POLICY II-C: CHILD ABUSE HOTLINE FOR CHILD MALTREATMENT REPORTS

09~~1~~/202~~011~~

Pursuant to Act 1240 of 1997, the Department of Human Services and the Arkansas State Police entered into an agreement for the Arkansas State Police Crimes Against Children Division to assume responsibility for the administration of the Child Abuse Hotline. ~~and the assumption of investigative responsibility as identified in Procedure II-D11. The Crimes Against Children Division (CACD) is composed of two sections: (1) the Child Abuse Hotline, and, (2) civilian employees who investigate child maltreatment reports.~~

All child maltreatment allegations are to be reported to the Child Abuse Hotline. No privilege, or contract, shall prevent anyone from reporting child maltreatment when the person is a mandated reporter. (~~s~~See Appendix I: Glossary for more information).

No privilege shall prevent anyone, except between a client and his lawyer or minister or Christian Scientist practitioner, and any person confessing to or being counseled by the minister, from testifying concerning child maltreatment.

The Arkansas Child Abuse Hotline must accept reports of alleged maltreatment when either the child or his family is present in Arkansas or the incident occurred in Arkansas. Another state may also conduct an investigation in Arkansas that results in the offender being named in a true report in that state and placed that state's Child Maltreatment Central Registry.

~~Upon receipt of a call from a health care provider involved in delivery or care of infants reporting an infant born and affected by Fetal Alcohol Spectrum Disorder (FASD), maternal substance abuse resulting in prenatal drug exposure to an illegal or a legal substance, or withdrawal symptoms resulting from prenatal drug exposure to an illegal or a legal substance the Arkansas Child Abuse Hotline shall accept such calls. However, such referrals are not considered official hotline reports and will not be investigated, but rather referred to DCFS for a Referral and Assessment (R and A). The Request for DCFS Assessment Screen accommodates instances where an individual is not reporting abuse/neglect but is requesting other services for the family.~~

~~PROCEDURE II-C6: Referrals on Children Born with Fetal Alcohol Spectrum Disorder~~

~~02/2015~~

~~The Child Abuse Hotline Worker will:~~

~~A. Upon receipt of a call from a health care provider involved in delivery or care of infants reporting an infant born and affected by Fetal Alcohol Spectrum Disorder (FASD), maternal substance abuse resulting in prenatal drug exposure to an illegal or a legal substance , or withdrawal symptoms resulting from prenatal drug exposure to an illegal or a legal substance select "Refer to DCFS for FASD" from the Request for DCFS Assessment screen. This FASD specific R and A request will be directed to the Central Office FASD Project Director inbox for assessment.~~

~~The FASD FSW or designee will:~~

~~A. Check CHRIS inbox at least one time each business day.~~

~~B. Contact the local county office supervisor to ask that a local FSW be assigned to coordinate the FASD assessment of the infant, as applicable, and to implement any the subsequent plan of safe care if applicable.~~

C. As applicable, cConduct all FASD assessments (to include but not limited to, home visit, review of birth records, facial screening, etc.) on referred infants within 14 calendar days of receipt of referral.

D. Determine whether Develop a plan of safe care in collaboration with the locally assigned FSW within 30 calendar days of receipt of the referral. The plan of safe care will be used to inform the case plan of the supportive services case that will be openeda plan of safe care is necessary. If it is determined during the assessment that there are other issues endangering the health or physical well-being of the child, call the Child Abuse Hotline to report the other allegations.

E. Within the close button on the Request for DCFS Assessment screen, document when completion of the assessment has been completed and whether athe plan of safe care is necessary.

F. If necessary, develop a plan of safe care in collaboration with the locally assigned FSW within 30 calendar days of receipt of the referral. The plan of safe care will be used to inform the case plan of the supportive services case that will be opened.

G. Once the plan of safe care has been developed and the supportive services case has been opened, assign the local FSW as primary and the FASD FSW as secondary.

H. Support the FSW regarding the implementation of a plan of safe care as appropriate.

The FSW Supervisor will:

A. Assign a local FSW at the local level to collaborate with the FASD FSW or designee on the FASD assessment, as applicable and any the plan of safe care if applicable.

B. Conference with the local FSW regarding the development and implementation of a plan of safe care if applicable.

The local Family Service Worker will:

A. Accompany the FASD FSW or designee on the assessment of the referred infant when possible (assessment should take place within 14 calendar days of receipt of the referral).

B. Collaborate with the FASD FSW regarding the development of the plan of safe care if applicable (any plan of safe care should be developed within 30 calendar days of receipt of the referral).

C. If After a plan of safe care is developed, open a supportive services case in CHRIS.

D. Conduct the Family Advocacy and Support Tool (FAST) and use the results from the FAST as well as the plan of safe care to inform the supportive services case.

E. Assume role as primary worker once the supportive services case is open and oversee implementation of the plan of safe care/supportive services case plan.

F. Assess the supportive services case for closure within 90 days of opening (if appropriate).

POLICY II-F: SUBSTANCE EXPOSED INFANT REFERRAL AND ASSESSMENTS

01/2020

The Division of Children and Family Services (DCFS) believes in coordinating with other state agencies and community partners to help strengthen and support families in an effort to prevent child abuse and neglect. The goal of prevention of child abuse and neglect extends to all families. However, as guided by the Comprehensive Addiction and Recovery Act (CARA), along with the Child Abuse Prevention and Treatment Act (CAPTA) it amended, the Division is specifically tasked with collaborating across systems to address the needs of substance exposed infants to prevent future child maltreatment of this vulnerable population.

DCFS, in coordination with other state agencies and community partners, strives to address the needs of substance exposed infants primarily through two (2) approaches:

A. Addressing the needs of substance exposed infants who are defined as neglected pursuant to A.C.A. 12-18-103(14)(B)(i)(a)-(b) (i.e., Garrett's Law referrals) and the needs of their families via an investigative response. For more information regarding this approach, please see Policy II-D: Investigation of Child Maltreatment Reports.

B. Implementing a referral process for healthcare providers involved in the delivery and care of infants to report, for the purpose of an assessment not related to a child maltreatment investigation, infants who have not been neglected as defined in A.C.A. 12-18-103(14)(B)(i)(a)-(b), but who are born with and affected by:
   1) A Fetal Alcohol Spectrum Disorder (FASD);
   2) Maternal substance abuse resulting in prenatal drug exposure to an illegal or legal substance; or
   3) Withdrawal symptoms resulting from prenatal drug exposure to an illegal or a legal substance.

   "Affected by" means:
   1) An infant exhibits a condition or conditions associated with the mother's use of alcohol during pregnancy or a healthcare provider has an articulated concern that the infant suffers from a fetal alcohol spectrum disorder;
   2) An adverse effect or effects in physical appearance or functioning that are either diagnosed or otherwise observed and are a result of the mother's use of a legal or illegal substance during pregnancy; or
   3) An infant exhibits withdrawal symptoms in physical appearance or functioning as a result of the mother's use of a legal or illegal substance during pregnancy.

   "Infant" means any child thirty (30) days old or less.

The remainder of this policy and related procedures are specific to approach B, herein after referred to collectively as prenatal substance exposure referrals and assessments.

