

Working with Families: Case Practice Guide

2018



NEW JERSEY DEPARTMENT
OF CHILDREN AND FAMILIES

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Introduction

When child protective services becomes involved, those families engaged as active participants in planning for themselves have greater success in creating safety and stability. This revised guide integrates information to support concurrent planning within the context of overall practice, from the time a report is received, through investigation, permanency work, and achievement of the long term goal, including reunification, adoption or Kinship Legal Guardianship. This guide is a result of ongoing efforts to improve practice by integrating the opportunities for teaming throughout a family's involvement with the agency. This is particularly important for children entering placement so that they may achieve permanency expeditiously. Staff from all levels of the New Jersey Division of Child Protection and Permanency participated in this revision, and their skill, insight and effort are evident throughout.

Beginning in 1974 with the passage of the Child Abuse Prevention and Treatment Act (CAPTA), the federal government has shaped child welfare practice, setting standards and requirements for states designed to assist them in achieving positive outcomes for children and families. The Adoption Assistance and Child Welfare Act (P.L. 272) in 1980, the Adoption and Safe Families Act (ASFA) in 1997, the Fostering Connections to Success and Increase Adoptions Act in 2008, and other related legislation, all focus on child safety and permanency planning. In addition, the federal government initiated a review process within each state, the Child and Family Service Review, to assess the progress of children within the child welfare system. The results have pointed states to best practices in child welfare that are strength based and family focused, that look for solutions with families, and are supported by teams that allow children to achieve safety, permanency and well-being. In New Jersey, our own Qualitative Review (QR) and Child Stat continues this process.

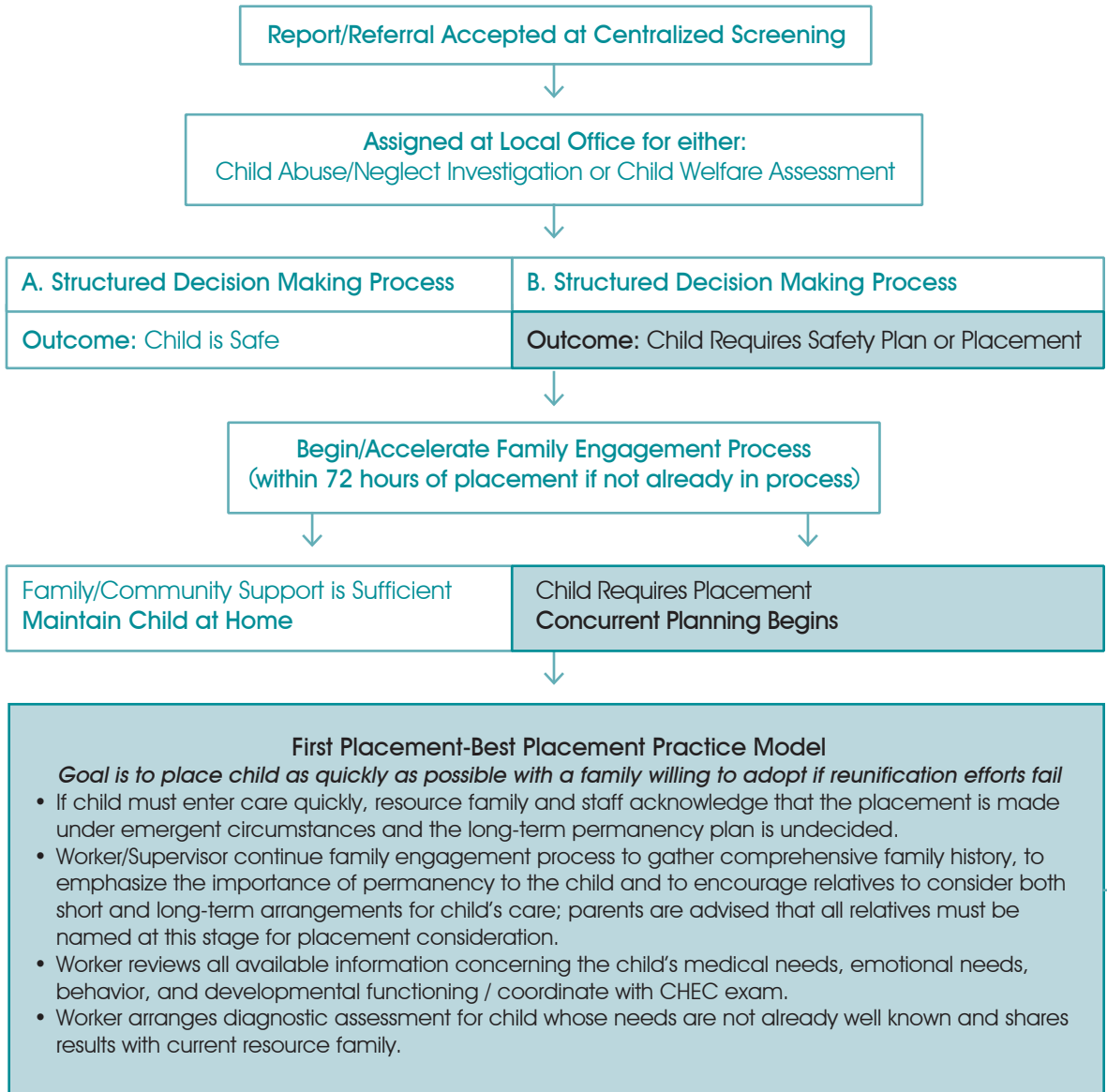
Elements of each new law have refined our practice, at first requiring that reasonable efforts to prevent placement be made, and that there is movement towards timely reunification if placement occurs. The Adoption and Safe Families Act highlighted the need for permanency and stability for children who are in care. Under ASFA, timely resolution of permanency is paramount, and a permanent home, preferably through adoption, must be secured for children who cannot be reunited with their birth families. Among the many provisions of Fostering Connections, are those that support school stability, intensive efforts to locate relatives, and extending services to adolescents to assist in their transition to adulthood.

In its intent to eliminate children remaining in foster care for long periods without permanency, ASFA made it clear that sequential planning with families was not effective in reducing length of stay in foster care, or the number of moves a child experienced during placement episodes. Prior to ASFA, children waited longer to achieve permanency and parents had no timeframe for making the changes necessary in their lives. New Jersey adopted concurrent planning practice prior to adopting its current practice model and saw improvements in these areas. This guide has been revised to align and integrate practice around concurrent planning, teaming and safety.

As federal laws have been adopted, New Jersey has reformed practice by attempting to meet families where they are and engage them in the goal of making meaningful change. Identifying the needs and areas where change is necessary for the family to function safely, parents and their team plan the activities and services that support achievement of jointly identified goals. If placement cannot be avoided, this same team plans concurrently for what is needed for reunification, while simultaneously preparing for the alternate permanency goal if reunification is not possible. The process begins at the initial response, continues with thorough assessment, and includes the informal and formal supports identified by the family. Child safety and well-being are paramount, and as the team moves through its work with the family, the opportunity for open discussion of progress, strengths and challenges creates clarity and the opportunity for positive outcomes for children and families.

Workflow Overview

Flow Chart



- Unit Supervisor and Worker conference within 0-30 days of placement to determine whether family circumstances match the poor prognosis Indicators for family reunification.
- If indicators suggest a poor prognosis for family reunification, decision is confirmed with Casework Supervisor and the resource family chosen is one who can both support the work with birth family and offer a permanent commitment to the child, if adoption becomes necessary.
- Family selection must be finalized within 60-90 days of placement to assure resource family is able to meet child's short and long-term needs.
- If necessary, ongoing effort maintained to locate a resource family comfortable with concurrent planning so that child reaches a potentially permanent home as quickly as possible.
- The Adoption Worker and Recruitment Specialist begin child specific recruitment as soon as it is known that child will require a select adoptive home and one is not readily available.



At placement, Permanency Worker responsible for:

- Seeking a resource family following First Placement-Best Placement model.
- Establishing frequent parent-child visitation throughout placement.
- Completing a full family assessment (if not yet completed) and individualized case plan to help parent to remedy risk to child.
- Full disclosure to parent(s) that permanency within 12 months is the primary goal (all permanency options - including adoption – to be discussed.)
- Educating parent(s) to fact that the choices they now make will determine whether or not child can return to their care.
- Tight coordination with the court to identify kin, establish case plan, insure parental notification of need to actually remedy the conditions that led to placement.
- A record of family background and medical history must begin for child's Life Book in accordance with N.J.S.A. 9:3-41.1, and to support adoption licensing regulations, if this becomes necessary.



In first year of placement, Permanency Worker is responsible for:

- Close adherence to case plan to help parent reunify their family.
- Helping maintain family bonds through high quality parent-child and child-sibling visitation arrangements.
- Continuing family engagement process to solidify reunification or discuss alternate permanency plan*.
- Providing candid, honest feedback to parent(s) regarding behavioral choices with a focus on outcomes, not promises or plans.
- Re-stressing the primacy of permanency in parent contacts and court hearings.
- Utilizing the 5th month Internal Review as a concurrent planning checkpoint to gauge progress towards family reunification and re-assess whether child is in a potentially permanent family.
- Utilizing a 10th month conference to determine whether the family situation warrants an ASFA exception or an adoption goal. If adoption, conference with DAG and assign to paralegal.
- Identify Adoption Worker and introduce to child.

Continued on page 5

- Permanency decision reached at 12-month permanency hearing.
- Case responsibility is transferred to an Adoption Worker immediately following the permanency hearing if the agreed upon goal is adoption.

**If parental situation has not shown improvement, adoption discussions should be strengthened between the 9th and 12th months of child's placement *If parental situation has shown solid improvement but requires a little more time, the need to file an exception to TPR is considered.*

Working with Families

Intake

Intake workers are the initial point of contact with a family. They are the first to engage them about the concerns that brought the family to the attention of the agency. They meet the family where they are, and assess the safety of the children in the home. What are the worries and concerns, the strengths and challenges?

There are many requirements for the investigation process that must be met concerning timeframes, information gathering and findings. Workers and supervisors are the

key to completing quality investigations. Their ability to be open and thorough, to understand a family's history, and to broadly consider all aspects of their functioning can make the difference in understanding what occurred.

For Discussion –

History - what is the family's story? What is their history of involvement with the Division? What collateral information must be considered in assessing them?

How can the core conditions of empathy and respect support the investigation process?

Supervisors support their staff by asking critical questions. They help staff to understand and determine how best to plan with the family. The pre and post-investigation conferences that prepare, review, analyze and de-brief are important components of intake supervision, and help to ensure the quality of the work.

Practice Considerations for Intake

Pre-Conference

Allegation and response requirements reviewed, prior history discussed (# and type of previous reports and findings) in view of current report.

Response timeframes, good faith efforts, CWS vs. CPS, coordinated response (police, prosecutor, etc.) and SPRU follow-up.

Coordinate with IAIU if appropriate.

Document the conference.

Investigation

Engage and Interview

- (Who/When/Where)
- Family Composition (including fathers/paternal relatives.)
- Identifying Information (name, DOB, SSN, race/ethnicity, addresses and relationship.)
- Awareness of safety for non-offending parent in DV cases (see appendix.)
- Separate interviews of all parties, and observation of children who are developmentally unable to speak, due to age or disability.

Observe and Assess

- Observation of family home (location, condition, etc.)
- Response to safety factors addressed.
- Take pictures and obtain video evidence.
- Assessment of safety and risk, (with safety protection planning, if required. see appendix.)
- Consideration of mental and physical health, substance abuse, domestic violence, physical and sexual abuse, and overall well-being.
- Consultation with Child Health Unit, Domestic Violence Liaison, CADC, LCSW as appropriate.
- CARI, Promis Gavel information, CIC.

Teaming and Planning

- Offer of initial FTM, prep and participation.
- Exploration of family supports and relative resources.
- Linkage to services and activities to meet immediate needs.

Collateral Information

- Check back with:
 - Original reporter.
 - The school or childcare (attendance, grade, progress, special education needs?)
 - The medical provider (injuries, chronic health concerns, routine care, medication use, including contact with the prescribing physician if there are allegations of medication abuse.)
 - Mental health or specific sources (police, neighbors, other service providers, etc.) for that family.
 - Coordinate with IAIU if appropriate.
- Are there special circumstances (tribal*, international, religious, cultural, etc.) that affect case handling?

* The Indian Child Welfare Act (ICWA) requires that members of federally recognized tribes have special inquiries and handling as determined by their tribal affiliation.

Post-Conference

What is the nature and extent of maltreatment?

What circumstances accompany maltreatment?

How does the child function day to day? (Behavior, peer relations, school performance, independence, attachments, communication & social skills, mental/physical health.)

Discipline – Parental concept and purpose of discipline, cultural practices, context.

How does the parent manage daily living? (Mental/physical health, substance use, employment, judgment, problem solving, communication, social & coping skills.)

Review, discussion and interpretation of verbal and written information received, and additional follow-up required. How does this inform decision making regarding findings, case opening, child/caregiver strengths and needs, etc.?

Legal/Law enforcement – Status of any police/prosecutor/court involvement in investigation, legal authority for placement, need for litigation.

Document the conference.

Case Disposition

Determination of Findings

- Aggravating and mitigating factors identified, findings are consistent with investigation information (see page 107).
- Identify whether abuse or neglect occurred by statutory definition of abuse and neglect.
- Inform by certified and regular mail, of findings/appeal, case opening/closing, and ensure that all investigation and related activities (Investigation/Child Welfare Summary, SDM tools, case plan, collaterals, etc.) are documented.

Placement - See page 19 - 47 for detailed activities regarding children in placement.

Transfer Conference/Record Review at Closing

Working with Families In Home

When children remain with their families, workers collaborate with them to ensure safety and stability. They become accountable allies, helping to identify strengths and supports to address the needs and challenges that are present. In reducing risk and enhancing safety, the likelihood of placement is reduced.

As families are supported by community and family connections, they are able to create a team that can sustain them in the long term. Using the planning process to

keep all those involved with the family aware of goals and family progress, the result is a coherent approach to the family's needs, and a customized plan matched to their current situation.

The ability to understand the long term view and to prioritize, track and adjust while working with a family is important. The core conditions of respect, empathy and competence and the use of solution-focused strategies will help establish an effective working relationship.

For Discussion –

What were the original reasons for the involvement of the agency?

What activities will enhance individual and family functioning?

How can we engage the family?

Key Events

- Teaming with family and Monthly Minimum Visitation Requirements (MVR)

Practice Considerations for Permanency

Upon Transfer to Permanency

Review current investigation, history, safety assessment and any safety protection plans, collateral information, evaluations, reports from service providers and court orders. Note risk level and MVR frequency.

Request closed records and any additional, updated information, if not already done.

Review family genogram, family composition and relationships, and family agreement and case plan.

Discuss questions or concerns at supervisory conference.

Teaming and Planning

Meet the family. Listen to their story. Discuss the current situation to discover what is working and not working. Review the current plans and activities.

When is the next meeting scheduled? If they originally declined, attempt to re-engage to encourage both teaming and planning. Are there others who should be included in addition to those already involved?

On regular visits, discuss the issues that originally involved the agency in the life of the family, and the progress and challenges in that area. What services and supports are in place, and are they sufficient? (Of the right frequency, intensity, etc.). Is adjustment needed?

Assessment

Assess child and family well-being on an ongoing basis.

What is the family's living situation? (Utilities, food, basic needs, housing, employment).

What is the educational status of the children? (Enrollment, attendance, progress, special needs).

What is the family's health/mental health status? (Routine medical/dental care, immunizations, chronic conditions, medications, health insurance for children, involvement in the Children's System of Care, etc.).

Are there additional factors identified that were not previously disclosed or recognized – e.g. domestic violence, substance abuse, etc. Arrange consultation regarding special factors as needed.

Assess the impact of trauma on family members, involve LCSW as needed.

Assess family/community supports.

Safety Protection Plans

Circumstances within a family may change. If at investigation or during ongoing work with a family, there are factors which create an unsafe situation, a safety protection plan may be created to maintain the child in his or her home (see page 78). When safety is of concern, the Safety Protection Plan must be designed to have an **immediate positive impact on the child**. CP&P views the Safety Protection Plan as a **short term** alternative to court action. **Each Safety Protection Plan must be individually crafted, based on the applicable safety factor(s) and the circumstances of the child.**

Safety Protection Plan interventions include one, or a combination of, the following:

- Direct intervention by the CP&P Worker or other CP&P staff as a safety resource, to achieve an immediate, positive impact on the child or the child's circumstances.
- Parent/caregiver uses appropriate resources - neighbors, relatives, or other individuals in the community as a safety resource.
- Use of community agencies or services as safety resources.
- The alleged perpetrator leaves the home, temporarily or permanently, either voluntarily or in response to legal action. (See policy CP&P-VIII-B-6-600, "Use of Safety Protection Plan Requiring Special Protocol").
- The non-abusing parent/caregiver moves to a safe environment with the child, where the alleged perpetrator has no access to the child.
- Other - The parent/caregiver or Worker identify a unique intervention that does not fit within options 1-5.

Safety protection plans **MUST** be conferenced with DAG within five days. When considering the use of a Safety Protection Plan to allow the child to remain in the home, questions to consider include, but are not limited to:

- Is it reasonable to expect the safety factor(s) identified will be eliminated in a short period of time;
- It is reasonable to expect that the child's exposure to the safety factor can be effectively managed and sufficiently minimized to assure the child is safe and may remain in the home until the safety factor is abated.

Implementation of a safety plan requires the approval of the case work supervisor and involves actions to manage the threats to the safety of the child. They may include, but are not limited to, the following:

- Crisis intervention
- Transportation Services
- Resource acquisition
- Financial help
- Homemaker Services
- Emergency medical or mental health care
- Substance Abuse Intervention
- Supervision/Monitoring
- In-home Health Care
- Day Care or After School Care
- Housing assistance/advocacy

Concurrent Planning Timeline - Working with Families Out of Home

Entry – 4th Month* Family Engagement and Early Placement Process

- Explain Concurrent Planning and child's need for permanency to birth family.
- Explain Concurrent Planning to resource family, including need to support reunification plan.
- Provide a preliminary overview of adoption and subsidy supports so that resource family knows what would or would not be available to child in future.
- Focus on achieving First Placement/Best Placement to meet child's needs.
- Obtain birth certificate, certified birth records, social security card.
- Assure child's caregiver is licensed as an approved resource family.
- Ensure that any required waivers are obtained.
- Ensure that life book work has begun to reinforce that the child's placement experience is important no matter what the final permanency outcome.



5th - 6th Month* Coordinate Permanency Focus with Internal Review

- Gather family background information in case a Child Summary is needed later.
- Complete 20-page CP&P Form 14-177, Family Medical History, with family.
- Meet with resource parent(s) to assess family commitment to permanency, explain adoption process and review supports available in subsidy program.
- Assess quality of care child is receiving and re-visit whether placement will meet both short and long-term needs.
- If placement commitment is questionable, begin process to move child to a potentially permanent home (may require child specific recruitment.)



10-12 Months* Preparation for Permanency Determination

- Determine whether family situation warrants an adoption case goal.
- If adoption, conference with DAG to review grounds for guardianship and assign to paralegal for guardianship complaint. Identify Adoption Worker to ensure a smooth transfer after permanency hearing.
- Schedule psychological evaluation of child (depending on age.)
- Determine whether a bonding evaluation is required for litigation.



Permanency Hearing

- Permanency goal is established - exception to TPR must be filed by 15th month –or-
- Goal of adoption is formally established (foster care, kinship care or select.)
- Assign to an Adoption Worker.

*This chart designates the standard permanency timeline, however individual case situations may require expedited permanency action.

Working with Families

Within Five Days of Placement

If a child cannot remain safely at home, even with a safety protection plan, out of home care is required. The activities that occur at placement offer opportunities to engage the family, identify relatives and friends who may provide support, and begin the formation of a team, if one is not in place. Placement has a significant impact on parents and children. The identification of needs and strengths, as well as assessment and planning, especially concurrent planning, must begin immediately. At every

For Discussion –

What are the safety and risk concerns, keeping in mind child well-being?

Who will raise the child if the parents are unable to do so – concurrent goal?

How can we facilitate placements to preserve homes that are willing to take large sibling groups?

stage of placement, there are decision points and discussions required between worker and supervisor, as well as tasks to ensure the health and well-being of the child. All children should be assessed regarding permanency, including the identification of family supports and connections. Although emergent placements may be made, the goal is to provide children with a setting that will meet their

needs in both the short and long term, and allow them to remain safely with siblings, extended family, or a well-matched foster parent if they cannot be reunified with their parents. (First placement, best placement).

