Supreme Court No. S274943
IN THE SUPREME COURT OF THE STATE OF CALIFORNIA

IN THE MATTER OF N.R., Minor.	Court of Appeal No. B312001 Superior Court Nos. 20CCJP06523, 20CCJP06523A
Los Angeles Department of Children and Family Services, Petitioner and Respondent, v. O.R., Objector and Appellant.	

Exhibits to Appellant's Judicial Notice Request

After the Unpublished Decision by the Second District Court of Appeal, Division Five Filed April 29, 2022

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By appointment of the Supreme Court of California under California Appellate Project-Los Angeles Independent Case System

Exhibits Appellant Requests This Court to Judicially Notice

Appellant, O.R., respectfully submits the attached exhibits he requests this Court to take judicial notice of.

Dated: December 14, 2022.

Respectfully submitted by,

/S/

Sean Burleigh, Attorney for Appellant

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Exhibit A: Selected Portions of the DSM-V-TR

Preface to DSM-5

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) is a classification of mental disorders with associated criteria designed to facilitate more reliable diagnoses of these disorders. With successive editions over the past 60 years, it has become a standard reference for clinical practice in the mental health field. Since a complete description of the underlying pathological processes is not possible for most mental disorders, it is important to emphasize that the current diagnostic criteria are the best available description of how mental disorders are expressed and can be recognized by trained clinicians. DSM is intended to serve as a practical, functional, and flexible guide for organizing information that can aid in the accurate diagnosis and treatment of mental disorders. It is a tool for clinicians, an essential educational resource for students and practitioners, and a reference for researchers in the field.

Although this edition of DSM was designed first and foremost to be a useful guide to clinical practice, as an official nomenclature it must be applicable in a wide diversity of contexts. DSM has been used by clinicians and researchers from different orientations (biological, psychodynamic, cognitive, behavioral, interpersonal, family/systems), all of whom strive for a common language to communicate the essential characteristics of mental disorders presented by their patients. The information is of value to all professionals associated with various aspects of mental health care, including psychiatrists, other physicians, psychologists, social workers, nurses, counselors, forensic and legal specialists, occupational and rehabilitation therapists, and other health professionals. The criteria are concise and explicit and intended to facilitate an objective assessment of symptom presentations in a variety of clinical settings—inpatient, outpatient, partial hospital, consultation-liaison, clinical, private practice, and primary care—as well in general community epidemiological studies of mental disorders. DSM-5 is also a tool for collecting and communicating accurate public health statistics on mental disorder morbidity and mortality rates. Finally, the criteria and corresponding text serve as a textbook for students early in their profession who need a structured way to understand and diagnose mental disorders as well as for seasoned professionals encountering rare disorders for the first time. Fortunately, all of these uses are mutually compatible.

These diverse needs and interests were taken into consideration in planning DSM-5. The classification of disorders is harmonized with the World Health Organization's *International Classification of Diseases* (ICD), the official coding system used in the United States, so that the DSM criteria define disorders identified by ICD diagnostic names and code numbers. In DSM-5, both ICD-9-CM and ICD-10-CM codes (the latter scheduled for adoption in October 2015) are attached to the relevant disorders in the classification.

Although DSM-5 remains a categorical classification of separate disorders, we recognize that mental disorders do not always fit completely within the boundaries of a single disorder. Some symptom domains, such as depression and anxiety, involve multiple diagnostic categories and may reflect common underlying vulnerabilities for a larger group of disorders. In recognition of this reality, the disorders included in DSM-5 were reordered into a revised organizational structure meant to stimulate new clinical perspectives. This new structure corresponds with the organizational arrangement of disorders planned for ICD-11 scheduled for release in 2015. Other enhancements have been introduced to promote ease of use across all settings:

- **Representation of developmental issues related to diagnosis.** The change in chapter organization better reflects a lifespan approach, with disorders more frequently diagnosed in childhood (e.g., neurodevelopmental disorders) at the beginning of the manual and disorders more applicable to older adulthood (e.g., neurocognitive disorders) at the end of the manual. Also, within the text, subheadings on development and course provide descriptions of how disorder presentations may change across the lifespan. Age-related factors specific to diagnosis (e.g., symptom presentation and prevalence differences in certain age groups) are also included in the text. For added emphasis, these age-related factors have been added to the criteria themselves where applicable (e.g., in the criteria sets for insomnia disorder and posttraumatic stress disorder, specific criteria describe how symptoms might be expressed in children). Likewise, gender and cultural issues have been integrated into the disorders where applicable.
- **Integration of scientific findings from the latest research in genetics and neuroimaging.** The revised chapter structure was informed by recent research in neuroscience and by emerging genetic linkages between diagnostic groups. Genetic and physiological risk factors, prognostic indicators, and some putative diagnostic markers are highlighted in the text. This new structure should improve clinicians' ability to identify diagnoses in a disorder spectrum based on common neurocircuitry, genetic vulnerability, and environmental exposures.
- **Consolidation of autistic disorder, Asperger's disorder, and pervasive developmental disorder into autism spectrum disorder.** Symptoms of these disorders represent a single continuum of mild to severe impairments in the two domains of social communication and restrictive repetitive behaviors/interests rather than being distinct disorders. This change is designed to improve the sensitivity and specificity of the criteria for the diagnosis of autism spectrum disorder and to identify more focused treatment targets for the specific impairments identified.
- **Streamlined classification of bipolar and depressive disorders.** Bipolar and depressive disorders are the most commonly diagnosed conditions in psychiatry. It was therefore important to streamline the presentation of these disorders to enhance both clinical and educational use. Rather than separating the definition of manic, hypomanic, and major depressive episodes from the definition of bipolar I disorder, bipolar II disorder, and major depressive disorder as in the previous edition, we included all of the component criteria within the respective criteria for each disorder. This approach will facilitate bedside diagnosis and treatment of these important disorders. Likewise, the explanatory notes for differentiating bereavement and major depressive disorder will provide far greater clinical guidance than was previously provided in the simple bereavement exclusion criterion. The new specifiers of anxious distress and mixed features are now fully described in the narrative on specifier variations that accompanies the criteria for these disorders.
- **Restructuring of substance use disorders for consistency and clarity.** The categories of substance abuse and substance dependence have been eliminated and replaced with an overarching new category of substance use disorders—with the specific substance used defining the specific disorders. "Dependence" has been easily confused with the term "addiction" when, in fact, the tolerance and withdrawal that previously defined dependence are actually very normal responses to prescribed medications that affect the central nervous system and do not necessarily indicate the presence of an addiction. By revising and clarifying these criteria in DSM-5, we hope to alleviate some of the widespread misunderstanding about these issues.
- **Enhanced specificity for major and mild neurocognitive disorders.** Given the explosion in neuroscience, neuropsychology, and brain imaging over the past 20 years, it was critical to convey the current state-of-the-art in the diagnosis of specific types of disorders that were previously referred to as the "dementias" or organic brain diseases. Biological markers identified by imaging for vascular and traumatic brain disorders and

specific molecular genetic findings for rare variants of Alzheimer's disease and Huntington's disease have greatly advanced clinical diagnoses, and these disorders and others have now been separated into specific subtypes.

- **Transition in conceptualizing personality disorders.** Although the benefits of a more dimensional approach to personality disorders have been identified in previous editions, the transition from a categorical diagnostic system of individual disorders to one based on the relative distribution of personality traits has not been widely accepted. In DSM-5, the categorical personality disorders are virtually unchanged from the previous edition. However, an alternative "hybrid" model has been proposed in Section III to guide future research that separates interpersonal functioning assessments and the expression of pathological personality traits for six specific disorders. A more dimensional profile of personality trait expression is also proposed for a trait-specified approach.
- **Section III: new disorders and features.** A new section (Section III) has been added to highlight disorders that require further study but are not sufficiently well established to be a part of the official classification of mental disorders for routine clinical use. Dimensional measures of symptom severity in 13 symptom domains have also been incorporated to allow for the measurement of symptom levels of varying severity across all diagnostic groups. Likewise, the WHO Disability Assessment Schedule (WHODAS), a standard method for assessing global disability levels for mental disorders that is based on the International Classification of Functioning, Disability and Health (ICF) and is applicable in all of medicine, has been provided to replace the more limited Global Assessment of Functioning scale. It is our hope that as these measures are implemented over time, they will provide greater accuracy and flexibility in the clinical description of individual symptomatic presentations and associated disability during diagnostic assessments.
- **Online enhancements.** DSM-5 features online supplemental information. Additional cross-cutting and diagnostic severity measures are available online (www.psychiatry.org/dsm5), linked to the relevant disorders. In addition, the Cultural Formulation Interview, Cultural Formulation Interview—Informant Version, and supplementary modules to the core Cultural Formulation Interview are also included online at www.psychiatry.org/dsm5.

These innovations were designed by the leading authorities on mental disorders in the world and were implemented on the basis of their expert review, public commentary, and independent peer review. The 13 work groups, under the direction of the DSM-5 Task Force, in conjunction with other review bodies and, eventually, the APA Board of Trustees, collectively represent the global expertise of the specialty. This effort was supported by an extensive base of advisors and by the professional staff of the APA Division of Research; the names of everyone involved are too numerous to mention here but are listed in the Appendix. We owe tremendous thanks to those who devoted countless hours and invaluable expertise to this effort to improve the diagnosis of mental disorders.

We would especially like to acknowledge the chairs, text coordinators, and members of the 13 work groups, listed in the front of the manual, who spent many hours in this volunteer effort to improve the scientific basis of clinical practice over a sustained 6-year period. Susan K. Schultz, M.D., who served as text editor, worked tirelessly with Emily A. Kuhl, Ph.D., senior science writer and DSM-5 staff text editor, to coordinate the efforts of the work groups into a cohesive whole. William E. Narrow, M.D., M.P.H., led the research group that developed the overall research strategy for DSM-5, including the field trials, that greatly enhanced the evidence base for this revision. In addition, we are grateful to those who contributed so much time to the independent review of the revision proposals, including Kenneth S. Kendler, M.D., and Robert Freedman, M.D., co-chairs of the Scientific Review Committee; John S. McIntyre, M.D., and Joel Yager, M.D., co-chairs of the Clinical and Public Health Committee; and Glenn Martin, M.D., chair of the APA Assem-

bly review process. Special thanks go to Helena C. Kraemer, Ph.D., for her expert statistical consultation; Michael B. First, M.D., for his valuable input on the coding and review of criteria; and Paul S. Appelbaum, M.D., for feedback on forensic issues. Maria N. Ward, M.Ed., RHIT, CCS-P, also helped in verifying all ICD coding. The Summit Group, which included these consultants, the chairs of all review groups, the task force chairs, and the APA executive officers, chaired by Dilip V. Jeste, M.D., provided leadership and vision in helping to achieve compromise and consensus. This level of commitment has contributed to the balance and objectivity that we feel are hallmarks of DSM-5.

We especially wish to recognize the outstanding APA Division of Research staff—identified in the Task Force and Work Group listing at the front of this manual—who worked tirelessly to interact with the task force, work groups, advisors, and reviewers to resolve issues, serve as liaisons between the groups, direct and manage the academic and routine clinical practice field trials, and record decisions in this important process. In particular, we appreciate the support and guidance provided by James H. Scully Jr., M.D., Medical Director and CEO of the APA, through the years and travails of the development process. Finally, we thank the editorial and production staff of American Psychiatric Publishing—specifically, Rebecca Rinehart, Publisher; John McDuffie, Editorial Director; Ann Eng, Senior Editor; Greg Kuny, Managing Editor; and Tammy Cordova, Graphics Design Manager—for their guidance in bringing this all together and creating the final product. It is the culmination of efforts of many talented individuals who dedicated their time, expertise, and passion that made DSM-5 possible.

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December 19, 2012

Substance-Related and Addictive Disorders

The substance-related disorders encompass 10 separate classes of drugs: alcohol; caffeine; cannabis; hallucinogens (with separate categories for phencyclidine [or similarly acting arylcyclohexylamines] and other hallucinogens); inhalants; opioids; sedatives, hypnotics, or anxiolytics; stimulants (amphetamine-type substances, cocaine, and other stimulants); tobacco; and other (or unknown) substances. These 10 classes are not fully distinct. All drugs that are taken in excess have in common the ability to directly activate the brain reward systems, which are involved in the reinforcement of behaviors and establishment of memories. Instead of achieving reward system activation through adaptive behaviors, these substances produce such an intense activation of the reward system that normal activities may be neglected. The pharmacological mechanisms by which each class of drugs produces reward are different, but the drugs typically activate the system and produce feelings of pleasure, often referred to as a "high." Furthermore, studies suggest that the neurobiological roots of substance use disorders for some individuals can be seen in their behaviors long before the onset of actual substance use (e.g., lower levels of self-control may reflect impairments of brain inhibitory mechanisms); research also suggests the negative impact of substance use itself on brain inhibitory mechanisms.

Note that the phrase "drug addiction" is not applied as a diagnostic term in this classification, although it is in common usage in many countries to describe severe problems related to compulsive and habitual use of substances. The more neutral term *substance use disorder* is used to describe the wide range of the disorder, from a mild form to a severe state of chronically relapsing, compulsive pattern of drug taking. Some clinicians will choose to use the phrase "drug addiction" to describe more severe presentations, but that wording is omitted from the official DSM-5 substance use disorder diagnostic terminology because of its uncertain definition and its potentially negative connotation.

In addition to the substance-related disorders, this chapter also includes gambling disorder, reflecting evidence that gambling behaviors activate reward systems similar to those activated by drugs of abuse and that produce some behavioral symptoms that appear comparable to those produced by the substance use disorders. Other excessive behavioral patterns, such as Internet gaming (see "Conditions for Further Study"), have also been described, but the research on these and other behavioral syndromes is less clear. Thus, groups of repetitive behaviors, sometimes termed *behavioral addictions* (with subcategories such as "sex addiction," "exercise addiction," and "shopping addiction"), are not included because there is insufficient peer-reviewed evidence to establish the diagnostic criteria and course descriptions needed to identify these behaviors as mental disorders.

The substance-related disorders are divided into two groups: substance use disorders and substance-induced disorders. The following conditions may be classified as substance-induced: substance intoxication, substance withdrawal, and substance/medication-induced mental disorders (diagnostic criteria and text are provided in this manual for substance/medication-induced psychotic disorders, bipolar and related disorders, depressive disorders, anxiety disorders, obsessive-compulsive and related disorders, sleep disorders, sexual dysfunctions, delirium, and neurocognitive disorders in their respective chapters). The term

substance/medication-induced mental disorder refers to symptomatic presentations that are due to the physiological effects of an exogenous substance on the central nervous system and includes typical intoxicants (e.g., alcohol, inhalants, cocaine), psychotropic medications (e.g., stimulants, sedative-hypnotics), other medications, (e.g., steroids), and environmental toxins (e.g., organophosphate insecticides).

The current section begins with a general discussion of criteria sets for substance use disorder, substance intoxication, substance withdrawal, and substance/medication-induced mental disorders, at least some of which are applicable across classes of substances. Reflecting some unique aspects of the 10 substance classes relevant to this chapter, the remainder of the chapter is organized by substance class. To facilitate differential diagnosis, the diagnostic criteria and text for the substance/medication-induced mental disorders are included with disorders with which they share phenomenology (e.g., substance/medication-induced depressive disorder is in the chapter "Depressive Disorders"). Note that only certain classes of drugs are capable of causing particular types of substance-induced disorders. The substance-related diagnostic categories associated with specific drug classes are shown in Table 1.

Substance-Related Disorders

Substance Use Disorders

Diagnostic Features

The essential feature of a substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems. As seen in Table 1, the diagnosis of a substance use disorder can be applied to all 10 substance classes included in this chapter except caffeine. For certain classes, some symptoms are less salient, and in a few instances not all symptoms apply (e.g., withdrawal symptoms are not specified for phencyclidine use disorder, other hallucinogen use disorder, or inhalant use disorder). Of note, the consumption of substances, including prescribed medications, may depend in part on cultural background, substance availability, and specific local drug regulations. Thus, there can be significant local or cultural variation in exposure (e.g., countries with cultural prohibitions against alcohol or other substance use may have a lower prevalence of substance-related disorders).

An important characteristic of substance use disorders is an underlying change in brain circuits that may persist beyond detoxification, particularly in individuals with severe disorders. The behavioral effects of these brain changes may be exhibited in the repeated relapses and intense drug craving when the individuals are exposed to drug-related stimuli. These persistent drug effects may benefit from long-term approaches to treatment.

Overall, the diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to use of the substance. To assist with organization, the diagnostic items making up Criterion A can be considered to fit within overall groupings of *impaired control, social impairment, risky use,* and *pharmacological criteria.* Impaired control over substance use is the first criteria grouping (Criteria 1–4). The individual may take the substance in larger amounts or over a longer period than was originally intended (Criterion 1). The individual may express a persistent desire to cut down or regulate substance use and may report mul-

TABLE 1 *Diagnoses associated with substance class*

	Psychotic disorders	Bipolar and related disorders	Depressive disorders	Anxiety disorders	Obsessive-compulsive and related disorders	Sleep disorders	Sexual dysfunctions	Delirium	Neurocognitive disorders	Substance use disorders	Substance intoxication	Substance withdrawal
Alcohol	I/W	I/W	I/W	I/W		I/W	I/W	I/W	X (mild; major)	X	X	X
Caffeine				I		I/W					X	X
Cannabis	I			I		I/W		I		X	X	X
Hallucinogens												
Phencyclidine	I	I	I	I				I		X	X	
Other hallucinogens	I*	I	I	I				I		X	X	
Inhalants	I		I	I				I	X (mild; major)	X	X	
Opioids			I/W	W		I/W	I/W	I/W		X	X	X
Sedatives, hypnotics, or anxiolytics	I/W	I/W	I/W	W		I/W	I/W	I/W	X (mild; major)	X	X	X
Stimulants**	I	I/W	I/W	I/W	I/W	I/W	I	I	X (mild)	X	X	X
Tobacco						W				X		X
Other (or unknown)	I/W	I/W	I/W	I/W	I/W	I/W	I/W	I/W	X (mild; major)	X	X	X

Note. X = The category is recognized in DSM-5.
I = The specifier "with onset during intoxication" may be noted for the category.
W = The specifier "with onset during withdrawal" may be noted for the category.
I/W = Either "with onset during intoxication" or "with onset during withdrawal" may be noted for the category.
Major = major neurocognitive disorder; mild = mild neurocognitive disorder.
*Also hallucinogen persisting perception disorder (flashbacks).
**Includes amphetamine-type substances, cocaine, and other or unspecified stimulants.

more severe clinical course (i.e., an earlier onset of a substance use disorder, higher levels of substance intake, and a greater number of substance-related problems).

Symptoms of tolerance and withdrawal occurring during appropriate use of prescribed medications given as part of medical treatment (e.g., opioid analgesics, sedatives, stimulants) are specifically *not* counted when diagnosing a substance use disorder. The appearance of normal, expected pharmacological tolerance and withdrawal during the course of medical treatment has been known to lead to an erroneous diagnosis of "addiction" even when these were the only symptoms present. Individuals whose *only* symptoms are those that occur as a result of medical treatment (i.e., tolerance and withdrawal as part of medical care when the medications are taken as prescribed) should not receive a diagnosis solely on the basis of these symptoms. However, prescription medications can be used inappropriately, and a substance use disorder can be correctly diagnosed when there are other symptoms of compulsive, drug-seeking behavior.