Healthcare providers involved in delivery or care of infants are required to make prenatal substance exposure referrals to the Arkansas Child Abuse Hotline. The Arkansas Child Abuse Hotline will accept prenatal substance exposure referrals. Upon receipt of a prenatal substance exposure referral from a health care provider, the Arkansas Child Abuse Hotline will assign the referral to DCFS for a Referral and Assessment (R and A). The Request for DCFS Assessment Screen accommodates instances where an individual is not reporting maltreatment but is requesting an assessment and appropriate services for the family based on an assessment of the family's strengths and needs.

Prenatal substance exposure referrals will be assigned to the appropriate county-level Differential Response (DR) staff (though prenatal substance exposure referrals are separate and apart from differential response allegations). For a prenatal substance exposure referral to be considered initiated, DR staff must make face-to-face contact with the infant or at least one (1) parent of the infant within seventy-two (72) hours of receipt of the referral from the hotline. If the infant and parent/caregiver are not seen together at the initiation, then DR staff must make

face-to-face contact with the individual not seen at initiation within five (5) calendar days of receipt of the referral as well any other adult household members within the same five (5) calendar day timeframe. During each contact with the parent(s)/caregiver(s), DR staff are responsible for engaging the family in an assessment of strengths and needs and developing a plan of safe care for the family. The plan of safe care will be designed to ensure the safety and well-being of an infant following the release of the infant from the care of a healthcare provider and include content that addresses the health and substance use disorder treatment needs of the infant and affected family or caregiver.

PROCEDURE II-F1: Prenatal Substance Exposure Referrals

01/2020

The Child Abuse Hotline Worker will:

A. Receive and document prenatal substance exposure referrals from health care providers involved in the delivery and care of infants with sufficiently identifying information as defined by Arkansas law.
B. Conduct a history check on all reports unless call waiting to be answered by the hotline have been waiting for fifteen (15) minutes or longer.
C. If the report qualifies as a prenatal substance exposure referral, select "Refer to DCFS for Assessment" from the Request for DCFS Assessment screen.
D. Inform the caller if the report does not constitute a prenatal substance exposure referral.

Procedure II-F2: Receipt and Assignment of Prenatal Substance Exposure Referrals

01/2020

The Differential Response Supervisor or designee will:

A. Check CHRIS inbox at least one (1) time in the morning and one (1) time in the afternoon each business day.
B. Assign each new referral to a DRT Specialist within four (4) hours of receipt excluding evenings, weekends, and holidays.

Procedure II-F3: Prenatal Substance Exposure Assessment and Plan of Safe Care

01/2020

The Differential Response Supervisor or designee will:

A. Conference with the DRT Specialist within one (1) business day after the DRT Specialist's initial face-to-face contact with the infant and at least one (1) parent/caregiver and discuss development of CFS-101: Plan of Safe Care.
B. Document all supervisor activities in CHRIS within one (1) business day of completion of each activity.
C. Regarding families with whom the DRT Specialist cannot make face-to-face contact, assess information and determine whether DRT Specialist has met due diligence no later than the seventh day after assignment.
D. Provide consultation to the DRT Specialist as appropriate.

The Differential Response Team (DRT) Specialist will:

A. Prepare for meeting the family by completing the following activities prior to making initial face-to-face contact with the family:

1) Interview other persons, including the individual(s) who called the report into the hotline, with information listed on the referral;
2) Conduct a Division of County Operations (DCO) records check of members of the household;
3) Conduct a CHRIS history search prior to contacting the family unless the report is received after hours or during the weekend or a holiday; and,
4) Contact the family by phone within twenty-four (24) hours of assignment, if a phone number is provided in the report or if appropriate considering initiation timeframe requirements to:
   a) Explain prenatal substance exposure assessments and plan of safe care;
   b) Schedule the initial family visit that will include at least the infant or one (1) parent/caretaker.

B. Consider the prenatal substance exposure referral initiated when:
1) The health and safety of the infant has been assessed within seventy-two (72) hours from the time the referral was received from the Child Abuse Hotline, or the DRT Specialist has met with at least one (1) parent/caregiver within seventy-two (72) hours from the time the referral was received at the Child Abuse Hotline (based on the reported needs or safety issues of the family, DRT Supervisor may require that the initial contact with the family occur sooner than seventy-two (72) hours); or,
2) Neither a health and safety assessment of the infant nor face-to-face contact with at least one (1) parent/caregiver could be made but due diligence has been exercised and documented within seventy-two (72) hours of receipt of the hotline referral. Due diligence must include:
   a) Making an announced (or unannounced, if needed) visit to the family at least three (3) times at different times of the day or on different days (provided the three (3) visits are within the appropriate initiation timeframes) in an attempt to assess the health and safety of the infant and develop a plan of safe care with the parent/caregiver; and,
   b) If a contact is not made via the efforts described in a) above, completing as many of the following activities necessary to establish face-to-face contact with the infant or at least one (1) parent/caretaker (note: efforts below may be done concurrently with activities described in item a) above):
      i. Contacting the reporter again if the reporter is known;
      ii. Contacting appropriate local DCO staff and requesting research of their record systems and other files to obtain another address;
      iii. Contacting the local post office and utility companies to request a check of their records;
      iv. Conducting Lexis Nexis search to attempt to locate the family;
   c) If after completion of all the due diligence activities listed above, no contact is made with the infant or a parent/caregiver by the sixth business day after assignment, document information on a case contact *(DRT Supervisor will assess the information and determine whether due diligence has been met, no later than the seventh day after case assignment)*;
   d) If DRT Supervisor deems that due diligence has been met, close referral.

C. Explain to the parent/caregiver prenatal substance exposure referrals including the development of the CFS-101: Plan of Safe Care, and that the Division must address any safety factors or needs as appropriate, to include report to the Child Abuse Hotline if child maltreatment is identified or there is reasonable cause to suspect maltreatment.

D. If the infant and parent/caregiver are not seen together at the initiation, then make face-to-face contact with the individual not seen at initiation within five (5) calendar days of receipt of the referral as well any other adult household members within the same five (5) calendar day timeframe.

E. Develop CFS-101: Plan of Safe Care with the family within fourteen (14) calendar days of receipt of the referral and ask the family if they are interested in continuing services with DCFS through a supportive services case.
1) If the family accepts continued services through a supportive services case, see Policy II-A: Supportive Services and related procedures using the CFS-101: Plan of Safe Care to inform the development of the case plan of the supportive services case that will be opened.
2) If the family declines continued services through a supportive services case,

a) Make any referrals noted on the CFS-101: Plan of Safe Care; and,
b) Within the close button on the Request for DCFS Assessment screen, document completion of the assessment and the plan of safe care.

F. Request a supervisor conference to review/discuss case information (i.e., allegation, risk/safety concerns, immediate needs, and other case specific information).

G. Document all activities in CHRIS within one (1) business day after they are completed.

POLICY II-JJ: EARLY INTERVENTION REFERRALS AND SERVICES

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For children who have or are at risk of a developmental delay, appropriate early intervention services are essential. Early intervention services are designed to lessen the effects of any potential or existing developmental delay. Ultimately early intervention services help the child learn and reach his or her individual potential with the support and involvement of the child's family, as appropriate. It is important for such services to begin as early as possible and for biological parents to be involved in decisions related to early intervention services.

