant, even after the worker questioned him. After being asked how he is punished at home, Vincent said that his mother tells him not to do whatever he did again, and she has also told him that "I'm going to punch you in the

face." Vincent denied his mother ever followed through. He did admit to being hit by his mother 4 times with a belt on his arms and legs. When asked by the CPS whether he has ever seen his mother acting "weird or out of place," Vincent denied that his mother heard voices or talked to herself. He did, however, say that his mother feels better when he takes care of her when she gets sick, and he clarified his mother's sickness as when she "gets a cold or when she doesn't feel good."

Vincent also explained that he makes his mother feel better by listening to her, watching television and being quiet. Asked about his father, Vincent said he sees his father on a regular basis. He likes to see his father because they go to the movies and the park.

The CPS observed an old scratch mark on Vincent's forehead and an old circular quarter-sized mark on his right arm. Vincent explained the mark on his forehead came from a fall while playing, but he did not have an explanation for the mark on his arm; he denied that it was the result of being hit. Vincent receives speech, counseling, and occupational therapy at his public school, where he is in special education.

On 09/17 the worker also had a face-to-face meeting with Andrea in the hospital, where she seemed heavily sedated. When the worker asked her about the incident that led to her hospitalization, Andrea reported that she took too many Zoloft, but did not know how many. She went on to explain that she took the pills because she was lonely and depressed. She said she called 911 after taking the pills so that EMS could take her and Vincent to a "different location."

Andrea said that she was seeing a psychiatrist named Dr. B., but she did not know how long or what his telephone number was. She denied hearing voices and past suicide attempts. She admitted she was hospitalized in Virginia while visiting a relative in May or June, but she refused to talk about it. Andrea said she takes Zoloft and Dilantin for her past diagnoses of depression and seizures, but she has not taken the medications on a regular basis. When asked how long ago it had been since she took the medication, Andrea responded by repeating herself. She asked to have Vincent placed with her sister, Elizabeth who reside in Brooklyn. She reported that she does not get along well with her mother or sister; and she hadn't seen them in over a month. She also stated that Vincent's father is involved because he brings her money.

An interview was held with Vincent's father John S., on 09/17 after the worker received a phone call from him. Mr. S. said that he heard from Andrea that morning advising him that Vincent was placed in foster care. The worker explained that Vincent was at ECS because his mother overdosed on pills. Mr. S. said he was aware that Andrea had mental problems but did not know how bad. He said that he had never lived with Andrea, and she appeared "fine" when he would see her. He said he only became aware of her mental problems recently, and Vincent never told him about any problems he was having at home or about any of his mother's unusual behaviors. Mr. S. was not aware of Andrea's prior hospitalizations. Mr. S. Said Vincent is his only child, and they have a close relationship. He visits his son three times a month, and he has always found him well groomed. He denied ever seeing marks on Vincent. When asked by the worker whether he was willing to care for Vincent, he refused because of his living conditions, which he would not further explain. He thought it would be best for Vincent to be placed with his aunt, Elizabeth.

The worker interviewed this maternal aunt, Elizabeth on 09/17 by telephone. She disclosed that Andrea was diagnosed a few years ago with schizophrenia, bipolar disorder, depression and epilepsy. Andrea was reportedly under the care of a psychiatrist at that time, but Elizabeth did not have any contact

information. She said Andrea attempted suicide and was in the hospital for at least a month in May or June.
At that time, Elizabeth said she cared for Vincent. Elizabeth further reported that Andrea had three or four more hospitalizations for the same reason, all occurring within a year. She could not give details of those hospitalizations. Elizabeth described Andrea as being unstable because of her mental health problems. She said the last time she saw Andrea was in July '07, and she had seen her crying and laughing at the same time. She also saw her talking to herself and hearing voices; however, she did not know what Andrea was saying. Elizabeth said that she has witnessed this behavior before. Vincent was described by Elizabeth as being very protective of his mother, saying nothing negative about her. Although Elizabeth disclosed that she is not close to her sister and hardly talks to her, she wants to be a resource for Vincent.

In exploring this possibility, the worker found that Elizabeth lives in a two-bedroom apartment with her husband and two children. She told Elizabeth that a visit would have to be made to her home to conduct a home study prior to Vincent's placement there. At that point, Elizabeth told the worker of prior ACS investigations, all of which were unfounded. She explained that these unfair reports were made by a woman in her building.

The worker also contacted Vincent's maternal grandmother, who said that she visits Andrea and Vincent on a regular basis. The worker discovered that this grandmother is not a placement resource because she currently lives in a rented single room. The grandmother said she witnessed Andrea "acting weird" only once when she was laughing and crying all at the same time, but she never questioned her about her behavior. She denied that Andrea talked to herself and was hearing voices, or that she abused drugs and alcohol. She described Andrea as being very loving towards Vincent, so she never considered him in danger while in his mother's care. When asked whether Vincent ever talked to her about his mother's behavior, she denied this. She too described Vincent as being "very protective" of his mother. She said she never felt Vincent was in any danger with his mother.

On 9/18 the worker contacted Vincent's school and spoke with his teacher for the past two years. She said that Vincent had been attending the school for the past three or four years and is in a special education program under District 75. She added that Vincent does have an IEP on file from about three years ago, which states that Vincent is diagnosed with autism. He has not displayed behavioral problems and is in a regular education, but he receives speech therapy, counseling and occupational therapy. She also stated that there was no prior suspicion of abuse or neglect and that he has good grades and attendance.

On 09/18 the CPS worker filed an Article X petition against Andrea and a remand was granted. Vincent's father did not appear in court as he had previously promised. The case was adjourned to 10/11.

On 09/20, the CPS called Vincent's father to ascertain why he had not gone to court and to inform him about the next court date. Mr. S. said he had gone to court, but he was late. He said he would show on 10/11. He was then asked if he could provide the names of any relatives that could be a resource for Vincent if maternal relatives should not be accepted. He said he did not have any in mind, but he would call back if he thought of any.

On 09/26, the CPS worker received a phone call from the psychiatrist, Dr. H, at the hospital where Andrea had been admitted. He said Andrea was discharged from inpatient psychiatric unit on 9/25 and was diagnosed with major depressive disorder and prescribed Zoloft. Andrea was also diagnosed with a

seizure disorder and was prescribed medication for this condition as well. The doctor recommended that Andrea continue to see the psychiatrist she had seen previously as an outpatient.

On 10/1 a 72-Hour conference was held at the foster care agency with the child evaluation specialist (CES), the unit supervisor, the supervisor and a worker from the foster care program, a worker from Association for Help of Retarded Children (AHRC), and Vincent's parents. During the conference Andrea produced her discharge form from the hospital recommending that she follow up at the other hospital with her psychiatrist, Dr. D. She said she had been seeing the psychiatrist for about a year. It was reported that Vincent was doing well in his program at AHRC where he was learning daily living skills and receiving after school care, and community integration services. In discussing plans for Vincent, Andrea could name only her sister, Elizabeth, and her mother as possible resources for Vincent, but she requested that neither be allowed to have contact with him without going through her. John said he thought Vincent should return to his mother's care. The conference ended with Andrea being advised that she must attend therapy weekly and also attend a parenting skills class.

On 10/11 both parents went to court where Andrea requested a 1028 hearing for Vincent. She produced a letter from her therapist, Dr. D., stating that she is being treated for major depressive disorder and has been compliant with therapy. Dr D. recommended that Vincent be reunited with his mother, writing that Andrea is capable of caring for her son.

On 10/12 the CPS worker made a home visit and met with Andrea. She noted that they lived in a clean, spacious one-bedroom apartment.

Andrea visited Vincent at the foster care agency on 10/13. Both were happy to see each other, and Vincent asked when he could go home with his mother. She explained to him that she couldn't make any promises. The foster care worker described them as having a strong positive bond and relating well to each other.