Severity and Specifiers

Substance use disorders occur in a broad range of severity, from mild to severe, with severity based on the number of symptom criteria endorsed. As a general estimate of severity, a *mild* substance use disorder is suggested by the presence of two to three symptoms, *moderate* by four to five symptoms, and *severe* by six or more symptoms. Changing severity across time is also reflected by reductions or increases in the frequency and/or dose of substance use, as assessed by the individual's own report, report of knowledgeable others, clinician's observations, and biological testing. The following course specifiers and descriptive features specifiers are also available for substance use disorders: "in early remission," "in sustained remission," "on maintenance therapy," and "in a controlled environment." Definitions of each are provided within respective criteria sets.

Recording Procedures

The clinician should use the code that applies to the substance class but record the name of the *specific substance*. For example, the clinician should record F13.20 moderate alprazolam use disorder (rather than moderate sedative, hypnotic, or anxiolytic use disorder) or F15.10 mild methamphetamine use disorder (rather than mild amphetamine-type substance use disorder). For substances that do not fit into any of the classes (e.g., anabolic steroids), the ICD-10-CM code for other (or unknown) substance use disorder should be used and the specific substance indicated (e.g., F19.10 mild anabolic steroid use disorder). If the substance taken by the individual is unknown, the same ICD-10-CM code (i.e., for "other [or unknown] substance use disorder") should be used (e.g., F19.20 severe unknown substance use disorder). If criteria are met for more than one substance use disorder, each should be diagnosed (e.g., F11.20 severe heroin use disorder; F14.20 moderate cocaine use disorder).

The appropriate ICD-10-CM code for a substance use disorder depends on whether there is a comorbid substance-induced disorder (including substance intoxication and substance withdrawal). In the first example in the paragraph above, the diagnostic code for moderate alprazolam use disorder, F13.20, reflects the absence of a comorbid alprazolam-induced mental disorder. Because ICD-10-CM codes for substance-induced disorders indicate both the presence (or absence) and the severity of the substance use disorder, ICD-10-CM codes for substance use disorders can be used only in the absence of a substance-induced disorder. See the individual substance-specific sections for additional coding information.

tiple unsuccessful efforts to decrease or discontinue use (Criterion 2). The individual may spend a great deal of time obtaining the substance, using the substance, or recovering from its effects (Criterion 3). In some instances of more severe substance use disorders, virtually all of the individual's daily activities revolve around the substance. Craving (Criterion 4) is manifested by an intense desire or urge for the drug that may occur at any time but is more likely when in an environment where the drug previously was obtained or used. Craving has also been shown to involve classical conditioning and is associated with activation of specific reward structures in the brain. Craving might be queried by asking if there has ever been a time when there were such strong urges to take the drug that the individual could not think of anything else. Current craving is often used as a treatment outcome measure because it may be a signal of impending relapse.

Social impairment is the second grouping of criteria (Criteria 5–7). Recurrent substance use may result in a failure to fulfill major role obligations at work, school, or home (Criterion 5). The individual may continue substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (Criterion 6). Important social, occupational, or recreational activities may be given up or reduced because of substance use (Criterion 7). The individual may withdraw from family activities and hobbies in order to use the substance.

Risky use of the substance is the third grouping of criteria (Criteria 8–9). This may take the form of recurrent substance use in situations in which it is physically hazardous (Criterion 8). The individual may continue substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (Criterion 9). The key issue in evaluating this criterion is not the existence of the problem, but rather the individual's failure to abstain from using the substance despite the difficulty it is causing.

Pharmacological criteria are the final grouping (Criteria 10 and 11). Tolerance (Criterion 10) is signaled by requiring a markedly increased dose of the substance to achieve the desired effect or a markedly reduced effect when the usual dose is consumed. The degree to which tolerance develops varies greatly across different individuals as well as across substances and may involve a variety of central nervous system effects. For example, tolerance to respiratory depression and tolerance to sedating and motor coordination may develop at different rates, depending on the substance. Tolerance may be difficult to determine by history alone, and laboratory tests may be helpful (e.g., high blood levels of the substance coupled with little evidence of intoxication suggest that tolerance is likely). Tolerance must also be distinguished from individual variability in the initial sensitivity to the effects of particular substances. For example, some first-time alcohol drinkers show very little evidence of intoxication with three or four drinks, whereas others of similar weight and drinking histories have slurred speech and incoordination.

Withdrawal (Criterion 11) is a syndrome that occurs when blood or tissue concentrations of a substance decline in an individual who had maintained prolonged, heavy use of the substance. After developing withdrawal symptoms, the individual is likely to consume the substance to relieve the symptoms. Withdrawal symptoms vary greatly across the classes of substances, and separate criteria sets for withdrawal are provided for the drug classes. Marked and generally easily measured physiological signs of withdrawal are common with alcohol, opioids, and sedatives, hypnotics, and anxiolytics. Withdrawal signs and symptoms with stimulants (amphetamine-type substances, cocaine, other or unspecified stimulants), as well as tobacco and cannabis, are often present but may be less apparent. Significant withdrawal has *not* been documented in humans after repeated use of phencyclidine, other hallucinogens, and inhalants; therefore, this criterion is not included for these substances. Neither tolerance nor withdrawal is necessary for a diagnosis of a substance use disorder. However, for most classes of substances, a past history of withdrawal is associated with a

criteria and discussion of delirium in the chapter "Neurocognitive Disorders." These sedative-, hypnotic-, or anxiolytic-induced mental disorders are diagnosed instead of sedative, hypnotic, or anxiolytic intoxication or sedative, hypnotic, or anxiolytic withdrawal only when the symptoms are sufficiently severe to warrant independent clinical attention.

Unspecified Sedative-, Hypnotic-, or Anxiolytic-Related Disorder

F13.99

This category applies to presentations in which symptoms characteristic of a sedative-, hypnotic-, or anxiolytic-related disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any specific sedative-, hypnotic-, or anxiolytic-related disorder or any of the disorders in the substance-related and addictive disorders diagnostic class.

Stimulant-Related Disorders

Stimulant Use Disorder
Stimulant Intoxication
Stimulant Withdrawal
Stimulant-Induced Mental Disorders
Unspecified Stimulant-Related Disorder

Stimulant Use Disorder

Diagnostic Criteria

A. A pattern of amphetamine-type substance, cocaine, or other stimulant use leading to clinically significant impairment or distress, as manifested by at least two of the following, occurring within a 12-month period:

1. The stimulant is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control stimulant use.
3. A great deal of time is spent in activities necessary to obtain the stimulant, use the stimulant, or recover from its effects.
4. Craving, or a strong desire or urge to use the stimulant.
5. Recurrent stimulant use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued stimulant use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the stimulant.
7. Important social, occupational, or recreational activities are given up or reduced because of stimulant use.

8. Recurrent stimulant use in situations in which it is physically hazardous.
9. Stimulant use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the stimulant.
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of the stimulant to achieve intoxication or desired effect.
    b. A markedly diminished effect with continued use of the same amount of the stimulant.

    Note: This criterion is not considered to be met for those taking stimulant medications solely under appropriate medical supervision, such as medications for attention-deficit/hyperactivity disorder or narcolepsy.
11. Withdrawal, as manifested by either of the following:
    a. The characteristic withdrawal syndrome for the stimulant (refer to Criteria A and B of the criteria set for stimulant withdrawal).
    b. The stimulant (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.

    Note: This criterion is not considered to be met for those taking stimulant medications solely under appropriate medical supervision, such as medications for attention-deficit/hyperactivity disorder or narcolepsy.

Specify if:

In early remission: After full criteria for stimulant use disorder were previously met, none of the criteria for stimulant use disorder have been met for at least 3 months but for less than 12 months (with the exception that Criterion A4, "Craving, or a strong desire or urge to use the stimulant," may be met).

In sustained remission: After full criteria for stimulant use disorder were previously met, none of the criteria for stimulant use disorder have been met at any time during a period of 12 months or longer (with the exception that Criterion A4, "Craving, or a strong desire or urge to use the stimulant," may be met).

Specify if:

In a controlled environment: This additional specifier is used if the individual is in an environment where access to stimulants is restricted.

Code based on current severity/remission: If an amphetamine-type substance intoxication, amphetamine-type substance withdrawal, or amphetamine-type substance-induced mental disorder is also present, do not use the codes below for amphetamine-type substance use disorder. Instead, the comorbid amphetamine-type substance use disorder is indicated in the 4th character of the amphetamine-type substance-induced disorder code (see the coding note for amphetamine-type substance intoxication, amphetamine-type substance withdrawal, or a specific amphetamine-type substance-induced mental disorder). For example, if there is comorbid amphetamine-induced depressive disorder and amphetamine use disorder, only the amphetamine-induced depressive disorder code is given, with the 4th character indicating whether the comorbid amphetamine use disorder is mild, moderate, or severe: F15.14 for mild amphetamine use disorder with amphetamine-induced depressive disorder or F15.24 for a moderate or severe amphetamine use disorder with amphetamine-induced depressive disorder. (The instructions for amphetamine-type substance also apply to other or unspecified stimulant intoxication, other or unspecified stimulant withdrawal, and other or unspecified stimulant-induced mental disorder.) Similarly, if there is comorbid cocaine-induced depressive disorder and cocaine use disorder, only the cocaine-induced depressive disorder code is given, with the 4th character indicating whether the comorbid cocaine use disorder is mild, moderate,

or severe: F14.14 for a mild cocaine use disorder with cocaine-induced depressive disorder or F14.24 for a moderate or severe cocaine use disorder with cocaine-induced depressive disorder.

Specify current severity/remission:

Mild: Presence of 2–3 symptoms.

F15.10 Amphetamine-type substance
F14.10 Cocaine
F15.10 Other or unspecified stimulant

Mild, In early remission

F15.11 Amphetamine-type substance
F14.11 Cocaine
F15.11 Other or unspecified stimulant

Mild, In sustained remission

F15.11 Amphetamine-type substance
F14.11 Cocaine
F15.11 Other or unspecified stimulant

Moderate: Presence of 4–5 symptoms.

F15.20 Amphetamine-type substance
F14.20 Cocaine
F15.20 Other or unspecified stimulant

Moderate, In early remission

F15.21 Amphetamine-type substance
F14.21 Cocaine
F15.21 Other or unspecified stimulant

Moderate, In sustained remission

F15.21 Amphetamine-type substance
F14.21 Cocaine
F15.21 Other or unspecified stimulant

Severe: Presence of 6 or more symptoms.

F15.20 Amphetamine-type substance
F14.20 Cocaine
F15.20 Other or unspecified stimulant

Severe, In early remission

F15.21 Amphetamine-type substance
F14.21 Cocaine
F15.21 Other or unspecified stimulant

Severe, In sustained remission

F15.21 Amphetamine-type substance
F14.21 Cocaine
F15.21 Other or unspecified stimulant

Specifiers

"In a controlled environment" applies as a further specifier of remission if the individual is both in remission and in a controlled environment (i.e., in early remission in a controlled environment or in sustained remission in a controlled environment). Examples of these environments are closely supervised and substance-free jails, therapeutic communities, and locked hospital units.

Exhibit B: Selected Portions of the DSM-III

Introduction

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This is the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association, better known simply as DSM-III. The development of this manual over the last five years has not gone unnoticed; in fact, it is remarkable how much interest (alarm, despair, excitement, joy) has been shown in successive drafts of this document. The reasons for this interest are many.

First of all, over the last decade there has been growing recognition of the importance of diagnosis for both clinical practice and research. Clinicians and research investigators must have a common language with which to communicate about the disorders for which they have professional responsibility. Planning a treatment program must begin with an accurate diagnostic assessment. The efficacy of various treatment modalities can be compared only if patient groups are described using diagnostic terms that are clearly defined.

Secondly, from its very beginning, drafts of DSM-III have been widely circulated for critical review and use by clinicians and investigators. This made them aware of the many fundamental ways in which DSM-III differs from its predecessor, DSM-II, and from its international contemporary, the mental disorders chapter of the ninth revision of the *International Classification of Diseases* (ICD-9). For example, DSM-III includes such new features as diagnostic criteria, a multiaxial approach to evaluation, much-expanded descriptions of the disorders and many additional categories (some with newly-coined names); and it does not include several time-honored categories.

Finally, interest in the development of this manual is due to awareness that DSM-III reflects an increased commitment in our field to reliance on data as the basis for understanding mental disorders.

BACKGROUND*

The first edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* appeared in 1952. This was the first official manual of mental disorders to contain a glossary of descriptions of the diagnostic categories. The use of the term "reaction" throughout the classification reflected the influence of Adolf Meyer's psychobiological view that mental disorders represented reactions of the personality to psychological, social, and biological factors. In the development of the second edition (DSM-II), a decision was made to base the classification on the mental disorders section of the eighth revision of the *International Classification of Diseases*, for which representatives of the American Psychiatric Association had provided consultation. Both DSM-II and

* Some readers may wish, for now, to skip *Background* and *The Process of Development of DSM-III* and plunge directly into *Basic Concepts* on p.5.

ICD-8 went into effect in 1968. The DSM-II classification did not use the term "reaction" and used diagnostic terms that by and large did not imply a particular theoretical framework for understanding the nonorganic mental disorders.

In 1974 the American Psychiatric Association, through its Council on Research and Development, appointed a Task Force on Nomenclature and Statistics to begin work on the development of DSM-III, recognizing that ICD-9 was scheduled to go into effect in January 1979. By the time this new Task Force was constituted, the mental disorders section of ICD-9, which included its own glossary, was nearly completed. Although representatives of the American Psychiatric Association had worked closely with the World Health Organization in the development of ICD-9, there was some concern that the ICD-9 classification and glossary would not be suitable for use in the United States. Most importantly, many specific areas of the classification did not seem sufficiently detailed for clinical and research use. For example, the ICD-9 classification contains only one category for "frigidity and impotence"—despite the substantial work in the area of psychosexual dysfunctions that has identified several specific types with different clinical pictures and treatment implications. In addition, the glossary of ICD-9 was believed by many to be less than optimal in that it had not made use of such recent major methodological developments as specified diagnostic criteria and the multiaxial approach to evaluation.

For these reasons the Task Force was directed to prepare a new classification and glossary that would, as much as possible, reflect the most current state of knowledge regarding mental disorders while maintaining compatibility with ICD-9. Like its predecessors, DSM-I and DSM-II, DSM-III had to be, first of all, clinically useful, while also providing a basis for research and administrative use.

The Task Force. Task Force members, and consultants from the fields of psychology and epidemiology, were selected because of their special interest in various aspects of diagnosis. Most had made significant contributions to the literature on diagnosis. As the work progressed, additional members were added to ensure representation of different perspectives and areas of expertise.

From the beginning, the Task Force functioned as a steering committee to oversee the ongoing work. All of its members shared a commitment to the attainment in DSM-III of the following goals:

—clinical usefulness for making treatment and management decisions in varied clinical settings;
—reliability of the diagnostic categories;
—acceptability to clinicians and researchers of varying theoretical orientations;
—usefulness for educating health professionals;
—maintaining compatibility with ICD-9, except when departures are unavoidable;
—avoiding the introduction of new terminology and concepts that break with tradition, except when clearly needed;
—reaching consensus on the meaning of necessary diagnostic terms that have been used inconsistently, and avoiding the use of terms that have outlived their usefulness;
—consistency with data from research studies bearing on the validity of diagnostic categories;

—suitability for describing subjects in research studies;
—being responsive during the development of DSM-III to critiques by clinicians and researchers.

The major job of the Task Force has been to determine the most effective strategies for ensuring that the final document attained each goal to as great an extent as possible without compromising the other goals. Thus, the Task Force evaluated all proposals for changes in DSM-III that might affect the attainment of these goals. These proposals came from members of the Task Force, advisory committees, liaison committees with professional organizations, and participants in the DSM-III Field Trials. Finally, the Task Force reviewed drafts of the text and diagnostic criteria.

In attempting to resolve various diagnostic issues, the Task Force relied, as much as possible, on research evidence relevant to various kinds of diagnostic validity. For example, when discussing a problematic diagnostic category, the Task Force considered how the disorder, if defined as proposed, provided information relevant to treatment planning, course, and familial pattern. It should come as no surprise to the reader that even when data were available from relevant research studies, Task Force members often differed in their interpretations of the findings.

Advisory Committees and Other Consultants. Successive drafts of DSM-III were prepared by fourteen advisory committees composed of individuals with special expertise in each substantive area. In addition, a group of consultants provided advice and information on a variety of special areas.

Council on Research and Development. This component of the American Psychiatric Association appointed the Task Force and regularly reviewed progress being made in the development of DSM-III. In addition, in the fall of 1978 the Council held an all-day meeting at which some APA members voiced concerns about certain aspects of DSM-III. After reviewing these concerns, the Council approved the Task Force's approach to solutions of the problems that had been raised.

Assembly Liaison Committee. In early 1976, the APA Assembly, composed of representatives from all of the APA's district branches, appointed a Liaison Committee to review the development of DSM-III and to report regularly to the Assembly. This committee received correspondence on major issues, reviewed successive drafts of DSM-III, and met a number of times with the chairperson of the Task Force. On several occasions the Assembly Liaison Committee arranged for the chairperson of the Task Force to discuss a particular controversial issue with the entire Assembly. The Assembly Liaison Committee was invaluable in articulating the concerns of the membership of the APA, which is composed largely of clinicians whose primary professional activity is patient care.

Other Components of the APA. The chairperson of the Task Force reported on several occasions to the Reference Committee and the Board of Trustees on specific issues of concern. In addition, in April 1979, a meeting was held with an

Ad Hoc Committee on DSM-III of the Board of Trustees to review specific concerns about DSM-III that had been expressed by members of the APA. Other components of the APA, such as the Committee on Confidentiality and the Committee on Women, also reviewed DSM-III from their own perspectives as it was being developed.

Liaison with Other Professional Organizations. The following groups that were particularly interested in the development of DSM-III established liaison committees with the Task Force: the Academy of Psychiatry and the Law, the American Academy of Child Psychiatry, the American Academy of Psychoanalysis, the American Association of Chairmen of Departments of Psychiatry, the American College Health Association, the American Orthopsychiatric Association, the American Psychoanalytic Association, and the American Psychological Association. These committees received drafts of DSM-III and were invited to make comments and suggestions and to express their concerns. In most instances, differences in points of view between a liaison committee and the Task Force were resolved to the satisfaction of all concerned. When this was not possible and differences were left unresolved, the issues were at least clarified.

THE PROCESS OF DEVELOPMENT OF DSM-III

In May 1975, at a special session of the Annual Meeting of the APA, an initial draft of the DSM-III classification was presented. At each subsequent Annual Meeting a special session was held on some aspect of DSM-III. In addition, a special conference was held in St. Louis, Missouri, in June 1976, to examine "DSM-III in Midstream." This conference, co-sponsored by the Missouri Institute of Psychiatry and the American Psychiatric Association, was attended by approximately 100 professionals with expertise or special interests in various aspects of DSM-III, most of whom had previously had no direct involvement in the development of DSM-III. As a result of discussions at this conference, additional diagnostic categories were added, some were deleted, and a decision was made to proceed with the development of the multiaxial system.

The DSM-III classification and the rationale for the strategies used in its development have been presented throughout the past four years at local, national, and international professional meetings. In addition, the 4/15/77 draft and successive drafts of DSM-III have been available to the profession for critical review. Throughout this period there has been continual consideration of various solutions to difficult diagnostic problems, often based on summaries of actual cases submitted to the Task Force from all quarters. Whenever possible, attempts have been made to seek the advice of experts in each specific area under consideration.

Field Trials. In the past, new classifications of mental disorders have not been extensively subjected to clinical trials before official adoption. The Task Force believed that field trials using drafts of DSM-III should be conducted during the development process to identify problem areas in the classification and to try out solutions to these problems. In addition, because of the many proposed changes in the classification, it was important to demonstrate its clini-

cal acceptability and usefulness in a variety of settings by clinicians of varying theoretical orientations.