REFERRALS TO DIVISION OF DEVELOPMENTAL DISABILITIES FOR EARLY INTERVENTION SERVICES SCREENING

When a child maltreatment investigation involving any children in the home under the age of three (3) is initiated, the Division will consider referring as appropriate all children in the home under the age of three (3) to the Division of Developmental Disabilities Services' (DDS) Children's Services for an early intervention (i.e., First Connections; this program is not the same as the waiver program) screening in an effort to enhance the well-being of these children. Any children under the age of three (3) involved in a substantiated case of child maltreatment (regardless of whether all of the children are named as alleged victims) must be referred to DDS Children's Services for an early intervention screening if not already referred while the investigation was pending. This will not only ensure DCFS compliance with the Child Abuse Prevention and Treatment Act (CAPTA) regarding substantiated cases of child abuse and neglect involving children under the age of three (3)~~,~~ but will further promote the well-being of this population.

DDS Children's Services will screen all of the children under the age of three (3) who have been referred to First Connections to determine their need and eligibility for early intervention services. If the results of the screening determine that a child will benefit from DDS early intervention services, the person serving as the parent (e.g., biological parent in a protective services case; other individual legally caring for the child involved in a protective services or foster care case including foster parents) must consent to allow his or her child to participate before services are initiated.

For children under the age of three (3), eligibility for DDS Children's Services will be determined by a screening assessment to determine the need for additional evaluations (if a child referred to DDS Children's Services is within 45 days or less of his or her third birthday, then DDS Children's services may forward the referral to the Arkansas Department of Education, Special Education (Part B)).

If warranted, a developmental evaluation for children under age three (3) will be completed in the areas of cognition, communication, social/emotional, physical, and adaptive as available and appropriate. Based upon the developmental evaluation results, a speech, occupational, ~~and/~~or physical therapy evaluation may be conducted as available and appropriate. All evaluation results as well as medical information, professional informed clinical opinion(s), and information gathered from biological parents and DCFS will be utilized to determine early intervention eligibility.

While a referral for early intervention services is encouraged for all children under three (3) when an investigation is initiated and is required for children under the age of three in substantiated cases of child maltreatment, a referral for early intervention services on behalf of any child suspected of having a developmental delay or disability may be sent at any time.

DDS EARLY INTERVENTION INDIVIDUALIZED FAMILY SERVICE PLANNING

If a child is determined to be eligible for services and the person acting as a parent on behalf of the child (e.g., biological parent involved in a protective services case; other individual legally caring for the child in a protective services or foster care case including foster parents) consents to services, Individualized Family Service Plan (IFSP) meetings will be held to develop an appropriate service plan for the child. IFSP activities and services must be added to the child's case plan.

Adult participation in the IFSP meetings and related decision-making on the child's behalf is required. If the child is involved in a protective services case or if a child in foster care has a goal of reunification, the child's biological parent(s) should be invited and encouraged to attend the IFSP meetings to make decisions related to Individualized Family Service Planning and early intervention services for his or her child.

However, another adult who is legally caring for the child on a daily basis may serve in place of the biological parent if:

A. The court orders that the child's parent/guardian shall have no involvement in the child's educational planning; or,
B. The child's parents cannot be located; or,
C. The goal is not reunification for those children involved in foster care cases.

If for one of the reasons listed above or if for any other reason the biological parent(s) is unable or unwilling to attend IFSP meetings and make the decisions related to early intervention services for his or her child, one of the following may serve as the parent to make decisions regarding early intervention planning and services for the child (provided the court has not issued a no contact order for the person selected to act in place of the parent):

A. Foster parent;
B. Guardian, generally authorized to act as the child's parent (but not the state if the child is a ward of the state; i.e., FSW may act as the liaison between DDS and the parent or surrogate parent, but the FSW may not be the sole contact ~~and/~~or decision-maker for a child);
C. An individual otherwise acting in place of a biological parent (e.g., grandparent, step-parent, or any other relative with whom the child lives);
D. An individual who is legally responsible for the child's welfare;

For any individual serving in place of the parent in the child's early intervention process, support in the form of DDS Surrogate Parent Training is available but not required. The local DDS Service Coordinator or designee can assist in coordinating the DDS Surrogate Parent Training. After an individual has completed the DDS Surrogate Parent Training, they may serve as a surrogate parent for any child.

However, an appointed DDS certified surrogate may be assigned by the lead Part C agency (i.e., DDS) to represent the child during the IFSP if there is no adult (as listed in items A-D above) available to represent the interests of the child. An appointed DDS surrogate parent is generally the least preferred option since this person does not have daily interaction with the child. Furthermore, a DDS certified surrogate parent will usually only be appointed in the event that the child's parent, foster parent, etc. is unable or unwilling to participate in the child's early intervention process and IFSP meetings.

In any situation in which an individual other than the biological parent (e.g., foster parent, relative, etc.) is acting on behalf of the child, that individual will be discharged when the child's biological parent is ready and able to resume involvement.

REFERRALS FOR FETAL ALCOHOL SYNDROME DISORDERS (FASD) SCREENING

Fetal Alcohol Syndrome Disorders is an umbrella term used to describe the range of effects or disorders that can occur in an individual whose mother consumed alcohol during pregnancy. All healthcare providers~~caretakers~~ involved in the delivery or care of infants must contact DHS regarding an infant born with and affected by~~with~~ a Fetal Alcohol Spectrum Disorder (FASD) as well as infants born with and affected by maternal substance abuse resulting in prenatal drug exposure to an illegal or a legal substance or withdrawal symptoms resulting from prenatal drug exposure to an illegal or a legal substance. A plan of safe care must also be developed for any infant born with and affected by an FASD, maternal substance abuse resulting in prenatal drug exposure to an illegal or a legal substance, or withdrawal symptoms resulting from prenatal drug exposure to an illegal or a

legal substance who is referred to the Division by a healthcare provider via the Child Abuse Hotline. Please see Policy II-F: Substance Exposed Infant Referral and Assessments and related procedures for more information.

-In addition, DCFS FSWs and Health Service Workers (HSW) will refer children who have known prenatal alcohol exposure ~~and~~or exhibit FASD symptoms ~~and/~~or behaviors to the local Resource Unit ~~DCFS FASD Unit for an FASD screening~~. ~~The FASD screening~~ The Resource Unit will collaborate with the child's FSW and HSW to~~will~~ help determine if early intervention ~~services~~ programs or other services specific to FASD are needed and connect the child and placement provider to such programs and services in an effort to better support the child and the placement provider.~~,~~

~~In order to conduct an effective FASD screening,~~ As part of this process, the FSW ~~and/~~or ~~Health Service Worker~~HSW will gather information regarding the child's in utero and birth history. Depending on the information collected ~~and the results of the screens~~, a referral for an FASD screening or diagnosis may be provided. ~~If a child is diagnosed with FASD~~Regardless of an FASD diagnosis, the following services may be offered to the family as available and appropriate:

- Referral to DDS (early intervention or DDS waiver), if applicable and available;
- Referral to specialized day care, if applicable;
- Referral to FASD family support group (available to biological, foster, and adoptive families), if available;
- FASD parenting classes (available to biological, foster, and adoptive families).

