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County of Santa Clara
Social Services Agency

353 West Julian Street
San Jose, California 95110-2335

DATE: February 6, 2024

TO: Honorable Board of Supervisors

FROM: Damion Wright, Director, Department of Family and Children's Services

SUBJECT: B.3 – Hospital Release and Transfer Protocol

At the December 19, 2023 Special Meeting of the Board of Supervisors, the Board requested a report back regarding hospital release and transfer protocols where a DFCS report has been made – both for County and non-County hospitals. This memorandum provides the requested information.

Welfare and Institution Codes (WIC), CDSS Policies and Procedures, and DFCS policy require that, if a child abuse report is called in to DFCS, no matter the location or scenario, a screening of that referral utilizing the Structured Decision Making (SDM) Hotline tool is required. That process is used to determine if a child abuse referral needs to be generated, if an in-person response is warranted, and the timeline for the response.

If a referral is generated, protocols and guidance provide direction to staff regarding what should occur when a child is ready for discharge from the hospital and/or transferring to another hospital during a child abuse investigation.

The protocols are as follows:

- Conducting an Emergency Response Assessment – Online Policies and Procedures (OPP) chapter for conducting Emergency Response assessments.
- Notifying Hospital Staff of Placing a Child in Temporary Custody – OPP chapter for engaging hospital staff and steps to place a child into protective custody while the child is at the hospital.
- Interim Direction issued on November 15, 2023 – Guidance issued by the DFCS director with interim update to policies and practice around removal of children.

The child welfare protocols are applicable to all hospitals, both County hospitals and non-County hospitals.

There are protocols and guidance for safe discharge of infants that have been exposed to substances upon birth.

- OPP Assessment Guide - Substance Use Disorders – OPP chapter providing practice and policy around working with families experiencing a substance use disorder.

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Since December 8, 2023, DFCS leadership has begun monthly collaborative meetings with the County's Health and Hospital System physicians, nurses and lead staff from Valley Medical Center (VMC), VMC's Neonatal Intensive Care Unit (NICU), Saint Louise and O'Connor Hospitals as well as the Supporting Protecting and Respecting Kids (SPARK) clinic staff, Child's Advocacy Center (CAC) team members, Kaiser Permanente and Stanford Children's Hospital staff. The goal of these monthly meetings is to support, track, monitor and advocate for the health and safety of at-risk children in Santa Clara County.

The hospitals in Santa Clara County also have Suspected Child Abuse and Neglect (SCAN) teams DFCS participates in that include physicians, nurse practitioners, nurses, medical social workers, law enforcement, and other individuals and groups when indicated. These meetings allow for discussion and sharing of information for what is needed medically for children and to ensure their safety, and to support plans of safe care for children being discharged from hospitals.

In addition, DFCS holds monthly meetings with leadership from VMC, SPARK clinic, and CAC staff in an effort to enhance the necessary policies for each partner and ensure the necessary collaboration to serve children and families. These meetings ensure a review of successes for the past month, areas of concern that need to be addressed, and then solutions and next steps are set to be supported by the next meeting. These meetings also involve a multi-disciplinary discussion of any cases needed with those persons involved with the family. Outcomes of these meetings have led to the following:

- Increased communication from hospital to follow up medical appointments and services.
- Collaborative training across teams
- Co-development of shared communication and policies that will be included into the annual review of the Joint Child Abuse Protocol for Santa Clara County
- Greater participation in Child and Family Team Meetings (CFTs) by medical providers

Efforts to involve medical providers in CFTs are a particular focus for DFCS. When CFTs include medical professionals who are involved with and/or treating an identified child, information is shared to identify any concerns or issues the doctor or nurse may have. CFTs allow for a collaborative effort for medical professionals to be a part of the planning specifically to address any child welfare concerns. Additionally, CFTs include establishing clear follow up for children, linking families to resources, and providing information to the larger group including DFCS and the family's network to ensure care and supervision is provided in a manner that is appropriate for the child in question.

DFCS will continue to expand partnerships with medical providers, including the CAC medical team and other County and community partners.

Attachments

- Attachment A - OPP Conducting an Emergency Response Assessment
- Attachment B - OPP Notifying Hospital Staff of Placing a Child in Temporary Custody
- Attachment C - Interim Direction issued on November 15, 2023

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- Attachment D - OPP Assessment Guide - Substance Use Disorders
- Attachment E - CAPTA Plans of Safe Care
- Attachment F - ACL 16-85 – Requirements and Guidelines for Creating and Providing a CFT
- Attachment G - ACL 18-23 – CFT Process Frequently Asked Questions and Answers
- Attachment H - ACL 22-35 – Timing and Frequency of CFTs

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Attachment A – OPP Chapter: Conducting an Emergency Response Assessment

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2-3 Conducting an Emergency Response Assessment

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- SOP & Practice Considerations
- Who Must Be Interviewed
- Your Rights (PUB13) & Information for Families (SCZ182) Pamphlets
- Required Disclosure to the Individual Suspect
- Active Duty Military
- ICWA Inquiry for Emergency Respone Referrals
- Case Consultation & Supervision
- Referrals Open Longer Than 29 Days
- Contacts
- Other References
- Legal Basis

Effective Date: 07/01/2019

Last Updated:10/13/2023

Non CWS/CMS Forms:

- Your Rights (PUB 13)
  - English (English-Large Print)
  - Spanish (Spanish-Large Print)
  - Vietnamese (Vietnamese-Large Print)

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- Information for Families Pamphlet (SCZ182)
  - English
  - Spanish
  - Vietnamese

- Your Child's Health and Education (JV-225)
  - English
  - Spanish

- Language/Ethnicity Designation Form (SCZ225)
  - English
  - Spanish
  - Vietnamese

- Case Language Designation Form (SCZ225a)
  - English
  - Spanish
  - Vietnamese

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- Language/Ethnicity s esignation & Case Language s esignation Form (SCZ225 & SCZ225a)- COM(INEs
  - English
  - Spanish
  - Vietnamese

- What Happens if Your Child is Removed from Your Home (SCZ183)
  - English
  - Spanish
  - Vietnamese

- Safety Organized Practice
  - Guides
  - (lank Tools

CWS/CMS Forms:

- Emergency Response Referral s ocument
- Screener Narrative

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- Investigative Narrative

POLICY

The purpose of a referral assessment is to gather a full picture of the family and the circumstances that generated the referral, identifying both safety and risk issues. After gathering as much information as possible, the social worker uses the SDM safety assessment to determine whether there are any safety threats present that put the children in immediate danger or serious harm. If so, the social worker seeks to use the family's and community's resources to identify whether any protective interventions can be implemented to help mitigate those threats and enable the children to remain in their homes during the investigation.

Both the Department of Family and Children's Services (DCS) and law enforcement have the authority to investigate cases of suspected child abuse or neglect and often coordinate investigations and share information throughout a case investigation. Additionally, DFCS is legally responsible for cross-reporting severe abuse and neglect to law enforcement. DFCS recognizes that contact with law enforcement can be traumatic for families, and unnecessary law enforcement contact can be counter-productive to DFCS's goals of building trust and promoting family healing. *Accordingly, law enforcement should not be routinely involved in DFCS investigations*.

DESK GUIDE

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A BRIEF NOTE ON SAFETY

DFCS takes the matter of safety seriously and recognizes that the nature of child welfare work can place social workers at risk of physical and emotional violence, threats, and verbal abuse. When possible, all adequate precautions must be taken to ensure the health and safety of personnel who will respond to respond to a referral. To mitigate these safety risks, staff should review and become familiar with the procedures and recommendations outlined in *OPP 23-1: Social Worker Safety* and *OPP 20-1: Security and Incident Reporting*.

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LAW ENFORCEMENT IN DFCS INVESTIGATIONS

If a referral is called into the Child Abuse and Neglect Center (CANC), the initial contact with a child may be made in collaboration with law enforcement. In some cases, the police or sheriff will have called the CANC; in other cases, the ER social worker calls law enforcement when there are safety concerns, if there is an emergency, or if the child needs to be taken into temporary custody. The law enforcement agency that has jurisdiction in a case is the agency that serves the area where the abuse is alleged to have occurred.

JOINT RESPONSE

DFCS has developed a *Joint Response Protocol (OPP 2-2)* with all law enforcement jurisdictions in Santa Clara County. The protocol establishes that a law enforcement officer's decision to place a

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child in temporary custody will include an independent investigation by a DFCS social worker. Under the 2023 Santa Clara County Child Abuse Protocol , social workers shall:

- Collaborate on the investigation with law enforcement while being midful that the officer's investigative focus may difffere from that of DFCS
- Check CWS/CMS records for all parents/legal guardians
- Interview parents, identified child victims, all other children in household or family, adult witnesses, and collaterals.
- Make clinical assessments informed by the use of SDM Safety and Risk Assessments and Safety Organized Practice tools.

Please refer to section below titled Reminders Regarding Consent When Conducting Collateral Investigations with Law Enforcement

OTHER SITUATIONS WITH LE INVOLVEMENT

DFCS recognizes that contact with law enforcement can be traumatic for families, and unnecessary law enforcement contact can be counter-productive to our goals of building trust and promoting family healing. Accordingly, law enforcement should **not** be routinely involved in DFCS investigations.

To promote consistency across ER units, social workers shall use the following guidelines to determine when it is appropriate to involve law enforcement.

- Sexual abuse

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        - After disclosure, the social worker should pause the investigation to contact law enforcement who will coordinate with the Child Advocacy Center for a forensic interview.
- If the social worker suspects that a child has been kidnapped or abducted.
- Death of a child due to abuse or neglect.
- Severe physical abuse defined an injury if left ***untreated*** *would cause permanent physical disfigurement, permanent disability or death*.
    - Examples include but are not limited to:
        - broken bones, or other injury which causes the inability to use an arm or bear weight on a leg
        - concussion,
        - head trauma (including loss of consciousness),
        - altered mental status,
        - significant bruising or other injury to the head, stomach or throat area or internal
    - Any injuries related to shaking or throwing an infant or child under three (3) years old.
    - Cruel discipline that results in injury (e.g., cigarette burns)
    - Any non-accidental injury to a child under (1) year old or a non-ambulatory child.

        Note: *In addition to contacting law enforcement, social workers should coordinate with Child Advocacy Center*.

- Concerns present related to the safety of the social worker, child or family.
- Law enforcement assistance is necessary to execute or enforce a court order or warrant.

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- The family is experiencing an emergency that cannot be addressed with crisis mental health or other community services.

Circumstances in which law enforcement intervention **may** be considered

The social worker, in consultation with their supervisor, may determine that a referral necessitates law enforcement intervention or a concurrent investigation to minimize repeat investigations. Before responding to any referral with a physical abuse allegation, a social worker may contact law enforcement and request an officer respond to the call.

Physical abuse reports that **do not** require a police intervention

- In cases where the child has sustained an injury but a determination has been made that a parent employed "reasonable physical discipline," law enforcement intervention is not necessary, nor is a cross-report. Please refer to the Investigating Allegations of Physical Injury (Link to 2-3X) section for further information.
- The child has sustained a mark, bruise, or another non-serious injury due to parental conduct.
    - In conjunction with their supervisor, the social worker may determine that there is no need for a concurrent law enforcement investigation, as the injuries are not severe, and SDM indicates that the family is safe without a plan. The social worker would still cross-report the incident to law enforcement.

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        - Examples of injuries that are not serious or minor include: mild redness or swelling, minor bruises (not including the head, stomach, and throat areas)/welts/scratches/abrasions, or brief and minor pain.
- Please refer to section below titled Reminders Regarding Consent When Conducting Collateral Investigations with Law Enforcement

REMINDERS REGARDING CONSENT WHEN CONDUCTING COLLATERAL INVESTIGATIONS WITH LAW ENFORCEMENT

Social workers may not conduct or participate in an interview of a child in tandem with law enforcement (LE) without **one of the following**:

- Parental consent,

    - Seeking parenting consent should always be considered, unless requesting consent would endanger the child's physical safety.
    - The Parental Consent for Interview (SCZ9B) is used when obtaining a parent's consent as evidenced by signature
        - If unable to obtain written consent, a parent can provide verbal consent which must be documented in CWS/CMS (contact & investigative narrative)

OR

- Exigent circumstances

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- "Exigency to interview" means that the child's is likely to suffer serious physical harm in the time it would take to obtain a court order to interview the child.
    - Determination should be made with social work supervisor, division manager along with County Counsel.

OR

- A court order
  - See *OPP Chapter 2-2.1: How to Obtain a Court Order to Interview a Child* for procedures.
  - In some circumstances, an interview order is required when LE requests that parents not be informed about the interview ahead of time.

If the law enforcement officer interviews the child without exigency, parental consent, or a court order, the social worker may NOT participate in that interview. The social worker does not have to leave the scene, but should leave the area where the law enforcement officer is interviewing the child.

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EMERGENCY RESPONSE INVESTIGATION OVERVIEW

Below is potential flow for the required tasks in an Emergency Response Investigation. As the circumstances of each referral and investigation are unique these steps may occur during different phases or at different times within the process, however, in most instances all these steps/tasks will be completed.

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Note: Throughout the investigation, social workers should work closely with their supervisors for support and guidance. Please refer to section is this chapter on case consultation and supervision for expectations.

Beginning an Emergency Response Investigation

Upon receiving the referral, the social worker:

1. **Reviews** the Assessment Guide in OPP Handbook 3 that applies to the referral.

2. **Reviews** the family's child welfare history, both in CWS/CMS and hard copy, if available.
    a. Determine how prior child welfare history relates to current concerns or shows patterns that relate to current concerns.
    b. Document the results of the child abuse history in the Contact Notebook and in the Investigative Narrative.

3. **Assesses** the need for law enforcement assistance and, if necessary, contacts the police or sheriff's jurisdiction where the alleged abuse occurred; if unsure, consults with a supervisor.
    a. The social worker may only interview a child in tandem with law enforcement when there is exigency to interview, parental consent to interview, or a court order to interview. However, the social worker may conduct all other aspects of his or her investigation.

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4. **Locates** the referral child in person within the required timeframe by going unannounced to the child's location.

5. **Accounts** for the whereabouts of all children associated with the family.

6. **Contacts** the reporting party, if known, and collateral contacts (i.e., neighbors, physicians, therapists, teachers, etc.) associated with the referral in person or by telephone.

   a. Interview collaterals regarding the care and well-being of each child and inquire about whether the child has Native American or Native Alaskan heritage.
   b. Attempt to gather additional information regarding the family that can be used to assess the validity of the allegations.
   c. Assess the level of danger and the validity of the allegations regarding each child based upon the collateral contact's perspective.
   d. Determine if any additional allegations exist, add allegations to referrals, as appropriate, and determine if additional services are necessary.
   e. Document in detail the findings of these contacts in the Contact Notebook and Investigative Narrative. Please refer to Timelines For Recording Contacts In CWS/CMS and Investigation Narrative and Other Documentation section in this chapter.

DURING THE ER INVESTIGATION PHASE

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As part of their investigation, the SW does the following**:**

1. **Completes all required interviews.** Please refer to section of Who Must Be Interviewed within this chapter.
    a. **Interviews*** and/or assesses all named children alleged to be abused, neglected, or exploited.
        - There are legal restrictions regarding *home entry* and *interviewing children* of which the social worker must be aware.
        - A *parent may refuse entry* into the family home, in which case the worker should not enter the family home.
        - Inquires about potential Native American or Native Alaskan heritage. See section below for more details.

    a. **Interviews*** and/or assesses of all other identified children in the household and/or family.
        - Please refer to Children Not Present during the Initial Face-to-Face Visits within this chapter.
        - **Inquires** about potential Native American or Native Alaskan heritage. See ICWA Inquiry for ER Referrals section below for more details.

    b. **Interviews*** the parent(s) or caregiver(s)
        - **Provides** the caregivers/parents with copies of the PUB13 and SCZ182. See section below for more details.
        - **Explains** to the parents the allegations reported within the referral
            - The identity of the reporting party must not be disclosed
            - Please refer to section below Required Disclosure to the Individual Suspect.

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- **Inquires** about any parents' current status as an active duty member of the military. See section below for more details.
- **Inquires** about potential Native American or Native Alaskan heritage. See ICWA Inquiry for ER Referrals section below for more details.

> ***Notes:***
> - During investigation and interviews, SW are required to conduct a global assessment of all risk areas or factors, which may endanger the child's safety. Please refer to section in this chapter – Global Assessment in Referral Investigations.
> - If during the course of an investigation, the SW is unable to locate the family or a particular family member, they are required to make reasonable attempts to locate the family. Please refer to section in this chapter – Reasonable Attempts to Locate a Family.

2. **Completes** SDM Safety Assessment, prior to leaving a child in the home or returning a child*, to inform assessment and determination of safety threats.
   If the child is determined to be **unsafe, the SW should **not** leave the home and should consult their supervisor for next steps.*

   Note: The SDM Safety Assessment must be entered into WebSDM, with 48 hours of the first contact with the child victim.
   Please refer to SDM Safety and Risk Assessments section in this chapter

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3. **Develops** a Safety Plan with the family and their circle of support to address any safety threats in efforts allow the child to remain safely in the home.
   a. Please refer to *OPP Chapter 3-16.4 Safety Planning*

      Reminder: Safety plan must be reviewed with and approved by a supervisor prior to leaving the child in a home.
   b. **Schedules** a follow-up Child and Family Team (CFT) meeting within 72 hours of establishing a safety plan.

4. **Requests and reviews** criminal background checks (CLETS). Please refer to *OPP Chapter on CLETS*.
   a. Determine if the results of any criminal record check indicate any charges or convictions related to harm or danger to the child, or if the history represents a pattern related to factors associated with immediate danger or risk to the child.
   b. Document the results of the criminal record checks on the Demographics Page of the Client's Notebook in the Arrests section and in the Investigation Narrative.

      Note: *SW can also request a Crime Analysis Report for the family's address if there is a concern that there has been a lot of police contact.*

5. **Collects** all available written reports (such as police reports, medical evaluations, etc.) and **files** them in the case file. (Please refer to *OPP Chapter 19-8 Requesting a Police Report, Crime Lab Report*)

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a. In addition, record relevant information from these reports in the Investigation Narrative to use in evaluating the disposition of the referral.

6. **Reviews** all prior referrals/cases that involve any family members and alleged perpetrators that are listed on the current referral on CWS/CMS.
   a. Confirm the completion by the client of any previous case plans and/or other planned services that were proposed on prior referrals/cases on CWS/CMS.
      - If it is not possible to fully determine the parent's compliance with prior case plan or planned services on CWS/CMS, request the hard copy of prior referrals and cases be retrieved from storage and review them upon receipt.
      - Evaluate the pattern of compliance as a risk factor regarding the current allegations.
   b. Contact the current (open case) or previous social worker/social work supervisor assigned to the case to gather additional information regarding the family.

7. **Arranges** for a medical examination of the child, if necessary, ensuring parent consent or a court order. (Please refer to *OPP Chapter 15-2 Medical Consent*)

8. **Determines which services**, if any, would best assist the family and protect the children.
   a. Such services are provided or arranged as soon as possible, including voluntary placement, if appropriate and agreed to by the parent/guardian.
   b. Document your efforts to provide referrals and the family's response.

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Please refer to Pre-Placement Preventive Services: When and When Not to Provide Them in this chapter.

9. **Completes** the SDM Risk Assessment and **evaluates**, using the SDM Safety and Risk Assessments, particularly the items listed below, to determine the appropriate interventions necessary.

   See OPP Chapters 3-16: Structured Decision Making (SDM) Overview, 3-16.2 SDM Safety & SCP Safety Assessment and 3-16.3 SDM Risk Assessment for policy and procedures.

CONCLUDING REFERRAL INVESTIGATION

1. **Evaluates**, using the SDM Safety and Risk Assessments, particularly the items listed below, to determine the appropriate interventions necessary.
   a. There are any safety threats present that place the child in immediate danger of serious harm/maltreatment;
   b. There are any household strengths or protective actions present that could contribute to the creation of a safety plan;
   c. There are in-home protective interventions that can be initiated through a safety plan to help mitigate the safety threats and keep the child safe in the home, or whether placement is the only protective intervention possible; and

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d. The child is at a low, moderate, high, or very high risk of experiencing subsequent maltreatment within the next 18-24 months.
    - Please refer to SDM Safety and Risk Assessments section in this chapter

2. **Determines** whether a referral to Family Court is necessary (e.g., in cases where there are visitation or custody disputes or to update an existing Family Court document)
    a. Family Court tel: (408) 534-5600.

3. **Using** the information gleaned from the SDM Safety and Risk Assessments and social work skills, the SW to determine the level of intervention necessary
    a. Take no further action.
    b. Refer the family to community services, Differential Response Services (*OPP 2-6.1*) or for further non-court DFCS services (OPP 5-3 & *6-2*).
    c. Refer the family for Informal Supervision Services through DFCS. (*OPP 5-5*)
    d. Considers if the matter requires the filing of an Out-of-Custody petition (e.g., the child is currently safe in the home but may need juvenile court monitoring) and schedules a consultation with SSPMII.
    e. Take the child into temporary custody.
        - This is only considered after all reasonable efforts have been exhausted, parent(s) are unable to participate in safety plan, caretaker absence by both parents, no available relative or alternative caregiver and a DFCS staffing with County Counsel. Please see chapter on *Case Consultations* .

DOCUMENTING REFERRAL INVESTIGATION & CONCLUSION

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1. **Updates** referral information/AFCARS
    a. Corrects any demographic information missing or discovered to be incorrect during investigation in Client Notebooks within
    CWS/CMS, including addresses, ethnicity/race, language of family and collaterals, date of birth, spelling of names etc.
    b. Uses navigation tools (Toolz Man) in CWS/CMS to ensure necessary AFCARS information is entered.

    For more information, please refer to *CWS/CMS Referral Investigation and Disposition Training Guide*.

2. **Concludes** all allegations in CWS/CMS
    a. Adds any additional allegations which may have come out during course of investigation
    b. Updates or adds the names of perpetrators to allegations.
    c. Enters the allegation conclusion and adds abuse information in the allegations tab to select abuse sub-category.

    For more information, please refer to *CWS/CMS Referral Investigation and Disposition Training Guide*.

3. **Documents a**ll observations, statements and facts gathered during the investigation from all sources.

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a. Including documentation of all alternate explanations and theories regarding the allegations offered by all sources and the information gathered by the social worker that confirms or denies these explanations.
b. **Records** all referrals provided to the family for community services.

4. **Creates and/or updates** all information in the referral, as applicable, including Client Notebooks, to ensure that the most accurate information about the referral and clients is maintained in the CWS/CMS database.
    a. **Adds** allegations to the Allegation Notebook, as necessary, when new allegations are discovered.
    b. **Ensures** that the correct perpetrator (if any) and/or perpetrator type is listed and that the Occurrence Information is correct.
    c. On the Conclusion Page, update the Abuse Information data field.
    d. **Notifies** the social work supervisor of any Safety Alert information pertaining to any clients.
        - The social work supervisor has the authority to enter Safety Alert information in the Client Notebook page.

5. **Creates** Investigative Narrative in CWS/CMS, adds county template and documents investigation including, but not limited to:
    a. Allegation summary (copy and paste from Screener Narrative)
    b. Brief summary of prior CWS referral and case history.
        - Include notes regarding contact with the previous social worker/social work supervisor.

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- If unable to contact either the current or previous social worker/supervisor, document efforts to contact them.
- In the event that contact with the social worker/supervisor was not made, a thorough review of existing records must be made.

▪ Document the client's compliance or lack thereof with the recommendations of prior referrals or cases.

- Evaluate the pattern of compliance as a risk factor regarding the current allegations and documents this assessment.

c. The results of the criminal record checks on the Demographics Page of the Client's Notebook in the Arrests section and in the Investigation Narrative.

d. SDM Safety and Risk Assessment results and any Safety Plans established to mitigate safety threats.

▪ Follow-up CFT results to solidify Safety Plan.
Note: Referrals cannot be closed with existing Safety Plans in place. Interventions must address and resolve identified safety threats.
Please refer to *Investigation Narrative and Other Documentation* section in this chapter.

6. **Completes and submits** a report to the Department of Justice (DOJ), as required.

a. If the investigation conclusion is "substantiated," and if criteria/circumstances are met for physical, emotional, and sexual abuse allegations, send a child abuse investigation report to the *Department of Justice (DOJ) (OPP 13-2)*.

b. **Documents** DOJ submission information in CWS/CMS and retain a copy in the case file, as the parent has the right to file a

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grievance about the DOJ report.

7. **Sends** Response to Mandated Reporter (Emergency Response Notification of Referral Disposition (IN-MNRPTR [12/92]), as required.

8. **Closes** the referral in CWS/CMS, if the child is to remain home and/or receive voluntary services.

   a. If the child is removed from the home, the Dependency Investigations social worker concludes the allegations and closes the referral.

For more information, please refer to *CWS/CMS Referral Investigation and Disposition Training Guide*.

DFCS takes the matter of safety seriously and recognizes that the nature of child welfare work can place social workers at risk of physical and emotional violence, threats, and verbal abuse. When possible, all adequate precautions must be taken to ensure the health and safety of personnel who will respond to respond to a referral. To mitigate these safety risks, staff should review and become familiar with the procedures and recommendations outlined in *OPP 23-1: Social Worker Safety* and *OPP 20-1: Security and Incident Reporting*.

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REASONABLE ATTEMPTS TO LOCATE A FAMILY

The ER social worker makes all of the following efforts before closing a referral on the grounds that the family cannot be contacted:

- Attempts at least two (2) home visits on different days at different times of day, leaving a business card each time.
- Makes at least two (2) phone calls to the home (if the family has a phone).
- Makes at least two (2) phone calls or sends text messages to each parents' known telephone numbers.
- Calls the reporting party to ask for more information regarding the family's whereabouts.
- Calls known relatives of the child to ask for information about the family's whereabouts.
- If the child is of school age, attempt to locate the child at school.
- Calls the CalWORKs eligibility worker, if applicable, to verify the family's address.
- Writes and sends a letter to the family; two copies of the letter should be sent, one by regular first class mail and one by certified mail with a receipt requested.
- Contacts the local law enforcement of jurisdiction and follows up with a written cross report.

If the ER social worker cannot contact the family after all of these steps have been taken, the ER social worker **consults the social work supervisor to get approval to close the referral**. All referrals must be closed within 30 days from the first contact.

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Note: SDM Safety and Risk assessments must still be completed accordingly by the social worker for closed referrals. (Please refer to *OPP Chapters: 3-16.2- SDM Safety and Substitute Care Provider Safety Assessments* and *3-16.3- SDM Risk Assessment*

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INTERVIEWING CHILDREN

The Fourth and Fourteenth Amendments to the U.S. Constitution guarantee parents and children the right to be free from unwarranted government intrusion. Under the Fourteenth Amendment, parents have the fundamental right to care, custody, and control of their children. Children have the right to be free from unreasonable governmental seizures under the Fourth Amendment. Social workers must carefully balance their need to investigate allegations of suspected child abuse, neglect, and exploitation against parents' and children's constitutional rights.