For these reasons, a series of field trials was conducted, beginning in 1977 and culminating in a two year NIMH-sponsored field trial from September 1977 to September 1979. In all, 12,667 patients were evaluated by approximately 550 clinicians, 474 of whom were in 212 different facilities, using successive drafts of DSM-III. Critiques of all portions of DSM-III by the field trial participants resulted in numerous changes, as did reviews of case summaries submitted by those participants. Frequently, participants completed questionnaires regarding specific diagnostic issues and their attitudes toward DSM-III and its innovative features. The results indicated that the great majority of participants, regardless of theoretical orientations, had a favorable response to DSM-III.

Perhaps the most important part of the study was the evaluation of diagnostic reliability by having pairs of clinicians make independent diagnostic judgments of several hundred patients. The results, which are presented in an appendix, generally indicate far greater reliability than had previously been obtained with DSM-II.

ICD-9-CM. Because of dissatisfaction with ICD-9 expressed by organizations representing subspecialties of medicine (not including the American Psychiatric Association), a decision was made to modify the ICD-9 for use in the United States by expanding the four-digit ICD-9 codes to five-digit ICD-9-CM (for clinical modification) codes whenever greater specificity was required. This modification was prepared for the United States National Center for Health Statistics by the Council on Clinical Classifications. The American Psychiatric Association, in December 1976, was invited to submit recommendations for alternate names and additional categories based on subdivisions of already existing ICD-9 categories. This made it possible for the developing DSM-III classification and its diagnostic terms to be included in the ICD-9-CM classification, which in January 1979 became the official system in this country for recording all "diseases, injuries, impairments, symptoms, and causes of death." The ICD-9-CM codes and diagnostic terms for mental disorders are included in Appendix D.

Many ICD-9-CM codes and terms are not included in the DSM-III classification. However, these are generally acceptable to third party payers and most record-keeping systems.

Final Approval. In May 1979, at the Annual Meeting of the APA in Chicago, the Assembly and the Council on Research and Development formally approved the final draft of DSM-III. In June, it was approved by the Reference Committee and the Board of Trustees.

BASIC CONCEPTS

Mental Disorder. Although this manual provides a classification of mental disorders, there is no satisfactory definition that specifies precise boundaries for the concept "mental disorder" (also true for such concepts as physical disorder and

mental and physical health). Nevertheless, it is useful to present concepts that have influenced the decision to include certain conditions in DSM-III as mental disorders and to exclude others.

In DSM-III each of the mental disorders is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is typically associated with either a painful symptom (distress) or impairment in one or more important areas of functioning (disability). In addition, there is an inference that there is a behavioral, psychological, or biological dysfunction, and that the disturbance is not only in the relationship between the individual and society. (When the disturbance is *limited* to a conflict between an individual and society, this may represent social deviance, which may or may not be commendable, but is not by itself a mental disorder.)

In DSM-III there is no assumption that each mental disorder is a discrete entity with sharp boundaries (discontinuity) between it and other mental disorders, as well as between it and No Mental Disorder. For example, there has been a continuing controversy as to whether or not severe depressive disorder and mild depressive disorder differ from each other qualitatively (discontinuity between diagnostic entities) or quantitatively (a difference on a severity continuum). The inclusion of Major Depression With and Without Melancholia as separate categories in DSM-III is justified by the clinical usefulness of the distinction. This does not imply a resolution of the controversy as to whether or not these conditions are in fact quantitatively or qualitatively different.

A common misconception is that a classification of mental disorders classifies individuals, when actually what are being classified are disorders that individuals have. For this reason, the text of DSM-III avoids the use of such phrases as "a schizophrenic" or "an alcoholic," and instead uses the more accurate, but admittedly more wordy "an individual with Schizophrenia" or "an individual with Alcohol Dependence."

Another misconception is that all individuals described as having the same mental disorder are alike in all important ways. Although all the individuals described as having the same mental disorder show at least the defining features of the disorder, they may well differ in other important ways that may affect clinical management and outcome.

Conditions Not Attributable to a Mental Disorder. In DSM-III it is recognized that a behavioral or psychological problem may appropriately be a focus of professional attention or treatment even though it is not attributable to a mental disorder. A limited listing of codes, taken from the V codes section of ICD-9-CM, is provided for noting such problems.

Descriptive Approach. For some of the mental disorders, the etiology or pathophysiological processes are known. For example, in the Organic Mental Disorders, organic factors necessary for the development of the disorders have been identified or are presumed. Another example is Adjustment Disorder, in which the disturbance is a reaction to psychosocial stress.

For most of the DSM-III disorders, however, the etiology is unknown. A variety of theories have been advanced, buttressed by evidence—not always

convincing—to explain how these disorders come about. The approach taken in DSM-III is atheoretical with regard to etiology or pathophysiological process except for those disorders for which this is well established and therefore included in the definition of the disorder. Undoubtedly, with time, some of the disorders of unknown etiology will be found to have specific biological etiologies, others to have specific psychological causes, and still others to result mainly from a particular interplay of psychological, social and biological factors.

The major justification for the generally atheoretical approach taken in DSM-III with regard to etiology is that the inclusion of etiological theories would be an obstacle to use of the manual by clinicians of varying theoretical orientations, since it would not be possible to present all reasonable etiological theories for each disorder. For example, Phobic Disorders are believed by many to represent a displacement of anxiety resulting from the breakdown of defensive operations for keeping internal conflict out of consciousness. Other investigators explain phobias on the basis of learned avoidance responses to conditioned anxiety. Still others believe that certain phobias result from a dysregulation of basic biological systems mediating separation anxiety. In any case, as the field trials have demonstrated, clinicians can agree on the identification of mental disorders on the basis of their clinical manifestations without agreeing on how the disturbances come about.

Because DSM-III is generally atheoretical with regard to etiology, it attempts to describe comprehensively what the manifestations of the mental disorders are, and only rarely attempts to account for *how* the disturbances come about, unless the mechanism is included in the definition of the disorder. This approach can be said to be "descriptive" in that the definitions of the disorders generally consist of descriptions of the clinical features of the disorders. These features are described at the lowest order of inference necessary to describe the characteristic features of the disorder. Frequently the order of inference is relatively low, and the characteristic features consist of easily identifiable behavioral signs or symptoms, such as disorientation, mood disturbance, or psychomotor agitation. For some disorders, however, particularly the Personality Disorders, a much higher order of inference is necessary. For example, one of the criteria for Borderline Personality Disorder is "identity disturbance manifested by uncertainty about several issues relating to identity, such as self-image, gender identity, long-term goals or career choice, friendship patterns, values and loyalties."

This descriptive approach is also used in the division of the mental disorders into diagnostic classes. All of the disorders without known etiology or pathophysiological process are grouped together on the basis of shared clinical features.

The subdivision of each diagnostic class into specific disorders, with even further subdivision in some cases, reflects the best judgment of the Task Force and its Advisory Committees that such subdivision will be useful. In this regard we have been guided by the judgments of those clinicians who will be making most use of each portion of the classification. For example, the subdivision of Psychosexual Dysfunctions into seven specific disorders is in response to the expressed needs of clinicians who specialize in the treatment of these conditions. (It soon became apparent that the criticism that a subdivision in a particular area of the classification was useless always came from clinicians who specialized

in other areas.) It should be noted, however, that the judgments of clinicians concerning the necessity for including new categories were not accepted uncritically. Although initially many new categories were added in an effort to be inclusive, experience in the field trials and lack of validity evidence from the literature resulted in the elimination of several proposed categories.

Diagnostic Criteria. Since in DSM-I, DSM-II, and ICD-9 explicit criteria are not provided, the clinician is largely on his or her own in defining the content and boundaries of the diagnostic categories. In contrast, DSM-III provides specific diagnostic criteria as guides for making each diagnosis since such criteria enhance interjudge diagnostic reliability. It should be understood, however, that for most of the categories the diagnostic criteria are based on clinical judgment, and have not yet been fully validated by data about such important correlates as clinical course, outcome, family history, and treatment response. Undoubtedly, with further study the criteria for many of the categories will be revised.

Multiaxial Evaluation. DSM-III recommends the use of a multiaxial system for evaluation to ensure that certain information that may be of value in planning treatment and predicting outcome for each individual is recorded on each of five axes, the first three of which constitute an official diagnostic evaluation.

Axes I and II include all of the mental disorders. (Two classes of mental disorders, Personality Disorders and Specific Developmental Disorders, are assigned to Axis II, whereas all of the other mental disorders are assigned to Axis I. The reason for this is discussed on p. 23. This does not imply that these Axis II disorders are not mental disorders.)

Axis III is for physical disorders and conditions. The separation of this axis from the mental disorders axes, is based on the tradition of separating those disorders whose manifestations are primarily behavioral or psychological (i.e., mental disorders) from those whose manifestations are not. It is necessary to have a term that can be applied to all of the disorders that are not considered "mental disorders." The phrase "organic disorder" would incorrectly imply the absence of physical factors in "mental" disorders. Hence, this manual uses the term "physical disorder," recognizing that the boundaries for these two classes of disorders ("mental" and "physical" disorders) change as our understanding of the pathophysiology of these disorders increases.

Axis IV, Severity of Psychosocial Stressors and Axis V, Highest Level of Adaptive Functioning Past Year, are for use in special clinical or research settings and provide information additional to the official DSM-III diagnoses (Axes I, II, and III) that is of value for treatment planning and predicting outcome.

Hierarchical Organization of Diagnostic Classes. In some mental disorders, for example, Organic Mental Disorders, there is a wide range of signs and symptoms. In others, such as Anxiety Disorders, only a limited range of signs and symptoms is seen. For this reason, the order in which diagnostic classes are listed represents, to some extent, a hierarchy in which a disorder high in the hierarchy may have features found in disorders lower in the hierarchy, but

not the reverse. This hierarchical relationship makes it possible to present the differential diagnosis of major symptom areas in a series of decision trees (see Appendix A).

Systematic Description. The text of DSM-III systematically describes each disorder in terms of current knowledge in the following areas: essential features, associated features, age at onset, course, impairment, complications, predisposing factors, prevalence, sex ratio, familial pattern, and differential diagnosis. Although descriptively comprehensive, DSM-III is not a textbook, since it does not include information about theories of etiology, management and treatment. It should also be noted that the DSM-III classification of mental disorders does not attempt to classify disturbed dyadic, family, or other interpersonal relationships.

Glossary of Technical Terms. Technical terms used in the text for describing the disorders are defined in a glossary in Appendix B.

Annotated Comparative Listing of DSM-II and DSM-III. The profession is entitled to know the rationale for all of the major changes that have resulted in the DSM-III classification of mental disorders. For this reason, included in Appendix C is a table containing an explanation for each major change made and new category added, with references from the scientific literature. With the use of this table, the reader can more easily make the transition from the DSM-II to the DSM-III classification and understand the reasons for the changes.

NEUROTIC DISORDERS

Throughout the development of DSM-III the omission of the DSM-II diagnostic class of Neuroses has been a matter of great concern to many clinicians, and requires an explanation.

When Freud first used the term "psychoneurosis," he was referring to only four subtypes: anxiety neurosis, anxiety hysteria (phobia), obsessive compulsive neurosis, and hysteria. Freud used the term both *descriptively* (to indicate a painful symptom in an individual with intact reality testing) and to indicate the *etiological process* (unconscious conflict arousing anxiety and leading to the maladaptive use of defensive mechanisms that result in symptom formation).

At the present time, however, there is no consensus in our field as to how to define "neurosis." Some clinicians limit the term to its descriptive meaning whereas others also include the concept of a specific etiological process. To avoid ambiguity, the term *neurotic disorder* should be used only descriptively. This is consistent with the use of this term in ICD-9. The term *neurotic process*, on the other hand, should be used when the clinician wishes to indicate the concept of a specific etiological process involving the following sequence: unconscious conflicts between opposing wishes or between wishes and prohibitions, which causes unconscious perception of anticipated danger or dysphoria, which leads to use of defense mechanisms that result in either symptoms, personality disturbance, or both.

The term *neurotic disorder* thus refers to a mental disorder in which the predominant disturbance is a symptom or group of symptoms that is distressing

to the individual and is recognized by him or her as unacceptable and alien (ego-dystonic); reality testing is grossly intact; behavior does not actively violate gross social norms (although functioning may be markedly impaired); the disturbance is relatively enduring or recurrent without treatment and is not limited to a transitory reaction to stressors; and there is no demonstrable organic etiology or factor.

Although many psychodynamically-oriented clinicians believe that the neurotic process always plays a central role in the development of neurotic disorders, there are other theories about how these disorders develop. For example, there are social learning, cognitive, behavioral, and biological models that attempt to explain the development of various neurotic disorders.

Thus, the term *neurotic disorder* is used in DSM-III without any implication of a special etiological process. Neurotic disorder, defined descriptively, is roughly equivalent to the psychoanalytic concept of "symptom neurosis." (This is distinguished from "character neurosis" which is roughly equivalent to the DSM-III concept of Personality Disorder. According to modern psychoanalytic theory, the neurotic process is involved in the development of both symptom neuroses and character neuroses.)

In DSM-III the Neurotic Disorders are included in Affective, Anxiety, Somatoform, Dissociative, and Psychosexual Disorders. These diagnostic classes are listed together in the DSM-III classification to facilitate the location of Neurotic Disorders. Preceding the listing of the class of Affective Disorders is a statement indicating that Neurotic Disorders are included in these five DSM-III classes.

It should be noted that the ICD-9 category Neurotic Disorders, also defined descriptively, includes only those categories that historically have been included as "neuroses" in previous standard classifications. These previous classifications did not contain some of the DSM-III categories, such as Psychosexual Disorders, that unquestionably include some disorders falling within the concept of Neurotic Disorders.

Alternative approaches to the issue of the relationship of Neurotic Disorders to the DSM-III classification were considered. If the DSM-III classification had included a category of Neurotic Disorders that was limited to those disorders included in the ICD-9 category, the potential value of the term Neurotic Disorder would have been limited by a lack of adherence to its descriptive meaning. On the other hand, to have grouped together all of the specific DSM-III categories that are usually considered to be Neurotic Disorders would have required separating some Affective Disorders from the other Affective Disorders, some Psychosexual Disorders from the other Psychosexual Disorders, and some Dissociative Disorders from other members of that class. The possible advantages of this approach seemed to be far outweighed by the disadvantage of fragmenting several diagnostic classes. Similarly, it was judged unwise to group all psychotic disorders together, as is done in ICD-9.

USING DSM-III

The major justification for the generally atheoretical approach taken in Several features are included that can help the user become adept at making

optimal use of the manual. By examining the listing of Axis I and Axis II diagnoses and conditions contained in Chapter 1, the user can become familiar with the organization of the classification into major and minor diagnostic classes. By studying Chapter 2, The Use of This Manual, the reader will learn how to use the multiaxial system, record principal and secondary diagnoses, indicate various levels of diagnostic certainty, and use the diagnostic criteria as guides in making diagnoses. Chapter 3 contains the text and criteria for all of the diagnostic categories. The user will want to pay particular attention to those sections that are most appropriate to the kind of clinical or research work that he or she does.

In making a DSM-III diagnosis the clinician may find it more convenient to consult the *Quick Reference to the Diagnostic Criteria from DSM-III*, (Mini-D), a pocket-sized booklet sold separately, that contains only the classification, the diagnostic criteria, a listing of the most important conditions to be considered in a differential diagnosis of each category, and an index. It should be noted that the index in both this book and the *Quick Reference* can be used when the clinician is in doubt about the DSM-III term that corresponds to a DSM-II term or to the name of some other widely used diagnostic category.

EVALUATION FOR TREATMENT PLANNING

Making a DSM-III diagnosis represents an initial step in a comprehensive evaluation leading to the formulation of a treatment plan. Additional information about the individual being evaluated beyond that required to make a DSM-III diagnosis will invariably be necessary.

For instance, the clinician considering a psychodynamically-oriented treatment will pay particular attention to the nature of the interaction of the patient with the clinician during the interview, focusing on the particular way the patient molds and distorts the interview situation in order to make it conform to his or her deeply ingrained (usually unconscious) fantasies, attitudes, and expectations about interpersonal relationships. The nature of these transference phenomena will be noted in order to predict future behavior in the treatment setting and to shed light on the patient's early developmental experiences and the conflicts that underlie the current disturbance. The clinician will note the patient's ability to reflect upon feelings and fantasies as they are being experienced. The clinician will also monitor his or her own responses to the patient as an indicator of the patient's unconscious conflicts and defensive style. Finally, the clinician will make a psychodynamic diagnostic formulation that is an explanation of the patient's psychopathology in terms of the nature of the unconscious conflicts and defense mechanisms, and the origins of the current behavior in early life experience.

The clinician considering behavior therapy will do a functional analysis of the behavior disturbance. This begins by defining the problem behavior as objectively as possible in terms of developmental history and present antecedents and consequences. These may be external (environmental, social) or internal (affects, cognitions). When appropriate, attention will be paid to the patient's idiosyncratic thinking patterns (cognitions) and unfounded beliefs

about himself or herself and his or her relationship to others (schemata) which may contribute to the onset or maintenance of the problem behavior. The frequency of the problem behavior and the circumstances under which it occurs are monitored during the behavioral analysis and as treatment progresses. The functional analysis leads to the formulation of a set of hypotheses concerning the acquisition and maintenance of the problem behavior, which is then tested by the application of a specific behavioral treatment.

A clinician considering family therapy will need information about how the presenting problem affects the "identified patient" and the other family members as individuals and as a social unit, how the family members relate to each other, and how they could more effectively provide mutual support in dealing with current and future problems. In addition, the clinician will want to know how the family fits into the broader social network, which includes the therapist and other health-care providers, and how the family can make most effective use of these resources.

The clinician considering somatic therapy will pay particular attention to how any abnormalities detected during a medical examination will affect the choice of a somatic therapy. If the patient is currently on a psychoactive medication and is not responding satisfactorily, it may be useful to clarify the diagnosis and treatment needs of the patient by observing the patient without medication, making sure that this is done in circumstances that protect the patient's welfare. The patient's response to previous somatic therapy and its adequacy in terms of choice, dosage, and duration will be reviewed. The patient's attitude toward somatic treatment will be explored; and when necessary, an attempt will be made to relieve unrealistic anxieties about such treatment.

CAUTIONS

The purpose of DSM-III is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat various mental disorders. The use of this manual for nonclinical purposes, such as determination of legal responsibility, competency or insanity, or justification for third-party payment, must be critically examined in each instance within the appropriate institutional context.

THE FUTURE

In the several years that it has taken to develop DSM-III, there have been several instances when major changes in initial drafts were necessary because of new findings. Thus, this final version of DSM-III is only one still frame in the ongoing process of attempting to better understand mental disorders.

Substance Use Disorders

In our society, use of certain substances to modify mood or behavior under certain circumstances is generally regarded as normal and appropriate. Such use includes recreational drinking of alcohol, in which a majority of adult Americans participate, and the use of caffeine as a stimulant in the form of coffee. On the other hand, there are wide subcultural variations. In some groups even the recreational use of alcohol is frowned upon, while in other groups the use of various illegal substances for recreational purposes is widely accepted. In addition, certain substances are used medically for the alleviation of pain, relief of tension, or to suppress appetite.

