# The Role of the Multidisciplinary Team in the Diagnosis and Treatment of Child Abuse and Neglect in Hawaii

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# FOREWORD

This report was prepared in response to Senate Concurrent Resolution No. 160, S.D. 1, H.D. 1, which was adopted during the Regular Session of 1992. The Resolution requests the Legislative Reference Bureau to study the increase in repetitive child abuse cases and evaluate the roles of the medical director and multidisciplinary team in the diagnosis and treatment of child abuse and neglect. This report contains the results of that study.

The Bureau extends its appreciation to all of those whose participation and cooperation made this report possible. Special thanks are extended to: Dr. Calvin Sia, Dr. Richard Mitsunaga, Dr. Judy Meyer, Dr. Vanessa Fidele, Dr. Stan Michels, Dr. Donald C. Derauf, Dr. Melinda Ashton, Dr. Steven Choy, Dr. Patti Shirakawa, Dr. Jane Stump, Ines Finin, Sylvia Lee, Jacqui desMarets, Professor Faye Untalan, Debby Lee, Marie Kunimura, Regina Gertsman, Donald Newville and Ricky Higashide.

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# Chapter 1

# INTRODUCTION

In recent years, more and more of Hawaii's children have become victims of child abuse and neglect. And, more of these child victims have sustained serious injuries requiring hospitalization. Sadly, some of the injuries inflicted on children have resulted in permanent disability and death.

Many of the cases involving serious injury, permanent disability and death are cases previously known to the Department of Human Services, Child Protective Services agency. The goals of the Department as mandated by law, which are to protect the child from harm or threatened harm and to prevent abuse and neglect,[1] are not being met.

Concern for Hawaii's children was brought to the attention of Hawaii's legislators by the joint effort of the Hawaii Chapter of American Academy of Pediatrics, the Department of Human Services and the Department's Child Protective Services agency. In April, 1992, the Legislature of the State of Hawaii adopted Senate Concurrent Resolution No. 160, S.D. 1, H.D. 1 (1992), entitled "Senate Concurrent Resolution Requesting a Study on the Increase in Repetitive Child Abuse Cases and an Evaluation of the Roles of the Medical Director and Multi-Disciplinary Team in the Diagnosis and Treatment of Child Abuse" (see Appendix A). This study has been prepared in response to the Legislature's direction.

The second chapter of this study reviews federal child abuse and neglect laws. The federal approach has continually emphasized the use of multidisciplinary teams in the diagnosis and treatment of child abuse and neglect. Chapter 3 outlines Hawaii's current statutory scheme for child protection. Chapter 4 provides the reader with a historical perspective on the inception and growth of Hawaii's Child Protective Services agency over the last twenty years and highlights possible reasons for the agency's ongoing difficulties. Chapter 5 identifies and summarizes the roles of the various units involved in child protection. Chapter 6 reports recent statistical data on the incidence of abuse and neglect in Hawaii. The final chapter, Chapter 7, contains findings and recommendations.

The findings and recommendations are based primarily on research conducted firsthand on the Kapio'lani Medical Center for Women and Children Child Protective Services Team on Oahu, the most highly developed multidisciplinary team in the State. The Kapiolani Medical Center for Women and Children Child Protective Services Team, hereinafter referred to as the Oahu CPS Team, was used as a model for discussion and identification of issues. Moreover, the Oahu CPS Team was responsible for the training of neighbor island team personnel in the late 1980s.[2] At present, problems existing between CPS teams and Child Protective Services agencies on the neighbor islands parallel problems on Oahu.[3] The recommendations made in this study address statewide multidisciplinary team concerns and are applicable statewide. Statewide implementation of uniform policy and protocol promotes a statewide standard of care for Hawaii's abused and neglected children.

## Endnotes

1. Hawaii Rev. Stat., §346-14 and Hawaii Admin. Rules, §17-920.1-1.

2. Interviews with Steven J. Choy, Ph.D., Director and Mental Health Consultant, Kapiolani Medical Center for Women and Children Child Protective Services Team, August and September, 1992; telephone interview with Mary Jo Westmoreland, Director, Child Protection Team of West Hawaii, October 22, 1992; and interview with Calvin Sia, M.D., Judy Meyer, M.D., Richard Mitsunaga, M.D., Art Wong, M.D., Vanessa Fidele, M.D., Medical Consultant, Kapiolani Medical Center for Women and Children Child Protective Services Team, Stan Michels, M.D., former Medical Consultant, Kapiolani Medical Center for Women and Children Child Protective Services Team, Melinda Aston, M.D., and Donald C. Derauf, M.D., former Medical Consultant, Kapiolani Medical Center for Women and Children Child Protective Services Team, August 14, 1992.

3. Ibid.

## Chapter 2

# FEDERAL APPROACH TO CHILD ABUSE AND NEGLECT

In the United States, the family is the most socially accepted and valued means for raising children. It is usually the safest and most nurturing environment available to a child. The child is a dependent member of the family and relies on its parents to provide for its physical and emotional well-being.[1] Parents endeavor to provide a nurturing setting for the child's development of self-esteem, self-confidence, and self-discovery. The family is given a wide range of freedom and privacy in deciding how children should be raised. The right to have a family and raise one's children has been deeply valued and legally protected in the United States. Ultimately, children grow up secure and healthy knowing that the family will protect them from outside forces that might hurt them.

Unfortunately, a great many American families do not live up to the standard described above and provide much less than a safe nurturing environment for their children. This is not, however, an aberration of twentieth century American society. By current standards, child abuse and neglect has existed for centuries. More importantly, society has expressed neither interest nor disapproval at certain historical methods of child rearing.

In Colonial America, flogging a child or inflicting physical punishment, to the point of drawing blood, was an acceptable norm of parental behavior.[2] It was not until the late nineteenth century when child labor laws burgeoned that child abuse and neglect became a legal concern. The use of children as a cheap labor force during the industrialization of America gave rise to a societal preoccupation with the exploitation of children, resulting in child protective laws. Further protective measures were taken in 1874 when the plight of eight-year-old Mary Ellen Wilson revealed repeated and brutal beatings at the hand of her foster mother. The national public furor and outrage over Mary Ellen's case led to the creation of hundreds of societies for the Prevention of Cruelty to Children. These societies were influential in developing legislation that broadened the power to intervene in the lives of children.[3]

Despite these early efforts at social reform and child protection, child abuse and neglect law remained largely dormant until 1962 when Dr. C. Henry Kempe and his colleagues alerted the medical profession to the possibility that a major cause of injuries and deaths in children was wilfully inflicted injury administered by a parent or caretaker. Dr. Kempe's article, entitled "The Battered Child Syndrome," was published in the Journal of the American Medical Association and gained intense public attention. Once child abuse had captured the attention of a portion of the medical profession it was also identified as a problem by social workers.[4]

In response, the federal government's Children's Bureau, the American Humane Association, the American Medical Association, and the Council on State Governments

developed model legislation for child abuse reporting laws.[5] In 1967, forty-four states had adopted the model proposal developed by the Children's Bureau and by 1970, all but three states had mandatory child abuse reporting laws.[6]

In 1973, Senator Walter Mondale introduced legislation ultimately enacted as the Child Abuse Prevention and Treatment Act.[7] The Subcommittee on Children and Youth and the Special Subcommittee on Human Resources received testimony on the legislation in hearings held in Washington, D.C., New York and Los Angeles. The testimony at these hearings indicated the need for a coordinated federal effort to assist in solving the complex and nationwide problem of child abuse and neglect. Although some effective programs existed on the local level, the problem of child abuse and neglect lacked both focus within the broader spectrum of social service programs and the necessary resources to facilitate such programs. The legislation received enormous bipartisan support and was passed by an overwhelming vote in the Senate. It was signed into law on January 3, 1974.[8]

The enactment of the Child Abuse Prevention and Treatment Act was a victory for those who advocated a broader interpretation of child abuse and neglect as a symptom of social dysfunctioning. The federal Act defined the following terms:

> 5106g. Definitions
>
> For purposes of this subchapter--
>
> (3) 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;
>
> (4) the term "child abuse and neglect" means the physical or mental injury, sexual abuse or exploitation, negligent treatment, or maltreatment of a child by a person who is responsible for the child's welfare, under circumstances which indicate that the child's health or welfare is harmed or threatened thereby, as determined in accordance with regulations prescribed by the Secretary;
>
> * * *
>
> (7) 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, molestation, prostitution, or other form of sexual exploitation of children, or incest with children;
>
> * * *
>
> (10) 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. . . .[9]

The Act established the framework for the child protective system as we know it today and provided for: (1) the establishment of a National Center on Child Abuse and Neglect within the Department of Health, Education and Welfare; (2) mandated programs for the collection and dissemination of information, including the incidence of child abuse and neglect; (3) a source of funding for basic research in the area of child abuse and neglect; (4) a source of funding for service delivery, resource, and innovative demonstration projects designed to prevent and/or treat child abuse and neglect; (5) an Advisory Board to assist tne Secretary of Health, Education and Welfare in seeking to coordinate federal programs; and (6) encouragement to states by way of grants for the payment of expenses involved in developing, strengthening, and carrying out child abuse and neglect prevention and treatment programs.[10] A major portion of the funds appropriated under the Act has been directed toward demonstration projects.

The demonstration projects and Demonstration Treatment Centers funded by the National Center on Child Abuse and Neglect (NCAAN) are structured in a variety of ways, and test various methods of delivering services to abused and neglected children and their families and of improving the capacity of existing regional, state, and local agencies to identify, treat, and prevent child abuse and neglect. Staffed by specially trained multidisciplinary teams of professionals and paraprofessionals, the Demonstration Treatment Centers are demonstrating what can be accomplished when the states have the time, resources, and training to meet the needs of multi-problem, abusive and neglecting families.[11] The interdisciplinary teams perform child protective investigations and child and family assessment, and provide direct treatment.

NCAAN implements the objectives of the Act and has become the lead agency in monitoring both federal and state activities in this area. NCAAN's "model" statutory program package provides standards for operating child abuse and neglect systems at the local level and a uniform definition of maltreatment. Included in the package are minimum requirements for an efficient and effective response to child abuse at the local level:

- a reporting system that ensures the swift and efficient handling of all reported incidents;

- adequate legal representation for all the parties involved in the maltreatment episode, including the child;
- the establishment and funding of a comprehensive and coordinated service system, including 24-hour hot line emergency services and ongoing counseling and support;
- a mechanism to ensure the prompt and effective interagency coordination between public and private service providers;
- establishment of a multidisciplinary team for the review of all suspected cases of maltreatment;
- training of all legal, medical, and mental health professionals and school personnel in the identification of abuse and neglect and the procedures for reporting such cases; and
- the establishment of community coordination councils, including representatives of both the professional and lay communities.[12] (Emphasis added)

The model standards have come to represent the core goals for both local child protective service agencies as well as child welfare advocates.

In 1974-75 NCAAN carried out a survey and assessment of the needs of agencies and organizations delivering services to abused and neglected children and their families. The NCAAN assessment indicated that: (1) there was an immediate need to train a core group of professionals and paraprofessionals in the diagnosis, reporting, and treatment of child abuse and neglect; and (2) suitable training curricula had to be developed as soon as possible for the training of a broad range of professionals.[13] Subsequent training funded by NCAAN consisted of developing new skills in multidisciplinary teamwork and coordination among professionals in child protection, social work, health, law, law enforcement, and education.[14] Training was enhanced by NCAAN publications on the effects and characteristics of child maltreatment, the roles of many of the professionals and agencies involved in case management and those working with abusive parents, coordination of community resources, the diagnosis process and treatment program, and central registers on child abusers.

NCAAN also developed a multidisciplinary curriculum package for use by local agencies in training programs. These federally funded programs target professionals and paraprofessionals in the fields of social work, health, law, law enforcement, and education. Since its inception, NCAAN has emphasized the value of multidisciplinary teamwork and coordination and system assessment of existing services. Child maltreatment and crisis programs have been encouraged to avoid merely increasing existing staff and to concentrate on moving into new areas and developing new programs that promise greater results. The Senate has commended NCAAN for the development of multidisciplinary investigative and assessment teams whose goal was to keep families together.[15]

The Act provides for grants to the states to develop, strengthen, and carry out child abuse and neglect prevention and treatment programs. Each state must meet the criteria set forth in the Act to qualify for federal assistance. These criteria deal with effective child abuse reporting procedures, comprehensive definition of child abuse and neglect, investigation of reports and administrative procedures, personnel and training. They also require safeguards, such as confidentiality of records and appointment of guardians *ad litem* for children involved in child abuse or neglect court proceedings. Finally, the Act requires that federal funds supplement and not supplant any state funds already being expended on child abuse and neglect programs.[16]

Coordination of federal child abuse and neglect programs is the responsibility of an Advisory Board created under the Act. The Board includes representatives from various federal agencies involved in the area of child abuse and neglect, such as the Departments of Justice, Labor, Interior, Agriculture, Housing and Urban Development, and Defense, as well as the Department of Health, Education and Welfare. A subsequent amendment to the Act expanded the Board to include at least three members from the public involved in the field of child abuse and neglect.

In successive years, Congress continued to assert and define the federal role in child abuse and neglect. In 1980, Congress passed the Adoption Assistance and Child Welfare Act of 1980 to provide incentives for permanency planning.[17] The Act emphasized that children should remain in or be reunited with their biological families and that the states must make reasonable efforts to prevent removal or to facilitate reunification.[18] In 1984, the Child Abuse Prevention and Treatment and Adoption Reform Act was extended for an additional three years by the Child Abuse Amendment of 1984.[19] And, again, in 1986, Congress passed the Children's Justice and Assistance Act to improve the handling, investigation and prosecution of child abuse cases, particularly those involving allegations of sexual abuse.[20] Finally, recent changes in 1990 address special procedures for the presentation of children's testimony in criminal cases prosecuted in the federal courts. The Crime Control Act of 1990 further provides funding for training court and legal personnel and encourages the use of multidisciplinary teams in cases involving child victims or witnesses.[21]

These numerous federal enactments demonstrate Congress' continued commitment to the federal role in the identification, treatment and prevention of child abuse and neglect in the United States. The federal approach has consistently encouraged and funded the training and use of multidisciplinary teams of professionals and paraprofessionals. The team approach has the potential to provide a highly comprehensive service delivery system. Nationwide, the federal enactments have had a profound impact on the development of state child abuse and neglect laws. Many states have followed the federal lead and embraced the use of multidisciplinary teams in their child protective service systems.

## Endnotes

1. Deborah Daro, Confronting Child Abuse: Research for Effective Program Design (New York: The Free Press, 1988), p. 9.

2. Katherine Hunt Federle, "The Legal Perspective," Interdisciplinary Perspectives in Child Abuse and Neglect, eds. Faye Untalan and Crystal Mills (New York: Praeger Publishers, 1992), p. 90, citing R.W. tenBensel, "The Scope of the Problem," 35 Juvenile and Family Court Journal 1-6 (1984).

3. Ibid., p. 91.

4. Richard Gelles, Family Violence (Newbury Park: Sage Publications, 1987), p. 63.

5. Federle, p. 91.

6. Ibid.

7. Child Abuse Prevention and Treatment Act, 42 U.S.C.A. sec. 5 (1983, Supp. 1992).

8. 1978 U.S. Code Cong. & Admin. News, p. 572.

9. 42 U.S.C.A. sec. 506g (1983, Supp. 1992).

10. 1978 U.S. Code Cong. & Admin. News, pp. 572-3.

11. Ibid.

12. U.S., Comptroller General, Report to the Congress: Increased Federal Efforts Needed to Better Identify, Treat and Prevent Child Abuse and Neglect (Washington D.C.: U.S. Government Printing Office), 1980.

13. 1978 U.S. Code Cong. & Admin. News, p. 575.

14. Ibid.

15. Federle, p. 92, citing Senate Report No. 167, 1977.

16. 1978 U.S. Code Cong. & Admin. News, p. 575.

17. Adoption Assistance and Child Welfare Act of 1980, Pub. L. 96-272, June 17, 1980, 94 Stat. 500 (Title 26, sec. 50B; Title 42, secs. 602, 603 note, 608, 612, 620-625, 627, 628, 652, 655 note, 658, 670-673, 673a, 674-676, 1305 note, 1308, 1318, 1320b-2, 1320b-3, 1382d, 1395y, 1395cc, 1396a, 1397, 1397a to 1397d, 1397e-1 note).

18. Federle, p. 92.

19. Child Abuse Amendments of 1984, Pub. L. 98-457, Oct. 9, 1984, 98 Stat. 1749, 42 U.S.C.A. secs. 5101 to 5106, 5111 to 5113, 5115, 10401 to 10412.

20. Children's Justice and Assistance Act of 1986, Pub. L. 99-401, Aug. 27, 1986, 100 Stat. 903, 42 U.S.C.A. secs. 290dd-3, 290ee-3, 5101, 5101 notes, 5103, 5105, 5117, 5117 notes, 5117a to d, 10601, 10603, 10603a.

21. Crime Control Act of 1990, Pub. L. 101-647, Nov. 29, 1990, 104 Stat. 4789, Pub. L. 102-190, Division A, Title X, Part G, sec. 1094(a), Dec. 5, 1991, 105 Stat. 1488 (Title 42, sec. 13041).

# Chapter 3

## HAWAII'S STATUTORY APPROACH TO CHILD ABUSE AND NEGLECT

Chapter 350 of the *Hawaii Revised Statutes*, entitled "Child Abuse," defines "child abuse or neglect" as the acts or omissions of any person who, or legal entity which, is in any manner or degree related to the child, is residing with the child, or is otherwise responsible for the child's care, that have resulted in the physical or psychological health or welfare of the child, who is under the age of eighteen, to be harmed, or to be subject to any reasonably foreseeable substantial risk of being harmed.[1] The circumstances indicating child abuse or neglect include, but are not limited to the following:

(1) The child exhibits evidence of injury--substantial bruising, internal or external bleeding, malnutrition, failure to thrive, burns, poisoning, fracture of any bone, subdural hematoma (intracranial injury), soft tissue swelling, extreme pain, extreme mental distress, gross degradation, and death--and the injury is neither justifiably explained nor the product of an accidental occurrence, or at variance in degree or type with the history given;

(2) The child is the victim of sexual contact or conduct, including, but not limited to, sexual assault as defined in the Penal Code, molestation, sexual fondling; incest, prostitution, obscene or pornographic photographing, filming or depiction, or other similar forms of sexual exploitation;

(3) The child is psychologically injured, as evidenced by an observable and substantial impairment in the child's ability to function;

(4) The child is not provided with adequate food, clothing, shelter, psychological care, physical care, medical care, or supervision; and

(5) The child is provided with dangerous, harmful or detrimental drugs, excluding such drugs properly prescribed by a practitioner.[2]

Hawaii's reporting laws establish mandatory reporting to the Department of Human Services (DHS) or the county police department of suspected or anticipated child abuse and neglect by the following persons, in their professional or official capacity:

(1) Any licensed or registered professional of the healing arts and any health-related occupation, including, but not limited to, physicians, psychologists, dentists, nurses, osteopathic physicians and surgeons, optometrists, chiropractors, podiatrists, pharmacists, and other health-related professionals;

(2) Employees or officers of any public or private school;

(3) Employees or officers of any public or private agency or institution providing social, medical, hospital, or mental health services, including financial assistance;

(4) Employees or officers of law enforcement agencies, including but not limited to, the courts, police department, correctional institutions, and parole or probation officers;

(5) Providers of child care, employees or officers of any childcare facilities, foster home or other similar institution;

(6) Medical examiners or coroners; and

(7) Employees of any public or private agency providing recreational or sports activities.[3]

Initial oral reports must be followed as soon thereafter as possible by written reports. When the police department is the initiating agency, a written report will not be filed with DHS unless the police department declines to take further action and DHS informs the police department that it intends to pursue the orally reported incident of child abuse or neglect. Persons subject to the mandatory reporting laws must provide DHS or the police department upon request with all information related to the child abuse or neglect incident, including but not limited to medical records and reports.[4]

It is a petty misdemeanor for mandated reporters to knowingly prevent another person from reporting or failing to provide information pertaining to the child abuse or neglect incident requested by DHS or the police department.[5] Persons who are not mandated reporters may orally report to DHS or the police department facts or circumstances which cause that person to have reason to believe that child abuse or neglect occurred or may occur in the reasonably foreseeable future.[6] All reports to DHS are confidential. Any person who intentionally makes an unauthorized disclosure of a report shall be guilty of a misdemeanor.[7] DHS must make every reasonable effort to maintain the confidentiality of the name of a reporter who requests confidentiality.[8]

Upon receiving a report concerning child abuse or neglect, DHS proceeds pursuant to chapter 587, *Hawaii Revised Statutes*, the Child Protective Act, and chapter 17-920.1, Hawaii Administrative Rules (Department of Human Services, Child Protective Services). DHS must inform the appropriate police department or office of the prosecuting attorney of relevant information concerning the child abuse or neglect case when it is required for the investigations of the case.

DHS must maintain a central registry of reported child abuse or neglect cases. When reports are found to be unsubstantiated or the petition arising from the reports is dismissed by

order of the Family Court the case must be expunged from the central registry.[9] A report is unsubstantiated when DHS is unable to substantiate allegations for lack of evidence or when the allegations contained in the report are found to be frivolous or to have been made in bad faith.

By law, anyone who in good faith makes a child abuse or neglect report is immune from any civil or criminal liability. Any individual who takes action on reporting and acts within the scope of their duty or responsibility is also immune from civil liability for acts and omissions.[10] However, individual immunity does not limit the liability of DHS, or any other state agency or private organization.[11]

Finally, neither the physician-patient privilege, the psychologist-client privilege, nor the spousal privilege shall be grounds for excluding evidence in any judicial proceeding resulting from a report of child abuse or neglect.[12]

Chapter 586, *Hawaii Revised Statutes*, entitled "Domestic Abuse Protection Orders", gives the Family Court authority to issue temporary restraining orders and protective orders to separate family or household members when necessary to prevent domestic abuse or the reoccurrence of abuse. If necessary, the court may provide further relief, including orders establishing temporary visitation of minor children and orders to either or both parties to participate in treatment or counseling services.

"Family and household members" is defined as spouses or former spouses, parents, children, persons related by consanguinity, and persons jointly residing or formerly residing in the same dwelling unit. "Domestic abuse" means:

(1) Physical harm, bodily injury assault, or the threat of imminent physical harm, bodily injury, or assault, extreme psychological abuse or malicious property damage, between family or household members; or

(2) Any act which would constitute an offense under section [*Hawaii Revised Statutes*] 709-906 [a Penal Code provision that deals with physical abuse of family and household members and is applicable to spouse abuse], or under part V [sexual offenses] or VI [child pornography] of chapter 707 [offenses against the person], committed against a minor family or household member by an adult family or household member.[13]

The Family Court takes requests for orders of protection upon the filing of a petition for relief (1) by a family or household member on the person's own behalf or on behalf of a family or household member who is a minor, incapacitated person, or "physically unable" person, or (2) by any state agency on behalf of a minor, incapacitated person, or "physically unable" person.[14]

The temporary restraining order (ninety days maximum) may be granted to restrain either or both parties from contacting, threatening or physically abusing each other or household members. One or both of the parties may be ordered to leave the premises during the period of restraint.[15]

After a hearing, a protective order may be issued, which can include all orders stated in the restraining order, and such further orders as the court deems necessary. Such orders may include establishing temporary visitation with regard to minor children and orders to either or both parties to participate in treatment or counseling services. The protective order may be issued for such further period as deemed appropriate by the court, not to exceed three years from the date the protective order is granted.[16] It is a misdemeanor to intentionally or knowingly violate any order of protection.[17]

The Family Court must designate an employee or appropriate nonjudicial agency to assist in preparing the petition.[18] Where the alleged abuse involves a minor family or household member, the designated employee or nonjudicial agency must report the matter to DHS, as required by chapter 350, and must notify DHS of the granting of the restraining order and of the hearing date.[19] DHS, in turn, will initiate an investigation and must report to the family court on the progress of their investigation on or before the hearing date.[20]

At the petitioner's request, a copy of any order for protection must be forwarded by the court clerk within twenty-four hours to the county police department.[21] Each county police department must "make available to other law enforcement officers in the same county, through a system for verification, information as to the existence and status of any order for protection..."[22]

Chapter 587, *Hawaii Revised Statutes*, entitled the "Child Protective Act," creates within the Family Court's jurisdiction a law whose purpose is to "safeguard, treat, and provide service and permanent plans for children who have been harmed or are threatened with harm."[23] A "child" is a person who is born alive and is under age eighteen; "family" is defined as:

> . . . each legal parent, the natural mother, the natural father, the adjudicated, presumed, or concerned natural father as defined under section 578-2, each parent's spouse, or former spouses, each sibling or person related by consanguinity or marriage, each person residing in the same dwelling unit, and any other person who or legal entity which is a child's legal or physical custodian, or guardian, or who is otherwise responsible for the child's care, other than an authorized agency which assumes such a legal status or relationship with the child under [Chapter 587].[24]

The definition of "harm" is similar to the description in chapter 350 of circumstances indicating child abuse or neglect for reporting purposes. "Imminent harm" means that there exists reasonable cause to believe that harm to the child will occur or reoccur within the next

ninety days. "Threatened harm" means any reasonably foreseeable substantial risk of harm to a child, considering the age of the child and the safe family home guidelines.[25] The safe family home guidelines include an extensive list of criteria to be considered:

(1) The current facts relating to the child which include:

(A) Age and vulnerability;

(B) Psychological, medical and dental needs;

(C) Peer and family relationships and bonding abilities;

(D) Developmental growth and schooling;

(E) Current living situation;

(F) Fear of being in the family home; and

(G) Services provided the child;

(2) The initial and any subsequent reports of harm and/or threatened harm suffered by the child;

(3) Date(s) and reason for child's placement out of the home, description, appropriateness, and location of the placement and who has placement responsibility;

(4) Historical facts relating to the alleged perpetrator and other appropriate family members who are parties which include:

(A) Birthplace and family of origin;

(B) How they were parented;

(C) Marital relationship history; and

(D) Prior involvement in services;

(5) The results of psychiatric/psychological/developmental evaluations of the child, the alleged perpetrator and other appropriate family members who are parties;

(6) Whether there is a history of abusive or assaultive conduct by the child's family or others who have access to the family home;

(7) Whether there is a history of substance abuse by the child's family or others who have access to the family home;

(8) Whether the alleged perpetrator(s) has acknowledged and apologized for the harm;

(9) Whether the non-perpetrator(s) who resides in the family home has demonstrated the ability to protect the child from further harm and to insure that any current protective orders are enforced;

(10) Whether there is a support system of extended family and/or friends available to the child's family;

(11) Whether the child's family has demonstrated an understanding and utilization of the recommended/court ordered services designated to effectuate a safe home for the child;

(12) Whether the child's family has resolved or can resolve the identified safety issues in the family home within a reasonable period of time;

(13) Whether the child's family has demonstrated the ability to understand and adequately parent the child especially in the areas of communication, nurturing, child development, perception of the child and meeting the child's physical and emotional needs; and

(14) Assessment (to include the demonstrated ability of the child's family to provide a safe family home for the child) and recommendation.[26]

The Child Protective Act is relatively complex, largely because it must balance the need to protect children against the need to respect family prerogatives and protect the due process rights of all parties. The Act seeks to:

> . . . provide children with prompt and ample protection from the harms detailed [in the Act], with an opportunity for timely reconciliation with their families where practicable, and with timely and appropriate service or permanent plans so they may develop and mature into responsible, self-sufficient, law-abiding citizens.[27]

Every reasonable opportunity and each appropriate resource should be used to maximize the legal custodian's potential for providing a safe family home for the child. Consideration should also be given to the religious, cultural, and ethnic values of the family when discussing and formulating service plans.