Social workers may not enter a family's home for a child welfare interview without parental consent. DFCS believes the best practice is to obtain consent in writing (see SCZ9B), but the parent may provide verbal consent, which the social worker should document in their investigation narrative.

- If the parent refuses to consent, or where the social worker has evidence that requesting consent would pose a danger to the child's physical safety or result in undue influence of the child's interview, the social worker may instead request a court order to interview the child.

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The social worker must provide specific evidence that requesting parental consent would endanger the child's physical safety or influence the child's interview.

- If a social worker believes that exigency to interview exists (*i.e.*, the child will suffer serious physical harm in the time it would take to obtain a court order), the worker must consult with a supervisor before proceeding with an interview of a child.
- Parents should have notice of and an opportunity to attend the social worker's interview of their child. If the social worker has concerns supported by articulable facts that the parent's presence will influence the child's responses, then the social worker may interview the child while the parent observes or listens from nearby. If the social worker has concerns supported by articulable facts that the parent's presence threatens the child's physical safety, then the social worker should consult with their supervisor and manager for the best way to proceed. The supervisor or manager should consult with County Counsel for legal advice, where needed.

- The social worker must inform the child of their right to be interviewed in a public or private setting, must inform the child that they have the right to have an adult support person present, must inform the child that they can decline the interview without consequence, and must inform the child that they can begin the interview and end it at any time without consequence. The social should inform any adult present for the interview that they must abide by confidentiality requirements of Penal Code § 11167.5.
- If a visual inspection of physical injuries is necessary, please refer to OPP Chapter 2-3.X Investigating Allegations of Physical Injury for additional guidance.

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- If sexual abuse is alleged, the social worker should contact law enforcement immediately, or as soon as practically possible, to conduct a joint initial interview with the child and, if necessary, arrange for the child to have a forensic interview at the Children Advocacy Center (CAC).
    - Parental consent or a court order to conduct a Multi-Disciplinary Interview (MDI). This should be handled by law enforcement, who will transport the child to the CAC for interview.
    - If there is not parental consent or a court order for the SW to observe the MDI interview, the SW should consult their supervisors as they may not be able to participate or observe MDI.
    - A child over 12 years old can consent to an MDI and a medical evaluation.
- For further information, see *Multi-Disciplinary Interviews (MDI)*.
- If the first contact takes place at a medical facility, the social worker:
    - Uses normal investigation approaches and gathers information from medical personnel, including information about the child's special needs.

See OPP Chapter 13-3: Home Entry

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IF A PARENT REFUSES TO ALLOW THE SOCIAL WORKER CONTACT WITH A CHILD AT THE CHILD'S HOME

At the first contact, social workers usually arrive unannounced, identify themselves, and explain the purpose of the visit. The worker must request the for parent's permission to enter the home. If a parent refuses to allow the worker to enter the home, the social worker can request to speak to the child outside the home or at another neutral location, such as the DFCS office, park, or other setting.

Note: A social worker may not enter a family home to conduct a child welfare check without parental consent or exigent circumstances.

In some situations where the parent refuses to allow the social worker to have contact with a child, the social worker may:

- Seek a Court order to interview the child. (Please refer *to OPP Chapter 2-2.1 How to Obtain a Court Order to Interview a Child*.)
- With parental consent, arrange to see the child at school if the child is of school age.
- Determine, with supervisory approval, that the situation does not warrant police involvement or any further attempt at contact.

For more information, please refer to *OPP Chapter 13-3: Home Entry*.

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CHILDREN NOT PRESENT DURING THE INITIAL FACE-TO-FACE VISIT

It is DFCS policy that the social worker interviews ALL children in a family or living in the home in the course of an investigation, whether or not they were present during the initial face-to-face interview.

When a social worker determines it is inappropriate to see one or more children absent during the initial contact, the social worker must consult with a supervisor to discuss/confirm this determination. The social worker must document any decision not to interview children who were absent at the initial contact in the case record, indicating:

- The date of the discussion with the supervisor.
- The rationale for not seeing the children.
- Any other facts leading to the decision not to interview any other children.

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SOP & PRACTICE CONSIDERATIONS

While conducting investigations, Social Workers are to draw on the values, principles and tools of the Structured Decision Making (SDM), Safety Organized Practice (SOP) and Child and Family Practice

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Model (CFPM). Examples include solution focused inquiry, safety mapping, development of harm and danger statements and eliciting the family and child's voice through Child and Family Team (CFT) meetings, three questions and with children, the Three Houses tool. While some tools or interventions may be required, SW are encouraged to use other tools, practices and interventions as need to gather a complete understanding of the situation, as well as identify harm, danger, complicating factors and family strengths to support and guide decision making.

Please see *OPP Chapter 23-4 Safety Organized Practice* and *Safety Organized Practice (SOP)* section of DFCS Forms library.

The following table identifies SOP components for use during investigations and where to document their use and outcomes in CWS/CMS.

SOP/ CFPM/SDM Components	Where to Document in CWS/CMS
• Three Questions • Solution Focused Questions • Cultural Responsiveness • Appreciative Inquiry • SDM Safety and Risk Assessment tools • Harm and Danger statements • Safety Goals • Behavioral language in safety plans • • Obtaining the voice of the child (such as Three Houses or Safety House) • Identification of family networks and use of networks in safety planning	• Contacts • Safety Plans • Court Reports • Family Engagement Efforts with Case Plan • Investigation Narrative

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• Safety Mapping • Child and Family Team Meetings	

The following are some activities which can be utilized during the investigation to help engage the family:

- Review the demographic information on record (names, spelling, gender at birth and/or identification, school of attendance for children etc.). Gathering this information can help in building rapport with the family as you engage them in a discussion.
    - Obtain information regarding the family or individual's ethnicity and preferred language. (Please refer to OPP Chapters *2-4: Identifying the Client's Language Needs* and *19-2.1: Entering Race/Ethnciity in CWS/CMS*)
- Ask the family to tell you about their culture and what may be important for the SW to know about how their family functions and needs they may have.
- Develop a genogram of ecomap. These tools can be a strong engagement tool and may assist in identifying safety and support networks for the family, if needed.
- Ask the family to describe what happened that resulted in a referral. Ask follow-up questions to seek greater detail and clarity.
- Ask and encourage the family members to share their views of the concerns/needs, what has worked if/when these arose in the past and what interventions they think might assist in addressing these.
- Offer assistance to the family's expressed needs for concrete services (food, transportation, clothing, medical, shelter, etc.)

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WHO MUST BE INTERVIEWED

When an in-person investigation of a referral is conducted, the following people must be interviewed:

- All children alleged to be abused, neglected, or exploited.*
  - Face-to-face contact is required.
  - See the above sections, Law Enforcement In DFCS Investigations and Interviewing Children, for laws and protocols for interviewing a child.

- All siblings in the home who are listed as "sibling abuse*" and "at risk." Division 31 states:
  - If the allegations are unfounded, the children listed as victims in the referral must be interviewed, as well as one adult with information regarding concerns.
  - If the allegations cannot be ruled out as unfounded, all children and all caregivers must be interviewed for the household where there are allegations.

- All children that were present at the time of the initial investigation*.

* **Note**: Best practice is for the investigating social worker to interview any children included as an alleged victim in a referral privately, separately, and outside of the presence of the alleged perpetrator(s), including children who are dependents of the court and placed in out-of-home care. However, a parent does have the right to be present during the social worker's interview with the child, even if that parent is the alleged perpetrator.

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- The person who made the report (referent).

- Any person who could reasonably have information about the allegation(s) and the condition of the children.
    - At least one adult (could be a parent) who has information about the allegations must be interviewed.
- The suspect, if the suspect's whereabouts are known, and law enforcement has not requested that the suspect not be interviewed.
    - Suspect(s) must be informed of the complaints or allegations made against them.

- All parents or legal guardians who have regular access to the child(ren) alleged to be abused or neglected.
    - In certain situations, phone interviews suffice.

- Fathers and mothers of the alleged victim who do not reside in the home may need to be interviewed if they possess pertinent information regarding the allegation(s) and the situation in the child victim's home.

If the social worker is unable to contact these parties within 2-3 weeks, the social worker:

- Consults with their supervisor about efforts to date.
- Documents all efforts to make contact.

If children are out of state or live in a different household, gather as much information as possible about how to contact them (address and phone number) and why the children are not in the home.

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Please see *OPP Chapter 2-5: Interviewing Children at School* for guidance regarding interviewing children at school.

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YOUR RIGHTS PAMPHLET (PUB13) & INFORMATION FOR FAMILIES PAMPHLET (SCZ 182)

During the initial contact with the parents of a child who is the subject of an abuse or neglect referral, the social worker is to provide the parent(s) with a copy of the Your Rights (PUB 13) and the Information for Families Pamphlets.

The Your Rights: Under California Welfare Programs (PUB13) includes, but is not limited to, the following information:

- Clients have the right to have services provided in their preferred language (right to an interpreter free of charge) to ensure they understand the reason for our involvement and how they can receive assistance.
- Public agencies are prohibited from providing services that are different from those provided to others based on race, color, national origin (including language), ethnic group identification, age, disability, religion, sex, sexual orientation, political affiliation, and marital status or domestic partnership.

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- How clients can file discrimination complaints.

The Information For Families Pamphlet (SCZ182) provides parents, legal guardians, and other caregivers with information about the following:

- Why a social worker visited the family in response to a child abuse or neglect report.
- How to contact the social worker conducting the assessment and his or her supervisor.
- The Department of Family and Children's Services.
- Child abuse and neglect reporting.
- Family Resource Centers.
- The Social Services Agency website.
- The Ombudsman Program.

The pamphlet's purpose is to ensure that parents, legal guardians, or other caregivers of children have written general information about the Emergency Response investigation process, the DFCS, and the Ombudsman Program. During the initial contact with the parent, legal guardian, or other caregivers of the child, the Emergency Response Social Worker shall:

- Briefly explain the purpose and contents of the pamphlet.
- Provide a copy of the pamphlet to the parent, legal guardian, or other caregivers of the child.
    - In-person (preferred delivery method).
    - By mail (if necessary).

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Note: The Emergency Response investigation is confidential, and the social worker should ensure that the pamphlet goes directly to the parent, legal guardian, or another caregiver of the child; and that unauthorized third parties do not view the pamphlet and become aware of the assessment.

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REQUIRED DISCLOSURE TO THE INDIVIDUAL SUSPECT

Public Law 108-36, the "Child Abuse Prevention and Treatment Act," requires the ER social worker, upon first contact with the suspect, to inform the individual of the complaints or allegations made against them in a manner consistent with laws protecting the rights of the person who made the child abuse or neglect referral. Some key points about the requirements of the law include:

- First contact could be the first face-to-face contact with the suspect or a telephone conversation if that is the first time the social worker has talked to the suspect.

Note: Face-to-face contact with the suspect is required if the abuse or neglect allegations are substantiated.

- Immediate notification is given to the suspect in general terms. For example, the social worker may mention they are investigating a report of alleged physical abuse of a specific child; failure to adequately supervise a child; suspected sexual abuse; or other specified types of child maltreatment.

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- The law does not give specific information on how much detail the social worker must immediately provide to the suspect. The social worker shall be careful not to compromise the child abuse investigation or a concurrent criminal investigation that may lead to criminal charges against a perpetrator of serious child maltreatment. Specifically, in cases of sexual or serious physical abuse, the social worker must coordinate carefully with law enforcement to ensure that criminal investigations are not undermined.

- Unless the court orders disclosure, the social worker must protect the identity of child abuse and neglect reporters, regardless of whether that person was a mandated or non-mandated reporter.
    - Do not name reporters, or include information that suggests the identity of the reporter, within the Investigative Narrative.

See *OPP Chapter 13-2: Reporting to the Department of Justice (DOJ)*.

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ACTIVE DUTY MILITARY

Under Welfare and Intuitions code (WIC) §328.1, county child welfare departments investigating child abuse or neglect allegations against the parent or guardian shall determine, as soon as practicable, if the parent or guardian is an Active Duty member of the Armed Forces of the United States. Documenting the military status of the parents can be entered on the Demographics tab in the Client Notebook section in the Child Welfare Services CWS/CMS. If known, the branch of service (Army,

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Navy, Marine Corp, Air Force…etc.) can be entered in the comment box section. This data must be captured inside CWS/CMS to be reported to the Administration for Children and Families in the annual National Child Abuse and Neglect Data System (NCANDS) report. Aside from this additional requirement, the Emergency Response Procedures outlined in this chapter shall be followed for allegations against an active-duty parent or guardian.

Note: Children of members of the Inactive Reserves, Inactive California Military Department, or retired military members are not included in this group. The Family Advocacy Program (FAP) is an advocacy program under the Department of Defense (DoD) designated to address domestic abuse; child abuse and neglect; and problematic sexual behavior in children and youth. The FAP services are available at every military installation where families are located. Santa Clara County does not currently have an MOU in place with FAPs. However, this does not necessarily preclude DFCS from working with installation FAPs. In the absence of a formalized working agreement/MOU, DFCS staff must maintain the confidentiality of privileged client information. When there is potential FAP involvement, staff should confer with management to obtain the most current best practices/procedures.

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ICWA INQUIRY FOR EMERGENCY RESPONSE REFERRALS

During the Emergency Response investigation, it is crucial to conduct a meaningful investigation into the applicability of the Indian Child Welfare Act (ICWA). The Emergency Response Social Worker is often the initial point of contact with the family. Therefore, they may interact with family members and others whom DFCS may not be able to contact or locate later on. California Law requires DFCS to

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ask the following individuals about the family or child's sulture including Native American or Alaskan heritage:

- Reporting Party (*initially completed by the CANC Social worker, if the reporting party has information regarding the family or child's culture*),
- Child(ren)
- Parents/legal guardians including stepparents
- grandparents,
- aunt and/or uncles,
- nieces and/or nephews,
- First cousins, second cousins
- Non-related extended family members, and other known interested parties (e.g. godparents) for cases that come to the attention of the Juvenile Court**.**

The Emergency Response Social Worker **must** make an ICWA inquiry of any of the above parties they encounter during the investigation and document their responses in the Investigative Narrative. The following questions **must** be used as a basis for the inquiry of each individual:

1. Does the child or parent have Native American ancestry? Yes: ☐ No: ☐

   a) Can you identify a tribe?

   b) If they cannot identify a tribe, ask: What state is the tribal ancestry from?

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2. Do you have any information that the child or either parent is an enrolled member of a tribe or eligible for enrollment?

   Yes: ☐ No: ☐

3. Does the child or a parent live on a reservation? Yes: ☐ No: ☐
4. Has the child ever been a ward of a tribal court? Yes: ☐ No: ☐
5. Does either parent or the child possess an ID card indicating membership or citizenship in a tribe? Yes: ☐ No: ☐
6. Who in you family knows the most about the family's history and how can I contact them?

- If the answer is **"no"** to questions one through five**, there is <u>no</u> "reason to believe"** that the child is Native American and the Emergency Response Social Worker only documents the ICWA Inquiry.
- If the answer to question 1 is "yes" and all other questions have a "no" response, the Emergency Response Social Worker only documents the ICWA inquiry.
- If any of the questions 2-5 receive a "**yes**" response, then the Emergency Response Social Worker should immediately contact the identified tribe (via telephone, fax, or email) to confirm tribal membership. If the tribe confirms membership, provide the tribe with the following:
    - The current status of the child and the referral investigation details. Share all Information gathered during the investigation, including safety and risk assessments (SDM), the Screener Narrative, and case notes. **Do not share the reporting party and any criminal background checks.** This allows for collaborative investigative efforts, decision-making for emergency removals, and placements.

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    - Inform the tribe of any unresolved safety-related concerns regarding the child and request the tribe participate in further investigative efforts, Child Family Team (CFT) meetings, and/or safety planning.
    - Inquire if the tribe could offer culturally appropriate resources that could mitigate these concerns.
- If there are no safety concerns and the tribe agrees, the referral may be closed.
- If there is a request by a parent for **Voluntary Family Reunification Services,** formal notice of the tribe is **required. Please contact County Counsel.**

Response	Outcome & Noticing Required	Continued Efforts
No to questions 1 through 5	**NO "reason to believe"** – No noticing requirements	No further efforts
Yes to questions 1 No to others	**Reason to believe** – the social worker must notify the respective tribes using the Informal noticing process. This applies only in a matter that requires Court Involvement. This notice is completed by the Dependency Investigations Social Worker.	No Further efforts other than the Emergency Response Social Worker documenting the family's Native American Ancestry in the Investigative Narrative and in CWS.
Yes to any questions 2 through 5	**Reason to know** formal noticing (**reason to know**)	The Emergency Response Social Worker must contact the Tribe

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	process is required. This applies only in a matter that requires Court Involvement. This notice is completed by the Dependency Investigations Social Worker.	if there is a safety concern, involve the Tribe in Child Family Team Meetings, safety planning, provide the Screener Narrative, and inquire about resources that the Tribe could provide for the family.

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GLOBAL ASSESSMENT IN REFERRAL INVESTIGATIONS

In addition to the specific requirements of Division 31 regulations regarding emergency response investigations, DFCS requires that all investigations include an assessment of the following risk areas:

- Substance abuse
- Domestic violence
- Physical abuse
- Mental illness
- Sexual abuse
- Commercialized Sexual Exploitation of Children (CSEC)
- Neglect
- Emotional abuse

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- Caretaker absence

The social worker should discuss any exceptions to this policy with a supervisor and must receive supervisory approval to exclude any assessment area(s).

Note: The social worker must document the assessment of the above risk areas in the CWS/CMS Contact and the Investigative Narrative.

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SDM SAFETY AND RISK ASSESSMENTS

ER social worker completes the SDM Safety and Risk Assessments to document the worker's essment process.

OPP Chapters: 3-16: Structured Decision Making (SDM) Overview, 3-16.2 SDM Safety & SCP Safety essment and 3-16.3 SDM Risk Assessment.

ETY ASSESSMENT

ety Assessment must be completed:

- On all referrals,
- After the initial face-to-face contact with all child victims, and
- Prior to leaving a child in the home or returning a child to the home during the investigation.

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- In WebSDM, within 48 hours of the first contact with the child victim.

RISK ASSESSMENT

Risk Assessment must be completed:

- On all substantiated and inconclusive referrals, OR
- Any unfounded referrals when considering a referral for Differential Response Diversion Services, OR
- On any new referral received on a current open case.
- After the Safety Assessment has been completed and the worker has reached a conclusion regarding the allegation and
- Prior to the decision to promote a case or close without continuing services.
- In WebSDM, within 30 days from the first face-to-face contact.

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ASSESSMENT OUTCOMES DEFINED: SUBSTANTIATED, INCONCLUSIVE, OR UNFOUNDED

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The social worker completes the SDM Safety Assessment as a tool for gathering information about existing safety threats. Based on information collected during the investigation process, the social worker determines whether the allegation(s) are substantiated, inconclusive, or unfounded. (Penal Code 11165.1 and 11165.12). After the investigation, the SDM Risk Assessment is completed. The SDM Safety and Risk Assessment Tools results should help guide the social worker's decision to promote the referral to a case or close the referral without services.

The possible outcomes are defined with corresponding actions below.

Outcome	Definition	Action
Substantiated	There is evidence that makes it more likely than not that child abuse, neglect, or exploitation, as defined, occurred.	• If there is physical evidence of abuse or if the child discloses allegations of sexual abuse to the social worker, immediately contact the law enforcement jurisdiction in which the abuse occurred. • See the above section, Law Enforcement Involvement in DFCS Investigations for laws and protocols for interviewing a child. • Provide services and/or take the child into custody and/or close the referral.

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		○ If there is a pending MDI, the social worker shall keep the referral open until the MDI occurs. • Document services offered and the family's willingness to follow up; let the family know that police could become involved. • Develop a safety plan for the child, and hold CFT afterward. • *Report to the Department of Justice* (DOJ) if guidelines are met.
Inconclusive	Not unfounded, but findings are there is insufficient evidence to determine whether abuse, neglect, or exploitation occurred.	• Provide services and/or close the referral. • Document the warning signs of abuse, even if these were not substantiated.
Unfounded	A referral is deemed false, inherently improbable, the result of an accidental injury, or a situation that does not constitute child abuse.	• Close referral and document rationale. • Offer services or referrals to services, if appropriate.

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TIMELINES FOR RECORDING CONTACTS IN CWS/CMS

All mandatory or required contacts in an Emergency Response Investigation, both attempted and completed, shall be entered into CWS/CMS as follows:

- Immediate Response or Joint Response referral documentation must be completed in CWS/CMS within 24 hours of the contact.
- 10-day Referral documentation in CWS/CMS must be completed by the end of the 10th day. Any subsequent contacts containing pertinent information regarding the investigation must be entered within 24 hours of the contact.

Note: The timeline for 10-day referrals begins on the day the referral call is received by the CANC, not the date the Emergency Response Social worker is assigned the referral.

For more information please, refer to *OPP Chapter 10-1 Contact Requirements*.

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PRE-PLACEMENT PREVENTIVE SERVICES: WHEN AND WHEN NOT TO PROVIDE THEM

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Per WIC § 306(b), a social worker shall consider pre-placement preventive services to a child and a family in order to eliminate the need to remove the child from the home. An exception to this occurs when the social worker determines that the child cannot safely remain at home, even with the provision of reasonable services. In that case, the child is placed into temporary custody without the provision of pre-placement preventive services.

Pre-placement preventive services may include but are not limited to the following:

- Case Management
- Safety planning and CFTs
- Counseling
- Crisis Intervention
- Emergency Shelter Care
- Parent Training
- Referrals to Community Resources
- Referrals for Public Assistance
- Respite Care
- Temporary/Emergency In-Home Caregiver services
- Teaching/Demonstrating Homemaker services
- Transportation

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- Determining whether a non-offending caretaker can provide for and protect the child from abuse and neglect. (WIC § 306(b)(3))
- Flex Funds or other financial resources available by DFCS.

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TEMPORARY CUSTODY

See *OPP Chapter 2-7: Taking a Child into Temporary Custody*.

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INVESTIGATION NARRATIVE AND OTHER DOCUMENTATION

Details of the investigation are documented in the CWS/CMS Investigation Narrative and CWS/CMS Contact entries.

To document the referral assessment, the social worker follows the guidelines for writing an Investigation Narrative. The documentation should be sufficient to provide any reader with a clear understanding of how the referral disposition was reached.

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Required or mandatory contacts with identified child victims, other children in the home, and the parent/legal guardian in Emergency Response Investigations must be entered as follows in CWS/CMS:

- Delivered service type: "Investigate Referral"
- Communication Method: "in-person"
- Referral status: "Attempted" or "Completed"
- Participant names: should include the names of the children or parent/legal guardian with whom the completed or attempted contact was made.

Additionally, explicitly include in the CWS/CMS Contact narrative the parent's consent for the social worker to:

- Enter the family home
- Interview the child alone
- Obtain any records
- Physically examine the child
- Have the child undergo an evidentiary medical examination

The social worker must document that consent was given, including what the social worker stated and the parent's or responsible adult's response, and if the consent was actual (verbal) or implied. When implied, document the gesture and include actions the worker took to confirm the consent. See *OPP Chapter 13-3: Home Entry*.

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CASE CONSULTATION & SUPERVISION

Given the safety issues, the magnitude of the decisions, and the short timelines within Emergency Response, regular communication/consultation between the social worker and their supervisor are essential to the process, as outlined below. If the assigned ER social worker and their supervisor do not agree on case decisions or direction, it is expected that they engage in discussion in an effort to come to a resolution. Consultation and discussion with the Division Manager should be the next step if a solution cannot be reached.

SOCIAL WORKERS

Social Workers are expected to communicate regularly with their supervisor on every referral, providing information regarding the following:

- Any safety issues that arise while the social worker is in the field.
- A brief summary of investigation and assessment, including if it appears:
    - The child may need to be detained, or a warrant may be sought, **OR**
    - Allegations can be addressed by the development of a Safety Plan
        - Must provide an outline of specific safety threats and associate actions to remedy or address these threats, which are detailed in the completed SCZ184-DFCS Safety Plan. (SCZ184-Spanish or SCZ184 Vietnamese)

          Note: Verbal approval of the supervisor must be secured for Safety Plans, followed by the supervisor's signature on the completed SCZ184 - DFCS Safety Plan for case records. (SCZ184-Spanish or SCZ184 Vietnamese)

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SOCIAL WORK SUPERVISORS

Social Work Supervisors must be available for consultation with the investigating social worker to:

- Address safety concerns and any other questions from the social worker in the field.
- Determine whether exigent circumstances exist or whether a warrant is necessary.
- Make the final determination to detain a child.
- Review and approve all potential Safety Plans, ensuring all safety threats are mitigated.
    - Sign all created Safety Plans to document approval.
- Review the referral, allegations, and completed documentation in the Emergency Response Referral to ensure CWS/CMS contains the following:
    - Complete and accurate information.
    - Allegations that match the information documented in the SDM tools.
    - Investigation notes reflect the completion of a global assessment.
- Review and approve the SDM Safety Assessment or the SCP Safety Assessment for every investigation completed within the mandated timeframes.
- Review and approve SDM overrides when appropriate.

Note: If a resolution cannot be reached, consultation and discussion with the Division Manager should be the next step.

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REFERRALS OPEN LONGER THAN 29 DAYS

If a referral is still open on the 30th day after the initial face-to-face contact with the child and it has been assessed that no further services are required, the social worker shall immediately close the referral.

When a child and family require services for more than 29 days after the initial face-to-face contact with the child, the ER social worker:

- Opens a *Non-Court Family Maintenance* case for the family and develops a case plan. (CDSS Div. 31 - 215 regulations)
- Will have had three (3) contacts with the child per Division 31 regulations.
- Will have had a Child Family Team Meeting (CFT)

Note: Under no circumstances is a referral to be kept open more than 29 days after the date of the initial face-to-face contact with the child.