In another court hearing on 10/15 Andrea withdrew her 1028 request and asked for unsupervised visits with Vincent based on Dr. D's letter of recommendation. The foster care worker said the visit at the agency had gone well. The judge ordered the CPS worker to contact Andrea's psychiatrist, saying the case would be recalled.

That same day the worker called Dr D. who confirmed that he had been seeing Andrea for 2 years, found her to be generally compliant, taking her medications as prescribed. Noting that the doctor had not seen Andrea for several months prior to 9/28 when he wrote the letter for her, the CPS worker asked if he was aware that Andrea had a "mental breakdown" and was hospitalized for this on 1/7, 5/7 and 9/15. The doctor said he was aware and still recommended reunification.

The worker then asked if the doctor was aware that when Andrea took the handful of Zoloft, she did this in the presence of her son. The doctor was unaware of this but did not change his position. He informed the worker that Andrea's condition would worsen if Vincent remained in care, saying she would become more depressed without him. He did not believe Andrea posed a risk to the safety of Vincent. He had seen her several times since her hospitalization and reported that she had been compliant with her 30-minute sessions. When the worker asked why he thought Andrea had not shown up for treatment for several months before this recent hospitalization, the doctor responded, "she just stopped coming." He added that when he saw her on 9/28, Andrea just said she was on "some sort of a trip." The doctor then ended the call, saying he was extremely busy, and disconnected.

When the case was recalled in court later that month, the CPS worker informed the judge that Andrea's psychiatrist had not seen her for several months prior to writing the letter. The judge then adjourned the case until 2/6/08 and ordered that all visits be supervised.

Real Cases Project: The Case Studies

ANNE M. CASE STUDY[8]

Case Details

Borough: Bronx
Type of Report: Initial
Source of Report: Social worker, Douglas Hospital
Date of Intake: 7/16/07
Date of Initial Home Visit with Subject: 7/17/07
Date Source Contacted: 7/17/07

Current Allegation: Inadequate Guardianship

Adults: Anne Taylor M, b. 5/11/75, mother
Peter M, b. 11/9/69, father

Children: Thomas, b. 3/15/01
Megan, b. 2/20/04

Allegation: Social worker from the hospital that treated Ms. M. for injuries resulting from the beatings inflicted on her by her husband during their vacation in Jamaica is concerned about mother's capacity to care for and protect children.

Children were present during father's attacks on their mother.

Family Background

Anne M. is 32 years old woman employed for the past year as a secretary, earning about $30,000 a year. She has been married to Peter M. for 7 years. They have two children, Thomas, aged 6, and Megan, aged 3. Peter is an insurance agent who earns approximately $70,000 a year. Peter and the 2 children are all U.S. citizens. Anne, who was born in Jamaica, is a permanent resident of the US. Peter's family is also from Jamaica, but he was born in the City. They are both Episcopalians. Since the DV incident and subsequent return to the States, Mr. M. has been living in an apartment he co-owns with his mother in Brooklyn.

There was no prior ACS contact with this family, but a search of Domestic Incident Reports at the Police department revealed two prior domestic violence incidents in which Mr. M. was named as the suspect in 12/2002 and 10/2003.

Current Investigation

In the morning of 7/17 child protective service (CPS) worker left phone messages for both Mr. and Ms. M. stating her name, contact number, agency, and need to schedule an appointment. Mr. M. returned the call at 2:00PM. When the CPS said she was conducting an investigation, he asked what the investigation was about and whom did it involve? The worker responded that she represented ACS and it was necessary for her to meet with him to discuss some safety concerns involving his children, Thomas and Megan. He explained that he was now living in Brooklyn, but he could be in the Bronx on Friday and agreed to a morning appointment at the worker's office.

Since Ms. M. did not return the call, the CPS made an unannounced visit to her apartment at 6:00 PM on 7/17. She was not at home, but the super agreed to take an envelope for her and said she should be home in 15-20 minutes. The worker waited and Ms. M. and the children appeared shortly. When the CPS explained the purpose of her visit, Ms. M. said she was planning to get the children dinner at Burger King and then go to Mr. M.'s apartment with the assistance of the police to serve her husband court papers for a temporary Order of Protection. She asked if the interview could take place at the restaurant. The worker replied yes, but a home assessment would have to be scheduled for the following day. Ms. M. said she was very nervous about losing her job but agreed to a 6:30 AM home visit on 7/18.

Subject's Account of Allegation

Ms. M. said her husband inflicted bruises on her on 7/10 in the presence of the children during their vacation in Jamaica. When the CPS asked what was going on between her and her husband when this incident occurred, Ms. M. explained that an old friend of hers called the week after they arrived and offered to show the family around. Her husband gave the friend directions to the house where they were staying, but when he arrived, Mr. M. said he didn't want to go and offered to stay home with the children. They were gone for about 3 hours, but when they returned her husband pulled the friend out of the car and assaulted him. He was then arrested and stayed one night in jail.

Several days later they got into an argument because he left no money for her when he went out alone, although he knew she needed to buy food for the dish she was cooking, and she was counting on his taking the children with him. When he came back, she yelled at him; he then came at her with a closed fist, saying he saw her friend's car waiting outside. He punched her repeatedly in the face, neck, shoulders and arms as he was shouting, "You're making a fool out of me" and "You ruin my vacation." She realized she was bleeding all over and there was blood on the walls and the floor. When she went into the shower, he continued punching her. He finally left, saying he was going to kill her friend.

She tried to call the police by dialing 999 but got no response so she ran with the children to an upstairs apartment. He came back and was banging at the door with a brick, so she decided to open the door before he got any angrier. She saw a knife in his pocket, but he saw the one she was holding. When he yelled, "let's go at it," she dropped her knife.

Her husband picked the knife up and held her in a choke hold while the children were screaming. He then became very frustrated with the children, screaming at them to shut up. When they did not stop, he took off his belt and started hitting them very hard. She tried to stop him from beating the children by jumping in front of them where she was hit across the back, neck and waist with the belt.

At that point the police arrived, alerted by a neighbor that it sounded like someone was trying to kill a woman. The police reportedly told her that if she had her husband arrested, she would be too because it takes two people to fight. They also told her if she wanted to press charges, she would have to stay in Jamaica to present evidence, they didn't know for how long.

She was able to get a flight to New York City for herself and the children early the next morning, 7/15. That evening she sought medical attention for herself and the children. The triage nurse in the ER called the police who interviewed Ms. M. and the children and observed the bruises. However, they said they could just keep a note on file. Because the incident occurred out of the country, they could not arrest Mr. M. They told Ms. M. she should go to Family Court and get an Order of Protection for herself and the children.

On 7/16 Ms. M. went to Family Court and obtained a temporary Order of Protection for the children, herself, the children's day care provider, babysitter, and various family members.

Initial Home Visit

At the home visit, it was clear that this 2-bedroom apartment was clean, well-organized and furnished, with plenty of food in the refrigerator, locks and guards on the windows, and smoke and carbon monoxide alarms. Ms. M. was able to show the worker the children's vaccination records and said the children have no special medical or mental health needs. Since the children share a twin bed in the 2nd bedroom, the worker explained why this was not a good idea and said she would help Ms. M. get a set of bunk beds for the children.

The worker looked at the medical report Ms. M. was given. The doctor wrote that Ms. M. had a perforated ear drum with nerve damage, possibly resulting in some hearing loss, as well as bruises over her right eye requiring some stitches.

The CPS worker observed the children for marks and bruises. Both of the children had visible welts on their backs and arms. Thomas reported that "daddy hit me hard there, and it still hurts. When I was going upstairs, daddy hit me on the back, and I was crying so he hit me again." Megan said, "daddy hit me right there," pointing to the welts on her arm, "daddy did it." When the CPS asked her if she could tell her what happened, Megan put her hands over her ears and said, "don't talk, don't talk."