The Act, designed to give DHS flexibility, authorizes DHS to investigate reports. DHS may enlist the cooperation of the county police department and interview the child and, if necessary, assume temporary protective custody of the child in order to conduct the interview. Neither the prior approval nor the presence of the family at the interview is required. After investigation, DHS can: (1) resolve the matter; (2) enter a voluntary service plan under which the family and authorized agencies cooperate to try to improve the situation; (3) assume temporary foster custody and file a petition with the family court; or (4) file a petition or ensure that a petition is filed by some other appropriate agency.[28]

A police officer must assume protective custody of a child if, in the discretion of the police officer, the child's family situation puts the child in imminent harm. The police officer then transfers protective custody to DHS. DHS automatically assumes temporary foster custody of the child. During DHS investigation, the child is placed in emergency foster care, unless the child is admitted to a hospital or similar institution. Within two working days, excluding Saturdays, Sundays and holidays, DHS must decide whether to (1) relinquish its temporary foster custody; (2) continue its assumption of temporary foster custody with voluntary placement of the child in foster care by the child's legal custodian; or (3) continue its assumption of temporary foster custody of the child and proceed as indicated above.[29]

Filing a petition triggers a formal process that can include temporary foster custody hearings, adjudicatory hearings, disposition hearings, permanent plan hearings, and various review hearings. A guardian *ad litem* is appointed for the child, and additional counsel may be appointed for the child and other parties.[30] Upon the filing of a petition, the court, on hearing, may issue an "order of protection." This order may, for example, require that a party stay away from the family home or from any other place presenting an opportunity for contact with the child that is not in the child's interests.[31]

Failure to comply with the terms or conditions of a court order issued under the Act leads to application of the penalties provided in section 710-1077, *Hawaii Revised Statutes* (criminal contempt), as well as other applicable provisions.[32]

Standards of proof differ depending on the nature of the hearing. In a temporary foster custody hearing, a determination that a child is subject to imminent harm "may be based upon any relevant evidence whatsoever, including, but not limited to, hearsay evidence when direct evidence is unavailable or when it is impractical to subpoena witnesses who will be able to testify to facts from personal knowledge." In an adjudicatory hearing, a determination that the child has been harmed or is subject to threatened harm "shall be based on a preponderance of the evidence," and normally only "competent and relevant evidence" is admissible. In any subsequent hearing other than a permanent plan hearing, any determinations must be based on a preponderance of the evidence, and any relevant evidence must be admitted. In a permanent plan hearing, a determination that permanent custody of a child be awarded to an appropriate authorized agency must be based on clear and convincing evidence; a determination that the child should be adopted must be based on a preponderance of the evidence.[33]

Chapter 588, *Hawaii Revised Statutes*, establishes a Children's Advocacy Program within the Judiciary to deal specifically with the problem of child sexual abuse, both intrafamilial and extrafamilial. Chapter 588 provides:

> For the purpose of this chapter, "child sexual abuse" means any of the offenses described under chapter 707, part V, when committed on a person under the age of sixteen years or as is set forth in paragraph (2) of the definition of harm in section 5872 [Child Protective Act].[34]

As noted above, part V of chapter 707 sets forth the sexual assault and incest crimes. Paragraph 2 of the definition of "harm" in chapter 587 deals with sexual harm. It is similar to the sexual contact or conduct provisions of chapter 350, set forth above.

The Director of the Children's Advocacy Program is appointed by the Administrative Director of the Courts.[35] The purposes of the program, in summary, are to: (1) develop interagency and inter-professional cooperation and coordination in the management of child sex abuse cases; (2) obtain evidence for criminal prosecution and civil child protective proceedings; (3) reduce the number of interviews of child sex abuse victims so as to minimize revictimization of the child; (4) coordinate the therapeutic and treatment program for child sex abuse victims and their families; (5) provide for a multidisciplinary team and case management approach that focuses first on the child victim's needs, second on family members who are supportive of the child and whose interests are consistent with the child's, and third on law enforcement and prosecutorial needs; (6) provide for the training and education of interviewers of child victims; and (7) serve as the focus of continuing information and referral for child sex abuse programs.[36]

## Endnotes

1. Hawaii Rev. Stat., §350-1.
2. Ibid.
3. Hawaii Rev. Stat., §350-1.1.
4. Ibid.
5. Hawaii Rev. Stat., §350-1.2.
6. Hawaii Rev. Stat., §350-1.3.
7. Hawaii Rev. Stat., §350-1.4(a).
8. Hawaii Rev. Stat., §350-1.4(b).
9. Hawaii Rev. Stat., §350-2(c).

10. Hawaii Rev. Stat., §350-3(a)
11. Hawaii Rev. Stat., §350-3(b).11
12. Hawaii Rev. Stat., §350-5.
13. Hawaii Rev. Stat., §586-1.
14. Hawaii Rev. Stat., §§586-2 and 586-3.
15. Hawaii Rev. Stat., §§586-4 and 586-5.
16. Hawaii Rev. Stat., §586-5.5.
17. Hawaii Rev. Stat., §586-11.
18. Hawaii Rev. Stat., §586-3(d).
19. Hawaii Rev. Stat., §586-10.5
20. Ibid.
21. Hawaii Rev. Stat., §586-10(a).
22. Hawaii Rev. Stat., §586-10(b).
23. Hawaii Rev. Stat., §587-1.
24. Hawaii Rev. Stat., §587-2.
25. Ibid.
26. Hawaii Rev. Stat., §587-25.
27. Hawaii Rev. Stat., §587-1.
28. Hawaii Rev. Stat., §587-21(b).
29. Hawaii Rev. Stat., §587-24.
30. Hawaii Rev. Stat., §587-34.
31. Hawaii Rev. Stat., §587-52.
32. Hawaii Rev. Stat., §587-77.
33. Hawaii Rev. Stat., §587-41.
34. Hawaii Rev. Stat., §588-2.
35. Hawaii Rev. Stat., §588-3.
36. Hawaii Rev. Stat., §§588-1 and 588-4.

# Chapter 4

## HAWAII'S CHILD PROTECTIVE SERVICES: A HISTORICAL PERSPECTIVE

In 1937, the State of Hawaii established the Department of Public Welfare the predecessor of the present Department of Human Services (DHS) to protect children and prevent family breakdown. In 1956, the Department of Public Welfare, the juvenile court, and the Honolulu Police Department jointly developed "Operation Help," an outreach program to initiate social services on a twenty-four-hour basis to families in crisis.

The enactment of a mandatory child abuse reporting law in 1967 was the first of a series of events that culminated, two years later, in the establishment of a multidisciplinary protective service center for the island of Oahu. With the passage of the mandatory reporting law, the Department of Public Welfare lacked sufficient staff to handle the increasing caseload. Community accusations that the Department's Oahu Branch was not adequately protecting children resulted, in 1969, in special legislative action providing for additional staff positions, the reestablishment of the protective service unit, and funds for a collaborative team. Late in 1969, the Department--renamed the Department of Social Services and Housing (DSSH) established the Children's Protective Services Center (CPSC).[1]

CPSC was designed as a child abuse and neglect intervention and treatment program. Under an agreement between the mandated agency, DSSH, and the Kauikeolani Children's Hospital, CPSC was housed in a rented building on the grounds of the hospital. An annually negotiated contract between DSSH and the hospital clearly delineated responsibilities between the social work and medical components of CPSC. State and federal moneys funded the program.

The protective service social work staff responded administratively to the public welfare agency and worked cooperatively with the medical component at the hospital. The social service component of CPSC received all reports of suspected child abuse and neglect via the Children's Hospital switchboard which provided a twenty-four-hour service. Workers rotated on intake and twenty-four-hour on-call duty, and were responsible for social service diagnosis and treatment.

The medical component provided diagnosis and treatment in physical medicine for the child, and psychiatric and psychological diagnostic evaluations of both child and family. All of the medical staff members--a full-time salaried medical director/pediatrician, a full-time pediatric nurse, two psychiatrists, and two psychologists--served as consultants to the social work staff and were paid through annually negotiated DSSH/Children's Hospital budget funds. In addition, the pediatrician was responsible for case management of child abuse and neglect cases in the hospital, which included supervising and instructing residents. The pediatric nurse provided nursing assistance in the hospital and community as needed and consultant training as requested.

The medical staff of CPSC revolved around the medical director who was, traditionally, the team pediatrician. The medical director reviewed the medical aspects of each case and all diagnostic workups; obtained medical information for a social worker if necessary; was available to professionals throughout the State for medical advice about cases; discussed medical diagnosis, prognosis, and treatment with reported families; and, if the caseworker desired, could act as a counselor to both parents and children.

The social work component of CPSC was staffed by an M.S.W. (Master of Social Work) supervisor, eight caseworkers, a social work aide, and clerical support. The social work aspect of CPSC received reports of suspected child abuse and neglect, conducted investigations, developed dispositional plans, and provided intervention services usually for a period of not more than three months. A core team comprised of the social work supervisor, the medical director, and a case social worker met informally every day to review all intake cases and give initial assessments.[2]

In emergency cases steps were taken immediately to alleviate the situation. Where immediate protection of the child was indicated and the parents resisted, the county police department was enlisted to remove the child from the home while DSSH requested an order for physical custody from the Family Court.

If, after initial screening and review, a case was accepted for further investigation, a complete written complaint was forwarded to the social work supervisor for assignment. The supervisor assigned the case to a CPSC social worker who followed through with the case until a treatment plan was determined and initiated. Cases were presented by the CPSC social worker at weekly meetings of a multidisciplinary team consisting of the CPSC's social work supervisor, the medical director/pediatrician, a pediatric psychologist, a pediatric psychiatrist, a pediatric nurse, and a state deputy attorney general. In addition to these fixed members, team case reviews included the social worker in charge of the case and sometimes physicians, lawyers, teachers, school counselors, public health nurses, police or others with firsthand knowledge of the family and child. The team provided diagnostic consultation and reviewed findings related to the development of treatment plans. The function of the collaborative teams was to recommend the most feasible treatment plan for the family.

At the close of each individual case presentation the team arrived at a consensus for treatment. However, the case social worker presenting the case retained final responsibility for deciding on and implementing the treatment plan prior to referring the case for ongoing treatment and follow-up. When the case social worker disagreed with the team recommendations and treatment plan, the social work supervisor often worked informally together with the medical director in formulating a suitable treatment plan acceptable to both social work and medical components of CPSC. It was mandatory for the case social worker to follow through with the final joint decision of the social work supervisor and the medical director.

The CPSC social worker was primarily responsible for following through with treatment plans and providing other types of intensive crisis services to prevent further abuse and neglect from occurring. Crisis services ranged from arranging for medical, psychiatric and psychological evaluations to aiding families in requesting financial assistance from DSSH. All CPSC staff members were available for consultation, and services were provided whether the child victim remained at home or was placed in foster care.

Intensive services were provided for a period of ninety days during which time support services or referral for long-term counseling were initiated with other social service agencies as needed. There were two long-term follow-up units: (1) Catholic Social Services, an agency under a purchase of service agreement with DSSH; and (2) South Family and Children's Services, a DSSH unit. The follow-up units were both geographically and administratively separate from CPSC.

In 1975, Hawaii's CPSC was evaluated by a team of experts in the field of child abuse and neglect. The purpose of the evaluation was to assess the overall effectiveness of CPSC and to recommend changes for increased effectiveness. The evaluation was one component of the Child Abuse Demonstration Center, later renamed Hawaii Family Stress Center, and was a three-year federally funded project. The members of the interdisciplinary team of consultants were chosen for their experience and expertise in the field of child abuse and neglect and upon the recommendation of the Child Welfare League of America, the Humane Society of America, and the Office of Child Development. The members of the evaluation team were: (1) Barton Schmitt, M.D., National Center for Child Abuse, Denver; (2) Anne Cohn, M.P.H., Berkeley Planning Associates, Berkeley; (3) Elizabeth Davoren, M.A., Urban Rural Systems Associates, Denver; and (4) Hans Hoel, A.C.S.W., former Director of Hennepin County Welfare Department, Child Services Division, Minneapolis.

The 1975 evaluation of CPSC was largely favorable with specific recommendations made to create an optimal system. The evaluation team applauded the implementation of "a most interesting model for handling abuse and neglect cases by virtue of housing the public protective services unit with a private hospital environment."[3] The model showed promise in bridging the gap between at least two of the major sectors--medical and social--both of which have important responsibilities for abuse and neglect problems. Nationwide interest and support for Hawaii's model urged the evaluation team to pursue ways to maximize its efficiency and effectiveness.[4]

The evaluation began with praise for CPSC but later criticized intra-agency conflicts between the medical team members and the social workers:

> First and foremost, there is much that is right with the current system--the highest reporting rate in the country, the 24-hour reporting hotline, dedicated CPSC workers, a humanistic and devoted CPSC supervisor, the ready availability of medical consultation, the willingness of the medical director to go to court for private physicians, weekly interdisciplinary team

> conferences, the free use of consultants, follow-up forms, strong pediatric nursing involvement, a willingness to be eclectic about treatment modalities, the current training of [child abuse and neglect] paraprofessionals and a nonpunitive legal system.
>
> There are also shortcomings. Their degree is from mild to moderate. They are not confined to any one agency or component of the system. The main shortcoming may well be the distrust and friction between different disciplines and agencies. Unless this is reconciled, many of the recommendations in this report may not be attainable. . . .[5] (Emphasis added)

The "distrust and friction" existed largely between the social work and medical fields:

> The CPSC workers operate under somewhat confusing conditions. Their jobs as currently defined or at least as currently operationalized cause them to have close to total control over what happened to abuse and neglect cases on Oahu. Concurrent with this apparent responsibility, the workers are not always viewed as experts by others in the community, particularly in the medical community, and the degree of responsibility which they should have is called into question. The result is conflicting messages over what the social workers can do and ought to be doing. I am not sure what the appropriate mix of responsibility should be for the social workers, but wisdom would suggest that the more diversified the input is into what should happen with specific abuse and neglect cases, given the state of knowledge in the field, the better the chances are for favorable outcomes. Thus, I would recommend that the responsibilities of the social workers be reclarified or respecified in ways that help or cause them to maximize the amount of multidisciplinary input on cases. This can in part be effected by increasing the numbers of cases reviewed by the Multidisciplinary Review Team, and should be beneficial to the workers and their clients. At the same time I would recommend that steps be taken to try to improve the image of the social workers in the community. This will likely happen, in part, as the social workers take a more multidisciplinary approach to their work; other actions, such as providing feedback on cases to those who refer the cases, can be equally helpful.[6] (Emphasis added)

The evaluation team favored a more unified administration of the multidisciplinary team. At the time of the 1975 evaluation there were two coordinators for CPSC, one for medical matters and one for social matters. As a result, communication and decision-making channels were confused and there was no clear authority in charge to assume overall responsibility for problem-solving and program planning. The recommendation was to appoint a child protection program administrator who did not have strong loyalties to either of the two disciplines, medical or social work. The administrator would carry responsibility for the entire

program, including the CPSC unit and multidisciplinary team, and all follow-up services, both within the department and those purchased from outside agencies.

It was felt that the program administrator should not overlap the duties of the social service unit supervisor. The unit supervisor should only be responsible for social work supervision of the social work staff and should not be involved in overall administrative matters. The supervisor should be co-equal with persons responsible for supervision of social workers in the follow-up units. Moreover, the social work supervisor must remain acutely aware of the delicate mix of social service and medical activity and not overstep the perimeters of the social work discipline.

Yet another source of friction resulted from a feeling among the medical personnel that the multidisciplinary team was underutilized. By 1975, CPSC social workers had almost complete control over disposition of cases--it was within their discretion whether or not to present a case for multidisciplinary team review and implement multidisciplinary team recommendations. The evaluation team recommended the development and implementation of definite criteria for bringing cases to multidisciplinary team review. The evaluation team pointed out that the optimal system would require review of every case.

The evaluation noted that each multidisciplinary team member should be made to feel involved and instrumental in the disposition of cases. To achieve this end, request for team review should be made available to anyone having firsthand knowledge of a case, including any psychiatrist, psychologist, nurse, or physician who has personally evaluated or treated the family.

In general terms, the evaluation revealed too much individualized decision-making and a lack of supportive input and cooperative decision-making. The evaluation team indicated that the development and implementation of specific criteria and guidelines for intake, investigation, formal psychiatric/psychological consultation, legal consultation, multidisciplinary team review/consultation, temporary foster home placement, severance of parental rights, referral of cases to the police for criminal investigation, and transfer of cases to follow-up units would encourage cooperative and consistent decision-making.

Finally, a chart audit conducted by the evaluation team examined the quality of care of fifty-nine cases of suspected child abuse and neglect accepted for investigation by CPSC. The chart audit revealed an inadequate critical data base in many of the cases and confusing, inconsistent recordkeeping in the case file. The "critical data base" is comprised of four items collected during the caseworker's evaluation: (1) physical exams; (2) trauma survey (complete skeletal x-rays); (3) psychological/psychiatric evaluation; and (4) a check for high risk characteristics.[7]

The most disturbing finding was the lack of medical examinations in cases where such examinations were indicated (necessary). Physical exams were indicated in one hundred percent of alleged physical abuse cases. Yet, physical exams were completed in only fifty

percent of the suspected physical abuse cases. Of the suspected sexual abuse cases audited, none of the alleged victims received physical exams. Trauma surveys were obtained in only thirty-three percent of the cases in which trauma surveys were indicated. The most incomplete critical data base was the category for "unconfirmed but probable physical abuse." Here, one hundred percent of the cases required a physical exam and high risk assessment, and sixty percent of the cases required trauma surveys. Only forty percent of the cases actually received physical exams, twenty percent of the cases received high risk assessment, and none of the cases received trauma surveys. As might be expected, a low critical data base correlated directly to a low percentage of adequate recommendations. Of the recommendations given in the "unconfirmed but probable physical abuse" cases, only twenty-one percent of the recommendations were deemed adequate by the evaluation team.

The chart audit was the most revealing portion of the overall evaluation. Caseworkers had failed in numerous cases to gather the data necessary to render a comprehensive assessment. The likelihood of an incomplete data base would be diminished with more consistent multidisciplinary team review. Each team member is responsible for assessing the adequacy of data provided in their area of expertise.

The findings of the 1975 evaluation were given careful consideration and DSSH attempted to implement most of the recommendations. However, even with the CPSC system improvements, the effectiveness of CPSC waned as the demands for services increased. During the years 1975-1978, the number of child abuse and neglect reports doubled. By 1979, there were approximately 285 child abuse and neglect cases being serviced by post-crisis follow-up units on Oahu, and about the same number of child abuse and neglect cases being serviced by other outlying DSSH units.[8] With an estimated reporting rate of eighteen percent for previously reported cases, concerns were expressed related to the management and effectiveness of the CPSC program.

In 1980, the Oahu Children's Protective Services Center Advisory Committee to Oahu Branch, Public Welfare Division, Department of Social Services and Housing, established a committee comprised of representatives of most community agencies involved in the protective services system. The committee conducted a statewide evaluation of the Children's Protective Services (CPS), which was intended to be a follow-up evaluation of the study conducted in 1975. The 1980 study was conducted under the auspices of the Kapiolani Children's Medical Center, where CPSC was located. The study reevaluated the then current status of the program, identified changes and new directions which should be made for improvement, and the most economical ways of accomplishing modification and improvement of operations.

The specific goals of the evaluation were to: (1) assess the quality of case management by caseworkers and supervisors, for all types of cases; (2) assess the nature and quantity of services provided by DSSH workers and other agency resources; (3) assess the effectiveness of the service delivery system in terms of recidivism; (4) assess the effectiveness of foster care; (5) assess the efficiency of overall organizational structure in

facilitating service delivery; and (6) identify major problem areas in the overall system and make recommendations.

The primary participants conducting the evaluation were a team of experts in the field of child abuse and neglect, selected for experience in three major areas: medical, social work and systems management. The team leader was Barton Schmitt, M.D., who also headed the 1975 evaluation team. James Cameron, M.S.W., brought twenty years of social work experience to the team in the areas of casework, supervision and planning councils. The third member of the team, Katherine Armstrong, M.S.W., Ph.D., was a member of the Berkeley Planning Associates staff which conducted the evaluations of federal child abuse demonstration projects initiated in 1974. She was also involved in evaluations of state protective service systems in California, with expertise in dealing with worker burnout.

Unfortunately, the 1980 evaluation recalled many of the same problems noted in the 1975 evaluation. In fact, many of these same problems had become more widespread in the expanding child protective services system. The comprehensive evaluation was highly critical of the entire child protective services system and isolated many areas with severe problems. Findings for the specific objectives of the study are summarized below.

(1) To assess the quality of case management by caseworkers and supervisors, for all types of cases.

- Social investigations reflected incomplete histories and poor definition of high risk characteristics.

- Medical diagnoses were not made for some serious cases. The CPS Team was used infrequently for diagnostic purposes and was not used in any of the 26 reabuse cases.

- Supervision over intake was almost nonexistent resulting in inconsistent intake of incoming complaints.

- Case records revealed little evidence that analytical psycho-social assessments were being conducted by social workers.

- Little or no joint planning between investigative and follow-up workers in development/follow-up of clearly identified treatment plans.

- Lack of monitoring of cases was associated with reabuse in the recidivism study. Once the case was referred to another agency, CPS often closed their file.

- Need to redefine CPS worker's role to focus upon investigation and case management and to develop additional resources for in-depth service delivery.

(2) To assess the nature and quantity of services provided by DSSH workers and other agency resources.

- Intensive, in-depth rehabilitative services are not being provided to the perpetrator, the family or the child.

- High caseloads result in lack of active case review and worker burnout. Recommended caseloads are 20-25. Cases often referred and then CPS case closed--problem appears to be partially due to high caseloads.

- Intensive counseling referrals often not made. The team concluded that abusive/neglectful families are not being engaged in remedial services.

- Need to redefine role of CPS worker as investigation and case management and to substantially reduce caseloads.

(3) To assess the effectiveness of the service delivery system in terms of recidivism.

- The system was not effective in preventing recidivism. Twenty-six of seventy-eight cases sampled on Oahu involved reabuse, including two deaths. A typical pattern emerged for most cases. First there were a series of unsubstantiated abuse/neglect complaints. Next, there were inadequate social work investigations and assessments. There was poor use of team, even after a series of complaints. Services to perpetrator were not provided or were inappropriate and ineffective. Related to this was the practice of making a referral and then closing the case. Of great concern was the number of cases opened and closed repeatedly, with no provision of services when the situation was already identified as abusive.

- Need to develop and implement a protocol for social work investigation and assessment, which addresses the issue of repeated complaints.

- Guidelines for team use should be followed.

- Use of effective services for remediation of abusive behavior is crucial, along with diligent monitoring of service effectiveness and the safety of the child.

(4) To assess the effectiveness of foster care.

- Severe fragmentation in services is evident, rendering foster care system ineffective. Many children remain in foster care too long while effective services are not provided to natural parents during placement.

(5) To assess the efficiency of the overall organizational structure in facilitating service delivery.

- Many of the problems of case management were results of inefficient organization and unclear administrative policies and procedures, and inadequate manpower.

- Caseloads are too high. Workers are overwhelmed and burned out, resulting in a high staff turnover rate. The high turnover rate affects the quality and continuity of service delivery. There is poor communication between workers, supervisors, and between units. There is no centralized statewide coordinator for the program.