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REFERENCE

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OTHER REFERENCES

- OPP Chapter 2-2: Joint Response (JR): DFCS and Law Enforcement
- OPP Chapter 2-2.1: How to Obtain a Court Order to Interview a Child
- OPP Chapter 2-3.3: Investigating Allegations of Physical Injury
- OPP Chapter 2-5: Interviewing Children at School
- OPP Chapter 2-7: Taking a Child into Temporary Custody
- OPP Chapter 3-16: Structured Decision Making (SDM) Overview
- OPP Chapter 3-16.2: SDM Safety & SCP Safety Assessment
- OPP Chapter 3-16.3: SDM Risk Assessment
- OPP Chapter 13-2: Reporting to the Department of Justice (DOJ)
- OPP Chapter 13-3: Home Entry
- OPP Chapter 13-4: Multi-Disciplinary Interviews (MDI)
- CWS/CMS Training Guide: Investigation Narrative
- CWS/CMS Training Guide: Contact

LEGAL BASIS

- Greene v. Camreta
- Calabretta v. Floyd (8/26/99, 9th , Cir., Yolo) 189 F.3 rd 808
- Doe v. Lebbos (11/4/03, 9 th Cir.) 348 F3d. 820
- Wallis v. Spencer (9/14/99, 9 th Cir., San Diego) 202 F.3d 1126
- Public Law 108-36, the Child Abuse Prevention and Treatment Act
- Penal Code (PC) § 11165.1 and 11165.12

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- Welfare and Institutions Code (WIC) § 306(b)
- California Department of Social Services (CDSS) Manual of Policies and Procedures (MPP) Div. 31-125
- All County Letter (ACL) No. 21-53: Senate Bill (SB) 907: Child Abuse Or Neglect Investigations Involving Military Families

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Attachment B – OPP Chapter: Notifying Hospital Staff of Placing a Child Into Protective Custody

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2-7.1 Notifying Hospital Staff of Placing a Child in Temporary Custody

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Effective Date: 06/27/2007

Last Updated: 08/22/2022

Non CWS/CMS Forms:

- Notification of Temporary Custody for Child in Hospital (SC155A)
- Notification of Change in Temporary Custody/Visitation for

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Child in Hospital (SC155B)

CWS/CMS Forms:

- Service Management Section: Contact Notes

POLICY

On occasion, hospital staff may make child abuse and neglect referrals when hospitals treat children. Sometimes, the allegation may be associated with the reason medical treatment was needed. For example, toxicology screens on newborns may be positive for illegal drugs or the child may have suffered fractures that are a result of physical abuse. When the child must remain at the hospital and there is suspected child abuse or neglect, an assessment must be made of the safety and risk factors surrounding the family's and the child's circumstances. If a child is determined to need placement in temporary custody for his or her safety, DFCS must give the hospital staff written notice of the custody action.

Written notice is given to hospital staff regarding temporary custody of a child who has been admitted when:

- The medical condition of the child is due to the conduct of parents, guardians or other caretakers who have custody and control of the child.

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- There is an immediate danger that the parent may remove the child or infant from the hospital.

DESK GUIDE

WHICH HOSPITALS APPLY

There is currently an agreement between DFCS and Valley Medical Center. Social workers may present the form to other area hospital staff with an explanation of its purpose. However, there has been no agreement reached with any other hospital regarding the use of the form.

DFCS/HOSPITAL PROTOCOL FOR NOTIFICATION OF TEMPORARY CUSTODY

After conducting a comprehensive assessment including the following:

- Clinical assessment based upon interview with the parents, child(ren), if appropriate, and any collateral and
- Completion of SDM Safety Assessment, and
- Consultation with his/her social work supervisor,

If the social worker determines that a child who has been admitted to a hospital is in need of being placed in temporary custody, the DFCS social worker:

1. Verbally states to the charge nurse and/or medical social worker and/or attending physician,

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that the social worker is placing the child into temporary custody.

2. Completes a Notification of Temporary Custody for Child in Hospital form.
    - One form must be completed for each child.
3. Requests appropriate hospital staff to put the original (color) form immediately into the child's medical chart.
    - Observe this activity and document it in a Contact Note.
4. Takes copy of SC 155a for case file.
    - Request hospital staff to make a copy of the Notification of Temporary Custody for Child in Hospital, if not completed on NCR paper.

For instances when the child is a safely surrendered baby please refer to OPP 3-10 Safely Surrendered Baby Protocol for additional requirements.

If...	**Then...**
Temporary custody occurs during day shift or swing shift (7 a.m. -9 p.m.)	• Alert the Placement Unit via the Placement Unit OD line (408)501-6868 of the temporary custody situation so that the Placement Unit staff can initiate placement activity. • Alert the CANC staff of temporary custody situation to provide verification of temporary custody to authorities.

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Temporary custody occurs during After Hours (9 p.m. - 7 a.m.)	Alert the After Hours Supervisor of temporary custody situation so that the coordinator can: • Provide back-up verification of temporary custody to authorities.

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DI SOCIAL WORKER'S RESPONSIBILITIES

Once assigned to Dependent Intake (DI), if the child remains in the hospital, the DFCS social worker:

- Maintains communication with the charge nurse of the hospital unit where the child is located.
- Notifies the hospital of changes in visitation parameters.

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HOW LONG DOES THE NOTICE STAY IN EFFECT

Notification of Temporary Custody remains in effect until:

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- The Initial Hearing, or
- The child is moved from the hospital to an out-of-home placement, or
- The hospital staff is notified of a change in custody prior to the Initial Hearing.
    - Social workers use the form Notification of Change in Protective Custody/Visitation for Child in Hospital (SC155b) to notify hospital staff of changes in custody or visitation.

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CHANGE OF CUSTODY STATUS OR VISITATION AUTHORIZATION

DFCS social workers notify hospital staff of changes in the child's temporary custody status or visitation authorization by:

- Faxing or hand-delivering to the charge nurse, the updated Notification of Change in Temporary Custody/Visitation for Child in Hospital with a copy of the original Notification of Temporary Custody of Child in Hospital attached.
- Calling the charge nurse to confirm receipt of the form.
    - The charge nurse puts the form immediately into the child's medical chart.
- Documenting in a Contact Note confirmation that the form was received.

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OTHER REFERENCES

- OPP Chapter 2-3: Conducting an Emergency Response Assessment
- OPP Chapter 13-10 Safely Surrendered Baby Protocol

LEGAL BASIS

- Welfare and Institutions Code § 306, 309, 319

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Attachment C – DFCS Interim Guidance provided on November 15, 2023

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County of Santa Clara
Social Services Agency
Department of Family & Children's Services

373 West Julian Street
San Jose, California 95110-2335

Date: November 15, 2023

To: DFCS Staff

From: Damion Wright, DFCS Director

Subject: Interim Direction

As we are in a very difficult time, the mission of DFCS is what I continue to focus on in guiding our next steps, and our work with all DFCS staff and our partners, ***to keep children safe and families strong by partnering with communities***.

Also, as we look at this complex and difficult work, there needs to be an understanding of where we currently are as a Department to identify our best practices in ensuring children are protected, and staff are supported.

In that, we need to have a clear approach to this work that must include:

- Determining the right support and intervention for the family from the beginning;
- Engaging families and communities to be part of safe solutions for children;
- Putting our eyes on and arms around vulnerable families in partnership with communities; and
- Establishing a safety culture through continuous quality improvement.

Our strategic focus areas have to be centered around safeguarding children, workforce support and development, race equity and leadership, and key partnerships.

As such, the department will be engaging in multiple clarification efforts to support collaborative decision making and to outline guidance. This is to ensure additional clarity and support is provided to our social workers, supervisors, and managers who are doing this complicated work. This is also ensuring that we are drilling down deeply into these critical decision making points with an overarching lens to ensure the immediate and ongoing safety of children.

In addition, there are children and youth that have higher risk factors because of their need and or vulnerability which are children 0 - 5 years and our older youth with complex needs; so, in making clear connective decisions around what we have learned, there will be some specific refinement in our work with "vulnerable children".

Lastly, we will continue to review all current practices, policies, and procedures including utilizing case reviews, data, and other information that can help drive our best decision making.

Please see the attached interim direction established around Safety Protocols here: Safety Protocol and Policy Update: Substance Exposed Newborns here: Policy - Drug Exposed Infants which will be reviewed after 60 days to determine whether any additional refinements are needed.

This interim direction, issued today, is effective immediately.

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11/15/23

Safety Protocols

SDM Safety Assessment Completion

Please continue to adhere to 3-16.2 SDM Safety and Substitute Care Provider Safety Assessments.

In reviewing **Safety Threats**, please ensure all safety threats in relation to referral allegations and investigation are reviewed, including but not limited to:

- #9: Current Circumstances, combined with information that the caregiver has or may have previously maltreated a child in his/ her care, suggest that the child's safety may be of immediate concern based on the severity of the previous maltreatment or the caregiver's response to the previous incident.
    - There must be both current, immediate threats to child safety AND related previous maltreatment that was severe and/or represents an unresolved pattern of maltreatment.
- #10: Other
    - Circumstances or conditions that pose an immediate threat of serious harm to a child, which are not already described in safety threats 1-9.
- All Safety Threats should be reviewed in relation to **Caregiver Complicating Behaviors**

DFCS Level of Intervention Determination

Please continue to adhere to 3-16.2 SDM Safety and Substitute Care Provider Safety Assessments in determining DFCS level of intervention.

Please continue to adhere to the SDM Safety Assessment Tool in accordance with the below-mentioned SDM policy and procedures:

- SECTION 4: PLACEMENT INTERVENTIONS
    - This section is only completed when, after considering complicating behaviors that may impact safety planning, household strengths and protective actions, the vulnerability of the child, and the in-home safety interventions that are available, the worker determines that placement is the only intervention for protection of the child.
    - If one or more safety threats are identified and the worker determines that in-home interventions are unavailable, insufficient, or may not be used, the final option is to indicate that the child will be placed by selecting placement interventions 10 or 11.

If Intervention #10 or #11 are indicated, the Social Worker, Supervisor, and Division Manager are to do the following:

- Discuss the case to confirm any necessary action; this is as guided by the SDM Safety Tool, Risk Assessment tool, and their clinical assessment.
- Division Manager is to discuss with County Counsel any legal parameters concerning the matter
    - This discussion will include only the Division Manager (and/or higher level manager or Executive Team). This meeting is for the purpose of legal consultation and is not case consultation.
- Division Manager will check in with Bureau Manager (or Assistant Director, if Bureau Manager unavailable) to determine DFCS' position in assessing for any Court intervention needed. This will take into account any legal parameters resulting from the Division Manager's legal consultation.
    - If DFCS' recommended direction is not in line with legal advice from County Counsel, a member of the Executive Team (Director or Assistant Directors) must be involved in the final decision
    - If an Assistant Director makes final decision not in line with County Counsel advisement, DFCS Director is to be notified at the time the decision is made.
    - Ultimate decision-making authority for all decisions related to child safety and placement is exclusively held by DFCS. County Counsel's role is to provide legal advice when requested to support compliance with legal requirements.
- After the final placement intervention decision is made:

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- Division Manager is to circle back to the DFCS Social Worker and Supervisor providing the decision and direction via email; the subject line shall read "DFCS Intervention Determination"
- Supervisor is to immediately document this decision and direction in CWS/ CMS as an Activity Note, including the name of the Division Manager, Bureau Manger, and Executive Team member consulted in reaching the decision; the first line of this Activity Note shall read "DFCS Intervention Determination", including the following:
  - The Safety Assessment guidance including but not limited to:
    - Safe ***or*** Safety Threat AND Safety Plan or Inability to Safe Plan, and if so,
    - Placement Intervention
  - the Risk Assessment details including but not limited to:
    - Final Risk Level
    - Recommended Decision
    - Planned Action
    - Any Supplemental Risk Items
- Division Manager is to work with County Counsel, if Court intervention is determined, and support the Social Worker and Supervisor, as needed.

Note: There will be a subsequent visual provided for this process.

Sibling Protocol

DFCS local policy is to generate a referral for any new child born to a parent within a DFCS case, both Voluntary or Court.

The referral will be generated based on safety/ risk concerns of siblings' open case as indicated in most recent completed SDM tool(s), and **Factors Influencing Child Vulnerability** (i.e. age is 0- 5) of the newly born child.

The referral determination shall ***not*** be overridden to be evaluated out, and will require an in-person investigation to determine support and or level of intervention for the newly born child in relation to the current open case.

The CANC Screener **reports** the incident, as follows, by sending a copy of the Screener Narrative via email to the following:

- DFCS Sr. Leadership Team
- Assigned Case Social Worker and his/her supervisor
- Social worker assigned to referral and his/her supervisor
- Supervisor of CANC Screening Social Worker who received the referral

A Case Consultation is required for any newly born children to parents in open DFCS cases; this case consultation must include the primary Social Worker and their Supervisor/ Manager as well as the Emergency Response Social Worker and their Supervisor/ Manager.

All cases that result in a different intervention determination than that of the current case status of other children in the home, will require Bureau Manager approval (i.e. parents in Court Family Reunification/ Maintenance and if another child/children is recommended to be in a Voluntary Family Maintenance).

All other elements of OPP Chapter 13-9 Sibling Protocol will be followed.

Pos Tox Children

Please see accompanying policy document "Policy Update: Substance-Exposed Newborns"

High Risk or Very High-Risk Referrals

If the Safety Assessment tool is Safe with a Plan, the referral is determined High Risk/ Very High-Risk involving children that are 0 – 5, non-verbal, and/or special needs, and the referral is substantiated, the social worker will be required to file an Out of Custody Petition, as there is an identified Safety Threat along with a substantiated allegation of abuse/ neglect.

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These cases will be considered as cases needing higher levels of intervention through Court and heightened DFCS monitoring in lieu of a Voluntary Family Maintenance Case.

In alignment with 3-16.4 Safety Planning, there should be a safety plan that matches the needs of the family including in-home visits, use of mandated reporters (i.e. PHN, mental health providers, etc.), providing in-home support or regularly viewing the child, and integration of others from safety network, as appropriate. As these are High Risk/ Very High-Risk cases, the minimum number of in-home visits as outlined in the safety plan/ case plan by the above-mentioned persons should ensure ongoing safety of a child in respect to their vulnerability.

DFCS local policy will be to not override any determination of “Promote” to a case for High Risk/ Very High-Risk cases where the referral is substantiated/ inconclusive for children that are 0 – 5, non-verbal and or special needs; the only exception to this policy will be as approved by a member of the Executive Team.

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11/15/2023

Policy Update: Substance-Exposed Newborns

Background

The type of response to a report of child abuse or neglect begins with an assessment of the child and family. The assessment must consider three factors and examine the interplay among those factors. The three factors are 1) imminent safety 2) future risk, and 3) current protective capacity. Both challenges and strengths must be identified in determining whether intervention by the Department of Family and Children's Services is necessary.

Update to Policy

The purpose of this memo is to provide further clarity and direction on the interplay between DFCS Online Policies and Procedures (Section 1-8) and the Structured Decision Making (SDM) tool when determining the response to allegation of substance abuse exposed newborns to determine risk posed to the child's safety.

Updated Procedures

DFCS local policy is ***all*** reports involving substance-exposed newborns shall be generated as referrals. This will be based on the SDM Hotline Tool as **Factors Influencing Child Vulnerability** section will have "Age 0 – 5 years" checked, and **SECTION 1A: CAREGIVER COMPLICATING BEHAVIORS** will have "substance abuse" checked as well.

Response Determination

Appropriate determinations will be made based on a child's discharge date:

- When there is an immediate discharge (i.e. child is to be discharged within 2 hours of the report being received by CANC), the referral will be determined as an Immediate Response with a required 2-hour response
- For any other discharge date, the referral will be determined an Immediate Response (within 24 hours)

The CANC screener will indicate the most up-to-date discharge date on the Screener Narrative.

Responsibilities of the Primary Emergency Response (ER) Social Worker
Throughout the time of the referral, the ER social worker will do the following:

- Keep the referral open for the maximum allowance of 29 days (**OPP 2-3 Conducting an Emergency Response Assessment/ Referrals Open Longer Than 29 Days)** to support monitoring caregiver acts of protection, if not opening a case
- Communicate with all providers including safety network regularly and document any contacts in CWS/ CMS within 24 hours
- Ensure the child is visited in the home at least weekly for the time period the referral is open, ensuring caregiver's involvement in services and ongoing safety of child; this will include assessing provisions, assessing caregiver's parenting ability, etc.
    - The weekly visits can be done by the primary ER social worker, social worker I, and or PHN
    - The primary ER social worker must visit the child at least twice, in-home, including an in-home visit, no more than three days prior to closure
- Communicate the importance of **safe sleep** with an newborn, and to assess the sleeping arrangements of the child

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- Social worker must engage and document engagement with the attending medical professionals, presumably those involved in the child abuse and neglect call or completing needs assessment of the family, medical specialist and or the medical team providing or overseeing care of the child.
    - The initial meeting should be centered around discharge planning, and a subsequent meeting prior to closure of the referral.
    - These meetings can be accomplished through a Child and Family Team (CFT) meeting.

The purpose of this engagement will be to ensure the family or caregiver is receiving the treatment and appropriate services required by the plan and the infant is safe and receiving appropriate care.

A clear plan of ongoing care of the child must be completed and evidenced within the case file, and a Supervisor/ Division Manager must review the plan

If the SDM guidance is Safe with a Plan, the plan must include coordination with the medical professionals supporting the child and family, along with regular, well-child checks.

If the SDM decision is to “Promote”, this determination will be ***unable*** to be overridden to “Do not promote” to a case.

As these vulnerable children require a higher level of support to the family to ensure there is ongoing safety, there will be a need for confirmation of a clear safety network in place, regularly seeing the child, and or there must be a higher level of DFCS intervention.

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Attachment D – OPP Chapter: Assessment Guide – Substance Use Disorders

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3-7 Assessment Guide: Substance Use Disorders

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Effective Date: 07/01/2019

Last Updated: 07/12/2023

Non CWS/CMS Forms:

- Drug Testing Authorization Request (SCZ 65)
- SCZ 414z Parent Education Referral (Spanish) (Vietnamese)

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Policy

The effect of Substance Use Disorders (SUDs) on families and its impact on children's safety and well-being is a common reason why families are referred to the child welfare system, even if it may not be the initial reason why a family was referred. Major areas of concerns include infants that are exposed to substances, and the abuse and/or neglect that a child could suffer from their parents/legal guardians' use of substances. Furthermore, according to the Children's Bureau (2020), substance use has a significant negative impact on the length of time that families reunify and children who were removed due to parental substance use are less likely to reunify and more likely to have future reports of abuse and neglect. Social workers (SWs) and the Child and Family Team (CFT) can be a key component of a parent/legal guardian's support team while they are recovering from a SUD by referring to the appropriate treatment services, encouraging parent/legal guardian participation, and supporting them through their path to recovery and to create a safe environment for their children while in their care.

DESK GUIDE

Effects of Substances on Parenting

Substance use from a parent/legal guardian is not cause to remove a child from care in itself, and the social worker (SW) must conduct a thorough assessment of the family to determine whether alcohol/drug use is impairing a parent/legal guardian's judgment and ability to care for the wellbeing and safety of the child.

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Substance use can negatively affect the way in which parents/legal guardians interact and care for their child(ren). Parents who have a SUD may have the following characteristics that could increase the risk of maltreatment:

- Difficulty regulating their own emotions and aggression
- Difficulty assessing and attending to their children's emotions and basic needs
- Diminished or unrealistic knowledge of parenting and child development
- Preoccupation with drug seeking
- Deriving less pleasure in the role as a parent
- Difficulties monitoring and supervising their child(ren)
- Lower levels of parental involvement, especially during incarceration or institutionalization

The National Institute on Drug Abuse have created a chart (see full chart here) to categorize how different substances can affect parenting. Below are some of the major substances and their general effects and effects on parenting. The full chart contains other drugs that may not be listed below. It is important to remember that not all individuals have the same effect on their parenting ability; however, it is still beneficial to understand how the consumption of different substances may affect parenting ability generally.

The Effects of Substances on Behavior and Parenting		
Substance	General Effects	Parenting Effects
Alcohol	• Lower inhibitions, often can lead to inappropriate	• May forget or neglect to attend to parenting responsibilities

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	or risky behaviors • Impairs judgment • Diminishes motor coordination	• A parent/legal guardian may stay out all night and leave the child(ren) alone due to intoxication • The parent/legal guardian may have rages and depressive episodes, which create an unstable home environment for the child(ren)
Cocaine	• Influx of energy and heightens senses • Increases irritability and aggression after prolonged use • Can result in psychotic distortions of thought where the user imagines or acts on projections to others	• A child's crying may be magnified in its intensity to a parent/legal guardian who is on cocaine • The parent/legal guardian may become angry or impatient with the child(ren) for any reason because of thought distortion and misperception

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Crack/Crack Cocaine	• This form rapidly cycles through the body so that the physical and psychological "high" vanishes quickly within 5 to 15 minutes, leaving anxiety, depression, paranoia, and an intense craving to return to the euphoric state • It heightens the feeling of power and control over one's life, feelings that may be lacking from the parent/legal guardian who is using it	• The parent/legal guardian might put the child(ren)'s health and wellbeing in jeopardy in order to pursue their habit (e.g. leaving an infant alone for hours while they seek the drug) • Homes may be barren of furniture and appliances that have been sold to purchase the drug • Child(ren) may not have any food to eat and have unmet basic needs • Can contribute to increased risk for sexual abuse in child(ren) as parent/legal guardians may prostitute their child(ren) to obtain the drug, and the

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		child(ren) may be vulnerable to adults for sexual abuse when they are left with inappropriate caregivers or taken to crack houses or other dangerous settings in the parent/legal guardian's pursuit of the drug
Fentanyl	• Short-acting drug that increases mood quickly and wears off quickly • Produces feelings of euphoria • Causes gastrointestinal tract to slow down • Side effect is respiratory depression which blocks the brain's ability to	• The parent/legal guardian might put the child(ren)'s health and wellbeing in jeopardy in order to pursue their habit • The parent/legal guardian may forget or neglect to attend to the child(ren)'s wellbeing, safety, and supervision needs

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	remember to breathe and can quickly lead to death	
Heroin	• Highly addictive that can lead to serious and even fatal health conditions • Injecting, snorting, or smoking causes initial euphoria, followed by an alternately wakeful and drowsy state • Tolerance of the drug develops with regular use and the parent/legal guardian must use more to produce the same effects • Dependence and addiction can develop easily and	• The parent/legal guardian may "nod out" while under the influence of heroin and be unable to supervise or protect their children • The parent/legal guardian may forget or neglect to attend to the child(ren)'s wellbeing, safety, and supervision needs

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	withdrawal can occur as soon as a few hours after the last use	
Marijuana	• Slows down the nervous system function, which produces a drowsy or calming effect	• The parent/legal guardian may forget or neglect to attend to the child(ren)'s wellbeing, safety, and supervision needs
Methamphetamine	• Releases high levels of dopamine, which stimulates brain cells, enhancing mood and body movement • Smoking or injecting causes euphoria that is intensive and lengthy. Snorting or ingesting produces a milder and less	• The parent/legal guardian may forget or neglect to attend to the child(ren)'s wellbeing, safety, and supervision needs • The parent/legal guardian's violence, aggression, and paranoia may lead to serious consequences for the child(ren) • Child(ren) may be exposed to hazardous home

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	intensive euphoria • After the initial euphoria, the parent/legal guardian "crashes" and becomes irritable, anxious, paranoid, aggressive, or empty feeling. The parent/legal guardian may use again to regain the euphoric state • Withdrawal symptoms may include psychotic episodes and extreme violence • Long-term use can lead to addiction and linked to long-term brain damage and other major health problems	if the drug is being "cooked" at their residence. This includes risk of explosions, fires, and unintentional absorption of the drug.

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Assessing the Family

It is often time difficult to determine when a person is using substances, as they may be using multiple substances both legal and illegal, and each drug may have a different effect on the person's behavior and demeanor. Individuals may also suffer from dual-diagnosis where they also have mental health challenges, and/or they may have physical or medical conditions that produce similar behaviors to drug use (e.g. slurred speech difficulties concentrating, easily distracted).

SWs must complete a full assessment of the family and interviewing each member individually to determine whether substance use is impacting the wellbeing and safety of the children.

Observations of the parent/legal guardian

- Bloodshot eyes/pupils are smaller or larger than usual
- Sudden weight loss or weight gain
- Deterioration of physical appearance and personal grooming habits
- Unusual smells on breath, body, or clothing
- Tremors, slurred speech, or impaired coordination
- Hyperactivity, agitation, or giddiness
- Changes in personality or attitudes
- Lethargic
- Fearful, anxious, or paranoid without reason
- Mood swings, angry outbursts, irritability

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Factors that may suggest parent/legal guardian substance use

- Changes in appetite or sleep patterns
- Drop in performance at work or school/being fired from multiple jobs, or being unemployed for long periods of time
- Unexplained need for money or financial problems
- Engaging in secretive behaviors
- Sudden changes in friends, hangout places, and hobbies

Questions to ask parent/legal guardian

- Frequency, duration, amount, and onset of substance use (helpful to determine whether the parent/legal guardian chronically uses substances, whether they had periods of sobriety, and whether the substance use became more frequent or if the usage increased)
- What substances the parent/legal guardian is currently using and have used in the past and for how long (sometimes a parent/legal guardian may admit to using marijuana but not admit to using methamphetamines unless asked whether they have used other substances for example)
- If they have ever attempted to stop using but have continued to use substances longer than they intended/ if they have ever wanted to cut down or stop using substances but could not
- Why they use substances (i.e. does the parent use to relieve emotional discomfort, due to stress, out of boredom, to forget traumatic events, etc.)
- Whether the children have access to drugs and paraphernalia (where do the parent/legal guardian store their substances?)

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- Willingness of the parent/legal guardian to address their substance use (scaling questions are useful here to determine motivation)
- Ability of the family to recognize how substance use can impact care for the children
- Where are the children when the parent/legal guardian uses? Is there anyone who currently cares for the children whenever the parent/legal guardian is under the influence of substances or going through withdrawal symptoms?
- Availability of family and/or non-relative extended family members who may be able to support the parent/legal guardian and protect the children (i.e. is there a grandparent that could watch the children while the parent/legal guardian uses substances?)
- If the family has stable income and housing
- Does the parent/legal guardian have any financial stressors
- Have the children missed school and medical appointments
- Do the parent/legal guardian has any criminal history related to substance use
- Whether the parent/legal guardian's use has affected their mental health or other areas of daily functioning (ability to maintain employment, ability to keep relationships, etc.).

Observations of the child(ren)

- Poor physical appearance (e.g. clothing, hygiene)
- Thinness as though they were not eating well
- Unusual affect for a child of their developmental age (e.g. fearful, excessively polite)

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Factors that may suggest neglect of the child(ren) due to substance use

- Child(ren) frequently left without adult supervision for extended periods of time
- Child(ren) often requests food from neighbors or from school
- Demonstrates unaddressed behavioral or academic problems in school
- Older children responsible for daily care (feeding, sending to school and supervision) of younger siblings because the parent is unable to do so

Observations of the Family Home

- Little to no food, clothing, furniture or appliances in the residence
- Situations which are hazardous to health (e.g. broken windows, hanging or exposed electrical wires, extreme clutter, rotten food, unwashed dishes, etc.)
- Little to no lighting, such as windows covered with dark drapes or blankets
- Bottles or cans of alcohol littered around the house
- Unusual number of people who enter and exit the home with no reasonable explanation
- No functioning utilities
- Drug paraphernalia accessible to children

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Substance Use and Mental Health (Co-occurring Disorders)

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Parent/legal guardians who have substance use challenges may also have co-occurring mental health challenges. It is important for SWs to understand the relationship between substance use and mental health disorders so that they can effectively discuss substance abuse as well as recommend and monitor treatment for their clients.