Ms. M. described her fear about her husband entering the apartment, explaining that before entering the apartment she leaves the children standing at the front door and dials 911 on her cell phone; she leaves the number on ready, so it can be pushed in an emergency. She then does a walk-through of the apartment to ensure her husband is not there.

Safety Plan

The worker discussed safety plans with Ms. M. She recommended that Ms. M. gather all vital documents in one safe place, pack a change of clothes for her and the children, have sufficient cash available in case she has to move in a hurry, and identify a place she can go unknown to her husband. Ms. M. agreed to these suggestions, saying she will request the assistance of a friend she has known for many years and will arrange a code word so others will know to call the police immediately if she calls and is in danger.

Ms. M. had already obtained an Order of Protection, but since she had difficulty serving him, the worker suggested she hire a process server.

Ms. M purchased new locks for both doors and requested help in getting them installed. The worker agreed to this but suggested she might want to explore the possibility of other apartments with her landlord. Ms. M. said she is not willing to do that at the moment because she likes the apartment and the community and feels safe once she enters and locks the door from the inside.

Court Involvement

Because of the safety concerns, the worker checked with a legal consultant in the agency and was told to prepare a complete W865d. Once this was reviewed, it was decided there were sufficient grounds for a neglect petition (Article 10) against Mr. M. The worker completed a COI (Court Ordered Investigation) and the court date was scheduled for 7/20. At the initial hearing Ms. M. was assigned an 18B lawyer, and the case was adjourned for a week.

Mr. M. refused to attend either court hearing. When he talked with the worker, he said a friend who works for ACS told him there was something wrong with this hearing. "What is this court date about?" When the worker explained the hearing involves the safety concerns ACS has about his children, he responded: "I know my wife must have reported that while we were on vacation, I hit my kids. She's angry and reported that I hit them in the US because she wants me arrested." When the worker asked if he could explain what happened, he said, "We went on vacation and she disrespected me by going on a date with another man... I was fighting with my wife and I took off my belt and hit my kids. I know I hit them, but I don't abuse my kids." The worker told him it was in his best interest to go to the court hearing. She also informed him that an Order of Protection has been issued, which means he must not contact them, go to their residence or the children's school. He is to make no contact and is to stay away from them.

At the 856 hearing on 7/20, the children were paroled to their mother on condition of weekly ACS supervision with announced and unannounced visits. Respondent father was to have supervised visitation with the children upon consent of the law guardian. And children were to be evaluated, especially for play therapy. (The children did not want to see their father at this time, but it was hoped they would be able to move beyond this incident once they were enrolled in therapy).

At the Article 10 hearing on 8/8, the earlier orders were continued. No decision was made because Mr. M. did not have an attorney; and the judge said he could not have a court-appointed lawyer because of his income. The hearing was continued until 8/20. When he appeared at this hearing, Mr. M. still did not have an attorney. The judge informed him if he appeared again without a lawyer, he would have to represent himself.

Ongoing Contacts

During the approximate 6 weeks after the initial investigation, the CPS worker had 3 visits with the family, made 3 additional unannounced evening visits but no one was home, and had numerous telephone conversations with Ms. M. and related others. The worker's supervisors reviewed her

activities several times during this time. She also tried to arrange an Elevated Risk conference with a child evaluation specialist (CES).
This conference was never held because the CES worker was unable to work out a time with Ms. M. due to her work schedule and childcare issues.

During this same period the CPS worker received at least 7 calls from Ms. M. Her calls involved checking on the phone number of the law guardian assigned to the children, requesting help with the children's day care fees because she wasn't sure her husband would pay, and reports of a couple of text messages she received from her husband. Also, since the department had provided mattresses and bunk beds for the children, several of her calls related to the fact that her daughter had a severe allergic reaction to the bed bugs in the new mattress. (The worker eventually arranged for replacement mattresses).

The worker's calls and visits were focused primarily on the children's welfare and response to the domestic violence incident. She also followed up to make sure Ms. M. had contacted the domestic violence program to which she had been referred. During her visit on 8/3 she talked with the children and then asked them to go play in their room. When the worker commented that Ms. M. must be concerned her husband was not following the Order of Protection, Thomas ran into the room and turned the TV up loud. When the worker asked why he had done this, he ran to his mother and put his head on the couch. His mother said that whenever his sister mentions daddy, he says, "no more daddy" and turns the TV up loud.

The worker made a visit to the children's day care program to discuss the children's progress. She was told that there had been no real change in the children's behavior. When she learned that Ms. M. had only given a copy of the Order of Protection to the head teacher, she said that each teacher should have a copy and called Ms. M. to remind her she must give each person a copy in order to protect the children.

On 8/17 the worker met with the family and the children's maternal grandmother (whom Ms. M. had named as her main support) at the day care center. During that meeting Ms. M. said she wanted to look for a new apartment. She was very nervous about staying in her current home. Ms. M. told the worker she would like to get some counseling for herself because she keeps having flashbacks to DV incident in Jamaica. She is worried that the children may also be having flashbacks and thinks they should have counseling too. When asked what she does to relieve her anxiety, she said she prays.

On 8/17 in the evening, the worker met with the mother and the children at the home of the babysitter whom Ms. M. had hired to cover while she is looking for a new apartment. Although she still seemed very anxious, the children were reportedly doing well and
related comfortably to the worker.

Elevated Risk Conference

On 8/30 an Elevated Risk Conference was held with Ms. M, the worker, and a child evaluation specialist. They discussed the history of domestic violence in the family. Ms. M. said they had several incidents in the past when her husband would get very angry, bump her and put his finger in her face. Thomas would run into the middle of them and say, "Don't talk to my mommy like that." Mr. M. would then go to the apartment he shares with his mother in Brooklyn for the weekend. There were two prior complaint of domestic violence in 2002 and 2003 when Ms. M. called the police after fights in which he

hit and choked her. However, the incident in Jamaica was the only one in which their father hurt the children physically in any way.

Ms. M. said Megan is very anxious to see her father and keeps asking to call daddy. She sometimes plays with toys and calls them daddy. She covers her ears if anyone gets loud. Thomas is willing to talk with his father, but he doesn't want to see him. Ms. M. wants her children to see their father, but she doesn't know how they can ever have a normal relationship.

She also mentioned that before the incident in Jamaica, they had a very close relationship with her husband's brothers, and they are her children's godfathers. They haven't said anything to her since the incident, but she is afraid to have her children visit them because their father may be there.

The child evaluation specialist said it was very important to get Mr. M. involved in services such as anger management and batterers' counseling. The plan recommended was that the CPS worker would continue monitoring the family, make strenuous attempts to engage Mr. M, and follow up on the referral of Mrs. M. to a domestic violence program.

A formal supervisory review was held on 8/31. It was noted that Mrs. M. response to the domestic violence was more than appropriate. She was always focused on safeguarding the children and removing them from the potential for more damage. She is looking forward to becoming engaged with a preventive service program that can help her deal with the domestic violence and other family needs.

Real Cases Project: The Case Studies

MARY S. CASE STUDY[9]

Case Details

Borough: Manhattan
Type of Report: Initial
Source of Report: Mother
Date of Intake: 9/29/2007
Date Source Contacted: 9/29/2007
Date of Initial Home Visit: 9/29/2007

Current Allegation: Inadequate Guardianship

Adults: Mary S., maternal grandmother and legal guardian
Susan, biological mother

Children: Jason, 15 y/o

Case Details

Allegation: The boy's mother, Susan, alleged that Mary S., the boy's maternal grandmother and legal guardian, is physically abusive and intimidating to 15yr old Jason. Yesterday 9-28-07, she reportedly punched the adolescent in the face after she told him to clean his bedroom. This is not the first time Mary has used physical force to intimidate Jason. He is afraid of his grandmother, as she has threatened to shoot him if he ever hits her back. Also, the grandmother goes out of town for days at a time and does not leave Jason any money for food. The last time she left was on Saturday and she did not return until Monday. Mary does not make an alternate plan for Jason's care when she travels out of state."