Key Events

- Pre-placement Physical, Call Mobile Response 72 hour Pre-Placement Conference, Family Team Prep, School Stability/Best Interest Determination.
- Initial Court Hearing, Initial Visit, and Initial MVR with Child.
- Resource Family Selection, Provision of Placement Documentation and initial joint assessment with Resource Family Unit.

The **72 hour conference** occurs either prior to placement, or no later than 72 hours after a child enters care. The **Family Team Meeting Prep** should begin in conjunction with this conference, to prepare for the initial FTM to be held within the first 30 days of placement. Information regarding school progress to assist with decision making concerning school stability, and whether it is in the child's best interest to remain in his or her current school should be gathered at this time.

Participants - 72 Hour Conference

The parents, the caseworker, the supervisor, the casework supervisor, and other interested parties.

- Begin the process of getting to know the family. Listen to their story and explore what relative resources and informal supports they may have. Ask open ended questions that offer the chance to share important information. Begin to gather information regarding the parents' strengths and needs. Discuss the child's need for stability and permanency, as well as timeframes.
- Read available information about the family, including family history on both parents and child specific information, as well as available information from existing educational, medical and mental health records prior to the conference.
- Begin completion of the Structured Decision Making (SDM) tools as part of the assessment process.

Specific to the 72 Hour Conference

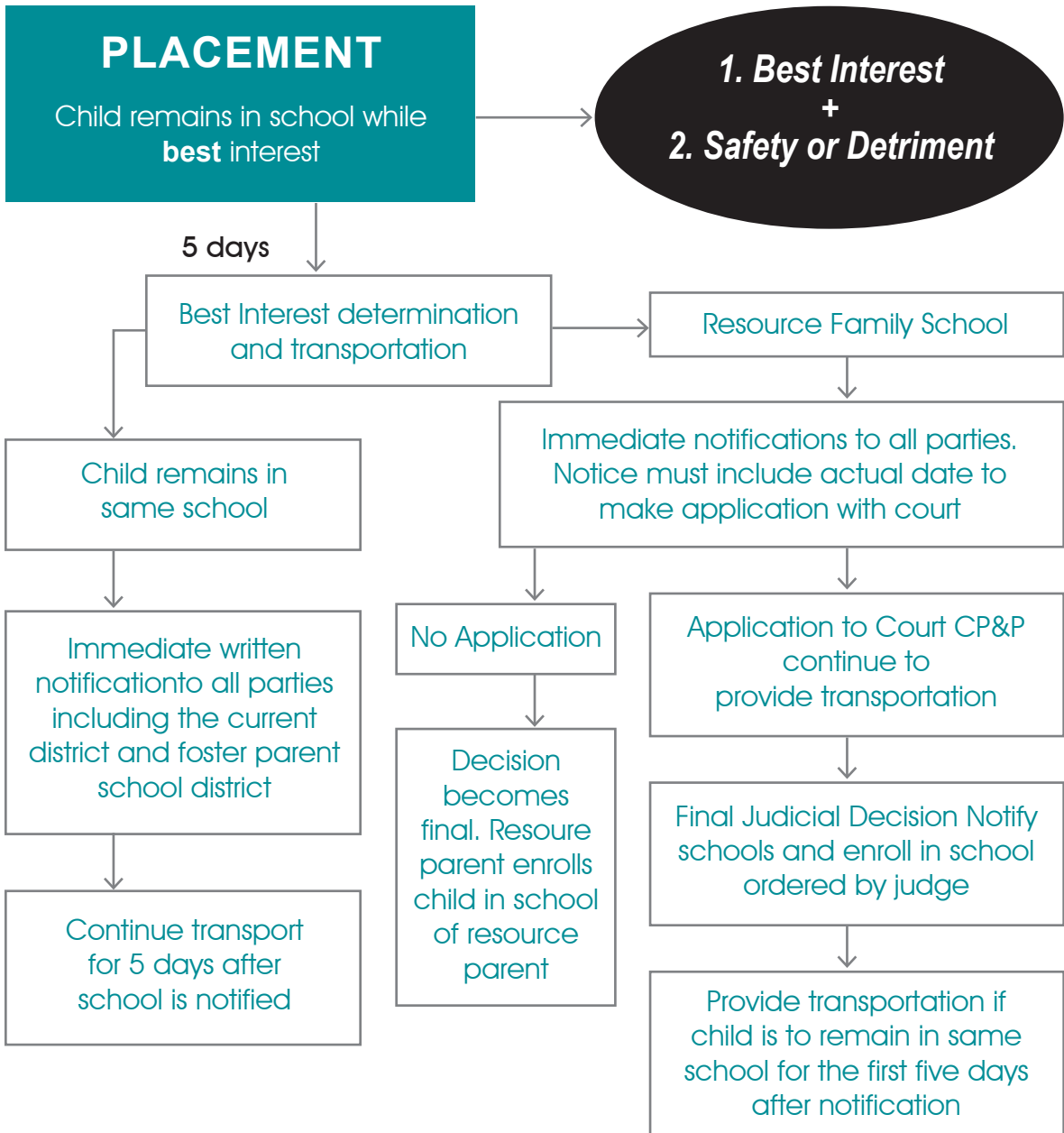
- All parties are to meet to discuss the need for safety and how the situation will need to change for the child to return home.
- Review efforts and services provided to prevent placement.
- Discuss the impact of placement upon the family, and begin a discussion with parents and any potential caregivers regarding child's need for permanency within 12 months (explore relatives, including those that reside out of state or out of country). Send out the 5-58 Thirty Day Notification to Relative of child's OOH placement.
- Discuss any immediate needs and determine if there are emotional, behavioral or cognitive protective capacities that offer opportunities for creating change to expedite reunification.
- Discussion of concurrent planning with families, and the need to have both plans progressing simultaneously.

Document the conference.

Practice Considerations Within 5 Days of Placement

	Explain to child what is happening and why, as appropriate to the child's age and developmental level, in the interest of full disclosure.
	Complete pre-placement physical and obtain report. Complete the mental health screening tool. Provide to Medical Unit. Share any available information regarding health or mental health concerns.
	Provide placement kit to Caregiver: foster parent ID letter, Medicaid Card, clothing check, medical information, Children's Bill of Rights.
	Ensure that Child Health Unit has the necessary information to refer for CHEC / CME exam.
	School Stability - Best Interest Determination - Arrange pre-school, child care and school transfers, if necessary, or interim transportation.
	Obtain information on all relatives, including fathers and their extended families. (CP&P 26-82)
	Determine if child falls under the jurisdiction of the Indian Child Welfare Act, or may have international family connections.
	See parent within 5 days of placement, complete full disclosure check list (CP&P 26-90), and share parent handbook.
	Begin preparation for the Family Team Meeting – listen to the family's story, identify formal and informal supports that may need to be part of the team, and focus on the family's strengths, protective capacities and needs. Complete resource family application.
	Seek a resource family using First Placement-Best Placement model and refer to Placing Children with Kinship Caregiver Policy/Presumptive. Determine what placement plans are least restrictive for the child. Complete resource family application. * Required for 72 hour conference.
	Identify services that are needed for family's immediate needs to work towards reunification. Begin case planning and linkage to services. * Required for 72 hour conference.
	Arrange and conduct 5 day parent/child visit and develop visitation plan. Observe family interaction during visit. Identify or confirm date/location for FTM, if arranged. * Required for 72 hour conference.
	Complete 5 day MVR – Conduct safety assessment and discuss child's adjustment to placement. Assess resource parent strengths and needs. Begin life book conversation and discuss full disclosure elements appropriate to the child's situation.
	CPRB - Notice Of Placement. Legal - Order to Show Cause - Note any non-negotiables for case planning.
	Obtain a signed copy of the Children's Bill of rights.

Education Stability Decision Tree



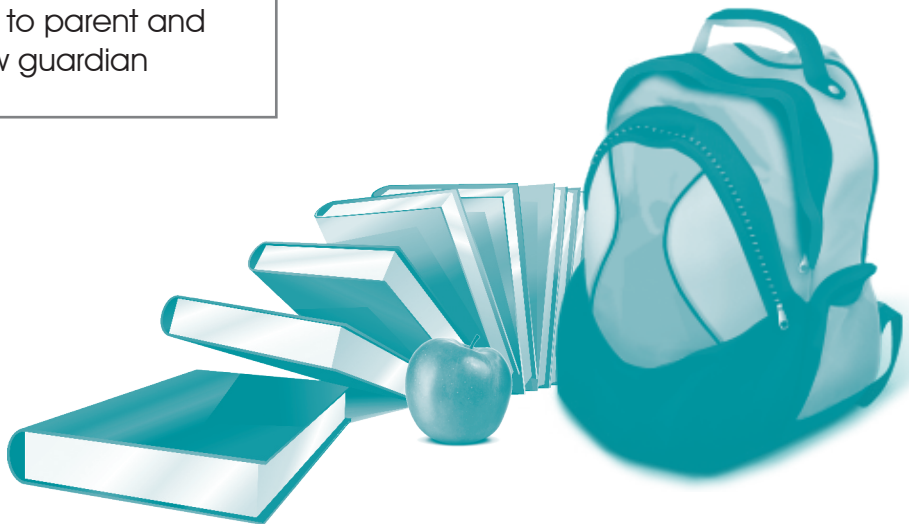
EXCEPTION

Child enrolled in school of
resource parent

2 days

Immediate enrollment
including notice to school
district of residence

Notice to parent and
law guardian



Full Disclosure Checklist (For Working With Children)

Have you:

	Shared reasons for parents' difficulties in clear and yet general terms.
	Clearly let children know they deserve to have the things they need right now.
	Listened to their questions and let them serve as a guide to what they might be thinking or need to hear.
	Helped the child tell his or her story in a safe way.
	Conveyed information in a way that does not present the parent as a bad person.
	Considered whether there is anything the child feels responsible for or might not understand.
	Been brief, concrete and honest.
	Used Life Books to help children piece together where they are, how they got there and where they are going.
	Told children why they are unable to return home when and if reunification has been ruled out.
	Other case specific concerns.
	Receive child's rights with child. Distribute copies and place copy of signature page in file.

Full Disclosure Checklist (For Working With Birth Families)

Have you talked to the birth parents/family about:

	Their rights and responsibilities.
	Their children's urgent need for them to be involved in planning, visitation and decision making about what will happen to them.
	Your role as a representative of the agency.
	The role of the Resource Family Parent.
	Their understanding of the circumstances that caused placement as well as the "official" reasons for placement.
	Permanency planning timeframes and the range of permanency planning options.
	Strengths, opportunities and resources that may exist as potential options to resolve issues that brought the family to the agency's attention.
	The developmental need of children for safety, connections to family & culture, and continuity of care.
	The agency's desire to give first consideration to potential adult relative care providers and assess their capacity to serve as placement and possible permanency resource.
	Relative placement funding/licensing options.
	Past involvement or present barriers to permanency planning, or other case specific issues.
	An agreeable visitation plan and expectations of visitation.
	Case planning, progress, and need for additional assessments/evaluations of the plan.

Full Disclosure Checklist (For Working With Resource Families)

Have you talked to the resource family parents/family about:

	Their rights and responsibilities as foster, adoptive or kinship parents. (involvement with visitation, school, court, and transportation needs.)
	Your role as a representative of the agency.
	Children's developmental need for safety, connections to family and culture and continuity of care.
	The child's urgent need for ongoing visitation with birth parents and siblings.
	The child's emotional need to be involved in planning and decision making about what will happen to them (as age appropriate).
	Permanency planning timeframes and the range of permanency planning options available to agency and Family Court.
	The agency's desire to give first consideration to potential adult relative care providers and assess their capacity to serve as placement and possible permanency resource.
	Sufficient background information as to why the child is in out-of-home care to equip the resource parents to provide for the child's daily safety and well-being .
	All available information in regard to the child's developmental milestones, medical background, CHEC exam results, trauma history (if any) and academic experiences.
	Sufficient family and social history to allow the resource parents an opportunity to reach an informed decision about a permanency commitment to the child, if needed.
	Relative placement funding/licensing options (if appropriate.)
	Any concerns about the resource family parent and/or quality of child care that may be present in the home.
	Discuss the Family Team Meeting process and court. Is the caregiver interested in having/participating, if applicable a Family Team Meeting?
	Other family specific issues.
	Share Children's bill of rights.
	Send out the 5-58 to all family members notifying of the child's OOH placement.

Working with Families

Within Thirty Days of Placement

During the first thirty days of placement, the investigation process may continue, and initial efforts to team with the family and to create a case plan occur. This is an important opportunity to gather information and build on the initial involvement with the family. How a family is asked to engage in planning and services is crucial - is there an invitation to participate in joint planning coupled with an explanation of the process? What are the non-negotiables? What is the family's goal? If Family Team Meetings are declined, or the parent is unavailable, what additional efforts are made to collaborate

with them to the extent that their circumstances allow? Is the importance of visitation and the role it plays in reunification made clear? Especially if the case has been opened prior to removal, how will the work with the family change? How thorough is the assessment of family needs and how well are their strengths understood? Has the collateral information been requested and reviewed? What services provide the best match for the identified needs of both the parent and child? How has the child adjusted to care, and are there any immediate concerns that must be addressed?

For Discussion –

What are the needs identified and the behavioral changes/outcomes required to address the safety and risk concerns that led to placement?

How can the parents build on their strengths and use their supports?

Key Events

- Initial FTM – within 30 days of placement

30 Day Staffing

Staff conference to be held within 30 days of a child's placement.

Incorporate this conference with formal transfer conference from Investigation to Permanency, if children were placed during investigation.

Participants

Supervisor and caseworker must be present.

Purpose

To ensure that the family and the agency are jointly creating a comprehensive and relevant case plan that addresses the issues that caused placement and begins concurrent planning for the children in care.

- Review the MVR schedule for child, resource family and parent, and ensure that **two** contacts for parent and child occurred during the first month of placement and are planned for the second month.
- If the resource worker completes the MVR, resource worker completes contact activity note in New Jersey Spirit.
- Discuss the SDM tools completed. What strengths and needs have been identified? What other assessment information has been gathered, and what does the historical record review reflect?
- Discuss the case plan. Was an initial FTM held? What are the identified goals, action steps/tasks, and the criteria of success? What could go wrong? Were parents/youth involved in developing the case plan and visitation plan? Do the identified services match the underlying needs that must be addressed in order for the children to return home safely?
- Review the Safety Assessment (CP&P 22-5 & 22-6) to ensure time-frames of all concerns are being met.
- If placed with a relative, follow relative care policy.
- Discuss family circumstances and whether there are factors that present barriers to family reunification. Reassess the appropriateness of the child's current placement in view of this discussion. Initiate a change to a more appropriate placement if warranted.
- Review the health and mental health information for the child/ren. Discuss recommended follow-up with the Child Health Unit and clinical consultant as needed.

- Engage other providers and partners as appropriate (CADC, DVL, LCSW, CHU, and Resource Unit)
- Discuss school progress. Is the child classified? Has the child remained in his/her home school? If not, is the child receiving the school services they need? How are attendance, adjustment and progress?
- Prepare for the 45-day Child Placement Review Board (CPRB) enhanced review.
- Review the most current court order. What is the parent's progress, and has the agency done all that was required?

Practice Considerations Within First 30 Days of Placement

	Engage the family and conduct the preparations for a Family Team Meeting within two weeks of placement. Encourage participation of the formal and informal supports that the family identifies, suggesting possible participants after listening to their story. Ask if the family has any international or tribal connections.
	Speak to the parents and identified supports to prepare for the meeting. Review the CP&P record and relevant collateral information.
	Conduct the initial meeting within 30 days of placement. If the family declines, plan collaboratively as possible with them outside of a formal meeting.
	Plan for follow-up meetings as family needs and circumstances require, keeping in mind the benchmark of quarterly meetings for children in placement.
	Use the information from the meeting and the review to complete the initial case plan with the family. Complete a visitation plan with the parents and assure ongoing visitation between parents and children at least weekly, as well as sibling visits. Ensure all visitation documentation is entered in NJ SPIRIT.
	Coordinate closely with the family and the court to identify kin, establish a service plan, and ensure parental notification of the need to resolve the conditions that led to placement.
	What are the transportation arrangements; what after school activities is the child/youth involved in or projected to be involved in and what are the transportation needs for these activities.

Practice Considerations Within First 30 Days of Placement

	Search for missing parents and relatives via formal search process. Follow-up on information obtained to locate missing family members. Provide 30 day notification as required by the Fostering Connections Act. (CP&P 5-58)
	Send for Birth Certificate, Birth and Medical Records, School Records and Social Security Cards.
	Complete any required educational stability activities as outlined previously within 0-5 days of placement.
	Refer parents for non-negotiable evaluations and services as indicated in the court order.
	Continue to explore relatives as placement resources and determine which relatives will be best able to meet the needs of the children in the long and short term.
	Update goals, legal status on each family member on NJ SPRIT. Ensure that all other documentation is complete.
	Take pictures of the children and their parents. Provide copies to the parents, retain copies for the record, and use a copy to begin the child's Life Book.
	Assure that the resource family and all other adults in the household are fingerprinted and that background checks have been completed and reviewed.
	Complete the entire resource family application and submit it to the Resource Family Unit so that the home can be studied, approved and licensed, if that has not already been done.
	Complete and review results of the mental health screening tool, and CME or CHEC, if available. Follow-up with needed services. Conference any mental health or medical needs with the nurse consultant, clinical consultant or involved providers. Arrange any recommended follow-up.
	When medical, mental health and educational records are obtained, initiate completion of medical history (CP&P 14-177), with the family providing the background and medical history.
	Refer to EIP in conjunction with the foster parents if the child is less than 3 years of age and a victim of substantiated abuse/neglect, or a child potentially in need of services.
	Prepare for the 45-day Child Placement Review Board (CPRB) enhanced review.
	Complete two monthly visits with child/ren during their first two months in placement.

Working with Families

Within Ninety Days of Placement

At ninety days, family participation in services and planned activities is underway. The investigation has been completed, the findings have been shared, and searches for missing parents or relatives may have located important people in the life of the family. Ideally there have been parent-child and sibling visits, in-home visits with parents, children and caregivers, and collateral information has been obtained and reviewed. The family and members of their team, including the permanency worker, are beginning to work productively together, and services are in place to address identified needs. The initial FTM has been completed. During monthly contacts, the connection between the changes required to

achieve reunification and the progress made is assessed. Tracking and adjustment is done, and the addition of members to the team is explored. Parents are encouraged to move forward in their efforts, and scaling questions may help them to express how they are feeling. The use of miracle and scaling questions may yield additional information.

For Discussion –

What is the progress made towards reunification?

Is permanency within the resource home achievable if reunification is not possible?

In the interest of full disclosure, the importance of permanency for children and the concept of concurrent rather than sequential planning are discussed with parents and caregivers. The range of permanency options, including an overview of adoption and KLG and relevant subsidy supports, are presented.

Key Events

- FTM – between day 30 and day 90 of placement

90 Day Staffing

Formal conference to involve the Casework Supervisor in permanency plans for children who have now been in placement for three months.

Required Participants

Casework Supervisor, Supervisor and Caseworker. Based on the Casework Supervisor's request, the Area Concurrent Planning Specialist, DAG, RDS, Resource Family Worker, nurse consultant or other participants will be included as appropriate.

Purpose

Use of the family reunification assessment (see page 101), comprehensive family assessments and case review for indicators of progress towards reunification and to see where case plan adjustments may be needed. Assess both the progress made towards achieving permanency and the appropriateness of the child's current placement as a potentially permanent home.

Practice Considerations Within First 90 Days of Placement	
	Follow-up on all referrals to service providers for parents.
	Obtain evaluations and reports from providers. Review and share information. Plan with the family to make adjustments or initiate additional activities or services recommended.
	Continue to explore relatives - Identify relatives and send 30 day notification to relatives of child's out of home placement. (CP&P 5-58). Rule out relatives who cannot be resources (CP&P 5-52).
	Assess the caregiver's ability and interest in providing a permanent plan for child and document in NJ SPIRIT.
	Follow up on progress of the resource family home study, fingerprint results, and licensing process, if applicable.
	Obtain all approved waivers on relative or kinship homes and submit to the Resource Home Unit.
	Finalize resource family selection by assessing whether they are able to meet the short and long-term needs of the child. Assess any opportunities to place siblings together.
	Transitional plan for youth 14 years or older is due.