- Fragmentation of service or delays in provision of services can be significantly reduced by having one worker follow a case for investigation and management.

(6) To identify major problem areas in the overall system and make recommendations.

- In depth therapeutic services are not being provided to the perpetrator, family and the child. Need to develop effective specialized therapeutic treatment capability within the agency and contract with effective treatment resources in the community.

- Need to establish clear policies and standardized procedures for case management to prevent cases from "slipping through the cracks."

- Initiate major reorganization of the foster care system that ensures provision of services to families, clear agreements with families, short and long range plans for children and procedures for termination of parental rights.

- Many cases do not receive physical exams, the multidisciplinary team and resources are underutilized or not readily available and legal resources are not sufficiently available in quantity or quality. Need to address child abuse/neglect as a multidisciplinary problem. There is a need for different disciplines to review and make input into a case. Procedures need to be developed for physical exams, existing guidelines

regarding use of team should be implemented, arrangements should be made on neighbor islands to establish teams and contracts with medical facilities.

- Implement reorganization plan to feature centralized intake, target groups' specialized services, staff rotation, improved supervisory accountability, streamlining of recording procedures, and preservice and inservice CPS worker training.[9]

The State of Hawaii Protective Services Program, like similar programs throughout the country, experienced problems and frustrations reflecting the need to make a transition from a traditional, outmoded system to a responsive, effective system which operationalized innovative concepts and procedures. The evaluation team's recommendations urged the use of consultant services utilizing expertise from well-functioning programs to help create effective procedures and generate staff enthusiasm for implementation.

Clearly, the child protective services system was in crisis. Understaffed and overburdened CPS social workers tried unsuccessfully to keep pace with the demands of an ever-growing child abuse and neglect caseload. In addition, due to statutory changes implemented by the State of Hawaii, the method of funding for CPSC changed. On July 1, 1981, the method of funding shifted to a purchase of service contract by DSSH with the Kapiolani Medical Center for Women and Children creating the Child Protective Services Team (CPS Team). Chapter 42D, *Hawaii Revised Statutes* (the successor to the then-existing law on the same subject), entitled "Grants, Subsidies, and Purchases of Service," defines "purchase of service" in relevant part as:

> . . . an appropriation of public funds for the provision of services by an organization to specific members of the general public on behalf of an agency to fulfill a public purpose.[10]

From an administrative standpoint, the CPSC, including the multidisciplinary team, was no longer under the joint auspices of DSSH and the medical center. Moreover, the purchase of service requirement changed the relationship between DSSH and the medical center--the social work and medical components were no longer equal partners in child protection. DSSH became the contractor for services and the medical center was subordinated to a service provider. Thus, although CPSC remained physically located on the grounds of the medical center, purchase of service requirements altered the dynamics of the CPSC by stratifying the medical and social work components.

Child Protective Services remained located within the medical center until the needs of both CPS and the medical center outgrew the available space.[11] Moreover, CPS was no longer the product of a partnership between DSSH and the medical center warranting a medical center presence. CPS Intake, Crisis and Investigative Social Services Section and the CPS Team moved to an office building located near the medical center. Although space

requirements on behalf of both CPS and the medical center necessitated the separation, CPS lost the benefit of proximity to the medical center and the daily interaction and support of the medical center staff.

With the caseload of child abuse and neglect cases increasing each year, CPS outgrew its office space and subsequently moved to its present location at Waiakamilo Business Center (WBC).[12] The Protective Service Intake, also known as the Child Abuse Hotline, also relocated to WBC. Unfortunately, DSSH did not make arrangements to share office space with the CPS Team at the new WBC office location. When CPS moved to its new offices at WBC, the CPS Team remained at the old office space near the medical center.[13] The physical separation of CPS from the CPS Team resulted in further fragmentation of the overall system. Services provided by the CPS Team increased, but not commensurate to the rate of increase to CPS cases. Hawaii's once nationally acclaimed arrangement of hospital, child protective services and multidisciplinary team all housed within the same facility was lost. The CPS Team, once an integral part of CPS, became an underutilized auxiliary service purchased by CPS' parent department, DSSH.

In the mid 1980s, the CPS system came under close scrutiny as allegations of case mismanagement were raised. CPS staffing difficulties intensified in 1984 when three DSSH employees faced criminal indictments for mishandling the child abuse and neglect case involving Ronica Ann Arcala. After several long months, the grand jury found no basis to return an indictment. Nevertheless, the three social workers were severely traumatized and soon after quit their CPS positions with DSSH. An exodus of CPS workers soon followed. Since the incident, CPS has experienced chronic recruitment and retention problems that seriously undermine the agency's ability to deliver quality services to abused and neglected children.[14]

The CPS social worker shortage persisted throughout the decade. On the average, CPS workers left their positions within two years.[15] A 1989 comprehensive study of foster care in Hawaii indicated that CPS social workers found themselves hampered by the instability of their work units due to rapid turnover and high caseloads:

> Among survey respondents, 36 percent had held their current positions for less than one year, a quarter less than 6 months, again reinforcing the numbers of new people on the job.
>
> * * *
>
> While caseload size can be difficult to determine with accuracy the average size for workers responding to the survey was 35. This number includes an average of 26 children and 15 families or over 46 individuals. When asked if their caseload was affected by the shortage of workers, three-quarters said yes. In addition, when asked the major reasons caseworkers leave their jobs, high caseloads was the response most frequently cited. According to survey responses most units appear to be operating at 80 percent

> capacity. If full capacity were achieved--that is, all authorized positions were filled, the caseloads would be reduced to about 28 per person. While not yet meeting good practice standards, filling existing positions would move the State a long way towards improving its caseload crisis.[16]

The study indicated that national organizations such as the Child Welfare League of America recommended case loads no higher than twelve cases per month for abusive investigators and seventeen families per month for ongoing social work. Relative to nationally recommended standards, Hawaii's social workers are indeed overburdened by high caseloads.

The study commended Hawaii's Departments of Human Services and Health for preferring the Master of Social Work (MSW) degree as a condition for employment. A statewide survey showed over half of all workers do possess training in social work at the bachelor's or master's level. This was twice the national average where approximately one-fourth of the public child welfare workers have BSWs or MSWs. The foster care study explained Hawaii's shortage of social workers as a problem of supply and demand:

> The problem is that the supply of MSW-trained people in Hawaii simply is not great enough to meet the demand for workers. In 1988, there were 71 School of Social Work graduates at the University of Hawaii (14 BSWs, 57 MSWs); yet, there were 140 social worker vacancies in the DHS alone, 65 of which were filled with emergency hires. In addition, there were 218 social work vacancies in other state agencies, the greatest in the Department of Health. While the number of social work graduates is projected to increase in 1990, the gap could not be closed even if all were to go to work in state agencies. The discrepancy between supply and demand is so great that the shortage could not be overcome without massive out-of-state recruitment.[17]

The study indicated that at least ten other states had dropped the MSW requirement over the past decade due to problems faced by public agencies in finding and keeping suitably educated staff. These states allow for a substitution of education and experience and have developed intensive programs of pre-service and in-service training for workers. The most elaborate of these programs, in states like Florida and Tennessee, last for several weeks and include intensive supervisor follow-up while on the job.[18]

Well aware of its personnel problems, DHS has taken steps to remedy it: adding positions in an effort to serve huge caseloads, instituting shortage pay for workers in high stress jobs such as child protective investigations, and increasing the use of emergency hires. The solutions, however, are not working fully. Caseloads remain far higher than recommended national standards and vacancies remain high throughout the agency. At one time, DHS even tried out-of-state recruitment. Unfortunately, positions filled by out-of-state hires tended to turn over quickly as these social workers struggled to adjust and cope with

Hawaii's culturally diverse population.[19] People who have been hired in temporary positions or on an emergency basis have become disgruntled with their status and lack of benefits. The foster care study summarized:

> To meet its worker shortage, Hawaii will need to place a greater emphasis on substituting education and experience coupled with a more extensive pre-service and in-service training program for formal social work credentials.
>
> In addition, emergency workers who have been on the job more than six months should have their performance reviewed and if satisfactory be placed on permanent status. Temporary positions should be converted to permanent positions.[20] (Emphasis added)

Clearly, there is no easy remedy for DHS' ongoing personnel problems. Evaluations of DHS/CPS over the last twenty years reveal reoccurring difficulties involving staffing shortages, high caseloads, high worker stress and burnout levels, high turnover rate, a greater demand than supply of qualified social workers, and low morale. In 1986, one study concluded:

> No change in organizational structure or program administration or service delivery or budget-making will be effective; no amount of money will be enough; no increase in the numbers of case workers or public health nurses or teachers or judges or administrators will make a difference unless each person whose responsibility it is to protect children from abuse and neglect decides that the children are more important than the system.
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> * * *
>
> What is really lacking is a fundamental sense of urgency among government personnel about getting help to abused and neglected children.[21]

Although these remarks may have been accurate in 1986, they appear to be no longer applicable today. Child Protective Service and CPS Team personnel, and others involved with child protection interviewed for the present study are genuinely committed and concerned about providing timely, appropriate and adequate intervention, treatment and services to children and families in need of protection. As the demands on the system increased, the ability to provide such treatment and services has been eroded by the personnel deficiencies described above. The commitment to protect children however, has not been eroded. Efforts must be made to provide CPS line workers with adequate support. And, most importantly, CPS needs to share the responsibility and the requisite stress related to child protection by relying more heavily on effective auxiliary services such as the CPS Team.

## Endnotes

1. U.S., Department of Health Education and Welfare, Child Abuse and Neglect: The Problem and Its Management (Washington: DHEW Publication No. (OHD) 75-30075, 1975), p. 172. Background information was also collected during interviews with Calvin Sia, M.D., July and August, 1992; and an interview with Department of Human Services Representatives Debby Lee, Assistant Program Administrator, Child Welfare Protective Services; Donald Newville, Assistant Oahu Branch Administrator, Family and Adult Services Division; Marie Kunimura, Purchase of Service Monitor, Child Welfare Protective Services; and Regina Gerstman, Assistant Program Administrator, Child Welfare Protective Services, August 7, 1992.

2. "Child Protective Services Handbook", Hawaii, Department of Human Services (mimeographed), sec. 1100.1. "Intake" is defined as those activities which occur between the time a report (verbal or written) is received until a clear decision has been made that the report is valid and is accepted for investigation.

3. Barton Schmitt, Anne Cohn, Elizabeth Davoren and Hans Hoel, "Children's Protective Services Center Evaluation Report" (Child Abuse Demonstration Center, 1975) (mimeographed), p. 12.

4. Ibid.

5. Ibid.

6. Ibid., pp. 17-18.

7. Ibid., p. 37.

8. Barton Schmitt, James Cameron and Katherine Armstrong, "An Evaluation of the Child Protective Service Program of the Hawaii State Department of Social Services and Housing" (Department of Social Services and Housing, Children's Protective Services Center Advisory Committee, and Kapiolani Children's Medical Center: 1980), p. II.A-2.

9. Ibid.

10. Hawaii Rev. Stat., §42D-1.

11. Information collected during a series of interviews with Steven J. Choy, Director and Mental Health Consultant, Kapiolani Medical Center for Women and Children Child Protective Services Team, August and September, 1992, and interview with Lee, Newville, Kunimura and Gerstman.

12. Ibid.

13. Choy interviews.

14. Franklin Sunn, memorandum regarding Senate Bill No. 1827, Senate Draft 2, Relating to Child Protection Act (set for hearing March 12, 1986).

15. Hawaii, "Specifications for the Development of a Child Abuse and Neglect Prevention and Treatment Program in Hawaii (Office of Children and Youth, 1987), p. 76.

16. Helaine Hornby, Mark Hardin, Tom Morton, Toni Oliver, Nancy McDaniel, Michael Petit and Robert McKeagney, A Comprehensive Study of Foster Care in Hawaii, Legislative Auditor (Honolulu: 1989), p. 75.

17. Ibid., p. 76.

18. Ibid., pp. 76-77.

19. Choy interviews; interview with Lee, Newville, Kunimura and Gerstman; and interview with Jane Stump, Ph.D., Social Work Consultant, Kapiolani Medical Center for Women and Children Child Protective Services Team, August 27, 1992.

20. Hornby, Hardin, Morton, Oliver, McDaniel, Petit and McKeagney, p. 75.

21. "An Examination of Child Abuse and Neglect Services in Hawaii" (Legislative Reference Bureau, Request No. 3453-A, 1986), p. 19.

# Chapter 5

# FUNCTIONS AND ROLES OF EACH CHILD PROTECTIVE SERVICES UNIT

Over the past twenty years, there has been an enormous expansion of Hawaii's program to prevent child abuse and neglect. The specialized agency responsible for investigation of reports of child abuse and neglect is the Child Protective Services (CPS).[1] CPS performs the following functions. They receive and screen reports; they investigate reports and determine whether child protective action is needed; they determine whether the child requires immediate protection; they determine what long-term protective measures and treatment services are needed and then seek the parents' consent for such measures and services; when a maltreated child is left at home or is returned home after having been in foster care, they supervise the parents' care of the child and monitor the provision of treatment services; and, finally, they close the case after it appears that the parents can properly care for the child or after parental rights have been terminated and the child has been placed for adoption. To the fullest extent possible, CPS seeks the parents' voluntary consent for the protective measures and treatment services deemed necessary. If the parents do not agree to CPS' plan, CPS may seek court authority to impose the plan on the parents.

Each of the functions described above is now performed by specialized units within CPS. This chapter describes the various CPS units and seeks to provide the reader with a conceptual framework for Hawaii's child protection system.

## General Intake

The General Intake Unit handles service requests to adults and families who are not involved with any other CPS unit. Adult services include care home placements, chore and adjustment services, and referrals to other community-based programs. If an application is approved, the case is transferred to a DHS Adult Services Unit for case management.

The family services processed by the Unit include foster care placements, assistance with child care due to developmental delays, job training, and employment. Childcare may also be requested in high risk protective situations, for example, where a mother requires respite assistance. In addition, the Unit handles adoption requests, homestudy requests from the neighbor islands, requests for courtesy supervision from other jurisdictions and, in potential Child Protective Act cases, provides initial services such as a filing of a petition for foster custody for children without legal guardians. The Unit also services children whose temporary legal custody has been awarded to DHS in a Termination of Parental Rights proceeding. Once approved for services, the above types of cases are transferred to either a Case Management Unit or a Dependent Children's Unit.

### Protective Services Intake Unit

The intake social worker at Protective Services Intake (PSI), also known as the Child Abuse Hotline, receives and assesses new reports of child abuse and neglect pursuant to chapter 350, *Hawaii Revised Statutes* (the child abuse law). On Oahu, intake phones are handled twenty-four hours a day, seven days a week. On the neighbor islands, calls are accepted by CPS during regular business hours. After hours calls must be made directly to the county police department. CPS defines "intake" as "those activities which occur between the time a report, both verbal or written, is received until a clear decision has been made that the report is valid and is accepted for investigation."[2] Reports may come from the public or from the county police department. An assessment is made whether to accept a report for investigation:

> The assessment essentially revolves around the credibility of the call and the urgency of response. In assessing credibility, the social worker must consider a number of factors, such as who the reporter is, how the information came to be known by the reporter, and descriptive information of the incident. If the reporter is a mandated reporter, such as a physician or teacher or if the incident was observed firsthand, and the description of the incident meets established criteria for determining child abuse and neglect, then the report would more likely be determined credible and warrant investigation.[3]

The decision also takes into consideration the magnitude of the alleged harm, imminent harm, or threatened harm to the child, the child's age and physical and mental abilities, the caretaker's ability to protect the child, and prior history of the child or family with CPS. A check of the Social Service Information System (SSIS) and Child Protective Services System (CPSS) is routinely done to provide history and case information, if any.[4] The intake worker may contact collateral sources (e.g., schools, social agencies, public health, nurses, doctors, hospitals) for more information to aid the worker in making an appropriate decision.[5]

If a report of child abuse and neglect (except sexual abuse reports) is accepted for investigation, the Unit submits reports to the Juvenile Crime Prevention Division (JCPD) and the county police department to the CPS Crisis/Investigative Units, and registers the report into the CPSS. There are two categories of response: (1) immediate response requires face-to-face contact by the worker with the victim within twenty-four hours, and (2) all other response requires face to face contact by the worker with the victim within one week, but preferably within seventy-two hours.[6] Conditions requiring immediate response include:

- any physical abuse of a child under one year old
- sexual abuse where the perpetrator is still in the home
- intentional drugging or poisoning

- abandoned children under twelve years old
- unsupervised children under nine years old or children with handicaps
- reports that parents with young children are psychotic, behaving in a bizarre manner or acting under the influence of drugs
- upon the death of a child when there are other children in the family
- cases with high scores on the risk assessment guideline[7]

If a sexual abuse report is accepted for investigation, PSI contacts the county police department and the Child Sexual Abuse Investigative Unit, formally known on Oahu as CPS Crisis/Investigative Unit 3. If a report is not accepted for further services, the PSI keeps a record of the report by filing the case notes according to the alleged perpetrator's name.

The county police department also investigates initial reports of abuse and neglect (received from the public or from the CPS), decides whether the child's family poses a substantial risk of imminent harm to the child and may take the child into protective custody pursuant to section 587-22(a), *Hawaii Revised Statutes*.

A child can be taken into the Department of Human Services' temporary foster custody without a court order only if there is an indication of immediate need for child safety and the county police department has taken the child into "protective custody" first.[8] When a child's custody is turned over to the Department in this way, the PSI arranges for the child's initial placement in an emergency shelter home, with relatives, the non-custodial parent (if divorced) or the non-abusive and non-neglecting parent, or in a regular foster home and arranges for a preplacement physical examination. Physical abuse is usually involved in such emergency situations. If the Crisis Unit investigates and confirms abuse, neglect, threatened harm, or risk of imminent harm, it may file a petition for temporary foster custody, elect to work voluntarily with the family toward creating a safe home environment, or recommend that no service plan be implemented.

### Crisis/Investigative Units

A Crisis Unit social worker investigates reports of child abuse and neglect to either confirm or dismiss abuse allegations. If a report is not confirmed, the case is closed and the Unit enters the parties' vital information into the CPSS. Information about the allegations is kept in a separate DHS file. Access to the CPSS registry or allegation history may be obtained by consent of all the parties involved or by court order.

The investigative phase is the most intrusive part of the CPS process and puts tremendous strain on the caseworker. "Investigation" is defined as "those activities which occur between the time an investigation is initiated until the report is unfounded or confirmed and transferred for case management services or terminated."[9] The purpose of the investigation is to confirm or rule out a report of child abuse or neglect.[10] The caseworker must also determine the safety of the child and take appropriate action to assure that the child is fully protected.[11] The intrusive nature of the investigation requires "skilled use of authority, demands quick decisions and actions and almost always places social workers in an adversarial role with parents."[12] The critical determination of whether child abuse and neglect has occurred cannot be made without direct interviewing and observation of the child, parents, or other informed or involved persons. Supplemental information and supporting documentation must be gathered and reviewed to assist the fact finding process. Documentation may include the alleged perpetrator's criminal history record, medical records, records of closed service cases (other than CPS), mental health records, and school records. Medical, behavioral, environmental, physical and scholastic indicators are all potentially relevant to the report of child abuse and neglect.[13]

Case social workers may ask the CPS Team medical and nurse consultants to assist in reviewing medical records. The medical and nurse consultants may also interview involved physicians, hospital review committees or other medical consultants.[14]

The Crisis Unit social worker is also responsible for arranging physical examinations and mental health examinations in cases involving serious child abuse and neglect, where the information is believed necessary to substantiate allegations, and in other circumstances outlined in the CPS Handbook. The social worker may also enlist the aid of the CPS Team in complex situations, serious cases of child abuse and neglect, and in situations where the worker must make critical decisions.[15] If a report of abuse or neglect is confirmed, the social worker may take a number of actions, each of which focuses on the protection of the child and the disposition of the report:

- A voluntary service plan may be established;
- The child may be removed from the family home and a temporary foster custody petition is filed in Family Court; or
- Other appropriate arrangements may be made to ensure the child's safety and a foster custody or family supervision petition may be prepared by this Unit for filing in Family Court.

In any event, DHS requires that the service plan be completed within sixty days of receipt of the child abuse and neglect report.[16] When the Family Court is involved, the service plan must be completed within thirty days from the date of the disposition hearing.[17]

During the investigation phase, supervisory review must occur:

- when the report is initially received, by the investigating unit;
- when the worker arrives at an assessment;
- when the worker arrives at a disposition; and
- when the worker petitions the court for jurisdiction.[18]

Upon completion of the investigation, the worker must contact the reporting person, if known, and notify them as to whether the report was confirmed or ruled out.[19]

DHS related that in recent years, approximately 4,000 reports of child abuse and neglect are made annually. An estimated 2,500 of the 4,000 reported cases are confirmed. One-half of the 2,500 cases, or 1,250 cases, are confirmed cases of child abuse or neglect but are subsequently closed out because social worker investigation and assessment reveals, typically, an isolated, one-time minor abuse situation where the family is motivated to get help on its own. Of the remaining 1,250 confirmed cases of child abuse and neglect, approximately one-third or 416 cases will be assessed as high risk cases indicating multidisciplinary team consultation.[20]

### Crisis/Investigative Unit 3

This unit, also known as the Sexual Abuse Unit, performs the same duties and functions as the CPS Crisis/Investigative Units except that it investigates only child sexual abuse reports.

### Case Management Units

Case management assists families in which child abuse and neglect have been confirmed by:

- identifying problems resulting in the child abuse or neglect incident;
- setting up goals and objectives to resolve these problems; and
- seeking and obtaining appropriate rehabilitative measures.[21]

Case management services are defined as "those activities the worker is engaged in after the investigation until a decision is made to terminate services or to transfer the case for long-term out-of-home placement services."[22] Case management social workers actively work with

families to achieve the goals of reunifying children with their families or maintaining children in their family homes.

The case management social worker must make a comprehensive assessment of the family before deriving an effective plan to assist the family. Elements to be considered in the assessment are as follows:

- fourteen safe home guidelines[23]
- identification of the problem or problems leading to the child abuse or neglect incident
- behavior and social functioning
- emotional patterns
- education and cognitive patterns
- current life situation and history
- family relationships and interaction

Social workers may choose to utilize psychiatric, psychological or CPS multidisciplinary team consultation to assist in the assessment of the family. In arranging for consultations or evaluations, use of the CPS Team is considered first. If the CPS Team is unable to meet the worker's request, then other resources are utilized.[24] Timeliness in making the assessment is essential as it serves as the foundation in development of a service plan. Caseworkers indicate that turnaround time for evaluations is often very slow, sometimes taking upwards of one month. Workers express frustration with such delays.[25] Regardless of the time spent waiting for evaluations, service plans must be completed within sixty days from the receipt of the report of child abuse and neglect by the Department.[26] When the Family Court is involved, the service plan must be completed within thirty days from the date of the disposition hearing.[27] The court also requires that permanency planning be considered at the twelve month review hearing, and be ordered at the eighteen month review hearing.[28]

The service plan specifies the conditions under which the protection of the child is to be assured. The plan states, with specificity, the goals, objectives, tasks, and responsibilities of all parties, and also indicates the consequences of compliance and noncompliance with the plan.[29] Social workers must make every effort to involve family members in the development of the service plan and to engage the family's commitment and cooperation.[30]

Follow-up by the case management social worker is critical to assure that the conditions of the service plan are being carried out by all parties. This is particularly true if

the child remains in the home environment. The worker must maintain regular contact with the family members and the treatment resources serving the family to:

- assure the family's use of the treatment services agreed upon;
- evaluate the family's progress in attaining the goals and objectives set forth in the service plan;
- assist the child and the child's family in planning and implementing the child's return home when reunification is warranted;
- assist the child and the child's family to plan for the permanent separation of the child from the child's family when indicated; and
- review the service plan as needed.[31]

Reunification of the child with the child's family is considered and implemented when the conditions creating an unsafe home have been alleviated. Oahu Branch CPS now requires the case management social worker to arrange for a conference with the CPS Team prior to reunification.[32] If the Department has legal jurisdiction over the child via the Family Court reunification can occur only with the court's review and consent.[33]

Permanent separation of the child from the child's family is considered when the family has clearly failed to comply with the conditions of the service plan and the home continues to be an unsafe home. The case management social worker must team cases with the CPS Team where permanency planning is being considered.[34]

Once the decision has been made to pursue permanent separation of the child from the child's family, the social worker may recommend:

- voluntary or involuntary termination of parental rights and adoption of the child;
- permanent care of the child by relatives or legal guardian(s);
- permanent, long-term foster care with a specified caretaker; or
- emancipation, if the child is 16 years or older.[35]

When permanent custody is awarded, the case is transferred to the Dependent Children's Unit for permanent placement planning.

### Dependent Children's Unit

The Dependent Children's units provide services to children who are determined to be in need of permanent out-of-home placement. The units conduct adoption studies and adoptive placements in situations where the child is known to the agency and the prospective adoptive parents are relatives. Other adoption studies are performed by the Foster Home Certification Unit. The units also conduct private adoption studies at the request of the Family Court; however, these studies are usually considered a low priority by the DHS.

### Deputy Attorney General

A deputy from the Attorney General's office is the attorney for the State, or more specifically in Child Protective Act cases, the Department of Human Services. The Department decides if a case goes to court and the deputy attorney general will only interfere with that decision based upon a matter of law.