Jason's mother, Susan, says she and her husband gave custody of him to her mother when she was 17 because they did not have any health insurance. Susan says she went to court and filed a petition to revoke her mother's guardianship and the next court date is October 26, 2007. However, she has to serve her mother the paperwork first. Susan says her mother is a retired New York State corrections officer, and she may still have her weapon."

Family Background

This African American family consists of the 53 year-old maternal grandmother, Mary; her 32 year old daughter, Susan; Susan's 15year old son, Jason; her 9 and 5 year old sons; her 43 year old companion, Stanley; and Stanley's 2 daughters, aged 13 and 18.

Mary is a retired corrections officer. She receives $6400.00/month in pension benefits and an undisclosed amount from disability. Mary has diabetes and high blood pressure and takes medication for the condition. Mary was granted legal guardianship of Jason in December 1992, when Susan was 17-years old. It was documented that Susan and Jason's father signed over guardianship to Mary, so that Jason could be covered by her medical insurance. Since that time, Jason has alternated between living with Susan and with Mary. Susan moved to Chicago while Mary continues to reside in NY. Jason's father is deceased; the cause of death was not mentioned.

In the summer of 2006, Jason asked to live with Mary and has resided with her ever since. Susan filed a petition in June 2007 for modification of guardianship that was awarded to Mary in 1992, but the case was dismissed because she failed to appear in court. In September 2007, she filed another petition regarding the matter of guardianship; the judge requested that ACS submit a COI (Court Ordered Investigation) by October 21, 2007.

A courtesy visit to Susan's home was conducted by Illinois Child Protective Services due to the COI request. Susan resides in Chicago suburb with Stanley, her two other sons and Stanley's two children. They live in a two-story home with three bedrooms. The home was equipped with carbon monoxide/smoke detectors however there were no window guards. Susan works at a grocery store and earns $650.00/bi-weekly. Stanley works at a hardware store and earns $800.00/bi-weekly. Stanley has a criminal background. During 1984-1989, he was arrested for attempted robbery, resisting arrest and possession of stolen property. He was imprisoned in 1989 and paroled in 1992.

Mary and Jason reside in 3-story private home in Upper Manhattan. The living room and kitchen are on the first floor. The worker observed food in the refrigerator. The family room Jason's bedroom, bathroom and laundry room are located on the second floor. Jason's room is equipped with a full size bed, dresser, desk and closet. Mary lives on the third floor, which has an office, bathroom and bedroom. The home, which is well kept and neat, is equipped with a smoke/carbon monoxide detector.

Jason is dark-skinned, slightly overweight, average height, and has a short haircut. He began a new Catholic high school this month. Mary pays the tuition for his school. He was reportedly left back in the 6th grade while residing with his mother due to excessive absences. Jason is active in sports and plays baseball. This past summer he participated in baseball camp, karate class and weight training. In addition, he attended tutoring for math and English, once a week. The CPS worker observed that he was free from marks and bruises. Reportedly, he has had no developmental delays or disabilities, and no mental health needs.

Current Investigation

The S. Family first became known to ACS on 9/29/07, at 6:06 p.m. when the mother of the alleged maltreated child filed a complaint with the State Central Registry. At 6:08 an Emergency Children's Services worker was assigned the case for intake. When the case was received, the CPS conducted family clearances in WMS, CCRS, ACRS+, LTS, and the SCR. It was noted that the alleged subject, Mary S. is listed in Connections as a foster parent.

CPS called the source of the report in Illinois to confirm the allegations. The source, the alleged maltreated child's mother, confirmed what was reported, and also informed the CPS that she filed a petition with Family Court to terminate the guardianship rights of Mary S. She told the CPS worker that she had her other two children in her care, she had not relinquished her parental rights of Jason, and

she is seeking to have him live with her again. She also disclosed that Jason often called her crying and told her that he fears his grandmother. Jason told her that Mary S. punched him in the face for not cleaning his room fast enough when he was asked to. She said this incident was not the first time Mary S. has used excessive corporal punishment while disciplining Jason. The source also disclosed that Mary S. has left Jason home alone for days at a time, the last incident having taken place the week before when she traveled to Boston without him. Mary S. reportedly left Jason without adult supervision and money for food. The source expressed her concern for Jason's safety and well-being, because Mary S. is a retired corrections officer that might still have a gun in the home.

Later that evening on 9/29 at 11:21 p.m., another worker attempted an unannounced home visit to the case address but was unsuccessful. The CPS worker attempted to make contact with anyone who might have been at the case address by repeatedly using the intercom that was located at the top of the stairs, as well as calling the home telephone number listed on the intake report.

The case was reassigned to the Manhattan field office the morning of 9/30 and assigned to a CPS worker who attempted an initial home visit at 5:00 P.M. There was no one home then, but the worker made face-to-face contact with the family at 7:30 AM the next morning, 10/1

Interviews

On 10/1/07, the CPS worker interviewed Mary and Jason at their home address. She explained the reason for the CPS visit and asked Mary to discuss her relationship with Jason. Mary began by saying that she and Jason get into conflicts because he does not listen. She stated that he did not clean his room or bathroom and did not do his homework when he was supposed to. Mary informed the CPS that she has had legal custody of Jason since his birth. She showed the CPS the court documents and the letters Jason's parents wrote to the court. Until 2004, Jason lived with Susan. In the summer of 2004, Jason visited her with his two brothers and stayed with her since that time. The worker inquired about the reason why he stayed, and Mary stated that Susan's boyfriend, Stanley, punched Jason in the stomach. Mary stated she does not like the way Stanley treats the children. She also said that all of the children wanted to stay with her, but Susan would not allow it.

Jason told her that Stanley had his older son get a knife and cut his younger brother on the back of the foot. He also told her Stanley knelt down and punched him in the face. The 9 year old reportedly saw a gun in Susan and Stanley's bedroom. She said she has told Stanley not to put his hands on her grandchildren. She asks her grandchildren if anyone has bothered them, but the children are "afraid to disclose any information." She feels Susan does not protect the children. Mary S. contacted the Child Protective Services in Chicago, but they did nothing.

Mary continued that she is very strict with Jason because she wants the best for him. She did not feel that that he would do well living with Susan. He was left back in the 6th grade because Susan allowed him to miss 34 days of school. Mary stated she lives for her grandchildren. Jason has his own phone and is allowed to speak with his mother at any time. Mary said Jason's problem is that he is lazy and does not like to do what he is told. She sent Jason away to baseball camp last summer and had him participate in weight training.

The CPS worker asked Mary if she punched Jason in the face. She stated that she told him to clean-up but got fed up with him and punched him in the face. The worker asked if she hits him often, and she said that she has hit him only five times in his life. She usually yells at him or takes things away. She

denied leaving any marks or bruises on him. She also denied hitting him with an object, but said when he was little, she spanked him with a belt. Mary told the CPS that she has diabetes and high blood pressure so she cannot get worked up. When the worker asked if they get along except for cleaning issues, she said yes.

Mary explained that she is trying to rescue Jason from being a deadbeat. He has no positive male influences, and she is trying her best to teach him dignity. She does not want to hurt him; she just wants him to grow up and be something. Mary admitted that she becomes hot headed when Jason does not listen. The worker asked if she thought Jason would benefit from counseling, and she stated she would be willing to accept services. Mary refused to provide her social security number and sign the HIPPA form, but she gave the contact information for Jason's physician.