Practice Considerations Within First 90 Days of Placement

	Assure ongoing visitation with parents/siblings and formulate or adjust the written visitation plan. Include other types of interaction as appropriate – attendance at school conferences, medical appointments, church or sports events, and phone calls.
	Organize visits to allow parents to practice protective capacities and parental activities. Set timeframes for reconsideration of visitation plans and activities, including sibling visits. Document visits in NJ SPIRIT including direct worker observation, visit logs, etc.
	Provide feedback to parents regarding progress. (Full Disclosure)
	Reinforce importance of permanency for children in parent contacts and court hearing. Complete concurrent planning guide to assess for expedited permanency.
	Explain concurrent planning, including a general overview of adoption and subsidy supports to caregivers. Provide written information and review the KLG vs. Adoption Form. (CP&P - 4-18, Rev. 4/10)
	Continue to work with the child on the life book. (Life Book resources on NJ SPIRIT)
	Follow up on services for the child as indicated. Review school progress, including attendance and academic performance, progress in counseling, visitation, etc. and adjust accordingly.
	Assure birth certificates, birth records, photographs, medical records, school records, CHEC results and social security cards have been requested and received, certified and filed in case record; verify the accuracy of names and other identifying information; verify that all match both legal and agency documents. Assure that caregiver has this information.
	Continue thorough documentation of all parties' progress with the case plan and/or court order, all visits, other contacts and collateral information.
	Review and complete the reunification assessment, caregiver strength and needs assessment (on biological parents), at three months from entry into placement, keeping in mind all information obtained from the family, documented history and collateral information.
	Update the family agreement and case plan as necessary.
	Assure ongoing compliance with court order by agency, parents and child.

Reunification

New Jersey Family Reunification Assessment is completed in NJ SPIRIT for open cases, where at least one child is in out-of-home placement and the goal is to reunite the child with the family. The assessment is also done when a household, which was not involved in the removal, is being considered as a reunification resource. Use this tool when a child is in out-of-home placement to:

- Evaluate and determine a Visitation Plan;
- Conduct a reunification assessment in the parent's/caregiver's home;
- Develop or revise a Permanency Plan.

Complete the Family Reunification Assessment:

- No later than three (3) months from the date of placement;
- Every three (3) months while a child continues in placement;
- Prior to any court hearing, to review the permanency goal and/or progress toward achieving case plan goals and objectives;
- At any time a child is being considered for return home.

In establishing conditions for reunification, the situation that precipitated the child's removal from the home, and the overall assessment and progress of the parents in resolving those circumstances, must be considered. Issues of parental capacity, attitude and behavior must **reflect the change** that has resulted from their participation in services, not mere attendance or compliance. The parent must have an enhanced capacity to protect and care for the child, ideally with the ongoing involvement of the informal and formal supports of the family team that has been created. Collateral information and observations from visits, as well as the parent's ability to manage any special needs that the child may have, should be part of the evaluation and planning for the child's return.

[See the reunification assessment on page 101.](#)

Working with Families

Within Four to Eight Months of Placement

The review held at the fifth month provides an objective view of the family situation. What's going well? What has gone wrong? How has the child adjusted to placement? The fifth month review gives an opportunity for all parties to review the child's health and well-being. Is there any medical or school follow-up needed? Have the recommendations from the CHEC or CME been followed? How is he or she progressing in school? Are there any concerns with visitation? Are siblings placed together or visiting each other? Is there a need for discussion of an alternate permanency plan?

The parent's understanding of what is necessary to have the child returned and what needs to be done so that reunification

may occur is also addressed. How are the services and informal supports helping the parent to make the changes necessary? What is their understanding of next steps, and how will the team plan to move forward?

What goals have been identified for the next FTM? Is the long term view clear?

This interval is where the assess-

ment of the family is updated. The child is re-screened for mental health needs via the Mental Health Screening Tool. The SDM tools, including the reunification assessment, are completed. The work of the family to prepare for reunification continues. If progress is limited, efforts to engage the family and assess other services or supports that might be integrated into the plan to improve the outcome are explored.

For Discussion –

What progress has been made in addressing safety and risk concerns?

What adjustments are required in the reunification plan?

Key Events

- FTM – between day 90 and day 180 of placement

5-Month Enhanced Review (Regional Review)

Formal internal review conducted by the Administrative Placement Reviewer (formerly Regional Reviewer) who serves as an independent consultant to all parties.

Participants

Parents, Administrative Placement Reviewer, Area Concurrent Planning Specialist, Supervisor, Caseworker, child (depending on age and appropriateness), caregiver, and any other interested parties. The Casework Supervisor, Adoption Supervisor, and Resource Family worker may attend as necessary.

NOTE: This review may occur in conjunction with a Family Team Meeting with the permission and agreement of the family and the reviewer.

Purpose

Focus on progress made in achieving the goals reflected in the case plan. Review the completion of key permanency tasks (such as searches for missing parents); evaluate parental participation and progress towards reunification; assess the effectiveness of services already provided and identify adjustments needed to meet the needs of the child, family or resource family; review the appropriateness and stability of the child's placement and verify that the home is licensed. This review is also meant to facilitate the identification of cases for early reunification, early Adoption or Kinship Legal Guardianship.

- Use this review as a concurrent planning checkpoint to gauge progress toward family reunification and re-assess whether the child is in a potentially permanent home.
- Ensure that case record includes birth certificates, birth records, Social Security card and health and education information on the child.
- Determine if the current home is the best placement for this child - does it meet both the child's short and long term needs?
- Discuss the status of the resource home. Is the home licensed and approved? Was a waiver needed and completed? If the placement is questionable, not appropriate or will not meet licensing requirements or the caregivers are not willing to provide a permanent plan, the process to identify another potentially permanent placement must begin.
- Review the Activities within 4-8 months of placement to ensure required activities have been completed.
- Review the Activities within 10 months of placement to identify the permanency activities that are required in the next 5 months.

Practice Considerations Within 4 to 8 Months of Placement

	Review court orders and discuss progress of parents in terms of litigation requirements including court ordered evaluations and services.
	Obtain initial assessments and reports from service providers, schools, mental health and medical resources, and update on an ongoing basis. Read and evaluate the information. As appropriate, discuss with providers, office consultants in the appropriate fields (medical, mental health, substance abuse, domestic violence) and supervisor or casework supervisor. Update the assessment of the family and plan with them to adjust services accordingly. File copies of all information received in the case record.
	Complete the Reunification Assessment Caregiver Strength and Needs Assessment (for the biological parents) by 6 months from placement.
	Assess quality of care child is receiving in their current home and their willingness to commit to a potential permanent plan to be sure that placement will meet both short and long-term needs of the child.
	Begin to explore other placement alternatives that can meet the child's short and long term needs if child needs to move; a child specific recruitment plan may be required. Consider DAG conference to obtain PRE-Adopt placement approval if case circumstances warrant.
	Observe visits and note the quality and nature of the interaction . For visitation completed by other parties, note the frequency of parent, child, and sibling contact, and how the visit is described. Document all information in NJ SPIRIT weekly.
	Gather fuller family background and medical information about the birth family. Ensure child's medical history (CP&P 14-177) is complete.
	Re-assess the child's mental health needs using the mental health screening tool (see appendix). If there is a need for any formal medical, educational or psychological evaluations that remain outstanding, make appropriate referrals.
	Reinforce the importance of permanency for children in all discussions with parents and at periodic court hearings.
	Discuss permanency with relatives and resource parents. Assess resource family commitment to permanency, explain adoption process and review supports available within the subsidy program, document accordingly.
	Ensure rule out letters are sent and documented.
	Ensure an updated photo of the child is in the record.

Practice Considerations Within 4 to 8 Months of Placement

	Expand each child's life book with additional photos, some discussion of why they are in placement, their experiences while in care, and background on their birth family.
	Prepare family for regional review, and ensure parents and all interested parties are invited. Update case plan with family in conjunction with review. Supervisor and caseworker attendance is mandatory.
	What progress has been made regarding non-negotiables? What issues are best addressed at the next FTM? Provide honest feedback to parents regarding the outcomes to date for all services and activities. (Full Disclosure).

Working with Families

Within Ten Months of Placement

At the tenth month, families with children in care are reaching a critical decision point. The progress of the parents and the ability of their team to support and sustain them may create circumstances where reunification is viable. Visitation, parenting supports, and other activities

to ensure the long term safety and stability of the home are intensified to bolster the likelihood of successful reunification.

If a lack of progress has made continued placement likely, the ten month family discussion offers an opportunity to redouble reunification efforts or to look at formalizing the alternate permanency plans that are in place. The decision to seek termination of parental rights or an

ASFA exception is made, and the preparation for completion of adoption or Kinship Legal Guardianship begins.

For Discussion –

What is the permanency plan for the children?

What is necessary to put the plan in place and have it happen?

Key Events

- FTM - between day 180 and day 270 of placement
- Ten Month Placement Review
 - Ten Month Family Discussion (*may be held in conjunction with FTM*)
 - Pre-Permanency Hearing Litigation Conference

Pre-Permanency Hearing Litigation Conference

The Pre-Permanency Hearing Litigation Conference which is held at the tenth month of placement identifies outstanding permanency tasks which must be completed prior to the permanency hearing. Once the goal of adoption has been established, the case must be assigned to an Adoption Worker within 5 days.

Ten Month Placement Review

This is a critical decision-making time in which the Division must prepare for the Permanency Hearing and either:

1. Approve an ASFA exception based on the improved circumstances of the parents and likelihood of family reunification or
2. Recommend the termination of parental rights for the purpose of adoption. Because so much hangs in the balance, this is a two step process which begins with a Family Engagement/Family Team Meeting in which all relevant parties are strongly encouraged to participate.

Step One - Family Discussion

The family discussion is conducted by the Casework Supervisor in order to assess case progress in regard's to the child's permanency plan.

Participants: Casework Supervisor, Supervisor, Caseworker, Parents, child (depending on age and appropriateness), caretaker, and any other interested parties (as appropriate). The Area Concurrent Planning Specialist may attend, if needed.

Purpose: Review is meant to assess the likelihood of family reunification within the timeframes recommended by state and federal law (ASFA).

- Hold a frank and focused discussion with the parents and family concerning their progress in remedying the conditions that led to their child's placement.
- Assess parent's readiness to resume child's care based on the progress to date.
- If parents have made significant progress - and family reunification is likely - discuss accelerating parent-child visitation.
- If family reunification is likely, discuss openly what type of support and/or monitoring will be needed during the child's transition home; adjust the service plan accordingly.
- If reunification seems unlikely based on the parent's lack of significant progress, this is the time to discuss the permanency plans available to the child (usually adoption or Kinship Legal Guardianship).
- Discuss with family and child(ren) that child is entitled to attend the permanency hearing.

Step Two - Litigation Conference

The litigation review is arranged and conducted by the Area Concurrent Planning Specialist in order to prepare for the Permanency Hearing.

Participants: Area Concurrent Planning Specialist, Casework Supervisor, Supervisor, Caseworker, PRS and/or Guardianship DAG, and others (as appropriate).

Purpose: Review is meant to establish the agency's recommended permanency goal in preparation for the Permanency Hearing typically held at the 12th month of placement.

- Review parent's progress in remedying conditions that lead to placement and determine if case goal should remain family reunification.
- Review the case record for required documentation to support the case goal.
- List any remaining tasks to be completed by the Permanency worker prior to the Permanency Hearing.
- Determine whether a family situation warrants an adoption goal; if so, discuss with DAG whether there are sufficient grounds to file a guardianship petition.
- Prepare for possible case transfer to an adoption worker and assignment to a paralegal. If adoption is the recommended case goal, an adoption worker is assigned as the co-worker (assignment coordinated between the Concurrent Planning Specialist and the adoption Casework Supervisor). Plans set for permanency worker to begin introducing the role of the adoption worker to the child and caregiver, however case responsibility remains with the permanency worker until goal is formally determined through the Permanency Hearing.
- Review the Practice Considerations at 10 months of placement.
- Review Practice Considerations for Adoption if the goal is changed to adoption at the permanency hearing.

Practice Considerations Within 10 Months of Placement

	Adjust and strengthen case plan and service provision based on ongoing teaming with the family, their progress, the results of the 5-month review, and court reviews. With the agreement of the family, conduct the ten month family discussion in conjunction with the FTM.
	Assess parental progress with services and track and adjust accordingly. Document planning and other activities thoroughly and accurately, especially concerning parental change.
	Obtain periodic updates from providers and informal supports regarding changed behaviors and achievement of goals. Work with the team on how their continued involvement can support the family, even when the agency is no longer involved.
	Assess the permanency of the child's placement in terms of the caregiver's ability to meet child's needs and their willingness to commit to potential permanent plan.
	Continue to monitor the child's adjustment to placement and assess whether any additional supports or services are needed.
	Assess the visitation plan in view of progress towards reunification. Adjust the frequency, duration or location of visits accordingly. Document each child's visits with parents and siblings, noting the interactions and participants.
	Ensure that all case documentation is thorough, accurate and up-to-date, and that assessments, reports and evaluations are discussed at the 10 month pre-permanency hearing litigation conference. Identify the goal to be presented at the permanency hearing.
	Complete any outstanding assessments of birth relatives and document results in case record.
	Complete the reunification assessment (in consultation with the resource worker) and caretaker strength and needs assessment at 9 months from date of placement (CP&P 22-27, see appendix).
	Discuss permanency Hearing and any special arrangements or considerations the child or young person may need.
	Discuss child's attendance at permanency hearing and any special arrangements, notifications that are needed.

Working with Families

Adoption

When reasonable efforts toward family reunification are unsuccessful and despite the offer of and/or provision of services, the parents are unable to resume the care of their child, the preferred permanency goal for that child is adoption.

The role of the Adoption Worker is to bring about the adoption of that child by his/her caregivers (Kin or Resource Family), or by Selected Adoptive Parents. While establishing a working relationship with the child, birth parents and caregivers, the worker gathers information, assesses plans for the child, and provides for services, support and understanding for all involved in the adoption process. Ongoing Family Team Meetings with birth parents, adoptive parents and children (if appropriate) are valuable tools in this effort.

A trusting, open and compassionate relationship between the child/ren and adoption worker is essential. The adoption worker assists the child/ren through a complex, confusing and often emotional process. Best practice is the standard throughout this

process, with the goal of helping a child to understand how he or she entered care, why return to his or her parents is not possible, and assisting in the transition to a permanent adoptive family. Each child's situation is unique, and the components required must be tailored to the situation of the particular child. The supervisor and worker should regularly conference to discuss new information, progress and questions as they arise to ensure the best possible outcome.

Adoption is the preferred permanent placement plan, as it provides children with the highest level of legal and emotional security. Kinship Legal Guardianship (KLG) can only be selected as the permanency goal when it is determined that Adoption is not feasible or likely, and is not in the best interest of the child. In selecting KLG as the permanency goal, CP&P has the obligation to affirm that KLG serves the child's best interests based on an assessment of individual case factors and/or an evaluation of the child's specific needs. KLG subsidy is approved through the office of Adoption Operations.

Factors to Consider When Deciding Adoption Vs. KLG:

- Child's age and legal status - older, legally free children be considered for KLG (KLG for children under the age of 12 requires Area Director approval). HOWEVER, all efforts to find an adoptive home have been exhausted.
- Recommendation of professional, i.e. therapists.
- Would termination of parental rights do more harm than good?
- Child's relationship with caregiver.
- Informed input from children - keeping in mind that children frequently feel they do not wish to be adopted based on lack of knowledge or fear of the unknown.
- Caregiver's feelings after receiving full disclosure regarding the child and the advantages/disadvantages of adoption and KLG.

Practice Considerations for Adoption

Upon receipt of the case, the following tasks need to be completed by the supervisor (within 5 days of the permanency hearing or the goal being changed to adoption):

Assign adoption worker as secondary worker with a case participant assignment to each child with a goal of adoption.

Open an adoption planning window for each child with a goal of adoption.

If goal is select or type undecided, open a child specific recruitment plan. Fill in page 1 and save. Make a secondary assignment to the child specific recruiter without a case participant assignment.

Verify case plan correctly reflects adoption goal.

Upon case assignment, the following tasks must be completed by the worker:

Read case record in its entirety, review supervisor's assignment dictation.
Schedule MVR within mandated timeframe.
Review visitation plan between parent, relatives and/or siblings; ensure proper services are in place. Make referrals if necessary.
Ensure court-ordered services are in place.
Determine status of caretaker's home with OOL/Resource Unit.
If child/ren have a Select Home goal, begin to gather required materials to send to Adoption Operation Exchange Unit to begin the matching process.

At first MVR (with Caregiver):

Explain worker's role and what caregiver can expect throughout the TPR process. Reinforce that work with the birth parents toward reunification remains an ongoing process.
Explore caregiver's commitment to the child/ren.
Obtain names of doctors, dentists, specialists, therapists; ask if additional services are needed.
Ensure Lifebook work has been initiated. Review Lifebook work to date.

At first visit (with Child/ren):

Determine child's understanding of why he/she is not with his birth family. Clarify any misconceptions/misunderstandings.
Ask child about school, living with this family, interests/hobbies; get to know the child.

At first visit (with Birth Parents):

Engage parent and discuss their understanding of how the child came into care and the goal of adoption.
Discuss what the parent can expect through the TPR process.
Explain child's need for safe, secure and permanent home; and discuss ASFA timeframes.
Determine the parent's understanding of the difference between TPR, Identified and General Surrender.

The Lifebook

Lifebook and identity work is ongoing and should have been initiated at placement. A child's Lifebook is a tool which can enable a child to understand circumstances of his placement in age-appropriate stages. There are many guides to creating Lifebooks; some are available on New Jersey Spirit.

The Litigation Process

All adoption cases are litigated, and as such, require diligent attention to elements of the various court orders. **The adoption worker and supervisor must review and comply with any provisions that require CP&P action. All referrals for court ordered services must be made upon receipt of the court order.**

Once the Guardianship Petition has been filed, the worker must continue to provide services to the parents and ensure proper documentation, certifications and reports are provided to the court. Regular communication between adoption staff and the DAG is critical. Based on the evidence provided by CP&P, the court may terminate parental rights, or continue reunification efforts. The parents may choose during this process to voluntarily surrender their parental rights. Surrender may be either general or identified. A general surrender allows CP&P the ability to decide where the child will be adopted. In an identified surrender, the individual(s) identified by the parent must adopt the child or the surrender is vacated and their parental rights are reinstated. Identified surrenders may be taken only in situations where the child is placed in a licensed Resource family home..

The Consent Process

When parental rights are terminated, the agency becomes the legal guardian of the child, and must consent to their adoption by a particular caretaker. The information gathered and reviewed in order to do this is the consent package.

In assembling the necessary documents and information, there are many timeframes that must be considered. This package should be completed and submitted to the local office manager within 60 days of a child becoming legally free. Components of the consent include an approved subsidy package, a copy of the Judgment of Guardianship, documentation regarding the child's adjustment, relationships, feelings about adoption, a pre-adoption medical, dental, Family Medical History, Child Summary, copy of the caretaker's Homestudy and current license (see policy for complete list).

The Subsidy Process

Subsidy is not automatic and is reserved for children with documented special needs (behavioral or medical), and for those children belonging to a race for which adoptive homes are not readily available. The adoption subsidy is designed to cover only a portion of the cost of raising a child and should be viewed by the adoptive family as partial assistance. It is a federal program and rates are determined according to guidelines established for that program.

Subsidy is a part of the consent process. It may include ongoing assistance through monthly board payments, medical insurance, or other identified services, such as day care. The determination of whether or not a child is subsidy eligible needs to be discussed early on in the process. The discussion with the caregivers regarding subsidy needs to be ongoing. All subsidy requests need to be approved by Adoption Operations prior to the submission of the consent package (see form 14-228 in the Forms Manual).

Following the Adoption Finalization

After the adoption is finalized, the case record for those child/ren adopted needs to be processed for closure, and a copy of the subsidy file must be sent to the Subsidy Unit of Adoption Operations within 45 days of finalization (see form number 14-228 in the Forms Manual).

Working with Resource Families

A licensed resource family is a family who is licensed and provides foster, adoptive, or kinship care for a child needing out-of-home placement. A licensed resource caregiver is responsible for parenting children placed in their care. The Federal Preventing Sex Trafficking and Strengthening Families Act of 2014 is designed to promote well-being and normalcy for youth in resource care by allowing resource caregivers to use their best judgment, in making day-to-day decisions regarding the youth in their care. The law promotes participation in age-appropriate activities and experiences that allow for the healthy development and well-being for youth in placement.