Deputies are assigned to handle the CPS case flow on a daily basis. Each deputy is assigned cases alphabetically according to the last name of the child that is the subject of the case. One deputy regularly attends CPS Team conferences and provides legal input, but is not a formal member of the CPS Team.

### CPS Team (Oahu)

The CPS Team on Oahu provides a wide range of expertise and serves as a highly reliable resource to CPS social workers. The CPS Team is funded through a purchase of service contract by DHS with the Kapiolani Medical Center for Women and Children. The role of the CPS Team is consultative and, as with all purchased services from private agencies, DHS keeps ultimate responsibility for the referred cases and delivery of services.

The Oahu CPS Team is composed of psychologists, physicians, clinical nurse specialists, social workers and team coordinators. A representative from the office of the Attorney General also attends team conferences and provides legal input, but is not a formal member of the team. The CPS Team provides independent consultation to DHS in complex situations, in serious cases of child abuse and neglect, and in situations where the worker must make critical decisions.[36] The purpose of having a team conference is to convene all the service providers involved with a case so that information can be shared and hence facilitate case management. By pooling all of the information from the various providers, a case can be perceived from the varying angles of each discipline: medical, nursing, psychological, social work and legal. Team conferences are utilized to address numerous issues such as assessing the safety and/or appropriateness of a home, determining medical and psycho-social needs of parents and child(ren), assessing progress with services which have been on-going, and assessing the appropriateness of services. Service providers are an

integral factor of any team conference as they are the people most directly involved with the family.

Past underutilization of the CPS Team led to the implementation of guidelines reflecting situations where teaming is mandatory:

(1) Where a child is hospitalized (medical or psychiatric);

(2) Where a child's return to the family is being considered;

(3) Where a death of a child has occurred due to possible [child abuse and neglect];

(4) Where permanency planning is being considered;

(5) Where a child is in the home in which serious abuse has occurred and the perpetrator is still in the home (this also includes sex abuse cases); and

(6) Where there is conflicting information surrounding the incident in which abuse has occurred.[37]

To date, CPS Oahu Branch is the only branch statewide with guidelines for mandatory teaming.[38]

Mandatory teaming guidelines in no way preclude teaming in other cases. The CPS Team can also be utilized in the following situations; however, the decision of whether or not to team is within the discretion of the CPS caseworker:

(1) Where there are conflicting professional recommendations;

(2) Where the caseworker has specific questions regarding diagnosis or treatment;

(3) Any physical abuse of a child under one year old;

(4) Any severe physical abuse of a child who is not hospitalized or in another safe setting;

(5) Any life threatening physical abuse (e.g., child is in intensive care unit), neglect (e.g., parents refusing help for suicidal child), or death; serious medical neglect (e.g., child will suffer permanent harm without medical attention);

(6) Homicidal actions (e.g., choking a child);

(7) Sexual abuse cases where alleged perpetrator is still in the home;

(8) Intentional drugging or poisoning (in order to have blood drawn for drug levels);

(9) Abandoned children generally under twelve years old;

(10) Unsupervised children under nine years old or with physical, emotional or mental handicap (in order to observe danger to child);

(11) Reports alleging that parents of young children are psychotic, behaving in a bizarre manner or acting on the influence of drugs;

(12) Failure to thrive is suspected;

(13) Total rejection in psychological abuse/neglect;

(14) Intellectual limitations are suspected;

(15) There is difficulty in determining the perpetrator;

(16) There is a past history of child abuse and neglect or family violence;

(17) Permanent separation may be indicated;

(18) When input from multiple disciplines is desired (medical, psychological, legal, nursing, social work) for comprehensive diagnosis or assessment;

(19) Multiple-problem family situation;

(20) Safety of the home question (placement planning); or

(21) Assistance in development/revision of service plan.[39]

Since implementation of the 1990 guidelines for mandatory teaming, the Oahu CPS Team has been greatly utilized. In 1990, 333 team conferences were convened. By 1991, the number of team conferences had risen to 412. This year, the Oahu CPS Team is being greatly utilized and is providing services of 140 to 150 percent above the contracted level of 300 team conferences. Increased utilization can also be attributed to joint efforts made by the CPS Team and DHS Oahu Branch administration to: (1) meet the CPS workers' needs; (2) make revisions to the team conference report to assure adequate justification for the CPS Team's analysis and recommendations; (3) develop specific and realistic recommendations for the CPS workers; and (4) assist the CPS worker in following through with CPS Team recommendations.[40]

Over ninety percent of CPS workers who utilized CPS Team services report satisfaction with how the concerns and issues raised were addressed by the CPS Team members at team conferences.[41] Notwithstanding indications of high utilization and satisfaction by CPS workers, effectiveness evaluations completed by CPS caseworkers revealed that some workers had never utilized the CPS Team for team conferences or consultative services, and that other caseworkers did not understand the function of the CPS Team or did not know what the Team does.[42] Ignorance of the CPS Team's function and services is particularly difficult to explain given the CPS Team's "Guide to Services" manual prepared to enable the CPS social worker to efficiently and effectively utilize the services available to his/her clients from the CPS Team program. Moreover, new caseworker orientation is provided by the CPS Team quarterly. This apparent unfamiliarity with the CPS Team and their services is likely due to the high caseworker turnover rate and the lack of education and experience of newly recruited caseworkers in the area of child abuse and neglect.[43]

The CPS Team's services are consultative in nature and final case management decisions are the responsibility of the Department. Services provided by the CPS Team are obtained by the CPS social worker by contacting the CPS Team office and requesting the particular service required. Team conferences are scheduled by the CPS worker and the team coordinator. The team coordinator prepares the case summary, acts as a recorder, and prepares the conference report and recommendations. Regularly scheduled CPS Team conferences are held Mondays, Wednesdays and Fridays at the DHS/CPS conference room at the Waiakamilo Business Center. Generally, CPS Team conferences are scheduled for one and a half hours and one case is discussed at length. Emergency team conferences for hospitalized cases are scheduled daily as needed at the respective medical centers. The CPS Team recognizes the urgency of the need to team difficult cases and attempts to schedule all team conferences in a timely manner. Emergency team conferences can be scheduled within days of the date of admission to the hospital. It usually takes several days for caseworkers and team members to assemble a complete data base. The program director/mental health consultant and medical consultant are available twenty-four hours for emergencies via operator-assisted pager. Two additional mental health consultants as well as two nurse consultants are available during working hours (8:00 am. to 4:30 p.m.) for emergencies via operator-assisted pager. The remaining members of the CPS Team can be contacted at the CPS Team office.

Despite increases in team conferences and overall utilization of team services, the CPS Team was forced to cut back on the number of services offered due to increased operating costs and decreased funding.[44] Moreover, in recent years a social work consultant was added to the CPS Team. The social work consultant is an invaluable member of the CPS Team and both CPS Team and DHS/CPS lineworkers advocated the staff addition. Unfortunately, there was no corresponding increase in funding to support the position, resulting in additional reductions of other professional service areas. The percentage decrease in services directly reflects the corresponding decrease in staff time. The actual number of contract service units for fiscal year 1992-1993 and 1993-1994 is 4478, almost

1,000 service units less than contracted for in fiscal year 1990-1991.[45] This reflects only 320 team conferences and reduced team services. Yet, the demand for team conferences and services has increased steadily since fiscal year 1990-1991. Funding has hampered the ability of the CPS Team to keep pace with the growing demands of the CPS system.

The shortage of team conference slots has resulted in a prioritization of cases based upon the severity of injury and perceived risk to the child. For example, cases involving children hospitalized due to suspected child abuse or neglect are mandatory team situations. A case involving a mother and her newborn baby, both of whom have tested positive for cocaine via hospital administered urine toxicology testing, is also a situation in need of teaming.[46] Ideally, teaming should occur in both cases prior to discharge from the hospital. If the CPS Team cannot accommodate both cases, the CPS Team is required to team the hospitalized injury case. The drug-abusing mother and her drug-exposed baby may be discharged without the benefit of a team conference. The CPS social worker is left in the unenviable position of making unilateral social work assessments regarding this multiple-problem high risk parent and baby. The CPS Team and CPS should not have to choose between high risk cases. All high risk cases should be afforded the expertise of both the CPS social worker and the CPS Team.

At a team conference, guests are invited to provide the CPS Team with additional information. Besides the CPS case social workers, guests may include service and treatment providers, therapists, outreach workers, and guardians *ad litem*.[47] The team conference is often the only time all known evaluations by various experts and state or other service providers are comprehensively assessed. Input from the caseworker and each of the disciplines represented on the team--medical, mental health, nursing, social work and legal--is encouraged in the development of the treatment plan. The CPS Team is a valuable asset for CPS, particularly given DHS/CPS' ongoing staffing difficulties and high turnover rate. The CPS Team has been able to maintain a stable staff of professionals in medicine, social work and mental health, thereby providing continuity in the standard of care.[48] Moreover, the etiology of child maltreatment involves medical, psychological and social factors. Decisions affecting the lives of abused and neglected children must take each of these factors into consideration. Inappropriate services or ineffective treatment plans will only delay the reunification of children with their families or will subject them to continued maltreatment.

Regarding the value of a multidisciplinary team, the late Dr. C. Henry Kempe, author of "The Battered Child Syndrome" and expert researcher-physician in the area of child abuse and neglect, wrote:

> . . .[F]amilies involved in child abuse and neglect are so complex and so draining on the emotional life of the social worker that the sharing of diagnosis, prognosis, and the development of a treatment plan by the social worker has become broadly accepted for the good of all. When the social worker is asked to carry this load alone, staff turnover rates are enormous and professional satisfactions are minimal. On the other hand, both

> professional satisfaction and the quality of care are improved when a team has an adequate data base for family diagnosis; can formulate a reasonable treatment plan which makes sense to the community; and has drawn up guidelines for following the family to insure the child's safety or, conversely, to assess failure of treatment.[49] (Emphasis added)

As outlined by Dr. Kempe, teams should share in diagnosis, prognosis and development of treatment plans. The Oahu CPS Team is set up to aid CPS in these important functions In addition to team conferences, the program provides medical, psychological and social consultation, assessment, and evaluations at the request of DHS. It coordinates and reviews psychological and psychiatric evaluations for DHS and provides medical and psychological testimony at Family Court regarding child abuse issues. It is also responsible for the assessment and coordination of services for children who have been hospitalized because of abuse, neglect and/or the risk of the same. As noted above, increased operating expenses and decreased funding resulted in the elimination of home visits and referrals, follow-up services, and training services. The CPS Team triggers its own internal follow-up on cases referred by CPS by scheduling to reteam a case typically three months after the initial case conference. No formal mechanism exists in the CPS process by which the CPS Team may follow-up cases. Moreover, there is no feedback mechanism from CPS to the CPS Team to assist in making assessments as to the appropriateness or inappropriateness of CPS Team recommendations.[50]

The Oahu CPS Team differs from most of the neighbor island teams in that it maintains full-time team coordinators and support staff, and one full-time nurse consultant. The remaining team members--mental health consultants (3), medical consultants (2), social work consultant (1), and an additional nurse consultant (1)--are all part-time.[51]

Because of the multidisciplinary nature of the CPS Team program, each professional is responsible for the quality of services and program development within his or her own discipline. The director, however, is responsible for the overall quality of services that the program provides.[52] Each discipline shares with the other team members the services that they have been providing or are currently developing in order to get input from all of the team members. All service revisions need to be approved by the director to ensure consistency with the Medical Center's policies and with the DHS contract obligations. The director reviews all of the CPS Team reports and attends every hospitalized (medical and psychological) case to assure that the assessment and recommendations reach the established standards of the CPS Team program. The day-to-day operations are discussed and problems resolved through weekly staff meetings. Program revisions and program development are accomplished through a series of staff retreats throughout the year. Any problems with the delivery of services are handled through an established Kapiolani Medical Center for Women and Children's grievance procedure. The CPS social workers are notified of this procedure to provide recourse to resolve problems that are not handled during the DHS supervisor/CPS Team meetings.[53]

## Endnotes

1. Portions of this chapter have been adapted from the Hawaii State Bar Association's Attorney's Manual for Handling Child Abuse and Neglect Cases in Hawaii, ed. Faye Kimura (Hawaii State Bar Association. Child and Parent Advocates Section, 1989) (mimeographed).

2. Hawaii, Department of Human Services, Child Protective Services Handbook (mimeographed) (hereafter referred to as CPS Handbook), sec. 1100.1.

3. Larry Lister, "The Social Work Perspective," Interdisciplinary Perspectives in Child Abuse and Neglect, eds. Faye Untalan and Crystal Mills (New York: Praeger Publishers. 1992), p. 26.

4. CPS Handbook, sec. 1100.4.

5. Ibid., sec. 1100.5.

6. Ibid., sec 1100.8.

7. Ibid.

8. Hawaii Rev. Stat., §587-22(b).

9. CPS Handbook, sec. 1200.1.

10. Ibid., sec. 1200.1.1.

11. Lister, p. 27.

12. CPS Handbook, sec. 1200.1.

13. Ibid, sec. 1200.1.2.

14. Ibid., sec. 1200.1.2a.

15. CPS Handbook, sec. 1200.5.3 and Hawaii Admin. Rules, §17-920.1-15(d).

16. Hawaii Admin. Rules, §17-920.118(a).

17. Hawaii Rev. Stat., §587-71(d).

18. CPS Handbook, sec. 1200.6.5.

19. Ibid., sec. 1200.7.6.

20. Interview with Debby Lee, Assistant Program Administrator, Child Welfare Protective Services, Department of Human Services, Donald Newville, Assistant Oahu Branch Administrator, Family and Adult Services Division, Marie Kunimura, Purchase of Service Monitor, Child Welfare Protective Services, and Regina Gerstman, Assistant Program Administrator, Child Welfare Protective Services, August 7, 1992.

21. CPS Handbook, sec. 1300.2.

22. Ibid.

23. Hawaii Rev. Stat., §587-25.

24. CPS Handbook, sec. 1300.4.7 and Hawaii Admin Rules, §17-920.1-15(d).

25. Lee, Newville, Kunimura and Gerstman interview.

26. Hawaii Admin. Rules, §17-920.118(a).

27. Hawaii Rev. Stat., §587-71(d).

28. Hawaii Rev. Stat., §§587-72(f) and (g).

29. Hawaii Rev. Stat., §587-26.

30. CPS Handbook, sec. 1300.5.

31. Ibid., sec. 1300.6.

32. Hawaii, Department of Human Services, Internal Communication Form dated August 27, 1990. This policy was created and implemented by Lei Lee Loy, Oahu Branch Administrator, CPS, and CPS Section Administrators.

33. CPS Handbook, sec. 1300.6.3 and Hawaii Rev. Stat., §§587-71 and 587-72.

34. Internal Communication Form dated August 27, 1990.

35. Hawaii Admin. Rules, §§17-920.122(b)(1), (2) and (3).

36. CPS Handbook, sec. 1200.5.3 and Hawaii Admin. Rules, §17-920.1-15(d).

37. Internal Communication Form dated August 27, 1990.

38. Information collected during a series of interviews with Steven J. Choy, Ph.D., Clinical Psychologist and Director, Kapiolani Medical Center for Women and Children Child Protective Services Team, August and September, 1992.

39. CPS Handbook, sec. 1200.5.3 and Hawaii Admin. Rules, §17-920.1-15(d).

40. Choy interviews.

41. Ibid.

42. CPS Team Evaluation Forms completed by Oahu CPS caseworkers Summer, 1992.

43. Professionals involved with in-service orientation and training of CPS case social workers find that newly recruited workers have inadequate background and training. Even those workers with a master's degree in social work lack clinical training and the skills to make a valid social assessment. These basic deficiencies can be overcome with more in-service training for new case social workers. Interview with Jane Stump, A.C.S.W., Ph.D., Social Work Consultant, Kapiolani Medical Center for Women and Children Child Protective Services Team, August 27, 1992, and interview with Prof. Faye Untalan, Ph.D., University of Hawaii, School of Public Health and Faculty Advisor to Oahu CPS, July 2, 1992.

44. Choy interviews.

45. Hawaii, Department of Human Services, Purchase of Service Request, Budget Period FY 92 and FY 93, Kapiolani Medical Center for Women and Children, Contract #DHS-92-POS-2049 dated June 5, 1991, and revised February 10, 1992.

46. At one time, the CPS Team tried to team all drug babies prior to discharge. Lack of funding resulting in fewer team conference slots forced the team to prioritize high risk cases. Drug baby cases were teamed only when team conference slots were available.

47. A guardian ad litem is a person appointed by the court to protect and promote the needs and best interests of the child or ward during the pendency of a particular court case. Hawaii Rev Stat., §§587-34 and 587-2.

48. Choy interviews.

49. C. Henry Kempe, "Foreword," Child Protection Team Handbook: A Multidisciplinary Approach to Managing Child Abuse and Neglect, ed. Barton Schmitt (New York: Garland STPM Press, 1978), p. xiv.

50. Choy interviews and interviews with CPS Team members, August and September, 1992.

51. The West-Hawaii CPS Team is also well-developed and has a full-time director, nurse consultant and support staff, and a part-time coordinator. West Hawaii has five medical consultants, five mental health consultants, six social work consultants. and one additional nurse consultant, all of whom are fee for service providers.

52. The position of "medical director" changed to "director" in 1986. The CPS Team is comprised of professionals from diverse fields and maintains generally two part-time members from each profession. It was felt that each member of the CPS Team played an equal role in the team process and that the director need not be the Team's medical consultant. At present, one of the CPS Team mental health consultants, Steven J Choy, Ph.D., serves as the program director for the CPS Team and is the member with the longest tenure on the Team.

53. Kapiolani Medical Center for Women and Children Child Protective Services Team, Guide to Services (Honolulu, 1992) (mimeographed), p. 26.

# Chapter 6

# INCIDENCE OF ABUSE AND NEGLECT

## Incidence of Abuse and Neglect[1]

Between 1969 and 1979, 6,956 confirmed reports of abuse and neglect were reported to the Department of Social Services and Housing. Since 1980, the cumulative total of reported and confirmed cases as well as the number of families and children involved in confirmed cases have more than doubled. Of the 24,000 confirmed reports of abuse and/or neglect since 1980, there were 43 reports where children have been permanently disabled and 38 where children have died. Though the military and their dependents make up about 11 percent of Hawaii's population, military families account for 16 percent of all confirmed cases of child abuse and neglect from 1980 to the present.[2]

Child abuse and neglect occurs in almost every neighborhood throughout the State. While reported and confirmed cases have occurred more frequently in certain geographic areas, there has been at least one confirmed case of child abuse or neglect in every census tract over the past 10 years.

In 1990, there were 4,407 reports of child abuse and neglect statewide. Of those 4,407 cases reported, 2,392 cases were confirmed.[3] This reflects an increase in the number of reports received; however, the number of confirmed reports is substantially the same as in prior years. There were 8.5 confirmed reports of child abuse and neglect per thousand children ages 0-17 years. However, the office responsible for compilation and publication of the yearly Statistical Report on Child Abuse and Neglect in Hawaii, the State of Hawaii, Department of Human Services, Family and Adult Services Division and the Planning Office, indicates that statistical data provided for the years 1989-1992 may be unreliable due to conversion from the Department of Human Services' Central Registry on Child Abuse and Neglect (CAN or CA/N Registry) to the new Child Protective Services System (CPSS). Dates for conversion to CPSS were staggered throughout the State as follows:

- East Hawaii, June 1989
- West Hawaii, April 1990
- Kauai, August 1990
- Maui, October 1990
- Oahu, February 1992[4]

Available data for 1990 reflect that Oahu had 1,481 confirmed reports or almost 62 percent of the state total. There has been a significant increase in reports and confirmed cases of abuse and neglect on the neighbor islands. Since 1980, reports and confirmed cases have tripled on Hawaii, Maui and Molokai. The number of reports doubled on Kauai and confirmed cases increased 50 percent over the last ten years. Hawaii had almost 18 percent of the State's confirmed cases in 1990 with 440. Maui Island followed with 304 confirmed cases or 13 percent of the state total. Kauai had 116 reports confirmed as abuse and neglect, making up almost 5 percent of the state total. Molokai had 46 confirmed reports of abuse and neglect in 1990 (2 percent of confirmed reports). Lanai had five, or one percent, of confirmed reports of abuse and neglect. As a result of increases in neighbor island reporting and confirmed cases, Oahu's percentage of statewide confirmed reports fell from 80 percent in 1980 to 62 percent in 1990, despite a dramatic increase of confirmed cases on Oahu from 848 to 1,481 over the same period. The majority of cases involving serious injury, however, remain clustered on Oahu.[5]

Between 1980 and 1989, the proportion of abused children kept in their homes has decreased from 79 percent to 68 percent. The Family Court places children in foster custody or returns children to their homes and monitors the family through family supervision. As of the beginning of 1989, the Family Court of the First Circuit had over 1,500 active abuse and neglect cases before it. Based on all cases filed, Hawaii's First Circuit Family Court became the eleventh largest family court in the country.[6] Since 1980, approximately 14,000 children remained in their homes while 5,000 children have been placed in foster custody.[7]

In the last few years, prior cases of confirmed abuse and neglect have been found in 350 to 400 (13 to 15 percent) of the confirmed reports to CPS each year. Of the 19,100 confirmed reports of abuse and neglect from 1980 through 1989, there were 16,600 with no prior confirmed report of abuse and neglect. There were 2,500 children with one or more prior reports of confirmed abuse.[8]

In recent years, almost a third of child victims who were identified as victims of previous confirmed reports were victimized again within the first six months following the previous substantiated report. Almost one-half of the children were victimized again within the first twelve months following the previous substantiated report. In fact, in the last year, two of five identified child abuse fatalities on Oahu were children already known as victims on the Child Protective Services System. Both children had been removed from their families by CPS. Both fatalities occurred within the first twelve months following reunification of the child with their family. Both victims were less than one year old.

Drug-exposed infants also present recidivism potential. In 1989, on Oahu, there were approximately 150 identified drug-exposed newborns of which 121 cases were accepted for investigation by CPS. Of the total number of cases, 21 percent or 32 of the drug-exposed infants were born to families who had been previously involved with CPS.[9] There are no statistics for Hawaii indicating whether or not these infants became victims of maltreatment or neglect. However, factors such as a new baby in the home and substance abuse are

frequently cited as factors precipitating abuse and neglect. The Honolulu Police Department estimates that 90 percent of the child abuse and neglect cases they investigate involve substance abuse.[10] Nationally, research indicates that children in substance-abusing families are considered at increased risk for child abuse and neglect.[11] Problems common to drug-dependent women place them at increased risk for inadequate parenting, while at the same time, characteristics of drug-exposed infants pose special difficulties for their mothers.

Even with successful prenatal programs such as Healthy Start, run by the Department of Health and private agencies, indications are that the number of drug-exposed infants identified on Oahu remains stable at an estimated 200 infants per year. Physicians involved with drug-exposed infants in Oahu's hospitals indicate that the identified cases reflect only the proverbial "tip of the iceberg" and that as many as 800 drug-exposed infants may be born annually statewide.[12]

Preliminary statistics for 1992 reveal that almost half of all families with drug-exposed infants have been previously involved with CPS.[13] This represents an increase of almost 30 percent since 1989. Yet, fewer cases each year involving drug-exposed infants are being accepted for investigation by CPS. The number of accepted cases involving drug-exposed infants has decreased by almost 50 percent since 1989.[14]

There are indications that injuries inflicted on children are becoming far more serious than in prior years. There has been a dramatic increase in serious injuries seen in hospital intensive care units.[15] Serious injuries include, but are not limited to: fractures, head trauma, intentional burns and scalds, whiplash shaking, hemorrhage or hematoma, and concussions. In 1989, on Oahu, 11 percent of hospitalized child abuse and neglect cases reflected serious injuries. By 1992, the rate of serious injury had increased to 28 percent.[16] At the same time, there has been a decrease in the age of victims. Better than 15 percent of child abuse and neglect victims are now less than one year old.[17] Forty-three percent of child abuse and neglect victims are five years old or younger.[18] These trends indicate that Hawaii will see increased cases of serious injuries inflicted on younger children and infants in the next few years. Reabuse of younger children and infants easily results in permanent disability or death.

A recent comprehensive study conducted by the Inter-Agency Council on Child Abuse and Neglect in Los Angeles County corresponded to trends evident in Hawaii, but on a much larger scale. The study revealed:

- 2,400 babies were born addicted to drugs. A much greater number of babies were born drug-exposed.

- Based on current and projected figures, Los Angeles public schools will begin the next century with at least 24,000 elementary school children who suffer the side effects of having been born addicted to drugs or alcohol.

- The very young were the most at risk of abuse. Of 48 abuse-related homicides, one-third involved victims under the age of six months. Babies under three months accounted for 31 percent of 5,996 child abuse cases reported to health officials.

- There were 48 abuse-related homicides. There were an additional 110 child deaths that were labeled "suspicious."

- While the number of reported child abuse cases declined slightly in 1989 from the previous year, the cases are becoming more serious.