~~A plan of safe care must also be developed for any infant born and affected with FASD, maternal substance abuse resulting in prenatal drug exposure to an illegal or a legal substance, or withdrawal symptoms resulting from prenatal drug exposure to an illegal or a legal substance who is referred to the Division by a healthcare provider via the Child Abuse Hotline. See Policy II-C and Procedure II-C6 for more specific information regarding healthcare providers reporting infants born with or affected by FASD.~~

PROCEDURE II-J~~I~~1: DDS Early Intervention Services Referrals

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When children under the age of three are involved in a substantiated case of child maltreatment, but a case is not opened, the investigator will:

A. Provide an overview of the benefits of early intervention services to the parent/guardian.
B. Make a referral to DDS for each child in the home (victims and non-victims) under age three (3).
    1) Complete form DHS-3300 available in CHRIS.
        a) The DHS-3300 can be accessed in the Information and Referral Screen (Investigate/Services/Ref Services; Select child who is being referred and then select add button).
        b) When the button "DCO-3350/DHS-3300" is selected, a dialogue box will open so that staff can select the form to be completed.
        c) Select the "OK" button to open the DHS-3300.
        d) Select "Developmental Disabilities" as the Receiving Agency.
        e) Select "Other" in the "Services Requested and Codes" section and enter "Early Intervention Screening Referral" in the specification box.
        f) Note in the comments box that a case will not be opened, so DCFS will have no further involvement.
        g) Complete the remainder DHS-3300 with as much information as possible.
            i. At minimum, the child's name, child's date of birth OR Social Security number, and FSW contact information must be entered.

2) Print the completed DHS-3300 to either scan and email or fax to the local DDS Services Coordinator.

C. Inform the parent/guardian that their child(ren) will be referred to DDS Children's Services to assess the child(ren)'s need and eligibility for early intervention services that may help the child learn and reach his or her individual potential.

When children under the age of three (3) are involved in a substantiated case of child maltreatment and a protective services or foster care case is subsequently opened, the FSW caseworker (either protective services or foster care, as applicable) will:

A. Provide an overview of the benefits of early intervention services to the parent/guardian.
B. Make a referral to DDS for each child in the home (victims and non-victims) under age three.
    1) Complete form DHS-3300 available in CHRIS.
        a) The DHS-3300 can be accessed in the Information and Referral Screen (Case/Services/Ref Services; Select child who is being referred and then select add button).
        b) When the button "DCO-3350/DHS-3300" is selected, a dialogue box will open so that staff can select the form to be completed.
        c) Select the "OK" button to open the DHS-3300
        d) Select "Developmental Disabilities" as the Receiving Agency.
        e) Select "Other" in the "Services Requested and Codes" section and enter "Early Intervention Screening Referral" in the specification box.
        f) Complete the remainder DHS-3300 with as much information as possible.
            i. At minimum, the child's name, child's date of birth OR Social Security number, and FSW contact information must be entered.
C. Print the completed DHS-3300 to either scan and email or fax to the local DDS Services Coordinator.
D. Inform the parent/guardian that their child(ren) will be referred to DDS Children's Services to assess the child(ren)'s need and eligibility for early intervention services.
E. Prior to the early intervention services intake meeting, provide the local DDS Services Coordinator with:
    1) Court-order, if applicable
    2) Copy of Social Security Card or number
    3) Copy of Medicaid Card or number, if applicable
    4) Any other pertinent information related to the request for the early intervention screening
    5) Copy of EPSDT, if available (parent must obtain)
    6) Copy of all evaluations, if applicable
G. Coordinate remaining paperwork and services, as applicable, with the local DDS Service Coordinator. This includes but is not limited to:
    1) Coordinating the completion of DMS-800: Authorization for Children's Medical Services if the early intervention intake meeting determines the child is eligible for DDS Children's Medical Services
    2) Providing a copy of the Family Advocacy and Support Tool (FAST) for any child involved in an in-home services case or a copy of the Child and Adolescent Needs and Strengths (CANS) functional assessment for any child involved in an out-of-home services case and the case plan once they are completed;
    3) Notifying, as applicable, PACE, Health Service Worker, and foster parent(s) that early intervention screening referral has already been made to DDS Children's Services per CAPTA requirements prior to PACE evaluation.
H. Invite DDS services coordinator and early intervention service providers to staffings if child is receiving early intervention services.
I. Keep the local DDS Service Coordinator informed of any changes to the case plan that may affect early intervention services and coordination.
J. Document contacts related to the DDS early intervention services referral in the contacts screen in CHRIS.
K. Update the child's case plan as appropriate.
L. Conference with supervisor as needed regarding the referral to DDS early intervention services.

Investigative and FSW Supervisors will:

A. Conference with the investigator ~~and/~~or FSW caseworker as needed regarding the child's DDS early intervention referral ~~and/~~or any subsequent services.
B. Notify, as necessary, his or her supervisor of any issues related to the child's DDS early intervention referral ~~and/~~or services.

Upon referral, the DDS Service Coordinator should:

A. Acknowledge receipt of the DHS-3300 via email or fax.
B. Arrange the early intervention intake meeting.
C. Assess and determine the need and eligibility of the child for services and notify in writing the DCFS Family Service Worker (FSW) and FSW Supervisor indicating the eligibility status and needs of the child, if applicable.
D. If it is determined that the child needs and is eligible for early intervention services:
    1) Provide a more detailed explanation to the parent/guardian of early intervention services including types, benefits, requirements, etc.
    2) Provide copies of the child's IFSP and any early intervention evaluations to the FSW.
    ~~3)~~ Keep the child's FSW and person serving as the parent informed of the child's progress and any changes in services.

PROCEDURE II-J~~J~~2: DDS Early Intervention Individualized Family Service Planning

01~~3~~4/2020~~13~~

The FSW will:

A. Regardless of the type of case (i.e., protective or foster care), include early intervention services and Individualized Family Service Planning (IFSP) meetings in the case plan as appropriate and ensure the biological parent participates IFSP and related services as appropriate.
B. If the biological parent is unable or unwilling to participate in IFSP (e.g., court orders that the child's parent/guardian shall have no involvement in child's educational planning, parents cannot be located; goal is not reunification):
    1) Ensure that an appropriate adult serving in place of the parent attends the IFSP meetings to act as a decision-maker regarding the child's early intervention services. The person serving in place of the parent is generally the person who is currently caring for the child (e.g., temporary guardian, foster parent, etc.).
        a) Ensure that a no contact order from the court pertaining to the person serving in the place of the parent does not exist and that the surrogate parent is otherwise appropriate.
        b) If the person selected to serve in the place of the parent would like to attend a DDS Surrogate Parent Training, contact the DDS Service Coordinator to request the DDS Service Coordinator to arrange the training.
        c) If the individual caring for the child/serving in place of the parent cannot attend or otherwise participate in the IFSP meetings, DDS will appoint a DDS certified surrogate parent.
C. Continue to update child's case plan accordingly with information from IFSP.
D. Conference with supervisor as needed regarding the child's IFSP.

The FSW Supervisor will:

A. Conference with the FSW as needed regarding the child's IFSP.
B. Notify, as necessary, his or her supervisor of any issues related to the child's IFSP.

PROCEDURE II-JJ3: FASD Referrals and Services

014/201320

Note: This procedure is applicable to those children already involved in an open DCFS case and who DCFS staff or providers suspect may be affected by FASD. This procedure is not applicable to infants born with and affected by FASD or prenatal drug exposure and reported to the Child Abuse Hotline by a healthcare provider. Please see Policy II-FC and Procedure II-C6related procedures for more information regarding infants born with and affected by FASD and prenatal drug exposure.