The worker met with Jason and first asked him about his summer. He relayed he attended baseball camp, karate class, and weight training. He also said that he has friends and speaks with them on the phone or when he goes outside. When asked if he likes his new high school, he said that he has made a lot of friends because of his involvement in sports. The worker asked Jason to describe his relationship with grandmother, and he said they get into disagreements because he does not do what he is told. He does not clean his room and bathroom when she asks. When the worker asked him if he liked living with his grandmother, he responded that he did, but missed his brothers. Asked if he wanted to live with his mother, he replied, "of course, what child doesn't." He continued that he wished he could live with both his mother and grandmother, but knew it was impossible. The worker asked why and he said, "because they do not get along."

Jason informed the CPS that he saw his brothers in June for his birthday and graduation. He also stated that he went to Chicago for his spring break. He stated he speaks with his mother daily. The worker asked Jason if he was scared of his grandmother, and he said no. Asked how he is disciplined, he said that his grandmother yells and curses at him. She hit him recently because he did not do what he was told. When asked where he was hit, he replied that she punched him in the face. The worker asked Jason about the last time she hit him, and he said about a year ago. In addition, she has thrown a boot at him, and it hit him in the arm. The worker asked if his grandmother threatened him, and he replied that she told him she will shoot him if he hits her. The worker asked if she has a gun, and he said he did not know. The CPS asked if he ever stayed home alone and he said, 'no.'

The worker attempted to contact his mother, the source, but she was unable to reach her. She contacted the pediatrician, Dr. S, who confirmed that Jason was seen on 6/29/2007. Dr. S. stated Jason has been coming to his office since October 2004, when he moved in with Mary. He relayed that he has never seen any marks and bruises on Jason. The CPS asked Dr. S if he suspected that Jason was abused and he said, "no."

On 10/7/07, the CPS met the source, Susan, in court and spoke with her about the case. The CPS asked Susan to discuss the issues and she responded that Jason is constantly calling her stating he wants to come home. Jason has made continuous complaints about his grandmother cursing at him and not feeding him every day. Susan stated that she does not like what is going on. The only reason she allowed Jason to stay since 2004 was because he asked to, but now he hates his grandmother. The worker asked how she knew he was punched in the face, and she said he called her crying about it. She added that Jason had wanted to stay with his grandmother to complete junior high school and return to Chicago for high school. She is petitioning to terminate guardianship and that was the reason she was in court.

The worker received a message from Mary regarding the petition that Susan filed for custody. When she spoke with Mary in court, Mary said she does not want Susan to obtain custody. She feels that Jason will not have the same opportunities if he leaves. She just wants him to graduate from high school, and then he can do whatever he wants.

On 10/10, the CPS received a request for a Court Ordered Investigation that was due on 10/21/07. Also, the court ordered the Child Protective Office in Illinois to complete a home study. On 10/14, the CPS worker contacted Mary's sister, Dorothy E. and asked her to describe her sister as a grandmother. Dorothy stated that her sister is very caring, supportive and concerned for her grandchildren. She stated that she has never observed any marks or bruises on Jason. She said Mary and Jason are close, and he never said he was abused. Asked if she knew where Jason wanted to live, she replied probably with his mother because he misses his brothers. However, Dorothy believes that residing with Mary would be the best for him because he is more adequately cared for. The CPS asked Dorothy if Mary uses drugs and alcohol. Dorothy stated that Mary was a corrections officer and a role model for the family. The worker asked if she had any concerns for the child, and she responded that she is worried that all of these current issues may affect Jason psychologically.

The CPS worker contacted Mary's neighbor, Mr. B. to discuss his relationship with her. Mr. B. stated that he has been friendly with Mary for eight years. The CPS asked what Mr. B's perception of Jason was, and he relayed that Jason is a good and happy child. He stated that Mary is a good caretaker and takes adequate care of Jason. The CPS asked Mr. B. if Jason disclosed that he was abused and he replied no. Mr. B. stated that Jason had his phone number and was told if he needed to discuss male issues to contact Mr. B. Mr. B. denied having seen any marks or bruises on Jason. He denied any knowledge of Mary abusing drugs or alcohol. He stated that Mary keeps to herself and rarely has guests over to her home. The CPS asked if Mr. B. had any concerns for Jason and he said no.

The CPS worker called Diane G., a friend of Susan's for a reference. Diane said that she has been friendly with Susan for four years. The CPS asked Diane how often she sees Susan's boys, and she said she sees them often. She said that the children appear happy and they were clean. Diane stated she has not observed any marks and bruises on the children. She felt the kids are well cared for. "Susan is a good mother, very caring, and always there for her children." Asked if she had ever met Jason, she said yes. Jason gets along well with his mother, and they are respectful towards each other. The worker asked if Susan misused drugs and alcohol, and she said no. Also, she stated that Susan did not have people coming in and out of the home.

The CPS contacted Tara J., another friend of Susan's. Tara said that she has known Susan for two years. She does not see the children often, but she speaks with Susan often. Tara denied knowing of any drug/alcohol use. She has never observed any mark or bruises on the children. Tara stated that Susan is very good with her children, so she does not have any concerns. She feels that Susan could care for all the children including Jason. She said she has never suspected any abuse and thinks the children are well taken care of.

On 10/19 the worker made an unannounced visit to Mary's home. She asked Mary how things have been going. She responded that Jason has been doing well in school thus far. Mary denied that Jason was acting any differently since their last court date. She said he has been his normal self. Mary told the worker that they return to court on 10/26, and she will let the judge make the decision. She would not fight the decision, but she is still not in agreement with Jason living with his mother. She wants what is best for him but does not feel that it is with his mother.

The worker spoke with Jason about school, and he said it was fine. Asked if he was worried about the court matter, he said that he did not feel his grandmother and mother should be in court. “They should settle it within the family.” Asked what he wanted the outcome to be, he stated that he wanted to go with his mother. He misses his brothers and his mother. The worker then asked how he felt about his grandmother, and he said he felt the same. He knows that his grandmother just wants him to make something out of himself and that she had his best interest in mind. He denied having any recent arguments and being hit by Mary. The worker asked when he last spoke with his mother, and he said the night before. Asked how he felt when he spoke to her, he said that he was happy but sad when he would hang up.

The CPS asked Jason if he liked Stanley, and he said yes. Jason stated that he was nice and that they get along. Asked if Stanley ever hit him, he said yes. On one occasion Stanley punched him in the face because he was not listening. Another time, Stanley punched him in the chest, in the presence of his mother “for being smart to him.” His mother did not say anything because he was being disrespectful. When the worker said to Jason, “and you still like him,” he replied, yes, because Stanley provides for him and his brothers. Also, Stanley buys food and clothes for them. He stated that Stanley is like a father figure since his father died.

The CPS asked if Stanley ever hit his brothers, and he said they have gotten a few spankings. They were hit with a belt. Jason then described an instance where Stanley beat the 9 year old because Susan was too upset. He was beaten for two minutes because he stole money from his mother’s bag. Asked if his mother hit him, he said yes, but only on serious cases. He was spanked a few times, but usually his mother talks to him or takes something away from him.

On 10/21, the CPS worker submitted the COI to the Manhattan Family Court. On 10/28/07, the CPS left a message for Mary regarding the outcome of the court hearing.