Roles within the Resource Family Support Unit

For more information regarding the roles within this unit please see CP&P IV-B-6-200

Resource Family Support Supervisor	<ul style="list-style-type: none">■ Oversees the work of the RFSW, the recruiter and the trainer, and the facilitator■ Ensures that all unit members are crossed trained
Resource Family Support Worker (RFSW)	<ul style="list-style-type: none">■ Develop, supports, and retains resource families
Resource Family Recruiter (recruiter) (supervised by ARF)	<ul style="list-style-type: none">■ Develops and implements a retention plan for the local office■ Ensures that the local office has a robust pool of resource homes to meet the needs of the children
Resource Family Trainer (trainer)	<ul style="list-style-type: none">■ Ensures resource families have obtained their pre-service and in-service trainings■ Provides feedback to the assigned RFSW
Resource Family Placement Facilitator (facilitator)	<ul style="list-style-type: none">■ Teams with the worker assigned to the child, the Child Health Unit, and RFSW to make sure that each child is placed in a resource home that can best meet their needs

Resource Family 150 Day Licensing Timeline

DAY 1 - 7

The Resource Family (RF) Supervisor reviews and approves the cleared, completed application, sends a copy to the Office of Licensing (OOL), and has an initial conference with the assigned Resource Family Support Worker (RFSW).

The RFSW contacts the applicant(s) to schedule an appointment to review the home study process.

DAY 7 - 30

By day 30, the RFSW has sent for necessary references for all household members and completes a home visit. The visit includes a review of SAFE Questionnaire One, a completed home inspection using the Checklist of Standards. Applicants should have already begun or are registered for pre-service training.

A supervisory conference is scheduled and completed.

DAY 30 - 60

On or before day 60, the RFSW conducts the next home visit and interviews the applicant(s) as outlined in the SAFE home study model. If a CARI/CHRI waiver is needed, it is prepared and submitted to the appropriate authorities.

A supervisory conference is scheduled and completed.

By Day 60 the RFSW submits DYFS 5-12, LO Manager 60 Day Review of Home Study form, to the LOM for review and signature. (DCF Policy II D 1802.5)

DAY 60 - 90

On or before day 90, a follow-up visit is made to the home to conduct interviews and ensure all obstacles/issues have been addressed as per the SAFE home study model. The RFSW completes the SAFE home study report utilizing all information gathered from references, questionnaires, and interviews with the applicant(s) and all household members.

A supervisory conference is scheduled and completed.

90 - 100

The RF Supervisor reviews/approves the SAFE home study and sends the Home Study Assessment Packet (HSAP) to the OOL within 2 days.

DAY 100 - 120

Within 5 days of receipt of the HSAP, OOL reviews it and notifies the Resource Family Staff of the outcome.

Within 20 days of receipt of the HSAP, the OOL inspector contacts the family and the inspection is completed.

The OOL inspector and the RFSW conduct a joint inspection of the home.

The inspector submits the inspection results to the OOL Supervisor within 7 days of inspection. The OOL Supervisor reviews for compliance within two days.

120 - 150

The inspection report is completed. If Level 1 Violations exist, the family and RFSW are advised of the violations. Re-inspection is completed within 30 days.

A recommendation for an application to be withdrawn or denied can be made at any time during the home study process. These recommendations must be made as early in the process as possible.

ON-GOING HOME STUDY PROCESS

All adults who reside or frequent the home should schedule a live-scan fingerprint appointment as soon as possible.

The resource family applicant(s) complete Questionnaire One of the SAFE assessment. All household members must be interviewed during at least one visit. Applicant(s) ensure all necessary documentation and references are secured as required. (personal, school/daycare, medical, employment, financial statement, criminal dispositions, marriage certificates, birth certificates, vehicle registration, etc.)

If a new household member moves into the home, additional time may be required.

Applicant(s) complete the required pre-service training:

Kinship training: 18 hours (6 sessions)

Non-kinship training: 27 hours (9 sessions)

The applicant must be available for a home inspection and interview by the OOL inspector.

If a re-inspection determines that Level 1 Violations can not be abated, enforcement by the Administrative Unit begins, to determine the appropriateness of denial. DAG, LOM, Chief, etc. may be consulted, as needed.

Key

RFSW

OOL

Applicant

Enforcement

Important Licensing Terms

Kinship - refers to a relative or family friend who has a bond with the child.

Presumptive Eligibility - refers to a situation where a kinship caregiver meets the requirements according to the presumptive eligibility policy based on the joint initial assessment. Therefore, eligible for resource family care payment, on behalf of the child/children in their care, based on the initial assessment, until the home study is completed. Please see CP&P policy

Child Abuse/Neglect Substantiation (CARI) and/or Criminal History (CHRI) Waiver - this is a mechanism for approving a pending or existing licensed resource family which would otherwise be denied or revoked. A waiver is required for all adult household members or frequent overnight guests who have a child abuse/neglect substantiation and/or who have been convicted or pled guilty to a criminal offense. The criminal offenses include felonies, disorderly persons, DUI and DWI. A waiver request may be considered by the local office for a criminal conviction or CARI substantiation on a case by case basis. More information about the waiver process can be found under CP&P-IV-B-2-300.

ASFA Disqualifier - When an applicant, or any adult residing in the household, is found to have a criminal conviction for a crime outlined in N.J.S.A. 30:4C-26.8d the person is permanently disqualified regardless of the amount of time that has passed.

Five Year ASFA Disqualifier - When an applicant, or any adult residing in the household, is found to have a criminal conviction for a crime outlined in N.J.S.A. 30:4C-26.8e the applicant is disqualified until five years have passed since the person was terminated from probation or parole, or was released without probation or parole from a correctional facility.

Structured Analysis Family Evaluation (SAFE) - is a comprehensive set of tools that the RFSW uses throughout the home study process to assist with the evaluation of a prospective resource family home.

Withdraw - This term describes the voluntary decision of the applicant to not move forward with the home- study and licensing process.

Denial - This term is used during the home study process when the RFSW makes the decision that the applicant is not in substantial compliance with regulations as specified in Chapter 122C: Manual of Requirements for Resource Family Parents.

Annual Inspection - The OOL inspector completes an annual interview with all household members in the resource home and a full physical site inspection.

Renewal - The OOL inspector completes an annual interview with all household members in the resource home and a full physical site inspection. To renew the license the following is also needed: a new Resource Family Licensing Application, updated medical exam and corresponding reference for all household members and frequent overnight adult guests, and current CARI & CHRI checks for all adults in the household or frequent overnight guests.

Office of Licensing - The licensing and regulatory authority of CP&P. OOL licenses and regulates resource family homes, child care centers, youth and residential programs, and adoption agencies.

Resource Family Inspector - Is an OOL representative who will visit and assess the resource family home for compliance with the Manual of Requirements for Resource Family Parents.

Institutional Abuse Investigation Unit - This is the unit that is assigned to investigation allegations of abuse and neglect in out of home settings including resource homes. The outcome of the IAIU investigation could impact the licensing of a resource home.

For more information on Placing Children with Kinship Caregivers please see CP&P IV-B-2-125

For more information on the Resource Home Application Process please see CP&P IV-B-2-150

For more information on denying, suspending, revoking or refusing to renew a license please see NJAC-10-122C-2-5

Teaming with and around Resource Parents

Resource Team Meetings (RTMs) are conferences that are held to determine how to move forward when there are concerns about a specific resource home. The Resource Family Support Worker, the Resource Unit Supervisor, the Office of Licensing Inspector, the Institutional Abuse Investigator, the Institutional Abuse Supervisor, and the caseworkers and supervisors assigned to the children in the home take part in the RTM.

Disruption Meetings- any time the local office is considering moving a child from a resource home there must be a conference to determine what could be done to stabilize the placement.

Resource Family Impact Team Meetings are conferences where a full qualitative review of the resource home takes place. The team which includes the Local Office Manager, the RFSW, the RFSW supervisor, the Resource Casework Supervisor, the Area Resource Family Specialist, the Office of Resource Families Case Practice Specialist, and the Office of Licensing Inspectors. The Resource Families to be discussed at these meetings are selected by the Area Resource Family Specialist in advance of the meeting.

Family Team Meetings (FTMs) can be held with resource families to help address questions and concerns. Resource families may also be invited to FTMs as a support to the children in their care and their families. Families should be encouraged to invite resource parents to their FTMs. If the family does not feel comfortable inviting the resource parent then the child's caseworker should collaborate with the resource parents to identify their view of the child's strengths and needs.

Working with Adolescents (ages 14 - 21)

Adolescence is the crucial time period where a young person is transitioning from childhood to adulthood. Regardless of the permanency goal or the unit that the adolescent is assigned to, the following practice should be incorporated into work with adolescents.

When working with adolescents the goal is to help them successfully transition to adulthood. It is important to help young people become self-sufficient while at the same time understanding that people are inter-dependent. The Youth Thrive Protective Factor framework can assist CP&P staff as well as the adolescents they work with to focus on certain area that if increased would decrease risk factors. See page 52 for information regarding Youth Thrive.

The CP&P staff must have a good assessment of the young person in order to help them reach their goals. This includes knowing the young person's CP&P history as well as getting to know the young person and asking him/her to share their history and goals. There are tools which can help with this assessment. Some of these tools including the Casey Life Skills Assessment and the Transitional Plan for Success can be accessed via the DCF Intranet under the Adolescent Services Tab.

Entering care or changing placements can be a traumatic event. For this reason CP&P is to insure that Mobile Response is dispatched to assess a young person entering a new placement. Mobile Response is accessed by calling Perform Care at 877-652-7624.

Many of the young people that are involved with CP&P have experienced trauma. The Clinical Consultant can review the case and help determine what evaluations and services would best meet the young person's needs.

Some of the young people that are involved with CP&P struggle with substance abuse and other un-healthy behavioral expressions. These young people can access services through Perform Care by calling 877-652-7624.

Some of the young people that are involved with CP&P have experienced domestic violence. The Domestic Violence Liaison who can help assess the young person and determine what services might be helpful.

Legal permanency (reunification, adoption, and Kinship Legal Guardianship) should be pursued when working with adolescence even if the goal is changed to Independent Living, Individual Stabilization, or Other Long Term Specialized Care.

CP&P should work with adolescents to help them develop and identify life-long connections including caring adults who will support them. A permanency pact can be used to formally define the roles of caring adults. More information about Permanency Pacts can be accessed on the DCF Intranet under the Adolescent Services tab.

CP&P can continue to work with young people age 18-21 if the young person has not achieved legal permanency or if the young person is eligible to re-open their case. The worker and the young person would complete the Voluntary Service Agreement (CP&P form 10-10). It is important to note that this practice should change when working with young people age 18-21 as services are voluntary and assisting them in becoming interdependent is even more critical. It is important to strike a balance between providing constructive support and assistance versus expecting young adults to do everything on their own.

The Office of Adolescent Services is an office within the Department of Children and Families which can assist the local office to ensure that young people are getting the support that they need. They have developed a timeline to assist staff in determining when certain tasks should be complete with adolescents. The timeline can be found on the DCF Intranet under the Adolescent Services Tab. OAS can be reached at 609-888-7100.

Case Conferencing

Throughout the life of the case

Case conferencing is an essential role of supervisors and Casework Supervisors. Conferences help develop the skills of workers and supervisors. Case conferences help to insure that the families we serve are getting the correct services and interventions so that they can meet their goals. Conferences should focus on a family's protective factors as well as challenges and concerns. Please see page and page for information regarding protective factors.

Conferences are held throughout the life of a case. As discussed earlier in this guide there are conferences that occur at specific intervals. For example, when a family is open in intake there is a pre-conference, a post-conference, and a closing or transfer conference. When a family is open in permanency and the children are in placement case conferences take place within 72-hours, at 30 days, at 90 days, at 5 months, and at 10 months. There are specific things to be discussed at each of these conferences as outlined on page-page of this guide.

Case conferences should be held on a regular basis so that the supervisor can be made aware of the progress/lack of progress that the family is making and provide the worker with guidance. A case conference should be held any time that a significant event occurs in the life of the family or a safety factor is identified. The Casework Supervisor should be included in the conference when the risk level is high or very high, when there is a critical incident, when there is a child death or near fatality, when there is a safety protection plan, an emergency removal or a hospital hold, when there is an unusual or questionable circumstance, or when the worker and supervisor do not agree on a finding or case goal.

The families that come to the attention of DCPD often have complex situations. The agency is fortunate to have a wide variety of professional consultants who can team with the casework staff. A variety of conferencing models known as Best Practice Case Conferencing Models have been developed. The conferencing models utilize the expertise of DCF staff as well as our consultants. Please see the best Practice Case Conferencing Toolbox on page 51.

Best Practice Case Conferencing Toolbox

Strengthening Families and Youth Thrive are Protective Factors Frameworks that support strengths-based case practice. If protective factors are increased, families and youth are strengthened, well-being is enhanced, and risk is reduced. The Strengthening Families Framework focuses on families with infants and young children. The Youth Thrive Framework focuses on pre-teen, adolescents and young adults. These frameworks should be infused into all case conference models and interactions with families.

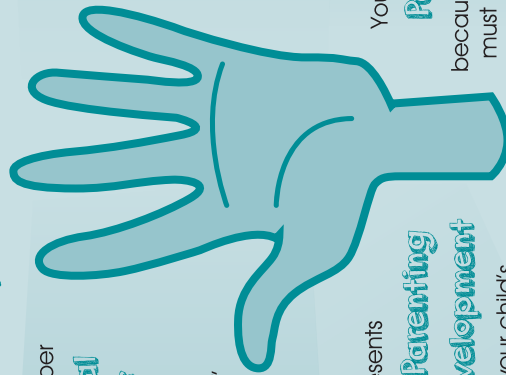
	Overview	Training	Participants	Lens
Foundational	<p>Back to Basics</p> <p>Represents an ongoing comprehensive case conferencing model between worker and supervisor. Supports full understanding and application of history to inform current decision making.</p>	Coaching by CPL	Line of supervision CP&P Staff Only	Focus on having a good assessment and understanding of underlying needs for all families.
Enhanced Models	<p>Focus on Supervision</p> <p>The goal is to support the critical thinking and leverage clinical support for families with mental health challenges. Supports full understanding and application of history.</p>	2 Full Day	CWS is driver of process. CP&P Staff contracted Provider	Strengthening supervision by developing a clinical lens.
	<p>Meeting of the Minds</p> <p>Brainstorms solutions on challenging adolescent case, taking into consideration the youth's history.</p>	None	All professionals involved in the case	Stabilizing placement
	<p>Permanency Round Tables</p> <p>Identity and address barriers to permanency for youth with delayed legal permanence. Youth aged 12+ in care for 24+ months without legal permanence.</p>	1 Day	DCF Staff Contracted Providers Community Stakeholders	Strengthening supervision by developing a clinical lens.
	<p>Early Childhood Conferences</p> <p>Strengthening families with at least one infant or young child, ages 0 - 5 years. There are no immediate safety concerns however there are identified risk factors.</p>	Coaching by CPL	CP&P Intake Staff, DVL, CADC, Clinical Consultant, CHU, Early Childhood Liaison, and Central Intake	Engagement and teaming to reduce risk factors and increase protective factors.

How to remember the 5 PROTECTIVE FACTORS that make your family strong.



Use your Thumb to remember
**Social & Emotional
Competence of
Children**

because a "thumbs up"
is one of the first ways
we learn to communicate
our emotions



Your Pinky Finger signifies
**Concrete Support
in Times of Need**
because it is the smallest
finger and reminds us that we
all need help sometimes.



Your Index Finger represents
**Knowledge of Parenting
and Child Development**
because you are your child's
1st teacher!

Your Ring Finger stands for
Parental Resilience
because your first commitment
must be to yourself in order
to be strong for others.



Your Middle Finger can
help you remember
Social Connections
because it should never
stand alone! We all need a
positive social network.

YOUTH Thrive

The 5 Protective and Promotive Factors

- Knowledge of adolescent development and the impact of trauma on the brain
- Social connections
- Cognitive, social, and emotional competency
- Concrete support in times of need
- Youth resilience



Practice Considerations

Working with families when there is concern of substance abuse

When there are concerns regarding substance abuse it is important to gather as much information as possible. Information can be gathered by:

- Interviewing the household members to determine if there is a history of substance use and if there are signs of substance use now (change in sleeping patterns, change in attitude, loss of job etc.)
- Interviewing neighbors where appropriate (example: if the referral indicates that there are strangers coming in and out of the house all night long a neighbor could confirm/disprove this)
- Obtaining local police checks, Promise Gavel, and CIC checks
- Obtaining collateral information from the child's school and doctor
- Obtaining collateral information from the caregiver's doctor where appropriate (example: the parent is prescribed psychotropic medication or opiates etc.)

Please see CP&P-II-E-1-300 Risk of Harm Due to Substance Abuse for requirements for investigation

The caseworker should refer the caregiver for a substance abuse evaluation if there are concerns about substance abuse. This is done by completing CP&P form 11-46. After completing the evaluation the CADC will provide written recommendations.

If a caregiver is referred to substance abuse treatment based on the substance abuse evaluation the caseworker must provide the treatment program with a copy of the case plan. The caseworker, the treatment provider, the caregiver, and the family's support system should work together throughout the treatment process.

Please see CP&P-V-B-1-200 Case Handling Protocol for Referrals of CP&P Clients to Substance Abuse Treatment Programs for more information regarding partnering with treatment agencies and clients.

Once the caregiver completes the recommended treatment there are several factors to consider before closing the case including but not limited to; the relapse plan, the support system, feedback from the treatment program, and the age and development of the child.

Closing the case is prohibited if the caregiver: has been referred for a substance abuse assessment and the assessment has not been completed; has been scheduled for substance abuse treatment and has not initiated treatment; is engaged in substance abuse treatment, or if there are unresolved child protective service or child welfare concerns. A Casework Supervisor must approve a case closure when the caregiver has completed or failed to engage in CP&P recommended substance abuse treatment.

Please see CP&P-III-C-8-300 Case Closure in Cases with Substance Abuse Disorder

Medication Assisted Treatment (MAT) is sometimes used for individuals struggling with opiate addiction. MAT uses medication in conjunction with other forms of treatment.

For more information on MAT please see page ### of this guide titled Medication Assisted Treatment-Frequently Asked Questions

Medication Assisted Treatment

Frequently Asked Questions

What is an Opioid Use Disorder?

Opioids are a derivative (either natural or synthetic) of opium, a drug manufactured from the poppy plant. They slow the body's autonomic nervous system functions, including heartbeat and breathing. Opioids reduce the intensity of pain signals to the brain and cause the brain to induce or increase pleasant feelings (euphoria).

Illicit opioids are drugs such as opium itself, and heroin. Prescription medications containing opioids include Codeine, Hydrocodone, Oxycodone, Hydromorphone, Morphine, Propoxyphene, Fentanyl, and Methadone. These drugs are commonly known by their brand names.

Opioid use disorders may develop due to use, misuse, or overuse of these drugs. Genes, temperament, and personal circumstances may put some people at higher risk for opioid use disorders.

Opioid dependence or addiction is characterized by:

- an increased, long-lasting reward value associated with using opioids;
- strong desire (craving) for opioids;
- increasing difficulty to control opioid use (use is compulsive, continuing despite the harm);
- increasing tolerance to opioids, resulting in the need to use greater amounts;
- permanent change in brain chemistry where withdrawal creates a strong drive to resume using.

Opioid addiction is a chronic disease, not unlike diabetes or heart disease. It is a medical condition that persists throughout an individual's life. While it cannot be cured, opioid use disorder can be managed with the proper treatment, enabling the individual to regain a healthy and productive life.

What is Medication Assisted Treatment?

Medication Assisted Treatment (MAT) uses medication in conjunction with outpatient counseling, residential treatment, behavioral therapies, and supportive recovery programs.

Opioid addiction is a chronic bio-psycho-social disease. Substance abuse counseling, mental health treatment, recovery support services, and self-help groups can successfully treat the disease's psychosocial aspects. MAT addresses the disease's biological aspects, including withdrawal symptoms, drug craving, and relapse. It helps the normalization of the individual's physiological function, which was disrupted by substance addiction. When these physiological symptoms are successfully treated, an individual can focus on other aspects of treatment.

When is MAT appropriate? What are the admission criteria for MAT treatment?

MAT may be considered if an individual has unsuccessfully attempted detoxification or other modalities of substance use disorder treatment that do not utilize MAT. Minimum standards for admission include the following: current addiction to an opioid drug or medication; onset of addiction at least one year prior to admission (program physician may waive requirement of one year history of addiction in certain circumstances, i.e. release from incarceration); individual meets criteria listed in the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders); program physician ensures individual has voluntarily chosen MAT; individual provides informed written consent to treatment.

No person under 18 may be admitted to maintenance treatment for opioid use disorder unless a parent, legal guardian, or designee of the appropriate State authority provides written consent.