- Common risk factors can contribute to both SUDs and mental health disorders. Both SUDS and mental health disorders can run in the family (e.g. alcoholism), which suggests that certain genes may be a risk factor. Environmental factors, such as stress and trauma, can be passed down through the generations and may contribute to the development of a mental health or substance use issue.
- Mental health disorders can contribute to substance use and SUDs. Some individuals may use substances as a form of self-medicating for their mental health challenges; however, although some substances may temporarily help with symptoms, they may also make the symptoms worse over time. Additionally, brain changes may enhance the rewarding effects of substances, making it more likely that the individual will continue to use.
- Substances and SUDs can contribute to the development of other mental health challenges, as it triggers changes in the brain structure and function, which makes a person more likely to develop a mental health disorder (e.g. a person may develop psychosis from long term methamphetamine use).
- Diagnosing both conditions may be difficult for mental health and substance use providers, as symptoms are often complex and can vary in severity. Symptoms might also overlap with each other, and providers may miss that a specific issue is related to the client's substance use or

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mental health presentation if the client does not disclose one or the other.

Which Challenge to Treat First?

In the past, it was common for clients who have co-occurring disorders to only receive treatment for one challenge at a time (i.e. a person might not be able to access therapy because their therapist believed that they need to address their substance use issues first). However, if a parent/legal guardian has a co-occurring challenge, then getting treatment for both disorders at the same time may result in better outcomes. SWs could advocate for their clients to access dual diagnosis treatment or make recommendations that integrate both mental health and substance use treatment in the client's treatment plan.

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Infants Exposed to Prenatal Substances

The use of substances while a mother is pregnant can disrupt normal development and cause a variety of short-term and long-term effects, which may include prenatal complications (e.g. low birth weight, inability to suckle), behavioral disorders, Neonatal Abstinence Syndrome, Fetal Alcohol Spectrum Disorders (FASDs), and a higher risk for the child to develop their own SUDs when they are adults.

Neonatal Abstinence Syndrome

This syndrome occurs when infants are exposed to substances in utero and then go through drug withdrawal after birth. When more than one substance is used, the symptoms are often worse. These substance are usually inclusive of:

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- Opioids like heroin and prescribed medicines such as codeine and oxycodone
- Stimulants such as amphetamines and cocaine
- Antidepressant medicines such as selective serotonin reuptake inhibitors (SSRIs)
- Depressants such as barbiturates, alcohol, or marijuana
- Nicotine from cigarette smoking

Symptoms usually start as soon as 24 to 48 hours after birth, and they may also start as late as 5 to 10 days after birth. Symptoms can include:

- Trembling
- Tight muscle tone
- Vomiting or diarrhea
- Sweating
- Breathing issues such as breathing really fast
- Excessive crying or high-pitched crying
- Overactive reflexes
- Poor feeding and sucking
- Fever or unstable temperature
- Sleep issues
- Seizures
- Yawning, stuffy nose, and sneezing
- Blotchy skin

Treatment for Neonatal Abstinence Syndrome depends on the presenting symptoms, age, and general health. Infants who suffer from this syndrome are irritable and have a difficult time being comforted. They may need extra calories due to increased activity, and they may need IV fluids if they are dehydrated or

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have severe vomiting or diarrhea. Some infants may also need additional medications to manage seizures or medications to relieve discomfort from the withdrawal.

Fetal Alcohol Spectrum Disorder (FASDs)

FASDs are a group of conditions that could occur in an infant who was exposed to alcohol before birth. The effects can include lifelong physical, behavioral, and learning challenges. FASDs cannot be diagnosed through medical tests, and other disorders, such as Attention-Deficit/Hyperactivity Disorder and Williams Syndrome, have similar symptoms to FASDs.

Signs and Symptoms of FASDs can range from mild to severe and affect each child differently as they grow up. Some of the signs and symptoms include:

- Low body weight
- Difficulty with attention
- Learning disabilities
- Poor reasoning and judgment skills
- Heart, kidney, or bone problems
- Poor coordination
- Poor memory
- Speech and language delays
- Sleep and sucking problems as an infant
- Shorter than average height
- Hyperactive behavior
- Difficulty in school
- Intellectual disability or low IQ
- Vision or hearing problems
- Smaller than average head size

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- Abnormal facial features, such as smooth ridge between the nose and upper lip

Factors to Consider when assessing substance exposed infant

Infants who are exposed to prenatal substances may not may not exhibit signs of substance dependence and they may or may not have a positive toxicology screening, as the tests are conducted within a specific timeframe and geared to detect the specific substances that the mother has used while pregnant with the child. Being exposed to prenatal substances does not constitute being automatically removed from their parent/legal guardian's care once the infant is born. It is the SW's job to assess whether the infant could safely remain in their parent/legal guardian's care and whether the parent/legal guardian is able to provide for the infant's needs.

Factors to consider:

- The infant's condition and/or special needs and disabilities
    - Is the parent/legal guardian able to meet the child's specialized medical needs such as learning how to use a feeding tube or ensuring that the child attends physical therapy?
- The nature and extent of the parents/legal guardians' substance use and treatment history
- Any other co-occurring issues such as mental health conditions and intimate partner violence in the home
- The presence of other children in the home and their current condition and care
- Family strengths and the involvement of the extended family and other natural support systems

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- The parent/legal guardian's level of willingness to address concerns and level of participation to safety plan in order to protect the infant's wellbeing and safety
- The availability of the family members and other natural support systems to assist with caregiver and providing other support as needed for the family
- Stable and safe housing

Use assessment tools and clinical judgment to determine next steps:

- Complete SDM Safety and Risk Assessments (See OPP 3-16.2 and 3-16.3) to determine the risk level and safety threats
- Attempt to develop a safety plan (See OPP 3-16.4) to address the safety threats in a Child and Family Team (See OPP 13-8) meeting with the family's natural support systems
- Identify the parents/legal guardians' motivations to access treatment and consider whether the mother and the infant would be good candidates for Parisi House on the Hill. See Chapter 6-3.1 for more information on Parisi House on the Hill and how to refer a family to their program
- Assess whether the parents/legal guardians are willing and able to participate in a non-court case to address safety concerns

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Treatment Services

Substance Use Treatment Services (SUTS) has merged with Behavioral Health Services so that clients can access their one

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hotline, 1(800) 704-0900 to be screened for the most appropriate services. If a parent/legal guardian requires substance use treatment, they can contact the Behavioral Health hotline, or they can contact (408) 491-4720, if they have an open court case and need to be screened for substance use treatment services.

There are different types of treatment services, and although SWs do not directly refer clients to specific types of treatment, it is important for the SW to understand the different types so that they know whether the parent/legal guardian was referred to the appropriate service and what to expect while the parent/legal guardian is participating in the referred service.

Residential Treatment*:* a structured, live-in program at a licensed treatment facility for clients who have problems with daily use of substances. Separate facilities are available for men, women, and women with children (see Parisi House on the Hill). Services that are offered include a comprehensive assessment of the client's substance use over time, individual and group counseling, crisis and family counseling as needed, and education on substance use. The length of residential services depends on an assessment of the individual's needs (Please note that some clients may be in residential treatment for three to four months; however, it is ultimately dependent on the client's needs and extensions can be made for the clients to stay longer if necessary).

Perinatal Residential Treatment: specific to women with SUDs who are pregnant at the time. They may stay up to 120 days following delivery. The women live on the premise and are supported through services that include treatment focusing on parenting and child development, pregnancy related services such as prenatal care, care during labor and delivery, postpartum care, and family planning, and recovery focused

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services through individual and group counseling and education.

Withdrawal Management/Detox Services: tailored to clients who use daily and are unable to stop using substances on their own or who are already in withdrawal and need additional supervision that does not require medical care from a doctor. Detox services provides a safe environment for clients to go through their withdrawal symptoms before they are screened and referred to the next appropriate level of care, which may be a residential treatment program or an outpatient treatment program. Detox services range from one to seven days and referrals to medical care are provided as needed.

Outpatient Services: offers a variety of non-residential community-based services and programs to meet the client's treatment needs. Services include case management, treatment planning, individual and group counseling, family therapy, education, crisis intervention, recovery services, and discharge planning. Services may be provided in person, by telephone, or by telehealth as appropriate. Outpatient treatment providers may coordinate with other supportive services such as primary health care, social services, housing, and community resources in order to meet their client's individualized needs. Usually clients should expect to have about nine hours of services per week while they are in an outpatient setting.

Intensive Outpatient Services: Offers the same services as outpatient services above, but provides up to 19 hours of services to clients per week. Clients often will be in counseling three times a week and once graduated from the intensive outpatient program, will move to an outpatient services program.

Partial Hospitalization Services: Not as common as outpatient or residential treatment services, partial hospitalization services are offered to clients who have co-occurring disorders such as

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mental health issues or physical health issues so that they can have access to medical, psychological, and psychiatric services through consultation or referral. This program provides a minimum of 20 or more hours of service per week to clients.

Perinatal Substance Abuse Program (PSAP): A program that provides comprehensive outpatient services to pregnant and parenting women with SUDs. They provide education around pregnancy, breastfeeding, child development, health education, nutrition education, practice life skills, wellness classes, healthy relationship classes, and recovery education through case management services, medication-assisted treatment (as needed), individual and group therapy, and drug testing. Furthermore, the program can provide prenatal care referrals, general medical screening and referrals, transportation services, on-site childcare, child development screening, early intervention referrals, and smoking cessation assistance.

Medication-Assisted Treatment (MAT): combines prescription medication, counseling, and behavioral therapies in their treatment program. Usually recommended to clients who use opioids, as they can prescribe medications such as methadone, buprenorphine, and injectable naltrexone to block the effects of opioids, relieve cravings, and help normalize bodily functions. In addition to medication, clients are provided with individual and group counseling, and case management for other needs such as employment, housing, psychiatric care, or primary medical care.

Aftercare/Recovery Services: After completing outpatient treatment, clients may be referred for on-going support after treatment. Services include continuation of individual and group counseling, relapse prevention, recovery monitoring, and linkage to support groups. Recovery services include weekly or monthly recovery coaching, peer-to-peer services, and referrals

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to housing, transportation, self-help, job training, education services, spiritual support, and family support.

Recovery Residences (formerly Transitional Housing): Structured living environments for clients who are engaged in outpatient services and need a safe space or temporary housing. It also allows for clients to develop a sober support system with others who may be also going through recovery.

For more information on the providers, their address, and how to contact them, please see the SUTS Provider List.

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Drug Testing

For information on how to refer a parent/legal guardian to drug testing services and what the different types of drug testing services the county provides, please see OPP 19-3: How to Refer a Client for Drug Testing.

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12-Step Meetings

12-step meetings are typically self-supported gatherings and usually held in churches, rented space, hospitals, treatment centers, jails, and even someone's backyard. The meetings are run by the members of the group and the meetings usually run for an hour at a time. During the meeting, members share their journey of addiction, in hopes that talking about their struggles with others going through the same or similar situations will lighten the weight of their burdens and install support and guidance in their own recovery. 12-step meetings usually have a similar structure that include: welcoming members without

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judgment, finding sponsors for members who need support, celebrating sobriety time, having an identified member speak about their experience and what the program has done for them, reading recovery literature and pick a topic of discussion, and ending with a moment of silence for those who have suffered from SUDs or saying the serenity prayer.

The 12 Steps of the 12-Step Meeting are:

1. Admitting powerlessness over the addiction
2. Believing that a higher power (in whatever form) can help
3. Deciding to turn control over to the higher power
4. Taking a personal inventory
5. Admitting to the higher power, oneself, and another person the wrongs that were done
6. Being ready to have the higher power correct any shortcomings in one's character
7. Asking the higher power to remove those shortcomings
8. Making a list of wrongs done to others and being willing to make amends for those wrongs
9. Contacting those who have been hurt, unless doing so would harm the person
10. Continuing to take personal inventory and admitting when one is wrong
11. Seeking enlightenment and connection with the higher power via prayer and meditation
12. Carrying the message of the 12-step to others in need

There are many different types of 12-step meetings that include Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Al-Anon (for family members and friends of alcoholics), and specific groups for specific substances such as Cocaine Anonymous and Heroin Anonymous.

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NOTE: Although the 12-Steps asks the parent/legal guardian to give into a higher power, that does not mean that the parent/legal guardian have to be religious or spiritual to participate. Giving into a higher power in this case is accepting the idea that the parent/legal guardian is not the center of the universe and a higher power could be interpreted as the members in the meeting, love, family, or positive energy. There is a variety of different meetings and although a parent/legal guardian may have not had a good experience with one meeting that they tried, there are many others that may meet their lifestyle and needs.

Meetings

List of Alcoholics Anonymous Meetings in San Jose

List of Narcotics Anonymous Meetings within 20 miles of San Jose

Al-Anonymous Meeting Search

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Celebrating Families

This parent education class follows an evidence-based curriculum which works with every members of the family to strengthen recovery from substances, break the cycle of addiction, and increase successful family reunification if the child(ren) are not in the home. This series focuses on fostering the development of safe, healthy, and addiction-free families by increasing resiliency factors and decreasing risk factors while incorporating addiction recovery concepts. All of the sessions are fully scripted and include: role-plays, handouts, children's stories, and activity sheets. If the SW is considering referring a

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parent/legal guardian to Celebrating Families, it is important to also consider how the class would be beneficial for the children to attend as well.

The objectives of Celebrating Families is to:

- Break the cycle of substance dependency and violence/abuse in families that increasing participant knowledge and use of healthy living skills including:
    - Better communication skills
    - Learn to appropriately express feelings
    - Demonstrate anger management skills
    - Use problem solving and decision making skills
    - Develop coping skills to deal with stressful situations
- Decrease participant use of substances and reduce relapse by teaching all members of the family about SUDs and its impact on families
- To positively influence family reunification by integrating recovery into daily family life and teaching healthy parenting skills by
    - Providing a safe, nurturing place for children and parents to talk and explore their feelings and choices
    - Facilitate trust through a process of bonding with consistent role models
    - Assist participants in developing self-awareness and self-worth
    - Educate participants about SUDs as a disease and how it affects family members

These objectives are taught through 16 sessions:

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• Healthy Living	• Chemical Dependency Affects the Whole Family
• Nutrition	• Goal Setting
• Communication	• Making Healthy Choices
• Feelings and Defenses	• Healthy Boundaries
• Anger Management	• Healthy Friendships and Relationships
• Facts about Alcohol, Tobacco, and other Drugs	• How We Learn
• Chemical Dependency is a Disease	

Celebrating Families holds sessions for all ages. Sessions for 3 year olds and 4-7 year olds vary in topics from those addressed with older children, as there are some topics that may be difficult for children of these age groups to comprehend.

Please see OPP Chapter 19-4 for further information on how to refer a parent to a parent education program.

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Confidentiality

SWs may become frustrated if they are trying to coordinate treatment and share information with the parent/legal guardian's substance use counselor, only to find that they receive little to no information back, been told that the

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parent/legal guardian cannot be confirmed to be in treatment, or told that only certain information could be shared. This is due to the nature of confidentiality that protects clients who have SUDs and are accessing treatment.

Under 42 Code of Federal Regulations (CFR), clients who are undergoing treatment for a SUD have their information protected so that they do not face adverse consequences in relation to issues such as criminal proceedings or domestic proceedings (child custody, divorce, employment). 42 CFR prohibits the disclosure of information that would identify a person who has a SUD unless the person provides written consent. The consent forms itself must also specific the amount and kind of information that is being disclosed and the purpose of disclosure. 42 CFR is stricter than the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which allows for the disclosure of health information for certain purposes without patient authorization, including treatment.

Therefore, if SWs are not receiving any information from substance use counselors, then they have not obtained written consent from the parent/legal guardian to have that specific information shared. SWs should use using the SCZ244 – Authorization for Use and Disclosure of Protected Health Information to obtain consent from the parent and then provide a copy to the service provider.

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The Stages of Relapse

Relapse is usually seen as one major event that occurs where the parent/legal guardian goes back to using substances. However, relapse is actually a process that can begin weeks, and sometimes months before the act of using the substance can occur. SWs who are able to recognize that a parent/legal

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guardian is going through relapse early can assist them back to the path of recovery. According to Melemis (2015), there are three stages of relapse: emotional, mental, and physical.

Emotional Relapse

During this stage, the parent/legal guardian is not thinking about using; however, their emotions and behaviors are setting them up for relapse down the road. Signs that someone may be going through an emotional relapse include:

- Bottling up emotions
- Isolating
- Not going to meetings or treatment
- Going to meetings or treatment but not sharing
- Focusing on others (fixated on other people's problems or focusing on how other people affect them)
- Poor eating and sleep habits

Mental Relapse

During this stage, the parent/legal guardian is starting to think about using substances again, but a part of them also does not want to use. Signs of mental relapse include:

- Cravings
- Thinking about people, places, or things
- Minimizing consequences of past use or glamorizing it

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associated with past use

- Looking for relapse opportunities
- Planning a relapse (e.g. I'll only use on my birthday)
- Thinking of ways to better control their use (e.g. If I measure out how much I use, then I won't get addicted again)
- Bargaining (e.g. If I use, it will only be 0.5oz, and only when I'm on vacation because I deserve it for the hard work I've been doing)
- Lying

Physical Relapse

This is the last stage where the parent/legal guardian starts actively using again. This stage can be divided into the "lapse" where they start the first time, and then "relapse" where they return to uncontrolled use. Most physical relapses occur as relapses of opportunity where the parent/legal guardian feel that they have a window where they will not be caught.

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How to Assist

If a SW suspects that a parent/legal guardian may be in the process of relapsing, it is important for the Child and Family Team to support the parent/legal guardian to return to treatment and actively develop a plan to prevent further relapse if possible. If the parent/legal guardian has a relapse prevention plan but it is no longer working, it may be important to revise the plan. Members of the Child and Family Team that may be important in this process could be: the SW, the substance use counselor, the mental health therapist, the natural support network, and the parent mentor/peer mentor/sponsor.

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Relapse Prevention Plans

A relapse prevention plan is a way to mitigate the risk of substance use relapse by identifying triggers and coping mechanisms that could help the parent/legal guardian in the moment when they are thinking of using their substance of choice again. The goal of a relapse prevention plan is for the parent/legal guardian to be aware of what might pose a risk to their recovery process, which could include people, places, things, and behaviors, and what action steps they need to take when their recovery is at risk of relapse.

What should be included in relapse prevention plan?

- Personal goals in recovery and motivation to make changes so that the parent/legal guardian is reminded why they are on the path to recovery and what they want to achieve for the future

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- How to avoid places or people who are linked to substance use, and what to do when these places and people cannot be avoided
- Triggers that bring up the need to use substances, which could include feelings or thoughts
- Healthy coping skills that could be used to prevent emotional distress or stressors
- Structured daily or weekly routine to help the parent/legal guardian stay busy and organized so they do not have time to be lonely or bored, risk factors that could lead to relapse
- Who they can reach out to whenever they are thinking about using substances again, the person's availability and phone number. In the beginning, this might be mainly professionals, and throughout the case, SW should encourage the parent/legal guardian to also develop natural supports that they can turn to so that they still have a support system even if professionals are no longer involved in the case

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Supporting Families During and After Treatment

SWs can support parents/legal guardians who are going through treatment by reducing the stigma around having a SUD, creating an empathetic relationship with the parent/legal guardian, and focusing on the individual's role of being a parent/legal guardian by doing the following:

- Acknowledging the stigma around substance use
- Use person-centered language (e.g. a person with substance use disorder instead of a drug addict)

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- Avoid guilt and shame tactics
- Emphasize the parent's strengths and promote resilience
- Respect the individual's role as a parent/legal guardian and involve them in decisions regarding their case plan and their children at all steps
- Acknowledging that relapse does happen during the recovery process and often time parents would have to go through a variety of treatment methods, such as multiple rounds of treatment, in order to maintain long-term recovery.
- Be aware of culture, and recognize that recovery may look different for each cultural group and individual. For example, a full recovery might mean not only recovering from symptoms of SUD but also reconnecting to the parent/legal guardian's cultural identify or recommitting to spiritual or religious practices.

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REFERENCE

CONTACTS

- SUTS Provider List.

Resources

- Understanding Screening and Assessment of Substance Use Disorders
- Melemis SM. Relapse Prevention and the Five Rules of Recovery. Yale J Biol Med. 2015 Sep 3;88(3):325-32. PMID: 26339217; PMCID: PMC4553654.
- Celebrating Families Information

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- OPP Chapter 3-16.2: SDM Safety and Substitute Care Provider Safety Assessments
- OPP Chapter 3-16.3: Risk Assessment
- OPP Chapter 3-16.4: Safety Planning
- OPP Chapter 6-3.1: Parisi House on the Hill
- OPP Chapter 13-8: Child and Family Team Meetings (CFT)
- OPP Chapter 19-3: How to Refer a Client for Drug Testing
- OPP Chapter 19-4: How to Refer a Client to Parent Education Program

LEGAL BASIS

- 42 U.S.C. 290dd-2

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Attachment E – Child Abuse Prevention and Treatment Act (CAPTA) – Foundation for Implementing Plans of Safe Care

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DRAFT – The Child Abuse Prevention and Treatment Act (CAPTA) with amendments made by sec. 133 within Title I of the *Trafficking Victims Prevention and Protection Reauthorization Act of 2022,* P.L. 117-348, enacted January 5, 2023.

DISCLAIMER: Please consult the U.S. Code for official or legal citations. This document was prepared by Children's Bureau staff and may not be cited as an authoritative source.

Child Abuse Prevention and Treatment Act

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[1] Section III, the Abandoned Infants Assistance Act, was repealed by sec. 7065(b) of P.L. 115-271.

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SECTION I: CHILD ABUSE PREVENTION AND TREATMENT ACT

Sec. 2. CONGRESSIONAL FINDINGS. [42 U.S.C. 5101, Note]

Congress finds that—

1. in fiscal year 2008, approximately 772,000 children were found by States to be victims of child abuse and neglect;

2.
   A. more children suffer neglect than any other form of maltreatment and close to 1/3 of all child maltreatment-related fatalities in fiscal year 2008 were attributed to neglect alone; and
   B. investigations have determined that approximately 71 percent of children who were victims of maltreatment in fiscal year 2008 suffered neglect, 16 percent suffered physical abuse, 9 percent suffered sexual abuse, 7 percent suffered psychological maltreatment, 2 percent experienced medical neglect, and 9 percent were victims of other forms of maltreatment;

3.
   A. child abuse or neglect can result in the death of a child;
   B. in fiscal year 2008, an estimated 1,740 children were counted by child protection services to have died as a result of abuse and neglect; and

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C. in fiscal year 2008, children younger than 1 year old comprised 45 percent of child maltreatment fatalities and 72 percent of child maltreatment fatalities were younger than 4 years of age;

4.
   A. many of these children and their families fail to receive adequate protection and treatment; and
   B. approximately 37 percent of victims of child abuse did not receive post-investigation services in fiscal year 2008;
5. African-American children, American Indian children, Alaska native children, and children of multiple races and ethnicities experience the highest rates of child abuse or neglect;
6. the problem of child abuse and neglect requires a comprehensive approach that—
   A. integrates the work of social service, legal, health, mental health, domestic violence services, education, and substance abuse agencies and community-based organizations;
   B. strengthens coordination among all levels of government, and with private agencies, civic, religious, and professional organizations, and individual volunteers;
   C. emphasizes the need for abuse and neglect prevention, assessment, investigation, and treatment at the neighborhood level;
   D. recognizes the need for properly trained staff with the qualifications needed to carry out their child protection duties; and
   E. recognizes the diversity of ethnic, cultural, and religious beliefs and traditions that may impact child rearing patterns, while not allowing the differences in those beliefs and traditions to enable abuse or neglect;
7. the failure to coordinate and comprehensively prevent and treat child abuse and neglect threatens the futures of thousands of children and results in a cost to the Nation of billions of dollars in tangible expenditures, as well as significant intangible costs;
8. all elements of American society have a shared responsibility in responding to child abuse and neglect;
9. substantial reductions in the prevalence and incidence of child abuse and neglect and the alleviation of its consequences are matters of the highest national priority;
10. national policy should strengthen families to prevent child abuse and neglect, provide support for needed services to prevent the unnecessary removal of children from families, and promote the reunification of families where appropriate;
11. the child protection system should be comprehensive, child-centered, family-focused, and community-based, should incorporate all appropriate measures to prevent the occurrence or recurrence of child abuse and neglect, and should promote physical and psychological recovery and social re-integration in an environment that fosters the health, safety, self-respect, and dignity of the child;
12. because both child maltreatment and domestic violence occur in up to 60 percent of the families in which either is present, States and communities should adopt assessments and intervention procedures aimed at enhancing the safety both of children and victims of domestic violence;

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13. because of the limited resources available in low-income communities, Federal aid for the child protection system should be distributed with due regard to the relative financial need of the communities;
14. the Federal Government should assist States and communities with the fiscal, human, and technical resources necessary to develop and implement a successful and comprehensive child and family protection strategy; and
15. the Federal Government should provide leadership and assist communities in their child and family protection efforts by—
    A. promoting coordinated planning among all levels of government;
    B. generating and sharing knowledge relevant to child and family protection, including the development of models for service delivery;
    C. strengthening the capacity of States to assist communities;
    D. allocating financial resources to assist States in implementing community plans;
    E. helping communities to carry out their child and family protection plans by promoting the competence of professional, paraprofessional, and volunteer resources; and
    F. providing leadership to end the abuse and neglect of the nation's children and youth.

Sec. 3. GENERAL DEFINITIONS. [42 U.S.C. 5101, Note]

In this Act—

1. the term 'child' means a person who has not attained the lesser of—
    A. the age of 18; or
    B. except in the case of sexual abuse, the age specified by the child protection law of the State in which the child resides;
2. the term 'child abuse and neglect' means, at a minimum, any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation (including sexual abuse as determined under section 111), or an act or failure to act which presents an imminent risk of serious harm;
3. the term 'child with a disability' means a child with a disability as defined in section 602 of the Individuals with Disabilities Education Act (2024 U.S.C. 1401), or an infant or toddler with a disability as defined in section 632 of such Act (202 U.S.C. 1432);
4. the term 'Governor' means the chief executive officer of a State;
5. the terms 'Indian', 'Indian tribe', and 'tribal organization' have the meanings given the terms in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b);
6. the term 'Secretary' means the Secretary of Health and Human Services;
7. except as provided in section 106(f), the term 'State' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands; and
8. the term 'unaccompanied homeless youth' means an individual who is described in paragraphs (2) and (6) of section 725 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a).

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Title I – GENERAL PROGRAM

Sec. 101. OFFICE ON CHILD ABUSE AND NEGLECT. [42 U.S.C. 5101]

a. ESTABLISHMENT.—The Secretary of Health and Human Services may establish an office to be known as the Office on Child Abuse and Neglect.
b. PURPOSE.—The purpose of the Office established under subsection (a) of this section shall be to execute and coordinate the functions and activities of this Act. In the event that such functions and activities are performed by another entity or entities within the Department of Health and Human Services, the Secretary shall ensure that such functions and activities are executed with the necessary expertise and in a fully coordinated manner involving regular intradepartmental and interdepartmental consultation with all agencies involved in child abuse and neglect activities.