Appendix S: Candidate Scoring Rubric

Candidate Scoring Rubric

Candidate Name:	
Job Position Applied for:	
Interviewer Name:	

	1 *unsatisfactory*	2 *satisfactory*	3 *average*	4 *above average*	5 *exceptional*
Telephone Interview					
Interest in position					
Related experience and qualifications					
Communication skills					
Invite to Face-to-Face Interview?	*Recommended*		*Not Recommended*		
Face-to-Face Interview, Behavioral Rehearsal and/or Mock Case Study					
Engagement and communication skills					
Knowledge					
Skills and abilities					
Advocacy and teaming skills					
Behavioral Rehearsal/Role Play					
Assessing skills					
Problem solving skills					
Active listening skills					
Ability to accept feedback					
Mock Case Study/Writing Sample					
Communication and writing skills					
Critical thinking skills					

Candidate's Strengths:	
Candidate's Weaknesses:	
Additional Notes/Comments:	
Final Recommendation	*Recommended* *Not Recommended*

Appendix T: SVS Observation Fidelity Tool

NEW JERSEY DEPARTMENT OF CHILDREN AND FAMILIES

Supportive Visitation Services (SVS) Observation Fidelity Tool

SVS Program Name: _____ **Visitation Specialist's Name**: _____

Observer's Name: _____ **Observer's Designation:** _____

Location *(e.g., program office; caregiver's home etc.)*: _____**Observation Date**: _____

Type of SVS Activity: ☐ Therapeutic Visit ☐ Supportive Visit ☐ Visitation Planning Meeting

Duration of observation (hrs.):_____ Portion of activity observed: ☐ All or most ☐ Over half ☐ Less than half

Directions: Observer, as you observe the visitation specialist's therapeutic or supportive visit or Visitation Planning Meeting, please rate each activity using the rating criteria described below. If you are not certain about a rating during observation, use the comment section to take notes and return to confirm your rating and calculate scores.

Definitions for Rating Criteria:

More Development Needed to Demonstrate the Skill (1)
The visitation staff needs more knowledge and practice to demonstrate this skill. S/he may or may not have a conceptual understanding of the skill or recognize in hindsight how the skill might have been used in a specific practice situation.

Beginning Evidence of Skill Demonstration (2)
The visitation staff demonstrates various behaviors related to the performance of the skill but needs additional opportunities to practice. He/she appears to understand the skill conceptually *and* offers beginning evidence in demonstrating it when opportunities arise. S/he is using primarily one or two techniques in an effort to demonstrate the skill and may not be able to use techniques in a consistent and purposeful manner.

Skill Demonstrated (3)
The visitation staff demonstrates skill at a level that demonstrates s/he effectively and comfortably performs skill in most cases as opportunities arise. Areas for additional growth exist but visitation staff effectively works with families.

Skill Exceeds Basic Standards (4)
The visitation staff goes beyond the basic standard required and performs skills easily and purposefully, consistently effective and sometimes exceptional. While she/he continuously strives to improve, there are no identified needs.

N/A (N/A)
This rating is used when there are no opportunities to observe this behavior during the visit activity. For instance, if no emergent questions were brought up during a visit, the observer would select "N/A" for "Visitation specialist answers any emergent questions" in the Engaging section.

Scoring Guidelines:

It is highly recommended observers to use the electronic document to input and calculate scores. Otherwise, please use the following scoring guidelines below.

Rating behaviors: Rate the behaviors from 1-4 in each Essential Function section. Put the corresponding rating number (1, 2, 3, or 4) or "N/A" in the appropriate box for each behavior.

Calculating the average score for each Essential Function:
First, calculate the Total Rating Score for the section. Add together all the rating scores for a total. Next, calculate the Average Rating for the section by dividing the total rating score by the number of items in the section minus the number of N/As. For example, in the Engaging Section there are 3 observation behaviors. If there are no N/As in this section, divide the total score by 3 to get the average score for this section. However, if there is 1 N/A for this section, divide the total rating score by 2 to get the average score.

Interpreting average scores:
The following Rating Criteria applies to average scores for each section:

0-1.6	More Development Needed
1.7-2.6	Beginning Evidence of Skill Demonstration
2.7-3.6	Skill Demonstrated
3.7-4	Exceed Basic Standards

Engaging *Establishing and maintaining relationships with family by building rapport through open communication, staff consistency, and involving family, DCP&P, resource parents, service providers and additional family members in all aspects of the visitation process*	**More Development Needed (1)**	**Beginning Evidence of Skill Demonstration (2)**	**Skill Demonstrated (3)**	**Exceeds Basic Standards (4)**	**N/A**	**SCORE**
1. Visitation specialist introduces self and welcomes family						
2. Visitation specialist answers any emergent questions						
3. Uses strengths-based strategies to elicit family input (e.g., positive reinforcement and reframing)						

Comments:

Total Rating Score for Engaging *Add together all the rating scores for this section.*	
Average Rating for Engaging *Divide the total rating score by the number of items in this category (3) minus the number of N/As.* *For example, if there is 1 N/A for this section, divide the total rating score by 2 to get the average score.*	
Rating Criteria for Engaging *More Development Needed, Beginning Evidence of Skill Demonstration, Skill Demonstrated or Exceed Basic Standards*	

Assessing *Using a process to collect information and use it to address immediate and underlying issues families may be experiencing*	**More Development Needed (1)**	**Beginning Evidence of Skill Demonstration (2)**	**Skill Demonstrated (3)**	**Exceeds Basic Standards (4)**	**N/A**	**SCORE**
1. Asks questions during in-person meetings with family, DCP&P workers and other collateral providers. Inquires about family history, goals, and ongoing and evolving needs to collect and confirm information.						
2. Gathers information from relevant sources. This may include information from: case records, the child's school reports, substance use evaluations, medical reports, mental health assessments, and any other relevant information to inform the assessment of the family.						
3. Inquires about the family's natural supports. Examples include maternal and paternal relatives, close friends, and community resources and supports.						
4. Discusses observations and assessments with parents and elicits feedback regarding parenting styles and behaviors.						
5. Incorporates gathered information from reviews, inquiry, observations, parent feedback and assessments in a visitation plan which includes recommendation of visitation level(s) and requirements for moving along the continuum from family's current level to less restrictive levels.						
Comments:						

Total Rating Score for Assessing *Add together all the rating scores for this section.*	
Average Rating for Assessing *Divide the total rating score by the number of items in this category (5) minus the number of N/As.* *For example, if there is 1 N/A for this section, divide the total rating score by 4 to get the average score.*	
Rating Criteria for Assessing *More Development Needed, Beginning Evidence of Skill Demonstration, Skill Demonstrated or Exceed Basic Standards*	

Active Listening *Using communication techniques that encourages free dialogue and mutual understanding*	**More Development Needed (1)**	**Beginning Evidence of Skill Demonstration (2)**	**Skill Demonstrated (3)**	**Exceeds Basic Standards (4)**	**N/A**	**SCORE**
1. Encourages open dialogue by inquiring about the family's goals and needs during weekly debriefings and visits and being receptive to feedback.						
2. Validates family's thoughts and feelings.						
3. Incorporates family's voice into process.						
4. Preps parent(s) for visitation planning meeting.						
5. Supports parent(s) in advocating for themselves during the meeting.						
6. Addresses the family in ways that are consistent with their cultural expectations.						
7. Presents open ended questions to encourage dialogue with a focus on potential solutions.						
8. Summarizes and reframes what is said to validate common understanding and encourage mutual dialogue.						
9. Recognizes non-verbal communication.						
10. Maintains good eye contact and posture.						
11. Takes notes, if needed, trying not to interrupt flow of conversation.						

Comments:

Total Rating Score for Active Listening *Add together all the rating scores for this section.*	
Average Rating for Active Listening *Divide the total rating score by the number of items in this category (11) minus the number of N/As.* *For example, if there is 1 N/A for this section, divide the total rating score by 10 to get the average score.*	
Rating Criteria for Active Listening *More Development Needed, Beginning Evidence of Skill Demonstration, Skill Demonstrated or Exceed Basic Standards*	

Teaming *Respectful and meaningful collaboration with families (and community partners) to achieve shared goals.*	**More Development Needed (1)**	**Beginning Evidence of Skill Demonstration (2)**	**Skill Demonstrated (3)**	**Exceeds Basic Standards (4)**	**N/A**	**SCORE**
1. Develops a plan with the family to identify steps they can take to meet their needs and/or steps staff can take to support the family. Follows up and revises plan as necessary.						
2. Links the family to community resources, formal and informal supports, and coordinates with DCP&P.						
3. Coaches families to advocate for themselves through modeling self-advocacy, problem-solving, persistence and supports them in navigating systems effectively.						
4. Encourages and supports family to maintain supplemental contact with children outside of visits, as appropriate. Examples may include: phone calls, emails, letters, social media and attendance at events such as school conferences and medical appointments.						
5. Shares relevant information from visits with DCP&P staff or other stakeholders as necessary.						
6. Involves community partners in planning meetings and considers their service recommendations, as appropriate, when completing the family's visitation plan.						
7. Defines clear roles for each member of the team including DCP&P and other collaborative staff so that all team members are working towards a common goal for the family.						
8. Visitation planning meeting includes discussion of family's progress.						
9. Visitation planning meeting includes updating goals.						
10. Visitation planning meeting includes determining if changes in supervision level, location and setting are appropriate.						