Is MAT substituting one drug for another?

No. Taking medication for opioid dependence is similar to taking medication for other chronic diseases. Used properly, the medication does not create a new addiction. It helps individuals manage their addiction and maintain their recovery. Medication need not, in all instances, be a long-term component of treatment.

What is Medication Assisted Treatment?

There are three medications currently used for opioid detoxification and maintenance:

- Methadone
- Buprenorphine (Suboxone, Zubslov)
- Naltrexone (Vivitrol)

Methadone is an opioid agonist. Opioid agonists activate certain opioid receptors in the brain, producing both a physiological response and a psychological response through a “time released” action that sustains the stability of abstinence and euphoria. Because it does not bind to all receptors, it allows for natural endorphin production. Methadone is taken daily and only prescribed and dispensed to treat opioid use disorder by a licensed Opioid Treatment Program (OTP).

Buprenorphine, a partial opioid agonist, works similarly to methadone. It activates certain opioid receptors, but blocks others from activation. It sustains the stability of abstinence, but unlike methadone it produces no feelings of euphoria. Buprenorphine prevents opioid withdrawal by producing mild agonist effects. It prevents larger opioid doses from producing greater effects (“ceiling effect”). Buprenorphine is taken daily and only prescribed by physicians certified in Addiction Medicine with a Drug Addiction Treatment Act of 2000 (DATA 2000) waiver.

Naltrexone, an opioid antagonist, is a post-withdrawal medication. It binds to opioid receptors with higher affinity than agonists but does not activate receptors. This effectively blocks the receptor, preventing the body from responding to opioids and endorphins. It reduces cravings and acute reinforcing (“reward”) effects. Administered by injection, the onset of the therapeutic effect is rapid and remains effective for four weeks. This aspect of Naltrexone assists with adherence to treatment. However, treatment is time-limited and requires opioid abstinence. For individuals not motivated to abstain from opioids, Naltrexone is less effective. Naltrexone is prescribed and administered by a Physician, Advanced Practice Nurse (APN), or a Physician’s Assistant (PA).

What is a “take home”? Why and when do people receive them?

A “take home” is unsupervised medication the patient can take home or to their living environment. “Take home” medication is regulated by federal and state government.

An individual’s eligibility for “take home” medication is mostly determined by their commitment to treatment. Eligibility considerations include absence of drug and alcohol use, regular clinic attendance, absence of behavioral problems, absence of known criminal activity (especially drug-related), a stable home environment, and assuring medication will be stored safely. Other considerations include the length of time an individual has been on MAT and the benefit of rehabilitation over diversion.

The “take-home” schedule is a slow, carefully administered six part process. It begins with the first ninety days of treatment and may involve one weekly dose. After achieving three years of stability, the individual may receive up to thirty days of medication to take home.

Diversion control is maintained through a “take home” agreement, safely storing medication, returning calls to the clinic, accounting for all used and unused doses, and a physician’s monitoring of the New Jersey Prescription Monitoring Program (PMP).

How long does someone stay on MAT?

In certain situations, especially involving less serious opioid use disorders, MAT may be a transition to abstinence, fostering a drug-free lifestyle in conjunction with a twelve step recovery focus. These include short-term (less than 30 days) and long-term (30 to 180 days) detoxification programs.

MAT is also used for maintenance treatment in instances of chronic opioid dependence, and can be indefinite, depending on the individual’s circumstances. MAT may continue for as long as an individual, physician, and clinical team believe the medication is assisting treatment and recovery.

How do you know when someone is ready to stop MAT?

Before starting the medically supervised MAT withdrawal process, the individual's readiness is assessed. The assessment examines the individual's long-term abstinence from opioids and other mood-altering substances, commitment to continued abstinence, self-motivation, treatment success, psychiatric and medical stability, social and economic stability, and existing support network. During the withdrawal process, the individual is reassured they may return to MAT, if necessary and appropriate. Pregnant women may not withdraw from methadone, either voluntarily or involuntarily, except when deemed medically necessary by the program's medical director.

My client is on MAT but still using illicit drugs. Why? What is the program doing to address this?

In these situations MAT programs may adopt a "harm reduction" public health approach. While acknowledging some people may not be ready to address their use of other substances, the "harm reduction" approach recognizes that MAT reduces certain public health risks associated with opioid use, such as diseases from sharing needles.

Although MAT is specific to opioid and alcohol use disorders, it is important to help individuals set goals to recover from all substance use. It is important to communicate and coordinate specific treatment goals and permanency planning timelines with the MAT provider. These goals should be encouraged through motivational counseling, therapies, and other supports to engage the individual in the treatment process. It may be necessary to intensify treatment, including additional medication, or referring the individual to a higher level of care. An individual should be discharged only when they've achieved their treatment goals or when MAT is no longer clinically indicated.

Poly-substance use is common among individuals in opioid use disorder treatment, including MAT. Other substances typically accompanying opioid use include alcohol, marijuana, benzodiazepines, and cocaine.

What does recovery look like? What is its impact on permanency planning?

MAT has many benefits. The agonist effects of both methadone and buprenorphine prevent aversive withdrawal symptoms, greatly increasing treatment retention. There is evidence methadone reduces non-opioid substance use and criminal behavior and improves health outcomes, employment, and social functioning.

MAT decreases the risk of relapse.

Treatment and maintenance intensity and duration vary among individuals. Relapse – often likely and part of recovery – also varies in duration and intensity. An individual’s recovery from opioid use disorder will likely not conform to ASFA timeframes.

What do I do if a parent presents as being high while on MAT? What could be causing this? What do I do if I think MAT is not working for a client?

Call the clinic immediately and discuss the matter with the provider. If your call is not successful or calling is not an option, contact the Office of Clinical Services at 609-888-7111.

My client is using and just learned she is pregnant. Do I send her to a detox program?

No. Consult with a CPSAI CADC and/or contact the Office of Clinical Services to discuss MAT (specifically methadone) and pregnancy. Methadone is considered the “gold standard” for opioid use treatment for pregnant women. It has been extensively studied and deemed safe. While opiate abstinence syndrome in the newborn is possible, the risk is outweighed by the benefits of methadone, including a lower neonatal morbidity and mortality rate among mothers and children; protecting the fetus from repeated withdrawal episodes in-utero; decreasing risk of obstetric and fetal complications; decreasing infection, which can be transmitted to child; and improving overall health and wellbeing.

Practice Considerations

Working with Families when there are Mental Health Concerns

Sometimes a caregiver's mental health issues can impact their ability to parent. Some signs of mental health issues are: extreme sadness/irritability; feelings of extreme highs or lows; excessive fears; social withdrawal; dramatic changes in eating or sleeping habits; strong feelings of anger; delusions; hallucinations; inability to cope with daily activities; suicidal thoughts, and homicidal thoughts.

When there are allegations that a caregiver is suffering from a mental health disorder the CP&P caseworker must carefully and thoroughly assess the situation. This is done by seeing the home, interviewing all household members and getting information from appropriate collateral resources including the child's school, the child's pediatrician, the caregiver's medical professionals, the police, and others.

Children can also experience mental health issues that can affect their ability to function.

When a caregiver or child is displaying symptoms of a mental health disorder the CP&P staff should conference with the Clinical Consultant. The Clinical Consultant may review the case record and can also determine whether the individual has obtained services from the Children's System of Care by searching in CYBER. Based on the information obtained, the Clinical Consultant can make recommendations regarding evaluations and services.

All children in the state of NJ with mental health concerns, emotional issues, or behavioral issues may access services through the Children's System of Care. The caregiver can access services on behalf of the young person by calling 877-652-7624.

When a child enters placement they will have a CHEC evaluation which is a comprehensive medical evaluation including a mental health assessment. The CHEC evaluation may yield recommendations for further evaluations and/or services.

CP&P has access to the Office of Clinical Services. This office has a team of psychiatrists and psychologists that are available review clinical records and offer consultation.

CP&P Domestic Violence (DV) Protocol at a Glance

Definitions

Domestic Violence is a pattern of coercive behavior used by the batterer to establish control and fear in a relationship against an intimate partner.

Coercive control is often established using threats, isolation, and deprivation of individual rights interspersed with acts of physical and/or sexual violence and can often be identified by using the Duluth Model Power and Control Wheel.

NOP is defined as any person defined as a victim of Domestic Violence.

Batterer is a perpetrator of domestic violence as demonstrated by behavior not self disclosure or diagnosis.

Safety in the Field

"A teamed response is required in cases that involved ongoing domestic violence situations where the alleged batterer resides in the home. A teamed response is preferred if the batterer does not reside in the home."

Notations of situations which may present risk to the personal safety of CP&P staff may be found in the "Documentation of Response Box" in NJ SPIIRIT.

Engagement/Interviewing

Order of Interview in DV cases should be:

- The non-offending parent however if the worker has a reason to believe that this will cause risk to the child, begin with the child
- The children beginning with the child who is the alleged victim, then the siblings, and then the other children in the home
- The person who is the batterer

When DV is present or suspected it is vital to interview the NOP and the children separate from the batterer. This can be accomplished in entirely different sessions.

The NOP should be consulted about safe engagement/interview of the batterer.

"Under no circumstance should information from the separate sessions with the NOP and the children be revealed to the batterer.

Case Plans

Separate case plans must be developed with the batterer and the non-offending pattern and her child/children. The batterer shall not have access to the NOP's case plan.

Cessation of the abusive behavior should be included in the batterer's case plan; this assists the worker in identifying who is responsible for the battering.

Placement

The child should remain in the care of the NOP whenever possible.

Placement with a known batterer is inappropriate.

Kinship placement with someone in the batterer's family must be cautiously considered, involve your DVL to assist you with assessment.

Ongoing Screening and Safety

Domestic Violence should continue with each contact with the family.

The screening should include identifying indications of coercive control, child endangerment, and isolation.

Context and content of the DV may impact the response and decision of the NOP. CP&P workers should develop ongoing safety around this reality.

Additions safety planning should be accomplished with the NOP around CP&P involvement. This should be accomplished minimally with every changes in the CP&P case i.e. court appearance, Family Team Meetings, Court discover process, change in visitation requirements for the batterer.

Special Legal Considerations

An order of Protection may be sought by CP&P, using Title 9, to have a batterer restrained from the home.

A Risk Assessment may be ordered by the court before visitation provisions are set with DV is present. It is imperative to involve your local DVL or DV program to assist with this assessment.

Recommended Services

Batterers Intervention, Domestic Violence Services, Assistance in helping NOP prohibit offender from the home

Specialized services for children including PALS. This program is also appropriate for children in a resource home that previously witnessed DV in their own home. Batterers should be recommended for criminal or court- mandated batterer intervention programs not anger management.

NOT ALLOWED:

Mandating restraining orders, couples counseling, general anger management programs, or mediation., forcing the NOP to leave the home.

Family Team Meetings

The batterer should not be in family team meetings with the non-offending parent/caregiver

Involve your DVL to assess any special circumstances of the possibility of safe considerations when a FTM might include both parties.

Documentation

A worker must consider the safety and confidentiality of the NOP in all documentation.

Keep a NOP address confidential and redacted from the verified complaints or any other documents that may be accessible for the batterer.

In a DV allegation, the NOP should rarely be coded as the perpetrator

Document the specific behaviors of the batterer that pose a risk to the NOP and children

When documenting an NOP response, be careful to accurately assess the impact of the violence. Document the potential risk of retaliation and harm by the batterer.

Safety Planning

When Domestic Violence is Present

Safety Planning with Adults

- Identify your partner's use of force so that you can assess the risk of physical danger to you and your children before it occurs.
- Identify safe areas of your house where there are no weapons and there are ways to escape. If arguments occur, try to move to those areas.
- Don't run to where the children are, as your partner may hurt them as well.
- If violence is unavoidable, make yourself a small target. Dive into a corner and curl up into a ball with your face protected and arms around each side of your head, fingers entwined.
- If possible, have a phone accessible at all times and know what numbers to call for help. Know where the nearest public phone is located. Know the number to your local shelter. If your life is in danger, call the police.
- Let trusted friends and neighbors know of your situation and develop a plan and visual signal for when you need help.
- Teach your children how to get help. Instruct them not to get involved in the violence between you and your partner. Plan a code word to signal them that they should get help or leave the house.
- Tell your children that violence is never right, even when someone they love is being violent. Tell them that neither you, or they, are at fault or are the cause of the violence, and that when anyone is being violent it is important to stay safe.
- Practice how to get out safely. Practice with your children.
- Plan for what you will do if your children tell your partner of your plan or if your partner otherwise finds out your plan.
- Keep weapons like guns and knives locked away and as inaccessible as possible.

- Make a habit of backing the car into the driveway and keeping to fueled. Keep the driver's door unlocked and others locked- for a quick escape.
- Try not to wear scarves or long jewelry that could be used to strangle you.
- Create several plausible reasons for leaving the house at different times of the day or night.

Safety Planning with Children

The most important thing to do when grown-ups fight is to stay safe!

Stay out of the fight. Safe places where you can go _____

Always look out for your siblings. My sibling (s) _____

Find a phone. Phone number _____

Everyone remember that fighting is never a child's fault!!!!!!

Think about something to do to feel better _____

You are brave!

Did you know...

- It's okay to express ANY feeling, as long as you don't hurt yourself, hurt anyone else, or break things.
- It's okay to say NO to someone who wants to get in your personal space.
- It's okay to keep safe distances from people who make you feel uncomfortable.
- It's okay to ask for help!

Practice Considerations for Children with Incarcerated Parents

Each family is unique. If they reveal that a parent is incarcerated, the need to engage and understand their situation becomes crucial. If a child is not in placement, the family may benefit from additional information or resources to assist in coping with the absence. If the child is entering care or is already in placement, the regular permanency work that occurs must take into account this additional element.

The absent parent's [contact information and any additional information](#) about them should be gathered. If the contact information is unknown, then a search using identifying information such as [full name, date of birth, and last known address](#) will be necessary. Locating a parent is important in terms of establishing paternity, discovering potential family caretakers, and in providing information about case planning, the child, and legal proceedings to the incarcerated parent. Once the parent is located, contact via phone, visit or letter should be made. [Social Service Departments within the facilities](#) are usually able to assist.

Once the incarcerated parent is located it is imperative that they are served with all court complaints and court orders, are afforded the opportunity to obtain legal representation, and are able to participate in scheduled hearings regarding their children.

As the social stigma and shame associated with incarceration sometimes make it difficult to discuss, child welfare workers should be sensitive to the feelings of family members. There may be a reluctance to provide particulars, such as the [type of offense or terms of the sentence](#). There may be anger or dismissal, with comments such as “He’s not around.” Children may not be aware that their parent is in prison. The Deputy Attorney General assigned to the matter may help determine if documents such as Judgments of Conviction, police records, etc. will be useful [in assessing the parent’s original situation, and whether the type and magnitude of the offense should preclude contact with the child](#). For example, a history of serious crimes against children, or sexual abuse, may mean that contact is not in a child’s best interests. If the matter is litigated within the family court, any conditions imposed by the court regarding contact must be followed.

Some inmates may have committed crimes that may have less impact on their ability to have positive relationships with their children. This may be especially true for those at the end of their sentences, who have successfully completed substance abuse or other treatment programs, or for those in minimum security or transitional re-entry facilities. In these situations, inclusion in the FTM process via phone or by providing written information, activities that support planning for reunification, such as visitation or counseling, should be explored. The usual conferences that occur should include information pertaining to the incarcerated parent.

The question of the nature of the incarcerated person's current relationship with the child, the age and special needs of the child, the geographic locations involved, and the involvement of the child's caretaker and siblings are all factors to consider in planning contact and service provision. All facilities in NJ have information posted on the NJ Department of Corrections website. All facilities vary in their visitation and contact arrangements. If visiting a parent or arranging a visit for a child, this information, and the assistance of the Department of Social Services within the facility, should be used to make a visitation plan. Tips for visitation or maintaining contact can be found online.

Whether a parent is housed at a minimum security, maximum security, state, federal or county institution, they can be approached about relative resources, medical history, and background information.

Quality Review

How Do We Know We Are Doing Well?

The Quality Review (QR) is a process by which we assess our practice and identify strengths and areas needing improvement. Reviews are conducted every other year in every county and consist of an in-depth case review method and practice appraisal process to find out how well children and families are doing and how well they are being served. Cases are reviewed to determine child and parent/caregiver status, recent progress, and related system practice and performance results.

I. Questions Explored via the QR

Questions about how children and families are doing include:

- Is the child safe from manageable risks of harm caused by others or by him/herself?
Is the child in a safe, stable home?
- Are the child's basic physical and health needs met?
- Is the child doing well in school? Is the child making academic progress?
- Is the child doing well emotionally and behaviorally?
- Are the parents/caregivers able and willing to assist, support, and supervise the child reliably on a daily basis?
- Is the child making progress in key life areas and are parents/caregivers satisfied with services being received?

Positive answers to these questions show that children and families are being effectively served. When negative patterns are found, improvements can and should be made to strengthen frontline practice, local services, and results.

Questions about how well the service system is working include:

- Do the child’s parents/caregivers, DCP&P caseworker, and service providers share a “big picture” understanding of the child and family situation, their identity, strengths and needs so that sensible supports and services can be planned?
- Do these “practice partners” share a long-term view of how services will enable the child and family to function successfully in their daily settings (e.g., home and school)?
- Does the child and family have a sensible service plan that organizes supports, services, and interventions to be provided and that includes informal and community supports as well as service providers?
- Are needed supports and services provided in a timely, competent, and culturally appropriate manner? Are services of sufficient intensity to achieve positive results for the child while strengthening the functional capacities of the family?
- Are the child’s caregivers getting the training and support necessary for them to be effective parents and maintain a safe and stable home for the children?
- Are the child’s and family’s services being coordinated effectively across settings, providers and agencies?
- Are the supports and services provided reducing risks and improving safety and family functioning? Is a sustainable support network being built with and for the family?
- Are services and results monitored frequently with timely adjustment to reflect changing needs and life circumstances? Are services effective in improving well-being and functioning while reducing risk?

II. What's Learned through the QR

The QR involves case reviews, observations, and interviews with key stakeholders. Results provide rich information to inform planning for improvement. Information gathered includes:

- Findings which profile local practice and results, and which suggest recurrent themes and patterns when considered across children and families reviewed.
- Understanding of contextual factors that affect daily frontline practice in the geographic areas being reviewed.
- Quantitative patterns of child and family status and practice performance results, based on key measures.
- Noteworthy accomplishments and successes.
- Emerging issues and challenges in current practice situations explained in local context.
- Critical learning and input for next-step actions and for improving program design, practice, and working conditions.
- Systemic issues that affect outcomes or practice that require resources or attention above the local level.

The results of the QR inform program improvement plans developed locally to build on the strengths and address any areas needing improvement.

Appendices

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Children's Bill of Rights

Department of Children and Families
Division of Child Protection and Permanency (CP&P)
Bill of Rights

To Ensure the Rights of Each Child and Youth in CP&P Placement

*This is a general list created in an effort to help you understand your rights while in an out-of-home placement.
Please note that there may be exceptions in certain cases.*

YOU HAVE THE RIGHT:

Overall

- To be given a copy of these rights; which has been signed by you.
- To be informed of your rights in a way that is easy to understand.
- To have these rights read and explained to you, if there is any confusion.
- To keep your information private to the extent possible under the law.
- To be who you are. To be able to express yourself as an individual in a respectful and meaningful way.
- To be involved in making decisions that affect your life, and to express your views about your placement.
- To receive adequate food, proper clothing, and safe shelter.
- To live in a safe, clean, caring & healthy environment; and to participate as a family member in the home in which you live.
- To participate in community and school activities such as sports, extracurricular activities, hobbies, clubs and other activities which enrich and inform your daily life.
- To participate in religious or spiritual activities of your choice, or the choice of your biological parent(s).
- To enjoy being in the outdoors at regular and frequent intervals.
- To have access to letter writing materials and stamps, and the use of the telephone to communicate with family members, friends and other persons with whom you have a positive relationship.
- To have a placement in the least restrictive setting which best fits your individual needs and reflects your best interest.
- To be heard and listened to, and to have adults explain things that you may not understand, in an age appropriate way.
- To have regular contact with the Department of Children and Families.
- To communicate and visit with your family and friends from whom you are living apart, in accordance with your case plan or transitional plan.
- To be involved in and drive transition planning and the development of your own case plan and goals through participating in Family Team Meetings, Court hearings, school meetings, and other meetings that involve making decisions about your life.
- To include safe and positive family, resource parents, caring adults, and other supports in your case planning and goal setting meetings.