- More children are being removed from abusive parents than ever before, more suspects are being arrested for child abuse, and more cases are being prosecuted.[19]

Unfortunately, no explanations were given for the apparent increase in repetitive child abuse and neglect cases. The data on both recidivism and the effectiveness of family treatment services for abusive or neglectful families are seriously lacking. Locally, the general absence of follow-up mechanisms within CPS only increases the overall lack of understanding. Nationally, research in child abuse and neglect has only been able to isolate those factors precipitating or escalating abusive or neglecting behavior:

> Depending upon what particular population of abusers is studied or sampled, it can be shown with statistical significance that abusive, neglecting behavior can be precipitated or escalated by such things as poverty, bad housing, unemployment, marital strife, alcoholism, drug abuse, difficult pregnancies and deliveries, lack of education, lack of knowledge of child development, prematurity and illness of infants, deaths in the family, and a host of other things. Any of these can become a critical stress, precipitating a crisis, ending in abuse or neglect.[20]

Awareness of the importance of such social factors in situations of abuse and neglect does not answer more basic questions: Why, under similar circumstances of stress, do some persons respond with abusive or neglecting behavior, while others do not? Why do the majority of people in a low socioeconomic group treat their children with adequate care and love, even in critical times? Conversely, why do some people with adequate housing and wealth seriously harm their infants? And, why do some people repeat abusive or neglectful behavior on their child victims?

Clearly, no two abusive or neglectful parents are exactly alike. Some share a number of characteristics which they exhibit in varying degrees, including: (1) a history of abuse in early life, developing over time into an inability to provide empathetic care for infants and

children; (2) excessively high expectations of infants and small children too early in the child's life, while, at the same time, disregarding the child's own feelings and wants; and (3) an impaired parent-child attachment.[21] Some abusive parents, however, exhibit none of these qualities.

There are no clear answers to most of the questions raised in child abuse and neglect research. The true magnitude of child abuse and neglect is not known. It is generally accepted that, both nationally and in Hawaii, there is vast underreporting of incidences of child abuse and neglect. Moreover, any research conducted on reported cases fails to include successful child abusers who are in some way insulated from the official reporting system. And, most child abuse researchers agree that the available research is plagued by inadequate samples, oversimplistic research design, conflicting definitions and unsophisticated analyses.[22] Sadly, at present one can only conclude without adequate explanation that, based upon figures and trends in both Hawaii and the rest of the nation, that the rate of repetitive child abuse and neglect cases is rising and that the incidents of abuse are increasing in severity.

## Endnotes

1. Unless otherwise noted, all data in this chapter were obtained from the DHS Central Registry on Child Abuse and Neglect and the Child Protective Services System and provided by Ricky Higashide of the Planning Office.

2. Hawaii, Department of Human Services, A Statistical Report on Child Abuse and Neglect in Hawaii, 1980-1987; A Statistical Report on Child Abuse and Neglect in Hawaii, 1989; A Statistical Report on Child Abuse and Neglect in Hawaii, 1990. Figures were updated by Ricky Higashide of the Planning Office in December, 1992.

3. This reflects the most recent figures available for 1990 and differs from figures in A Statistical Report on Child Abuse and Neglect in Hawaii, 1990. Letters from Ricky Higashide to Jan Yamane Taschner, September 14, 1992, and December 10, 1992.

4. Interview with Ricky Higashide, Planning Office, Department of Human Services, August 17, 1992.

5. Hawaii, Department of Human Services, A Statistical Report on Child Abuse and Neglect in Hawaii, 1990. Figures were updated by Ricky Higashide of the Planning Office in December, 1992.

6. Michael Town, "Introduction," Attorney's Manual for Handling Child Abuse and Neglect Cases in Hawaii, ed. Faye Kimura (Hawaii State Bar Association, 1989), p vii.

7. Hawaii, Department of Human Services, A Statistical Report on Child Abuse and Neglect in Hawaii, 1980-1987; A Statistical Report on Child Abuse and Neglect in Hawaii, 1989; A Statistical Report on Child Abuse and Neglect in Hawaii, 1990.

8. Ibid. Figures were updated by Ricky Higashide of the Planning Office in December, 1992.

9. Statistics compiled by the Kapiolani Medical Center for Women and Children Child Protective Services Team, Spring, 1992. Interview with Steven J. Choy, Ph.D, Mental Health Consultant and Director, Kapiolani Medical Center for Women and Children Child Protective Services Team, August and September, 1992.

10. Suzanne Toguchi, Mae Mendelson, Ruby Edwards and Pauline Okino, "Seeking Community Based Strategies for Children at Risk for Abuse and Neglect" (Decisions '87/Action'88, 1989), p. 52.

11. Susan Kelley, "Parenting Stress and Child Maltreatment in Drug Exposed Children," Child Abuse & Neglect: The International Journal, Vol. 16, No. 3, 1992, p. 317.

12. The medical community identifies drug-exposed infants by urine toxicology screening. The toxicology screening is administered only after a suspicion of drug use or drug exposure has been raised. Various indicators of drug exposure include, but are not limited to:

    (1) Obstetric/gynecological records;
    (2) Prior babies born with drug exposure;
    (3) Prior history of substance abuse and agency involvement;
    (4) Babies born out of the hospital;
    (5) Prior history of prostitution;
    (6) Manifestation of drug exposure in newborn;
    (7) Comments regarding maternal substance abuse made by relatives and friends to hospital medical staff; and
    (8) Observation of mother intoxicated or acting under the influence of drugs.

    Information collected over a series of interviews with Donald C. Derauf, M.D., Kapiolani Medical Center for Women and Children and former Medical Consultant, Kapiolani Medical Center for Women and Children Child Protective Services Team, August and September 1992, and interview with Calvin Sia, M.D., Judy Meyer, M.D., Richard Mitsunaga, M.D., Art Wong, M.D., Vanessa Fidele, M.D., Medical Consultant, Kapiolani Medical Center for Women and Children Child Protective Services Team, Stan Michels, M.D., former Medical Consultant, Kapiolani Medical Center for Women and Children Child Protective Services Team, Melinda Ashton, M.D., and Donald C. Derauf, M.D., former Medical Consultant, Kapiolani Medical Center for Women and Children Child Protective Services Team, August 14, 1992.

13. Statistics compiled by the Kapiolani Medical Center for Women and Children Child Protective Services Team, Spring, 1992.

14. Ibid.

15. Ibid.

16. Ibid.

17. Hawaii, Department of Human Services, A Statistical Report on Child Abuse and Neglect in Hawaii, 1989.

18. Ibid.

19. The Honolulu Advertiser, November 22, 1990, p. F-3.

20. Brandt Steele, "Psychodynamic Factors in Child Abuse," The Battered Child, eds. Ray Helfer and Ruth Kempe (4th Ed., Chicago: The University of Chicago Press, 1987), p. 82.

21. Ibid., pp. 83-89.

22. For example, see David Finkelhor, "Introduction," A Sourcebook on Child Sexual Abuse, David Finkelhor and others (Beverly Hills: Sage, 1986), p. 12.

# Chapter 7

# FINDINGS AND RECOMMENDATIONS

Senate Concurrent Resolution No. 160, S.D. 1, H.D. 1 (1992), calls for the Legislative Reference Bureau to study the increase in repetitive child abuse cases and evaluate the roles of the medical director, multidisciplinary team, and case social worker in the diagnosis and treatment of child abuse. Specifically, the Bureau was asked to:

(1) Determine the reasons for the increase in repetitive child abuse cases reported to Child Protective Services and whether the incidences of abuse are increasing in severity;

(2) Evaluate the role and utilization of each multidisciplinary team, in the diagnosis and treatment of child abuse reported to Child Protective Services;

(3) Examine and make recommendations on the management of the child abuse status monitoring system; and

(4) Make recommendations on improving and encouraging a more effective collaborative effort between the involved disciplines, including recommendations for legislation which will address the role and utilization of multidisciplinary teams in order to assure a statewide standard of care for abused and neglected children and minimize occurrences of reabuse.

## (1) Determine the reasons for the increase in repetitive child abuse cases reported to Child Protective Services and whether the incidences of abuse are increasing in severity

### Findings

Unfortunately, there is no way at present to determine with any accuracy reasons for the increase in repetitive child abuse cases reported to CPS. One might surmise that the increase results from an inability of CPS and family treatment services to correct abusive and neglecting behavior once a family has been reported. Some adults, despite high quality emergency and on-going intervention and treatment services, are incapable or unwilling to learn from the services offered and do not alter their behavior. Notwithstanding all good intentions and good faith efforts to end the cycle of abuse and neglect, reabuse most often occurs within the first six months to twelve months following the previous substantiated report--a period during which there occurs great intervention and involvement with the family. Clearly, reabuse occurs even with CPS involvement and support services. However, because few if any evaluations have been conducted on the effectiveness of CPS intervention and family services to resolve abusive and neglectful family situations in Hawaii, any link between

such intervention and services and child abuse and neglect recidivism is at this juncture purely conjecture.

As to the severity of injuries, it is clear that injuries inflicted on child victims are far more serious than in prior years. Cases seen in hospital intensive care units reflect dramatic increases in serious injuries, including fractures, head trauma, intentional burns and scalds, shaken baby syndrome (whiplash shaking), hemorrhage and hematoma, and concussions. The rate of serious injury has increased on Oahu from eleven percent in 1989 to twenty-eight percent in 1992. This fact becomes even more alarming when coupled with trends, both local and national, reflecting a decrease in the age of victims. In Hawaii, almost one-half of all child victims are under five years old, with better than fifteen percent less than one year old. Serious injury inflicted on a small child or infant easily results in permanent disability or death.

## (2) Evaluate the role and utilization of each multidisciplinary team in the diagnosis and treatment of child abuse reported to Child Protective Services

### Findings

Defining the CPS Team's role and duties is a sensitive area. The conflict arises between DHS/CPS and the CPS Team over the issue of control of cases. The Department of Human Services is mandated by statute as the authorized agency to receive children for control, care, maintenance, or placement.[1] As already noted, although the Department may enlist the services of other public or private agencies and/or purchase services from private agencies, the Department retains ultimate responsibility for the case and the delivery of services. As a result, DHS is reluctant to delegate any decision-making authority regarding child protection cases to any outside public or private agency or purchase of service contractor.

Similar conflicts have plagued other child protection agencies and multidisciplinary teams across the country. An article written about Colorado teams identifies the problem:

> Control becomes an issue when the agency responsible for child protection services perceives the advisory nature of the team as a threat, and fears that the recommendation will be inappropriate and detrimental to the child. Such resistance will lessen if the team is well trained and its role relative to the agency is clarified. Even more important in diminishing this resistance, however, is an awareness that the team assists the CPS worker and the agency in helping clients. . . . Issues of control must be addressed as an ongoing task in team maintenance.[2]

In Colorado, the basic role and function of teams is prescribed by statute. The statutory provision provides that teams will review all cases within seven days of the receipt of the report and also will make findings regarding the adequacy of response of the various

agencies.[3] Colorado teams have expanded their role by providing consultation and recommendations regarding diagnostic and treatment decisions. Moreover, many of the teams serve additional functions such as educating the community, taking stands on system issues, participating in treatment, and making efforts to fill the gaps in service delivery.[4]

DHS must make decisions regarding the role of the multidisciplinary team statewide. If teams are to assist with diagnosis, assessment, or treatment planning for families, as provided in section 17-920.1-2, Hawaii Administrative Rules, then it must be decided how team recommendations will be treated. This policy should be implemented statewide to promote uniformity.

Even Colorado lacks uniformity in implementation of team recommendations. The teams operate in an "advisory only" capacity as designated by law. Therefore, the CPS unit is often the pivotal factor in implementing team recommendations. Some departments have formal policies. In six counties, only the director has the authority to reject team recommendations, following discussion of reasons with the team. In four counties, the process is much more informal and is left to the discretion of the assigned worker. The majority of counties, twenty, leave the decision to the discretion of the supervisor and worker. Seven Colorado courts mandate case review by child protection teams and accept team recommendations as priority considerations in lieu of the case plan submitted by CPS. Still other counties represent that they have "no policy" regarding implementation of team recommendations.[5]

Amidst this vast array of extremes, DHS must strike a balance. When few, if any, team recommendations are incorporated in the CPS case plan, the result can be frustration, decreased morale, or even team disbandment. Past and present members of the Oahu CPS Team expressed extreme frustration when CPS Team recommendations were either disregarded or inaccurately interpreted by caseworkers, and the team was neither notified, provided with an explanation, nor informed as to the subsequent treatment plan or services implemented by DHS/CPS.[6] At the other extreme, court acceptance of team recommendations as priority considerations in lieu of the case plan submitted by CPS may result in similar frustration and conflicts among protective service workers. Caseworkers point out that pitfalls common to teams are that they make too many recommendations or ones that are unrealistic or not feasible. Teams may have an unrealistic view of what client systems are designed to accomplish.[7]

### Recommendations

It is recommended that DHS/CPS develop a written protocol for conflict resolution pertaining to team recommendations between DHS/CPS and CPS multidisciplinary teams. It is also recommended that the protocol be implemented statewide in the Department's child protective services rules, chapter 17-920.1, Hawaii Administrative Rules.

Team recommendations should be implemented in cases appropriately referred to the CPS Team. If the caseworker disagrees with CPS Team recommendations, the team conference is the most appropriate time to raise concerns. Concerns raised during the conference can be addressed by all members of the team and recommendations altered, if necessary, to reach a consensus for treatment and services. If no resolution is possible between the caseworker and the team, the caseworker's supervisor and the team director should work together to reach an agreement. If an agreement cannot be reached at this level, the final step should involve discussions between the section or branch administrator and the team director. Only the section or branch administrator should have the authority to override team recommendations. The team must then be provided with an explanation.

Although the team may have alternatives for taking some form of legal action, such as submitting a motion or petition to the Family Court, such action should be avoided if possible. It is important that teams make every effort to resolve conflicts amicably and avoid polarization with DHS/CPS. On the other hand, both DHS/CPS and the team must remain mindful that a child's best interest should never be compromised in order to avoid an adversarial position.

### (3) Examine and make recommendations on the management of the child abuse status monitoring system

#### Findings

There exists no feedback mechanism whereby the Oahu CPS Team is notified by the CPS caseworker of further developments in cases teamed or whether services implemented for treatment were followed through and ultimately deemed successful or unsuccessful. The team is apprised of developments only in cases where the team schedules its own follow-up team conference at the time of the initial team conference. This internal follow-up mechanism is the only mechanism available to the team for feedback and follow-up.

Feedback is the only mechanism by which the multidisciplinary team can assess the effectiveness of its services to DHS/CPS and to its clients, the abused or neglected child and his/her family. Due to funding constraints, the team becomes involved with only the most difficult, multiple-problem child abuse and neglect cases. These cases typically involve high risk, volatile, crisis-oriented situations. The treatment plans developed for the child and family by the team in conjunction with the case social worker must be closely monitored for progress and consideration given to the ongoing safety of the child. Periodic feedback must be provided to enable the team to:

(1) Assist the CPS caseworker in assessing the continued safety of the home by providing on-going support and appropriate recommendations;

(2) Review and evaluate cases for therapeutic progress and setbacks;

(3) Revise treatment programs to suit the changing needs of the cases;

(4) Monitor compliance with the treatment plan and assess the effectiveness of treatment services; and

(5) Evaluate case outcomes for cases the team has staffed, thereby decreasing chances for future error.

In recent years, DHS/CPS indicated that it encouraged follow-up memos every three months. However, the follow-up memos were deemed a low priority item and became more and more delinquent. The procedure was soon disregarded by CPS personnel and was subsequently aborted.[8]

Recommendations

It is recommended that follow-up memos be made mandatory for all cases referred to the team. Prior DHS/CPS procedures and present team internal review procedures suggest that a case should be reviewed three months after the initial team conference. The three-month time frame allows families involved with services ample time to improve home life to the extent that the abused or neglected child may remain in or return to the home. If families are unable to improve home life with services during the three-month period, the caseworker and team need to reevaluate the situation and make necessary adjustments in treatment and service provisions. The team needs to receive updated information pertaining to cases teamed, both successful and unsuccessful.

In cases scheduled for reteaming by the caseworker and team at the three-month period, the follow-up memo becomes a valuable tool for the caseworker in bringing the members of the team current with case developments. In cases where a new caseworker has been assigned during the three-month interval, the three-month follow-up memo will require the caseworker to compile a comprehensive report, thereby familiarizing the new worker with the specifics of the case. Three-month reteaming conferences are often attended by newly assigned caseworkers who are less than adequately prepared.[9] Lack of preparation by the caseworker--often the only person at the reteaming conference with first-hand knowledge of the family's progress--results in an insufficient data base and a less effective or ineffective team conference. CPS caseworkers should be encouraged to provide teams with safe home guidelines documenting the current functioning of the family at the reteaming conference.

Follow-up memo and feedback requirements should be implemented in the Department's child protective service rules, chapter 17-920.1, Hawaii Administrative Rules.

**(4) Make recommendations on improving and encouraging a more effective collaborative effort between the involved disciplines, including recommendations for legislation**

**which will address the role and utilization of multidisciplinary teams in order to assure a statewide standard of care for abused and neglected children and minimize occurrences of reabuse**

## Findings

Currently, the State of Hawaii has five multidisciplinary teams, one for the City and County of Honolulu, one each for the counties of Maui and Kauai, and two for Hawaii County, West Hawaii (Kailua-Kona) and East Hawaii (Hilo). Recently, funding has become available to set up a sixth team to service the islands of Molokai and Lanai.

Although the multidisciplinary team approach to child protection has been a part of Hawaii's child protection scheme since its inception in 1969, the multidisciplinary team is neither mandated by statute nor given any direct role in the child protection process. The team's function as an auxiliary service is purely consultative in nature on cases deemed appropriate for teaming by DHS/CPS. There is little consistency statewide between Crisis/Investigative Units and Case Management Units as to which cases should be teamed.

The diversity of maltreatment cases necessitates that expertise from a variety of disciplines be considered in the case management and service planning process. Collaboration among those disciplines routinely involved in child abuse and neglect cases has been consistently documented as both an efficient use of public resources and an effective way to enhance outcomes.[10] While responsibility for a given case should be retained by one caseworker, input from all relevant sources should be sought in the assessment and service planning process. This type of collaboration not only widens the worker's understanding of the case, but also acts as a safeguard against individual human error and can relieve some of the anxiety a single worker would naturally feel if assessing the situation alone.

Nationwide, thirty-two states reflect statutory provisions referring to child protection or multidisciplinary teams. Currently, Hawaii's child protection statutes neither mandate, define, nor refer to multidisciplinary teams as part of the overall child protection scheme. Sixteen states have statutes that mandate the establishment of teams. Thirteen states have optional establishment of multidisciplinary teams. The states with the most complete legislative schemes include Colorado, Florida, Tennessee, Massachusetts, Indiana, Montana, South Dakota, North Dakota, California and West Virginia. The four elements common to each of these complete statutory schemes are:

(1) When a team must be established;

(2) Which agency is responsible for creating/hosting the team;

(3) Powers, limitations, duties of the team; and

(4) Protection of teams, agency, and team members.[11]

Of the states, Colorado and Florida, both leaders in the area of child abuse and neglect, have the most complete statutory schemes and numerous highly developed multidisciplinary teams. In 1984, Colorado had nineteen statutorily mandated teams and twenty-three additional teams. Some counties had more than one team and some teams in rural areas served more than one county. In 1988, Florida had eighteen major teams and eight smaller teams in less populous areas. Moreover, state funds supported one full-time salaried pediatrician to coordinate the activities of the child protection teams. The funds for the program were administered by the Children's Medical Services Program Office. In 1987, Florida committed $5.7 million for the statewide child protection teams, a sum indicative of Florida's commitment to the multidisciplinary team approach.[12]

Without statutory establishment of multidisciplinary teams and a statewide commitment to the team approach, Hawaii's teams are more likely to be voluntarily cut from the DHS purchase of service budget in years of economic instability and insufficient funding. In fact, recent DHS budget cuts reflect a lack of commitment to the team approach. DHS reduced the funding for CPS teams statewide by five percent in fiscal year 1992-1993 and is projecting an additional thirty-eight percent in fiscal year 1994-1995, reflecting a total reduction in funding of forty-three percent. This reduction in funding severely limits the ability of CPS teams statewide to keep pace with the growing numbers of CPS cases appropriate for teaming. The budget constraints are staggering:

| | Fiscal Year 1992-1993 | Fiscal Year 1994-1995 |
|---|---|---|
| Oahu | $543,293.00 | $318,360.00 |
| East Hawaii | 46,165.00 | 28,622.00 |
| West Hawaii | 240,110.00 | 149,488.00 |
| Kauai | 17,910.00 | 11,104.00 |
| Maui | 48,065.00 | 34,479.00 |
| Molokai and Lanai | 9,447.00 | |
| TOTAL | $904,990.00 | $542,053.00 |

Only one purchased service, homebase services, did not suffer severe budget reductions. Clearly, purchased services, including the CPS teams, are currently viewed as luxury services rather than essential services. Philosophically, this approach to CPS team services must change. If the Legislature believes more use should be made of CPS teams, then the teams should be mandated by statute and funded as an essential part of the larger child protective services scheme. Without adequate funding, CPS teams will be unable to address the needs of Hawaii's abused and neglected children. And any failure to address these needs is the responsibility of this community.

The role of the team may fluctuate if not carefully defined by statute. The multidisciplinary teams are in an ideal position to provide support to an ailing DHS/CPS

problems related to inadequate numbers of qualified social workers, high job-related stress levels and subsequent burnout. DHS must look toward auxiliary services, such as the multidisciplinary team, and redefine its role to provide meaningful and much needed support:

> Teams are not substitutes for careful casework or child protective services investigations and case management. Teams do not make legal decisions, hold hearings, or act like courts. Teams can, however, help assure a thoughtful and reasonable response to a child's and family's problem, support a protective service agency, and provide important, perhaps essential data to courts.
>
> Team recommendations appear to increase the likelihood that services for a child or family will be carried out. When the team members and caseworkers who consulted with teams were asked to rank eight ways in which the team helped caseworkers, both groups independently ranked "support" as the most valuable aspect of teams. Thus, teams may help alleviate "burnout" and reduce feelings of isolation. Teams can also form the nucleus around which a community identifies the extent of its child abuse problem and develops the socio-political framework to begin to do something about it.[13]

Evaluations of DHS/CPS over the last twenty years reflect a need for caseworkers and their supervisors to share the responsibility of child protection cases.

Typically, state statutes mandating establishment of multidisciplinary teams allocate the responsibility of appointing the team to the department in charge of child protection, the Department of Social Welfare, Public Welfare, Human Services, or its local equivalent.

The Florida statute states, "The department shall develop, maintain, and coordinate the services of one or more multidisciplinary child protection teams in each of the service districts of the department."[14] Similarly, the Colorado statute provides:

> (6)(a) It is the intent of the general assembly to encourage the creation of one or more child protection teams in each county or contiguous group of counties. In each county in which reports of fifty or more incidents of known or suspected child abuse have been made to the county department or the local law enforcement agency in any one year, the county director shall cause a child protection team to be inaugurated in the next following year.[15]

Most common are statutes indicating that the department or the director of the county department:

. . . shall name the members of the state child protection team;[16]

. . . shall make available to each community a multidisciplinary advisory team;[17] and

> . . . shall appoint and convene a community-wide, multidisciplinary child protection team. . . .[18]

Language creating teams in Hawaii must not preclude the creation of more than one team in any given county or on any island. The particular needs of the various communities must be taken into consideration. For example, Hawaii County has two teams and Maui County will soon have two teams.[19] Although Hawaii and Maui counties represent only 13 and 12 percent, respectively, of the State's total of confirmed cases of child abuse and neglect, the physical features of each county necessitate two teams. Hawaii County's two teams service geographically separate areas at great distance from each other, Hilo and Kailua-Kona. Similarly, Maui County's two teams will service separate islands; one team for Maui and one team for Molokai and Lanai. On the other hand, the City and County of Honolulu has only one team, yet represents nearly 70 percent of all confirmed cases statewide. Arguably, although easily accessible by one team, the City and County of Honolulu merits more than one team based on the number of cases the team is expected to service. Therefore, language specifically mandating the creation of one or more teams, such as the Florida and Colorado statutes, is most appropriate for the State of Hawaii.

In conjunction with mandating establishment of multidisciplinary teams, care must be taken to carefully define the teams and their roles. Section 17-920.12, Hawaii Administrative Rules, provides definitions for "multidisciplinary team" and other related terms that are suitable as statutory definitions, provided the role of the team remains "consultative" in nature:

> §17-920.12 Definitions. As used in this chapter:
>
> * * *
>
> "Consultant teams" or "diagnostic team" or "multidisciplinary team" or "team" means those persons who provide consultation through a formal arrangement with the [Department of Human Services] to assist social workers with multidisciplinary diagnosis, assessment, or treatment planning for families. Consultant teams may include, but are not limited to, social workers, medical personnel, psychiatrists, psychologist[s], and other related professionals.[20]

Included in the definition may be language providing that a representative of the office of the Attorney General may be designated by that office to participate and provide legal input. In addition, the definition may indicate the minimum number of members necessary to comprise a team and the professional qualifications of such members.[21] Ideally, a team should be comprised of at least one consultant from each of the following disciplines: (1) medical; (2) mental health; (3) social work; (4) nursing; and (5) legal.

The optimal team conference should be attended by a multidisciplinary team consisting of one consultant from each discipline mentioned above, the CPS case social worker, and, where possible, other individuals and professionals directly involved with the case. The absence of any one member should not necessitate cancellation of the scheduled team conference. Past experience reveals that decisions do not require input from each discipline in every case, although for practical purposes each team member is encouraged to contribute to the diagnosis and treatment decisions in each case. Some cases require a heavier emphasis in a particular area and less in another. Whether a team conference should be canceled due to the absence of any given member should be left to the discretion of the team members present. Any hesitation by any member present to team a case due to the absence of a particular consultant should result in a rescheduling of the team conference, except in emergency cases where such a practice would not be prudent and in the best interest of the child.[22]

To provide continuity in membership, the definition may also designate a term of membership (e.g., one-year term, two-year term, etc.). Members of the team need to express a strong commitment to participate for at least one year. Turnover of members is both a cause and result of poor team functioning. Moreover, team membership must be stable if the team is to provide consistency and continuity for DHS/CPS.