Comments:

Total Rating Score for Teaming *Add together all the rating scores for this section.*	
Average Rating for Teaming *Divide the total rating score by the number of items in this category (5)10 minus the number of N/As.* *For example, if there is 1 N/A for this section, divide the total rating score by 4 to get the average score.*	
Rating Criteria for Teaming *More Development Needed, Beginning Evidence of Skill Demonstration, Skill Demonstrated or Exceed Basic Standards*	

Coaching *Targeted instruction to parents about improving parenting skills, family dynamics and other identified goals that support reunification or other permanent placement discharge.*	**More Development Needed (1)**	**Beginning Evidence of Skill Demonstration (2)**	**Skill Demonstrated (3)**	**Exceeds Basic Standards (4)**	**N/A**	**SCORE**
1. Helps families learn how their child's behavior is shaped by the adult's words, actions and attitudes.						
2. Encourages and supports parents to incorporate and demonstrate skills they have learned or developed to meet the unique needs of their child(ren).						
3. Observes and intervenes or redirects parent with verbal reminders to cue learned parenting skills, when direct intervention by visitation specialist is not needed.						
4. Validates parents' and/or children's progress.						
5. Reviews goals and expectations of visits.						
6. Works with the family to address any fears, barriers, and parenting challenges.						
7. Explores potential problems and coaches parent(s) on strategies to use during visits.						
8. Asks parents how they feel the visit went and allows parents to express their feelings and concerns.						
9. Comments favorably on some aspect of child's and parent's interaction in the visit.						
10. Makes suggestions for improvement as necessary.						

Comments:

Total Rating Score for Coaching *Add together all the rating scores for this section.*	
Average Rating for Coaching *Divide the total rating score by the number of items in this category (10) minus the number of N/As.* *For example, if there is 1 N/A for this section, divide the total rating score by 9 to get the average score.*	
Rating Criteria for Coaching *More Development Needed, Beginning Evidence of Skill Demonstration, Skill Demonstrated or Exceed Basic Standards*	

Therapeutic Intervening *Purposeful use of evidence-based/-informed techniques intended to help families identify and process emotions and apply positive coping skills*	**More Development Needed (1)**	**Beginning Evidence of Skill Demonstration (2)**	**Skill Demonstrated (3)**	**Exceeds Basic Standards (4)**	**N/A**	**SCORE**
1. Uses trauma-informed therapeutic approaches to assist and support family members. (ex. Re-Establish Safety; identify triggers; develop health coping skills; Decrease in Traumatic Stress Symptoms; Practice Trauma Processing or Integration.)						
2. Addresses concerns and supports family goals with a focus on decreasing family conflict, improving communication, developing the parent's ability to identify and appropriately redirect child's inappropriate behaviors and decreasing the risk of abuse or neglect within the family.						
3. Directly intervenes with children and models parenting techniques and skills to promote healthy attachment and increased child wellbeing.						
4. Models for parents how to support children during transitions in and out of visits.						
5. Assesses and normalizes child's responses to transitioning into and out of the visit.						
6. Provides feedback and positive reinforcement on parenting skills and interactions.						
7. Educates parents on child development.						
8. Observes how the parent responds to and uses information provided.						
9. Aligns frequency of intervening to parental needs and skills.						
10. Empowers and allows parents to be the lead in caring for their children with support from the Visitation Specialist, as needed.						
Comments:						

Total Rating Score for Therapeutic Intervening *Add together all the rating scores for this section.*	
Average Rating for Therapeutic Intervening *Divide the total rating score by the number of items in this category (10) minus the number of N/As.* *For example, if there is 1 N/A for this section, divide the total rating score by 9 to get the average score.*	
Rating Criteria for Therapeutic Intervening *More Development Needed, Beginning Evidence of Skill Demonstration, Skill Demonstrated or Exceed Basic Standards*	

Appendix U: Monthly Data Reporting Requirements and Instructions

SVS MONTHLY DATA REPORTING - INSTRUCTIONS

MONTHLY SERVICE REPORTS

Monthly Service Reports include service, intake, and discharge data. SVS Programs should follow the instructions below for sending the Monthly Service Reports:

1. Complete an excel document, with 3 separate tabs (Services, Intakes, Discharges) for all activities that occurred in the report month. The document must contain ALL of the data points listed below, in the order provided, following formatting instructions as indicated (i.e., dates, times, etc.). Please do not delete and/or change the order of columns and use consistent naming conventions and response options. The NJS Person ID# should be for the primary visiting adult(s).

a. Services Tab – Data Columns

NJS Case ID	NJS Person ID	Service Date (MM-DD-YY)	Service Start Time (HH:MM AM/PM)	Service End Time (HH:MM AM/PM)	Service Duration (minutes)	Service Type*	SVS Program Name (Agency-County)

*Service type should include ALL the following activities and be labeled as indicated: assessment, visitation planning meeting, therapeutic visit, supportive visit, unsupervised monitoring visit, aftercare visit, parent debriefing, child debriefing or transportation. Only include services that occurred in the monthly reporting period, not those that were scheduled but ultimately cancelled.

b. Intakes Tab – Data Columns

NJS Case ID	NJS Person ID	Intake Date (MM-DD-YY)	First Visit Date (MM-DD-YY)	Referral Date (MM-DD-YY)	SVS Program Name (Agency-County)

Intake date – the date the intake was completed. Please do not include missed and/or cancelled intakes.

First visit date – the date of the family's first visit with the SVS program. The first visit may occur before a formal intake.

Referral date – the date your SVS program receives the completed referral from DCP&P including signatures and SAR.

c. Discharges Tab – Data Columns

NJS Case ID	NJS Person ID	Discharge Date (MM-DD-YY)	Discharge Reason	SVS Program Name (Agency-County)

2. Upload the Excel document onto the myNewJersey portal following the naming convention: Agency_Services_Reporting Month Reporting Year. (ex. Services_FamilyConnections_June_2018).