- To be made aware of services, supports, and resources that will help you to achieve your goals identified in your case or transition plan.
- To understand how you may raise concerns about your care and treatment. You can talk directly with your assigned CP&P Worker or his or her direct Supervisor in the Local CP&P Office. You can also share your concerns by contacting the Office of Advocacy (Telephone: 1-877-543-7864 – Email: askdcf@dcf.state.nj.us).

Health

- To be a voice in your medical treatment.
- To receive proper medical care on a routine or emergency basis.
- To have an accurate, current, and full health assessment.
- To receive up-to-date visits with health care professionals (e.g., doctors and dentists).
- To have access to mental health services, as needed, or as mandated.
- To receive your health records as requested, starting at age 18 or upon case closure.
- To be aware of and maintain contact with your assigned Child Health Nurse.

Safety

- To be free from physical, mental, or emotional abuse.
- To be free from needless physical control and isolation.
- To be free from abuse, neglect, exploitation, discrimination, and harassment.
- To be protected from all forms of physical and sexual harassment.
- To be free from sexual abuse, physical punishment, or the threat of such action.
- To be in an environment free from drugs and risky conditions.

Education

- To an educational program to help you with your exact needs to make sure you can learn in the best way possible.
- To be in a safe and substance free learning environment.
- To have a “voice” in your own education and to achieve your educational goals.
- To have an Individualized Education Plan (IEP) developed specifically for you (if the school district agrees it is appropriate); and to participate in the development of such a plan.
- To participate in the decision-making process to establish which educational setting is in your best interest.

- To have access to your student record. If you are 18 or older, you have the right to obtain a copy of your education record from your school district. If you are under 18, you must go through your CP&P Worker or caregiver to get your records.
- To receive support, guidance, and encouragement in planning for your future; before and after graduation from high school.

Court Involvement

- To have regular communication with your Worker, or provider who is supervising your care and treatment.
- To be in contact with your Law Guardian or Law Guardian Investigator, and (if appointed) the Court Appointed Special Advocate (CASA worker).
- To be informed of an upcoming court hearing by a Resource Parent, as soon as they receive this notification in the mail.
- To be notified by your Law Guardian - of the date, time, purpose, and place of the placement hearing at least 15 days in advance.
- To participate in permanency hearings which involve you and your family.
- To have transportation to attend your permanency hearing. If needed, your CP&P Worker, Law Guardian, or Law Guardian Investigator can make these arrangements for you.

Acknowledgement of Receipt and Understanding
of
Bill of Rights
From the New Jersey Department of Children and Families
Division of Child Protection and Permanency

I

[Print the name of the child/youth]

understand and have received a copy of the Children and Youth Bill of Rights from the New Jersey Department of Children and Families, Division of Child Protection and Permanency.

Signature (child/youth)

Date

Worker's Signature

Date

Copy for Child/Youth

Structured Decision Making

Safety Assessment (In-Home)

Below are the definitions of each item to be assessed when making a safety assessment.

Caregiver leaves child with a person unwilling to provide care.

- Caregiver demonstrates poor planning for child's care.
- Caregiver has left the child with someone but the caregiver has not returned according to plan.
- Caregiver did not express plans to return for the child.
- Caregiver has been gone longer than the person keeping the child expected/or is willing to wait.
- Caregiver makes inadequate and/or inappropriate babysitting or child care arrangements or demonstrates very poor planning for the child's care.

Child is fearful of caregiver, other family members, or other people living in or having access to the home.

- Child cries, cowers, cringes, trembles, or otherwise exhibits fear in the presence of certain individuals or verbalizes such fear.
- Child exhibits severe anxiety (for example: nightmares, insomnia) related to situations associated with a person in the home.
- Child has reasonable fears of retribution or retaliation from caregiver.

Caregiver is verbally hostile when talking to or about the child and/or has extremely unrealistic expectations for the child's behavior.

- Describes child as evil, stupid, ugly, or in some other demeaning or degrading manner.
- Curses and/or repeatedly puts child down.

- Scapegoats a particular child in the family.
- Expects a child to perform or act in a way that is impossible or improbable for the child's age and/or developmental status (for example: babies and young children expected not to cry, expected to be still for extended periods, be toilet trained or eat neatly, expected to care for younger siblings, expected to stay alone).
- Child is seen by either caregiver as responsible for the caregivers' problems.
- Caregiver did not express plans to return for the child.
- Uses sexualized language to describe child or in name calling (for example: whore, slut, etc.).

Caregiver caused serious physical harm to the child or has made a plausible threat to cause serious physical harm.

- Other than accidentally, caregiver caused serious abuse or injury (for example: shaken baby syndrome, fractures, poisoning, suffocating, shooting, burns, bruises/welts, bite marks, choke marks, etc.)
- An action, inaction, or threat that would result in serious harm (for example: threats to kill, starve, lock out of home, etc.)
- Plans to retaliate against child for CPS investigation.
- Caregiver has used torture or physical force, which bears no resemblance to reasonable discipline.
- Caregiver fears he/she will maltreat child and/or request placement.

Caregiver's explanation for the child's injury or physical condition is inconsistent with the nature of the injury or condition.

- Caregiver denies knowledge of a child's injury or condition and such denial appears implausible.
- Caregiver's explanation for how an injury occurred is contrary to the nature of the injury. (i.e., linear welt marks on the thigh are explained as child tripped on the sidewalk and fell)

- Medical statements from a physician indicate that an injury could be the result of abuse, but caregiver denies abuse.
- There are significant discrepancies between explanations given by the caregiver, the child other household members, and/or other collateral sources of information.
- Facts related to the condition, incident, and injury, as observed by CPS and/or supported by medical or other professionals, contradict the caregiver's explanation.

Caregiver refuses access to the child, or there is reason to believe that the caregiver is about to flee, and/or the child's whereabouts cannot be ascertained.

- Caregiver has previously fled in response to a CPS investigation.
- Caregiver has removed child from a hospital against medical advise.
- Caregiver has a history of keeping child at home, away from peers, school, or other outsiders for extended periods.
- Caregiver is highly transient.
- Caregiver hides the child or refuses access.

Caregiver has not, will not, or is unable to provide care and supervision necessary to protect the child from potentially serious harm, including harm from self (child) or other persons living in or having access to the home.

- Caregiver does not or cannot attend to the child so that care goes unnoticed or unmet (for example: although the caregiver may be present, the child can wander outdoors alone, play with dangerous objects, play on unprotected window ledge, or be exposed to other serious hazards).
- Caregiver leaves child alone. (time period varies with age and developmental stage)
- Caregiver's whereabouts are unknown.

- Caregiver does not or is unable to protect the child from violence in the home, criminal activity, and/or other harmful behaviors between adults or children in or having access to the home.
- Caregiver cannot control the behavior of a child living in the home, including immediate and/or impending serious harm to himself or others. (e.g., substance abuse or provocative behavior)

Caregiver has not, will not, or is unable to meet the child's immediate needs for food, clothing, shelter, and/or medical or mental health care.

- No food provided or available to child, or child starved or deprived of food or drink for prolonged periods.
- Child without minimally warm clothing in cold months.
- No housing or emergency shelter; child must or is forced to sleep in the street, car, etc.; housing is unsafe, without heat, etc.
- Caregiver does not seek treatment for child's immediate and dangerous medical conditions or does not follow prescribed treatment for such conditions.
- Child appears malnourished.
- Child has exceptional needs and/or behaviors which caregivers cannot/will not meet.
- Child is suicidal and caregivers will not take protective action.
- Child shows effects of maltreatment, such as serious emotional symptoms and lack of behavior control or serious physical symptoms.

Child sexual abuse/exploitation is suspected and circumstances suggest that child safety may be an immediate concern.

- Access to child by possible or confirmed perpetrator continues to exist.
- It appears that caregiver or others have committed rape, sodomy, or has had other sexual contact with child.
- Caregiver or others have forced or encouraged child to engage in sexual performances or activities.

The child's physical living conditions are hazardous and immediately threatening. Based on the child's age and developmental status, assess whether physical living conditions are hazardous and immediately threatening, such as:

- Leaking gas from stove or heating unit.
- Dangerous substances or objects stored in unlocked lower shelves or cabinets, under sink or in the open, including regulated or illicit drugs and/or drug paraphernalia.
- Lack of water or utilities (heat, plumbing, electricity) and no alternate provisions made, or alternate provisions are inappropriate. (for example: stove, unsafe space heaters)
- Open, broken, or missing windows, without screens or guards.
- Exposed electrical wires.
- Excessive garbage or rotted or spoiled food that threatens health.
- Serious illness or significant injury has occurred due to living conditions and these conditions still exist. (for example: lead poisoning, rat bites)
- Evidence of human or animal waste throughout living quarters.
- Guns or other weapons are not locked.

Caregiver's behavior is violent or out of control.

- Extreme physical or verbal, angry or hostile outbursts at child.
- Use of brutal or bizarre punishment. (for example: scalding with hot water, burning with cigarettes, forced feeding)
- Domestic violence is likely to place the child at risk of harm.
- Use of guns, knives, or other instruments in a violent way.

- Violently shakes or chokes baby or young child to stop a particular behavior.
- Behavior that seems out of touch with reality, fanatical, or bizarre.
- Behavior that seems to indicate a serious lack of self-control. (for example: reckless, unstable, raving, and explosive)

Caregiver's drug or alcohol use seriously affects his/her ability to supervise, protect, or care for the child. Caregiver has misused a drug or alcoholic beverages to the extent that control of his or her actions is lost or significantly impaired. As a result, the caregiver is unable, or will likely be unable to care for the child, or has harmed the child, or is likely to harm the child. Examples such as:

- Caregiver's behavior outside the home (drugs, violence, aggressiveness, hostility) creates an environment within the home which threatens the child's safety (e.g., drug parties, association with gangs, drive-by shootings).
- Adult uses child to sell or transport drugs.
- Drug transactions occur in the home.
- Caregiver drives with child in the vehicle while under the influence of drugs or alcohol.

Caregiver's involvement in criminal activity seriously affects his/her ability to supervise, protect, or care for the child.

- Caregiver is involved or engaged in criminal activity, and such involvement places the child in serious danger of immediate harm. As a result, the caregiver is unable, or will likely be unable, to care for the child, or has harmed the child, or is likely to harm the child.

Caregiver's emotional stability, developmental status, or cognitive deficiency seriously impairs his/her ability to supervise, protect, or care for the child.

- Caregiver's refusal to follow prescribed medications impedes ability to parent the child.
- Caregiver's inability to control emotions impedes ability to parent the child.
- Caregiver acts out or exhibits distorted perception that impedes ability to parent the child.
- Caregiver's depression impedes ability to parent the child.
- Due to cognitive delay the caregiver lacks the basic knowledge related to parenting skills such as:
 - Not knowing that infants need regular feedings:
 - Failure to access and obtain basic/emergency medical care:
 - Proper diet; or
 - Adequate supervision.

Other factors that place the child in immediate and/or impending danger of serious harm. Examples of other factors:

- Household member has past convictions regarding violent behaviors and acts toward others (e.g., assault and battery, homicide, sexual assault or rape, or criminal acts involving weapons).
- Previous involuntary termination of parental rights.
- Previous death of a child due to abuse or neglect.
- Previous criminal conviction for child abuse or neglect.
- Previous criminal conviction for child abuse or neglect in another state or jurisdiction.
- Known CPS history/pattern of repeated incidents of serious maltreatment.

NEW JERSEY CP&P
SAFETY ASSESSMENT (IN HOME)

Case Name: _____	Assessment Date: _____	Time: _____; _____ a.m.
Case ID #: _____	Last Updated On: _____	
Assigned To: _____	Last Updated by: _____	
Local Office: _____	Current Status: _____	
SPRU <input type="checkbox"/>	Conducted by: _____	

Section 1: Safety Factor Identification – The factors listed below are behaviors or conditions that are associated with a child being in immediate and/or impending danger of serious harm. Identify the presence or absence of each factor by circling “yes” or “no.” *Circle “yes” if the safety factor exists for any child in the household*, including biological, adopted, related, foster, para, and pre-adoptive children. Consider the vulnerability of each child living in the home throughout the assessment. Remember, young children are particularly vulnerable, and older children with mental, emotional, and/or physical disabilities and children who have been repeatedly victimized often cannot protect themselves. Refer to safety factor definitions.

1. Yes No Caregiver leaves child with a person unwilling to provide care.
2. Yes No Child is fearful of caregiver(s), other family members, or other people living in or having access to the home.
3. Yes No Caregiver is verbally hostile when talking to or about the child and/or has extremely unrealistic expectations for the child’s behavior.
4. Yes No Caregiver caused serious physical harm to the child or has made a plausible threat to cause serious physical harm.
5. Yes No Caregiver’s explanation for the child’s injury or physical condition is inconsistent with the nature of the injury or condition.
6. Yes No Caregiver refuses access to the child, or there is reason to believe that the caregiver is about to flee, and/or the child’s whereabouts cannot be ascertained.
7. Yes No Caregiver has not, will not, or is unable to provide care and supervision necessary to protect the child from potentially serious harm, including harm from self (child) or other persons living in or having access to the home.
8. Yes No Caregiver has not, will not, or is unable to meet the child’s immediate needs for food, clothing, shelter, and/or medical or mental health care.
9. Yes No Child sexual abuse/exploitation is suspected and circumstances suggest that child safety may be an immediate concern.
10. Yes No The child’s physical living conditions are hazardous and immediately threatening.
11. Yes No Caregiver’s behavior is violent or out of control.
12. Yes No Caregiver’s drug or alcohol use seriously affects his/her ability to supervise, protect, or care for the child.
13. Yes No Caregiver’s involvement in criminal activity seriously affects his/her ability to supervise, protect, or care for the child.

14. Yes No Caregiver's emotional stability, developmental status, or cognitive deficiency seriously impairs his/her ability to supervise, protect, or care for the child.

15. Yes No Other factors that place the child in immediate and/or impending danger of serious harm (specify):

**IF NO SAFETY FACTORS ARE IDENTIFIED, GO TO SECTION 3.
IF ANY SAFETY FACTOR IS MARKED "YES," PROCEED TO SECTION 2.**

Section 2: Safety Response and Interventions – For each issue identified in Section 1, consider the resources available in the family and the community that might help to keep the child(ren) safe. Check each response taken to protect the child(ren) and explain below. Describe *all* safety interventions taken or immediately planned by you or anyone else, and explain in Section 4, Safety Protection Plan, how each intervention protects (or protected) each child.

Note: If any child is being removed from the home, mark safety response 7, 8, or 9.

- 1. Direct intervention by worker/agency as a safety resource.
- 2. Caregiver will use appropriate resources, neighbors, or other individuals in the community as safety resources.
- 3. Use of community agencies or services as safety resources.
- 4. The alleged perpetrator leaves the home, either voluntarily or in response to legal action.
- 5. The non-maltreating caregiver moves to a safe environment with the child(ren).
- 6. Other: (The caregiver or worker identified a unique intervention for an identified safety issue that does not fit within items 1-5.)

Explain: _____

The child(ren) is being removed and placed or re-placed as authorized by:

- 7. A court order.
- 8. An emergency removal (pursuant to N.J.S.A. 9:6-8.29 and 8.30).
- 9. A pre-existing authorization which gives CP&P authority to move/re-place the child(ren).

Explain: _____

If no safety factors are selected, please check question number 10.

- 10. No Safety Interventions Required

Explain why safety responses 1-6 could not be used to keep the child safe:

Section 3: Safety Decision – Identify your safety decision below. Check one box only. This decision should be based on the assessment of all safety issues *as it relates to every child in the household*, and any other information known about this case.

The Safety Decision indicated below is based on your responses in the Safety Factors and Safety Interventions sections above.

A. Safe: There are no children likely to be in immediate and/or impending danger of serious harm--no safety issues were identified. All children remain in the home.

B. Safety Protection Plan Required:
Controlling safety interventions have been taken since the referral was received, and those interventions (Section 2, #1-6 above) have been incorporated into a Safety Protection Plan. All children remain in the home with a Safety Protection Plan in place.

C. Unsafe/Removal Required:
One or more children will be in immediate and/or impending danger of serious harm if not placed out of the home. Note: Check this only if safety intervention #7, 8, or 9 in Section 2 is selected as the only available intervention for any child in the home.

List all children who are being placed in Division custody.

If a child is being removed, and any child will remain in the home, a Safety Protection Plan must be completed for the children in the home.

Child 1:	DOB:
Child 2:	DOB:
Child 3:	DOB:
Child 4:	DOB:
Child 5:	DOB:
Child 6:	DOB:

Worker's Signature: _____ **Date:** ____/____/____

Supervisor's Signature: _____
Conference Date: ____/____/____

For any assessment with a safety factor present:

Casework Supervisor's Signature: _____
Conference Date: ____/____/____

Conference Notes: _____

Section 4: Safety Protection Plan

For each safety factor marked "yes," describe the specific issues and behaviors observed, who is affected by the safety issue, what the specific safety plan is, and how the plan will be monitored. Should the services

provided under this safety plan or any modified or subsequent safety plans prove to be ineffective, the child will be placed into foster care.

Safety Factor #	Specific Safety Issues/Behaviors	Names of Children/Adults Involved/Affected	Specific Safety Action	Implementation and Monitoring

Completed by: _____ on ____/____/____
(Name/Signature of Worker) (Date)

(Office)

Parent/Caregiver Signature: _____ **Date:** ____/____/____

Parent/Caregiver Signature: _____ **Date:** ____/____/____

Comments: _____

Supervisor Review/Approval: _____
Date: ____/____/____

Child Safety Assessment

Out of Home Placement

CP&P is required to assess the safety of each child for whom it has legal authority to place out of home. The responsibility to assess safety extends to children placed within the State of New Jersey as well as to New Jersey children out of state.

When children are placed in a resource home safety is assessed using CP&P form 22-6.

When children are placed in a congregate care setting safety is assessed using CP&P form 22-10.

Every time that the child's worker or the resource family unit worker interacts with the child they must assess the child's immediate safety and wellbeing.

When a child is placed in a resource home in the state of New Jersey the assigned caseworker or SPRU worker completes CP&P form 22-6 at the time of placement. The assigned caseworker completes the form again within 5 days of placement/re-placement, and at every MVR.

When a child is placed in a resource home out of state the assigned caseworker completes the 22-6 on the day of placement and every six months after.

When a child is placed in a congregate care setting or independant living setting the assigned caseworker completes CP&P form 22-10 within one month of placement, every six months after, when the child calls the caseworker in crisis, and when the youth is on leave from placement.

The resource family suport worker completes CP&P form 22-6 when following up with a corrective action plan, during the annual re-evaluation, and when requesting a waiver for exception to population limits.

The Office of Licensing completes CP&P form 22-6 annually during the 1 year licensing inspection and during the 3 year licensing renewal.

IAIU and SPRU investigators complete CP&P form 22-6 when investigation abuse/neglect in a resource home.

The Office of the Public Defender Conflict Investigation Unit completes this form when investigating a CP&P employee, and employee's relative, or other conflict matter.

New Jersey Child Safety Assessment (Resource Homes)

Subject Child(ren): _____

Case ID # _____ IAIU # _____

Assigned Staff/Resource Home Identification

Safety Assessment Conducted On: _____ Date: _____ Time: _____ a.m. p.m.

BY (print name) _____ LOCAL OFFICE/IAIU/PDCU _____

(print name) _____ RPSW/Other _____

Resource Parent's Name _____ Vendor # _____

Interval/Purpose of Safety Assessment _____

Part A. All Persons In the Resource Home

List **all** children residing in the resource home at the time of the Safety Assessment home visit:

Name of Child	Case ID number Person ID number	Date of Birth	Relationship to Family/Household	On Cover Sheet	Interviewed or Observed	Date Seen	Interviewed or Observed	Date Seen
1.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Int. <input type="checkbox"/> Obs.		<input type="checkbox"/> Int. <input type="checkbox"/> Obs.	
2.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Int. <input type="checkbox"/> Obs.		<input type="checkbox"/> Int. <input type="checkbox"/> Obs.	
3.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Int. <input type="checkbox"/> Obs.		<input type="checkbox"/> Int. <input type="checkbox"/> Obs.	
4.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Int. <input type="checkbox"/> Obs.		<input type="checkbox"/> Int. <input type="checkbox"/> Obs.	
5.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Int. <input type="checkbox"/> Obs.		<input type="checkbox"/> Int. <input type="checkbox"/> Obs.	
6.				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Int. <input type="checkbox"/> Obs.		<input type="checkbox"/> Int. <input type="checkbox"/> Obs.	