Sec. 102. ADVISORY BOARD ON CHILD ABUSE AND NEGLECT. [42 U.S.C. 5102]

a. APPOINTMENT.—The Secretary may appoint an advisory board to make recommendations to the Secretary and to the appropriate committees of Congress concerning specific issues relating to child abuse and neglect.
b. SOLICITATION OF NOMINATIONS.—The Secretary shall publish a notice in the Federal Register soliciting nominations for the appointment of members of the advisory board under subsection (a).
c. COMPOSITION.—In establishing the board under subsection (a), the Secretary shall appoint members from the general public who are individuals knowledgeable in child abuse and neglect prevention, intervention, treatment, or research, and with due consideration to representation of ethnic or racial minorities and diverse geographic areas, and who represent—
    1. law (including the judiciary);
    2. psychology (including child development);
    3. social services (including child protective services);
    4. health care providers (including pediatricians)
    5. State and local government;
    6. organizations providing services to disabled persons;
    7. organizations providing services to adolescents;
    8. teachers;
    9. parent self-help organizations;
    10. parents' groups;
    11. voluntary groups;
    12. family rights groups;
    13. children's rights advocates; and
    14. Indian tribes or tribal organizations.
d. VACANCIES.—Any vacancy in the membership of the board shall be filled in the same manner in which the original appointment was made.
e. ELECTION OF OFFICERS.—The board shall elect a chairperson and vice-chairperson at its first meeting from among the members of the board.

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f. DUTIES.—Not later than 1 year after the establishment of the board under subsection (a), the board shall submit to the Secretary and the appropriate committees of Congress a report, or interim report, containing—
    1. recommendations on coordinating Federal, State, tribal, and local child abuse and neglect activities with similar activities at the Federal, State, tribal, and local level pertaining to family violence prevention;
    2. specific modifications needed in Federal, State, and tribal laws and programs to reduce the number of unfounded or unsubstantiated reports of child abuse or neglect while enhancing the ability to identify and substantiate legitimate cases of child abuse or neglect which place a child in danger; and
    3. recommendations for modifications needed to facilitate coordinated national data collection with respect to child protection and child welfare.

Sec. 103. NATIONAL CLEARINGHOUSE FOR INFORMATION RELATING TO CHILD ABUSE. [42 U.S.C. 5104]

a. ESTABLISHMENT.—The Secretary shall through the Department, or by one or more contracts of not less than 3 years duration let through a competition, establish a national clearinghouse for information relating to child abuse and neglect.
b. FUNCTIONS.—The Secretary shall, through the clearinghouse established by subsection (a)—
    1. maintain, coordinate, and disseminate information on effective programs, including private and community-based programs, that have demonstrated success with respect to the prevention, assessment, identification, and treatment of child abuse or neglect and hold the potential for broad scale implementation and replication;
    2. maintain, coordinate, and disseminate information on the medical diagnosis and treatment of child abuse and neglect;
    3. maintain and disseminate information on best practices related to differential response;
    4. maintain and disseminate information about best practices used for achieving improvements in child protective systems;
    5. maintain and disseminate information about the requirements of section 106(b)(2)(B)(iii) and best practices relating to the development of plans of safe care as described in such section for infants born and identified as being affected by substance abuse or withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder;
    6. maintain and disseminate information relating to—
        A. the incidence of cases of child abuse and neglect in the United States;
        B. the incidence of such cases in populations determined by the Secretary under section 105(a)(1) of the Child Abuse Prevention, Adoption, and Family Services Act of 1988 (42 U.S.C. 5105 note); and
        C. the incidence of any such cases related to substance abuse;
    7. provide technical assistance upon request that may include an evaluation or identification of—

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A. various methods and procedures for the investigation, assessment, and prosecution of child physical and sexual abuse cases;
B. ways to mitigate psychological trauma to the child victim; and
C. effective programs carried out by the States under this Act;

8. collect and disseminate information relating to various training resources available at the State and local level to—
   A. individuals who are engaged, or who intend to engage, in the prevention, identification, and treatment of child abuse and neglect; and
   B. appropriate State and local officials to assist in training law enforcement, legal, judicial, mental health, education, child welfare, substance abuse treatment services, and domestic violence personnel and;
   C. collect and disseminate information, in conjunction with the National Resource Centers authorized in section 310(b) of the Family Violence Prevention and Services Act, on effective programs and best practices for developing and carrying out collaboration between entities providing child protective services and entities providing domestic violence services.
9. collect and disseminate information, in conjunction with the National Resource Centers authorized in section 310(b) of the Family Violence Prevention and Services Act, on effective programs and best practices for developing and carrying out collaboration between entities providing child protective services and entities providing domestic violence services.

c. COORDINATION WITH AVAILABLE RESOURCES.—
   1. IN GENERAL.—In establishing a national clearinghouse as required by subsection (a), the Secretary shall—
      A. consult with other Federal agencies that operate similar clearinghouses;
      B. consult with the head of each agency involved with child abuse and neglect on the development of the components for information collection and management of such clearinghouse and on the mechanisms for the sharing of such information with other Federal agencies and clearinghouses;
      C. develop a Federal data system involving the elements under subsection (b) which, to the extent practicable, coordinates existing Federal, State, tribal, regional, and local child welfare data systems which shall include—
         i. standardized data on false, unfounded, unsubstantiated, and substantiated reports;
         ii. information on the number of deaths due to child abuse and neglect;
         iii. information about the incidence and characteristics of child abuse and neglect in circumstances in which domestic violence is present; and
         iv. information about the incidence and characteristics of child abuse and neglect in cases related to substance abuse;
      D. through a national data collection and analysis program and in consultation with appropriate State and local agencies and experts in the field, collect, compile, and make available State child abuse and neglect reporting information which, to the extent practical, shall be universal and

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case specific and integrated with other case-based foster care and adoption data collected by the Secretary;

E. compile, analyze, and publish a summary of the research conducted under section 104(a);
F. collect and disseminate information that describes best practices being used throughout the Nation for making appropriate referrals related to, and addressing, the physical, developmental, and mental health needs of victims of child abuse or neglect; and
G. solicit public comment on the components of such clearinghouse.

2. CONFIDENTIALITY REQUIREMENT.—In carrying out paragraph (1)(D), the Secretary shall ensure that methods are established and implemented to preserve the confidentiality of records relating to case specific data.

Sec. 104. RESEARCH AND ASSISTANCE ACTIVITIES AND DEMONSTRATIONS. [42 U.S.C. 5105]

a. RESEARCH.—
1. TOPICS.—The Secretary shall, in consultation with other Federal agencies and recognized experts in the field, carry out a continuing interdisciplinary program of research, including longitudinal research, that is designed to provide information needed to better protect children from child abuse or neglect and to improve the well-being of victims of child abuse or neglect, with at least a portion of such research being field initiated. Such research program may focus on—
A. the nature and scope of child abuse and neglect;
B. causes, prevention, assessment, identification, treatment, cultural and socio-economic distinctions, and the consequences of child abuse and neglect, including the effects of child abuse and neglect on a child's development and the identification of successful early intervention services or other services that are needed;
C. effective approaches to improving the relationship and attachment of infants and toddlers who experience child abuse or neglect with their parents or primary caregivers in circumstances where reunification is appropriate;
D. appropriate, effective and culturally sensitive investigative, administrative, and judicial systems, including multidisciplinary, coordinated decision making procedures with respect to cases of child abuse and neglect;
E. the evaluation and dissemination of best practices, including best practices to meet the needs of special populations, consistent with the goals of achieving improvements in child protective services systems of the States in accordance with paragraphs (1) through (14) of section 106(a);
F. effective approaches to interagency collaboration between the child protection system and the juvenile justice system that improve the delivery of services and treatment, including methods for continuity of treatment plan and services as children transition between systems;
G. effective practices and programs to improve activities such as identification, screening, medical diagnosis, forensic diagnosis, health

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evaluations, and services, including activities that promote collaboration between—

i. the child protective service system; and

ii. (I) the medical community, including providers of mental health and developmental disability services; and

(II) providers of early childhood intervention services and special education for children who have been victims of child abuse or neglect;

H. an evaluation of the redundancies and gaps in the services in the field of child abuse and neglect prevention in order to make better use of resources;

I. effective collaborations, between the child protective system and domestic violence service providers, that provide for the safety of children exposed to domestic violence and their non-abusing parents and that improve the investigations, interventions, delivery of services, and treatments provided for such children and families;

J. the nature, scope, and practice of voluntary relinquishment for foster care or State guardianship of low-income children who need health services, including mental health services;

K. the impact of child abuse and neglect on the incidence and progression of disabilities;

L. the nature and scope of effective practices relating to differential response, including an analysis of best practices conducted by the States;

M. child abuse and neglect issues facing Indians, Alaska Natives, and Native Hawaiians, including providing recommendations for improving the collection of child abuse and neglect data for Indian tribes and Native Hawaiian communities;

N. the information on the national incidence of child abuse and neglect specified in clauses (i) through (x) of subparagraph (O); and

O. the national incidence of child abuse and neglect, including—

i. the extent to which incidents of child abuse and neglect are increasing or decreasing in number and severity;

ii. the incidence of substantiated and unsubstantiated reported child abuse and neglect cases;

iii. the number of substantiated cases that result in a judicial finding of child abuse or neglect or related criminal court convictions;

iv. the extent to which the number of unsubstantiated, unfounded and false reported cases of child abuse or neglect have contributed to the inability of a State to respond effectively to serious cases of child abuse or neglect;

v. the extent to which the lack of adequate resources and the lack of adequate training of individuals required by law to report suspected cases of child abuse and neglect have contributed to the

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inability of a State to respond effectively to serious cases of child abuse and neglect;

vi. the number of unsubstantiated, false, or unfounded reports that have resulted in a child being placed in substitute care, and the duration of such placement;

vii. the extent to which unsubstantiated reports return as more serious cases of child abuse or neglect;

viii. the incidence and prevalence of physical, sexual, and emotional abuse and physical and emotional neglect in substitute care;

ix. the incidence and prevalence of child maltreatment by a wide array of demographic characteristics such as age, sex, race, family structure, household relationship (including the living arrangement of the resident parent and family size), school enrollment and education attainment, disability, grandparents as caregivers, labor force status, work status in previous year, and income in previous year;

x. the extent to which reports of suspected or known instances of child abuse or neglect involving a potential combination of jurisdictions, such as intrastate, interstate, Federal-State, and State-Tribal, are being screened out solely on the basis of the cross-jurisdictional complications; and

xi. the incidence and outcomes of child abuse and neglect allegations reported within the context of divorce, custody, or other family court proceedings, and the interaction between this venue and the child protective services system.

2. RESEARCH.—The Secretary shall conduct research on the national incidence of child abuse and neglect, including the information on the national incidence on child abuse and neglect specified in clauses (i) through (xi) of paragraph (1)(O).
3. REPORT.—Not later than 4 years after the date of the enactment of the CAPTA Reauthorization Act of 2010, the Secretary shall prepare and submit to the Committee on Education and the Workforce of the House of Representatives and the Committee on Health, Education, Labor and Pensions of the Senate a report that contains the results of the research conducted under paragraph (2).
4. PRIORITIES.—
   A. IN GENERAL.— The Secretary shall establish research priorities for making grants or contracts for purposes of carrying out paragraph (1).
   B. PUBLIC COMMENT.— Not later than 1 year after the date of enactment of the CAPTA Reauthorization Act of 2010, and every 2 years thereafter, the Secretary shall provide an opportunity for public comment concerning the priorities proposed under subparagraph (A) and maintain an official record of such public comment.

4[2]. STUDY ON SHAKEN BABY SYNDROME.— The Secretary shall conduct a study that –

[2] So in law.

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C. identifies data collected on shaken baby syndrome;
D. determines the feasibility of collecting uniform, accurate data from all States regarding—
    i. incidence rates of shaken baby syndrome;
    ii. characteristics of perpetrators of shaken baby syndrome, including age, gender, relation to victim, access to prevention materials and resources, and history of substance abuse, domestic violence, and mental illness; and
    iii. characteristics of victims of shaken baby syndrome, including gender, date of birth, date of injury, date of death (if applicable), and short- and long-term injuries sustained.

b. PROVISION OF TECHNICAL ASSISTANCE.—
    1. IN GENERAL.—The Secretary shall provide technical assistance to State and local public and private agencies and community-based organizations, including disability organizations and persons who work with children with disabilities and providers of mental health, substance abuse treatment, and domestic violence prevention services, to assist such agencies and organizations in planning, improving, developing, and carrying out programs and activities, including replicating successful program models, relating to the prevention, assessment, identification, and treatment of child abuse and neglect.
    2. EVALUATION.—Such technical assistance may include an evaluation or identification of—
        A. various methods and procedures for the investigation, assessment, and prosecution of child physical and sexual abuse cases;
        B. ways to mitigate psychological trauma to the child victim;
        C. effective programs carried out by the States under titles I and II; and
        D. effective approaches being utilized to link child protective service agencies with health care, mental health care, and developmental services to improve forensic diagnosis and health evaluations, and barriers and shortages to such linkages.
    3. DISSEMINATION.—The Secretary may provide for and disseminate information relating to various training resources available at the State and local level to—
        A. individuals who are engaged, or who intend to engage, in the prevention, identification, and treatment of child abuse and neglect; and
        B. appropriate State and local officials to assist in training law enforcement, legal, judicial, medical, mental health, education, child welfare, substance abuse, and domestic violence services personnel in appropriate methods of interacting during investigative, administrative, and judicial proceedings with children who have been subjected to, or whom the personnel suspect have been subjected to, child abuse or neglect.

c. AUTHORITY TO MAKE GRANTS OR ENTER INTO CONTRACTS.—
    1. IN GENERAL.—The functions of the Secretary under this section may be carried out either directly or through grant or contract.
    2. DURATION.—Grants under this section shall be made for periods of not more than 5 years.

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3. PREFERENCE FOR LONG-TERM STUDIES.—In making grants for purposes of conducting research under subsection (a) of this section, the Secretary shall give special consideration to applications for long-term projects.

d. PEER REVIEW FOR GRANTS.—
   1. ESTABLISHMENT OF PEER REVIEW PROCESS.—
      A. In General.—To enhance the quality and usefulness of research in the field of child abuse and neglect, the Secretary shall, in consultation with experts in the field and other Federal agencies, establish a formal, rigorous, and meritorious peer review process for purposes of evaluating and reviewing applications for assistance through a grant or contract under this section and determining the relative merits of the project for which such assistance is requested.
      B. MEMBERS.—In establishing the process required by subparagraph (A), the Secretary shall only appoint to the peer review panels members who—
         i. are experts in the field of child abuse and neglect or related disciplines, with appropriate expertise related to the applications to be reviewed; and
         ii. are not individuals who are officers or employees of the Administration for Children and Families.
      C. MEETINGS.—The peer review panels shall meet as often as is necessary to facilitate the expeditious review of applications for grants and contracts under this section, but shall meet not less often than once a year.
      D. CRITERIA AND GUIDELINES.—The Secretary shall ensure that the peer review panel utilizes scientifically valid review criteria and scoring guidelines in the review of the applications for grants and contracts.
   2. REVIEW OF APPLICATIONS FOR ASSISTANCE.—Each peer review panel established under paragraph (1)(A) that reviews any application for a grant shall—
      A. determine and evaluate the merit of each project described in such application;
      B. rank such application with respect to all other applications it reviews in the same priority area for the fiscal year involved, according to the relative merit of all of the projects that are described in such application and for which financial assistance is requested; and
      C. make recommendations to the Secretary concerning whether the application for the project shall be approved. The Secretary shall award grants under this section on the basis of competitive review.
   3. NOTICE OF APPROVAL.—
      A. MERITORIOUS PROJECTS.—The Secretary shall provide grants and contracts under this section from among the projects which the peer review panels established under paragraph (1)(A) have determined to have merit.
      B. EXPLANATION.—In the instance in which the Secretary approves an application for a program without having approved all applications ranked above such application (as determined under paragraph (2)(B)), the Secretary shall append to the approved application a detailed explanation

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of the reasons relied on for approving the application and for failing to approve each pending application that is superior in merit, as indicated on the list under paragraph (2)(B).

e. DEMONSTRATION PROGRAMS AND PROJECTS.—The Secretary may award grants to, and enter into contracts with, entities that are States, Indian tribes or tribal organizations, or public or private agencies or organizations (or combinations of such entities) for time-limited, demonstration projects for the following:
    1. PROMOTION OF SAFE, FAMILY-FRIENDLY PHYSICAL ENVIRONMENTS FOR VISITATION AND EXCHANGE.—The Secretary may award grants under this subsection to entities to assist such entities in establishing and operating safe, family-friendly physical environments—
        A. for court-ordered, supervised visitation between children and abusing parents; and
        B. to facilitate the safe exchange of children for visits with noncustodial parents in cases of domestic violence.
    2. EDUCATION, IDENTIFICATION, PREVENTION, AND TREATMENT.—The Secretary may award grants under this subsection to entities for projects that provide educational identification, prevention, and treatment services in cooperation with child care and early childhood education and care providers, preschools and elementary and secondary schools.
    3. RISK AND SAFETY ASSESSMENT TOOLS.—The Secretary may award grants under this subsection to entities for projects that provide for the development of research-based strategies for risk and safety assessments relating to child abuse and neglect.
    4. TRAINING.—The Secretary may award grants under this subsection to entities for projects that involve research-based strategies for innovative training for mandated child abuse and neglect reporters.

Sec. 105. GRANTS TO STATES, INDIAN TRIBES OR TRIBAL ORGANIZATIONS, AND PUBLIC OR PRIVATE AGENCIES AND ORGANIZATIONS. [42 U.S.C. 5106]

a. GRANTS FOR PROGRAMS AND PROJECTS.—The Secretary may make grants to, and enter into contracts with entities that are States, Indian tribes or tribal organizations, or public agencies or private agencies or organizations (or combinations of such entities) for programs and projects for the following purposes:
    1. TRAINING PROGRAMS.—The Secretary may award grants to public or private organizations under this subsection—
        A. for the training of professional and paraprofessional personnel in the fields of health care, medicine, law enforcement, judiciary, social work and child protection, education, child care, and other relevant fields, or individuals such as court appointed special advocates (CASAs) and guardian ad litem, who are engaged in, or intend to work in, the field of prevention, identification, and treatment of child abuse and neglect, including the links between domestic violence and child abuse and neglect;

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B. to improve the recruitment, selection, and training of volunteers serving in public and private children, youth, and family service organizations in order to prevent child abuse and neglect;
C. for the establishment of resource centers for the purpose of providing information and training to professionals working in the field of child abuse and neglect;
D. for training to enhance linkages among child protective service agencies and health care agencies, entities providing physical and mental health services, community resources, and developmental disability agencies, to improve screening, forensic diagnosis, and health and developmental evaluations, and for partnerships between child protective service agencies and health care agencies that support the coordinated use of existing Federal, State, local and private funding to meet the health evaluation needs of children who have been subjects of substantiated cases of child abuse or neglect;
E. for the training of personnel in best practices to meet the unique needs of children with disabilities, including promoting interagency collaboration;
F. for the training of personnel in best practices to promote collaboration with the families from the initial time of contact during the investigation through treatment;
G. for the training of personnel regarding the legal duties of such personnel and their responsibilities to protect the legal rights of children and families;
H. for the training of personnel in childhood development including the unique needs of children under age 3;
I. for improving the training of supervisory and nonsupervisory child welfare workers;
J. for enabling State child welfare agencies to coordinate the provision of services with State and local health care agencies, alcohol and drug abuse prevention and treatment agencies, mental health agencies, other public and private welfare agencies, and agencies that provide early intervention services to promote child safety, permanence and family stability;
K. for cross training for child protective service workers in research-based strategies for recognizing situations of substance abuse, domestic violence, and neglect;
L. for developing, implementing, or operating information and education programs or training programs designed to improve the provision of services to infants or toddlers with disabilities with life-threatening conditions for—
    i. professionals and paraprofessional personnel concerned with the welfare of disabled infants with life-threatening conditions, including personnel employed in child protective services programs and health care facilities; and
    ii. the parents of such infants; and
M. for the training of personnel in best practices relating to the provision of differential response.

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2. TRIAGE PROCEDURES.—The Secretary may award grants under this subsection to public and private agencies that demonstrate innovation in responding to reports of child abuse and neglect, including programs of collaborative partnerships between the State child protective services agency, community social service agencies and family support programs, law enforcement agencies, developmental disability agencies, substance abuse treatment entities, health care entities, domestic violence prevention entities, mental health service entities, schools, churches and synagogues, and other community agencies, to allow for the establishment of a triage system that—
    A. accepts, screens, and assesses reports received to determine which such reports require an intensive intervention and which require voluntary referral to another agency, program, or project;
    B. provides, either directly or through referral, a variety of community-linked services to assist families in preventing child abuse and neglect; and
    C. provides further investigation and intensive intervention when the child's safety is in jeopardy.
3. MUTUAL SUPPORT PROGRAMS.—The Secretary may award grants to private organizations to establish or maintain a national network of mutual support, leadership, and self-help programs as a means of strengthening families in partnership with their communities.
4. KINSHIP CARE.— The Secretary may award grants to public and private entities to assist such entities in developing or implementing procedures using adult relatives as the preferred placement for children removed from their home, where such relatives are determined to be capable of providing a safe nurturing environment for the child and where such relatives comply with the State child protection standards.
5. LINKAGES AMONG CHILD PROTECTIVE SERVICE AGENCIES AND PUBLIC HEALTH, MENTAL HEALTH, SUBSTANCE ABUSE, DEVELOPMENTAL DISABILITIES, AND DOMESTIC VIOLENCE SERVICE AGENCIES.—The Secretary may award grants to entities that provide linkages among State or local child protective service agencies and public health, mental health, substance abuse, developmental disabilities, and domestic violence service agencies, and entities that carry out community-based programs for the purpose of establishing linkages that are designed to ensure that a greater number of substantiated victims of child maltreatment have their physical health, mental health, and developmental needs appropriately diagnosed and treated, in accordance with all applicable Federal and State privacy laws.
6. COLLABORATIONS BETWEEN CHILD PROTECTIVE SERVICE ENTITIES AND DOMESTIC VIOLENCE SERVICE ENTITIES.—The Secretary may award grants to public or private agencies and organizations under this section to develop or expand effective collaborations between child protective service entities and domestic violence service entities to improve collaborative investigation and intervention procedures, provision for the safety of the non-abusing parent involved and children, and provision of services to children exposed to domestic violence that also support the caregiving role of the non-abusing parent.

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7. GRANTS TO STATES TO IMPROVE AND COORDINATE THEIR RESPONSE TO ENSURE THE SAFETY, PERMANENCY, AND WELL-BEING OF INFANTS AFFECTED BY SUBSTANCE USE.—
   A. PROGRAM AUTHORIZED.—The Secretary is authorized to make grants to States for the purpose of assisting child welfare agencies, social services agencies, substance use disorder treatment agencies, hospitals with labor and delivery units, medical staff, public health and mental health agencies, and maternal and child health agencies to facilitate collaboration in developing, updating, implementing, and monitoring plans of safe care described in section 106(b)(2)(B)(iii). Section 112(a)(2) shall not apply to the program authorized under this paragraph.
   B. DISTRIBUTION OF FUNDS.—
      i. RESERVATIONS.—Of the amounts made available to carry out subparagraph (A), the Secretary shall reserve—
         I. no more than 3 percent for the purposes described in subparagraph (G); and
         II. up to 3 percent for grants to Indian Tribes and tribal organizations to address the needs of infants born with, and identified as being affected by, substance abuse or withdrawal symptoms resulting from prenatal drug exposure or a fetal alcohol spectrum disorder and their families or caregivers, which to the extent practicable, shall be consistent with the uses of funds described under subparagraph (D).
      ii. ALLOTMENTS TO STATES AND TERRITORIES.—The Secretary shall allot the amount made available to carry out subparagraph (A) that remains after application of clause (i) to each State that applies for such a grant, in an amount equal to the sum of—
         I. $500,000; and
         II. an amount that bears the same relationship to any funds made available to carry out subparagraph (A) and remaining after application of clause (i), as the number of live births in the State in the previous calendar year bears to the number of live births in all States in such year.
      iii. RATABLE REDUCTION.—If the amount made available to carry out subparagraph (A) is insufficient to satisfy the requirements of clause (ii), the Secretary shall ratably reduce each allotment to a State.
   C. APPLICATION.—A State desiring a grant under this paragraph shall submit an application to the Secretary at such time and in such manner as the Secretary may require. Such application shall include—
      i. a description of—
         I. the impact of substance use disorder in such State, including with respect to the substance or class of

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substances with the highest incidence of abuse in the previous year in such State, including—

aa. the prevalence of substance use disorder in such State;

bb. the aggregate rate of births in the State of infants affected by substance abuse or withdrawal symptoms or a fetal alcohol spectrum disorder (as determined by hospitals, insurance claims, claims submitted to the State Medicaid program, or other records), if available and to the extent practicable; and

cc. the number of infants identified, for whom a plan of safe care was developed, and for whom a referral was made for appropriate services, as reported under section 106(d)(18); and

II. the challenges the State faces in developing, implementing, and monitoring plans of safe care in accordance with section 106(b)(2)(B)(iii);

III. the State's lead agency for the grant program and how that agency will coordinate with relevant State entities and programs, including the child welfare agency, the substance use disorder treatment agency, hospitals with labor and delivery units, health care providers, the public health and mental health agencies, programs funded by the Substance Abuse and Mental Health Services Administration that provide substance use disorder treatment for women, the State Medicaid program, the State agency administering the block grant program under title V of the Social Security Act (42 U.S.C. 701 et seq.), the State agency administering the programs funded under part C of the Individuals with Disabilities Education Act (20 U.S.C. 1431 et seq.), the maternal, infant, and early childhood home visiting program under section 511 of the Social Security Act (42 U.S.C. 711), the State judicial system, and other agencies, as determined by the Secretary, and Indian Tribes and tribal organizations, as appropriate, to implement the activities under this paragraph;

IV. how the State will local monitor development and implementation of plans of safe care, in accordance with section 106(b)(2)(B)(iii)(II), including how the State will monitor to ensure plans of safe care address differences between substance use disorder and medically supervised substance use, including for the treatment of a substance use disorder;

V. if applicable, how the State plans to utilize funding authorized under part E of title IV of the Social Security Act (42 U.S.C. 670 et seq.) to assist in carrying

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out any plan of safe care, including such funding authorized under section 471(e) of such Act (as in effect on October 1, 2018) for mental health and substance abuse prevention and treatment services and in-home parent skill-based programs and funding authorized under such section 472(j) (as in effect on October 1, 2018) for children with a parent in a licensed residential family-based treatment facility for substance abuse; and

VI. an assessment of the treatment and other services and programs available in the State, to effectively carry out any plan of safe care developed, including identification of needed treatment, and other services and programs to ensure the well-being of young children and their families affected by substance use disorder, such as programs carried out under part C of the Individuals with Disabilities Education Act (20 U.S.C. 1431 et seq.) and comprehensive early childhood development services and programs such as Head Start programs;

ii. a description of how the State plans to use funds for activities described in subparagraph (D) for the purposes of ensuring State compliance with requirements under clauses (ii) and (iii) of section 106(b)(2)(B); and

iii. an assurance that the State will comply with requirements to refer a child identified as substance-exposed to early intervention services as required pursuant to a grant under part C of the Individuals with Disabilities Education Act (20 U.S.C. 1431 et seq.).