This diagnostic class deals with behavioral changes associated with more or less regular use of substances that affect the central nervous system. These behavioral changes in almost all subcultures would be viewed as extremely undesirable. Examples of such behavioral changes include impairment in social or occupational functioning as a consequence of substance use, inability to control use of or to stop taking the substance, and the development of serious withdrawal symptoms after cessation of or reduction in substance use. These conditions are here conceptualized as mental disorders and are therefore to be distinguished from nonpathological substance use for recreational or medical purposes.

The disorders classified in this section are to be distinguished from the corresponding portions of the Organic Mental Disorders section. Whereas the Substance Use Disorders refer to the maladaptive behavior associated with more or less regular use of the substances, the Substance-induced Organic Mental Disorders describe the direct acute or chronic effects of these substances on the central nervous system. Almost invariably, individuals who have a Substance Use Disorder will also at various times have a Substance-induced Organic Mental Disorder, such as an Intoxication or Withdrawal.

For most classes of substances, pathological use is divided into Substance Abuse and Substance Dependence, defined below:

SUBSTANCE ABUSE

Pattern of pathological use

Impairment in social or occupational functioning due to substance use

Minimal duration of disturbance of at least one month

SUBSTANCE DEPENDENCE

Tolerance or withdrawal

(For Alcohol Dependence and Cannabis Dependence a pattern of pathological use or impairment in social or occupational functioning is also required. For the exception of Tobacco Dependence, see p. 176.)

SUBSTANCE ABUSE

Three criteria distinguish nonpathological substance use from Substance Abuse.

A pattern of pathological use. Depending upon the substance, this may be manifested by: intoxication throughout the day, inability to cut down or stop use, repeated efforts to control use through periods of temporary abstinence or restriction of use to certain times of the day, continuation of substance use despite a serious physical disorder that the individual knows is exacerbated by use of the substance, need for daily use of the substance for adequate functioning, and episodes of a complication of the substance intoxication (e.g., alcoholic blackouts, opioid overdose).

Impairment in social or occupational functioning caused by the pattern of pathological use. Social relations can be disturbed by the individual's failure to meet important obligations to friends and family, by display of erratic and impulsive behavior, and by inappropriate expression of aggressive feelings. The individual may have legal difficulties because of complications of the intoxicated state (e.g., car accidents) or because of criminal behavior to obtain money to purchase the substance. (However, legal difficulties due to possession, purchase, or sale of illegal substances are highly dependent on local customs and laws, and change over time. For this reason, such legal difficulty on a single occasion should not be considered in the evaluation of impairment in social functioning for diagnostic purposes.)

Occupational functioning can deteriorate if the individual misses work or school, or is unable to function effectively because of being intoxicated. When impairment is severe, the individual's life can become totally dominated by use of the substance, with marked deterioration in physical and psychological functioning. Incapacitation is more frequently associated with chronic Opioid and Alcohol Dependence than with dependence on other substances.

Frequently individuals who develop Substance Use Disorders also have preexisting Personality Disorders and Affective Disorders with concomitant impairment in social and occupational functioning. It is therefore necessary to determine that the social or occupational impairment associated with the diagnosis of Substance Abuse or Dependence is actually due to the use of the substance. The best clue is a change in functioning that accompanies the onset of a pathological pattern of substance use, or the development of physiological dependence.

Duration. Abuse as used in this manual requires that the disturbance last at least *one month.* Signs of the disturbance need not be present continuously throughout the month, but should be sufficiently frequent for a *pattern* of pathological use causing interference with social or occupational functioning to be apparent. For example, several episodes of binge drinking causing family arguments during a one-month period would be sufficient even though between binges the individual's functioning was apparently not impaired.

Isolated instances of pathological use of a substance can be adequately diagnosed by noting the specific Organic Brain Syndromes that were associated with this use. For example, a history of one or more instances of maladaptive use of alcohol over a three-week period may be noted as prior episodes of Alcohol Intoxication.

SUBSTANCE DEPENDENCE

Substance Dependence generally is a more severe form of Substance Use Disorder than Substance Abuse and requires physiological dependence, evidenced by either tolerance or withdrawal. Almost invariably there is also a pattern of pathological use that causes impairment in social or occupational functioning, although in rare cases the manifestations of the disorder are limited to physiological dependence. An example would be an individual's inadvertently becoming physiologically dependent on an analgesic opioid given to him by a physician for the relief of physical pain.

The diagnosis of all of the Substance Dependence categories requires only evidence of tolerance or withdrawal, except for Alcohol and Cannabis Dependence, which in addition require evidence of social or occupational impairment from use of the substance or a pattern of pathological substance use.

Tolerance. Tolerance means that markedly increased amounts of the substance are required to achieve the desired effect or there is a markedly diminished effect with regular use of the same dose. When the substance used is illegal and mixed with various diluents or with other substances, tolerance may be difficult to determine. In the case of alcohol, it should be noted that there are wide individual variations in the capacity to drink large quantities of alcohol without intoxication. Since some persons have the capacity to drink large amounts despite limited drinking experience, the distinguished feature of tolerance is that the individual reports that the amount of alcohol he or she can drink before showing signs of intoxication has increased markedly over time.

Withdrawal. In withdrawal, a substance-specific syndrome follows cessation of or reduction in intake of a substance that was previously regularly used by the individual to induce a physiological state of intoxication. See Withdrawal as an Organic Brain Syndrome, p. 122.

Many heavy coffee drinkers are physiologically dependent on caffeine and exhibit both tolerance and withdrawal. However, since such use generally does not cause distress or social or occupational impairment, and since few if any of these individuals have difficulty switching to decaffeinated coffee or coffee substitutes, the condition does not appear to be of clinical significance. Therefore, caffeine dependence is not included in this classification of mental disorders. In contrast, Caffeine Intoxication is often clinically significant, and therefore is included (p. 160).

CLASSES OF SUBSTANCES

Five classes of substances are associated with both abuse and dependence: alcohol, barbiturates or similarly acting sedatives or hypnotics, opioids, ampheta-

Exhibit C: Sen. Select Com. on Children & Youth, SB 1195 Task Force, Report on Child Abuse Reporting Laws

CALIFORNIA LEGISLATURE

SENATE SELECT COMMITTEE ON
CHILDREN AND YOUTH
SENATOR ROBERT PRESLEY, CHAIRMAN

SB 1195 TASK FORCE

CHILD ABUSE REPORTING LAWS, JUVENILE COURT DEPENDENCY STATUTES, AND CHILD WELFARE SERVICES

JANUARY, 1988

SENATE SELECT COMMITTEE ON CHILDREN & YOUTH/SB 1195 TASK FORCE

Child Abuse Reporting Laws, Juvenile Court Dependency Statutes, and Child Welfare Services

January, 1988

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SENATE SELECT COMMITTEE ON CHILDREN & YOUTH/SB 1195 (Presley)
TASK FORCE

Child Abuse Reporting Laws, Juvenile Court Dependency Statutes, and Child Welfare Services

EXECUTIVE SUMMARY

Senate Bill 1195 (Presley - Chapter 1122, Statutes of 1986) required the Senate Select Committee on Children and Youth to convene a task force which would make recommendations on how to bring greater coordination among child abuse reporting statutes, child welfare services, and juvenile court proceedings. The Legislature's charge to the task force was to examine existing statutes and practices and make recommendations for any changes needed to ensure maximum continuity of protection for children at risk of abuse, neglect, and exploitation. The results of the task force's work are contained in SB 243 (Presley - Chapter 1485, Statutes of 1987), SB 834 (Presley - Chapter 1310, Statutes of 1987), and SB 1219 (Presley - Chapter 1459, Statutes of 1987). This report documents the intent of these new laws and outlines the task force's additional recommendations.

Part I: The New Legislation

The task force began its work guided by the conviction that child abuse reporting standards must clearly define to the community and child protection agencies all instances where children are believed to be at risk of abuse or neglect. The task force recognized that these reporting standards must be broad in scope so that questionable situations will be reported and assessed. In this way, child protection officials have greater opportunity to intervene at an early point to protect at-risk children. To ensure the most effective reporting standards, the task force made recommended changes to existing child abuse reporting laws, primarily for purposes of clarification. These changes are contained in SB 1219 which:

° Clarifies that the reference to corporal punishment in the definition of child abuse is a reference to unlawful corporal punishment;

° clarifies that mutual affray between minors is not child abuse;

° supplements numerical cross reference to other code sections with more meaningful definitions;

° clarifies cross-reporting requirements among child protection agencies; and

- authorizes county welfare departments to determine if an immediate, in-person response to a child abuse report is necessary, based upon a professional assessment.

The task force then turned to the statutes which permit child protection agencies to bring a child to the attention of the juvenile court because the abuse or neglect cannot be remedied on a voluntary basis with the child's family. Because the entry of a child and his/her family into the dependency court system is a critical and imposing step, the task force sought to balance protections afforded to the family with the needs of the child and the ability of the family to protect the child from harm. The amended juvenile court law is represented in SB 243, which provides comprehensive guidelines to child welfare agencies in deciding when a child needs the protection of the court, and, once in the judicial system, in effectively reconstructing a safe environment in which an at-risk child may live.

The new jurisdictional standards represented in SB 243 (Welfare and Institutions Code Section 300 et seq.) were developed with the understanding that these statutes are the threshold for juvenile court intervention into families. Thus SB 243 replaces the current vague language of Welfare and Institutions Code Section 300 with ten specific grounds for declaring a child a dependent of the court:

- Physical abuse (serious physical harm);

- physical/medical neglect;

- serious emotional damage;

- sexual abuse;

- severe physical abuse or sexual abuse (maintains current language; extends application upward to children under the age of 5; no reunification services required);

- cruelty;

- parent convicted of causing the death of another child through abuse or neglect (no reunification services required);

- minor left without provision for support or care and supervision; and

- siblings abused or neglected.

SB 243 recognizes that once court intervention is determined necessary, children and parents should receive appropriate legal representation, time-limited and clearly focused protective and/or reunification services, and permanency planning at the earliest possible stage for those children who cannot live safely with their family.

Clearly, this increased focus on the risk to the child and the need for focused, time-limited service delivery requires greater sophistication and training on the part of child protection agencies and mandated reporters. Therefore, the task force developed SB 834 to initiate a statewide curriculum and training program focused on assessment of child abuse and neglect. This training is to be available prior to implementation of SB 243 and will provide professional tools for timely and accurate assessment of children at risk.

* * *

In short, the task force accomplished its charge to bring coordination among the child abuse reporting statutes, child welfare services, and dependency court proceedings by:

° Broadly and clearly defining child abuse reporting standards (SB 1219);

° outlining jurisdictional grounds for dependency to clarify areas of uncertainty and enhance the court's ability to protect abused and neglected children (SB 243); and

° initiating a training program so that child protection professionals can further increase their skills of assessment, service planning and permanent placement (SB 834).

Part II: Additional Recommendations/Unresolved Issues

While the changes incorporated in SB 243, SB 834, and SB 1219 are comprehensive in scope, the task force uncovered numerous other problems in child welfare matters for which it was felt additional legislation would be necessary or for which remedies were not immediately apparent. Among the issues is the ongoing need for adequate services to meet the needs of at-risk families, especially services which are targeted at the prevention of abuse or neglect, as well as services to meet the needs of minors who will no longer be eligible for juvenile court adjudication effective January 1, 1990. Other issues relate to juvenile court procedures, the growing number of special needs children for whom dependency procedures may be inappropriate or inadequate (infants born with AIDS), the need for additional child welfare services data collection, the special circumstances relating to incarcerated or institutionalized parents of dependent children, accountability for false child abuse reporting, and others. Therefore, the task force makes the following recommendations:

° There should be a comprehensive review of available services to prevent the need for juvenile court intervention in child abuse and neglect cases, together with a review of the need for additional preventive and placement services, by an oversight body such as the Auditor General or the Legislative Analyst;

° after the identification of necessary preventive and placement services, an evaluation should be undertaken to determine whether these services should be delivered through the Child Welfare Services system, or whether another system would be more appropriate. The evaluation should address how the services should be funded;

° a new permanent placement option should be developed for special needs children who cannot be reunified with their families which would ultimately allow more of such children to be adopted;

° issues relating to entry into the dependency system, family reunification, foster care placement, and permanency planning for infants and children with AIDS cannot be resolved under the current Child Welfare Services system. The Legislature should convene representatives of the public and private health sectors and child welfare services to address these issues;

° legislative clarification is needed to refine the standing and rights of individuals seeking to participate in juvenile court dependency proceedings;

° legislative clarification is needed regarding procedures for taking a child's testimony in chambers. The task force recommends that the Child Victim/Witness Judicial Advisory Committee examine this matter;

° current requirements regarding reunification services for incarcerated or institutionalized parents of dependent children are in need of clarification. However, the task force recommends that additional information must be gathered before policy decisions are made, such as statistical information regarding numbers of such children in foster care, practices and procedures utilized by counties for notifying incarcerated/institutionalized parents of court proceedings, and recidivism rates of parents with custody of children;

° a statewide, automated system for gathering and processing county Child Welfare Services data must be developed;

° resolution of conflicting state and federal requirements relating to confidentiality and other matters is necessary to ensure cooperation between county welfare departments and military personnel when child abuse or neglect is alleged to have occurred on federal military installations;

° the task force also discussed the issue of ensuring accountability for individuals who knowingly make false reports of child abuse or neglect or who make such reports with reckless disregard for the truth. However, the task force was unable to suggest any legislative remedies beyond the civil remedies currently provided for in statute and the proposal which is currently pending in SB 1461.

* * *

In summary, the report recommends that a major legislative priority should be the developing of means to ensure the funding and provision of public and private services:

° To alleviate family crises which threaten the well being of children;

° to prevent the breakup of families; and

° to reunify families when children must be removed for their safety.

INTRODUCTION

Senate Bill 1195 (Presley - Chapter 1122, Statutes of 1986) required the Senate Select Committee on Children and Youth to convene a task force which would make recommendations on how to bring greater coordination among child abuse reporting statutes, child welfare services, and juvenile court dependency proceedings. The Legislature's charge to the task force was to examine existing statutes and practices and make recommendations for any changes in order to ensure maximum continuity of protection for children at risk of abuse, neglect and exploitation. The results of the task force's work are contained in SB 243 (Presley - Chapter 1485, Statutes of 1987), SB 834 (Presley - Chapter 1310, Statutes of 1987), and SB 1219 (Presley-Chapter 1459, Statutes of 1987). The purpose of this report is to document the intent of these new laws and to outline the task force's additional recommendations.

Task force members came from several disciplines and often represented varying positions within a single discipline. They included state and county social service agencies, the Attorney General's Office, parents' and children's advocates (from both the legal and social policy fields), a dependency court representative, and a mental health practitioner. In addition, the task force received testimony as well as numerous documents from many individuals and concerned groups regarding child welfare policy and practice.

The task force began its work guided by the conviction that child abuse reporting standards must clearly define to the community and child protection agencies all instances where children are believed to be at risk of child abuse or neglect. The task force recognized that these reporting standards must be broad in scope so that questionable situations will be reported and assessed. In this way, child protection officials have greater opportunity to intervene at an early point to protect at-risk children. To ensure the most effective reporting standards, the task force made recommended changes to existing child abuse reporting laws, primarily for purposes of clarification. These changes are contained in SB 1219.

The task force then turned to the statutes which permit child protection agencies to bring a child to the attention of the juvenile court because the abuse or neglect cannot be remedied on a voluntary basis with the child's family. Because the entry of a child and his/her family into the dependency court system is a critical and imposing step, the task force sought to balance protections afforded to the family with the needs of the child and the ability of the family to protect the child from harm. The amended juvenile court law is represented in SB 243, which provides comprehensive guidelines to child welfare agencies in

once in the judicial system, in effectively reconstructing a safe environment in which an at-risk child may live.

The new jurisdictional standards represented in SB 243 (Welfare and Institutions Code Section 300 et seq.) were developed with the understanding that these statutes are the threshold for juvenile court intervention into families. The standards for reporting child abuse and neglect as contained in Penal Code Section 11165 et seq., and the standards for assessment and voluntary services to families with children at risk, remain broad, thereby permitting the opportunity for evaluation and, when appropriate, providing services which help to reduce risk and increase safety for the child. But, when the family cannot provide protection, the court is asked to assume the role of substitute parent -- a critical intervention into the normal role of the family. When this happens, the description of harm to the child must be clearly articulated so that all involved parties understand the problems and what must change if the family is to function on its own again.

SB 243 recognizes that once court intervention is determined necessary, children and parents should receive appropriate legal representation, time-limited and clearly focused protective and/or reunification services, and permanency planning at the earliest possible stage for those children who cannot live safely with their family.

Clearly, this increased focus on the risk to the child and the need for focused, time-limited service delivery requires greater sophistication and training on the part of child protection agencies and mandated reporters. Therefore, the task force developed SB 834 to initiate a statewide curriculum and training program focused on assessment of child abuse and neglect. This training is to be available prior to implementation of SB 243 and will provide professional tools for timely and accurate assessment of children at risk.

In short, the task force accomplished its charge to bring coordination among the child abuse reporting statutes, child welfare services, and dependency court proceedings by:

° Broadly and clearly defining child abuse reporting standards (SB 1219);

° outlining jurisdictional grounds for dependency to clarify areas of uncertainty and enhance the court's ability to protect abused and neglected children (SB 243); and

° initiating a training program so that child protection professionals can further increase their skills of assessment, service planning and permanent placement (SB 834).

A more detailed account of each of these bills is presented below (Part I). Following this description, this report then examines the task force's additional recommendations (Part II).

PART I: THE NEW LEGISLATION

SB 243 (Presley)

Changes to WIC Section 300. Senate Bill 243 substantially changes the definitions of abuse and neglect contained in Welfare and Institutions Code Section (WIC) 300. These changes were the most controversial aspects of the legislation. Some individuals believed that no changes should have been made; others objected to the wording of specific subsections. It should be noted that the changes in Section 300 affect only court jurisdiction; SB 243 does not alter the definitions contained in the child abuse reporting law (contained in Penal Code Section 11165 et seq.). Thus, there should not be any decline as a result of SB 243 in the number or kinds of cases which must be reported to and investigated by child protective service agencies (CPS). Nor will there be a change in the types of cases eligible for voluntary services pursuant to Welfare and Institutions Code Section 330.

Specific versus General Language. The reason for revising Welfare and Institutions Code Section 300 is to provide more clear-cut guidance to social workers and judges regarding the types of situations which the Legislature considers abusive or neglectful. The task force determined that greater specificity was needed in order to ensure more uniform application of the law throughout the state and to ensure that court intervention does not occur in situations the Legislature would deem inappropriate.

The language of the prior Section 300 is extremely broad and vague. Court jurisdiction is authorized if a minor is "in need of proper and effective parental care," "not provided with the necessities of life" or a "suitable place of abode," or whose "home is...unfit...by reason of neglect...or physical abuse." No definitions are provided for "abuse," "neglect," "suitable," "proper." SB 243 provides definitions of these terms, definitions which focus on more specific harms to a child's physical well being, emotional development or physical safety.

The revisions to WIC Section 300 reflect the belief that while children should be protected from a wide range of harms, inappropriate intervention can be harmful to children and parents. Investigations and court hearings are traumatic for parents and children, particularly in cases where children are removed from their homes during the investigation process. Children can suffer real emotional damage. Vague statutes make

inappropriate intervention more likely. Given the enormous variation in background, training and experience of child welfare workers and police, vague standards lead to highly variable practices in different counties and even within counties. While task force members believed that, under current law, most cases which are brought to court do require court involvement, a review of court petitions indicated that in every county at least some cases appeared not to belong in the dependency system.