#### Recommendations

Legislative concern that Hawaii's abused and neglected children receive multidisciplinary services, including medical, mental health, nursing, legal, as well as social services, should be reflected in statutory provisions. Hawaii's statutes should mandate establishment of multidisciplinary teams. Moreover, Hawaii's statutes must define multidisciplinary teams and related terms, and define the role of the team in the larger child protection framework.

## OTHER ISSUES

### Mandatory Teaming Guidelines

#### Findings

Effective August 1990, mandatory teaming guidelines were established and implemented by CPS Oahu Branch. Agreement as to the scope of the guidelines was accomplished through cooperation between the CPS Team's director and CPS branch level administration. To date, CPS Oahu Branch is the only CPS branch statewide with mandatory teaming guidelines. The guidelines state:

> Effective August 1990 (per ICF dated August 27, 1990) the following situations require mandatory teaming:

1. Where a child is hospitalized (medical or psychiatric).

2. Where a child's return to the family is being considered.

3. Where a death of a child has occurred due to possible abuse and neglect.

4. Where permanency planning is being considered.

5. Where a child is in the home in which serious abuse has occurred and the perpetrator is still in the home (this also includes sex abuse cases).

6. Where there are [sic] conflicting information surrounding the incident in which abuse has occurred.[23]

Prior to implementation of the mandatory teaming guidelines, the CPS Handbook indicated situations in which teams were to be utilized. Situations appropriate for referral to the multidisciplinary team were enumerated in a list. These handbook procedures are the operational guidelines for section 17-920.1-15(d), Hawaii Administrative Rules. Generally, the decision to refer a case to the multidisciplinary team was left to the discretion of the case social worker. Supervisors often, but not always, provided input into the decision.

Without the mandatory guidelines, the Oahu CPS Team was greatly underutilized relative to the total number of CPS cases. In other words, the CPS Team services increased, but at a much slower rate than the increases evident in the CPS caseload. Moreover, the CPS Team noticed that its services were inconsistently utilized. Certain CPS units regularly utilized team services while other units rarely if ever requested teaming or other services. Neighbor island teams currently report similar inconsistencies. Case referral to a multidisciplinary team is determined by the nature and severity of the child abuse or neglect case. Theoretically, then, assuming random assignment of cases to CPS units, the rate of utilization of the team by individual CPS units should have been similar. In reality, however, a great disparity existed. The referral of a case to the CPS Team was not solely determined by the appropriateness of the case for teaming, but also by whether a particular unit was more or less inclined to utilize team services. Supervisor and caseworker subjective judgment played too great a role in the decision-making process. This realization, among other factors, led to the development of the mandatory teaming guidelines.[24]

Since implementation of the mandatory guidelines, CPS Oahu Branch is more effectively and consistently utilizing CPS Team services. The result is an islandwide standard of care for child abuse and neglect cases appropriate for teaming. Mandatory utilization of team services in the designated situations has enabled new and less experienced workers to tap team resources they might not have been aware of and to acquaint them with team members. More experienced workers have learned to share the responsibility and stress of

high risk cases. Personal contact and a good working relationship between caseworkers and supervisors and team members is the best way to engender trust.

#### Recommendations

It is recommended that mandatory teaming guidelines be implemented in the *Hawaii Revised Statutes*. Mandatory teaming guidelines will assure that situations in need of multidisciplinary assessment will receive the appropriate multidisciplinary team services. Moreover, the guidelines will assure statewide uniformity in the utilization of multidisciplinary team services and a statewide standard of care for the more complex, severe cases of child abuse and neglect. Additional funding must be provided to enable the CPS Teams to comply with the teaming guidelines.

A comprehensive statute should also list situations appropriate for teaming. However, the guidelines must not limit teaming to only those situations provided. Teaming should be available in all complex situations, serious cases of child abuse and neglect, and situations where the worker must make critical decisions. The optimal system might also encourage the teaming of all child deaths under one year of age, regardless of the suspicion of child abuse or neglect. Recent studies reveal that for every known abuse-related homicide there are more than two child deaths labeled "suspicious." The incidence of abuse or neglect-related child deaths may be much higher than indicated by prior statistics. Identification of abuse-related homicides through child death reviews is yet another area within Child Protective Services where a CPS Team's expertise may contribute to a greater understanding of child abuse and neglect.

### Drug Exposed Infants

#### Findings

In the last decade drug-exposed infants have added significantly to the tidal wave of abuse and neglect cases sweeping over the family courts. Large urban courts report staggering increases in their juvenile and family dockets. For example, the New York City Family Court experienced a 471 percent increase in neglect filings between 1984 and 1989, mostly attributable to drugs. In Dade County (Miami), Florida, in 1989, thirty-five percent of all abuse and neglect petitions filed in the Model Dependency Court involved babies born drug-exposed.[25]

Although children born with drugs in their system as a result of maternal drug use is not new, cocaine has only recently become a significant part of the problem. The National Institute on Drug Abuse estimated that in 1990 six million women of childbearing age used illegal drugs with one million using cocaine. Of particular concern to professionals is the dramatic increase in cocaine use among pregnant women. Nationwide, it is estimated that at least 100,000 infants are born annually who have been exposed prenatally to cocaine.[26] The

problem may be growing as a consequence of the spread of "crack" cocaine, a highly addictive and relatively inexpensive form of cocaine. "Crack" is the street name for small chunks or rocks of freebase cocaine which have been extracted from cocaine powder. In Hawaii, drug-exposed infants are most frequently exposed prenatally to cocaine and crystal methamphetamine.[27] Crystal methamphetamine, more commonly known as "crystal meth," or "ice," is a relatively new, highly addictive synthetic drug used more widely in Hawaii and areas of California than in other parts of the United States.

The dramatic rise in drug-abusing parents has placed a serious strain on an already overburdened child protective service system. The increased demand for foster care nationwide has increased nearly thirty percent from 1986 to 1989 and is attributed to the increased number of substance-abusing families. In Washington, D.C., parental substance abuse generated a fifty-eight percent increase in the number of children placed in foster care.[28]

Studies have connected substance abuse to child abuse and neglect.[29] The correlation between drug and alcohol misuse and child abuse or neglect ranges as high as eighty-three percent.[30] Moreover, an estimated 675,000 children are seriously mistreated annually by an alcoholic or drug abusive caretaker.[31] The question may arise as to whether a substance abusing person is a "high risk parent," and therefore likely to abuse their child. Clearly, a child may not be adjudicated to be neglected on the basis of statistics. However, drug addiction and misuse is certainly a factor to consider in determining a parent's fitness in the sense of having the minimal capacity necessary to care for a child. The link between child abuse and substance abuse is still regarded as one of association and not causation. As there is rarely only one issue present in abuse cases, the addiction of the parent becomes one of the considerations. Drug addiction may well be an indication of other individual or family problems. While all mothers who use drugs may not abuse their children, neglect is almost certain in households where resources, both financial and emotional, are diverted to obtaining and using drugs.

One recent study examined the relationship between prenatal exposure to drugs and parenting stress and child maltreatment and revealed that, as predicted, mothers who used drugs during pregnancy reported higher levels of stress than foster mothers and comparison mothers on total parenting stress, child related stress, and parent related stress as measured by the Parenting Stress Index.[32] A strong association was found between maternal use of drugs and child neglect and maltreatment serious enough to necessitate removal of the children by child protective services. The association between maternal use of drugs and child neglect and maltreatment found in the study is consistent with findings from other studies.[33] Over forty percent of the drug-exposed children were placed in foster care within the first eleven months after birth, most often with maternal grandmothers.[34] The study concluded that drug-dependent mothers need careful monitoring and intensive intervention by child protection service agencies.[35]

In Hawaii, most of the drug-exposed infants identified by health care professionals to date have been identified in hospitals on the island of Oahu. As noted earlier in this study, the number of identified drug-exposed infants remains fairly constant at approximately 200 babies annually. The actual number of drug-exposed infants is much higher. Although few drug-exposed infants have been identified on the neighbor islands, one cannot infer that drug-exposed infants do not exist there, but rather that they have merely not been identified by health care professionals. In fact, in the last year, the West Hawaii (Kailua-Kona) CPS Team reports that ten drug-exposed babies were identified and reported in their area.[36] Indications are that the number of drug-exposed infants identified in West Hawaii is likely to increase in the next few years. It may be safe to conclude, however, that as with other categories of child neglect and maltreatment, the majority of drug-exposed baby cases will be clustered on Oahu.

Hawaii's Healthy Start program, begun in 1987 and which provides an intensive program of home visits to parents at risk of abusing their children, has made great strides toward providing successful home visitor services to high risk parents, some of whom are substance abusers. Recent reports reveal that although half of the at-risk parents in the program had been reported as child abusers, not one of them was a repeat child abuser during the four years of participation in Healthy Start.[37] Unfortunately, Healthy Start was not designed to address the needs and concerns of drug-exposed babies and their substance-abusing parents. And, in fact, the program explicitly refuses to accept high risk protective cases. Drug-exposed infants and their substance-abusing parents do not benefit from this highly successful and widely acclaimed neonatal screening and support program. CPS remains the designated agency and is best equipped to address the needs of drug-exposed infants and their substance-abusing parents.

At present, drug-exposed infants identified on Oahu by health care professionals are reported to CPS. However, many of the cases reported to CPS are being screened out and are not accepted for investigation.[38] DHS/CPS administrators indicate that present procedures dictate that in cases where the mother or newborn had a positive urine toxicology screen, CPS is notified and the mother is informally interviewed. If the mother is willing to participate in a services program, the case is not formally accepted nor investigated. Participation in a services program is voluntary and is available only as space permits. If CPS follows up with the case and finds that the mother subsequently failed to attend the services program, CPS deems that the risk to the baby has risen and may get more actively involved. If a mother initially refuses to participate in a program, CPS is notified and accepts the case for investigation. Most of the decisions made early on in drug-exposed infant cases are unilateral decisions made by the case social worker.[39] More and more the CPS Team has become unable to participate in the decision-making process because of lack of funding.

Unfortunately, follow-up on many of the drug baby cases is difficult if not impossible. Because most drug baby cases are no longer being formally accepted for investigation by CPS and are screened out at the intake level, these cases do not receive the attention required in cases formally accepted by CPS. Overburdened caseworkers necessarily

prioritize their caseloads and focus on formally accepted cases requiring more immediate attention and investigation.

CPS Team members and former members indicate that attempts were made in recent years to team every identified drug-exposed baby case before discharge from the hospital. However, funding constraints made this practice impossible.[40] CPS Team members currently express grave concerns regarding the safety of drug-exposed infants and have teamed many cases where these infants have subsequently become victims of neglect or maltreatment. CPS Team members view drug-exposed infants as high risk cases and address parental substance abuse as a capacity issue. It is important to distinguish that the area to focus on is the mother's ability to care for her drug-exposed infant and not the harm to the baby *in utero*. The question becomes, then, whether the substance-abusing mother is able to provide quality care for her drug-exposed infant. A thorough investigation by CPS and a CPS Team conference may begin to answer this threshold question. And, if appropriate, intervention and treatment can aid the parent in gaining the strength and ability necessary to adequately provide for the child. The emphasis must be upon providing a safe nurturing environment for the infant as well as rehabilitating the mother.

The CPS Team identifies both medical and psycho-social reasons for the high risk assessment. A child may have documented signs and symptoms of the effects of prenatal drug exposure, or the child may be asymptomatic. Prenatally, it may be possible only to estimate the degree of risk to the child. Postnatally, a child may be at substantial risk of harm not only because of the direct effects of a drug, but also because the parent's conduct or condition creates a dangerous environment. Finally, a child may have been harmed without a current means to diagnose the harm, but there may be indications of a continuing need to observe the child over time before the effects of the harm will be detectable. Often the effects of drug exposure do not surface in an infant until several weeks after birth--long after the mother and child have been discharged from the hospital. Infants who appear normal without physical or mental deficiency or impairment are not risk free. Drug-exposed babies are considered at risk for motor delay or dysfunction. Indeed, the long-term neuro-developmental consequences of *in utero* cocaine exposure have yet to be defined.[41] Health care and social work professionals can only underscore the child's need for a stable and nurturing home environment.

Evidence that a newborn infant tests positive for a drug in its bloodstream or urine is not sufficient, in and of itself, to support a determination that the child is maltreated or to take protective custody of such a child. Whether the mother is or will be abusive or neglectful takes into account a variety of other factors. Evidence of a positive toxicology screening is significant enough in most states to constitute grounds for a child abuse report. Hawaii's current abuse and neglect reporting law permit, but do not require, a report based upon an infant's drug exposure. Hawaii's laws are silent on the subject, leaving the determination of whether the condition falls within the reporting act's general definition of abuse and neglect to the individual reporter's discretion.

Some states require that upon receipt of such a report, a child protective services investigation must occur.[42] Investigations are meant to assess the ability of the parent to care for the child, taking into account the infant's needs and the parent's ability or capacity to meet those needs. In Washington, the state Department of Social and Health Services' policy enumerates additional factors the investigation must address, including the history and pattern of parental substance abuse, parental mental health and physical condition, the home environment (including presence of other substance abusers), the physical condition and medical needs of the child, support available to the parent(s), prior history of abuse and neglect by parents, and chemical dependency testing and monitoring of the parent(s).[43] The National Association of Public Child Welfare Administrators issued a policy statement in January, 1991, consistent with this approach, stating that:

> A positive drug test of a newborn or the child's mother will precipitate a report to the public CPS agency to determine if the child is at risk of harm or in need of protection. A positive drug test is a factor in such an investigation, but should not be used in and of itself as the sole basis for court action or the involuntary removal of the child.[44]

Implementation of such procedures and protocols to address the needs of drug-exposed infants are vital as drug use escalates in the United States among women of childbearing age.

The latest report issued in October, 1992, by the United States Department of Health and Human Services based on its Drug Abuse Warning Network, shows significant increases in the number of cocaine-related hospital emergencies and hospital visits related to heroin and other drugs during the first three months of 1992. Of particular relevance to this study, the report also shows a twenty-eight percent increase in cocaine emergencies among persons under twenty-five years old.[45] After only one year of decline in 1990, the drug problem escalated in 1991 and continues its upward climb in 1992 at a rate far exceeding past figures.

### Recommendation

It is recommended that upon receipt of a report involving a drug-exposed infant, formal acceptance of the case by CPS and a thorough child protective services investigation must occur. The investigation should assess the ability of the parent to care for the child, taking into account the infant's specialized needs and the parent's ability or capacity to meet those needs. Careful monitoring and frequent follow-up by CPS are necessary as both the condition of the mother and the condition of the newborn are highly volatile. CPS caseworkers must remain mindful that drug dependency or the effects of drug exposure in infants may not surface until some time after discharge from the hospital.

It is recommended that DHS/CPS develop and implement policy and protocol applicable statewide to assess and service cases involving infants prenatally exposed to drugs. Appended to this study are policies and protocols implemented by the Department of

Health and Rehabilitative Services, Dade County, Florida (Appendix C), and the Department of Children's Services, Los Angeles County, California (Appendix D), intended to provide examples of functioning systems.

Finally, it is further recommended that cases involving drug-exposed infants be included in the CPS Team mandatory teaming guidelines. The CPS Team can lend guidance and support to the CPS caseworker, particularly where CPS Team members have developed an expertise in this area.[46] A CPS Team conference should occur before discharge of the mother and baby from the hospital.

If mandatory teaming of drug babies is adopted by DHS/CPS, DHS funding for the CPS Team should increase commensurately, thereby enabling the CPS Team to accommodate the caseload. Present funding is inadequate and has necessitated prioritization of child abuse and neglect cases. This results in an inability to team all cases requiring CPS Team expertise. Particularly on Oahu, where the CPS Team is already functioning at 140-150 percent of their contracted level, mandatory requirements to team all drug-exposed infants will not be satisfied unless DHS provides adequate funding. CPS workers have indicated in CPS Team evaluations a desire to have a full-time CPS Team staff. An alternative to full-time staff would be to create two CPS Teams consisting of part-time staff. Both alternatives would allow greater efficiency and flexibility, particularly for emergency cases and consultations. A fully-staffed CPS Team must be available to CPS workers when cases appropriate for teaming arise.

## Office Location

### Findings

On Oahu, Protective Service Intake Units, CPS Crisis/Investigative Units and CPS Case Management Units are all located at one central location, the Waiakamilo Business Center. The Oahu CPS Team, however, is located at a separate office location near the Kapiolani Medical Center for Women and Children.

### Recommendations

Where possible, the CPS multidisciplinary team office should be physically located at the same location as CPS. Accordingly, if possible, the Oahu CPS Team should be relocated to share office space with CPS at the Waiakamilo Business Center. Both the DHS/CPS workers and the multidisciplinary team members would benefit greatly by sharing common office space:

(1) CPS workers and team members can lend each other daily mutual support.

(2) CPS workers can more easily approach team members informally to discuss concerns and share information regarding ongoing cases.

(3) CPS workers become more familiar with team conferences and other team services.

(4) Observation of team conferences can serve as ongoing in-service training for less experienced caseworkers.

(5) Shared office space promotes team effort, comradery and cross-training. Caseworkers and team members will be encouraged through direct contact to appreciate the level of expertise each person brings to the child protective services effort.

(6) Daily contact and interaction between team members and caseworkers may help break down existing language barriers. Team members can facilitate communication with caseworkers by simplifying professional jargon and terminology that often interferes with successful interpersonal communication. At the same time, caseworkers need to learn from team members and rely more heavily on their professional expertise and knowledge.

## Endnotes

1. Hawaii Rev. Stat., §587-2.

2. Janet Motz and Michael Schultz, "Rural Child Protection Team," The New Child Protection Team Handbook, eds. Donald Bross, Richard Krugman, Marilyn Lenherr, Donna Rosenberg and Barton Schmitt (New York: Garland Publishing, Inc., 1988), p. 33.

3. Colo. Rev. Stat., §§19-3-308(6) and (7).

4. Motz, pp. 356.

5. Marilyn Lenherr, Carol Haase and Janet Motz, "Program and Case Coordination," The New Child Protection Team Handbook, p. 250.

6. Information collected during a series of interviews with Kapiolani Medical Center Child Protective Services Team members, August and September, 1992.

7. CPS Team evaluations completed by Oahu CPS caseworkers, Summer, 1992.

8. Interview with Debby Lee, Assistant Program Administrator, Child Welfare Protective Services, Donald Newville, Assistant Oahu Branch Administrator, Family and Adult Services Division, Marie Kunimura, Purchase of Service Monitor, Child Welfare Protective Services, and Regina Gerstman, Assistant Program Administrator for Child Welfare Protective Services, August 7, 1992.

9. Information collected during a series of interviews with Kapiolani Medical Center Child Protective Services

Team members, August and September, 1992, and personal observation made by Jan Yamane Taschner during team conferences, August and September, 1992.

10. Deborah Daro, Confronting Child Abuse: Research for Effective Program Design (New York: The Free Press., 1988), p. 84.

11. Donald Bross, "The Legal Basis for Child Protection Teams," The New Child Protection Team Handbook, eds. Donald Bross, Richard Krugman, Marilyn Lenherr, Donna Rosenberg and Barton Schmitt (New York: Garland Publishing, Inc., 1988), p. 353.

12. J. M. Whitworth and Carol Haase, "Stages of Team Development," The New Child Protection Team Handbook, p. 489.

13. Bross, Krugman, Lenherr, Rosenberg and Schmitt, "Preface," The New Child Protection Team Handbook, p. xx.

14. Fla. Stat., §415.5055.

15. Colo. Rev. Stat., §19-3-308(6) (a).

16. N.D. Cent. Code, §50-25.1-04.1.

17. Tenn. Code Ann., §37-1-407(a).

18. Ind. Code, §31-6-1114.18

19. Budgetary allowances for fiscal year 1992-1993 allowed for the creation of a multidisciplinary team for the islands of Molokai and Lanai. Recent budget cuts for fiscal year 1994-1995 will require the reabsorption of the Molokai/Lanai team into the Maui island team.

20. Hawaii Admin. Rules, §17-920.12.

21. Colorado requires a minimum of three members. Colo. Rev. Stat., §19-3-303. Indiana requires no less than five (5) and no more than eleven (11) members. Ind. Code, §31-6-11-15. Tennessee requires their child abuse review team be composed of at least the following persons: (1) a representative of the department of human services; (2) a physician; (3) a psychologist or psychiatrist; and (4) a social worker. Tenn. Code Ann., §37-1-407. North Dakota provides that the child protection team may not be composed of fewer than three persons. N. D. Cent. Code, §50-25-1-03.

22. Because of the speed with which emergency cases are scheduled for teaming (usually within days of case referral), it can be difficult to assemble full team personnel on short notice. Best efforts are made by the team to provide for a full team. Having back-up team members and the requisite funding for such members would alleviate certain scheduling difficulties.

23. Hawaii, Department of Human Services, Child Protective Services Handbook (mimeographed) (hereafter referred to as CPS Handbook), sec. 1200.5.3. This policy was created and implemented by Lei Lee Loy, Oahu Branch Administrator, CPS, and CPS Section Administrators via Internal Communication Form (ICF) dated August 27, 1990. Interviews with Steven J. Choy, Ph.D., Mental Health Consultant and Director, Kapiolani Medical Center for Women and Children Child Protective Services Team, August and September, 1992.

24. Ibid.

25. Judith Larsen, Robert Horowitz and Ira Chasnoff, "Medical Evidence in Cases of Intrauterine Drug and Alcohol Exposure," 18 Pepperdine L. Rev. 279 (1991), p. 279.

26. Susan Kelley, "Parenting Stress and Child Maltreatment in Drug-exposed Children," Child Abuse and Neglect: The International Journal, Vol. 16, No. 3 (1992), p. 318.

27. Information collected during a series of interviews with Donald C. Derauf, M.D., Kapiolani Medical Center for Women and Children, August and September, 1992.

28. Kelley, p. 318.

29. Ibid.

30. R.W. tenBensel, "Assessing the Dynamics of Child Abuse and Neglect," 1984 Juv. & Fam. Ct. J. 37.

31. National Committee for Prevention of Child Abuse, Substance Abuse and Child Abuse Fact Sheet (Chicago: National Committee for Prevention of Child Abuse, 1989.

32. R. R. Abidin, Parenting Stress Index (Third Ed., Charlottesville: Pediatric Psychology Press, 1990).

33. Kelley, p. 317.

34. Ibid. The findings that over forty percent of drug-exposed children in the study were in foster homes has serious economic and social consequences. It is estimated that the cost of foster care for one child ranges from $3,600 to $5,000 annually; specialized foster care for children with medical problems can cost between $4,800 and $36,000 annually. United States, General Accounting Office, Drug Exposed Infants: A Generation at Risk (Washington, D.C., GAO/HRD-90-138, 1990).

35. Kelley, pp. 326-327.

36. Telephone interview with Mary Jo Westmoreland, Director, Child Protection Team of West Hawaii, October 22, 1992.

37. The Honolulu Advertiser, September 1, 1992, p. B-2.

38. Information collected during a series of interviews with Steven J. Choy, Ph.D., Clinical Psychologist and Program Director, Kapiolani Medical Center for Women and Children Child Protective Services Team, August and September, 1992.

39. Lee, Newville, Kunimura and Gerstman interview.

40. Choy interviews.

41. A propensity to sudden infant death syndrome (SIDS) in cocaine-exposed infants has also been suggested, although others have not confirmed the relationship. Placing Infants at Risk: Parental Addiction and Disease, Children's Hospital National Medical Center, 99th Congress, 2d Session (1986) (testimony of Ira Chasnoff); J. Riley, N. Brodsky and R. Porat, "Risk for SIDS in Infants with In-utero Cocaine Exposure: A Prospective Study, Pediatr. Res. 23:454A (1988); B. Lounsbury, M. Lifshitz and G. Wilson, "In Utero Exposure to Cocaine and Risk of SIDS, Pediatr. Res. 25:102A (1989). Further research suggests that drug-abusing mothers who use intravenous drugs during pregnancy place themselves and their infants at increased risk of exposure to the human immunodeficiency virus (HIV). Kelley, p. 327.

42. The following states specifically refer to drug-exposed or drug dependent infants in their statutes: Florida, Illinois, Massachusetts, Minnesota, Oklahoma, Utah and Indiana.

43. Washington, Washington State Department of Social and Health Services, Treatment Protocol for Chemical Using Pregnant Women, p. 78 (Jan. 1990); see also Oregon, Oregon Department of Human Resources, Women, Drugs and Babies: Guidelines for Medical and Protective Services Response to Infants Endangered by Drug Abuse During Pregnancy, pp. 23-27 (Oregon Children's Services Division, 1989) and Florida, State of Florida, Department of Health and Rehabilitative Services, Substance Abused Newborns (HRS Regulation No. 1506) (1988).

44. Larsen, Horowitz and Chasnoff, pp. 316-317.

45. The Honolulu Advertiser, October 24, 1992, p. A-1.

46. For example, Jane Stump, Ph.D., Social Work Consultant, Kapiolani Medical Center for Women and Children Child Protective Services Team, recently authored Our Best Hope: Early Intervention for Prenatally Drug-exposed Infants and Their Family (New Jersey: CWLA, 1992).