D. USES OF FUNDS.—Funds awarded to a State under this paragraph may be used for the following activities, which may be carried out by the State directly, or through grants or subgrants, contracts, or cooperative agreements:

i. Improving State and local systems with respect to the development and implementation of plans of safe care, which—

I. shall include parent and caregiver engagement, as required under section 106(b)(2)(B)(iii)(I), regarding available treatment and service options, which may include resources available for pregnant, perinatal, and postnatal women; and

II. may include activities such as—

aa. developing policies, procedures, or protocols for the administration or development of evidence-based and validated screening tools for infants who may be affected by substance use withdrawal symptoms or a fetal alcohol spectrum disorder and pregnant, perinatal, and postnatal women whose infants may be affected by substance use withdrawal symptoms or a fetal alcohol spectrum disorder;

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bb. improving assessments used to determine the needs of the infant and family;
cc. improving ongoing case management services; and
dd. improving access to treatment services, which may be prior to the pregnant woman's delivery date; and
ee. keeping families safely together when it is in the best interest of the child.

ii. Developing policies, procedures, or protocols in consultation and coordination with health professionals, public and private health facilities, and substance use disorder treatment agencies to ensure that—
   I. appropriate notification to child protective services is made in a timely manner as required under section 106(b)(2)(B)(ii);
   II. a plan of safe care is in place, in accordance with section 106(b)(2)(B)(iii), before the infant is discharged from the birth or health care facility; and
   III. such health and related agency professionals are trained on how to follow such protocols and are aware of the supports that may be provided under a plan of safe care.

iii. Training health professionals and health system leaders, child welfare workers, substance use disorder treatment agencies, and other related professionals such as home visiting agency staff and law enforcement in relevant topics including—
   I. State mandatory reporting laws established under section 106(b)(2)(B)(i) and the referral and process requirements for notification to child protective services when child abuse or neglect reporting is not mandated;
   II. the co-occurrence of pregnancy and substance use disorder, and implications of prenatal exposure;
   III. the clinical guidance about treating substance use disorder in pregnant and postpartum women;
   IV. appropriate screening and interventions for infants affected by substance use disorder, withdrawal symptoms, or a fetal alcohol spectrum disorder and the requirements under section 106(b)(2)(B)(iii); and
   V. appropriate multigenerational strategies to address the mental health needs of the parent and child together.

iv. Establishing partnerships, agreements, or memoranda of understanding between the lead agency and other entities (including health professionals, health facilities, child welfare professionals, juvenile and family court judges, substance use disorder treatment programs, early childhood education programs, maternal and child health and early intervention professionals (including home visiting providers), peer-to-peer recovery programs such as parent mentoring programs, and housing

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agencies) to facilitate the implementation of, and compliance with section 106(b)(2) and clause (ii) of this subparagraph, in areas which may include—

I. developing a comprehensive, multi-disciplinary assessment and intervention process for infants, pregnant women, and their families who are affected by substance use disorder, withdrawal symptoms, or a fetal alcohol spectrum disorder, that includes meaningful engagement with and takes into account the unique needs of each family and addresses differences between legal, medically supervised substance use, including for the treatment of substance use disorder, and substance use disorder;

II. ensuring that treatment approaches for serving infants, pregnant women, and perinatal and postnatal women whose infants may be affected by substance use, withdrawal symptoms, or a fetal alcohol spectrum disorder, are designed to, where appropriate, keep infants with their mothers during both inpatient and outpatient treatment; and

III. increasing access to all evidence-based medication-assisted treatment approved by the Food and Drug Administration, behavioral therapy, and counseling services for the treatment of substance use disorders, as appropriate.

v. Developing and updating systems of technology for improved data collection and monitoring under section 106(b)(2)(B)(iii), including existing electronic medical records, to measure the outcomes achieved through the plans of safe care, including monitoring systems to meet the requirements of this Act and submission of performance measures.

E. REPORTING.—Each State that receives funds under this paragraph, for each year such funds are received, shall submit a report to the Secretary, disaggregated by geographic location, economic status, and major racial and ethnic groups, except that such disaggregation shall not be required if the results would reveal personally identifiable information on, with respect to infants identified under section 106(b)(2)(B)(ii)—

i. The number who experienced removal associated with parental substance use;

ii. The number who experienced removal and are reunified with parents, and the length of time between such removal and reunification;

iii. the number who are referred to community providers without a child protection case;

iv. the number who receive services while in the care of their birth parents;

v. the number who receive post-reunification services within 1 year after a reunification has occurred; and

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vi. the number who experienced a return to out-of-home care within 1 year after reunification.

F. SECRETARY'S REPORT TO CONGRESS.—The Secretary shall submit an annual report to the Committee on Health, Education, Labor, and Pensions and the Committee on Appropriations of the Senate and the Committee on Education and the Workforce and the Committee on Appropriations of the House of Representatives that includes the information described in subparagraph (E) and recommendations or observations on the challenges, successes, and lessons derived from implementation of the grant program.

G. ASSISTING STATES' IMPLEMENTATION.—The Secretary shall use the amount reserved under subparagraph (B)(i)(I) to provide written guidance and technical assistance to support States in complying with and implementing this paragraph, which shall include—

i. technical assistance, including programs of in-depth technical assistance, to additional States, territories, and Indian tribes and tribal organizations in accordance with the substance-exposed infant initiative developed by the National Center on Substance Abuse and Child Welfare;

ii. guidance on the requirements of this Act with respect to infants born with and identified as being affected by substance use or withdrawal symptoms or fetal alcohol spectrum disorder, as described in clauses (ii) and (iii) of section 106(b)(2)(B), including by—

I. enhancing States' understanding of requirements and flexibilities under the law, including by clarifying key terms;

II. addressing state-identified challenges with developing, implementing, and monitoring plans of safe care, including those reported under subparagraph (C)(i)(II);

III. disseminating best practices on implementation of plans of safe care, on such topics as differential response, collaboration and coordination, and identification and delivery of services, for different populations, while recognizing needs of different populations and varying community approaches across States; and

IV. helping States improve the long-term safety and well-being of young children and their families;

iii. supporting State efforts to develop information technology systems to manage plans of safe care; and

iv. preparing the Secretary's report to Congress described in subparagraph (F).

H. SUNSET.—The authority under this paragraph shall sunset on September 30, 2023.

b. DISCRETIONARY GRANTS.—In addition to grants or contracts made under subsection (a) of this section, grants or contracts under this section may be used for the following:

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1. Respite and crisis nursery programs provided by community-based organizations under the direction and supervision of hospitals.
2. Respite and crisis nursery programs provided by community-based organizations.
3. Programs based within children's hospitals or other pediatric and adolescent care facilities, that provide model approaches for improving medical diagnosis of child abuse and neglect and for health evaluations of children for whom a report of maltreatment has been substantiated; and
4.
    A. Providing hospital-based information and referral services to—
        i. parents of children with disabilities; and
        ii. children who have been victims of child abuse or neglect and their parents.
    B. Except as provided in subparagraph (C)(iii), services provided under a grant received under this paragraph shall be provided at the hospital involved—
        i. upon the birth or admission of a child with disabilities; and
        ii. upon the treatment of a child for child abuse and neglect.
    C. Services, as determined as appropriate by the grantee, provided under a grant received under this paragraph shall be hospital-based and shall consist of—
        i. the provision of notice to parents that information relating to community services is available;
        ii. the provision of appropriate information to parents of a child with disabilities regarding resources in the community, particularly parent training resources, that will assist such parents in caring for their child;
        iii. the provision of appropriate information to parents of a child who has been a victim of child abuse or neglect regarding resources in the community, particularly parent training resources, that will assist such parents in caring for their child and reduce the possibility of child abuse and neglect;
        iv. the provision of appropriate follow-up services to parents of a child described in subparagraph (B) after the child has left the hospital; and
        v. where necessary, assistance in coordination of community services available to parents of children described in subparagraph (B).

        The grantee shall assure that parental involvement described in this subparagraph is voluntary.

    D. For purposes of this paragraph, a qualified grantee is an acute care hospital that—
        i. is in a combination with—
            I. a health-care provider organization;
            II. a child welfare organization;
            III. a disability organization; and

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IV. a State child protection agency;

ii. submits an application for a grant under this paragraph that is approved by the Secretary;

iii. maintains an office in the hospital involved for purposes of providing services under such grant;

iv. provides assurances to the Secretary that in the conduct of the project the confidentiality of medical, social, and personal information concerning any person described in subparagraph (A) or (B) shall be maintained, and shall be disclosed only to qualified persons providing required services described in subparagraph (C) for purposes relating to conduct of the project; and

v. assumes legal responsibility for carrying out the terms and conditions of the grant.

E. In awarding grants under this paragraph, the Secretary shall—

i. give priority under this section for two grants under this paragraph, provided that one grant shall be made to provide services in an urban setting and one grant shall be made to provide services in rural setting; and

ii. encourage qualified grantees to combine the amounts received under the grant with other funds available to such grantees.

5. Such other innovative programs and projects that show promise of preventing and treating cases of child abuse and neglect as the Secretary may approve.

c. EVALUATION.—In making grants for projects under this section, the Secretary shall require all such projects to be evaluated for their effectiveness. Funding for such evaluations shall be provided either as a stated percentage of a demonstration grant or as a separate grant or contract entered into by the Secretary for the purpose of evaluating a particular demonstration project or group of projects. In the case of an evaluation performed by the recipient of a grant, the Secretary shall make available technical assistance for the evaluation, where needed, including the use of a rigorous application of scientific evaluation techniques.

SEC. 106. GRANTS TO STATES FOR CHILD ABUSE OR NEGLECT PREVENTION AND TREATMENT PROGRAMS. [42 U.S.C. 5106a]

a. DEVELOPMENT AND OPERATION GRANTS.—The Secretary shall make grants to the States, from allotments made under subsection (f) for each State that applies for a grant under this section, for purposes of assisting the States in improving the child protective services system of each such State in—

1. the intake, assessment, screening, and investigation of reports of child abuse or neglect;

2.

A. creating and improving the use of multidisciplinary teams and interagency, intra-agency, interstate, and intrastate protocols to enhance investigations; and

B. improving legal preparation and representation, including—

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i. procedures for appealing and responding to appeals of substantiated reports of child abuse or neglect; and
ii. provisions for the appointment of an individual appointed to represent a child in judicial proceedings;

3. case management, including ongoing case monitoring, and delivery of services and treatment provided to children and their families;
4. enhancing the general child protective system by developing, improving, and implementing risk and safety assessment tools and protocols, including the use of differential response;
5. developing and updating systems of technology that support the program and track reports of child abuse and neglect from intake through final disposition and allow interstate and intrastate information exchange;
6. developing, strengthening, and facilitating training including—
    A. training regarding research-based strategies, including the use of differential response, to promote collaboration with the families;
    B. training regarding the legal duties of such individuals;
    C. personal safety training for case workers; and
    D. training in early childhood, child, and adolescent development;
7. improving the skills, qualifications, and availability of individuals providing services to children and families, and the supervisors of such individuals, through the child protection system, including improvements in the recruitment and retention of caseworkers;
8. developing, facilitating the use of, and implementing research-based strategies and training protocols for individuals mandated to report child abuse and neglect;
9. developing, implementing, or operating programs to assist in obtaining or coordinating necessary services for families of disabled infants with life-threatening conditions, including—
    A. existing social and health services;
    B. financial assistance;
    C. services necessary to facilitate adoptive placement of any such infants who have been relinquished for adoption; and
    D. the use of differential response in preventing child abuse and neglect;
10. developing and delivering information to improve public education relating to the role and responsibilities of the child protection system and the nature and basis for reporting suspected incidents of child abuse and neglect, including the use of differential response;
11. developing and enhancing the capacity of community-based programs to integrate shared leadership strategies between parents and professionals to prevent and treat child abuse and neglect at the neighborhood level;
12. supporting and enhancing interagency collaboration between the child protection system and the juvenile justice system for improved delivery of services and treatment, including methods for continuity of treatment plan and services as children transition between systems;
13. supporting and enhancing interagency collaboration among public health agencies, agencies in the child protective service system, and agencies carrying out private community-based programs—

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A. to provide child abuse and neglect prevention and treatment services (including linkages with education systems), and the use of differential response; and
B. to address the health needs, including mental health needs, of children identified as victims of child abuse or neglect, including supporting prompt, comprehensive health and developmental evaluations for children who are the subject of substantiated child maltreatment reports; or

14. developing and implementing procedures for collaboration among child protective services, domestic violence services, and other agencies in—
    A. investigations, interventions, and the delivery of services and treatment provided to children and families, including the use of differential response, where appropriate; and
    B. the provision of services that assist children exposed to domestic violence, and that also support the caregiving role of their non-abusing parents.

b. ELIGIBILITY REQUIREMENTS.—
    1. STATE PLAN.—
        A. IN GENERAL.—To be eligible to receive a grant under this section, a State shall submit to the Secretary a State plan that specifies the areas of the child protective services system described in subsection (a) that the State will address with amounts received under the grant.
        B. DURATION OF PLAN.—Each State plan shall—
            i. remain in effect for the duration of the State's participation under this section; and
            ii. be periodically reviewed and revised as necessary by the State to reflect changes in the State's strategies and programs under this section.
        C. ADDITIONAL INFORMATION.—The State shall provide notice to the Secretary—
            i. of any substantive changes, including any change to State law or regulations, relating to the prevention of child abuse and neglect that may affect the eligibility of the State under this section; and
            ii. of any significant changes in how funds provided under this section are used to support activities described in this section, which may differ from the activities described in the current State application.
    2. CONTENTS.—A State plan submitted under paragraph (1) shall contain a description of the activities that the State will carry out using amount received under the grant to achieve the objectives of this title, including—
        A. an assurance that the State plan, to the maximum extent practicable, is coordinated with the State plan under part B of title IV of the Social Security Act (42 U.S.C. 621 et seq.) relating to child welfare services and family preservation and family support services;
        B. an assurance in the form of a certification by the Governor of the State that the State has in effect and is enforcing a State law, or has in effect and is operating a statewide program, relating to child abuse and neglect that includes—

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i. provisions or procedures for an individual to report known and suspected instances of child abuse and neglect, including a State law for mandatory reporting by individuals required to report such instances;

ii. policies and procedures (including appropriate referrals to child protection service systems and for other appropriate services) to address the needs of infants born with and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder, including a requirement that health care providers involved in the delivery or care of such infants notify the child protective services system of the occurrence of such condition of such infants, except that such notification shall not be construed to—

   I. establish a definition under Federal law of what constitutes child abuse or neglect; or

   II. require prosecution for any illegal action.

iii. the development of a plan of safe care for the infant born and identified as being affected by substance abuse or withdrawal symptoms or Fetal Alcohol Spectrum Disorder to ensure the safety and well-being of such infant following release from the care of healthcare providers, including through—

   I. addressing the health and substance use disorder treatment needs of the infant and affected family or caregiver; and

   II. the development and implementation by the State of monitoring systems regarding the implementation of such plans to determine whether and in what manner local entities are providing, in accordance with State requirements, referrals to and delivery of appropriate services for the infant and affected family or caregiver;

iv. procedures for the immediate screening, risk and safety assessment, and prompt investigation of such reports;

v. triage procedures, including the use of differential response, for the appropriate referral of a child not at risk of imminent harm to a community organization or voluntary preventive service;

vi. procedures for immediate steps to be taken to ensure and protect the safety of a victim of child abuse or neglect and of any other child under the same care who may also be in danger of child abuse or neglect and ensuring their placement in a safe environment;

vii. provisions for immunity from civil or criminal liability under State and local laws and regulations for individuals making good faith reports of suspected or known instances of child abuse or neglect, or who otherwise provide information or assistance, including medical evaluations or consultations, in connection with a report,

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investigation, or legal intervention pursuant to a good faith report of child abuse or neglect[3];

viii. methods to preserve the confidentiality of all records in order to protect the rights of the child and of the child's parents or guardians, including requirements ensuring that reports and records made and maintained pursuant to the purposes of this title shall only be made available to—

I. individuals who are the subject of the report;

II. Federal, State, or local government entities, or any agent of such entities, as described in clause (ix);

III. child abuse citizen review panels;

IV. child fatality review panels;

V. a grand jury or court, upon a finding that information in the record is necessary for the determination of an issue before the court or grand jury; and

VI. other entities or classes of individuals statutorily authorized by the State to receive such information pursuant to a legitimate State purpose;

ix. provisions to require a State to disclose confidential information to any Federal, State, or local government entity, or any agent of such entity, that has a need for such information in order to carry out its responsibilities under law to protect children from child abuse and neglect;

x. provisions which allow for public disclosure of the findings or information about the case of child abuse or neglect which has resulted in a child fatality or near fatality;

xi. the cooperation of State law enforcement officials, court of competent jurisdiction, and appropriate State agencies providing human services in the investigation, assessment, prosecution, and treatment of child abuse and neglect;

xii. provisions requiring, and procedures in place that facilitate the prompt expungement of any records that are accessible to the general public or are used for purposes of employment or other background checks in cases determined to be unsubstantiated or false, except that nothing in this section shall prevent State child protective services agencies from keeping information on unsubstantiated reports in their casework files to assist in future risk and safety assessment;

xiii. provisions and procedures requiring that in every case involving a victim of child abuse or neglect which results in a judicial proceeding, a guardian ad litem who has received training appropriate to the role, including training in early childhood, child,

[3] Section 3(b) of P.L. 115-424 also provides Federal immunity from civil liability or criminal prosecution for any individual making a good faith report, or who provides information or assistance in connection with a report or investigation of child abuse or neglect; there shall also be a presumption that the person acted in good faith; and if the defendant prevails in a federal civil action, the court may award costs and reasonable attorney's fees incurred by the defendant.

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and adolescent development, and who may be an attorney or a court appointed special advocate who has received training appropriate to that role (or both), shall be appointed to represent the child in such proceedings—

I. to obtain first-hand, a clear understanding of the situation and needs of the child; and

II. to make recommendations to the court concerning the best interests of the child;

xiv. the establishment of citizen review panels in accordance with subsection (c);

xv. provisions, procedures, and mechanisms—

I. for the expedited termination of parental rights in the case of any infant determined to be abandoned under State law; and

II. by which individuals who disagree with an official finding of child abuse or neglect can appeal such finding;

xvi. provisions, procedures, and mechanisms that assure that the State does not require reunification of a surviving child with a parent who has been found by a court of competent jurisdiction—

I. to have committed murder (which would have been an offense under section 1111(a) of title 18 if the offense had occurred in the special maritime or territorial jurisdiction of the United States) of another child of such parent;

II. to have committed voluntary manslaughter (which would have been an offense under section 1112(a) of title 18 if the offense had occurred in the special maritime or territorial jurisdiction of the United States) of another child of such parent;

III. to have aided or abetted, attempted, conspired, or solicited to commit such murder or voluntary manslaughter;

IV. to have committed a felony assault that results in the serious bodily injury to the surviving child or another child of such parent;

V. to have committed sexual abuse against the surviving child or another child of such parent; or

VI. to be required to register with a sex offender registry under section 113(a) of the Adam Walsh Child Protection and Safety Act of 2006 (42 U.S.C. 16913(a));

xvii. an assurance that, upon the implementation by the State of the provisions, procedures, and mechanisms under clause (xvi), conviction of any one of the felonies listed in clause (xvi) constitute grounds under State law for the termination of parental rights of the convicted parent as to the surviving children (although case-by-case determinations of whether or not to seek termination of parental rights shall be within the sole discretion of the State);

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xviii. provisions and procedures to require that a representative of the child protective services agency shall, at the initial time of contact with the individual subject to a child abuse or neglect investigation, advise the individual of the complaints or allegations made against the individual, in a manner that is consistent with laws protecting the rights of the informant;

xix. provisions addressing the training of representatives of the child protective services system regarding the legal duties of the representatives, which may consist of various methods of informing such representatives of such duties, in order to protect the legal rights and safety of children and families from the initial time of contact during investigation through treatment;

xx. provisions and procedures for improving the training, retention, and supervision of caseworkers;

xxi. provisions and procedures for referral of a child under the age of 3 who is involved in a substantiated case of child abuse or neglect to early intervention services funded under part C of the Individuals with Disabilities Education Act (20 U.S.C. 1431 et seq.);

xxii. provisions and procedures for requiring criminal background checks that meet the requirements of section 471(a)(20) of the Social Security Act (42 U.S.C. 671(a)(20) for prospective foster and adoptive parents and other adult relatives and non-relatives residing in the household;

xxiii. provisions for systems of technology that support the State child protective service system described in subsection (a) and track reports of child abuse and neglect from intake through final disposition;

xxiv. provisions and procedures requiring identification and assessment of all reports involving children known or suspected to be victims of sex trafficking (as defined in section 103(10) of the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7102(10)[4]); and

xxv. provisions and procedures for training child protective services workers about identifying, assessing, and providing comprehensive services for children who are sex trafficking victims, including efforts to coordinate with State law enforcement, juvenile justice, and social service agencies such as runaway and homeless youth shelters to serve this population;

C. an assurance that the State has in place procedures for responding to the reporting of medical neglect (including instances of withholding of medically indicated treatment from infants with disabilities who have life-threatening conditions), procedures or programs, or both (within the State child protective services system), to provide for—

i. coordination and consultation with individuals designated by and within appropriate health-care facilities;

[4] Section 7102(10) of title 22, referred to in subsec. (b)(2)(B)(xxiv), was redesignated section 7102(12) of title 22 by Pub. L. 115–427, §2(1), Jan. 9, 2019, 132 Stat. 5503.

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ii. prompt notification by individuals designated by and within appropriate health-care facilities of cases of suspected medical neglect (including instances of withholding of medically indicated treatment from infants with disabilities who have life-threatening conditions); and

iii. authority, under State law, for the State child protective services system to pursue any legal remedies, including the authority to initiate legal proceedings in a court of competent jurisdiction, as may be necessary to prevent the withholding of medically indicated treatment from infants with disabilities who have life-threatening conditions;

D. a description of—

i. the services to be provided under the grant to individuals, families, or communities, either directly or through referrals aimed at preventing the occurrence of child abuse and neglect;

ii. the training to be provided under the grant to support direct line and supervisory personnel in report taking, screening, assessment, decision making, and referral for investigating suspected instances of child abuse and neglect;

iii. the training to be provided under the grant for individuals who are required to report suspected cases of child abuse and neglect;

iv. policies and procedures encouraging the appropriate involvement of families in decision-making pertaining to children who experienced child abuse or neglect;

v. policies and procedures that promote and enhance appropriate collaboration among child protective service agencies, domestic violence service agencies, substance abuse treatment agencies, and other agencies in investigations, interventions, and the delivery of services and treatment provided to children and families affected by child abuse or neglect, including children exposed to domestic violence, where appropriate; and

vi. policies and procedures regarding the use of differential response, as applicable;

E. an assurance or certification that the programs or projects relating to child abuse and neglect carried out under part B of title IV of the Social Security Act [42 U.S.C. 621 et seq.] comply with the requirements set forth in paragraph (1) and this paragraph.

F. an assurance or certification that programs and training conducted under this title address the unique needs of unaccompanied homeless youth, including access to enrollment and support services and that such youth are eligible for under parts B and E of title IV of the Social Security Act [42 U.S.C. 620 et seq., 670 et seq.] and meet the requirements of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11301 et seq.); and

G. an assurance that the State, in developing the State plan described in paragraph (1), has collaborated with community-based prevention agencies and with families affected by child abuse or neglect.

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Nothing in subparagraph (B) shall be construed to limit the State's flexibility to determine State policies relating to public access to court proceedings to determine child abuse and neglect, except that such policies shall, at a minimum, ensure the safety and well-being of the child, parents, and families;

3. LIMITATION.—With regard to clauses (vi) and (vii) of paragraph (2)(B), nothing in this section shall be construed as restricting the ability of a State to refuse to disclose identifying information concerning the individual initiating a report or complaint alleging suspected instances of child abuse or neglect, except that the State may not refuse such a disclosure where a court orders such disclosure after such court has reviewed, in camera, the record of the State related to the report or complaint and has found it has reason to believe that the reporter knowingly made a false report.
4. DEFINITIONS.—For purposes of this subsection—
    A. the term "near fatality" means an act that, as certified by a physician, places the child in serious or critical condition; and
    B. the term "serious bodily injury" means bodily injury which involves substantial risk of death, extreme physical pain, protracted and obvious disfigurement, or protracted loss or impairment of the function of a bodily member, organ, or mental faculty.

c. CITIZEN REVIEW PANELS.—
    1. ESTABLISHMENT.—
        A. IN GENERAL.—Except as provided in subparagraph (B), each State to which a grant is made under this section shall establish not less than 3 citizen review panels.
        B. EXCEPTIONS.—
            i. ESTABLISHMENT OF PANELS BY STATES RECEIVING MINIMUM ALLOTMENT.—A State that receives the minimum allotment of $175,000 under section 203(b)(1)(A) [42 U.S.C. 5116(b)(1)(A)] of this title for a fiscal year shall establish not less than 1 citizen review panel.
            ii. DESIGNATION OF EXISTING ENTITIES.—A State may designate as panels for purposes of this subsection one or more existing entities established under State or Federal law, such as child fatality panels or foster care review panels, if such entities have the capacity to satisfy the requirements of paragraph (4) and the State ensures that such entities will satisfy such requirements.
    2. MEMBERSHIP.—Each panel established pursuant to paragraph (1) shall be composed of volunteer members who are broadly representative of the community in which such panel is established, including members who have expertise in the prevention and treatment of child abuse and neglect, and may include adult former victims of child abuse or neglect.
    3. MEETINGS.—Each panel established pursuant to paragraph (1) shall meet not less than once every 3 months.
    4. FUNCTIONS.—

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A. IN GENERAL.—Each panel established pursuant to paragraph (1) shall, by examining the policies, procedures, and practices of State and local agencies and where appropriate, specific cases, evaluate the extent to which State and local child protection system agencies are effectively discharging their child protection responsibilities in accordance with—
   i. the State plan under subsection (b) of this section;
   ii. the child protection standards set forth in subsection (b) of this section; and
   iii. any other criteria that the panel considers important to ensure the protection of children, including—
      I. a review of the extent to which the State and local child protective services system is coordinated with the foster care and adoption programs established under part E of title IV of the Social Security Act (42 U.S.C. 671 et seq.); and
      II. a review of child fatalities and near fatalities (as defined in subsection (b)(4) [of this section]).

B. CONFIDENTIALITY.—
   i. IN GENERAL.—The members and staff of a panel established under paragraph (1)—
      I. shall not disclose to any person or government official any identifying information about any specific child protection case with respect to which the panel is provided information; and
      II. shall not make public other information unless authorized by State statute.
   ii. CIVIL SANCTIONS.—Each State that establishes a panel pursuant to paragraph (1) shall establish civil sanctions for a violation of clause (i).