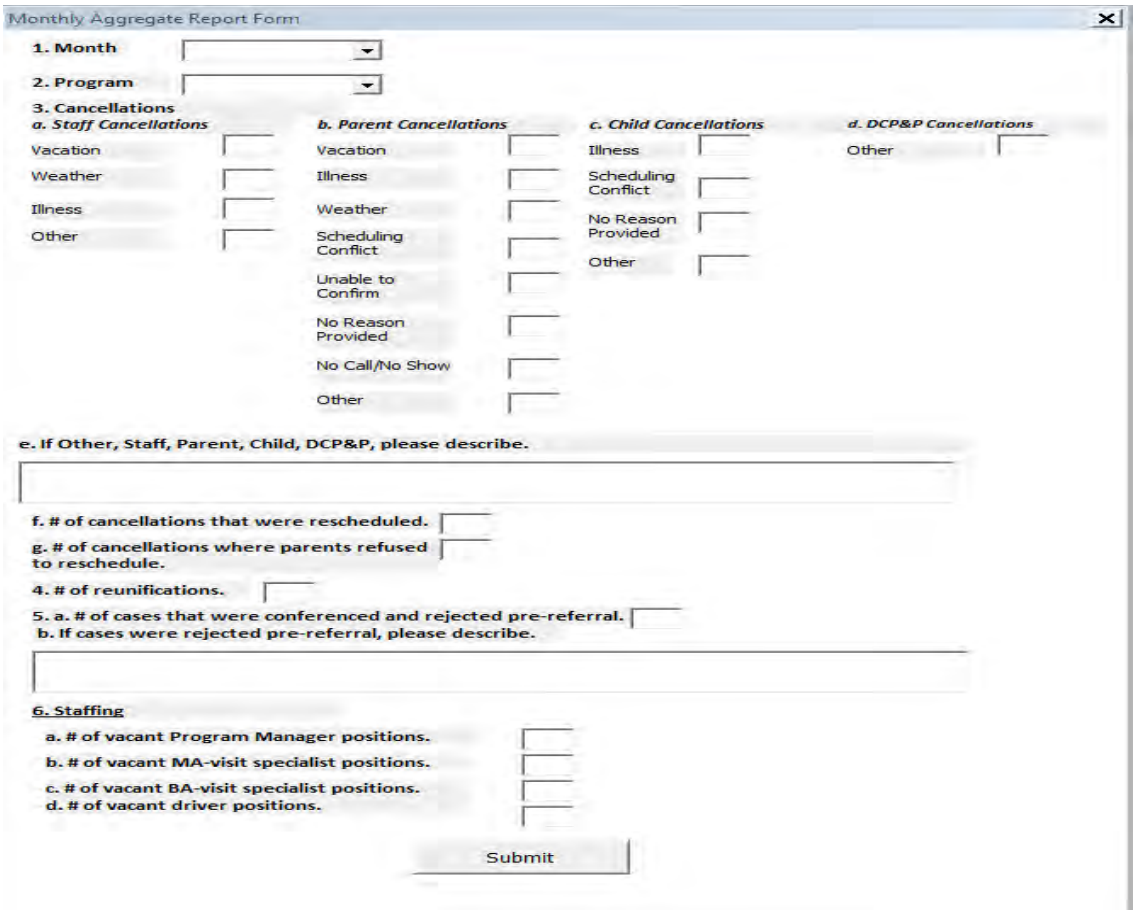
MONTHLY AGGREGATE REPORTS

Monthly Aggregate Reports are completed through an Excel Form and contain only aggregate data. Before you begin, PLEASE NOTE:

- Ensure you have enabled macros.
- You will NOT be able to save information entered and return to it at a later date. If you close the form before hitting "Submit," the information you've inputted will be lost and you will need to redo the entire form.
- If you choose the "Submit" button, the information you've inputted will be submitted. If you hit the "Submit" button before you've fully completed the form, you will need to reopen the form and start again.

Monthly Aggregate Report Instructions:

1. After reviewing the guidance for each question below, click the button to complete the report.



Question 1: Please choose the month/year of the data that you are reporting, NOT the date you are completing the form. For example, if you are completing the form in September 2018 for the month of July 2018, choose July 2018 in this question.

Question 2: Please choose your Program Name. **If your agency covers more than one county, please complete different report for each county.**

Question 3: Please provide the number of cancellations by type. If there are cancellations in ANY of the "Other" categories, please describe in the text box (3.e.). In 3.f., please indicate the number of all cancellations that month that were rescheduled.

Question 4: Please provide the number of reunifications that occurred that month.

Question 5: Please indicate the number of cases that were rejected pre-referral. If this occurred, please describe in the text box in (5.b.).

Question 6: Please list the number of each type of staff vacancy present at any time within the reporting month.

2. Once you have answered all of the questions, click the "Submit" button. This will also exit you out of the form. Click the "Click Here to Complete Monthly Reporting Form" button again if you need to submit for another county.

3. Once you have submitted all of the forms and are ready to upload onto the myNewJersey portal, save as an Excel Workbook (.xlsx), NOT a Macro-Enabled Excel Workbook. Use the naming convention to save the file: Aggregate_Agency_Reporting Month Reporting Year. (ex. Aggregate Family Connections_June_2018).

4. Upload the document into your folder on the myNewJersey portal.

NOTE: When you “submit” the information, it does not automatically send it to DCF. You must save the workbook as indicated above and upload the document to the myNewJersey portal.

PROVIDER REPORTING SCHEDULE

Monthly Service Data	Monthly Service Data Reports (Due to DCF by 1st Friday of month)	Quarterly Reporting Calls
January	March	June
February	April	
March	May	
April	June	September
May	July	
June	August	
July	September	January
August	October	
September	November	
October	December	March
November	January	
December	February	

NOTE: Monthly SVS Program Monthly Dashboards will be shared by DCF through the myNewJersey portal two (2) weeks after monthly service data is received by DCF. Please ensure correct dates and times are reported for each visit – both in the monthly services report and in NJ SPIRIT – for successful DCF visit matching. Please ensure visits are entered into NJ SPIRIT timely within five (5) days after the visit occurs.

Appendix V: SVS Family Satisfaction Survey

Supportive Visitation Services
Satisfaction Survey

Dear Caregiver,

New Jersey's Department of Children and Families is working with *insert SVS Provider Agency* to gather feedback on your satisfaction with the Supportive Visitation Services (SVS) Program. As part of this, we would like to hear your thoughts on your experience with the SVS Program. Below are some questions asking about your overall experience with the SVS Program. The questions will not last more than 10 minutes. The answers you give us will remain confidential. We will not link your answers to your name or any identifiable information.

Your feedback is much appreciated!

1. What agency do you currently receive Supportive Visitation Services from?	
☐ Care Plus	☐ Family Connections

2. In what county are you receiving Supportive Visitation Services?			
☐ Essex	☐ Morris	☐ Passaic	☐ Sussex

3. How long have you been enrolled in the Supportive Visitation Services program?					
☐ < 1 month	☐ 1-3 months	☐ 4-6 months	☐ 7-9 months	☐ 10-12 months	☐ > 1 year

4. People from the SVS Program really seem to care about me.						
☐ None of the time	☐ Very rarely	☐ A little of the time	☐ Some of the time	☐ A good part of the time	☐ Most of the time	☐ All of the time

5. I would come back to the SVS Program if I need help again.						
☐ None of the time	☐ Very rarely	☐ A little of the time	☐ Some of the time	☐ A good part of the time	☐ Most of the time	☐ All of the time

6. I would recommend the SVS Program to people I care about.						
☐ None of the time	☐ Very rarely	☐ A little of the time	☐ Some of the time	☐ A good part of the time	☐ Most of the time	☐ All of the time

7. People from the SVS Program really know what they are doing.						
☐ None of the time	☐ Very rarely	☐ A little of the time	☐ Some of the time	☐ A good part of the time	☐ Most of the time	☐ All of the time

8. I get the kind of help from the SVS Program that I really need.						
☐ None of the time	☐ Very rarely	☐ A little of the time	☐ Some of the time	☐ A good part of the time	☐ Most of the time	☐ All of the time

9. People from the SVS Program accept me for who I am.						
☐ None of the time	☐ Very rarely	☐ A little of the time	☐ Some of the time	☐ A good part of the time	☐ Most of the time	☐ All of the time

10. People from the SVS Program seem to understand how I feel.						
☐ None of the time	☐ Very rarely	☐ A little of the time	☐ Some of the time	☐ A good part of the time	☐ Most of the time	☐ All of the time

11. I feel I can really talk to people from the SVS Program.

☐ None of the time	☐ Very rarely	☐ A little of the time	☐ Some of the time	☐ A good part of the time	☐ Most of the time	☐ All of the time
12. The help I get from the SVS Program is better than I expected.						
☐ None of the time	☐ Very rarely	☐ A little of the time	☐ Some of the time	☐ A good part of the time	☐ Most of the time	☐ All of the time
13. Please provide any additional comments about your responses or experience with the Supportive Visitation Services Program.						

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