Legislative guidance on the meaning of abuse and neglect is also necessary because the concepts of abuse and neglect involve value judgments about what constitutes proper parenting. There are also varying perspectives on the degree of supervision needed by children of different ages and what constitutes an unsafe home environment. The fact that there was substantial disagreement over specific definitions among members of the task force and among many of the individuals and groups participating in the Legislature's hearings demonstrates the need for legislative guidance. All of the participants in the process, like the protective service workers and police officers who must enforce the law, were concerned with protecting children. Yet they had different visions of who needs protection, as well as how such protection should be provided. Because a decision to bring a family into the court process has such enormous consequences on the children and parents, resolution of these value conflicts and differences in professional judgment, should not be left to the many individual workers. SB 243 reflects the task force's belief that these judgments should be made within the context of clear legislative guidelines.

Finally, the task force believed that defining the types of harms which justify intervention will result in more effective utilization of resources. It must be stressed that the specific language was not adopted to address a problem of limited resources, but was designed to cover those situations where authoritative intervention is appropriate to protect children. However, in the task force's view, broad court jurisdiction should not be thought of as a panacea for an adequate, comprehensive system of services for the varying needs of children and families.

Specific grounds adopted. The question of whether the particular definitions of harms provided in SB 243 are too narrow or too broad is separate from the question of whether the law should be left vague or made more specific. Many definitions are possible. The task force spent a great deal of time on the wording of each section and several legislative committees reviewed the specific language in lengthy hearings.

In arriving at definitions, the task force was concerned with identifying situations where intervention is reasonably

necessary. When children are threatened with serious harm, intervention obviously is needed. However, intervention into a family situation is a difficult task. Sensitively done it can be very beneficial; done poorly or inadequately, it may worsen, rather than improve a parent's function. Thus the benefits of court intervention must be carefully balanced with potential harm in arriving at definitions of abuse and neglect.

Underlying SB 243 is the judgment that court intervention is not appropriate unless there is good reason to believe that the parent's conduct towards the minor constitutes a significant threat to the minor's physical or emotional well being. The harm must be reasonably "serious." Although the legislation defines the harms more specifically than current law, it is not possible to give a highly specific definition of the phrase "serious" without being too restrictive. The legislation is intended to convey the judgment that court intervention is not appropriate just because a social worker, teacher or child welfare professional thinks that a parent's behavior is somewhat undesirable or may pose some detriment to the child.

Thus again, SB 243 reflects value judgments regarding the types of harms that justify court intervention. While the task force believed that these judgments are reflective, for the most part, of the values that currently guide most county agencies, the legislation should lead some agencies not to file petitions in some cases which they now inappropriately bring to court.

Turning to the specific provisions of WIC Section 300, SB 243 does not change existing definitions of sexual abuse or emotional harm. All instances of sexual behavior between an adult and child are covered. In instances where the intervention is based solely on emotional damage, the legislation requires that there be clear evidence that the child's functioning is impaired as the result of the parent's conduct.

SB 243 potentially expands the scope of intervention with regard to siblings of children who have been abused. It clarifies that such siblings are within the jurisdiction of the court if there is evidence that the siblings are at risk of being abused. However, SB 243 also makes it clear that there must be specific reasons to believe that the siblings are threatened with harm; thus, it specifies some of the factors that should be considered in making this determination.

With regard to "neglect," the most general basis and most common reason for intervention, the legislation specifies that the focus of intervention should be on possible physical harm to the child. This harm can result from a dangerous physical environment, failure to adequately supervise the child, or a failure to provide adequate food, clothing or medical care. The critical

factor is that there must be reference to specific harms the child has suffered or is likely to suffer.

Perhaps the most controversial part of the legislation is the definition of physical abuse. Under SB 243, WIC Section 300(a) specifies that in order for a court to assume jurisdiction, it must find that a child has been injured by a parent or that the child is at "substantial risk" of injury, and that the injury was "serious" or was inflicted in such a manner that might have been serious. Serious physical harm obviously includes such things as broken bones, burns, facial or head injuries, injuries to internal organs, or injuries to substantial portions of the body. It also includes any injuries to very young children. Where less serious injuries, for example bruises on the arms or backs of legs, are inflicted in a manner that might have caused more serious injury, court jurisdiction is authorized as well. Further, court jurisdiction for such inappropriate actions as kicking, punching, or choking a child, or the infliction of injury to a child with an instrument, is intended to be covered by the language.

The legislation specifies that corporal punishment ("spanking") of a child is not, in and of itself, grounds for intervention. This is consistent with existing case law, although the vagueness of Section 300 has resulted in some such cases being brought to court. Neither California, nor any other state, forbids corporal punishment by parents. By making this clear to police and child welfare workers, the legislation does not express approval of such punishment. It merely states that such action is neither illegal nor, in and of itself, abusive. It must be recognized that all instances of physical punishment which lead to bruising or any evidence of injury still must be reported to child protective service agencies and investigated by workers. In cases of minor bruising the worker will have to determine if more serious injury is likely to occur. The task force strongly supports development of voluntary services to help parents develop alternative means of discipline.

Finally, appropriate deference has been allowed for parents' preference for spiritual treatment of medical or mental health problems, provided there is no danger of serious physical harm or illness or serious emotional damage.

In total, WIC Section 300 contains ten specific grounds for dependency:

- Physical abuse (serious physical harm);
- physical/ medical neglect;
- serious emotional damage;

° sexual abuse;

° severe physical or sexual abuse (applies to minors under the age of 5; no reunification services required);

° cruelty;

° parent convicted of causing the death of another child through abuse or neglect (no reunification services required);

° minor left without provision for support or care and supervision;

° siblings abused or neglected.

Additionally, incorporated in the new Section 300 is a statement of the Legislature's intent "to provide maximum protection for children who are currently being physically, sexually, or emotionally abused, being neglected, or being exploited, and to protect children who are at risk of that harm." The intent paragraph also emphasizes the "focus on the preservation of the family whenever possible" and provision for the "full array of social and health services to the child and family," including voluntary services. This statement of intent is consistent with existing Child Welfare Services law.

It should be noted that SB 243 includes two, successive versions of WIC Section 300 which are identical except for one phrase in subsection (b) -- "...or inability," and one phrase in subsection (c) -- "...or who has no parent or guardian capable of providing appropriate care." The version containing these phrases is effective only from January 1, 1989 to December 31, 1989. It is included so that certain classes of minors who are currently served by the child welfare system will continue to be served until agencies more appropriately equipped to handle these classes of minors are able to develop alternative systems for them. Specifically, mentally ill minors, medically fragile infants, and so-called "status offenders" (runaway, truant or incorrigible minors), effective January 1, 1990, will no longer be eligible for adjudication and will not be served by child welfare services and the juvenile courts unless their condition is the result of their parents' behavior. Absent parental abuse or neglect, these children are not well served by the child welfare system. In particular, mentally ill minors should be treated and served by the mental health system which is staffed with professionals trained to meet the needs of these children. Nor should parents of mentally ill minors be subjected to the juvenile court's intervention, which generally implies parental unfitness.

The delay in implementation is designed to allow ample time to train child protective service workers in the significant changes made to the Welfare & Institutions Code (see SB 834), as well as to develop alternative programs for minors who will no longer be subject to juvenile court adjudication. SB 243 further mandates the Health and Welfare Agency to prepare recommendations for new programs to be implemented by January 1, 1990, including appropriate funding sources and service delivery systems. These recommendations are to be submitted to the Legislature by January 1, 1989.

Other Changes to Dependency Law. SB 243 brings all matters relating to a dependent child, including custody issues, within the jurisdiction of the juvenile court [WIC Sections 301(a) and (c) and 304]. WIC Section 301 also provides for notice to the parents or guardians of all court proceedings and specifically provides that copies of probation reports must be served personally, or by mail, on the parents or guardians.

More precise guidelines are set forth for police officers and social workers regarding temporary detention of minors (WIC Sections 305 and 306). In addition to the requirement of reasonable cause to believe a minor comes within the definitions in WIC Section 300, WIC Section 305 now requires a police officer to determine that there is immediate danger to the minor to justify the detention, or that the minor is in immediate need of medical care. A provision has been added to prevent release of a minor from a hospital if the release "poses an immediate danger to the child's health or safety." These guidelines are consistent with those adopted and utilized by the Commission on Peace Officers Standards and Training (POST).*

As in present law, a social worker may take a minor into custody who is a dependent child, or if there is reasonable cause to believe the child is described under WIC Section 300(b) or (g) (neglected, mistreated or abandoned) and is in immediate need of

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* The task force understands that some uncertainty and confusion exists within the law enforcement community on the interpretation of the new WIC 305 language (also WIC 306). The concern is that the wording might be interpreted in a way to preclude an officer from taking into custody a child who has not been abused prior to law enforcement intervention, but who nevertheless is in current danger of abuse. To ensure that all children are protected, it is recommended that urgency legislation be introduced to remove the term "continued" in WIC 305 and 306 and resolve possible misinterpretation on this section in SB 243.

medical care or is in immediate danger of continued abuse, or the physical environment poses a threat to the safety of the child. The new WIC Section 306 requires an assessment of reasonable services which, if provided, would eliminate the need for removal of the minor. The social worker must specifically determine if a referral to public assistance would avoid the need for removal. Available services must be utilized to prevent detention. (See also WIC Section 319). The changes to WIC Section 306 do not become effective until January 1, 1989, in concert with WIC Section 300.

Some modifications have been made to the requirements of existing law dealing with the notification of parents of detained children. County welfare departments must make a diligent effort to ensure regular telephone contact between parent and child prior to the detention hearing, unless deemed detrimental to the child [Section 308(a)]. The right to make a telephone call has been clarified to apply to children aged 10 and older. Other children retain their right to a facilitated telephone call.

A new WIC Section 318, effective from January 1, 1988 to December 31, 1988, replaces the present Section 318. It adds new responsibilities for appointed counsel in dependency proceedings and clarifies the responsibility of the court to determine if a conflict of interest exists between a dependent minor and the petitioning agency, or other public or private counsel. Counsel's responsibilities when appointed to represent a minor are specifically set forth, including a mandate for a personal interview of all minors four (4) years of age or older.

Effective January 1, 1989, the provisions of WIC Section 318 are incorporated into a new WIC Section 317, which also defines the court's responsibility for providing counsel to parents and guardians. Barring an intelligent waiver, appointed counsel for indigent parents is mandated if their dependent minor has been or may be placed out of home on the recommendation of the petitioning agency. Representation by appointed counsel for minors as well as parents shall be continuing ("vertical representation") and include proceedings to terminate parental rights or to institute or set aside legal guardianship. The changes are delayed in implementation in order to allow counties adequate time to reorganize staff and to secure adequate funding, pursuant to SB 709 (Chapter 1211, Statutes of 1987) to cover any additional costs attributable to the changes contained in SB 243.

When considering the detention of a minor, a new WIC Section 319 mandates the court to "make a determination on the record as to whether reasonable efforts were made to prevent or eliminate the need for removal" from the home and specifies a list of services to be considered in making that determination.

Other significant additions and changes contained in SB 243 are as follows:

° Deletes from WIC Section 319(c) the inappropriate reference to "violation" of a juvenile court order when considering whether a minor should continue to be detained out of the parent or guardian's home;

° lowers the age in WIC Section 335 for service of the petition on a minor from age 14 or more to age 10 or more;

° adds WIC Section 342 to require the filing of a subsequent petition whenever new facts indicate reasonable cause to believe a minor who is already adjudicated under Section 300 may also fall within the description of another subsection of Section 300;

° adds a provision to WIC Section 350 to enable the court to make a finding that the probation department has not met its burden of proof at any court hearing regarding dependency;

° corrects WIC Section 355 to require the court to interpose objections on behalf of an unrepresented "parent or guardian" instead of "minor"; and

° makes technical changes to many other sections, including the combining of present WIC Sections 355.1 through 355.7 into one new WIC Section 355.1.

New Procedure for Terminating Parental Rights. SB 243 substantially modifies the procedure for permanently severing parental rights in cases where the child is a dependent of the court. The new procedure will apply to minors adjudicated dependents of the court on or after January 1, 1989. Unlike current practice, which requires the filing and prosecution of a separate civil court action pursuant to Civil Code Section 232, all termination proceedings for children who are dependents will be heard in the juvenile court, as part of the regular review process. The task force reasoned that by eliminating the need to file the separate Civil Code Section 232 action, minors who are adoptable will no longer have to wait months and often years for the opportunity to be placed with an appropriate family on a permanent basis.

Under the new provisions, a juvenile court must hold a "permanency" hearing within 120 days of the time it decides that no further reunification services shall be provided to the parents. The procedures are specified in WIC Section 366.26. While the permanency hearing may be ordered following the initial dispositional hearing, pursuant to WIC Section 361.5(b), the six month review, pursuant to WIC Section 366.21(e), or the twelve month review, pursuant to WIC Section 366.21(g), it must be held

within eighteen months of the time the minor was first removed from the parent's custody, pursuant to WIC Section 366.22. At the permanency hearing the court has only three options: Termination leading to adoption, guardianship, or long term foster care. The Court is to choose the disposition best for the child; however, as under present law, adoption is the preferred disposition, long term foster care the least preferred.

The critical substantive change is that in order to terminate parental rights the court need make only two findings: (a) That there is clear and convincing evidence that it is likely that the minor will be adopted; and (b) that there has been a previous determination (at the dispositional or six, twelve or eighteen month hearing) that reunification services shall not be offered. In essence, the critical decision regarding parental rights will be made at the dispositional or review hearing, that is, that the minor cannot be returned home and that reunification efforts should not be pursued. In such cases, the decision to terminate parental rights will be relatively automatic if the minor is going to be adopted.

Termination would not be permissible, however, in the following situations:

a) Termination would be detrimental to the child due to the strength of the parent-child relationship. There is substantial clinical evidence that some children in foster care retain very strong ties to their biological parents. Since termination in such situations is likely to be harmful to the child, courts should retain parental ties if desired by both the parents and the child;

b) an older child objects to termination. In these cases adoption is unlikely to be successful;

c) children in residential facilities. When a child is in a residential treatment facility, termination generally is not needed to ensure a stable placement or to prevent breaking any new attachments the child forms. Moreover, terminating parental rights might result in leaving a child without any parents if another permanent home cannot be found when he or she is ready to leave the residential treatment facility. Even if reunion with the parents is unlikely, and the parents visit only sporadically, it is preferable to encourage them to visit and maintain ties with the child, since the child may derive psychological benefit from knowing he or she does in fact have parents. Termination would be allowed, however, if the child should not be returned to the parents after residential care and there is another long term family placement available;

d) children placed with relatives who are willing to provide permanent care but do not wish to adopt. It is common practice to place children with relatives. When a child is placed with a relative, termination is both unnecessary and unwise unless the relative wishes to adopt the child or is unwilling to provide long term care. As long as the relative is willing to provide long term care, the child's needs for stability and attachment are satisfied.

In designing the new juvenile court termination procedure, it was the intent of the task force to eliminate duplication between the regular review hearings and the termination hearing. Therefore, the decisions made at the review hearing regarding reunification are not subject to relitigation at the termination hearing. This hearing determines only the type of permanent home.

The new WIC Section 366.26 also requires the court to consider appointment of counsel for parents or minors who do not have retained or appointed counsel. The same counsel shall not represent both the minor and his or her parent. If the minor's testimony is required, current language found in WIC Section 350 and Civil Code Section 232(b) is retained and placed in this section providing for testimony outside the presence of the minor's parents or guardian. In addition, no petition for adoption may be heard until appellate rights have been exhausted and preference for adoptive placement is given to the relative caretaker or foster parent when the child has formed substantial emotional ties.

SB 243 also requires the county welfare department to conduct and prepare an extensive assessment including, in part, documentation of efforts to locate absent parents and degree of parent-child contact, evaluation of the minors' medical and emotional status, and an evaluation of the likelihood that the minor will be adopted, including any identified prospective adoptive caretakers. This assessment must be prepared and submitted whenever the court orders a hearing pursuant to WIC Section 366.26.

Notice provisions in connection with the proceeding to develop a permanent plan are added in WIC Section 366.23. If the recommendation is termination of parental rights, precise procedures and methods of notice are required.

SB 834 (Presley)

One of the key issues raised during December, 1986 hearings of the Senate Select Committee on Children and Youth was California's lack of a statewide, coordinated training program providing practice-relevant training to public and private

nonprofit child welfare practitioners. In light of this finding, it was the view of the task force that one of the most immediate ways to improve California's statewide child protection efforts would be through the provision of practice-relevant training which would be specific to the needs of the various professionals providing child welfare services to at-risk families. SB 834 was proposed to establish that training program.

Child Welfare Services (CWS) are statutorily defined in WIC Section 16500 et seq. They include:

° The Emergency Response Program, which provides immediate in-person responses to reports of abuse, neglect, or exploitation;

° the Family Maintenance Program, which is designed to provide time-limited protective services to prevent or remedy abuse, neglect, or exploitation, for the purpose of preventing separation of children from their families;

° the Family Reunification Program, which is designed to provide time-limited foster care services when children cannot safely remain home and need temporary foster care while services are provided to reunite the family; and

° the Permanent Placement Program, which is designed to provide an alternate permanent family structure for children who cannot safely remain at home.

While it was the intention of the task force to require that all of the professionals delivering child welfare services, as well as mandated child abuse reporters, should receive training, the task force also recognized that funding limitations would likely require the provision of training in stages. As a result, the task force proposed that Emergency Response social workers be given the highest priority for immediate training and that the Child Welfare Training Advisory Board, established by SB 834, be authorized to oversee training programs and to advise the Director of the State Department of Social Services in prioritizing the efforts of the program. It was the view of the task force that the continuing increase in child abuse allegations in California, the highly legal and technical nature of child abuse investigations, the need to protect the due process rights of children and alleged abusers, the complexity of child abuse situations, and the need for sensitive yet effective authoritative interventions to protect children, demanded that the highest training priority be given to those practitioners who respond to reports of abuse or neglect and make recommendations to the court regarding the need for dependency and other protective service interventions.

In summary, SB 834 does the following:

° Requires the Department of Social Services to select an agency to provide a statewide training program for public and private practitioners who work under the mandates of the child abuse reporting and child welfare services statutes. Specifically, the training would be required to:

1. Train county child welfare services social workers, social workers in agencies under contract to the counties to provide child welfare services, and mandated child abuse reporters.

2. Provide practice-relevant training to those persons and develop curriculum materials and training resources. The training is to include, but not be limited to, crisis intervention, investigative techniques, rules of evidence, indicators of abuse and neglect, assessment criteria, intervention strategies, and legal requirements of child abuse reporting laws.

3. Assess the program's performance annually. The assessment is to include the number of persons trained, the type of training provided, and the degree to which the training is perceived by participants to be useful in practice.

° establishes a Child Welfare Training Advisory Board composed of nine members appointed by the Director of the State Department of Social Services to facilitate the development of the training program;

° requires an appropriation of funds for the training through the annual Budget Act. If the allocation is insufficient, the State Department of Social Services is to prioritize the efforts of the program in consultation with the Child Welfare Training Advisory Board;

° amends the funding formula for statewide training and technical assistance programs which are contracted out by the Office of Child Abuse Prevention pursuant to AB 1733 (Chapter 1398, Statutes of 1982) in order to redirect these funds to the child welfare training program.

SB 1219 (Presley)

While the framework of California's child abuse reporting laws dates to 1963, the basis of the current reporting laws were established by SB 781 (Chapter 1071, Statutes of 1980). Since 1980, the child abuse reporting laws have been amended numerous times. These amendments have typically focused on the

definitions of child abuse, the categories of mandated reporters, and reporting procedures. Because the amendments have been made over a period of years, changes have been incorporated in a piecemeal fashion. It was the view of the task force that the language of the child abuse reporting laws needed clarification, and in some instances consolidation, to enhance their linkage with the child dependency laws under WIC Section 300 et seq., and the child welfare services laws under WIC Section 16500 et seq., to promote a more coordinated body of laws regarding the protection of children.