C. PUBLIC OUTREACH.—Each panel shall provide for public outreach and comment in order to assess the impact of current procedures and practices upon children and families in the community and in order to meet its obligations under subparagraph (A).

5. STATE ASSISTANCE.—Each State that establishes a panel pursuant to paragraph (1)—
   A. shall provide the panel access to information on cases that the panel desires to review if such information is necessary for the panel to carry out its functions under paragraph (4); and
   B. shall provide the panel, upon its request, staff assistance for the performance of the duties of the panel.
6. REPORTS.—Each panel established under paragraph (1) shall prepare and make available to the State and the public, on an annual basis, a report containing a summary of the activities of the panel and recommendations to improve the child protection services system at the State and local levels. Not later than 6 months after the date on which a report is submitted by the panel to the State, the appropriate State agency shall submit a written response to State and local child protection systems and the citizen review panel that describes whether or how the

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State will incorporate the recommendations of such panel (where appropriate) to make measurable progress in improving the State and local child protection system.

d. ANNUAL STATE DATA REPORTS.—Each State to which a grant is made under this section shall annually work with the Secretary to provide, to the maximum extent practicable, a report that includes the following:
    1. The number of children who were reported to the State during the year as victims of child abuse or neglect.
    2. Of the number of children described in paragraph (1), the number with respect to whom such reports were—
        A. substantiated;
        B. unsubstantiated; or
        C. determined to be false.
    3. Of the number of children described in paragraph (2)—
        A. the number that did not receive services during the year under the State program funded under this section or an equivalent State program;
        B. the number that received services during the year under the State program funded under this section or an equivalent State program; and
        C. the number that were removed from their families during the year by disposition of the case.
    4. The number of families that received preventive services, including use of differential response, from the State during the year.
    5. The number of deaths in the State during the year resulting from child abuse or neglect.
    6. Of the number of children described in paragraph (5), the number of such children who were in foster care.
    7.
        A. The number of child protective service personnel responsible for the—
            i. intake of reports filed in the previous year;
            ii. screening of such reports;
            iii. assessment of such reports; and
            iv. investigation of such reports.
        B. The average caseload for the workers described in subparagraph (A).
    8. The agency response time with respect to each such report with respect to initial investigation of reports of child abuse or neglect.
    9. The response time with respect to the provision of services to families and children where an allegation of child abuse or neglect has been made.
    10. For child protective service personnel responsible for intake, screening, assessment, and investigation of child abuse and neglect reports in the State—
        A. information on the education, qualifications, and training requirements established by the State for child protective service professionals, including for entry and advancement in the profession, including advancement to supervisory positions;
        B. data of the education, qualifications, and training of such personnel;
        C. demographic information of the child protective service personnel; and

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D. information on caseload or workload requirements for such personnel, including requirements for average number and maximum number of cases per child protective service worker and supervisor.

11. The number of children reunited with their families or receiving family preservation services that, within five years, result in subsequent substantiated reports of child abuse or neglect, including the death of the child.
12. The number of children for whom individuals were appointed by the court to represent the best interests of such children and the average number of out of court contacts between such individuals and children.
13. The annual report containing the summary of activities of the citizen review panels of the State required by subsection (c)(6).
14. The number of children under the care of the State child protection system who are transferred into the custody of the State juvenile justice system.
15. The number of children referred to a child protective services system under subsection (b)(2)(B)(ii).
16. The number of children determined to be eligible for referral, and the number of children referred, under subsection (b)(2)(B)(xxi), to agencies providing early intervention services under part C of the Individuals with Disabilities Education Act (20 U.S.C. 1431 et seq.).
17. The number of children determined to be victims described in subsection (b)(2)(B)(xxiv).
18. The number of infants—
    A. identified under subsection (b)(2)(B)(ii);
    B. for whom a plan of safe care was developed under subsection (b)(2)(B)(iii); and
    C. for whom a referral was made for appropriate services, including services for the affected family or caregiver; under subsection (b)(2)(B)(iii).

e. ANNUAL REPORT BY SECRETARY.—Within 6 months after receiving the State reports under subsection (d) of this section, the Secretary shall prepare a report based on information provided by the States for the fiscal year under such subsection and shall make the report and such information available to the Congress and the national clearinghouse for information relating to child abuse and neglect.

f. ALLOTMENTS.—
    1. DEFINITIONS.—In this subsection:
        A. FISCAL YEAR 2009 GRANT FUNDS.—The term ‘fiscal year 2009 grant funds’ means the amount appropriated under section 112 for fiscal year 2009, and not reserved under section 112(a)(2).
        B. GRANT FUNDS.—The term ‘grant funds’ means the amount appropriated under section 112 for a fiscal year and not reserved under section 112(a)(2).
        C. STATE.—The term ‘State’ means each of the several States, the District of Columbia, and the Commonwealth of Puerto Rico.
        D. TERRITORY.—The term The term ‘territory’ means Guam, American Samoa, the United States Virgin Islands, and the Commonwealth of the Northern Mariana Islands.

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2. IN GENERAL.—Except as otherwise provided in this section, the Secretary shall make allotments to each State and territory that applies for a grant under this section in an amount equal to the sum of—
    A. $50,000; and
    B. an amount that bears the same relationship to any grant funds remaining after all such States and territories have received $50,000, as the number of children under the age of 18 in the State or territory bears to the number of such children in all States and territories that apply for such a grant.
3. ALLOTMENTS FOR DECREASED APPROPRIATION YEARS.—In the case where the grant funds for a fiscal year are less than the fiscal year 2009 grant funds, the Secretary shall ratably reduce each of the allotments under paragraph (2) for such fiscal year.
4. ALLOTMENTS FOR INCREASED APPROPRIATION YEARS.—
    A. MINIMUM ALLOTMENTS TO STATES FOR INCREASED APPROPRIATION YEARS.—In any fiscal year for which the grant funds exceed the fiscal year 2009 grant funds by more than $1,000,000, the Secretary shall adjust the allotments under paragraph (2), as necessary, such that no State that applies for a grant under this section receives an allotment in an amount that is less than—
        i. $100,000, for a fiscal year in which the grant funds exceed the fiscal year 2009 grant funds by more than $1,000,000 but less than $2,000,000;
        ii. $125,000, for a fiscal year in which the grant funds exceed the fiscal year 2009 grant funds by at least $2,000,000 but less than $3,000,000; and
        iii. $150,000, for a fiscal year in which the grant funds exceed the fiscal year 2009 grant funds by at least $3,000,000.
    B. ALLOTMENT ADJUSTMENT.—In the case of a fiscal year for which subparagraph (A) applies and the grant funds are insufficient to satisfy the requirements of such subparagraph (A), paragraph (2), and paragraph (5), the Secretary shall, subject to paragraph (5), ratably reduce the allotment of each State for which the allotment under paragraph (2) is an amount that exceeds the applicable minimum under subparagraph (A), as necessary to ensure that each State receives the applicable minimum allotment under subparagraph (A).
5. HOLD HARMLESS.—Notwithstanding paragraphs (2) and (4), except as provided in paragraph (3), no State or territory shall receive a grant under this section in an amount that is less than the amount such State or territory received under this section for fiscal year 2009.

Sec. 107. GRANTS TO STATES FOR PROGRAMS RELATING TO INVESTIGATION AND PROSECUTION OF CHILD ABUSE AND NEGLECT CASES. [42 U.S.C. 5106c]

a. GRANTS TO STATES.—The Secretary, in consultation with the Attorney General, is authorized to make grants to the States for the purpose of assisting States in developing, establishing, and operating programs designed to improve—

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1. the assessment and investigation of suspected child abuse and neglect cases, including cases of suspected child sexual abuse and exploitation, in a manner that limits additional trauma to the child and the child's family;
2. the assessment and investigation of cases of suspected child abuse-related fatalities and suspected child neglect-related fatalities;
3. the investigation and prosecution of cases of child abuse and neglect, including child sexual abuse and exploitation; and
4. the assessment and investigation of cases involving children with disabilities or serious health-related problems who are suspected victims of child abuse or neglect.

b. ELIGIBILITY REQUIREMENTS.—In order for a State to qualify for assistance under this section, such State shall—
   1. fulfill the requirements of section 106(b) [of this title];
   2. establish a task force as provided in subsection (c) [of this section];
   3. fulfill the requirements of subsection (d) [of this section];
   4. submit annually an application to the Secretary at such time and containing such information and assurances as the Secretary considers necessary, including an assurance that the State will—
      A. make such reports to the Secretary as may reasonably be required; and
      B. maintain and provide access to records relating to activities under subsections (a) and (b) of this section; and
   5. submit annually to the Secretary a report on the manner in which assistance received under this program was expended throughout the State, with particular attention focused on the areas described in paragraphs (1) through (3) of subsection (a) of this section.

c. STATE TASK FORCES.—
   1. GENERAL RULE.—Except as provided in paragraph (2), a State requesting assistance under this section shall establish or designate, and maintain, a State multidisciplinary task force on children's justice (hereinafter referred to as "State task force") composed of professionals with knowledge and experience relating to the criminal justice system and issues of child physical abuse, child neglect, child sexual abuse and exploitation, and child maltreatment related fatalities. The State task force shall include—
      A. individuals representing the law enforcement community;
      B. judges and attorneys involved in both civil and criminal court proceedings related to child abuse and neglect (including individuals involved with the defense as well as the prosecution of such cases);
      C. child advocates, including both attorneys for children and, where such programs are in operation, court appointed special advocates;
      D. health and mental health professionals;
      E. individuals representing child protective service agencies;
      F. individuals experienced in working with children with disabilities;
      G. parents;
      H. representatives of parents' groups;
      I. adult former victims of child abuse and or neglect; and

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J. individuals experienced in working with homeless children and youths (as defined in section 725 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a)).

2. EXISTING TASK FORCE.—As determined by the Secretary, a State commission or task force established after January 1, 1983, with substantially comparable membership and functions, may be considered the State task force for purposes of this subsection.

d. STATE TASK FORCE STUDY.—Before a State receives assistance under this section, and at three year intervals thereafter, the State task force shall comprehensively—

1. review and evaluate State investigative, administrative and both civil and criminal judicial handling of cases of child abuse and neglect, including child sexual abuse and exploitation, as well as cases involving suspected child maltreatment related fatalities and cases involving a potential combination of jurisdictions, such as intrastate, interstate, Federal-State, and State-Tribal; and
2. make policy and training recommendations in each of the categories described in subsection (e) of this section. The task force may make such other comments and recommendations as are considered relevant and useful.

e. ADOPTION OF STATE TASK FORCE RECOMMENDATIONS.—

1. GENERAL RULE.—Subject to the provisions of paragraph (2), before a State receives assistance under this section, a State shall adopt recommendations of the State task force in each of the following categories—
   A. investigative, administrative, and judicial handling of cases of child abuse and neglect, including child sexual abuse and exploitation, as well as cases involving suspected child maltreatment related fatalities and cases involving a potential combination of jurisdictions, such as intrastate, interstate, Federal-State, and State-Tribal, in a manner which reduces the additional trauma to the child victim and the victim's family and which also ensures procedural fairness to the accused;
   B. experimental, model, and demonstration programs for testing innovative approaches and techniques which may improve the prompt and successful resolution of civil and criminal court proceedings or enhance the effectiveness of judicial and administrative action in child abuse and neglect cases, particularly child sexual abuse and exploitation cases, including the enhancement of performance of court appointed attorneys and guardians ad litem for children, and which also ensure procedural fairness to the accused; and
   C. reform of State laws, ordinances, regulations, protocols, and procedures to provide comprehensive protection for children, which may include those children involved in reports of child abuse or neglect with a potential combination of jurisdictions, such as intrastate, interstate, Federal-State, and State-Tribal, from child abuse and neglect, including child sexual abuse and exploitation, while ensuring fairness to all affected persons.
2. EXEMPTION.—As determined by the Secretary, a State shall be considered to be in fulfillment of the requirements of this subsection if—
   A. the State adopts an alternative to the recommendations of the State task force, which carries out the purpose of this section, in each of the

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categories under paragraph (1) for which the State task force's recommendations are not adopted; or

B. the State is making substantial progress toward adopting recommendations of the State task force or a comparable alternative to such recommendations.

f. FUNDS AVAILABLE.—For grants under this section, the Secretary shall use the amount authorized by section 10603a of this title (42 U.S.C. 10603a).

Sec. 108. MISCELLANEOUS REQUIREMENTS RELATING TO ASSISTANCE. [42 U.S.C. 5106d]

a. CONSTRUCTION OF FACILITIES.—
   1. RESTRICTION ON USE OF FUNDS.—Assistance provided under this Act may not be used for construction of facilities.
   2. LEASE, RENTAL, OR REPAIR.—The Secretary may authorize the use of funds received under this Act—
      A. where adequate facilities are not otherwise available, for the lease or rental of facilities; or
      B. for the repair or minor remodeling or alteration of existing facilities.

b. GEOGRAPHICAL DISTRIBUTION.—The Secretary shall establish criteria designed to achieve equitable distribution of assistance under this Act among the States, among geographic areas of the Nation, and among rural and urban areas of the Nation. To the extent possible, the Secretary shall ensure that the citizens of each State receive assistance from at least one project under this Act.

c. LIMITATION.—No funds appropriated for any grant or contract pursuant to authorizations made in this Act may be used for any purpose other than that for which such funds were authorized to be appropriated.

d. SENSE OF CONGRESS.—It is the sense of Congress that the Secretary should encourage all States and public and private entities that receive assistance under this title to—
   1. ensure that children and families with limited English proficiency who participate in programs under this title are provided with materials and services through such programs in an appropriate language other than English; and
   2. ensure that individuals with disabilities who participate in programs under this title are provided with materials and services through such programs that are appropriate to their disabilities.

e. ANNUAL REPORT.—State that receives funds under section 106(a) [42 U.S.C. 5106A] shall annually prepare and submit to the Secretary a report describing the manner in which funds provided under this Act, alone or in combination with other Federal funds, were used to address the purposes and achieve the objectives of section 106.

Sec. 109. COORDINATION OF CHILD ABUSE AND NEGLECT PROGRAMS [42 U.S.C. 5106e]

The Secretary shall prescribe regulations and make such arrangements as may be necessary or appropriate to ensure that there is effective coordination among programs related to child abuse and neglect under this Act and other such programs which are assisted by Federal funds.

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Sec. 110. REPORTS. [42 U.S.C. 5106f]

a. COORDINATION EFFORTS.—Not later than 1 year after the date of enactment of the CAPTA Reauthorization Act of 2010, the Secretary shall submit to the Committee on Education and Labor of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a report on efforts to coordinate the objectives and activities of agencies and organizations which are responsible for programs and activities related to child abuse and neglect. Not later than 3 years after that date of enactment, the Secretary shall submit to those committees a second report on such efforts during the 3-year period following that date of enactment. Not later than 5 years after that date of enactment, the Secretary shall submit to those committees a third report on such efforts during the 5-year period following that date of enactment.

b. EFFECTIVENESS OF STATE PROGRAMS AND TECHNICAL ASSISTANCE.—Not later than 2 years after the date of enactment of the CAPTA Reauthorization Act of 2010 and every 2 years thereafter, the Secretary shall submit to Committee on Education and Labor of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a report evaluating the effectiveness of programs receiving assistance under section 106 in achieving the objectives of section 106.

c. STUDY AND REPORT RELATING TO CITIZEN REVIEW PANELS.—
    1. IN GENERAL.—The Secretary shall conduct a study to determine the effectiveness of citizen review panels, established under section 106(c), in achieving the stated function of such panels under section 106(c)(4)(A) of—
        A. examining the policies, procedures, and practices of State and local child protection agencies; and
        B. evaluating the extent to which such State and local child protection agencies are fulfilling their child protection responsibilities, as described in clauses (i) through (iii) of section 106(c)(4)(A).
    2. CONTENT OF STUDY.—The study described in paragraph (1) shall be completed in a manner suited to the unique design of citizen review panels, including consideration of the variability among the panels within and between States. The study shall include the following:
        A. Data describing the membership, organizational structure, operation, and administration of all citizen review panels and the total number of such panels in each State.
        B. A detailed summary of the extent to which collaboration and information-sharing occurs between citizen review panels and State child protective services agencies or any other entities or State agencies. The summary shall include a description of the outcomes that result from collaboration and information sharing.
        C. Evidence of the adherence and responsiveness to the reporting requirements under section 106(c)(6) by citizen review panels and States.
    3. REPORT.—Not later than 2 years after the date of enactment of the CAPTA Reauthorization Act of 2010, the Secretary shall submit to the to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Education and Labor of the House of Representatives a report that contains the results of the study conducted under paragraph (1).

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d. STUDY AND REPORT RELATING TO IMMUNITY FROM PROSECUTION FOR PROFESSIONAL CONSULTATION IN SUSPECTED AND KNOWN INSTANCES OF CHILD ABUSE AND NEGLECT.—
    1. STUDY.—The Secretary shall complete a study, in consultation with experts in the provision of healthcare, law enforcement, education, and local child welfare administration, that examines how provisions for immunity from prosecution under State and local laws and regulations facilitate and inhibit individuals cooperating, consulting, or assisting in making good faith reports, including mandatory reports, of suspected or known instances of child abuse or neglect.
    2. REPORT.—Not later than 1 year after the date of the enactment of the CAPTA Reauthorization Act of 2010, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Education and Labor of the House of Representatives a report that contains the results of the study conducted under paragraph (1) and any recommendations for statutory or regulatory changes the Secretary determines appropriate. Such report may be submitted electronically.

Sec. 111. DEFINITIONS. [42 US.C. 5106g]

a. Definitions.— For purposes of this title [42 U.S.C. 5101 et. seq.]—

1. the term ‘Alaska Native’ has the meaning given the term ‘Native’ in section 3 of the Alaska Native Claims Settlement Act (43 U.S.C. 1602);
2. the term ‘infant or toddler with a disability’ has the meaning given in section 632 of the Individuals with Disabilities Education Act (20 U.S.C. 1432);
3. the term ‘Native Hawaiian’ has the meaning given the term in section 7207 of the Elementary and Secondary Education Act of 1965 (20 U.S.C 7517);
4. the term “sexual abuse” includes—
    A. the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or
    B. the rape, and in cases of caretaker or inter-familial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children; and
5. the term “withholding of medically indicated treatment” means the failure to respond to the infant’s life-threatening conditions by providing treatment (including appropriate nutrition, hydration, and medication) which, in the treating physician’s or physicians’ reasonable medical judgment, will be most likely to be effective in ameliorating or correcting all such conditions, except that the term does not include the failure to provide treatment (other than appropriate nutrition, hydration, or medication) to an infant when, in the treating physician’s or physicians’ reasonable medical judgment—
    A. the infant is chronically and irreversibly comatose;
    B. the provision of such treatment would—
        i. merely prolong dying;
        ii. not be effective in ameliorating or correcting all of the infant’s life-threatening conditions; or

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iii. otherwise be futile in terms of the survival of the infant; or

C. the provision of such treatment would be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane.

b. SPECIAL RULE.—

1. IN GENERAL. – For purposes of section 3(2) and subsection (a)(4), a child shall be considered a victim of 'child abuse and neglect' and of 'sexual abuse' if the child is identified, by a State or local agency employee of the State or locality involved, as being a victim of human trafficking.
2. STATE OPTION.— Notwithstanding the definition of 'child' in section (3)(1), a State may elect to define that term for purposes of the application of paragraph (1) to section (3)(2) and subsection (a)(4) as a person who has not attained the age of 24.

Sec. 112. AUTHORIZATION OF APPROPRIATIONS. [42 U.S.C. 5106h]

a. IN GENERAL.—
   1. GENERAL AUTHORIZATION.—There are authorized to be appropriated to carry out this title, $120,000,000 for fiscal year 2010, and such sums as may be necessary for each of the fiscal years 2011 through 2015.
   2. DISCRETIONARY ACTIVITIES.—
      A. IN GENERAL.—Of the amounts appropriated for a fiscal year under paragraph (1), the Secretary shall make available 30 percent of such amounts to fund discretionary activities under this title.
      B. DEMONSTRATION PROJECTS.—Of the amounts made available for a fiscal year under subparagraph (A), the Secretary shall make available not more than 40 percent of such amounts to carry out section 104.

b. AVAILABILITY OF FUNDS WITHOUT FISCAL YEAR LIMITATION. — The Secretary shall ensure that funds appropriated pursuant to authorizations in this title shall remain available until expended for the purposes for which they were appropriated.

Sec. 113. RULE OF CONSTRUCTION. [42 U.S.C. 5106i]

a. IN GENERAL.—Nothing in this Act shall be construed—
   1. as establishing a Federal requirement that a parent or legal guardian provide a child any medical service or treatment against the religious beliefs of the parent or legal guardian; and
   2. to require that a State find, or to prohibit a State from finding, child abuse or neglect in cases in which a parent or legal guardian relies solely or partially upon spiritual means rather than medical treatment, in accordance with the religious beliefs of the parent or legal guardian.

b. STATE REQUIREMENT.—Notwithstanding subsection (a), a State shall, at a minimum, have in place authority under State law to permit the child protective services system of the State to pursue any legal remedies, including the authority to initiate legal proceedings in a court of competent jurisdiction, to provide medical care or treatment for a child when such care or treatment is necessary to prevent or remedy serious harm to the child, or to prevent the withholding of medically indicated treatment from children with life threatening conditions. Except with respect to the withholding of medically indicated

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treatments from disabled infants with life threatening conditions, case by case determinations concerning the exercise of the authority of this subsection shall be within the sole discretion of the State.

Sec. 114. MONITORING AND OVERSIGHT.

The Secretary shall conduct monitoring to ensure that each State that receives a grant under section 106 is in compliance with the requirements of section 106(b), which—

1. shall—
    A. be in addition to the review of the State plan upon its submission under section 106(b)(1)(A); and
    B. include monitoring of State policies and procedures required under clauses (ii) and (iii) of section 106(b)(2)(B); and
2. may include—
    A. a comparison of activities carried out by the State to comply with the requirements of section 106(b) with the State plan most recently approved under section 432 of the Social Security Act;
    B. a review of information available on the website of the State relating to its compliance with the requirements of section 106(b);
    C. site visits, as may be necessary to carry out such monitoring; and
    D. a review of information available in the State's Annual Progress and Services Report most recently submitted under section 1357.16 of title 45, Code of Federal Regulations (or successor regulations).

TITLE II—COMMUNITY-BASED GRANTS FOR THE PREVENTION OF CHILD ABUSE AND NEGLECT

Sec. 201. PURPOSE AND AUTHORITY. [42 U.S.C. 5116]

a. PURPOSE.—It is the purpose of this title—
    1. to support community-based efforts to develop, operate, expand, enhance, and coordinate initiatives, programs, and activities to prevent child abuse and neglect and to support the coordination of resources and activities, to better strengthen and support families to reduce the likelihood of child abuse and neglect; and
    2. to foster an understanding, appreciation, and knowledge of diverse populations in order to be effective in preventing and treating child abuse and neglect.
b. AUTHORITY.—The Secretary shall make grants under this title on a formula basis to the entity designated by the State as the lead entity (referred to in this title as the "lead entity") under section 202(1) for the purpose of—
    1. developing, operating, expanding, and enhancing community-based and prevention-focused programs and activities designed to strengthen and support families to prevent child abuse and neglect that are accessible, effective, culturally appropriate, and build on existing strengths that—
        A. offer assistance to families;
        B. provide early, comprehensive support for parents;

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C. promote the development of parenting skills, especially in young parents and parents with very young children;
D. increase family stability;
E. improve family access to other formal and informal resources and opportunities for assistance available within communities, including access to such resources and opportunities for unaccompanied homeless youth;
F. support the additional needs of families with children with disabilities through respite care and other services;
G. demonstrate a commitment to involving parents in the planning and program implementation of the lead agency and entities carrying out local programs funding under this title, including involvement of parents of children with disabilities, parents who are individuals with disabilities, racial and ethnic minorities, and members of other underrepresented or underserved groups; and;
H. provide referrals to early health and developmental services;

2. fostering the development of a continuum of preventive services for children and families, including unaccompanied homeless youth, through State and community-based collaborations and partnerships both public and private;
3. financing the start-up, maintenance, expansion, or redesign of specific community-based child abuse and neglect prevention program services (such as respite care services, child abuse and neglect prevention activities, disability services, mental health services, substance abuse treatment services, domestic violence services, housing services, transportation, adult education, home visiting and other similar services) identified by the inventory and description of current services required under section 205(a)(3) as an unmet need, and integrated with the network of community-based child abuse and neglect prevention program to the extent practicable given funding levels and community priorities;
4. maximizing funding through leveraging of funds for the financing, planning, community mobilization, collaboration, assessment, information and referral, startup, training and technical assistance, information management and reporting, reporting and evaluation costs for establishing, operating, or expanding community-based and prevention-focused programs and activities designed to strengthen and support families to prevent child abuse and neglect; and
5. financing public information activities that focus on the healthy and positive development of parents and children and the promotion of child abuse and neglect prevention activities.

Sec. 202. ELIGIBILITY. [42 U.S.C. 5116a]

A State shall be eligible for a grant under this title for a fiscal year if—

1.
A. the Governor of the State has designated a lead entity to administer funds under this title for the purposes identified under the authority of this title, including to develop, implement, operate, enhance, or expand community-based and

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prevention-focused programs and activities designed to strengthen and support families to prevent child abuse and neglect;

B. such lead entity is an existing public, quasi-public, or nonprofit private entity (which may be an entity that has not been established pursuant to State legislation, executive order, or any other written authority of the State that exists to strengthen and support families to prevent child abuse and neglect) with a demonstrated ability to work with other State and community-based agencies to provide training and technical assistance, and that has the capacity and commitment to ensure the meaningful involvement of parents who are consumers and who can provide leadership in the planning, implementation, and evaluation of programs and policy decisions of the applicant agency in accomplishing the desired outcomes for such efforts;

C. in determining which entity to designate under subparagraph (A), the Governor should give priority consideration equally to a trust fund advisory board of the State or to an existing entity that leverages Federal, State, and private funds for a broad range of child abuse and neglect prevention activities and family resource programs, and that is directed by an interdisciplinary, public-private structure, including participants from communities; and

D. in the case of a State that has designated a State trust fund advisory board for purposes of administering funds under this title (as such, title was in effect on the date of the enactment of the Child Abuse Prevention and Treatment Act Amendments of 1996) and in which one or more entities that leverage Federal, State, and private funds (as described in subparagraph (C)) exist, the Governor shall designate the lead entity only after full consideration of the capacity and expertise of all entities desiring to be designated under subparagraph (A);

2. the Governor of the State provides assurances that the lead entity will provide or will be responsible for providing—

   A. community-based and prevention-focused programs and activities designed to strengthen and support families to prevent child abuse and neglect composed of local, collaborative, public-private partnerships directed by interdisciplinary structures with balanced representation from private and public sector members, parents, adult former victims of child abuse and neglect, and public and private nonprofit service providers and individuals and organizations experienced in working in partnership with families with children with disabilities;

   B. direction through an interdisciplinary, collaborative, public-private structure with balanced representation from private and public sector members, parents, adult former victims of child abuse and neglect, public sector and private nonprofit sector service providers, and parents with disabilities; and

   C. direction and oversight through identified goals and objectives, clear lines of communication and accountability, the provision of leveraged or combined funding from Federal, State, and private sources, centralized assessment and planning activities, the provision of training and technical assistance, and reporting and evaluation functions; and

3. the Governor of the State provides assurances that the lead entity—

   A. has a demonstrated commitment to parental participation in the development, operation, and oversight of the community-based and prevention-focused

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programs and activities designed to strengthen and support families to prevent child abuse and neglect;

B. has a demonstrated ability to work with State and community-based public and private nonprofit organizations to develop a continuum of preventive, family centered, comprehensive services for children and families through the community-based and prevention-focused programs and activities designed to strengthen and support families to prevent child abuse and neglect ;

C. has the capacity to provide operational support (both financial and programmatic) training, technical assistance, and evaluation assistance, to community-based and prevention-focused programs and activities designed to strengthen and support families to prevent child abuse and neglect, through innovative, interagency funding and interdisciplinary service delivery mechanisms; and

D. will integrate its efforts with individuals and organizations experienced in working in partnership with families with children with disabilities, parents with disabilities, and with the child abuse and neglect prevention activities of the State, and demonstrate a financial commitment to those activities.