List **all** adults residing in or frequenting the resource home. Include any person present at the time of the Safety Assessment home visit:

Name of Adult	Date of Birth	Relationship to Family/Household	On Cover Sheet	Interviewed or Observed	Date Seen	CARI Check	CHRI Check
1.			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Int. <input type="checkbox"/> Obs.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Int. <input type="checkbox"/> Obs.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Int. <input type="checkbox"/> Obs.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Int. <input type="checkbox"/> Obs.		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Resource Parent's Name
Conducted by Name/Title
Conducted by Name/Title

Vendor # _____

Date of Assessment Visit
Office _____
Office _____

Case ID # _____ IAU # _____
Case ID # _____
Case ID # _____

Part B. Safety Factor Identification

Directions: Consider the following 18 safety factors when determining whether a child(ren) in placement is **safe**. The factors are behaviors or conditions that are associated with a child being in danger of immediate, serious harm. Identify the presence or absence of **each** factor, 1-18, by checking "yes" or "no" (**required**). If a factor is not applicable, check "no." If a child is in danger due to an unspecified factor, check "yes" at 19, "other," and explain at "specify."

	YES	NO
1. Resource parent leaves a child alone who is not competent to care for himself, or resource parent leaves child with person unwilling or unable to provide adequate care.	<input type="checkbox"/>	<input type="checkbox"/>
2. Child is fearful of resource parent(s), other family members, or other people living in or having access to the home.	<input type="checkbox"/>	<input type="checkbox"/>
3. The behavior of a child living in the home threatens immediate harm to himself or to others and the resource parent cannot control the behavior.	<input type="checkbox"/>	<input type="checkbox"/>
4. Resource parent is verbally hostile when talking to/about the child and/or the resource parent has extremely unrealistic expectations for child's behavior.	<input type="checkbox"/>	<input type="checkbox"/>
5. Violence among adults living in or having access to the home seriously impairs the necessary supervision or care and/or the physical safety of the child.	<input type="checkbox"/>	<input type="checkbox"/>
6. Resource parent has caused serious harm to the child or has made a plausible threat to cause serious harm to the child.	<input type="checkbox"/>	<input type="checkbox"/>
7. Resource parent has an unconvincing or illogical explanation for the child's injury or physical condition.	<input type="checkbox"/>	<input type="checkbox"/>
8. Resource parent refuses access to the child; there is reason to believe that the family is about to flee; or the child's whereabouts cannot be ascertained.	<input type="checkbox"/>	<input type="checkbox"/>
9. Resource parent has not/cannot/will not protect child from potential serious harm, including harm from other persons living in or having access to the home.	<input type="checkbox"/>	<input type="checkbox"/>
10. Resource parent is unwilling or unable to meet the child's immediate needs for supervision, food, clothing, shelter, and/or medical or mental health care.	<input type="checkbox"/>	<input type="checkbox"/>
11. Resource parent or other person living in or having access to the home has previously severely harmed or endangered a child or another person, and circumstances indicate that he is a present danger to a child.	<input type="checkbox"/>	<input type="checkbox"/>
12. Resource parent appears indifferent to child's safety and/or injuries or other health conditions that merit resource parent's immediate attention/concern.	<input type="checkbox"/>	<input type="checkbox"/>
13. Child sexual abuse/sexual exploitation is suspected and circumstances suggest that continued sexual abuse is an immediate concern.	<input type="checkbox"/>	<input type="checkbox"/>
14. Physical conditions in the home are hazardous and immediately threaten the child's safety – for example: utilities are shut off; the home is lit by candles and/or heated by a gas stove or by unsafe space heaters; etc.	<input type="checkbox"/>	<input type="checkbox"/>
15. Resource parent's behavior is violent or out-of-control.	<input type="checkbox"/>	<input type="checkbox"/>
16. Drug and/or alcohol use by resource parent(s) or others living in or having access to the home places the child in immediate danger.	<input type="checkbox"/>	<input type="checkbox"/>
17. Resource parent's involvement in criminal activity or criminal activity of any other person(s) living in or having access to the home endangers the child.	<input type="checkbox"/>	<input type="checkbox"/>
18. Physical or mental health or mental limitations of resource parents or other persons living in or having access to the home places child in immediate danger.	<input type="checkbox"/>	<input type="checkbox"/>
19. Other (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>

IF NO SAFETY FACTORS ARE MARKED "YES," GO TO PART C, SAFETY DECISION, AND CHECK "SAFE."

IF "YES" IS CHECKED FOR ANY FACTOR, COMPLETE PART D, IF A CHILD WILL REMAIN IN THE HOME.

RISK: Indicate the likelihood (i.e., risk) of future maltreatment of a child in this resource home: **LOW** **MODERATE** **HIGH** **VERY HIGH**

Note: The term, "risk," does NOT address the severity of the potential maltreatment, injury or harm, but, rather, the likelihood of the occurrence of an event.

IF RISK of future maltreatment is VERY HIGH or HIGH, immediately conference with your Supervisor.

Resource Parent's Name
Conducted by Name/Title
Conducted by Name/Title

Vendor #

Date of Assessment Visit
Office
Office

Case ID #
Case ID #
Case ID #

IAIU #

PART C. Safety Decision

Directions: Check the appropriate box below to identify the safety decision. Check "SAFE" only if NO safety factors were identified in Part B, Factors 1-19. Base the decision on the assessment of all safety factors listed in Part B, together with any other available information gathered.

SAFE: The child(ren) is not likely to be in danger of immediate serious harm at this time.

Worker's/Investigator's signature _____ Date _____
RESW/Other signature _____ Date _____
Supervisor's signature _____ Conference date _____

UNSAFE: SAFETY PROTECTION PLAN IS NEEDED FOR child(ren) _____

One or more **safety actions** have been or are being taken. This action(s) creates sufficient safety to allow the named child(ren) to remain in the home/current placement during this immediate time period. (SEE PART D.)

Worker's/Investigator's signature _____ Date _____
RESW/Other signature _____ Date _____
Supervisor's signature _____ Conference date _____
Casework Supervisor's signature (CP&P only) _____ Conference date _____

SAFETY MUST BE REASSESSED NO LATER THAN (date) _____ BY (CP&P office) _____

UNSAFE: REMOVAL/RE-PLACEMENT IS REQUIRED FOR child(ren) _____

Removal and re-placement is the **only safe alternative** for the above named child(ren) at this time. If the child(ren) is not placed, the child(ren) will likely be in danger of immediate, serious harm.

Worker's/Investigator's signature _____ Date _____
RESW/Other signature _____ Date _____
Supervisor's signature _____ Conference date _____
Casework Supervisor's signature (CP&P only) _____ Conference date _____

Note: A Safety Protection Plan is even if all children are removed from the home, whereby "Removal" is the plan.

Resource Parent's Name
Conducted by Name/Title
Conducted by Name/Title

Vendor #

Date of Assessment Visit
Office
Office

Case ID # IAIU #
Case ID #
Case ID #

**DIVISION OF CHILD PROTECTION AND PERMANENCY
OUT-OF-HOME SAFETY PROTECTION PLAN AND SERVICE NEEDS**

Child: _____ Name _____ Case ID # - IAIU # _____

Resource Parent's Name: _____

Resource Parent's Name: _____

- Plan to be developed with the resource parent(s)
- Focus on issues related to the safety and welfare of the child
- Identify unmet service needs of child, support needs of resource parent(s)
- Indicate who is responsible for implementing and monitoring the plan
- Give copy of the plan to the resource parent(s) and each staff participant
- Attach additional sheets, as needed
- Consult a Supervisor before finalizing the plan

(A) Safety Factor # Specify Need or Safety Concern	(B) Names of Child(ren) Adult(s)	(C) Action Taken During Home Visit	(D) Action to Be Taken Later Identified Service Needs	By (Date)	(E) Responsible Party to Implement Plan	(F) Follow-Up Date

NO CURRENT SERVICE NEEDS IDENTIFIED

Name of Supervisor Consulted on the Plan: _____

Completed by: _____ Signature/Title _____ Date _____

Completed by: _____ Signature/Title _____ Date _____

Name of Office/Unit: _____

Name of Office/Unit: _____

Resource Parent: _____ Signature _____ Date _____

Resource Parent: _____ Signature _____ Date _____

FOR CP&P USE ONLY Casework Supervisor Review/Approval			
Supervisor Review/Approval _____ Signature _____	Date _____	Signature _____	Date _____

Resource Parent's Name
Conducted by Name/Title
Conducted by Name/Title

Vendor #

Date of Assessment Visit
Office
Office

Case ID #
Case ID #
Case ID #

TAU #

PART E. CONFERENCE NOTES/ADDITIONAL INSTRUCTIONS/FOLLOW UP:
Concerns, Risk, Recommendations, Need for Collaterals, Need for Services

(Signature)

(Date)

(Signature)

(Date)

State of New Jersey
DEPARTMENT OF CHILDREN AND FAMILIES
Division of Child Protection and Permanency

CONGREGATE CARE QUESTIONNAIRE

Date of Interview _____

Program Type _____ Name of Facility _____

Child's/Youth's Name _____ Case ID # _____

Person ID # _____

Investigation # _____

INTERVIEW WITH CHILD/YOUTH

1. Does the building(s) seem safe to you? Yes No
Do you know how to get out of the building(s) if there is an emergency? Yes No
2. Do you have access to, or know where the telephone is located? Yes No
Are you allowed to use it? Yes No
3. Is there a staff person or other adult that you feel you can talk to about any problems you might have with other residents or staff? If so, who? (Identify in "comments" section, below.) Yes No
4. Is there anything or anyone here who scares or frightens you? (If yes, identify in "comments" section, below.) Yes No
5. Do you feel that there is enough supervision by staff, specifically at night? (Note: This question does not apply to independent living settings.) Yes No
6. Have you ever been hurt or injured by anyone here? (If yes, identify in "comments" section, below.) Yes No
7. Do you bring concerns to the attention of staff ("house parent," other adult, or person in charge in independent living setting)? Yes No
8. Do you know how to get in touch with the nurse or get medical care? Yes No

COMMENTS

Use this space to explain any concerns identified during the interview.

For IAIU: Enter remedial action taken, concerns, risk, recommendations for follow up, need for collateral contacts, need for services.

Check if continued on page 3

CP&P/IAIU STAFF ACTIVITY CHECKLIST

A. Was the facility Social Worker or Administrator advised of any concerns raised by the child/youth (“house parent,” other adult, or person in charge of the independent living setting/program)? Yes No

Specify who was advised. Explain: _____

B. Check boxes, as applicable, to document actions taken by the Worker/Investigator while at the congregate care facility/independent living setting:

- Complete a Congregate Care Questionnaire during field visit to facility/home.
- Interview child/youth alone.
- Interview child’s Social Worker/Counselor/other staff/adult in charge.
- See the child’s room. Assure child/youth has appropriate sleeping arrangements.
Note: Child/youth must have his or her own bed.
- Walk through the facility/independent living setting.
- Complete sections of CP&P Form 26-81a/b, Family Summary/ Case Plan/Court Report Out-of-Home, as applicable.
- Facility nurse seen (not required).
- Additional actions taken. Specify _____

Explain: _____

AFTER THE FIELD CONTACT/INTERVIEW

The following agencies/staff were advised that the child/youth was interviewed using this questionnaire:

- Other CP&P staff. Specify _____
- IAIU
- Office of Licensing
- Other. Specify _____

WORKER/INVESTIGATOR SIGNATURE

Print Name Signature Date

SUPERVISOR SIGNATURE/APPROVAL

Print Name Signature Date

Structured Decision Making

Risk Assessment (In-Home)

In addition to assessing safety, the level of risk must also be determined:

CP&P 22-23
(rev. 3/2007)

NEW JERSEY CP&P FAMILY RISK ASSESSMENT

Case Name: _____ Case ID #: _____ Local Office: _____
 Worker Name: _____ Worker ID #: _____ Primary Caregiver: _____
 Supervisor Name: _____ Supervisor ID #: _____ Secondary Caregiver: _____
 Date Completed: _____

NEGLECT

1. Current Referral is for Neglect
 - a. No0
 - b. Yes1
2. Prior Investigations (assign highest score that applies)
 - a. None0
 - b. One or more, abuse only1
 - c. One or two for neglect2
 - d. Three or more for neglect3
3. Household has Previously Received Child Protective Services
 - a. No0
 - b. Yes1
4. Number of Children Involved in the Current Child Abuse/Neglect Investigation
 - a. One, two, or three0
 - b. Four or more1
5. Age of Youngest Child in the Home
 - a. Two or older0
 - b. Under two1
6. Primary Caregiver Provides Physical Care Inconsistent with Child Needs
 - a. No0
 - b. Yes1
7. Primary Caregiver has a Past or Current Mental Health Problem
 - a. No0
 - b. Yes1
8. Primary Caregiver has Past or Current Alcohol and/or Drug Problem (check applicable items and add for score)
 - a. Not applicable0
 - b. Alcohol (current or historic)1
 - c. Drug (current or historic)1
9. Characteristics of Children in Household (check applicable items and add for score)
 - a. Not applicable0
 - b. Medically needy/failure to thrive1
 - c. Developmental or physical disability1
 - d. Positive toxicology screen at birth1
10. Housing (check applicable items and add for score)
 - a. Not applicable0
 - b. Current housing is physically unsafe1
 - c. Homeless at time of investigation2

ABUSE

1. Current Referral is for Abuse
 - a. No0
 - b. Yes1
2. Number of Prior Abuse Investigations/Assessments
 - a. None0
 - b. One1
 - c. Two or more2
 (actual number: _____)
3. Household has Previously Received Child Protective Services
 - a. No0
 - b. Yes1
4. Prior Physical Injury to a Child Resulting from Abuse/Neglect
 - a. No0
 - b. Yes1
5. Primary Caregiver's Explanation of Incident (check applicable items and add for score)
 - a. Not applicable0
 - b. Blames child1
 - c. Justifies maltreatment of a child2
6. Two or More Incidents of Domestic Violence in the Past 12 Months
 - a. No0
 - b. Yes2
7. Primary Caregiver Characteristics (check applicable items and add for score)
 - a. Not applicable0
 - b. Provides insufficient emotional/psychological support1
 - c. Employs excessive/inappropriate discipline1
 - d. Domineering caregiver1
8. Primary Caregiver has a History of Abuse or Neglect as a Child
 - a. No0
 - b. Yes1
9. Secondary Caregiver has Past or Current Alcohol and/or Drug Problem
 - a. No0
 - b. Yes, alcohol and/or drug (check all applicable)1
 - Alcohol Drug
10. Characteristics of Children in Household (check appropriate items and add for score)
 - a. Not applicable0
 - b. Delinquency history1
 - c. Developmental disability1
 - d. Mental health/behavioral problem1

TOTAL NEGLECT RISK SCORE _____

TOTAL ABUSE RISK SCORE _____

SCORED RISK LEVEL

Neglect Score Abuse Score Scored Risk Level

VERY HIGH RISK CASE STATUS CONDITIONS

- 1. Sexual abuse case AND the perpetrator may have access to the child victim.
- 2. Non-accidental injury to a child under age three years.
- 3. Severe non-accidental injury.
- 4. Parent/caregiver action or inaction resulted in death of a child due to abuse or neglect (previous or current).

DISCRETIONARY OVERRIDE

- 5. If yes, override risk level
Discretionary override reason:

FINAL RISK LEVEL

Worker Signature: _____ Date: _____

Supervisor Review/Approval: _____ Date: _____

Structured Decision Making

Reunification Assessment (Out of Home)

CP&P 22-27
(rev. 03/2007)

NEW JERSEY CP&P FAMILY REUNIFICATION ASSESSMENT

Case Name: Case ID #: Household Name:
 Worker Name: Worker ID #: Local Office:
 Supervisor Name: Supervisor ID #: Reassessment #:
 Date Completed: Removal Household? Yes No

Complete for cases where any child has been removed from the home and remains in placement with a permanency plan goal of reunification.

A. REUNIFICATION RISK REASSESSMENT

R1. Initial Family Risk Level (after overrides)	Score
<input type="checkbox"/> a. Low	0
<input type="checkbox"/> b. Moderate	3
<input type="checkbox"/> c. High	4
<input type="checkbox"/> d. Very High	5
<input type="checkbox"/> e. No initial risk assessment	4

R2. Household's Progress Toward Case Plan Goal(s)

<input type="checkbox"/> a. Successfully met all current case plan outcomes; continuing cooperation with ongoing services; substantial compliance in all of the applicable priority need areas	-2
<input type="checkbox"/> b. Actively participating in services; pursuing outcomes detailed in the case plan; partial compliance in all of the applicable priority need areas	-1
<input type="checkbox"/> c. Partial participation in pursuing outcomes in the case plan; some compliance in at least one of the applicable priority need areas	0
<input type="checkbox"/> d. Minimal level of participation in pursuing outcomes of the case plan; marginal compliance with case plan tasks	2
<input type="checkbox"/> e. Refuses involvement in services; non-compliance with case plan tasks	4

R3. Has There Been a New Substantiation (in this household) since the last Family Risk Assessment, Risk Reassessment, or Reunification Assessment?

<input type="checkbox"/> a. No	0
<input type="checkbox"/> b. Yes	6

Total Risk Score

RISK LEVEL

<u>Score</u>	<u>Risk Level</u>
-2 to 1	<input type="checkbox"/> Low
2 to 3	<input type="checkbox"/> Moderate
4 to 5	<input type="checkbox"/> High
6 and above	<input type="checkbox"/> Very High

VERY HIGH RISK CASE STATUS CONDITIONS. If any of the conditions below are applicable during the current reassessment period, circle yes, and indicate the final risk level as very high.

- Yes No 1. Sexual abuse case AND the perpetrator may have access to the child victim.
- Yes No 2. Non-accidental injury to a child under age three years.
- Yes No 3. Severe non-accidental injury.
- Yes No 4. Parent/caregiver action or inaction resulted in death of a child due to abuse or neglect (previous or current).

DISCRETIONARY OVERRIDE. If yes, indicate reason and increase or decrease the final risk classification by one level.

- Yes No 5. If yes, override risk level:

Discretionary override reason: _____

FINAL RISK LEVEL (Circle/check final level assigned):

Low

Moderate

High

Very High

B. VISITATION PLAN EVALUATION
Check visitation compliance for each child.

Child Name:
(if multiple children,
separate pages)

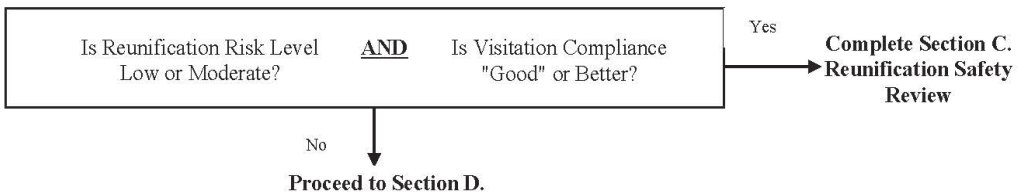
Compliance with Plan

- a. No visitation plan, check the reason:
- 1) Parent(s)/Caregiver(s) incarcerated
 - 2) Parent(s)/Caregiver(s) in treatment facility
 - 3) Court order prohibits
 - 4) Unable to locate
 - 5) Other, specify:

STOP. GO TO SECTION D.

- b. **Excellent** – parent(s)/caregiver(s) has met all requirements related to visitation; no missed scheduled visits by the parent/caregiver; all parent/caregiver-child interactions appear to be positive and appropriate during the visits. Visits are unsupervised.
- c. **Good** – parent(s)/caregiver(s) has met most of the requirements related to visitation. Parent/Caregiver-child interaction appears to have been appropriate during the visits. Visits may have been rescheduled in advance by parent/caregiver with a legitimate reason. If visitation was supervised, visits are now unsupervised.
- d. **Fair** – parent(s)/caregiver(s) has met some requirements related to visitation. Parent/Caregiver-child interaction is sometimes appropriate during visits but continued improvement is required. No more than one missed visit without legitimate explanation or advance notice/confirmation. Visits may be supervised or unsupervised.
- e. **Poor** – parent(s)/caregiver(s) has met few requirements related to visitation. Visits are supervised. More than one missed visit without legitimate explanation and/or advance notice/confirmation, and/or parent/caregiver has demonstrated poor parent/caregiver-child interaction during visitation.
- f. **None** – parent(s)/caregiver(s) has failed to visit, or visits have been suspended due to parental behavior or professional reports of adverse reactions by the child due to visitation or court order.