**Appendix A**

THE SENATE
SIXTEENTH LEGISLATURE, 1992
STATE OF HAWAII

S.C.R. NO. 160 S.D.1 H.D.1

# SENATE CONCURRENT RESOLUTION

REQUESTING A STUDY ON THE INCREASE IN REPETITIVE CHILD ABUSE CASES AND AN EVALUATION OF THE ROLES OF THE MEDICAL DIRECTOR AND MULTI-DISCIPLINARY TEAM IN THE DIAGNOSIS AND TREATMENT OF CHILD ABUSE.

WHEREAS, the executive committee of the Hawaii Chapter, American Academy of Pediatrics, met to discuss the significant increase in child abuse cases beyond what has been seen in previous years; and

WHEREAS, a review of recent cases indicates an escalation in the severity of injuries in comparison with cases previously known to Child Protective Services; and

WHEREAS, practicing pediatricians have expressed concern over the absence of feedback from Child Protective Services about the status of children they have reported; and

WHEREAS, although the original concept of addressing child abuse through a multi-disciplinary team effort remains sound, the role and working relationship between multi-disciplinary teams and case social workers is not consistent throughout the state; now, therefore,

BE IT RESOLVED by the House of Representatives of the Sixteenth Legislature of the State of Hawaii, Regular Session of 1992, that the Legislative Reference Bureau determine the reasons for the increase in repetitive child abuse cases reported to Child Protective Services and whether the incidences of abuse are increasing in severity; and

BE IT FURTHER RESOLVED that the Bureau also evaluate the role and utilization of each multi-disciplinary team, in the diagnosis and treatment of child abuse reported to Child Protective Services; and

BE IT FURTHER RESOLVED that the Bureau examine and make recommendations on the management of the child abuse status monitoring system; and

BE IT FURTHER RESOLVED that the Bureau also make recommendations on improving and encouraging a more effective collaborative effort between the involved disciplines, including recommendations for legislation which will address the role and utilization of multidisciplinary teams in order to assure a statewide standard of care for abused and neglected children and minimize occurrences of reabuse; and

BE IT FURTHER RESOLVED that the Legislative Reference Bureau report its findings and recommendations to the Legislature no later than twenty days prior to the convening of the Regular Session of 1993; and

BE IT FURTHER RESOLVED that certified copies of this Resolution be transmitted to the Director of the Legislative Reference Bureau and the Director of Human Services.

# Appendix B

## GLOSSARY OF ACRONYMS

| | |
|---|---|
| BSW | Bachelor of Social Work |
| CA/N Registry | Central Registry on Child Abuse and Neglect |
| CPS | Child Protective Services |
| CPSC | Child Protective Services Center |
| CPSS | Child Protective Services System |
| DHS | Department of Human Services |
| DPW | Department of Public Welfare |
| DSSH | Department of Social Services and Housing |
| HPD | Honolulu Police Department |
| HRS | *Hawaii Revised Statutes* |
| JCPD | Juvenile Crime Prevention Division |
| MSW | Master of Social Work |
| NCAAN | National Center on Child Abuse and Neglect |
| PSI | Protective Services Intake |
| SSIS | Social Services Information System |
| WBC | Waiakamilo Business Center |

# INFANTS PRENATALLY EXPOSED TO DRUGS

## INTRODUCTION

Referrals on drug/alcohol-affected newborns come to DCS' attention in three ways: directly from the hospital following the child's birth, through a community referral alleging drug/alcohol abuse by parent(s), and through a community referral for allegations unrelated to drug/alcohol abuse. This module is a tool to assist the CSW in making an appropriate assessment for this most vulnerable population. The risk factors identified in this module are designed to remind the CSW of what to look for and what questions to ask in assessing the level of danger for a substance-involved infant.

As the assessment process unfolds, two issues are of particular importance. First, drug-affected newborns represent an extremely high risk population of children. They are more likely to have medical complications or special care needs and their symptoms of irritability, lethargy, poor feeding, and poor sleeping can be stressful for their caretakers. In addition, substance abusing parents often have difficulty providing minimally adequate care even for healthy infants. Therefore, the CSW must assess each referral involving a newborn with great care, giving careful consideration to the risk factors stated in this module.

Second, identification of infants prenatally exposed to drugs cannot be based solely on the results of toxicology (tox) screens. Infants who have been exposed to drugs during their mothers' pregnancy may have negative drug screens at the time of birth. Many newborns, who have been affected by drugs, have not had drug screens while in the hospital. Some newborns with positive drug screens are not reported to DCS. Finally, it is likely that many children who are referred for problems other than drug/alcohol abuse during their mothers' pregnancy, are, in fact, drug/alcohol-affected infants. Remember, the absence of a tox screen, a negative screen, or the denial of drug use by a parent does not necessarily mean that the child is safe. Each case must be assessed thoroughly, deliberately, and knowledgeably.

Because of the specialized skill involved in assessing a newborn who may be at risk, a separate Risk Assessment Guide has been prepared. The factors and risk predictors have been developed in conjunction with local health care and substance abuse experts. The indicators are critical measures of the level of risk present. While this Guide is required for the initial assessment, it is also recommended as a way of helping the parent focus on areas needing improvement and as an aid in determining when a baby can safely be returned home. By comparing the first assessment results with a later evaluation, progress can be more objectively measured.

NOTE: When an assessment is being made on an infant prenatally exposed to drugs and there are other siblings in the home, the standard "Risk Assessment Guide" shall be used for the siblings.

## RISK FACTORS

The following are examples of risk indicators; the CSW may think of others. The "Risk Assessment Guide for Infants Prenatally Exposed to Drugs" presents a broad range of factors to consider; they include but are not limited to:

## HIGH RISK FACTORS

### Child

- Infant receiving medication for drug withdrawal and/or has one or more of the following symptoms: vomiting, diarrhea, poor sleeping, marked tremors, poor feeding, high-pitched cry, lethargy, seizures.

- Any preterm infant (born at or before 36 weeks); any infant who has physical or medical problems which significantly impact vital life functions or physical and intellectual development; any infant requiring special equipment or medication (e.g., infant with cardiac defect, apnea, visual or hearing handicap, seizure disorder).

### Parent

NOTE: The father's drug status is also important. However, because he can only indirectly affect the prenatal infant, here he is considered in the environmental and household factors.

- Mother's drug use is more than 2 times a week and/or <u>any</u> use of PCP or "crack."

- Mother has entered 3rd trimester of pregnancy, or drug treatment history indicates she is not in drug treatment program.

- Mother has unrealistic expectations/perceptions of child's behavior; poor perception of reality; demonstrates poor impulse control; history of criminal behavior, or mental illness.

- Mother is uncooperative with DCS or refuses to acknowledge problem.

- Mother denies symptoms or is unresponsive to infant's needs (e.g., lack of response to crying of infant, poor eye contact, infrequent visiting, inappropriate expectations, and criticism of child).

- There are pending child abuse/neglect investigations or previous abuse/neglect incidents of a serious nature.

Environment

- No supportive family or friends available; geographically isolated from community services; no phone and/or transportation available.

- Anyone in household suspected to be involved in drug activity (sale, use, manufacturing).

- Home unclean with safety or health hazards; no evidence of preparation for infant's arrival.

- Few of the educational, medical or environmental needs of siblings being met.

LOW RISK FACTORS

Child

- Withdrawal symptoms are not apparent.

- Infant has no apparent medical or physical problems.

- Infant requires routine pediatric care and has no special equipment or medication.

Parent

- Mother is not currently using drugs.

- Mother entered drug treatment early in pregnancy, has remained in program, and is considered compliant.

- Mother has no apparent intellectual, emotional, or physical limitations; has realistic expectations of the child, and has no history of violent behavior.

- Mother has demonstrated a willingness to work with DCS to resolve problems.

- Mother has exhibited appropriate parenting skills and knowledge regarding the infant's follow-up care requirements and is responsive to the infant's needs.

- There is another adult in the home who is a supportive/stabilizing influence and is available to assist with caretaking. There is no known history of abuse or neglect.

Environment

- There are supportive family members, neighbors, or friends available and committed to help.
- No member of household is known to be involved in drug activity (sale, use, and/or manufacturing).
- Home is relatively clean with no apparent safety or health hazards; utilities are operable, and there is no infestation of rodents or vermin. There is evidence of preparation for infant's arrival (clothing, furnishings, formula).

GUIDELINES FOR ASSESSMENT

In assessing the safety of the home for an infant prenatally exposed to drugs, it is essential to evaluate factors involving the child, the parent, and the environment. It is the interaction of variables within each of these three areas which produces a picture of parents' ability to provide care, safety, and protection for the medically fragile child. The following are factors regarding the child, parent, and environment which need to be explored.

Child

- What is the child's medical condition? Are there special care needs? How medically fragile is the child? To what extent is the child irritable or lethargic? Are there special equipment or medication needs?
- What medical follow-up is needed?

Parent

- What is the parent's pattern and history of drug use? What drug(s) were taken? How often? Is the parent using drugs now? What is the method of use?
- What is the parent's history of drug treatment? When did she enter? Is she currently in treatment? Is she considered compliant?
- Does the parent have physical, intellectual, or emotional problems which would impact her ability to care for the child?

- Does the parent exhibit appropriate parenting skills and seem responsive to the infant's needs? Did the mother have prenatal care? Are her expectations and perceptions realistic?

- What is the parent's age, school, and/or work history? How many other children are in the home?

- Have there been previous allegations of abuse or neglect?

Environment

- What supports are available? Are there responsible family members or friends who can assist the parent in caring for the child? Does the parent have supports within the community, e.g., church or community group? Are other household members suspected to be involved in drug activity? Is there a history of violence within the household?

- What are the environmental conditions of the home? Is the home clean? Are utilities working? Are there safety hazards? Is there evidence of preparation for the infant?

- Are siblings well cared for? Are immunizations current? Do siblings attend school on a regular basis? (Complete standard "Risk Assessment Guide" for siblings.)

## DEALING WITH COURT

For the court to detain a child, it must make a finding that detention is a matter of urgent necessity for the child's protection. The fact that a positive tox screen exists may not meet this test. It is critical that the CSW supply the court with the results of the initial assessment at the detention hearing if there is a clear need to detain the child. The answers to the above questions can provide such evidence. If the written medical report is available, it should be attached to the petition documents going to court.

REMINDER: This module and the companion guide are not a substitute for the CSW's professional judgment. Rather, these are mental prompters which can assist and enhance structured decision making.

MW:rhb
1387 MW/FS3
9/87

# HOW TO ASSESS FOR RELEASE TO RELATIVE FOR INFANTS PRENATALLY EXPOSED TO DRUGS

## GOAL

The goal of this module is to provide the CSW with detailed information about how to make complete and thorough assessments of a relative when considering his/her home as a possible placement for an infant who has been prenatally exposed to drugs.

> NOTE: This module should be used in conjunction with module B-5 - How To Assess For Release To Relatives. That module provides the general concepts while this module is concerned with the special considerations of placing infants prenatally exposed to drugs.

## INTRODUCTION

Infants that have been prenatally exposed to drugs often suffer from severe medical problems and exhibit behaviors not normally found in infants who have not been exposed to drugs. They often require special care and additional attention which places an especially heavy burden on the caretaker. When placing these infants, it is important that the potential caretaker be thoroughly assessed as to his/her willingness and ability to take on this heavy responsibility prior to the placement of the infant.

## POLICY AND GUIDELINES

State regulation provides that a relative's home has priority when considering the most appropriate placement for a child. However, prior to the final decision to place an infant who has been exposed to drugs, the CSW must make a thorough assessment, consider all significant elements, and determine that the relative is both willing and capable of taking on the responsibility that caring for this type of infant requires.

## DECISION-MAKING FACTORS

Numerous factors need to be considered when assessing relatives as possible placement alternatives for infants prenatally exposed to drugs. Personal traits, including his/her understanding of and willingness to comply with the level of care required, must be considered along with general ability to provide the proper care. In addition, the CSW must also assess the physical and social environment of the relative's home to assure that the decision to place with the relative would be one based on sound casework practice and good social work judgment.

The following factors must be considered by the CSW as part of the assessment of the relative for possible placement of a drug exposed infant.

1. Drug and/or Alcohol Use

   The relative should be drug-free and not allow any type of drug use/abuse in their home by any person. Current drug use or alcohol abuse by the relative or any other person in the home would render the home unuseable.

2. History of Abuse, Neglect or Violence in the Home

   A history of abuse, neglect or violence in the relative's home should be a signal to the CSW to carefully scrutinize the current family composition and interactions. This history of abuse, neglect, or violence may involve the relative as a perpetrator or as a victim, or may only involve other family members and not the relative directly. Prior involvement of the relative and family members with DCS and law enforcement should be assessed before making a decision to place.

3. Relative's Physical, Intellectual or Emotional Abilities/ Control

   The relative who will be the primary caregiver of the infant should have no limitations which would significantly impact the ability to care for the child. The relative needs to be emotionally and mentally stable. It is very important that the relative has a clear and complete understanding of the child's problems as well as realistic expectations of what to expect when caring for the child.

4. Relative's Level of Cooperation

   The relative must be willing to work with the agency and the CSW to follow the case plan and provide for the infant's special medical and physical needs. The CSW should be especially aware of, and take time to assess further, those relatives who are overly compliant or appear to give "lip service" only, as well as those who display a superficial understanding of their role and responsibility as caretaker.

   A relative who seems disinterested in caring for the infant, is evasive, or doesn't appear to believe that there is a problem with either the parent or the child should not be selected as a caregiver.

5. Relative's Parenting Skills and Responsiveness to Infant (Plan for Child)

A relative who has a prior successful parenting experience should be assessed positively for this particular factor. A relative who has had no prior parenting experience but who indicates a willingness to acquire the necessary skills should also be viewed positively.

A relative who indicates unrealistic expectations or has displayed only inadequate or inappropriate parenting in the past should not be used for placement of an infant.

6. Relationship Between Relative and Parent

A relative should be assessed positively for this factor if (s)he is supportive of the parent/child relationship but at the same time is able to acknowledge the problem and set and enforce reasonable limits for the parent(s).

An infant should not be placed with a relative who is unable to set or enforce limits with the parent(s) and/or denies there is a problem and/or is unable to support the parent/child relationship and/or has his/her own conflict with the parent that will interfere with the parent/child relationship.

The parent's approval or disapproval of a particular relative should be considered by the CSW. Valid concerns should be addressed; however, the best interests of the minor remain the first consideration regardless of the parent's agreement with the placement decision.

7. Ability and Willingness to Protect the Child

A relative caretaker is, of course, expected to protect the child. While this is usually not a problem, it should be given special consideration when assessing a relative in situations where the parent's behavior has the potential to become violent or disruptive or in some manner threaten or compromise the safety of the baby.

In these situations the CSW is responsible for assuring the safety of the child as much as possible. This can be done by either obtaining a court order that gives permission not to reveal the whereabouts of the child or by considering placement in a nonrelated caregiver's home.

8. Relative's Access to Medical Care

An infant prenatally exposed to drugs has a potential for numerous medical problems and may require much more involvement and assessment by medical staff than a healthy infant. Because of this, it is important that the relative caregiver have immediate access to transportation and to a phone in the event of an emergency. Proximity and easy access to medical facilities would also be positive indicators.

While the absence of the above-mentioned factors does not preclude the relative from placement consideration, it should alert the CSW that this is an area that will require the CSW's attention and intervention in order to support the relative in meeting the infant's needs.

9. Living Environment (Furnishings/Health/Safety)

The relative's home should be fairly clean with no apparent safety or health hazards. The utilities should be operable and there should be no infestation of rodents or vermin. There should be evidence of, or a willingness to prepare for the infant's arrival. This would include having a place for the infant to sleep, adequate and appropriate clothing and diapers, sufficient formula, etc. The caretaker is also required to have an infant car seat.

A relative who is unwilling or unable to prepare for the infant's arrival or to properly clean the house and comply with health and safety standards should not be considered as an appropriate placement alternative.

CONCLUSION

The infant prenatally exposed to drugs is at high risk of endangerment due to the physical and medical problems that may exist. It is, therefore, especially important to assure that the caregiver chosen to care for the infant be as capable and as prepared as possible.

In order to choose the best placement, the CSW must assure that the assessment done on any relative be thorough, objective, and accurate, and that the final placement decision be made with the minor's best interest in mind.

TP:rhb
2828 TP/FS11
12-28-87

COUNTY OF LOS ANGELES DEPARTMENT OF CHILDREN'S SERVICES

CASE NAME _____

STATE NUMBER _____

ASSESSMENT GUIDE FOR INFANTS
PRENATALLY EXPOSED TO DRUGS

List infant(s) being assessed in Part A. Assess Infant(s) for each risk factor and enter name(s) under Low, Intermediate or High Risk in Part B. Write N/A if factor does not apply or Unknown if information is not known. Write analysis of risk in Part C. Assess siblings on standard Assessment Guide.

A. Child(ren) _____ _____

| | B. FACTOR | LOW RISK | INTERMEDIATE RISK | HIGH RISK |
|---|---|---|---|---|
| CHILD | 1. Infant's drug withdrawal symptoms | | | |
| | 2. Special medical and/or physical problems | | | |
| | 3. Special care needs of child | | | |
| CARETAKER | 4. Current drug use | | | |
| | 5. Drug treatment history | | | |
| | 6. Prenatal care | | | |
| | 7. Parent's physical intellectual, or emotional abilities | | | |
| | 8. Parent's level of cooperation | | | |
| | 9. Parent's awareness of impact of drug use on child | | | |
| | 10. Parenting skills and responsiveness to infant | | | |
| | 11. History of abuse/neglect | | | |
| ENVIRONMENT (PHYSICAL & SOCIAL) | 12. Father or parent substitute in home Name _____ | | | |
| | 13. Strength of family support systems | | | |
| | 14. Drug use in home | | | |
| | 15. Sibling assessment (use standard Risk Assessment Guide for sibs) | | | |
| | 16. Environmental condition of home | | | |

C. CSW Analysis (consider risk factors and family strengths)

_____

_____

_____

_____

_____

CSW _____ Date _____

76A929G DCS 181 (11/88)

ASSESSMENT MATRIX FOR INFANTS PRENATALLY EXPOSED TO DRUGS

| | FACTOR | (a) LOW RISK | (b) INTERMEDIATE RISK | (c) HIGH RISK |
|---|---|---|---|---|
| 1. | Infant's drug withdrawal symptoms | Withdrawal symptoms not apparent | Mild tremors; sleeps ¢ least 3 hrs. after feeding; feeding well; normal stools | Vomiting; watery stools; fever; sleeps less than 2 hrs. after feeding; marked tremors; poor feeding; high pitched cry; seizures; lethargic; on meds for drug withdrawal |
| 2. | Special medical &/or physical problems | No apparent med. or phys. prob. | Minor med. or phys. prob. which do not significantly affect infant's vital life functions or physical & intellectual development | Any pre-term inf. (born at or before 36 wks.) &/or phys. or med. prob. which significantly impact vital life functions or phys. & intel. developm. (e.g., cardiac defect, apnea, visual or hearing handicap, seizure disorder) |
| 3. | Special care needs of child | Only routine pediatric care; no special equipment or medication | Monthly pediatric care visits & no medicine or special equipment | Requires 2 or more monthly visits for pediatric care &/or special equipment or medication |
| 4. | Current drug use | Not currently using any drugs | Occasional 1-2x wk. or wknd. use | Use more than 2x wk.; any use of PCP or Crack |
| 5. | Drug treatment history | Entered drug trtmt. early in pregnancy, remains in program & considered compliant | Entered drug trtmt. early in pregnancy, remains in program, but attendance sporadic &/or continues to use drugs | Not in drug trtmt. program or entered in 3rd trimester |
| 6. | Prenatal care | Sought early prenatal care and consistent with follow-up | Sought prenatal care in 2nd trimester but inconsistent w/prenatal follow-up/medical advice | Did not seek prenatal care until 3rd trimester; no prenatal care |
| 7. | Parent's physical, intellectual, or emotional abilities | No intellectual/ physical limitations; realistic expectations of child; in full control of mental faculties | Mild physical/emotional handicap; mild intellectual limitations which would not significantly impact ability to care for child | Mod. to severely handicapped; poor perception of reality; unrealistic expectations/ perceptions of child's behavior; severe intellectual limitations; incapacity due to alcohol/drug intoxication; past criminal/ mental illness; poor impulse control (i.e., demonstrated evidence of violence in home) |
| 8. | Parent's level of cooperation | Willingness & ability to work w/agency to resolve problem & protect child | Overtly compliant w/investigator &/or presence in home of non-drug using adult to assure minimal cooperation w/agency & follow thru w/med. recommend. | Doesn't believe there is prob.; refuses to cooperate; disinterested or evasive |
| 9. | Parent's awareness of impact of drug use on child | Expresses concern/ interest about drugs' effect on child & sought professional advice & counseling | Displays concern/interest in child but denies symptoms & special needs | Displays lack of concern/ interest for child & denies symptoms |
| 10. | Parenting skills & responsiveness to infant | Parent exhibits appropriate parenting skills & knowledge re: special medical follow-up care and is responsive to infant's needs | | Parent may prov. appr. phys. care but is unresponsive to infant's needs (i.e., lack of response to crying of infant. Poor eye contact, infrequent visits, inappropriate expectations and criticism of child) |
| 11. | History of abuse/ neglect | No known history of abuse/neglect | Prior protective services provided to child or sibs. with that episode resolved & case closed | Pending child abuse/neglect investigation; previous abuse/ neglect of serious nature; prior dependency |
| 12. | Father or parent substitute (F or PS) in home. name _____ (Circle F or PS to specify) | F or PS in home, who is a supportive/ stabilizing influence & available to assist w/caretaking | Stable F or PS in home, but assumes only minimal caretaker responsibility for child | F or PS who resides w/family & has poor impulse control (i.e., demonstrated evidence of violence in home), &/or is involved in drug activity |
| 13. | Strength of family support systems | Family, neighbors, or friends available & committed to help; membership in church, community, or social group | Family supportive but not in geographic area; some support from friends & neighbors; limited community services available | No relatives or friends available/committed; geographically isolated from community service; no phone; no transportation available |
| 14. | Drug use in home | No member of household suspected to be involved in drug activity (sale, use, and/or mfg.) | | Any one in the household suspected to be involved in drug activity |
| 15. | Sibling assessment (use standard Risk Assessment Guide for sibs.) | Education, medical & environmental needs being met for all sibs | Some but not all educ., med., & environ. needs being met for all sibs. | Few educ., med., & environ. needs being met for all sibs. |
| 16. | Environmental condition of home | Home relatively clean w/no apparent safety or health hazards; utilities operable; no infestation of rodents & vermin. Evidence of preparation for infant's arrival (clothing, furnishings, formula) | Home rel. clean (see a) but no evid. of prep. for infant's arrival | Home unclean w/safety or health hazards; no evidence of prep. for infant's arrival |

# ASSESSMENT GUIDE FOR RELEASE TO RELATIVE FOR INFANTS PRENATALLY EXPOSED TO DRUGS

List infant(s) to be placed and potential relative caretaker's name and relationship in Part A. . Assess the potential relative caretaker for each risk factor and check the appropriate risk level (Low, Intermediate or High). Write N/A if the factor does not apply or the information is unknown. Write analysis of risk in Part C.

A. Child(ren) _____ _____

Relative's name _____

Relative's relationship to child _____

| | B. FACTOR | LOW RISK | INTERMEDIATE RISK | HIGH RISK |
|---|---|---|---|---|
| CHILD | The risk factors for this child are assessed on the Assessment Guide for Infants Prenatally Exposed to Drugs. Please refer to that Guide for specific information and risk levels on this child. | | | |
| RELATIVE | 1. Relative's drug/ alcohol use | | | |
| | 2. Relative's history of abuse/neglect/violence | | | |
| | 3. Relative's physical/ intellectual or emotional abilities | | | |
| | 4. Relative's level of cooperation | | | |
| | 5. Relative's parenting skills and responsiveness to infant | | | |
| | 6. Quality of relationship between relative and parent | | | |
| ENVIRONMENT (P & S) | 7. Relative's ability to protect child | | | |
| | 8. Relative's access to medical resources | | | |
| | 9. Relative's living environment (furnishings/health/safety) | | | |

C. CSW analysis (consider risk factors and relative strengths)

_____

_____

_____

_____

_____

CSW _____ Date _____

76A929R DCS 182 (11/88)

ASSESSMENT MATRIX FOR RELEASE TO RELATIVE FOR INFANTS PRENATALLY EXPOSED TO DRUGS

The risk factors for the child are described on the Assessment Matrix for Infants Prenatally Exposed to Drugs. Please refer to that Matrix for specific information on risk assessment levels of infants prenatally exposed to drugs.

| | FACTOR | (a) LOW RISK | (b) INTERMEDIATE RISK | (c) HIGH RISK |
|---|---|---|---|---|
| RELATIVE | 1. Relative's drug/ alcohol use | Not known to currently be using drugs or allowing drug use in the home | | Known use of drugs or alcoholism |
| | 2. Relative's history of abuse/neglect/violence | No known history of abuse/neglect or violence in the home | | Prior involvement with DCS or law enforcement or a history of abuse/neglect or violence in the home |
| | 3. Relative's physical/ intellectual or emotional abilities | No intellectual/physical limitations; realistic expectations of child; in full control of mental faculties | Mild physical/emotional handicap; mild intellectual limitations which would not significantly impact ability to care for child | Mod. to severely handicapped; poor perception of reality; unrealistic expectations/perceptions of child's behavior; severe intellectual limitations; incapacity due to alcohol/drug intoxication; past criminal/mental illness; poor impulse control (i.e., demonstrated evidence of violence in home) |
| | 4. Relative's level of cooperation | Willingness to work with agency, to follow case plan, and provide for child's special medical and physical needs | Overtly compliant or appears to give "lip service" only; superficial understanding of their role and responsibility | Disinterested or evasive, doesn't believe there is a problem with parent or child |
| | 5. Relative's parenting skills and responsiveness to infant | Evidence of prior successful parenting | No prior experience with parenting but indicates willingness to acquire necessary skills | Evidence of inadequate prior parenting; unrealistic expectations |
| | 6. Quality of relationship between relative and parent | Relative supportive of parent/child relationship but able to set limits; acknowledges parent's problem | | Unable to set limits with parent and/or denies problem; conflict that will interfere with parent/child relationship or is unable to support parent/child relationship |
| ENVIRONMENT (PHYSICAL & SOCIAL) | 7. Relative's ability to protect child | Parent's behavior would not compromise safety of child | | Parent is violent or disruptive and threatens the safety of the child or caretaker |
| | 8. Relative's access to medical resources | Has own transportation, own phone; close to medical resources | Access to transportation and a phone | No transportation or phone; substantial distance from medical resources |
| | 9. Relative's living environment (furnishings/health/safety) | Home relatively clean w/no apparent safety or health hazards; utilities operable; no infestation of rodents & vermin; evidence of preparation for infant's arrival (clothing, furnishings, formula) | Home rel. clean (see a) but no evid. or prep. for infant's arrival | Home unclean w/safety or health hazards; no evidence of prep. for infant's arrival |

HRS REGULATION
No. 150-6

STATE OF FLORIDA
DEPARTMENT OF HEALTH AND
REHABILITATIVE SERVICES
TALLAHASSEE, October 15, 1988

Health

SUBSTANCE ABUSED NEWBORNS

1. Purpose. This policy provides for a system of identification, reporting and provision of needed services to drug or alcohol involved newborns, and babies born to mothers who are addicted to or abusing drugs or alcohol.