Therefore, the changes outlined in SB 1219 are designed to clarify the definitions of reportable child abuse, the duties of mandated reporters, and the responsibilities and authority of local law enforcement and county welfare and probation departments. It was the intention of the task force to propose clarifying language in SB 1219 which would eliminate existing ambiguities and assist all of the professionals involved in the protection of children -- local law enforcement agencies, county welfare and probation departments, the professionals mandated to report child abuse and neglect, as well as the community at large.

The following specific changes to the Penal Code reporting laws were enacted under SB 1219:

° Clarifies that the reference to corporal punishment in the definition of child abuse is a reference to "unlawful" corporal punishment, as defined elsewhere in the Penal Code;

° amends the term "child abuse" to exclude mutual affray between minors. The task force believed that clarification was necessary to exclude schoolyard fights from the definition of child abuse;

° supplements numerical cross reference to Penal Code sections in the definition of sexual assault with a listing of the type of conduct included. This change was added to assist mandated reporters in determining what constitutes reportable sexual assault of a child, recognizing that they generally do not have access to the full Penal Code;

° amends cross-reporting requirements to mandate law enforcement agencies to report suspected child abuse or neglect to county welfare departments only when it is alleged to have occurred as a result of the action of a parent or guardian, or as a result of the failure of a parent or guardian to adequately protect the minor from abuse or neglect. Since county welfare departments are only responsible for intervening in abuse and neglect situations which involve a person responsible for the child's welfare, the task force believed it was inappropriate to

refer cases to county welfare departments which do not involve the person responsible for the child's care. Such referrals set up false expectations that county welfare departments will intervene and provide services in situations that do not stem from the acts or omissions of parents or guardians (stranger abuse, for example);

° authorizes county welfare departments to determine if an immediate, in-person response to a report of child abuse or neglect is necessary, based upon a professional assessment which must include collateral contacts, a review of previous referrals, and an evaluation of any other information relevant to the allegation. The task force believed that professional assessment after receipt of a child abuse report should be seen as an opportunity for an in-person response if abuse or neglect is present or likely. This initial professional assessment will be made through governing regulations developed by the State Department of Social Services which clearly delineate the steps to be taken before a decision is made that a face-to-face contact is not appropriate, in order to ensure uniform county compliance and implementation.

PART II: ADDITIONAL RECOMMENDATIONS/UNRESOLVED ISSUES

While the changes incorporated in SB 243, SB 834, and SB 1219 are comprehensive in scope, the task force uncovered numerous other problems in child welfare matters for which it was felt additional legislation would be necessary or for which remedies were not immediately apparent. Among the issues is the ongoing need for adequate services to meet the needs of at-risk families, especially services which are targeted at the prevention of abuse or neglect, as well as services to meet the needs of minors who will no longer be eligible for juvenile court adjudication effective January 1, 1990. Other issues relate to juvenile court procedures, the growing number of special needs children for whom dependency procedures may be inappropriate or inadequate (infants born with AIDS or drug dependencies, for example), the need for additional Child Welfare Services (CWS) data collection, the special circumstances relating to incarcerated or institutionalized parents of dependent children, accountability for false child abuse reporting, and others. This section of the report describes these and other problems and, where possible, presents the task force's recommendations.

Services Issues

An issue consistently brought to the attention of the task force was the need for additional services for at-risk families and children. Representatives of public and private service agencies and advocates for children and parents expressed concern that prevention programs such as respite care, in-home caretakers, teaching/demonstrating homemakers, family therapy, support groups, parenting training and substance abuse rehabilitation programs are inadequate and should be expanded. County social service agencies, particularly in large urban counties, generally reported a lack of such prevention services and, therefore, an inability to accommodate in a timely fashion those families who require these services.

The task force recognized that these services, if adequate, could keep families from coming to the attention of the court, or for those who come to the attention to the court, prevent the need to remove children. In addition, the task force recognized that some minors who are presently adjudicated as dependents will no longer be served by the child welfare service system, effective January 1, 1990; therefore, alternative services must be developed for this category of minors. (SB 243 mandates the Health and Welfare Agency to report to the Legislature by January 1, 1989 its recommendations for alternative programs, funding streams, and service delivery systems for minors who will no longer be subject to adjudication.)

While the task force was uncertain about the precise impact of SB 243 on existing service demands, the task force affirmed the principle that the best alternative to removal of a child and placement in out-of-home care is a sufficient level of preplacement preventive services. The issue is discussed in more detail below.

° New Requirements for Reasonable Efforts. Under SB 243, WIC Section 306 (which governs the conditions under which a social worker may determine that a child must be removed from the natural home and placed in protective custody) states that in order to to provide maximum protection for children who are abused or neglected, a full array of social and health services should be available. It requires the social worker to consider if the provision of CWS services or a referral to public assistance would eliminate the need to take temporary custody of a child, and to utilize such services as are available. WIC Section 319 (which governs the court in determining whether a child should be returned home or continued in protective custody) requires the court to make a finding that reasonable efforts were made to prevent the removal of the child and to determine if there are available services to prevent the need for further detention. The court must also review the decision made by the social worker on whether or not to refer the family to public assistance.

A finding that reasonable efforts have been made in each case is required in order to qualify the child for federal foster care funds. These funds pay for 50% of AFDC placement costs. Under the federal Adoption Assistance and Child Welfare Act (PL 96-272), if the court finds that reasonable efforts have not been made in a given case, the state may not seek federal foster care reimbursement for the child. Therefore, the task force believes that the reasonable efforts language will provide an incentive to establish and fund services which would prevent the need to remove children from their families and ensure the maximum federal reimbursements.

However, the task force felt that the level of need for such preventive services is unclear. Therefore, the task force recommends that a comprehensive review of available services, combined with a review of the need for additional services, should be undertaken by an oversight body such as the Auditor General or the Legislative Analyst.

Moreover, the definition of "reasonable efforts" is unclear. The following listing was presented to the task force as indicative of the types of services that should be provided to children and families in order to show that reasonable efforts were made:

- Family preservation services (usually in-home, intensive services for brief period);

- generic family-based/family-centered services (usually not as intensive as family preservation);

- cash payment to meet emergency needs or to provide ongoing support;

- services to meet basic needs such as food, clothing, housing, and shelter for families;

- services to address specific problems, such as in-home respite care, out-of-home respite care, child care, treatment for substance abuse/chemical addiction, treatment for physical or emotional abusers and victims, treatment for sexual abusers and victims, mental health counseling/psychotherapy in a day treatment setting, parenting training, life skills training, and household management.

° Children and Families Not Subject to Juvenile Court Intervention But Who May Be at Risk. There exists another group of children and families who are not likely to come to the attention of the courts (neither under the prior guidelines of WIC Section 300 nor under those adopted by SB 243) until, possibly, the family situation deteriorates to the point that children need to be removed from home. These are children living in situations of neglect whose homes could be improved with minor assistance. The only source of identification of these fragile families has been the social service system. Some of these children are repeatedly reported to child protective agencies, but the threat to their health or safety is not considered severe enough for court intervention. Some of these families may be found in voluntary family maintenance programs, where services are provided for up to one year; however, supervision tends to be limited because of the crush of more serious cases. The real problem appears to be a lack of child welfare and other social servi s available to assist these families in the absence of a crisi Again, the task force recognized that the level of need for services, as well as the size of the population in need of services, are unknown factors.

For both groups of at-risk children, those who will come to the attention of the courts, and those not likely to, the key to avoiding long term foster care is early help. At this time, the courts and the social service agencies are organized to respond only when a major crisis exists, far beyond the point when early help would have saved a deteriorating situation.

° Who Should Provide These Services? Members of the task force agreed that after the identification of necessary preventive and placement services, an evaluation should be undertaken to determine whether these services should be delivered through the CWS system or whether another system would be more appropriate. One of the primary purposes of SB 243 is to delineate clearly the types of families which are best served in the dependency setting. Because a child has a mental health problem, a substance abuse problem, a serious medical condition, or demonstrates severe acting out, does not mean the child should become a dependent of the court and that his/her family should receive child welfare services. A variety of service resources which enable families to find help in overcoming their problems must be developed in appropriate agencies.

Several groups, task forces, and committees are already working on some of these areas. The task force recommends coordination of their proposals in order to avoid future duplication. Among those studying these areas include:

Senate Select Committee on Children and Youth. SB 243 mandates the Committee to conduct a hearing on the implementation of SB 243 and its effectiveness in ensuring protection for children who are at risk of abuse or neglect. The hearing shall be held prior to January 1, 1991. In addition, members of the task force are committed to continued, quarterly meetings, under the guidance of the Committee, to review of SB 243's implementation to ensure its effectiveness in protecting at-risk children and families.

Legislative Analyst. SB 243 mandates that the Analyst report to the Legislature on the effect of SB 243 no later than January 1, 1992.

Health and Welfare Agency. SB 243 requires the Agency to review the effect of SB 243 on minors adjudged dependents of the juvenile court, including any minors presently eligible for adjudication who will not be eligible for adjudication after January 1, 1990. It further mandates that the Agency prepare recommendations for new programs to be implemented by January 1, 1990, to meet the needs of these minors. The recommendations are to include appropriate funding sources and service delivery systems. The Health and Welfare Agency has recently convened an Out-of-Home-Care Task Force, which includes a broad representation of agencies and advocacy groups who are identifying populations in need of out-of-home care, service needs and licensing issues, and service delivery and coordination issues. Among the issues addressed by the Agency task force include the need for related services to reduce the need for foster care placement and supplement foster care placement.

The AB 4411 Task Force. AB 4411 (Chapter 830, Statutes of 1986) directed the State Department of Social Services to establish a task force to conduct a study of the problems of medically fragile children in care outside of an acute care hospital who are dependents or potential dependents of the court. The AB 4411 task force is to focus on the problems of medically fragile children and report to the Legislature their findings and recommendations. Recommendations are to include: Changes in licensing categories, how to ensure the ability to serve the medically fragile child, qualifications and training of care givers and suggested funding for any specific recommendations.

The Child Victim/Witness Judicial Advisory Committee. This committee is presently reviewing investigative and judicial practices and procedures as they pertain to child victims and witnesses, with particular emphasis on recommendations for coordination of related civil and criminal proceedings.

The task force recommends that any proposals for new or expanded programs which are developed by these and other groups stress access to services outside the dependency court system for those children whose service needs do not stem from abuse or neglect in the home. A variety of service resources which enable families to overcome their problems, not just those ordered by the juvenile court and offered through the child welfare system, should be developed by appropriate agencies working in coordination with one another. Additionally, alternative due process systems must be developed other than juvenile court dependency which would allow out-of-home placement for needed but not dependency-related services. One recommendation presented to the task force would be the development of a voucher system with which families could choose from a menu of services.

Infants Born with AIDS

The past five years have seen a major increase in the allegations of child abuse and neglect. In conjunction with the growth in reported incidences, the severity of cases has also increased, many clearly related to substance abuse. Thus, the child welfare system has seen a dramatic increase in the numbers of high risk children needing child protective services. In addition, the future dependent care system will be increasingly stressed by children with AIDS. There is a pressing need for activities at the state and local level to address issues of young children with AIDS. Additional resources and specialized care are needed in both the child welfare and foster care programs.

Therefore, the task force believes it is imperative that the Legislature convene representatives of the public and private sectors to address the multiple issues of drug dependency and

AIDS issues for children. Of primary importance to child welfare advocates is the correlation between AIDS, drug abuse, and sexual molestation. The task force agrees that the following concerns must be addressed:

° Should AIDS testing be required for parents and children from high risk backgrounds?

° What is the role of informed consent as it relates to testing children?

° Whenever possible, children with AIDS who need placement should be placed with the smallest population of other children to reduce chances of reinfection.

° Foster care/reimbursement rates may need to be raised for foster parents who care for children with AIDS.

° Foster parents of AIDS children need intensive support services (respite care, counseling, for example).

° There are unmet service needs to deal with the effects on parents or other children living with someone dying from AIDS.

° What is the best mechanism for linking with health care/dental care providers?

° How can counties begin to recruit and train foster parents for AIDS children before the need for homes becomes critical?

° Should AIDS testing for children from high risk backgrounds be required before making permanent placement decisions?

° What are the legal implications of placing a child for adoption or in foster care with as yet undiagnosed AIDS?

In short, the task force believes that dependency issues for children with AIDS are enormously complex and in urgent need of further study. It is likely that the number of children entering the dependency system with these conditions will stress existing resources beyond their ability to provide necessary services.

Special Needs Children

SB 243 continues to provide the court with three options when children cannot be reunified with their parents pursuant to the new WIC Section 366.26: Terminating parental rights for adoption, ordering legal guardianship, or ordering long term foster care placement. These options are appropriate for most children. However, county welfare departments supervise many

special needs children for whom extremely comprehensive efforts are required to determine whether or not an appropriate adoptive family can be found, when adoption is the preferred permanent plan.

For those children who are not immediately adoptable but for whom recruitment efforts have historically been successful in locating adoptive homes, a fourth permanent plan option would provide for an extended but still time-limited period to pursue these efforts. Active recruitment efforts would be made without disrupting a child's adjustment to an alternate long term plan, yet the child would have the opportunity to be placed in an adoptive family. Should the recruitment efforts be unsuccessful, the court could still order legal guardianship or long term foster care placements.

Specifically, the task force recommends new legislation to amend WIC 366.26 to include a fourth option which would allow the court, without permanently terminating parental rights, to identify for specifically defined special needs children adoption as the permanent placement goal and order that efforts be made to locate appropriate adoptive families for these children for a period not to exceed 180 days. The task force believes that the new fourth option would provide special needs children with the opportunity for a permanent home, instead of forcing the court to precipitously terminate parental rights or order an alternate permanent plan.

Party Status in Juvenile Court

The juvenile court is regularly faced with parties other than the biological parents of a dependent child who are requesting standing to participate in the court proceedings. The court must weigh the confidential nature of the proceedings against the desire to obtain all available information and the need to act in the best interests of the minor. Among those who routinely seek entry into juvenile court proceedings are foster parents, defacto parents, and extended family members. These individuals are treated with wide disparity in various courtrooms, ranging from being given standing to participate to requiring a formal motion to participate as substantiated by expert psychological witnesses, and from appointing counsel to denying the right to counsel.

The task force believes that refinement of the definition, standing, and rights of those seeking party status is needed to eliminate confusion and clarify varying appellate court decisions. Questions to be answered include: Who has a right to court appointed counsel? Does a person seeking defacto parent status need or have the right to court appointed counsel in order

to assert this status? By what burden of proof is the court to judge the parent-child psychological relationship in determining whether to grant standing?

Further, the task force recommends in determining what legislative guidance needs to be given, careful attention must be paid to the particular stage of the proceedings. A stepparent who has been the primary parental figure since infancy of a minor now twelve years old might need standing at the initial stages of detention, while a non-caretaking uncle desirous of placement may not bear consideration for standing until dependency has been established. Even then the parent's and the child's right to privacy require careful consideration. Finally, a foster parent who has established a strong relationship with a child and who desires permanent placement of the child, may appropriately request standing at the permanency planning stage but be denied standing at earlier stages because of his or her special interest in the proceedings.

Testimony of Children in Chambers

The taking of children's testimony in chambers under specific circumstances as authorized by Civil Code Section 232(b) and WIC Section 350(b) has been upheld as permissible by the appellate courts. Problems in implementation of these provisions have arisen, however, as the code sections themselves do not detail the procedures to be followed in determining when a child's testimony should be taken in chambers. Further, existing law does not provide guidance in determining how to take a child's testimony in chambers if the child's parents are proceeding without an attorney and object to being excluded.

The task force initially thought that only technical changes in existing law would be needed to clarify and resolve these matters. However, difficult issues regarding due process and rights of confrontation quickly surfaced. Moreover, the task force was aware that the legislatively established Child Victim/Witness Judicial Advisory Committee is studying this area carefully. As a result, the task force chose not to address these matters further, leaving it to be noted in this report as an unresolved issue which should be addressed further by the Child Victim/Witness Judicial Advisory Committee. The task force also noted that laws relating to the taking of children's testimony in chambers have never been enacted for family law hearings, although the concerns addressed by such statutes apply equally to family law hearings.

Incarcerated and Institutionalized Parents

SB 243 repeals prior law specifying that family reunification services must be provided upon the release of an incarcerated or institutionalized parent. In its place, SB 243 requires that reasonable services be provided to reunify the family unless the court determines that the services would be detrimental to the minor, based upon a nonexclusive list of factors to be considered (such as age of the child, degree of parent-child bonding, length of treatment or incarceration, etc.). SB 243 also specifies that a parent may be required to attend counseling, parenting classes, or vocational training as a part of the service plan.

These provisions represented the task force's consensus for improvements. However, the task force also agreed that there are remaining issues to be resolved, but that additional information is needed before attempting further legislation. Advocates for prisoners with children estimate that there are 6000 incarcerated women and 45,000 incarcerated men with minor children. Further estimates are that about one-third of the children with incarcerated mothers are in foster care. There are no figures for fathers. The members of the task force, as well as providers of services to this population, agreed that the collection of data and study of the following:

° Census of the population of incarcerated parents with children in foster care, including a distinction between those with previous existing relationships and those with no contact;

° statistical information regarding the numbers of children in foster care with incarcerated/institutionalized parents;

° practices and procedures utilized by counties for notifying incarcerated parents of dependency proceedings;

° barriers which discourage parents from attending juvenile court hearings;

° recidivism rates of parents with custody of children;

° frequency of visits to incarcerated/institutionalized parents by children placed in foster care.

Additionally, other significant issues came to the task force's attention which could not be resolved. These include:

° Whether increased assistance to relatives, such as legal assistance with guardianships, would lessen the need for dependency proceedings;

° whether it is feasible to establish circumstances under which a nonabusive parent would be denied services, such as a lengthy prison term;

° how to improve communication and access between the county with custody of the child and the incarcerated parent, and between the county and the correctional system.

Parental Rights When Children Are in Long Term Out-of-Home Placement

Under existing law, parents can lose long term custody of their children although their parental rights may not be terminated. Such children are in guardianships or long term foster care placement. Existing WIC Section 366.3 allows parents of such children to re-petition for custody or visitation and reunification services, should their situation improve and allow for custody to be resumed. Under SB 243, such parents will receive notice of failed guardianships or any juvenile court hearings regarding the minor.

However, some advocates for parents reported to the task force that additional clarification was needed. The most likely case would involve noncustodial parents who are not in a position to seek custody at the time of intervention but whose circumstances later improve. The task force did not develop additional legislative recommendations as the consensus was that present law is adequate. Nevertheless, the task force agreed that such parents should have the right to seek custody and/or services and that future legislation may be necessary for clarification if local practice is contrary to existing law.

Child Welfare Services Information Concerns

The task force recognized that while reports of child abuse and neglect continue to escalate, there is no statewide Child Welfare Services (CWS) reporting system providing both accurate and current information on individual county CWS programs. Yet the State Department of Social Services (SDSS) is responsible for monitoring each county's CWS program and knowing when and what statutory and regulatory changes are needed to ensure that CWS programs are effectively in place to protect at-risk children and their families.

Currently, CWS information is obtained from four sources: the Preplacement Preventive Services Report, the Foster Care Information System, special statistical surveys, and county compliance reviews. The Preplacement Preventive Services Report is designed to collect aggregate caseloads for the Emergency

Response and Family Maintenance programs; the Foster Care Information System collects child specific information on children in the Family Reunification and Permanency Planning programs; and the surveys and compliance reviews are conducted periodically to gather needed information which is not available from the other two sources. However, these four sources still do not provide sufficient information to adequately assess the CWS programs. In addition, these evaluations often contain information which is inaccurate or out of date.