IF RISK LEVEL IS LOW OR MODERATE AND PARENT(S)/CAREGIVER(S) HAS ATTAINED AT LEAST A "GOOD" LEVEL OF COMPLIANCE WITH THE VISITATION PLAN, COMPLETE THE REUNIFICATION SAFETY REVIEW. OTHERWISE, GO TO SECTION D.



C. REUNIFICATION SAFETY REVIEW

Part 1. Safety Factors (indicate yes or no)

1. Caregiver leaves (or has left) child with a person unwilling to provide care.
2. Child is fearful of caregiver(s), other family members, or other people living in or having access to the home.
3. Caregiver is verbally hostile when talking to or about the child and/or has extremely unrealistic expectations for the child's behavior.
4. Caregiver caused serious physical harm to the child or has made a plausible threat to cause serious physical harm.
5. Caregiver's explanation for the child's injury or physical condition is inconsistent with the nature of the injury or condition.
6. Caregiver refuses (or has refused) access to the child, or there is reason to believe that the caregiver is about to flee, and/or the child's whereabouts cannot be ascertained.
7. Caregiver has not, will not, or is unable to provide care and supervision necessary to protect child from potentially serious harm, including harm from self (child) or other persons living in or having access to the home.
8. Caregiver has not, will not, or is unable to meet the child's immediate needs for food, clothing, shelter, and/or medical or mental health care.
9. Child sexual abuse/exploitation is suspected and circumstances suggest that child safety may be an immediate concern.
10. The child's physical living conditions are hazardous and immediately threatening.
11. Caregiver's behavior is violent or out of control.
12. Caregiver's drug or alcohol use seriously affects his/her ability to supervise, protect, or care for the child.
13. Caregiver's involvement in criminal activity seriously affects his/her ability to supervise, protect, or care for the child.
14. Caregiver's emotional stability, developmental status, or cognitive deficiency seriously impairs their ability to supervise, protect, or care for the child(ren).
15. Other factors that place the child in immediate and/or impending danger of serious harm (specify):

Part 2. Safety Documentation

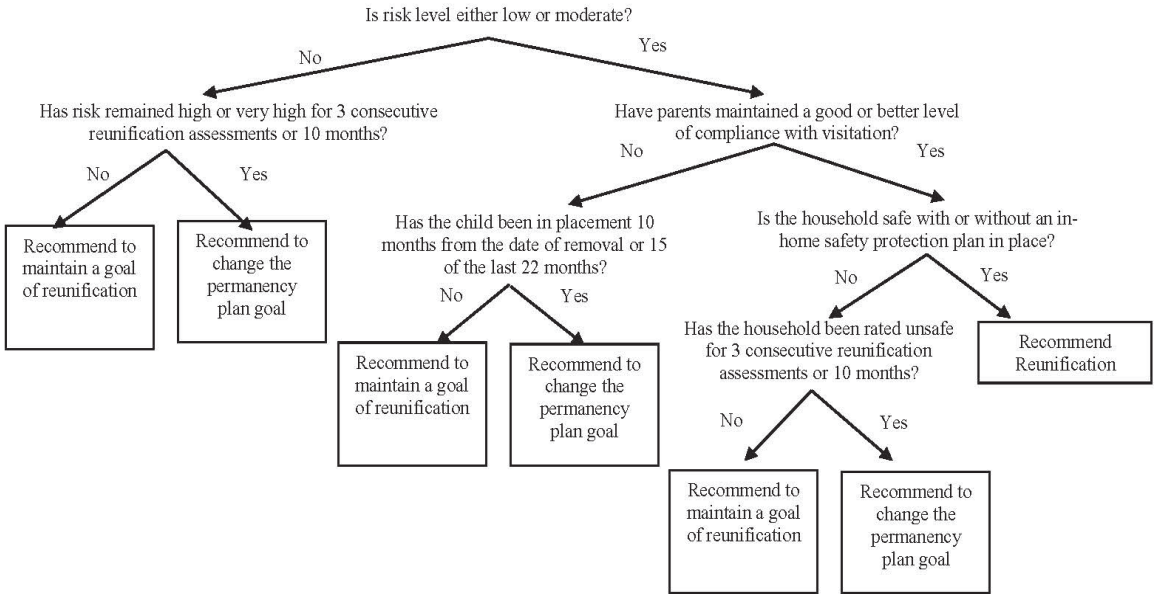
- A. No safety factors are present. Safety factors that resulted in the child's removal (as documented on the initial safety assessment) are no longer present, and no additional safety factors were identified. *Document how safety issues were resolved.*
- B. One or more safety factors are present. *Describe the specific safety plan and/or service interventions that will be put in place to address safety concern(s). If the only intervention to ensure safety is continued out-of-home placement, document why other interventions could not be implemented to reunify the child(ren) at the present time.*

Part 3. Safety Decision

- A. Safe (no safety factors are present in the household).
- B. In-Home Safety Protection Plan Required (one or more safety factors are present, but services are in place to mitigate safety concerns).
- C. Unsafe (one or more safety factors are present, and interventions are not available or possible to ensure child safety in the home; all children remain in custody).

D. PERMANENCY PLAN GUIDELINES

Complete for each child in out-of-home care. Enter results below in Section E.



E. PERMANENCY PLAN RECOMMENDATION SUMMARY

Child's Name (if multiple children, separate rows below)	Removal Date	Permanency Plan Recommendation from Section D Above				Override Y/N (indicate Reason below)	Worker's Final Permanency Plan Recommendation
		(check one)					
		Reunification	Maintain a Goal of Reunification	Change Permanency Plan*	New Goal		

*If "change permanency plan" is marked, you must enter the new goal

Override reason:

(Note: If a child is recommended for reunification by use of an override, a reunification safety assessment must be completed.)

F. CURRENT CASE STATUS (check one):

- 1. Case remains open with at least one child in placement. (Future reunification assessments required.)
- 2. Case remains open. All children reunified. (Child Protective Services continue and future risk reassessments required.)
- 3. Permanency plan approved by the court and/or TPR granted. (No future reunification assessments required.)
- 4. Other, specify:

New Permanency Goals:

Maintenance in Own Home – family stabilization
Reunification with parent from whom removed
Reunification to other parent
Reunification with relative from whom removed
Reunification with family friend from whom removed
Kinship Legal Guardianship with a relative
Kinship Legal Guardianship with a family friend
Kinship Legal Guardianship with a resource family
Independent Living
Individual Stabilization (Adults Only)

Adoption - Relative
Adoption - Family Friend
Adoption - Resource Family
Adoption - Selected Home
Adoption - Type Not Yet Decided
ACI (Adoption Complaint Investigation)
Long-term foster care with custody (Court Order pre 1/2005)
Long-term foster care without custody (set before 1/2005)
Other Long-term Specialized Care
Documentation only – no goal/services provided

Investigative Findings Decision Making Tree

Investigator determines whether or not a preponderance of evidence indicates that a child is abused or neglected as defined in N.J.S.A § 9:6-8.21.

If Yes

Investigator determines whether one or more of the absolutely substantiating circumstances specified in N.J.A.C. 10:129-7.4 exists.



If No

Investigator determines whether there is any evidence that a child was harmed or placed at risk of harm.

If Yes

**The Abuse or
Neglect is
Not Established**

If No

**The Abuse or
Neglect is
Unfounded**

Absolutely Substantiating Circumstances (NJAC 10:129-7.4)

1. The death or near death of a child as a result of abuse or neglect;
2. Subjecting a child to sexual activity or exposure to inappropriate sexual activity or materials;
3. The infliction of injury or creation of a condition requiring a child to be hospitalized or to receive significant medical attention;
4. Repeated instances of physical abuse committed by the perpetrator against any child;
5. Failure to take reasonable action to protect a child from sexual abuse or repeated instances of physical abuse under circumstances where the parent or guardian knew or should have known that such abuse was occurring; or
6. Depriving a child of necessary care which either caused serious harm or created a substantial risk of serious harm.

If No → Consider both the Aggravating and Mitigating Factors in N.J.A.C. 10:129-7.5

Mitigating Factors

1. Remedial actions taken by the alleged perpetrator before the investigation was concluded;
2. Extraordinary, situational, or temporary stressors that caused the parent or guardian to act in an uncharacteristic abusive or neglectful manner;
3. The isolated or aberrational nature of the abuse or neglect; and
4. The limited, minor, or negligible physical, psychological, or emotional impact of the abuse or neglect on the child.

If Mitigating Factors Prevail →

**The Abuse or Neglect is
Established**

Aggravating Factors

1. Institutional abuse or neglect;
2. The perpetrator's failure to comply with court orders or clearly established or agreed-upon conditions designed to ensure the child's safety, such as a child safety plan or case plan;
3. The tender age, delayed developmental status or other vulnerability of the child;
4. Any significant or lasting physical, psychological, or emotional impact on the child;
5. An attempt to inflict any significant or lasting physical, psychological, or emotional harm on the child;
6. Evidence suggesting a repetition or pattern of abuse or neglect, including multiple instances in which abuse or neglect was substantiated or established; and
7. The child's safety requires separation of the child from the perpetrator.

If Aggravating Factors Prevail →

**The Abuse or Neglect is
Substantiated**

If Yes →

Mental Health Screening Tool

NEW JERSEY MENTAL HEALTH SCREENING TOOL (0 TO 5 YEARS)

Child's Name: _____ Date of Birth: _____
 NJS: Case# _____ Person ID# _____
 Casework/supv/contact info _____

Please check applicable boxes. Following each question are examples of behaviors or problems that would require a "YES" check. **Please circle any that apply.** This list is not exhaustive. If you have a question about whether or not to check "YES", please offer relevant information in the COMMENTS section.

YES	NO	Unknown	Behavior
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>1. Does this child exhibit unusual or uncontrollable behavior?</p> <p>0 – 18 mos: Crying that is excessive in intensity or duration; persistent arching, "floppiness," or stiffening when held or touched; cannot be consoled by caregiver; cannot initiate or maintain sleep without extensive assistance in the absence of stressors such as noise or illness</p> <p>18 – 36 mos: Any of the behaviors above; extremely destructive, disruptive, dangerous or violent behavior; excessive or frequent tantrums; persistent and intentional aggression despite reasonable adult intervention; excessive or repetitive self-injurious behavior (e.g. head banging) or self-stimulating behavior (e.g. rocking, masturbation); appears to have an absence of fear or awareness of danger</p> <p>3 – 5 yrs: Any of the behaviors above; frequent night terrors; excessive preoccupation with routine, objects or actions (e.g. hand washing – becomes distraught if interrupted, etc.); extreme hyperactivity; excessively "accident-prone;" repeated cruelty to animals; lack of concern or regard for others; severe levels of problem behavior in toileting (e.g. encopresis, smearing) and aggression (e.g. biting, kicking, property destruction)</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>2. Does this child seem to be disconnected, depressed, excessively passive, or withdrawn?</p> <p>0 – 18 mos: Does not vocalize (e.g. "coo") cry or smile; does not respond to caregiver (e.g. turns away from his/her face; makes or maintains no eye contact; interaction with others does not appear to be pleasing); does not respond to environment (e.g. motion, sound, light, activity, etc.); persistent and excessive feeding problems.</p> <p>18 – 36 mos: Any of the above; fails to initiate interaction or share attention with other with whom s/he is familiar; unaware or uninvolved with surroundings; does not explore environment or play; does not seek caretaker/adult to meet needs (e.g. solace, play, object attainment); few or no words; fails to respond to verbal cues.</p> <p>3 – 5 yrs: Any of the above; does not use sentences of 3 or more words; speech is unintelligible; excessively withdrawn; does not play or interact with peers; persistent, extremely poor coordination of movement (e.g. extremely clumsy); unusual eating patterns (e.g. refuses to eat, overeats; repetitive ingestion of nonfood items); clear and significant loss of previously attained skills (e.g. no longer talks or is no longer toilet trained).</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>3. Has this child made statements or acted in ways that present a danger to self, other people, animals or property?</p> <p><i>Attempted suicide; made suicidal gestures; expressed suicidal ideation; assaultive to other children or adults; reckless and puts self in dangerous situations; attempts to or has sexually assaulted or molested other children, etc.</i></p> <p>Placement, Childcare, Education Status</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>4. Does this child exhibit behaviors that may not allow him/her to remain in his/her current living, preschool and/or childcare situation?</p> <p><i>The child's behavior, and/or the caregiver's inability to understand and manage these behaviors, threaten the child's ability to benefit from a stable home environment, or preschool or childcare situation.</i></p> <p>History</p>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>5. Has the child experienced sexual abuse, serious or repeated physical or emotional abuse, serious or chronic neglect, or been exposed to serious violent behavior or trauma in his/her home in the last 90 days?</p> <p><i>Subjected to or witnessed serious physical abuse, domestic violence or sexual abuse, e.g., bruising in unusual areas ,rarely held or responded to, forced to watch torture or sexual assault, witness to murder, etc.</i></p>

Please continue to page 2

If you checked any of the above boxes “YES”, child should be referred for assessment. For the young child, a next step will usually include a consult with the child’s pediatrician. Assessments may be completed by a pediatric neurologist, a neurodevelopmentalist, or a mental health professional. Please report your findings to the CHU nurse for assistance.

If applicable, identify the agency and provider to which the child has been referred:

COMMENTS/ADDITIONAL INFORMATION: _____

NEW JERSEY MENTAL HEALTH SCREENING TOOL (6 YEARS TO ADULT)

Child's Name: _____ **Date of Birth:** _____
NJS: Case# _____ **Person ID#** _____
Casework/supv/contact info _____

Please check applicable boxes on both sides of this form. Following each question are examples of behaviors or problems that would require a "YES" check. **Please circle any that apply.** This list is not exhaustive. If you have a question about whether or not to check "YES", please indicate the issues under the COMMENTS section on the reverse side of the form.

YES	NO	Unknown	Part 1 - IDENTIFIED RISK
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. Has this child been a danger to him/herself or to others in the last 90 days? <i>Attempted suicide; made suicidal gestures; expressed suicidal ideation; assaultive to other children or adults; reckless and puts self in dangerous situations; attempts to or has sexually assaulted or molested other children, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Does this child have behaviors that are so difficult that maintaining him/her in his current living or educational situation is in jeopardy? <i>Persistent chaotic, impulsive or disruptive behaviors; daily verbal outburst; excessive noncompliance; constantly challenges the authority of caregiver; requires constant direction and supervision in all activities; requires total attention of caregiver; overly jealous of caregiver's other relationships; disruptive levels of activity; wanders the house at night; excessive truancy; fails to respond to limit setting or other disciplines, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Has the child exhibited bizarre or unusual behaviors in the last 90 days? <i>History or pattern of fire-setting; cruelty to animals; excessive, compulsive or public masturbation; appears to hear voices or respond to other internal stimuli (including alcohol or drug induced); repetitive body motions (head banging) or vocalizations (e.g. echolalia); smears feces, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Does the child have an immediate need for psychotropic medication consultation and/or prescription refill? <i>Either needs immediate evaluation of medication or needs a new prescription.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Does this child have a history of psychiatric hospitalization, psychiatric care and/or prescribed psychotropic medication? <i>Child has a history of psychiatric care, either inpatient or outpatient, or is taking prescribed psychotropic medication.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Has the child experienced sexual abuse, serious or repeated physical or emotional abuse, serious or chronic neglect, or been exposed to serious violent behavior or trauma in his/her home in the last 90 days? <i>Subjected to or witnessed serious physical abuse, domestic violence or sexual abuse, e.g., bruising in unusual areas, forced to watch torture or sexual assault, witness to murder, etc.</i>

If you checked any of the above boxes YES, this indicates that the need for Mental Health assessment and/or assistance is urgent.

If all the above are either NO or UNKNOWN, please continue on reverse side.

COMMENTS/ADDITIONAL INFORMATION: _____

YES	NO	Unknown	Part 2 - RISK ASSESSMENT
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. This child has a history of the behaviors or experiences listed on the front page, "Identified Risk" section, that occurred more than 90 days ago. List: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. Does the child have problems with social adjustment? <i>Regularly involved in physical fights with other children or adults; verbally threatens people; damages possessions of self or others; runs away; truant; steals; regularly lies; mute; confirmed due to serious law violations; does not seem to feel guilt after misbehavior, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. Does this child have problems making and maintaining healthy relationships? <i>Unable to form positive relationships with peers; provokes and victimizes other children; gang involvement; does not form bond with caregiver, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Does this child have problems with personal care? <i>Eats or drinks substances that are not food; regularly emuretic during waking hours (subject to age of child); extremely poor personal hygiene.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Does this child have significant functional impairment? <i>No known history of developmental disorder, and behavior interferes with ability to learn at school; significantly delayed in language; "not socialized" and incapable of managing basic age appropriate skills; is selectively mute, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Does this child have significant problems managing his/her feelings? <i>Severe temper tantrums; screams uncontrollably; cries inconsolably; significant and regular nightmares; withdrawn and uninvolved with others; whines or pouts excessively; regularly expresses the feeling that others are out to get him/her; worries excessively and preoccupied compulsively with minor annoyances; regularly expresses feeling worthless or inferior; frequently appears sad or depressed; constantly restless or overactive, etc.</i>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Is this child known to abuse alcohol and/or drugs? <i>Child regularly uses alcohol or drugs.</i>

If you checked any of the above boxes YES, this indicates child should be referred for a mental health assessment.

Please forward the form to:

(Could be preprinted to have the address of local Mental Health agency.)

COMMENTS/ADDITIONAL INFORMATION: _____

Mental Health Follow Up Response

Name: _____ Date: _____

MH Assessment complete; no follow up MH service required.

MH Assessment complete; MH follow up required.

Other: _____

NJ MHST 6-adult
new April 2011

Visitation

Documentation Guide & Relative Documentation Guide

CASE NAME:

CASE ID#:

DATE OF VISIT:

TIME OF VISIT:

LOCATION:

PARTICIPANTS:

SUPERVISING STAFF:

OBSERVATIONS	MOTHER (P1)			FATHER (P2)			NOTES
	YES	NO	N/A	YES	NO	N/A	
PARENT'S STATUS AT VISIT							
PARENT DEMONSTRATES: Good Hygiene Appropriate dress Sober Demeanor Arrives on time Remains for entire visit							
COMMUNICATION SKILLS							
PARENT DEMONSTRATES: Sensitivity to the child's feelings Attention to child's statements without ignoring or changing what the child says Use of child friendly language Emotional, verbal and nonverbal support without hostility or distraction and responsiveness to the child's cues Respect for the child and an understanding of the child's needs (does not seek reassurances or "quiz" the child about his/her feelings or the situation)							
PHYSICAL SPACE & INTIMACY NEEDS							
PARENT SHOWS: Respect for child's physical space Understanding of need to join with child's play or let child initiate play (neither over nor under-involved) Safe and comfortable interaction with the child overall (no threatening, intimidation, intrusive behavior)							

OBSERVATIONS	MOTHER (P1)			FATHER (P2)			NOTES
	YES	NO	N/A	YES	NO	N/A	
CONFLICT EXPLORATION RESOLUTION							
Parent sets appropriate behavior limits/discipline (vs. use of negative terms, cursing, criticizing, etc.)							
Parent handles child's anger & frustrations and seeks to calm the child rather than escalating conflict.							
Parent has the goal of mutual enjoyment of the interaction							
Parent provides appropriate modeling and is not argumentative or manipulative							
UNDERSTANDING OF CHILD'S DEVELOPMENTAL STAGE							
Parent has reasonable expectations of child's abilities and provides care appropriate for the child's developmental stage. (i.e diaper changes, appropriate snacks, assistance with dressing, etc.)							
Parent greets and separates from child appropriately							
Parent provides activities, comforts, reassures, and encourages the child							
Parent understands impact of adult behavior on child (makes no promises that can't be kept, is mindful of safety, etc.)							
<input type="checkbox"/> NEED FOR INTERVENTION DURING THE VISIT (Explain what happened, how staff handled it & how the parent reacted. Attach additional sheets if needed.)							
OVERALL IMPESSION OF THE VISIT:							

Concurrent Planning

Integrated Practice Work Group

The following are those who participated in the revision and integration of the concurred planning guide. The functions of those in the group include case practice and implementation specialists, case practice liaisons, local office managers, workers, supervisors and case work supervisors in intake, permanency and adoption, concurrent planners, assistant area directors and area directors, area quality coordinators, legal affairs, and CP&P Deputy Directors.

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Brooke Arnold	Kerry Hauber	Jessica Payne
Lori Barry	Arlene Hey	Florence Racine
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Keith DeLoatch	Steve Little	Brian Thatcher
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Susan Fiorilla	Kathleen Niedt	Kathi Way
Darlene Fusco	Kathleen Nimberger	Shelly Wimberly
		Nayamka Williams

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