Sec. 203. AMOUNT OF GRANT. [42 U.S.C. 5116b]

a. RESERVATION.—The Secretary shall reserve 1 percent of the amount appropriated under section 5116i of this title for a fiscal year to make allotments to Indian tribes and tribal organizations and migrant programs.

b. REMAINING AMOUNTS.—

1. IN GENERAL.—The Secretary shall allot the amount appropriated under section 5116i of this title for a fiscal year and remaining after the reservation under subsection (a) of this section among the States as follows:

A. 70-PERCENT.—70 percent of such amount appropriated shall be allotted among the States by allotting to each State an amount that bears the same proportion to such amount appropriated as the number of children under the age of 18 residing in the State bears to the total number of children under the age of 18 residing in all States (except that no State shall receive less than $175,000 under this subparagraph).

B. 30-PERCENT.—30 percent of such amount appropriated shall be allotted among the States by allotting to each State an amount that bears the same proportion to such amount appropriated as the amount of private, State, or other non-Federal funds leveraged and directed through the currently designated State lead entity in the preceding fiscal year bears to the aggregate of the amounts leveraged by all States from private, State, or other non-Federal sources and directed through the current lead entity of such States in the preceding fiscal year.

2. ADDITIONAL REQUIREMENTS.—The Secretary shall provide allotments under paragraph (1) to the State lead entity.

c. ALLOCATION.—Funds allotted to a State under this section—

1. shall be for a 3-year period; and
2. shall be provided by the Secretary to the State on an annual basis, as described in subsection (b) of this section

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Sec. 204. APPLICATION. [42 U.S.C. 5116d]

A grant may not be made to a State under this title unless an application therefore is submitted by the State to the Secretary and such application contains the types of information specified by the Secretary as essential to carrying out the provisions of section 202, including—

1. a description of the lead entity that will be responsible for the administration of funds provided under this title and the oversight of programs funded through the community-based and prevention-focused programs and activities designed to strengthen and support families to prevent child abuse and neglect which meets the requirements of section 202;
2. a description of how the community-based and prevention-focused programs and activities designed to strengthen and support families to prevent child abuse and neglect will operate, including how community-based child abuse and neglect prevention programs provided by public and private, nonprofit organizations, will be integrated into a developing continuum of family centered, holistic, preventive services for children and families;
3. a description of the inventory of current unmet needs and current community-based and prevention-focused programs and activities to prevent child abuse and neglect, and other family resource services operating in the State;
4. a budget for the development, operation, and expansion of the community-based and prevention-focused programs and activities designed to strengthen and support families to prevent child abuse and neglect that verifies that the State will expend in non-Federal funds an amount equal to not less than 20 percent of the amount received under this title (in cash, not in-kind) for activities under this title;
5. an assurance that funds received under this title will supplement, not supplant, other State and local public funds designated for the start up, maintenance, expansion, and redesign of community-based and prevention-focused programs and activities designed to strengthen and support families to prevent child abuse and neglect;
6. a description of the State's capacity to ensure the meaningful involvement of parents who are consumers, of family advocates, and of adult former victims of child abuse or neglect, who can provide leadership in the planning, implementation, and evaluation of the programs and policy decisions of the applicant agency in accomplishing the desired outcomes for such efforts;
7. a description of the criteria that the entity will use to develop, or select and fund, community-based and prevention-focused programs and activities designed to strengthen and support families to prevent child abuse and neglect as part of network development, expansion, or enhancement;
8. a description of outreach activities that the entity and the community-based and prevention-focused programs designed to strengthen and support families to prevent child abuse and neglect will undertake to maximize the participation of racial and ethnic minorities, children and adults with disabilities, homeless families and those at risk of homelessness, unaccompanied homeless youth, and members of other underserved or underrepresented groups;
9. a plan for providing operational support, training, and technical assistance to community-based and prevention-focused programs and activities designed to strengthen and support

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families to prevent child abuse and neglect for development, operation, expansion and enhancement activities;

10. a description of how the applicant entity's activities and those of the network and its members (where appropriate) will be evaluated;
11. a description of the actions that the applicant entity will take to advocate systemic changes in State policies, practices, procedures, and regulations to improve the delivery of community-based and prevention-focused programs and activities designed to strengthen and support families to prevent child abuse and neglect services to children and families; and
12. an assurance that the applicant entity will provide the Secretary with reports at such time and containing such information as the Secretary may require.

Sec. 205. LOCAL PROGRAM REQUIREMENTS. [42 U.S.C. 5116e]

a. IN GENERAL.—Grants made under this title shall be used to develop, implement, operate, expand, and enhance community-based, and prevention-focused programs and activities designed to strengthen and support families to prevent child abuse and neglect that—
    1. assess community assets and needs through a planning process that involves parents, local public agencies, local nonprofit organizations, and private sector representatives in meaningful roles;
    2. develop a comprehensive strategy to provide a continuum of preventive, family-centered services to children and families, especially to young parents, to parents with young children, and to parents who are adult former victims of domestic violence or child abuse or neglect, through public-private partnerships;
    3.
        A. provide for core child abuse and neglect prevention services, which may be provided directed by the local recipient of the grant funds or through grants or agreements with other local agencies, such as—
            i. parent education, mutual support and self help, and parent leadership services;
            ii. respite care services;
            iii. outreach and followup services, which may include voluntary home visiting services; and
            iv. community and social service referrals; and
        B. provide access to optional services, including—
            i. referral to and counseling for adoption services for individuals interested in adopting a child or relinquishing their child for adoption;
            ii. child care, early childhood education and care, and intervention services;
            iii. referral to services and supports to meet the additional needs of families with children with disabilities and parents who are individuals with disabilities;
            iv. referral to job readiness services;
            v. referral to educational services, such as academic tutoring, literacy training, and General Educational Degree services;
            vi. self-sufficiency and life management skills training;

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vii. community referral services, including early developmental screening of children;
viii. peer counseling; and
ix. domestic violence service programs that provide services and treatment to children and their non-abusing caregivers.

4. develop leadership roles for the meaningful involvement of parents in the development, operation, evaluation, and oversight of the programs and services;
5. provide leadership in mobilizing local public and private resources to support the provision of needed child abuse and neglect prevention program services; and
6. participate with other community-based and prevention-focused programs and activities designed to strengthen and support families to prevent child abuse and neglect in the development, operation, and expansion of networks where appropriate.

b. PRIORITY.—In awarding local grants under this title, a lead entity shall give priority to effective community-based programs serving low-income communities and those serving young parents or parents with young children, including community-based child abuse and neglect prevention programs.

Sec. 206. PERFORMANCE MEASURES. [42 U.S.C. 5116f]

A State receiving a grant under this title, through reports provided to the Secretary—

1. shall demonstrate the effective development, operation, and expansion of a community-based and prevention-focused programs and activities designed to strengthen and support families to prevent child abuse and neglect that meets the requirements of this title;
2. shall supply an inventory and description of the services provided to families by local programs that meet identified community needs, including core and optional services as described in section 202 which description shall specify whether those services are supported by research;
3. shall demonstrate that they will have addressed unmet needs identified by the inventory and description of current services required under section 204(3)[5];
4. shall describe the number of families served, including families with children with disabilities, and parents with disabilities, and the involvement of a diverse representation of families in the design, operation, and evaluation of community-based and prevention-focused programs and activities designed to strengthen and support families to prevent child abuse and neglect, and in the design, operation and evaluation of the networks of such community-based and prevention-focused programs;
5. shall demonstrate a high level of satisfaction among families who have used the services of the community-based and prevention-focused programs and activities designed to strengthen and support families to prevent child abuse and neglect;
6. shall demonstrate the establishment or maintenance of innovative funding mechanisms, at the State or community level, that blend Federal, State, local, and private funds, and innovative, interdisciplinary service delivery mechanisms, for the development, operation, expansion, and enhancement of the community-based and prevention-focused

[5] This represents the probable intent of Congress. The 2010 CAPTA reauthorization changed 205(3) to 204(3) in paragraph (4), but that citation does not exist in paragraph (4).

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programs and activities designed to strengthen and support families to prevent child abuse and neglect;
7. shall describe the results of evaluation, or the outcomes of monitoring, conducted under the State program to demonstrate the effectiveness of activities conducted under this title in meeting the purposes or the program; and
8. shall demonstrate an implementation plan to ensure the continued leadership of parents in the on-going planning, implementation, and evaluation of such community-based and prevention-focused programs and activities designed to strengthen and support families to prevent child abuse and neglect.

Sec. 207. NATIONAL NETWORK FOR COMMUNITY-BASED FAMILY RESOURCE PROGRAMS. [42 U.S.C. 5116g]

The Secretary may allocate such sums as may be necessary from the amount provided under the State allotment to support the activities of the lead entity in the State—

1. to create, operate, and maintain a peer review process;
2. to create, operate, and maintain an information clearinghouse;
3. to fund a yearly symposium on State system change efforts that result from the operation of the community-based and prevention-focused programs and activities designed to strengthen and support families to prevent child abuse and neglect;
4. to create, operate, and maintain a computerized communication system between lead entities; and
5. to fund State-to-State technical assistance through bi-annual conferences.

Sec. 208. DEFINITIONS. [42 U.S.C. 5116h]

For purposes of this title:

1. COMMUNITY REFERRAL SERVICES.—The term "community referral services" means services provided under contract or through interagency agreements to assist families in obtaining needed information, mutual support and community resources, including respite care services, health and mental health services, employability development and job training, and other social services, including early developmental screening of children, through help lines or other methods.
2. COMMUNITY-BASED AND PREVENTION-FOCUSED PROGRAMS AND ACTIVITIES TO PREVENT CHILD ABUSE AND NEGLECT.—The term "community-based and prevention-focused programs and activities to strengthen and support families to prevent child abuse and neglect" includes organizations such as family resource programs, family support programs, voluntary home visiting programs, respite care programs, parenting education, mutual support programs, and other community programs or networks of such programs that provide activities that are designed to prevent or respond to child abuse and neglect.
3. RESPITE CARE SERVICES.— The term “respite care services” means short term care services, including the services of crisis nurseries, provided in the temporary absence of

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the regular caregiver (parent, other relative, foster parent, adoptive parent, or guardian) to children who—

A. are in danger of child abuse or neglect;
B. have experienced child abuse or neglect; or
C. have disabilities or chronic or terminal illnesses.

Such services shall be provided within or outside the home of the child, be short-term care (ranging from a few hours to a few weeks of time, per year), and be intended to enable the family to stay together and to keep the child living in the home and community of the child.

Sec. 209. AUTHORIZATION OF APPROPRIATIONS. [42 U.S.C. 5116i]

There are authorized to be appropriated to carry out this title, $80,000,000 for fiscal year 2010 and such sums as may be necessary for each of the fiscal years 2011 through 2015.

SECTION II: ADOPTION OPPORTUNITIES

Sec. 201. CONGRESSIONAL FINDINGS AND DECLARATION OF PURPOSE. [42 U.S.C. 5111]

a. FINDINGS.—Congress finds that—
   1. on the last day of fiscal year 2009, some 424,000 children were living in temporary foster family homes or other foster care settings;
   2. most children in foster care are victims of child abuse or neglect by their biological parents and their entry into foster care brought them the additional trauma of separation from their homes and often their communities;
   3. on average, children entering foster care have more physical and mental health needs than do children in the general population, and some require intensive services because the children entering foster care—
      A. were born to mothers who did not receive prenatal care;
      B. were born with life-threatening conditions or disabilities;
      C. were born addicted to alcohol or other drugs; or
      D. have HIV/AIDS;
   4. each year, thousands of children in foster care, regardless of their age, the size of the sibling group they are a part of, their racial or ethnic status, their medical condition, or any physical, mental or emotional disability they may have, are in need of placement with permanent, loving, adoptive families;
   5.
      A. States have made important strides in increasing the number of children who are placed in permanent homes with adoptive parents and in reducing the length of time children wait for such a placement; and
      B. many thousands of children, however, still remain in institutions or foster homes solely because of legal and other barriers to such a placement;
   6.

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A. on the last day of fiscal year 2009, there were 115,000 children waiting for adoption;
B. children waiting for adoption have had parental rights of all living parents terminated or the children have a permanency goal of adoption;
C.
i. the average age of children adopted with public child welfare agency involvement during fiscal year 2009 was a little more than 6 years; and
ii. the average age of children waiting for adoption on the last day of that fiscal year was a little more than 8 years of age and more than 30,000 of those children were 12 years of age or older; and
D.
i. 25 percent of the children adopted with public child welfare agency involvement during fiscal year 2009 were African-American; and
ii. 30 percent of the children waiting for adoption on the last day of fiscal year 2009 were African-American;

7. adoption may be the best alternative for assuring the healthy development of children placed in foster care;
8. there are qualified persons seeking to adopt such children who are unable to do so because of barriers to their placement and adoption; and
9. in order both to enhance the stability of and love in the home environments of such children and to avoid wasteful expenditures of public funds, such children—
   A. should not have medically indicated treatment withheld from them; or
   B. be maintained in foster care or institutions when adoption is appropriate and families can be found for such children.

b. PURPOSE.—It is the purpose of this title to facilitate the elimination of barriers, including geographic barriers, to adoption and to provide permanent and loving home environments for children who would benefit from adoption, particularly older children, minority children, and children with special needs, including disabled infants with life-threatening conditions, by providing a mechanism to—
   1. promote quality standards for adoption services, pre-placement, post-placement, and post-legal adoption counseling, and standards to protect the rights of children in need of adoption;
   2. maintain an Internet-based national adoption information exchange system to—
      A. bring together children who would benefit from adoption and qualified prospective adoptive parents who are seeking such children;
      B. conduct national recruitment efforts in order to reach prospective parents for children awaiting adoption; and
      C. connect placement agencies, prospective adoptive parents, and adoptive parents to resources designed to reduce barriers to adoption, support adoptive families, and ensure permanency; and
   3. demonstrate expeditious ways to free children for adoption for whom it has been determined that adoption is the appropriate plan.

Sec. 203. INFORMATION AND SERVICES. [42 U.S.C. 5113]

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a. ESTABLISHMENT IN DEPARTMENT OF HEALTH AND HUMAN SERVICES.—
IN GENERAL.—The Secretary shall establish in the Department of Health and Human Services an appropriate administrative arrangement to provide a centralized focus for planning and coordinating of all departmental activities affecting adoption and foster care and for carrying out the provisions of this title. The Secretary shall make available such consultant services, on-site technical assistance and personnel, together with appropriate administrative expenses, including salaries and travel costs, as are necessary for carrying out such purposes, including services to facilitate the adoption of older children, minority children, and children with special needs, particularly infants and toddlers with disabilities who have life-threatening conditions, and services to families considering adoption of children with special needs.
b. REQUIRED ACTIVITIES.— In connection with carrying out the provisions of this title, the Secretary shall—
    1. conduct (directly or by grant to or contract with public or private agencies or organizations) an education and training program on adoption, and prepare, publish, and disseminate (directly or by grant to or contract with public or private agencies and organizations) to all interested parties, public and private agencies and organizations (including, but not limited to, hospitals, health care and family planning clinics, and social services agencies), and governmental bodies, information and education and training materials regarding adoption, adoption assistance programs, and post-legal adoption services;
    2. conduct, directly or by grant or contract with public or private organizations, ongoing, extensive recruitment efforts on a national level, including efforts to promote the adoption of older children, minority children, and children with special needs, develop national public awareness efforts to unite children in need of adoption with appropriate adoptive parents, and establish a coordinated referral system of recruited families with appropriate State or regional adoption resources to ensure that families are served in a timely fashion;
    3. notwithstanding any other provision of law, provide (directly or by grant to or contract with public or private agencies or organizations) for—
        A. the operation of a national adoption information exchange system (including only such information as is necessary to facilitate the adoptive placement of children, utilizing computers and data processing methods to assist in the location of children who would benefit by adoption and in the placement in adoptive homes of children awaiting adoption); and
        B. the coordination of such system with similar State and regional systems;
    4. provide (directly or by grant to or contract with public or private agencies or organizations, including adoptive family groups and minority groups) for the provision of technical assistance in the planning, improving, developing, and carrying out of programs and activities relating to adoption, and to promote professional leadership training of minorities in the adoption field;
    5. encourage involvement of corporations and small businesses in supporting adoption as a positive family-strengthening option, including the establishment of adoption benefit programs for employees who adopt children;
    6. support the placement of children in kinship care arrangements, preadoptive, or adoptive homes;

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7. increase the effective use of public or private agencies (including community-based and other organizations) by States, or sectarian institutions, for the recruitment of potential adoptive and foster families and to provide assistance in the placement of children for adoption, including assisting in efforts to work with organizations that promote the placement of older children, minority children, and children with special needs;
8. consult with other appropriate Federal departments and agencies in order to promote maximum coordination of the services and benefits provided under programs carried out by such departments and agencies with those carried out by the Secretary, and provide for the coordination of such aspects of all programs within the Department of Health and Human Services relating to adoption;
9. maintain (directly or by grant to or contract with public or private agencies or organizations) a National Resource Center for Special Needs Adoption to—
    A. promote professional leadership development of minorities in the adoption field;
    B. provide training and technical assistance to service providers and State agencies to improve professional competency in the field of adoption and the adoption of children with special needs;
    C. facilitate the development of interdisciplinary approaches to meet the needs of children who are waiting for adoption and the needs of adoptive families; and
    D. identify best practices to reduce adoption disruption and termination;
10. provide (directly or by grant to or contract with States, local government entities, tribal child welfare agencies, public or private licensed child welfare or adoption agencies or adoptive family groups and community-based organizations with experience in working with minority populations) for the provision of programs aimed at increasing the number of minority children (who are in foster care and have the goal of adoption) placed in adoptive families, with a special emphasis on recruitment of minority families—
    A. which may include such activities as—
        i. outreach, public education, or media campaigns to inform the public of the needs and numbers of such children;
        ii. recruitment of prospective adoptive families for such children, including developing and using procedures to notify family and relatives when a child enters the child welfare system;
        iii. expediting, where appropriate, the legal availability of such children;
        iv. expediting, where appropriate, the agency assessment of prospective adoptive families identified for such children;
        v. formation of prospective adoptive family support groups;
        vi. training of personnel of—
            I. public agencies;
            II. private child welfare and adoption agencies that are licensed by the State; and

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III. adoptive parents organizations and community-based organizations with experience in working with minority populations;
vii. education and training of prospective adoptive or adoptive parents;
viii. use of volunteers and adoptive parent groups; and
ix. any other activities determined by the Secretary to further the purposes of this title; and

B. shall be subject to the condition that such grants or contracts may be renewed if documentation is provided to the Secretary demonstrating that appropriate and sufficient placements of such children have occurred during the previous funding period; and

11. provide (directly or by grant to or contract with States, local government entities, or public or private licensed child welfare or adoption agencies) for the implementation of programs that are intended to increase the number of older children (who are in foster care and with the goal of adoption) placed in adoptive families, with a special emphasis on childspecific recruitment strategies, including—
    A. outreach, public education, or media campaigns to inform the public of the needs and numbers of older youth available for adoption;
    B. training of personnel in the special needs of older youth and the successful strategies of child-focused, child-specific recruitment efforts; and
    C. recruitment of prospective families for such children.

c. SERVICES FOR FAMILIES ADOPTING SPECIAL NEEDS CHILDREN.—
    1. IN GENERAL.—The Secretary shall provide (directly or by grant to or contract with States, local government entities, public or private licensed child welfare or adoption agencies or adoptive family groups) for the provision of post legal adoption services for families who have adopted special needs children.
    2. SERVICES.—Services provided under grants made under this subsection shall supplement, not supplant, services from any other funds available for the same general purposes, including—
        A. individual counseling;
        B. group counseling;
        C. family counseling;
        D. case management;
        E. training public agency adoption personnel, personnel of private, child welfare and adoption agencies licensed by the State to provide adoption services, mental health services professionals, and other support personnel to provide services under this subsection;
        F. assistance to adoptive parent organizations;
        G. assistance to support groups for adoptive parents, adopted children, and siblings of adopted children;
        H. day treatment; and
        I. respite care.

d. IMPROVING PLACEMENT RATE OF CHILDREN IN FOSTER CARE.—

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1. IN GENERAL.—The Secretary shall make grants for improving State efforts to increase the placement of foster care children legally free for adoption, according to a pre-established plan and goals for improvement.
2. APPLICATIONS; TECHNICAL AND OTHER ASSISTANCE.—
    A. APPLICATIONS.—Each State entering into an agreement under this subsection shall submit an application to the Secretary that describes the manner in which the State will use funds during the 3 fiscal years subsequent to the date of the application to accomplish the purposes of this section. Such application shall be in a form and manner determined to be appropriate by the Secretary, consistent with the purpose of this title. Each application shall contain information that—
        i. describes how the State plans to improve the placement rate of children in permanent homes;
        ii. describes the methods the State, prior to submitting the application, has used to improve the placement of older children, minority children, and children with special needs, who are legally free for adoption;
        iii. describes the evaluation the State plans to conduct, to identify the effectiveness of programs and methods of placement under this subsection, and submit to the Secretary; and
        iv. describes how the State plans to coordinate activities under this subsection with relevant activities under section 473 of the Social Security Act (42 U.S.C. 673).
    B. TECHNICAL AND OTHER ASSISTANCE.—The Secretary shall provide, directly or by grant to or contract with public or private agencies or organizations—
        i. technical assistance and resource and referral information to assist State or local governments with termination of parental rights issues, in recruiting and retaining adoptive families, in the successful placement of older children, minority children, and children with special needs, and in the provision of pre- and post-placement services, including post-legal adoption services; and
        ii. other assistance to help State and local governments replicate successful adoption-related projects from other areas in the United States.
    C. EVALUATION.—The Secretary shall compile the results of evaluations submitted by States (described in subparagraph (A)(iii)) and submit a report containing the complied results to the appropriate committees of Congress.
3. PAYMENTS.—
    A. IN GENERAL.—Payments under this subsection shall begin during fiscal year 1989. Payments under this section during any fiscal year shall not exceed $1,000,000. No payment may be made under this subsection unless an amount in excess of $5,000,000 is appropriated for such fiscal year under section 5115(a) of this title.

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B. REVERSION OF UNUSED FUNDS.—Any payment made to a State under this subsection which is not used by such State for the purpose provided in paragraph (1) during the fiscal year payment is made shall revert to the Secretary on October 1st of the next fiscal year and shall be used to carry out the purposes of this title.

e. ELIMINATION OF BARRIERS TO ADOPTIONS ACROSS JURISDICTIONAL BOUNDARIES.—
   1. IN GENERAL.—The Secretary shall award grants to, or enter into contracts with, States, local government entities, public or private child welfare or adoption agencies, adoption exchanges, or adoption family groups to carry out initiatives to improve efforts to eliminate barriers to placing children for adoption across jurisdictional boundaries.
   2. SERVICES TO SUPPLEMENT NOT SUPPLANT.—Services provided under grants made under this subsection shall supplement, not supplant, services provided using any other funds made available for the same general purposes including—
      A. developing a uniform home study standard and protocol for acceptance of home studies between States and jurisdictions;
      B. developing models of financing cross-jurisdictional placements;
      C. expanding the capacity of all adoption exchanges to serve increasing numbers of children;
      D. developing training materials and training social workers on preparing and moving children across State lines; and
      E. developing and supporting initiative models for networking among agencies, adoption exchanges, and parent support groups across jurisdictional boundaries.

Sec. 204. STUDY AND REPORT OF UNLICENSED OR UNREGULATED ADOPTION PLACEMENTS. [42 U.S.C. 5114]

a. IN GENERAL.—The Secretary shall provide for a study (the results of which shall be reported to the appropriate committees of the Congress not later than eighteen months after passage of the Keeping Children and Families Safe Act of 2003) designed to determine—
   1. the nature, scope, and effects of the interstate (and, to the extent feasible, intrastate) placement of children in adoptive homes (not including the homes of stepparents or relatives of the child in question) by persons or agencies;
   2. how interstate placements are being financed across State lines;
   3. recommendations on best practice models for both interstate and intrastate adoptions; and
   4. how State policies in defining special needs children differentiate or group similar categories of children.

b. DYNAMICS OF SUCCESSFUL ADOPTION.—The Secretary shall conduct research (directly or by grant to, or contract with, public or private nonprofit research agencies or organizations) about adoption outcomes and the factors affecting those outcomes. The Secretary shall submit a report containing the results of such research to the appropriate

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committees of Congress not later than the date that is 36 months after the date of the enactment of the Keeping Children and Families Safe Act of 2003.

c. INTERJURISDICTIONAL ADOPTION.—Not later than 1 year after the date of the enactment of the Keeping Children and Families Safe Act of 2003, the Secretary shall submit to the appropriate committees of Congress a report that contains recommendations for an action plan to facilitate the interjurisdictional adoption of foster children.

Sec. 205. AUTHORIZATION OF APPROPRIATIONS. [42 U.S.C. 5115]

a. There are authorized to be appropriated, $40,000,000 for fiscal year 2010, and such sums as may be necessary for each of the fiscal years 2011 through 2015 to carry out programs and activities authorized under this subtitle.
b. Not less than 30 percent and not more than 50 percent of the funds appropriated under subsection (a) shall be allocated for activities under subsections (b)(10) and (c) of section 203.
c. The Secretary shall ensure that funds appropriated pursuant to authorizations in this title shall remain available until expended for the purposes for which they were appropriated.

Section III, the Abandoned Infants Assistance Act, was repealed by sec. 7065(b) of P.L. 115-271.