To adequately manage and assess the four Child Welfare Services programs, the State Department of Social Services reported to the task force that it believes a statewide CWS case management system is needed which will collect case specific information on children in each of the four programs. This information should provide historical and longitudinal information on each child, collect aggregate information for program management purposes, and provide complete and reliable information to assess county compliance. The task force also believes that the information must be accurate, timely, and readily accessible to state and county staff to enable them to make appropriate, expeditious program decisions. The information should also be useful to the Legislature in determining whether policy changes are needed and whether sufficient funds have been allocated to provide an appropriate level of services.

Specifically, the SDSS recommends that data gathered should enable current and accurate answers to the following questions:

° Who are the children receiving CWS?

Has the child been referred previously? If so, how many times and when was the most recent referral?

Who referred the child (e.g., neighbor, police, school)?

Under which CWS program is the child currently receiving services?

Under which CWS program(s) has the child previously received services? How long did the child remain in each program?

How old is the child? What is the child's ethnicity? the child's sex? What disabilities does the child have?

Is the child part of a sibling group? What is the composition of the sibling group? Where are the siblings located?

° Why are these children receiving CWS?

Has the child been physically abused?

Has the child been sexually abused?

Has the child been neglected or abandoned?

Has the child been exploited?

° Where are these children residing while receiving CWS ?

Was the child removed from a custodial/noncustodial parent, guardian, or relative?

Has the child ever been removed before? If so, how many times, and when was the most recent removal?

Is the child living with a custodial/noncustodial parent or guardian?

Is the child placed with relatives?

Is the child placed in an emergency shelter care facility?

Is the child placed in a foster home or a group home?

Is the child's placement appropriately licensed, or is it exempt from licensing?

What is the child's address?

Is the child placed with siblings?

How many placements has the child had? How long did each placement last?

° What are the goals for the child receiving CWS, and how will these be achieved?

Is the child to remain with the parent or guardian?

Is the child to be removed from the parent or guardian?

Is the child to be returned to the parent or guardian?

Is a guardian being sought for the child?

Will the child be maintained in long term foster care?

What services is the child receiving?

° Who is responsible for the children receiving CWS?

What county is responsible for the child?

What agency within the county is responsible for the child? Who is the social worker?

Has the child been freed for adoption for twelve months and no petition for adoption been granted?

Is the child receiving CWS by voluntary agreement with the parent or guardian, or by court order?

Is there a foster family agency involved?

° Are CWS regulations being met?

Are agencies responding to emergency referrals within required time frames?

Is the child's situation being assessed and reassessed according to the required time frames of the program?

Is an individual service plan being developed within the required time frames?

Is the court assessing the child's progress in the CWS system as frequently as required?

Is the child being visited as frequently as required?

Are foster parents being contacted as frequently as required?

Is the child's adoptability being determined, when appropriate?

The State Department of Social Services reported that it is currently conducting a study to determine the feasibility of designing a statewide online case management information system similar to other systems which are already in operation at the state level, or accessing other individually operated county automated data systems. Specifically, the primary focus of the feasibility study is to analyze all practical automated systems in order to determine the most viable method for gathering and processing county and statewide CWS data.

In addition to these data, however, the task force recommends that additional data are needed which will help to understand the way in which reports of abuse and neglect are responded to by CWS workers. The SDSS reported that 60% of all cases where abuse or

neglect is suspected are closed after the initial investigation. However, these figures do not reveal whether the report was unfounded (false, or no abuse or neglect found); unsubstantiated (insufficient evidence to make a finding of abuse or neglect); or whether a family might have been in need of some services (most likely prevention services) but there were insufficient resources available and/or the worker's caseload was already unmanageably high. Moreover, some concern was expressed to the task force over the new provision of SB 1219 which allows an initial assessment in determining whether or not an immediate face-to-face response is required. Therefore, in addition to the above information, data collection should also focus on the following items:

- The number of reports received;
- the number of these reports responded to face-to-face;
- the number of reports responded to in some other fashion, and the reason why;
- the number of unfounded cases;
- the number of unsubstantiated cases;
- the number needing prevention services where no referral was available.

Accountability for False Reports

The task force discussed the issue of ensuring accountability for individuals who knowingly make false reports of child abuse or neglect or who make reports with reckless disregard for the truth. This issue was addressed in response to the perception among many professionals that as public awareness increases, there has been an increase in false reports of child abuse, especially allegations of sexual abuse in the context of custody and visitation disputes. Those individuals who falsely report appear to be using their increased knowledge and sophistication to willfully manipulate the legal system to achieve their personal agendas, such as attempting to gain custody of a child or deny visitation rights to the accused, or retaliating against a family member or neighbor. Such false allegations are disruptive to the judicial system and cause mental and financial suffering to the falsely accused party. In some circumstances, the false allegations also have a detrimental affect on the children who may be subjected to detailed interviews and/or removed from the home.

While the task force recognized that the best available evidence indicates that false reports constitute a small percentage of total reports, the consensus was that the matter warranted serious consideration because of the potential trauma caused to a child unnecessarily removed, potential damage to an individual's reputation from a false report, and the seriousness of the resulting consequences. However, this issue proved difficult to address. Among the factors to be considered are the following:

° California, as does every state, attempts to encourage its citizens to protect children by reporting suspected child abuse without fear of legal consequences through the provision of statutory immunity from civil and criminal liability to persons making good faith reports.

° California's statute provides that no mandated reporter who "reports a known or suspected instance of child abuse shall be civilly or criminally liable for any report required or authorized by this statute." The statute further provides that "[a]ny other person reporting a known or suspected instance of child abuse shall not incur civil or criminal liability as a result of any report authorized by this article unless it can be proven that a false report was made and the person knew that the report was false or was made with reckless disregard of the truth or falsity of the report, and any such person who makes a report of child abuse known to be false or with reckless disregard of the truth or falsity of the report is liable for any damages caused." (Penal Code Section 11172, subd.(a)).

° Mandated reporters must report when they "reasonably suspect" child abuse; they are fully protected from civil and criminal liability for making such a report. For other reporters, California statutes clearly permit civil actions against those who knowingly make false reports or knowingly make reports with reckless disregard for the truth or falsity of the report. Further, existing law also authorizes a court to order a party, and/or his attorney, to pay reasonable expenses incurred by another party as a result of bad faith or frivolous actions intended to cause delay.

In light of these facts, the task force discussed the following remedies:

° Civil Remedies. Those individuals who believe they have been the object of a deliberate false report may secure counsel and then try to prove the report was knowingly false or made with reckless disregard for the truth. However, most individuals do not pursue this course of action because of the expense and time involved, or because they are advised by counsel of the difficulties in proving that a report was knowingly false or made with reckless disregard for the truth.

Yet the language of the statute is quite explicit in permitting civil actions against those citizens who knowingly make false reports or knowingly make reports with reckless disregard for the truth. As a result the task force made no recommendations for changes to this statute.

° Criminal Remedies. Since civil remedies for false reports are difficult to pursue and prevail in under existing law, the task force discussed the possibility of creating a specific misdemeanor sanction for false reports. But the task force was reluctant to create a new crime, particularly one that appeared relatively difficult to enforce and one that might discourage legitimate reports by persons who fear being charged with a crime.

° Family Law Remedies. One additional approach discussed was the imposition of court sanctions in family law proceedings on a person who makes a groundless accusation of child abuse against another person. This approach is currently being considered by the Legislature through Senate Bill 1461. SB 1461 would require the imposition of a sanction of up to $5,000 against a party to a family law proceeding, or his or her attorney, or both, if the court finds that an allegation of child abuse made against another party in that proceeding was groundless and made in bad faith to harass the party so accused. The bill would also require the Judicial Council to incorporate a statement on the petition for dissolution of marriage giving notice of the sanctions, which could act as a deterrent to false reports. Caution must be urged in these instances, however, since legitimate cases of child abuse often surface during a dissolution. Failure to make an appropriate finding could result in punishment of parents legitimately concerned about protecting their child and placement of the child in the custody of, or ordering visitation with, an abusing parent.

In summary, existing law authorizes a court to order a party, and/or his attorney, to pay reasonable expenses incurred by another party as a result of bad faith or frivolous actions intended to cause delay. Civil actions for slander or malicious prosecution are also available. The task force felt that if the authority of these laws does not deter the making of false allegations, it is difficult to see how the addition of similar, albeit more specific, laws would curb the vexatious instincts of some individuals. Nevertheless, the task force also recognized that false allegations of child abuse have ramifications which warrant consideration of additional imposition of monetary sanctions in family law proceedings, since abuses occur most frequently in this situation. Such allegations could result in the loss of custody of the children, the loss of a job, and the accumulation of large attorney's fees. Moreover, where the children are taken out of the home or are used as pawns in a

difficult divorce action, the impact of false allegations on the children may be the equivalent of child abuse.

The task force remains concerned about those who may be falsely accused. However, the task force supports the state's goal of encouraging its citizens to protect children by reporting suspected child abuse and is unable to suggest any legislative remedies beyond the civil remedies currently provided for in statute and the proposal currently in the Legislature (SB 1461).

Issues in Child Abuse Investigations on Federal Property

Public Law (PL) 99-145, enacted in November of 1985, established a Department of Defense (DOD) Family Advocacy Program (FAP) and Family Advocacy Committee (FAC) and encourages states to report to the Secretary of Defense suspected instances of child abuse involving military personnel. Memoranda of Understanding are encouraged between local governments and federal authorities at each federal military installation to facilitate cooperation in dealing with child abuse involving military personnel or their dependents.

In attempting to comply with the DOD's formal request for state assistance in a joint federal/state effort to establish cooperative reporting procedures regarding suspected instances of child abuse involving military personnel on federal property, the State Department of Social Services has encountered several issues concerning confidentiality provisions for both federal and state child abuse records. The task force felt that resolution of many of these issues is necessary before cooperative efforts between county welfare department and military installation officials can be realized. Major issues are summarized as follows:

° Conflicting Federal Confidentiality Requirements. PL 99-145, which encourages the reporting of suspected child abuse to representatives of the Secretary of Defense, appears to be in conflict with the federal confidentiality requirements expressed at 45 CFR Section 1340.14(i)(2)(viii), which prohibit sharing of such information with persons other than categories specified. Military personnel are not a specified category with whom child abuse information may be shared.

° State Confidentiality Requirements. California law, contained in Penal Code Section 11167.5, prohibiting the sharing of any child abuse report information except to specified individuals, does not include various potentially involved persons among those individuals specified in law who may receive child abuse report information. For example, military policemen (MP) at entrances of a military installation are required to know

the identity of visitors and the purpose and destination of the visit. When possible abuse has been identified, the Family Advocacy Representative (FAR) accompanies the social worker to the home. The FAR is frequently present throughout interviews on base regarding allegations of child abuse.

In addition to the presence of this "unauthorized" person at the interview session, neither the state nor the county has control over any written records kept by the FAR, nor over any accessibility to records kept by other military personnel. It is also not clear whether the federal intent is to have child welfare and other social services provided to families.

Military establishment interests also seem to focus on the determination of the impact of the alleged abuse on the alleged perpetrator's capacity to perform his or her military responsibilities. The federal government is the employer of alleged child abuse perpetrators who are members of the military. This presents a unique circumstance under which an employer has access to child abuse report information involving an employee. It could result in sanctions against military personnel for whom an allegation of abuse is later found to be unsubstantiated.

° Other Jurisdictional Concerns. Various matters relating to civilian dependents residing on military property, civilian abusers residing on federal property, and prosecution rights are unclear. Some states have established policy on a base by base basis. U.S. Military Justice applies only to active duty military personnel; it does not apply to civilian dependents residing on federal lands. When abuse by military personnel occurs on nonfederal property, is investigation of abuse in this circumstance subject to local or federal law, or both?

° Mobility of Military Personnel. The nature of employment with the military often involves travel and frequent changes of duty stations. In the event of alleged abuse, there is no guarantee that a family will remain at a duty station for the period of time needed to receive child welfare services. In addition, since child abuse report information may not be shared with military personnel, there may be no way to follow up on an abuse allegation. The alleged perpetrator may be relocated before an investigation could be completed and there would be no record of prior abuse allegations in the new location.

CONCLUSION

The task force believes that SB 243, SB 834, and SB 1219 will go far towards ensuring greater continuity among child abuse reporting laws, dependency statutes, and child welfare services and, consequently, enabling the greater protection of at-risk children and families. Much work remains to be done in these areas, however, and the task force, in coordination with other interested groups and agencies, will need to continue their efforts on behalf of abused and neglected children and their families. A major priority of the task force and other groups must be developing means of ensuring the funding and provision of public and private services to alleviate family crises which threaten the well being of children, to prevent the breakup of families, and to reunify families when children need to be removed for their safety.

Exhibit D: Minutes from the Meetings of the Task Force on Child Abuse Reporting Laws

MINUTES OF SB 1195 TASK FORCE MEETING

JANUARY 30, 1987

ANNOUNCEMENTS:

1. The Wald language is now in bill form (SB 243).

2. Senator Richardson's training bill has been reintroduced (SB 254). Jane announced that there would be a meeting on Monday, February 2, 1987 among interested parties to discuss short-term and long-range funding sources for CWS/mandated reporter training.

3. Loren announced that Santa Barbara County has done a study of their CWS referrals that are determined to be unsubstantiated or unfounded. He and Nina Grayson are planning to review the findings of this study to get more precise information regarding types of referrals that possibly should be excluded from the mandatory reporting requirements.

4. Jean McIntosh reported on the incidence of drug-addicted infants in the Los Angeles CWS caseload. The concern about the increasing size of this population and the mounting difficulty of recruiting suitable placement resources was reiterated.

5. It was agreed that the next Task Force meeting would be held in Sacramento on February 19th and 20th. Task Force members will be advised of the exact location as soon as possible. Additionally, the April 3rd meeting has been changed to April 10th.

The remainder of the meeting was dedicated to a thorough discussion of WIC Section 300. The Task Force was able to reach consensus of language as listed below although it should be noted that additional changes may be required after members have had the opportunity to discuss the proposed language with their constituencies/administrations.

1. It was initially agreed that revisions to Section 300 are, in fact, necessary, with the caveats that (1) care is taken to make sure that the system will not exclude a child who is in danger, and (2) implicit in the authority to intervene is the responsibility to provide the services needed to resolve the situations.

2. Section 300(a): The language agreed upon is as follows:

"The minor has suffered, or there is a demonstrated danger that the minor is at risk of suffering, serious physical harm, inflicted nonaccidentally upon him or her by his or her parent or guardian."

3. Section 300(b): The language tentatively agreed upon is as follows:

"The minor has suffered, or there is a demonstrated danger that the minor is at risk of suffering, serious physical harm or illness, as a result of the failure of his or her parent, guardian or primary caretaker to adequately supervise or protect the minor, or by the willful failure of the parent, guardian or primary caretaker to provide the minor with adequate food, clothing, shelter or medical treatment, or by the inability of the parent, guardian or primary caretaker to provide regular care for the minor due to the parent, guardian or primary caretaker's use of drugs, alcohol or mental illness or developmental disability. No person may be judged a dependent child solely due to the lack of an emergency shelter for the family."

With respect to the definition of "primary caretaker," it was agreed that: "For the purposes of this Section, a primary caretaker is defined as a person assuming a parental role during an extended or continuing absence of the parent or guardian."

4. Section 300(c): The language tentatively agreed upon is as follows: "The minor is suffering serious emotional damage, evidenced by severe anxiety, depression or withdrawal, or untoward aggressive behavior toward self or others as a result of the conduct of the parent or guardian."

It should be noted that the descriptive term "untoward agressive behavior" may need to be changed.

5. Section 300(d): The language agreed upon is as follows:

"The minor has been sexually abused as defined in subdivision (b) of Section 11165 of the Penal Code by his or her parent or guardian, or a member of his or her household, or the parent or guardian has failed to adequately protect the minor from sexual abuse when the parent or guardian knew or reasonably should have known that the minor was in danger of sexual abuse."

6. Section 300(e): The language tentatively agreed upon is as follows:

   "The minor is under the age of three and has suffered physical abuse by a parent, or by any person known by the parent, if the parent knew or reasonably should have known that that person was physically abusing the minor..." The remainder of the Section reads as currently proposed by Michael. It should be noted that the last sentence of this Section, referencing Section 332, may or may not be necessary. Michael's intent with respect to its inclusion in Section (e) needs to be clarified.

7. Section (f): It was agreed to delete this Section.

8. Section (g): It was agreed to delete this Section.

9. Section (h): It was not clear to the Task Force why this Section has been included. It was agreed to leave this Section in the bill, substituting the language as presently written in Section 361.5(b)(4), until this issue can be discussed further with Michael.

10. Section (i): It was agreed to accept the language as written with the exception of modifying the first clause as follows: "The minor has been left without provision for care or support;..."

11. Section (j): It was agreed to delete this Section.

12. Section (k): It was agreed that this Section should remain as written.

13. Section (l): It was agreed to delete this Section.

At the next meeting, these agreements will be reviewed and additional changes will be made as necessary. Additionally, the remainder of SB 243 will be reviewed and work will begin on revisions to the Reporting Law.

MINUTES OF SB 1195 TASK FORCE

FEBRUARY 19-20, 1987

ANNOUNCEMENTS:

1. Jane introduced Dr. Sherry Skidmore who has joined the Task Force as the representative of the California Psychological Association.

2. Jane provided a bill status update: SB 243 is the only bill, of the package of bills previously discussed by the Task Force, in print as yet. Language has gone to Legislative Counsel for the Attorney General spot bill which is to be used as the vehicle for reporting law revisions. Work is continuing to address the training needs for social workers and mandated reporters via Senator Richardson's SB 254 and an additional bill to be carried by Senator Presley.

3. Jane updated the Task Force on the efforts of other task forces which are addressing related issues. These include the Child Victim Witness Advisory Committee and Senator Watson's task force to study the effect of child abuse reporting laws on education personnel.

4. Loren reported on his discussions with CWS supervisory staff in Santa Barbara County. He also informed the Task Force of CWDA's expectation that the Task Force will deal with the issue of requirements for response times to child abuse and neglect referrals.

5. Jean announced that Congressman George Miller is holding hearings on the increasing number of babies with AIDS and the potential impact of this problem on the child welfare services system. She will provide the Task Force with a copy of the testimony she presents at the hearing.

A discussion followed of the proposed changes to Section 300 that were tentatively agreed upon at the last meeting. Additional revisions were proposed and agreed upon as described below. Except where otherwise noted, the revisions reference the language contained in the Task Force Minutes of the January 30th meeting.

1. Section 300(a): Delete the comma after "harm." Replace "him or her" and "his or her" with "the minor" and "the minor's" respectively.

2. Section 300(b): beginning on line 10 of this Section, the language is modified to read: "...guardian or primary caretaker's mental illness, developmental disability or substance abuse. No person may be judged a dependent child solely due to the lack of an emergency shelter for the family."

Note: there was considerable discussion with respect to 300(b) regarding the issue of failure to provide medical treatment based on religious beliefs. It was agreed that this issue needs to be addressed, possibly through cross-reference to another Section (e.g. 360-361). Margie Schwartz will work on this issue and it will be discussed again at the next meeting.

3. Section 300(c): The language was modified to read: The minor is suffering serious developmental delay, or serious emotional damage evidenced by severe anxiety, regression, depression or withdrawal, or untoward aggressive behavior toward self or others as a result of the conduct of the parent or guardian."