If a child is symptomatic of FASD, the Family Service Worker (FSW) or Health Service Worker (HSW) will:

A. Gather information regarding the child's in utero and birth history to determine if the biological mother consumed alcohol (e.g., at what points during the pregnancy, amount consumed, frequency consumed, etc.) and/or any illegal substances while pregnant with child.
B. Complete and submit CFS-099: FASD Screening Referral to the appropriate Resource Supervisor or designeeFASD Director via fax (see CFS-099 for the current fax number).
C. Collaborate with the FASD Resource Unit to ensure the child and placement provider receives any necessary referrals and accesses any needed services as per the results and recommendations of the FASD screening and/or diagnosis.
D. Conference with supervisor as needed regarding FASD referrals and services.

The FSW Supervisor will:

A. Conference with the FSW as needed regarding FASD referrals and services.
B. Notify, as necessary, his or her supervisor of any issues related to the FASD referrals and services.

The Resource Supervisor or designee will:

A. Review the CFS-099: FASD Screening Referral.
B. Assign the referral to a local Resource Worker.
C. Provide the completed CFS-099: FASD Screening Referral to the assigned Resource Worker for review.

The assigned Resource Worker will:The FASD Director will:

A. Review the CFS-099: FASD Screening Referral.
B. Work with the child's FSW and HSW to coordinate appropriate referrals and screenings for the child and placement provider.

A. Review the completed CFS-099: FASD Screening Referral.
B. Assign the FASD FSW (or self-assign if FASD FSW is unavailable) to conduct an FASD screening.
C. Collaborate with the FASD FSW and child's FSW to make necessary referrals or access services per the results and recommendations of the FASD screening and/or diagnosis.

The FASD FSW will:
Conduct FASD screenings as assigned.
A. Communicate results of FASD screening and/or diagnosis to the child's FSW and FASD Director.
B. For all children screened for and/or diagnosed with FASD, collaborate with FASD Director and child's FSW to make appropriate referrals or access services per the results and recommendations of the FASD screening and/or diagnosis.

Due to the insertion of new Policy II-F: Prenatal Substance Exposure Referrals and Assessments into DCFS Policy and Procedure Manual Section II: Referrals to Assess Family Strengths and Needs, the following lettering and numbering technical revisions are required to subsequent policies and procedures found in Section II. There are no content changes in these policies or procedures.

POLICY II-GF: TEAM DECISION MAKING

01/202019

Procedure II-GF1: Team Decision Making Initiation and Referral

01/202019

Procedure II-GF2: Team Decision Making Preparation

018/202015

Procedure II-GF3: Team Decision Making Meeting

018/202015

Procedure II-GF4: Team Decision Making Review

018/202015

Procedure II-GF5: Team Decision Making Follow-Up

01/202019

POLICY II-HG: COMMUNITY NOTIFICATION OF SEX OFFENDERS

019/202005

Procedure II-HG1: Notification of Sex Offenders

01/2020

POLICY II-IH: FAMILY IN NEED OF SERVICES

018/202013

Procedure II-IH1: Family in Need of Services

01/2020

POLICY II-KJ: SEX OFFENDER WITH CUSTODY OR UNSUPERVISED VISITATION RIGHTS

012/202008

Procedure II-KJ1: Sex Offender with Custody or Unsupervised Visitation Rights

01/2020

Arkansas Department of Human Services
Division of Children and Family Services ~~FASD~~
Prenatal Substance Exposure Plan of Safe Care

Upon receipt of a prenatal substance exposure referral, the Division of Children and Family Services (DCFS) Differential Response staff member will meet with the family named in the referral to gather information related to the health and substance use treatment needs of the infant and affected family or caregiver. This information will be used to develop a plan of safe care which is designed to ensure the safety and well-being of the infant and family.

Basic Information:

Parent(s), Legal Guardian, or Custodian Name(s):
(include the guardian or custodian of the child if different from the child's parent)

Parent(s), Legal Guardian, or Custodian Address(es):

Parent(s), Legal Guardian, or Custodian Phone:

Infant Name: Infant DOB:

Infant Weight: Height: APGAR Score: Head Circumference:

Infant Pediatrician: Mother Health Care Provider(s):

Mother's Health Insurance Information: *(carrier name, Medicaid number, etc.)*

Questions for Parent/Caretaker:

Did rounding pediatrician at the hospital make recommendations regarding scheduling visits with medical providers/specialists for your infant outside of upcoming well-child visits? If yes, please describe and indicate if any follow-up appointments have been scheduled:

Did your parents or other family members use alcohol or other substances to the point it caused problems in the home?

Does your current partner struggle with alcohol or other substances?

Have you struggled with alcohol or other substances in the past?

If yes, follow up questions may inquire about topics such as past treatment plans, medication administered treatment, prescriptions, other drugs of choice, where treatment was received, participation in treatment?.

Did you struggle with alcohol or other substances during pregnancy?

If yes, follow up questions may inquire about topics such as current treatment plans, medication administered treatment, prescriptions, other drugs of choice, where treatment was received, participation in treatment.

Parent's Currently Prescribed Medication(s) (if applicable):

How do you describe your support system (this could include family, friends, support groups, treatment providers, etc.)?

For Differential Response Specialist:

Please discuss the following topics with the family while developing the Plan of Safe Care:

- ☐ Safe sleep
- ☐ Importance of scheduling/keeping infant well-child visits
- ☐ Importance of scheduling/keeping mother's postpartum visit with her obstetrician/gynecologist
- ☐ Importance of scheduling/keeping any specialized medical appointments for infant and mother
- ☐ General information about postpartum depression and information on local supports
- ☐ Coping with crying
- ☐ Symptoms of infant drug withdrawal and how to manage those symptoms at home/when to call doctor
- ☐ Resources regarding child development (e.g., CDC's Milestone Tracker app)
- ☐ Information on Access Arkansas to determine potential eligibility for over 30 support and benefit programs offered through the State of Arkansas (e.g., Arkansas Works, SNAP, Child Care Assistance, etc.)
- ☐ Information on other local community services and supports that may be of assistance to the family

Please discuss the following possible referrals with family while developing the Plan of Safe Care as applicable to the specific mother (or other primary caregiver) and infant:

- ☐ Al-Anon Family Group
- ☐ Alcoholics Anonymous
- ☐ Child Care Assistance (i.e., daycare vouchers)
- ☐ Drug or alcohol assessment
- ☐ Drug or alcohol treatment
- ☐ Early intervention services (Part C/First Connections), if applicable
- ☐ FASD support group
- ☐ Genetic screening for further FASD testing and possible diagnosis
- ☐ Home visiting program (http://www.arhomevisiting.org/) based on residence of family and needs of family
- ☐ Mental health services
- ☐ Nar-Anon Family Group
- ☐ Narcotics Anonymous
- ☐ Postpartum Services International-AR Chapter
- ☐ Specialized day care
- ☐ **Women, Infants, and Children (WIC)** Programs, such as WIC Breastfeeding Support Line and Breastfeeding Peer Counselor Program, as applicable, and Baby and Me Program, where applicable
- ☐ Other:
- ☐ Other:

☐ **Supportive Services Case accepted**

Family desires supportive services to strengthen family functioning and ensure the health and safety of the infant. By signing this form, the family agrees to work with an assigned DCFS staff member in relation to continued assessment, case planning, and service coordination to build upon any referrals made during the course of the development of the Plan of Safe Care. However, the family understands they may choose to stop participation in a supportive services case at any point. Services are to be selected based on strengths and needs of the infant, parent(s), and other family members listed in this plan of safe care and may be adjusted as necessary through the supportive services case plan.