2. Effective Date. October 15, 1988

3. Scope. The Department of Health and Rehabilitative Services shall be informed of all newborn infants who are born to mothers who are addicted to or have abused drugs during the childbearing period in the following manner:

a. Report of Physically Drug Dependent Newborn.

(1) If anyone has reasonable cause to suspect that a newborn is physically drug dependent or a situation of actual or threatened harm exists, this knowledge or suspicion must be reported immediately to the FLORIDA ABUSE REGISTRY (required by 415.504 (1) Florida Statutes).

(2) The abuse registry shall notify the district Child Protective Investigation Unit which will commence an immediate child protective investigation. The child protective investigator will inform the county public health unit which will conduct a separate home evaluation and family assessment.

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OPR: DH
DISTRIBUTION: X: OSES (2); OP (1); PD (1); DH (2); DHD (6); DHA (1); OSPI (2); OPAR (2); DHP (10); DHPM (10); ASGA (25); DHPP (3); DHPD (1); PDP (2); PDDR (1); PDDM (1); PDAA (1); PDADM (5); PDCM (5); PDCYF (5); PDDS (1); PDES (1); DHDE (1); DHDA (1); DHPW (1); DHPF (1); Auditor General (14).

DISTRICTS DISTRIBUTE AS FOLLOWS:

| District | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DA | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 55 |
| DMAS | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 11 |
| DPM | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 11 |
| DPOCYF | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 22 |
| DPOHE | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 11 |
| CPHU Dir. | 4 | 14 | 16 | 7 | 2 | 5 | 4 | 7 | 5 | 1 | 2 | 67 |
| CPHU Nurs. Directors | 10 | 18 | 20 | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 10 | 128 |
| Total | 24 | 42 | 46 | 27 | 22 | 25 | 24 | 27 | 25 | 21 | 22 | 305 |

b. Referral of Other at Risk Newborns with Related Substance Abuse Concerns. If no child abuse is threatened, physical drug dependency or harm suspected, but there is a substance abuse concern with the newborn or family, the attending health professional should make a referral to the district or county public health unit for a family assessment and service provision through the district telephone network. The consent of the client is required for this referral. The primary responsibility for the health care of these families will be assumed by the public health nurse.

4. Explanation of Terms.

a. Child Abuse. This term refers to situations in which a child's physical, mental and emotional well-being is harmed or threatened with harm by the acts or omissions of a parent, other person responsible for the child's welfare or institutional staff; it includes sexual abuse. (415.503 (3) Florida Statutes)

b. Child Protective Investigator (CPI). The department's authorized agent located in each district within the state and responsible for conducting child protection investigations of allegations that children have been abused or neglected by a parent or other person responsible for their welfare or institutional staff.

c. Harm to Children. This term includes, but is not limited to an injury of a newborn infant evidenced by that infant's being born physically dependent on certain controlled drugs and actual or potential failure of a parent to supply a child with adequate food, clothing, shelter, supervision or health care, although financially able or offered financial or other means to do so. (415.503 (8) Florida Statutes)

d. Health Care Case Manager. The health care case manager, who is usually the public health nurse, plans and provides nursing care, referrals, follow-up, monitoring, education, counseling and coordinates other activities necessary to enhance the well-being of the family.

e. District Telephone Network. The district telephone network is the system for receiving referrals of substance abused newborns directly from health care providers and child protective investigators. Each district should ensure that every hospital and birth center has the appropriate telephone number for referrals to the district or in some areas, the county public health unit. The district office shall establish and maintain a plan for timely referral to the county public health unit.

f. Physically Drug Dependent Newborn. A physically drug dependent newborn is an infant under 28 days of age who exhibits abnormal growth or, abnormal neurological patterns or, abnormal behavioral patterns, and for whom there is documented evidence that the mother used Scheduled I or II drugs during her pregnancy. Documented evidence for this condition is: Admission by the mother of drug use during pregnancy, a positive maternal drug screen during pregnancy or the early postpartum period or a positive newborn drug screen.

g. Reasonable Cause to Suspect. Indicators for reasonable cause to suspect that a newborn is physically drug dependent are:

(1) Directly observing the pregnant woman while she is using drugs. This should be by a relative, household member or other reliable source.

(2) Admission by the mother of drug use during pregnancy.

(3) A positive drug screen of the newborn.

(4) A positive maternal drug screen during pregnancy or the early postpartum period.

h. Reports to the FLORIDA ABUSE REGISTRY. The FLORIDA ABUSE REGISTRY's statewide single number (1-800-96 ABUSE) should be utilized for the reporting of all suspected child abuse or neglect.

5. References.

a. Florida Statutes.

| | | |
|---|---|---|
| (1) | Chapter 415 | Protection from Abuse, Neglect and Exploitation |
| (2) | Chapter 415.503 | (3) & (8) Definitions of Terms |
| (3) | Chapter 415.504 | Mandatory Reports of Child Abuse |
| (4) | Chapter 893 | Drug Abuse and Prevention Control |
| (5) | Chapter 893.03 | Standards and Schedules |

b. Manuals and Handbooks.

(1) HRSM 175-21, Child Protective Services Policy and Procedure Manual

(2) HRSP 175-1, Child Protective Services Investigation Decisions Handbook

(3) HRSP 150-1 Public Health Nursing Handbook

(4) HRSM 205-10 Abuse Registry Call-Floor Manual

6. Procedures.

a. General.

(1) Each district administrator shall contact local public and private hospitals and birth centers in writing, notifying them of this policy and the procedures that are to be used. The responsible person(s) shall be advised of the telephone number(s) to be used within the district to make appropriate referrals to the district telephone network or reports to the FLORIDA ABUSE REGISTRY. Reports or referrals should be made as soon as possible, after the situation is identified to facilitate a predischarge investigation and/or evaluation.

(2) THE FLORIDA ABUSE REGISTRY and affected district offices of child protective investigators shall be informed of the appropriate telephone number(s) for referrals to the distict telephone network.

(3) District administrators will notify alcohol, drug abuse and mental health contract providers, in writing that the families and abusing pregnant women involved in these situations will be given the highest priority in service provision.

b. Specific.

(1) Report of Physically Drug Dependent Newborns.

(a) If there is reasonable cause to suspect that a newborn is physically drug dependent or a situation of actual or threatened harm exists, a report shall be made to the FLORIDA ABUSE REGISTRY.

(b) The registry will receive the information as an abuse report and transmit it to the appropriate district for investigation by the child protective investigator.

(c) The child protective investigator will commence an investigation immediately and notify the county public health unit at the same time. The public health nurse will assess the family and home environment and provide health care case management for these families. The county public health unit will follow the same schedule and procedures as those specified below for other at risk newborns [paragraph 6b(2)(a-e)].

(d) If the counselor receiving the call at the FLORIDA ABUSE REGISTRY determines that there is not sufficient information for an abuse report, the counselor will advise the health professional to call the district telephone network with this referral for services.

(e) When the call is to be handled as an abuse or neglect report, the child protective investigator is to follow established investigation guidelines as presently outlined in the HRSM 175-21, Child Protective Services Policy and Procedures Manual and HRSP 175-1, Child Protective Services Investigation Decisions Handbook.

(2) Referral of Other At Risk Newborns with Related Substance Abuse Concerns.

(a) When a newborn with a related substance abuse concern, other than those required to be reported to the FLORIDA ABUSE REGISTRY, is identified by a health professional, the health professional is requested to refer that family to the county public health unit through the district telephone network. The consent of the client is required for this referral. When a referral is received by the district or county public health unit, the following information must be obtained within 24 hours from the physician and/or other referring hospital staff.

1. Home address and phone number, if available, of the mother upon discharge;

2. Drug or alcohol symptoms of the infant and any medical complications as specified by the physician;

3. Projected (or actual) time and date of discharge of the mother and infant.

(b) Home Evaluation and Family Assessment Schedule.

1. Predischarge. The public health nurse will conduct a home evaluation and family assess ment prior to the discharge of the infant.

2. Postdischarge. Within 48 hours after the infant is discharged from the hospital, the public health nurse will conduct a home evaluation and assessment. The forty-eight hour requirement may be extended to five days, if a predischarge home evaluation and family assessment was conducted and satisfactory conditions were found.

(c) Content of the Evaluation.

1. The home evaluation will be an environmental and family assessment focused on the safety and quality of care provided for the child. This will include the following points:

a. health conditions of the infant, if at home.
b. family composition and parenting capabilities of those persons in the home;
c. environmental condition of the home;
d. identification of services needed beyond those provided by the county public health unit.

2. If the home evaluation reveals that the mother is not able to care for the child due to her drug or alcohol dependency and she is unwilling to receive treatment, a report of neglect must be made to the FLORIDA ABUSE REGISTRY.

(d) Reports of Evaluation. The public health nurse will provide the results of the home evaluation to the referring hospital or birth center and physician. The results will also be provided to the child protective investigator for those children who were referred to the county public health unit for an assessment. Additional follow-up information regarding the family will also be provided as indicated.

(e) Referral to Community Resources. The public health nurse will serve as health care case manager and will make referrals for services needed. Such services may include medical services; Aid to Families with Dependent Children (AFDC); food stamps; Women, Infants and Children (WIC), nutritional services; alcohol or drug abuse treatment; and Children's Medical Services (CMS); Voluntary Family Services (VFS). As case manager, the public health nurse will obtain follow-up information from the service referrals for further assessment. The HRS programs to which these referrals are made are responsible for providing follow-up information to the public health nurse regarding disposition of any referral and periodic reports as to services rendered.

7. Reporting Requirements.

a. Districts shall submit quarterly to the State Health Office (DH) a referral log with a copy to Operations (OP). (See Appendix A. Copies, 8-1/2 x 14, can be obtained from DH.) Reports are due April 15, July 15, October 15 and January 15th.

b. The referral log (Report of Substance Abused Newborns Referred to the County Public Health Unit) shall include the following information for each infant referred:

(1) Name of the infant and birth weight;
(2) Name of referring hospital;
(3) Time and date of referral;
(4) Time and date hospital contacted after initial referral;
(5) Date infant discharged from hospital;
(6) Date(s) of home assessment;
(7) Disposition of referral.
(8) Reason for referral: ___ cocaine abuse,____ alcohol, ___ polydrug use other: (specify) _____
(9) Evidenced by: ___ presence in newborn,____ presence in mother,____ history of drug use, other (specify) _____.
(10) Prenatal care: ____ number of prenatal visits, ____ month began care.

8. Reporting Procedures. Districts shall develop operating procedures (in accordance with HRSR 5-2, Departmental Administrative Publications System) as necessary to implement this regulation.

9. A model letter to local hospitals and physicians is included for your convenience. (See Appendix B.)

BY DIRECTION OF THE SECRETARY:

Charles S. Mahan, M.D.
Deputy Secretary for Health

HRS REGULATION
NO. 125-3

STATE OF FLORIDA
DEPARTMENT OF HEALTH AND
REHABILITATIVE SERVICES
TALLAHASSEE, March 1, 1989

Program Policy Development

# STAFFING PROCESS FOR INFANTS AND CHILDREN WITH COMPLEX MEDICAL PROBLEMS

1. Purpose. This regulation establishes the requirements and responsibilities for securing the most appropriate services, integrating service delivery and assigning accountability for the provision and payment of services for infants and children with complex medical problems.

2. Scope. This regulation applies to all programs and staff within the Department of Health and Rehabilitative Services that provide services to infants and children with complex medical problems.



3. References.

a. HRSM 145-1, Children's Medical Services.

b. HRSM 145-4, Child Protection Team.

c. HRSM 160-2, Developmental Services Client Services.

d. HRSP 175-1, Child Protective Services Investigation Decisions Handbook.

e. HRSM 175-7, Protective Services Supervision and Treatment.

f. HRSR 150-6, Substance Abused Newborns.

g. HRSR 230-6, Medicaid Case Management.

4. Definitions.

a. "Case management" means the service of assisting an individual in accessing needed medical, social, educational and other service needs.

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OPR: PDCM
DISTRIBUTION: X: OSES(2); OP(1); ASGA(5); PD(1); PDCM(5); PDCYF(5); PDDS(5); PDDM(2); HS(2); Auditor General(14).

Districts Distribute as Follows:

| District | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DA | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 11 |
| DDA | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 11 |
| DPM | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 12 |
| DPOCM | 10 | 15 | 15 | 15 | 10 | 20 | 15 | 15 | 10 | 10 | 20 | 155 |
| DPOCYF | 10 | 15 | 15 | 15 | 10 | 20 | 15 | 15 | 10 | 10 | 20 | 155 |
| DPODM | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 11 |
| DPODS | 10 | 15 | 15 | 15 | 10 | 20 | 15 | 15 | 10 | 10 | 20 | 155 |
| DPOHS | 10 | 15 | 15 | 15 | 10 | 20 | 15 | 15 | 10 | 10 | 20 | 155 |
| Total | 44 | 64 | 64 | 64 | 44 | 84 | 64 | 64 | 44 | 44 | 85 | 665 |

b. "Case manager" means a professional who is assigned the responsibility of providing or arranging for individual program services directly to or on behalf of a recipient.

c. "Lead case manager" means the individual who accepts primary responsibility for assuring that all services specified in the Individual/Family Service Plan have been arranged for and delivered by the professionals involved in the case. This individual becomes the central focal point for all information relative to the case in question.

d. "Infants and children with complex medical problems" means individuals, ages 0-21, who have chronic debilitating diseases or conditions of one or more physiological or organ systems which generally make them dependent upon 24-hour a day medical/nursing/health supervision or intervention.

(1) This population generally will be eligible for services from at least two of the following HRS programs; Children's Medical Services, Developmental Services, Health or Children, Youth and Families.

(2) This population is characterized by disorders such as severe bronchopulmonary dysplasia requiring ventilator support, malabsorption syndromes requiring mechanical feeding support, sequelae of near-drowning incidents, severe neurological problems with uncontrolled seizures, etc.

e. "Individual/Family Service Plan" means a written document prepared by professionals involved with the individual child/family which specifies the services required; outlines accountability for arranging and delivering services and outlines accountability for financing services.

f. "Staffing" means a face-to-face meeting initiated by the lead case manager or any staff member who recognizes the case complexity. The staffing is held to prepare an integrated and coordinated Individual/Family Service Plan, to clarify roles, to assign financial and service responsibility and to assure integrated and complimentary service delivery.

g. "Program" means a program entity of the Department of Health and Rehabilitative Services such as Children's Medical Services, Children, Youth and Families, Health or Developmental Services Programs.

h. "Substance Abused Newborns" means infants under 28 days of age who exhibit abnormal growth or, abnormal neurological patterns or, abnormal behavioral patterns, and for whom there is documented evidence that the mother used Schedule I or II drugs during her pregnancy. Documented evidence for this condition is : admission by the mother of drug use during pregnancy, a positive maternal drug screen during pregnancy or the early postpartum period or a positive newborn drug screen.

i. "Staffing participants" means those individuals from HRS programs, the child's family/caretaker, community providers, hospital staff, etc. who have been involved with the child or who will be involved with the child based upon service needs.

5. Children to be Staffed. A staffing must be held for all infants or children with complex medical problems who may be receiving departmental services from more than one program. Examples of children who should be staffed include but are not limited to the following:

a. An infant or child with a complex medical problem who is awaiting placement, but for whom alternative placements to the hospital setting or other current setting have not been identified.

b. An infant or child who has complex medical problems that typically require the efforts of a variety of programs/agencies in assuring that comprehensive services are available and delivered.

c. There are indications that the family is not capable of managing the care of the infant or child at home at this time.

d. There are indications that the child is at risk for abuse/neglect.

e. A hospital, private agency or the family has contacted HRS to request assistance for an infant or child with complex medical problems.

6. Responsibility for Requesting a Staffing. Generally, the lead case manager will request a staffing; however, anyone may request a staffing for infants or children who meet one of the criteria outlined in paragraphs 5a thru e above. The lead case manager will make arrangements for the staffing.

7. Designation of a Lead Case Manager.

a. The lead case manager for infants or children with complex medical problems who are not receiving services from the Children, Youth and Families Program will be a CMS case management nurse. Children, Youth and Families will accept lead case management responsibility for infants and children pending dependency dispositions.

b. The HRS County Public Health Units will retain lead case management responsibility for substance abused newborns without complex medical problems and CYF involvement.

8. Assessment of the Child/Family Needs.

a. A comprehensive assessment should be conducted on infants and children with complex medical problems and must include at a minimum the following areas:

(1) Family demographics to include legal custodian, living arrangements, modes of transportation, etc.

(2) Medical/health history.

(3) Psychosocial history.

(4) Environmental assessment.

(5) Developmental/behavioral history.

(6) Educational status of the child.

(7) Financial assessment to include the availability of third party resources.

b. It is important that the physician most familiar with the infant or child provide medical information, appropriate placement alternatives and recommendations concerning follow-up treatment.

c. All other programs involved with the infant or child will be identified through inquiry into the Client Information System. Those programs will be contacted by the lead case manager in order to request any information they may have on the infant or child and will be invited to participate in the assessment process and the staffing.

d. The assessment will be conducted cooperatively among programs. For instance, Children, Youth and Families may conduct the social assessment; Children's Medical Services may conduct the medical assessment; Developmental Services may conduct the developmental/behavioral assessment; Health may conduct the environmental assessment, etc. Careful planning must occur in conducting the assessments to avoid duplicate assessments or multiple individuals converging on the family at the same time.

e. HRS staff should be included in hospital discharge planning as a part of the assessment process.

f. A time frame for completing all assessments will be stipulated at the initial staffing if all assessments have not been completed at that time.

9. Staffing Participants.

a. Every HRS program known to be involved with the child/family will be included in the staffing. A Medicaid representative should also be included in the staffing. Other providers should be included, particularly hospital staff and school personnel or providers who will be involved in the care of the child post-discharge or upon placement of the child into an alternative care setting.

b. The family or caretaker and any other significant individuals should be involved in the staffing.

c. The District Administrator will appoint one individual with sufficient authority to resolve conflicts that may occur as a result of the staffing. The individual should have the authority to make decisions about funding and other issues raised during the staffing that could not be resolved by staffing participants.

10. Staffing Time frames.

a. The initial staffing will, optimally, be conducted within a few days after the request for a staffing. In all cases, the initial staffing will be held within seven working days from the request for a staffing.

b. HRS staff who are knowledgeable about an infant or child who is hospitalized will begin service planning as soon after hospital admission as possible, but not later than seven working days following admission. This will require effective communication with hospital staff and medical providers about the necessity for early discharge planning.

11. Staffing Process.

a. The physician's treatment recommendations and appropriate alternative placement recommendations for the infant or child will be available for the initial staffing and included in the individual/family service plan.

b. The staffing process will consider the medical/health, psychosocial, environmental, developmental, therapeutic (therapies), educational, transportation and financial needs of the child/family as well as any concerns the family raises during the staffing.

c. The staffing process will identify services that can be potentially provided by the family or caretaker and specify the additional training that is required to assist the family or caretaker in meeting the needs of the infant or child.

12. Individual/Family Service Plan.

a. A written individual/family service plan will be developed by the staffing participants that addresses all the areas of need that were identified through the comprehensive assessment process.

b. The lead case manager will assure that the plan is written within seven working days of the staffing. A copy of the written plan will be distributed to all members involved in the staffing. The lead case manager will maintain responsibility for tracking achievement of the activities/services listed in the plan.

c. Areas to be addressed in the plan include:

(1) Medical/health needs and services required.

(2) Psychosocial needs and services required.

(3) Environmental needs and services required including transportation.

(4) Educational needs and services required.

(5) Developmental needs and services required.

(6) Therapeutic and family support needs and services required.

(7) Financial needs and services required.

d. The individual/family service plan will identify the individuals who will be responsible for assuring that appropriate services are obtained, the time frame within which those services will be obtained, and the barriers that exist to obtaining those services.

e. The individual/family service plan will also address the services for which the family or caretaker will be responsible.

f. The individual/family service plan will identify the parties (agencies) that will be financially responsible for obtaining specified services.

g. Maximum use of third party resources is absolutely essential. If the possibility of using third party resources has not been fully assessed, the availability of third party resources should be determined prior to finalization of the plan.

h. The individual/family service plan will identify all service needs including those that may not be met due to a lack of resources or service providers.

i. Service delivery will be coordinated with family schedules and transportation schedules so that the family will not be burdened by fragmented and frequent appointments.

j. When the service plan has been developed, all parties (HRS program staff, family members and other providers) must be clear as to who is responsible for meeting various aspects of the service plan requirements. The plan will be signed by all staffing participants including the family or caretaker.

k. At the staffing during which consensus is reached on an individual/family service plan, a date will be set to review the plan.

13. Review of the Individual/Family Service Plan.

a. The first review of the individual/family service plan by staffing participants will be conducted on the date established at the initial staffing. In all instances this should be no later than three months from the initial staffing. Appropriate, timely intervals for subsequent reviews will be established based upon the time frames established for delivery or follow-up of services specified in the plan.

b. The lead case manager will invite all staffing participants to review the plan and request reports from each participant in order to facilitate a written update of the plan. All revisions in the plan needed to meet the changing needs of the child/family will be made in writing within seven working days of the staffing.

c. If the previously designated lead case manager is no longer appropriate, because of a change in the current primary needs of the child/family, a new lead case manager will be assigned based upon consensus of the staffing participants.

d. Staffing participants will notify the lead case manager of changes in case managers within three working days of the change.

e. The lead case manager will be notified when the infant or child is no longer eligible for a program due to changes in financial or program status. The lead case manager will notify other staffing participants of this change.

f. No program involved with the child/family will close the child/family to a particular program service (e.g., homemaker or respite care) without concurrence of all other programs involved.

g. A staffing will be held when all HRS programs have provided or secured the services required for the child/family and closure to HRS services is contemplated. This staffing will include the family/caretaker. Appropriate referrals to other agencies, if necessary, should be identified and made.

h. At all times, the lead case manager will assure that appropriate information is shared with all agencies/providers involved in the care and treatment of the child. The lead case manager is empowered to call a meeting of staffing participants when needed for effective case management planning.

14. Unresolved Staffing Issues.

a. If agreement cannot be reached regarding services or provider responsibilities, a process will be in place in each district to mediate differences and assure provision of needed services. The process will involve the individual designated by the District Administrator who has the authority and responsibility to manage conflict resolution and to make decisions on behalf of the department.

b. If the individual designated by the District Administrator cannot resolve the conflict, the District Administrator will intervene.

c. If differences cannot be resolved in the district, the Deputy Secretary for Operations (DSO) should be contacted. DSO will call upon the resources of the involved programs to resolve differences and assist in meeting the needs of the child/family.

15. Tracking and Data Collection.

a. Districts will track the progress of infants and children with complex medical problems and their families. The District Program Manager will be responsible for assuring that data is collected on these infants and children. Data to be collected will include at a minimum:

(1) Name and date of birth.

(2) Diagnosis

(3) HRS program involved.

(4) Family size and income.

(5) Type of third party, including Medicaid.

(6) Placement of infant or child (e.g., foster care, own home, hospital).

(7) Annual departmental expenditures by type of service for the infant or child.

(8) Date of closure to a particular HRS program.

b. A central tracking mechanism will be established and may include automated systems, where feasible. The tracking will begin at the point the infant or child is referred to the department or is currently known to the department. Data will be updated quarterly.

16. District Operating Procedures. Each district shall develop an operating procedure to implement the requirements of the regulation within the district. The district operating procedure will identify the positions (or individuals) appointed by the District Administrator in accordance with paragraphs 9c and 15a of this regulation.

BY DIRECTION OF THE SECRETARY:

ROBERT B. WILLIAMS
Deputy Secretary for
Programs