☐ **Supportive Services Case not recommended**

Family has support systems in place and child and the home environment appear safe at this time. By signing this form, the family accepts responsibility for contacting DHS to request services if the need arises.

☐ **Supportive Services Case declined by family**

Family does not want services rendered or offered by the Department of Human Services, Division of Children and Family Services. By signing this form, the family acknowledges that prenatal exposure to alcohol and controlled substances and the services designed to support families with substance exposed infants have been explained and information has been given to the family about local and statewide services that may be available. DCFS staff may still make appropriate referrals to other services and supports prior to closing the non-investigative substance exposed infant referral but are not responsible for following up on those referrals.

☐ **Hotline report needed**

DCFS staff has identified safety concerns for the child/children. The family has been notified that a hotline report will be made.

Printed Name of Client: _____

Client Signature: _____

Date: _____

Printed name of DCFS Representative: _____

DCFS Representative Signature: _____

Date: _____

~~*Upon receipt of a referral from the Child Abuse Hotline concerning an infant born with and affected by Fetal Alcohol Spectrum Disorder (FASD), the Division of Children and Family Services (DCFS) FASD case manager or designee met with the family named in the referral to conduct an FASD assessment. Based on the assessment, DCFS and the family will move forward with the selected actions below to comprise an appropriate plan of safe care for the family.*~~

☐ **Supportive Services Case accepted**

Family is in need of supportive services to strengthen family functioning and ensure the health and safety of the child(ren). By signing this form the family agrees to participate in the selected services offered below:

- ☐ Work with an assigned primary family service worker
- ☐ Work with an assigned a secondary FASD family service worker
- ☐ Accept referral to Genetics if applicable
- ☐ Consider a referral to Developmental Disability Service (DDS) if applicable
- ☐ Accept a referral to specialized day care if applicable
- ☐ Participate in a recommended FASD support group
- ☐ Participate in a recommended FASD parenting class
- ☐ Accept a referral to drug and/or alcohol assessment if applicable
- ☐ Accept a referral to drug and/or alcohol recovery center if applicable
- ☐ Accept a referral to *Access to Recovery* (ATR) if applicable

☐ **Supportive Services Case not recommended**

Family has support systems in place and child and the home environment appear safe at this time. By signing this form the family accepts responsibility for contacting DHS to request services if the need arises.

☐ **Supportive Services case refused**

Family does not want services rendered and/or offered by the Department of Human Services, Division of Children and Family Services. By signing this form, the family acknowledges that FASD and the services designed to support families affected by FASD have been explained and information has been given to the family about local and statewide services that may be available.

☐ **Hotline report needed**

DHS FASD case manager feels the home environment presents safety concerns for the child/children in the home. The family has been notified that a hotline report will be made.

Printed Name of Client: _____

Client Signature: _____

Date: _____

Printed name of FASD representative: _____

FASD Representative Signature: _____

Date: _____

CFS-101 (01/2013)

State of Arkansas
92nd General Assembly
Regular Session, 2019

A Bill

HOUSE BILL 1452

By: Representative Barker
By: Senator T. Garner

For An Act To Be Entitled

AN ACT TO AMEND THE LAW CONCERNING REFERRALS ON CHILDREN BORN WITH FETAL ALCOHOL SPECTRUM DISORDER; AND FOR OTHER PURPOSES.

Subtitle

TO AMEND THE LAW CONCERNING REFERRALS ON CHILDREN BORN WITH FETAL ALCOHOL SPECTRUM DISORDER.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code § 12-18-310 is amended to read as follows:

12-18-310. Referrals on children born with and affected by Fetal Alcohol Spectrum Disorder or prenatal drug exposure to an illegal drug or a legal substance.

(a) All healthcare providers involved in the delivery or care of infants shall:

(1) Contact the Department of Human Services regarding an infant born with and affected ~~with~~ by:

(A) ~~a~~ A fetal alcohol spectrum disorder;

(B) Maternal substance abuse resulting in prenatal drug exposure to an illegal or a legal substance; or

(C) Withdrawal symptoms resulting from prenatal drug exposure to an illegal or a legal substance; and

(2) Share all pertinent information, including health information, with the department regarding an infant born with and affected

~~with~~ by:

(A) ~~a~~ A fetal alcohol spectrum disorder;

(B) Maternal substance abuse resulting in prenatal drug exposure to an illegal or a legal substance; or

(C) Withdrawal symptoms resulting from prenatal drug exposure to an illegal or a legal substance.

(b) The department shall accept referrals, calls, and other communications from healthcare providers involved in the delivery or care of infants born with and affected ~~with~~ by:

(1) ~~a~~ A fetal alcohol spectrum disorder;

(2) Maternal substance abuse resulting in prenatal drug exposure to an illegal or a legal substance; or

(3) Withdrawal symptoms resulting from prenatal drug exposure to an illegal or a legal substance.

(c)(1) ~~The department shall develop a~~ A plan of safe care shall be developed for infants affected ~~with~~ by:

(A) ~~a~~ A fetal alcohol spectrum disorder;

(B) Maternal substance abuse resulting in prenatal drug exposure to an illegal or a legal substance; or

(C) Withdrawal symptoms resulting from prenatal drug exposure to an illegal or a legal substance.

(2)(A) The plan of safe care shall be designed to ensure the safety and well-being of an infant following the release of the infant from the care of a healthcare provider.

(B) A plan of safe care shall include content that addresses the health and substance use disorder treatment needs of the infant and affected family or caregiver.

APPROVED: 3/29/19

§ 5106a. Grants to States for child abuse or neglect prevention and treatment programs

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

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

(2)

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

(B)improving legal preparation and representation, including--

(i)procedures for appealing and responding to appeals of substantiated reports of child abuse or neglect; and

(ii)provisions for the appointment of an individual appointed to represent a child in judicial proceedings;

(3)case management, including ongoing case monitoring, and delivery of services and treatment provided to children and their families;

(4)enhancing the general child protective system by developing, improving, and implementing risk and safety assessment tools and protocols, including the use of differential response;

(5)developing and updating systems of technology that support the program and track reports of child abuse and neglect from intake through final disposition and allow interstate and intrastate information exchange;

(6)developing, strengthening, and facilitating training including--

(A)training regarding research-based strategies, including the use of differential response, to promote collaboration with the families;

(B)training regarding the legal duties of such individuals;

(C)personal safety training for case workers; and

(D)training in early childhood, child, and adolescent development;

(7)improving the skills, qualifications, and availability of individuals providing services to children and families, and the supervisors of such individuals, through the child protection system, including improvements in the recruitment and retention of caseworkers;

(8)developing, facilitating the use of, and implementing research-based strategies and training protocols for individuals mandated to report child abuse and neglect;

(9)developing, implementing, or operating programs to assist in obtaining or coordinating necessary services for families of disabled infants with life-threatening conditions, including--

(A)existing social and health services;

(B)financial assistance;

(C)services necessary to facilitate adoptive placement of any such infants who have been relinquished for adoption; and

(D)the use of differential response in preventing child abuse and neglect;

(10)developing and delivering information to improve public education relating to the role and responsibilities of the child protection system and the nature and basis for reporting suspected incidents of child abuse and neglect, including the use of differential response;

(11)developing and enhancing the capacity of community-based programs to integrate shared leadership strategies between parents and professionals to prevent and treat child abuse and neglect at the neighborhood level;

(12)supporting and enhancing interagency collaboration between the child protection system and the juvenile justice system for improved delivery of services and treatment, including methods for continuity of treatment plan and services as children transition between systems;

(13)supporting and enhancing interagency collaboration among public health agencies, agencies in the child protective service system, and agencies carrying out private community-based programs--

(A)to provide child abuse and neglect prevention and treatment services (including linkages with education systems), and the use of differential response; and

(B)to address the health needs, including mental health needs, of children identified as victims of child abuse or neglect[;], including supporting prompt, comprehensive health and developmental evaluations for children who are the subject of substantiated child maltreatment reports; or

(14)developing and implementing procedures for collaboration among child protective services, domestic violence services, and other agencies in--

(A)investigations, interventions, and the delivery of services and treatment provided to children and families, including the use of differential response, where appropriate; and

(B)the provision of services that assist children exposed to domestic violence, and that also support the caregiving role of their nonabusing parents.

(b) Eligibility requirements.

(1) State plan.

(A) In general. To be eligible to receive a grant under this section, a State shall submit to the Secretary a State plan that specifies the areas of the child protective services system described in subsection (a) that the State will address with amounts received under the grant.

(B) Duration of plan. Each State plan shall--

(i)remain in effect for the duration of the State's participation under this section; and

(ii)be periodically reviewed and revised as necessary by the State to reflect changes in the State's strategies and programs under this section.

(C) Additional information. The State shall provide notice to the Secretary--

(i)of any substantive changes, including any change to State law or regulations, relating to the prevention of child abuse and neglect that may affect the eligibility of the State under this section; and

(ii)of any significant changes in how funds provided under this section are used to support activities described in this section, which may differ from the activities described in the current State application.

(2) Contents. A State plan submitted under paragraph (1) shall contain a description of the activities that the State will carry out using amounts received under the grant to achieve the objectives of this *title [42 USCS §§ 5101* et seq.], including--

(A)an assurance that the State plan, to the maximum extent practicable, is coordinated with the State plan under part B of title IV of the Social Security Act (*42 U.S.C. 621* et seq.) relating to child welfare services and family preservation and family support services;

(B)an assurance in the form of a certification by the Governor of the State that the State has in effect and is enforcing a State law, or has in effect and is operating a statewide program, relating to child abuse and neglect that includes--

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

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

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

(II)require prosecution for any illegal action;

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

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

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

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

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

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

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

(viii)methods to preserve the confidentiality of all records in order to protect the rights of the child and of the child's parents or guardians, including requirements ensuring that reports and records made and maintained pursuant to the purposes of this Act [*42 USCS §§ 5101* et seq.] shall only be made available to--

(I)individuals who are the subject of the report;

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

(III)child abuse citizen review panels;

(IV)child fatality review panels;

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

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

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

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

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

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

(xiii)provisions and procedures requiring that in every case involving a victim of child abuse or neglect which results in a judicial proceeding, a guardian ad litem, who has received training appropriate to the role, including training in early childhood, child, and adolescent development, and who may be an attorney or a court appointed special advocate who has received training appropriate to that role (or both), shall be appointed to represent the child in such proceedings--

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

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

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

(xv)provisions, procedures, and mechanisms--

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(D)a description of--

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

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

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

(iv)policies and procedures encouraging the appropriate involvement of families in decisionmaking pertaining to children who experienced child abuse or neglect;

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

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

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

(F)an assurance or certification that programs and training conducted under this title address the unique needs of unaccompanied homeless youth, including access to enrollment and support services and that such youth are eligible for under parts B and E of title IV of the Social Security Act (*42 U.S.C. 621* et seq., *670* et seq.) and meet the requirements of the McKinney-Vento Homeless Assistance Act (*42 U.S.C. 11301* et seq.); and

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

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

(3) Limitation. With regard to clauses (vi) and (vii) of paragraph (2)(B), nothing in this section shall be construed as restricting the ability of a State to refuse to disclose identifying information concerning the

individual initiating a report or complaint alleging suspected instances of child abuse or neglect, except that the State may not refuse such a disclosure where a court orders such disclosure after such court has reviewed, in camera, the record of the State related to the report or complaint and has found it has reason to believe that the reporter knowingly made a false report.

(4) Definitions. For purposes of this subsection--

(A)the term "near fatality" means an act that, as certified by a physician, places the child in serious or critical condition; and

(B)the term "serious bodily injury" means bodily injury which involves substantial risk of death, extreme physical pain, protracted and obvious disfigurement, or protracted loss or impairment of the function of a bodily member, organ, or mental faculty.

(c) Citizen review panels.

(1) Establishment.

(A) In general. Except as provided in subparagraph (B), each State to which a grant is made under this section shall establish not less than 3 citizen review panels.

(B) Exceptions.

(i) Establishment of panels by states receiving minimum allotment. A State that receives the minimum allotment of $ 175,000 under section 203(b)(1)(A) [*42 USCS § 5116b(b)(1)(A)*] for a fiscal year shall establish not less than 1 citizen review panel.

(ii) Designation of existing entities. A State may designate as panels for purposes of this subsection one or more existing entities established under State or Federal law, such as child fatality panels or foster care review panels, if such entities have the capacity to satisfy the requirements of paragraph (4) and the State ensures that such entities will satisfy such requirements.

(2) Membership. Each panel established pursuant to paragraph (1) shall be composed of volunteer members who are broadly representative of the community in which such panel is established, including members who have expertise in the prevention and treatment of child abuse and neglect, and may include adult former victims of child abuse or neglect.

(3) Meetings. Each panel established pursuant to paragraph (1) shall meet not less than once every 3 months.

(4) Functions.

(A) In general. Each panel established pursuant to paragraph (1) shall, by examining the policies, procedures, and practices of State and local agencies and where appropriate, specific cases, evaluate the extent to which State and local child protection system agencies are effectively discharging their child protection responsibilities in accordance with--

(i)the State plan under subsection (b);

(ii)the child protection standards set forth in subsection (b); and

(iii)any other criteria that the panel considers important to ensure the protection of children, including--

(I)a review of the extent to which the State and local child protective services system is coordinated with the foster care and adoption programs established under part E of title IV of the Social Security Act (*42 U.S.C. 670* et seq.); and

(II)a review of child fatalities and near fatalities (as defined in subsection (b)(4)).

(B) Confidentiality.

(i) In general. The members and staff of a panel established under paragraph (1)--

(I)shall not disclose to any person or government official any identifying information about any specific child protection case with respect to which the panel is provided information; and

(II)shall not make public other information unless authorized by State statute.

(ii) Civil sanctions. Each State that establishes a panel pursuant to paragraph (1) shall establish civil sanctions for a violation of clause (i).

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

(5) State assistance. Each State that establishes a panel pursuant to paragraph (1)--

(A)shall provide the panel access to information on cases that the panel desires to review if such information is necessary for the panel to carry out its functions under paragraph (4); and

(B)shall provide the panel, upon its request, staff assistance for the performance of the duties of the panel.

(6) Reports. Each panel established under paragraph (1) shall prepare and make available to the State and the public, on an annual basis, a report containing a summary of the activities of the panel and recommendations to improve the child protection services system at the State and local levels. Not later than 6 months after the date on which a report is submitted by the panel to the State, the appropriate State agency shall submit a written response to State and local child protection systems and the citizen review panel that describes whether or how the State will incorporate the recommendations of such panel (where appropriate) to make measurable progress in improving the State and local child protective system.

(d) Annual State data reports. Each State to which a grant is made under this section shall annually work with the Secretary to provide, to the maximum extent practicable, a report that includes the following:

(1) The number of children who were reported to the State during the year as victims of child abuse or neglect.

(2) Of the number of children described in paragraph (1), the number with respect to whom such reports were--

(A)substantiated;

(B)unsubstantiated; or

(C)determined to be false.

(3) Of the number of children described in paragraph (2)--

(A)the number that did not receive services during the year under the State program funded under this section or an equivalent State program;

(B)the number that received services during the year under the State program funded under this section or an equivalent State program; and

(C)the number that were removed from their families during the year by disposition of the case.

(4) The number of families that received preventive services, including use of differential response, from the State during the year.

(5) The number of deaths in the State during the year resulting from child abuse or neglect.

(6) Of the number of children described in paragraph (5), the number of such children who were in foster care.

(7)

(A) The number of child protective service personnel responsible for the--

(i)intake of reports filed in the previous year;

(ii)screening of such reports;

(iii)assessment of such reports; and

(iv)investigation of such reports.

(B) The average caseload for the workers described in subparagraph (A).

(8) The agency response time with respect to each such report with respect to initial investigation of reports of child abuse or neglect.

(9) The response time with respect to the provision of services to families and children where an allegation of child abuse or neglect has been made.

(10) For child protective service personnel responsible for intake, screening, assessment, and investigation of child abuse and neglect reports in the State--

(A)information on the education, qualifications, and training requirements established by the State for child protective service professionals, including for entry and advancement in the profession, including advancement to supervisory positions;

(B)data on the education, qualifications, and training of such personnel;

(C)demographic information of the child protective service personnel; and

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

(11) The number of children reunited with their families or receiving family preservation services that, within five years, result in subsequent substantiated reports of child abuse or neglect, including the death of the child.

(12) The number of children for whom individuals were appointed by the court to represent the best interests of such children and the average number of out of court contacts between such individuals and children.

(13) The annual report containing the summary of the activities of the citizen review panels of the State required by subsection (c)(6).

(14) The number of children under the care of the State child protection system who are transferred into the custody of the State juvenile justice system.

(15) The number of children referred to a child protective services system under subsection (b)(2)(B)(ii).

(16) The number of children determined to be eligible for referral, and the number of children referred, under subsection (b)(2)(B)(xxi), to agencies providing early intervention services under part C of the Individuals with Disabilities Education Act (*20 U.S.C. 1431* et seq.).

(17) The number of children determined to be victims described in subsection (b)(2)(B)(xxiv).

[18](17) The number of infants--

(A)identified under subsection (b)(2)(B)(ii);

(B)for whom a plan of safe care was developed under subsection (b)(2)(B)(iii); and

(C)for whom a referral was made for appropriate services, including services for the affected family or caregiver, under subsection (b)(2)(B)(iii).

(e) Annual report by the Secretary. Within 6 months after receiving the State reports under subsection (d), the Secretary shall prepare a report based on information provided by the States for the fiscal year under such

subsection and shall make the report and such information available to the Congress and the national clearinghouse for information relating to child abuse and neglect.

(f) Allotments.

(1) Definitions. In this subsection:

(A) Fiscal year 2009 grant funds. The term "fiscal year 2009 grant funds" means the amount appropriated under section 112 [*42 USCS § 5106h*] for fiscal year 2009, and not reserved under section 112(a)(2) [*42 USCS § 5106h(a)(2)*].

(B) Grant funds. The term "grant funds" means the amount appropriated under section 112 [*42 USCS § 5106h*] for a fiscal year and not reserved under section 112(a)(2) [*42 USCS § 5106h(a)(2)*].

(C) State. The term "State" means each of the several States, the District of Columbia, and the Commonwealth of Puerto Rico.

(D) Territory. The term "territory" means Guam, American Samoa, the United States Virgin Islands, and the Commonwealth of the Northern Mariana Islands.

(2) In general. Except as otherwise provided in this section, the Secretary shall make allotments to each State and territory that applies for a grant under this section in an amount equal to the sum of--

(A)$ 50,000; and

(B)an amount that bears the same relationship to any grant funds remaining after all such States and territories have received $ 50,000, as the number of children under the age of 18 in the State or territory bears to the number of such children in all States and territories that apply for such a grant.

(3) Allotments for decreased appropriation years. In the case where the grant funds for a fiscal year are less than the fiscal year 2009 grant funds, the Secretary shall ratably reduce each of the allotments under paragraph (2) for such fiscal year.

(4) Allotments for increased appropriation years.

(A) Minimum allotments to States for increased appropriations years. In any fiscal year for which the grant funds exceed the fiscal year 2009 grant funds by more than $ 1,000,000, the Secretary shall adjust the allotments under paragraph (2), as necessary, such that no State that applies for a grant under this section receives an allotment in an amount that is less than--

(i)$ 100,000, for a fiscal year in which the grant funds exceed the fiscal year 2009 grant funds by more than $ 1,000,000 but less than $ 2,000,000;

(ii)$ 125,000, for a fiscal year in which the grant funds exceed the fiscal year 2009 grant funds by at least $ 2,000,000 but less than $ 3,000,000; and

(iii)$ 150,000, for a fiscal year in which the grant funds exceed the fiscal year 2009 grant funds by at least $ 3,000,000.

(B) Allotment adjustment. In the case of a fiscal year for which subparagraph (A) applies and the grant funds are insufficient to satisfy the requirements of such subparagraph (A), paragraph (2), and paragraph (5), the Secretary shall, subject to paragraph (5), ratably reduce the allotment of each State for which the allotment under paragraph (2) is an amount that exceeds the applicable minimum under subparagraph (A), as necessary to ensure that each State receives the applicable minimum allotment under subparagraph (A).

(5) Hold harmless. Notwithstanding paragraphs (2) and (4), except as provided in paragraph (3), no State or territory shall receive a grant under this section in an amount that is less than the amount such State or territory received under this section for fiscal year 2009.

History

(Jan. 31, 1974,*P.L. 93-247*, Title I, § 106 [107][8], as added April 25, 1988, *P.L. 100-294*, Title I, § 101, *102 Stat. 103*; Oct. 25, 1989, *P.L. 101-126*, § 3(a)(1), (2), *103 Stat. 764*; May 28, 1992, *P.L. 102-295*, Title I, Subtitle B, § 114(a)-(c), *106 Stat. 192*; Nov. 4, 1992, *P.L. 102-586*, § 9(b), *106 Stat. 5037*; Oct. 3, 1996, *P.L. 104-235*, Title I, Subtitle A, §§ 107, 113(a)(1)(A), *110 Stat. 3071*, 3079.)

(As amended June 25, 2003,*P.L. 108-36*, Title I, Subtitle A, § 114(a)-(d), *117 Stat. 808*; Dec. 20, 2010, *P.L. 111-320*, Title I, Subtitle A, § 115, *124 Stat. 3467*; May 29, 2015, *P.L. 114-22*, Title VIII, § 802(b), *129 Stat. 263*; July 22, 2016, *P.L. 114-198*, Title V, § 503(b), (c), *130 Stat. 729*; Jan. 7, 2019, *P.L. 115-424*, § 3(a), *132 Stat. 5470*.)

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