Note: With respect to 300(c), it was agreed that:

a. There needs to be further thought about a better way to define the conduct of the parent or guardian.

b. "Untoward aggressive behavior" still does not strike the Task Force as a satisfactory descriptive term.

c. The consensus of the Task Force is that this Section is not intended to include pre-natal conduct.

4. Section 300(d): The language was modified as follows:

"The minor has been sexually abused, or there is a demonstrated danger that the minor is at risk or being sexually abused, as defined in subdivision (b) of the Penal Code ....." The remainder of the language in this Section remains unchanged.

5. Section 300(e): Following a great deal of discussion it was decided to change the age reference in this section to five instead of three in order to generate input/reaction from interested parties. The first line of this Section is therefore modified to read:

"The minor is under the age of five and has suffered...." Otherwise the language remains the same.

After discussion with Michael regarding his intent with respect to the inclusion of the last sentence of this Section, referencing Section 332, that this sentence should remain in the revised language.

Note: From this point forward in the minutes, reference should be made to SB 243 as introduced on January 26, 1987 rather than to SB 1195 Task Force Minutes of prior meetings.

6. Section 301: It was tentatively agreed that the word biological should be struck wherever it appears in this Section: p.14, line 39; p.15, lines 5 and 9. It was also agreed that (b) and (c) should be renumbered as (a) and (b).

7. Section 304: After extensive discussion regarding the potential impact of this Section, it was tentatively agreed to leave it in for the time being with the following modification:

Beginning on line 21, the language is modified to read:

"In deciding issues between the parents or between a parent and a guardian regarding custody of a minor who has been adjudicated a dependent of the juvenile court, the juvenile court may review any records that would be available to the domestic relations division of a superior court hearing such a matter."

Note: In discussing the potential cost impact of the proposed Sections 304 and 317, it was agreed that it would be helpful to get some estimates of possible reductions in caseloads that may result from implementation of the proposed Section 300 provisions. Marsena agreed to try to get some input from the counties on this issue.

7. Section 305: It was tentatively agreed to retain the current 305 language with the addition of a new subsection (d) to read as follows:

"Before taking a minor into custody, a peace officer shall consider in consultation with the social worker, if available, whether there are any reasonable services available which, if provided to the minor's parent, guardian or caretaker, or to the minor, would eliminate the need to take the minor into temporary custody or if there is a suitable alternative voluntary residence for the minor."

8. Section 306: It was tentatively agreed to retain the current 306 language with the exception that subsection (c) is amended to read as follows:

"The minor has been left without any provision for support; or the minor's parent has been incarcerated or institutionalized and cannot arrange for the care of the minor; or a relative or other adult custodian with whom the child has been left by the parent is unwilling or unable to provide care or support for the child and the whereabouts of the parent who left the child is unknown and reasonable efforts to locate him or her have been unsuccessful." (This is the language that is currently found in Section 300 (i)).

9. Section 307: Although SB 243 deletes this section, it was suggested that it be put back in. If this decision is made exact language will be developed at a later meeting.

10. Section 308: It was tentatively agreed that the following changes would be made to the language:

P. 19, line 12: delete "place where he or she is being held" and substitute "exact whereabouts of the minor";

P.19, line 21: add "," after nondisclosure and delete "prior to the detention hearing,";

P.19, line 27: amend to read "where the minor is being held in which case the county welfare department shall be responsible for ensuring regular telephone contact between the parent and child prior to the detention hearing." The remaining language in this Section remains the same.

This concluded the discussion of Section 300 et seq. There followed extensive discussion of proposed ideas for freedom from parental custody actions. The following tentative agreements were reached:

1. Conduct permanency planning hearing as it is currently done under 366.25 WIC. The statute will include detail of actions that need to be done prior to the PPH in order to determine appropriate recommendation. Jean McIntosh agreed to provide the Task Force with this information.

2. The 232 petition would be ordered to be filed in the Juvenile Court within a specified period of time from the PPH. The number of days that would fall within the specified time period has not been decided.

3. The 232 action would be heard in Juvenile Court but by a judge other than the judge who conducted the permanency planning hearing and ordered the filing of the 232. In this way it will be heard by a judge who hopefully understands both dependency cases and the need to provide stability for the children in a timely fashion.

4. The 232 would have to be completed within six months from the return of cite unless there is a show of good cause stated on the record.

5. There would be a preference for appointment of the same attorneys in the 232 action as represented the parties in the dependency.

MINUTES OF THE SB 1195 TASK FORCE
MARCH 13, 1987

1. Two additional meetings have been scheduled on April 24 and May 8, in the State Capitol (April 24 - Rm. 3191, May 8 - Rm. 115.) The next scheduled meeting is April 10, Rm. 113, State Capitol.

2. Section 300 (b) was further modified by adding the following to the end of the section: "No minor shall be found to be a person described by this section if the wilfull failure of the parent or guardian to provide adequate medical treatment is based on a sincerely held religious belief and if a less intrusive court intervention alternative is available."

3. Section 300 (c) was further modified to read: "The minor is suffering serious emotional damage evidenced by severe anxiety, regression, depression or withdrawal, or untoward aggressive behavior toward self or others as a result of the conduct of the parent or guardian.

   No person shall be found to be a person described by this section if the wilfull failure of the parent or guardian to provide adequate mental health treatment is based on a sincerely held religious belief and if a less intrusive court intervention alternative is available."

4. It was agreed that we will add the sexual exploitation portion of Section 11165 (b) of the Penal Code and any other appropriate Penal Code sections to the end of Section 300 (d). Also, we will add the phrase "For purposes of this section sexual abuse means both sexual abuse and sexual exploitation.

5. Section 300 (i) was amended to read "The minor has been left without provision for care or support; the minor's parent has been incarcerated or institutionalized and cannot arrange for the care of the minor; or a relative or other adult custodian with whom the child resides or has been left by the parents is unwilling or unable to provide care or support for the child; the whereabouts of the parents are unknown and reasonalble efforts to locate them have been unsuccessful."

6. There was a very tenuous agreement to do the following:

   a. Combine the Permanency Planning Hearing and the Civil Code 232 process.

   b. Require mandatory counsel for the parent(s).

   c. Include the attached changes to WIC 366.25.

It was also agreed that the above items are a package and that there would not be any agreement to proceed with the items individually with the possible exception of the WIC 366.25 stuff.

MINUTES OF THE SB1195 TASKFORCE

APRIL 10, 1987

1. The next Task Force meeting will be on April 24 in State Capitol Rm. 3191. Discussion will focus primarily on changes to the Child Abuse Reporting Law. Some time will also be devoted to unresolved issues surrounding proposed changes to WIC Sect. 366.2(e) regarding guardian ad litem.

2. SB243 is set for hearing before Senate Judiciary Committee on April 28. However, if insufficient members are present due to holiday travel, the hearing may be put over until May 5, which is the latest date for bills to clear this policy committee. Since SB1219, which is the vehicle for reporting law changes, is not an appropriation measure, the deadline for its passage out of policy committee is later in May.

3. Despite concerns expressed from several quarters that the proposed WIC 300 language too narrowly restricts circumstances in which children come under the jurisdiction of the juvenile court, the members agreed that no changes are warranted. Instead, it was agreed that the members need to lobby legislative committee members to clarify that enactment of the language will not preclude less seriously abused/neglected children and their families from receiving voluntary services or referral to other appropriate resource agencies. Also, the controversial restrictive term "demonstrated danger" may be used as a bargaining chip and the term "substantial risk" substituted if this becomes a sticking point to passage.

4. The Task Force members agreed that AB2274-Frazee language for WIC Sect. 317 to provide counsel to parents should not be considered apart from a provision for combining permanency planning hearing and termination of parental rights proceedings. Jane Henderson was requested to contact Assemblyman Frazee about having AB2274 withdrawn.

5. It was agreed that WIC Sect. 280 should be amended to include cross-references to sections 358, 358.1, 361.5, 364, 366, and 366.2.

6. It was agreed to amend proposed WIC Sect. 304 by deleting the phrase "utilize any services, and" on line 32 of page 10 of the March 30 version of SB243.

7. It was agreed to retain the language of existing statute for WIC Sect. 305 removal standards with two modifications: (1) Delete the introductory phrase "Who is under the age of 18 years" from subsections (a) and (c); and (2) Eliminate the period at the end of the existing language in

subsection (a) and add "and is in immediate need of medical care, or is in immediate danger of continued physical or sexual abuse, or whose physical environment poses an immediate threat to the child's health or safety."

8. Changes to existing statutory language of WIC Sect. 306 are:
In subsection (a) add "(g)" after the words "Section 300";

In subsection (b) delete the words "and is in need of care." at the end and substitute "and is in immediate need of medical care, or is in immediate danger of continued physical or sexual abuse, or whose physical environment poses an immediate threat to the child's health or safety.";

In subsection (c) after the word "subdivision" delete the words "(a) or (b) of Section 300." and substitute "(g).";

Add new subsection (c) to read "(c) Before taking a minor into custody a social worker shall consider whether there are any reasonable services available which, if provided to the minor's parent, guardian, or caretaker, or to the minor, would eliminate the need to remove the minor from the custody of his or her parent, guardian, or caretaker. If those services are available they shall be utlized."

9. Agreed changes to proposed WIC Sect. 308 language as it appears in the March 30 version of SB243 are to delete subsection (b) and redesignate subsection (c) as (b). New language is to be inserted in subsection (a) on line 29 between "held." and "The" to read "In such instances when the whereabouts cannot be disclosed, the peace officer or social worker shall make diligent efforts for insuring regular telephone contact between the parent and child, prior to the detention hearing.".

10. Changes are necesssary to proposed WIC Sect. 309 language in the March 30 version of SB243 on page 15, line 25 to make references to new Sect. 300 provisions read "described in subdivision (a), (b), (c), (d), or (e) of".

11. Language is to be added to proposed WIC Sect. 315 on page 15, line 36 between "article," and "the" to read "and has not been released,". (This and all following references are to the March 30 version of SB243)

12. Proposed WIC Sect. 316 language on page 16 is to be changed on lines 10 and 11 to delete "and" at the end of line 10 and substitute "any", and on page 11 after "minor" insert "over the age of 10". On line 14 delete "over the age of 10".

13. Changes to proposed WIC Sect. 317 are to delete the entire

first sentence of subsection (b) commencing with "In" on page 16, line 24 and ending with "minor." on line 27. Also delete the word "other" at the end of line 27 and substitute "may" for "shall" at the end of line 29. In subsection (c) substitute the words "the parent or" for "the" at the beginning of line 3, page 17, and on line 5 insert "parent or" between "the" and "minor". In subsection (d) on line 11 insert "for the minor" between "counsel" and "shall". Also, in line 22 substitute "four" for "five".

14. It was agreed to retain existing statutory language in WIC Sect. 328 without change.

15. It was agreed to delete the last paragraph of proposed WIC Sect. 336, subsection (e), page 23, lines 14-17 inclusive.

16. In proposed WIC Sect. 353 on page 23, line 28, place a "." after "present" and capitalize the "t" in "the".

17. In proposed WIC Sect. 355.1(a) on page 24, line 30 delete "or (c)" and insert "or" between "(a)" and "(b)".

18. In proposed WIC Sect. 364(e) on page 30, lines 24 and 28 revise Section 300 cross-references to read "subdivision (a), (d), or (e)".

19. In proposed WIC Sect. 366.2(c) on page 31, line 22 insert "provided or" between "services" and "offered", and delete "family" and substitute "parents to enable them to resume custody".

20. In proposed WIC Sect. 366.2(e) on page 32, line 15 delete "The probation", delete all of line 16 and delete "detriment" on line 17. (The same deletion is to be made to subsection (f), page 33, lines 28 and 29.) On line 36 delete "(i)" and substitute "(g)".

21. In proposed WIC Sect. 366.25(c)(1) on page 37, line 3 insert "by clear and convincing evidence" after "determines" at the end of the line.

22. The Task Force members agreed to retain provisions linking the permanency planning hearing (PPH) with termination of parental rights (TPR) proceedings under the jurisdiction of the juvenile court. However, the timing of the TPR hearing will be changed to 120 days after the (PPH). Because of federal compliance requirements that a PPH be held no later than 18 months after a child's placement, language will have to be carefully drafted to indicate that cases receiving the full 18 months of service will have a PPH at 18 months. The PPH will determine whether or not the child is to return home or be placed in a permanent alternative setting(i.e., adoption, guardianship, or long term foster

care). The hearing held 120 days after the PPH will determine whether to terminate the parents' rights and which permanent alternative placement is most appropriate for the child. Michael Wald agreed to draft language for this purpose.

23. The Task Force members agreed that, tentatively, SB243 should go forward with language that both provides vertical representation for parents and combines PPH and TPR proceedings under the jurisdiction of the juvenile court. The most likely strategy for successful implementation of these significant changes is to phase in the provision for vertical representation of parents effective July 1, 1988 followed 18 months later by implementation of the combined PPH/TPR proceeding effective January 1, 1990.

24. The Task Force reviewed Penal Code reporting law language proposed by Michael Wald with the goal of narrowing the scope of circumstances to be reported and limiting reporting to only situations of intrafamilial abuse. It appears highly unlikely that law enforcement and district attorneys will agree to reporting of only intrafamilial abuse. The members did agree, however, that clarification should be provided in statute regarding the role and responsibilities of county welfare agencies for cases of non-familial abuse. These issues will serve as the starting point for items of discussion during the April 24 Task Force meeting.

Exhibit E: County Welfare Departments' Letters in Support of SB 243

GLENN COUNTY
DEPARTMENT OF SOCIAL SERVICES
P. O. Box 611
141 South Lassen Street
Willows, California 95988
916-934-7714

Don K. Louderback, Director

September 16, 1987

The Honorable George Deukmejian
Governor, State of California
State Capitol
Sacramento, CA 95814

RE: SB 243 (Presley) - RECOMMEND SIGNATURE

Dear Governor Deukmejian:

The Glenn County Department of Social Services recommends your signature on SB 243, by Senator Robert Presley, which would more clearly define the basis for making a child a dependent of the juvenile court under WIC 300, clarify local child welfare agency and judicial procedures, streamline the permanency planning process for children who are unable to return to their parents, and ensure the appointment of legal counsel for children and parents brought into juvenile court due to an allegation of child abuse or neglect.

Under current law, WIC 300 is broadly focused on the actions of the parent or guardian rather than on the harm to the child. As a result, it is widely open to interpretation by the courts, individual child protection workers and local child protection agencies. SB 243 proposes clearer standards for dependency which are focused on the harm to the child and the action or inaction of the parents, guardian or caretaker which contributed to the child's condition. It is our department's view that state law should be more specific about when an authoritative intervention by government is appropriate to protect children. We recommend that the language of SB 243 is a balanced approach which ensures a child can be protected from harm while the legal rights of parents and guardians are equitably respected.

SB 243 represents the combined efforts of a Task Force established by state law which includes representatives of the Attorney General, public defenders, the ACLU, county welfare departments, the State Department of Social Services, Judicial Counsel, the Juvenile Courts, and advocates for children and parents. The Glenn County Department of Social Services recommends your approval of the important reforms included in SB 243.

Sincerely

Annette Nelson, Interim Director
GLENN COUNTY DEPARTMENT OF SOCIAL SERVICES

cc: Honorable Robert Presley
Lee D. Kemper, CWDA Executive Director
Jim Mann, Chairman, Glenn County Board of Supervisors

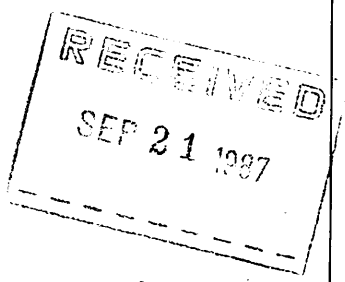
people helping people

COUNTY OF SONOMA
SOCIAL SERVICE DEPARTMENT

2550 PAULIN DRIVE
P.O. BOX 1539
SANTA ROSA, CALIFORNIA 95402-1539
(707) 527-2715

PAUL M. ALLEN, JR.
DIRECTOR

PAUL W. ROUNTREE
ASSISTANT DIRECTOR



September 18, 1987

The Honorable George Deukmejian
Governor, State of California
State Capitol
Sacramento, CA 95814

Dear Governor Deukmejian:

RE: SB 243 (Presley) - RECOMMEND SIGNATURE

The Sonoma County Board of Supervisors and the Director of the Social Service Department recommend and urge your signature on SB 243, by Senator Robert Presley, which would more clearly define the basis for making a child a dependent of the juvenile court and judicial procedures, streamline the permanency planning process for children who are unable to return to their parents, and ensure the appointment of legal counsel for children and parents brought into juvenile court due to an allegation of child abuse or neglect.

Under current law, WIC 300 is broadly focused on the actions of the parent or guardian rather than on the harm to the child. As a result, it is widely open to interpretation by the courts, individual child protection workers and local child protection agencies. SB 243 proposes clearer standards for dependency which are focused on the harm to the child and the action or inaction of the parent, guardian or caretaker which contributed to the child's condition. It is our department's view that state law should be more specific about when an authoritative intervention by government is appropriate to protect children. The language of SB 243 is a balanced approach which ensures a child can be protected from harm while the legal rights of parents and guardians are equitably respected.

SB 243 represents the combined efforts of a Task Force established by state law which includes representatiaves of the Attorney General, public defenders, the ACLU, county welfare departments, the State Department of Social Services, Judicial Counsel, the Juvenile Courts, and advocates for children and parents. The Sonoma County Board of Supervisors and the Director of the Social Service Department recommend your approval of the important reforms included in SB 243.

Very truly yours,

Paul M. Allen, Jr.

Paul M. Allen, Jr.
Director

cc: Honorable Robert Presley ✔
Lee D. Kemper, CWDA Executive Director
CSAC

HUMAN SERVICES AGENCY

2115 WEST WARDROBE AVENUE
MAILING ADDRESS P.O. BOX 112
TELEPHONE (AREA CODE 209) 385-3000
MERCED, CALIFORNIA 95341-0112

Eligibility Services
Social Services
Administrative Service
Project Planning
Refugee Services
Public Conservator

JOHN CULLEN
Director

September 18, 1987

The Honorable George Deukmejian
Governor, State of California
State Capital
Sacramento, CA 95814

Dear Governor Deukmejian:

RE: SB 243 (Presley) - RECOMMEND SIGNATURE

The Merced County Human Services Agency recommends your signature on SB 243, by Senator Robert Presley, which would more clearly define the basis for making a child a dependent of the Juvenile Court under WIC 300, clarify local child welfare agency and judicial procedures, streamline the permanency planning process for children who are unable to return to their parents, and ensure the appointment of legal counsel for children and parents brought into Juvenile Court due to an allegation of child abuse or neglect.

Under current law, WIC 300 is broadly focused on the actions of the parent or guardian rather than on the harm to the child. As a result, it is widely open to interpretation by the courts, individual child protection workers and local child protection agencies. SB 243 proposes clearer standards for dependency which are focused on the harm to the child and the action or inaction of the parent, guardian, or caretaker which contributed to the child's condition. It is our agency's view that state law should be more specific about when an authoritative intervention by government is appropriate to protect children. We recommend that the language of SB 243 is a balanced approach which ensures a child can be protected from harm while the legal rights of parents and guardians are equitably respected.

SB 243 represents the combined efforts of a Task Force established by state law which includes representatives of the Attorney General, Public Defenders, the ACLU, county welfare departments, the State Department of Social Services, Judicial Counsel, the Juvenile Courts, and advocates for children and parents. The Merced County Human Services Agency recommends your approval of the important reforms included in SB 243.

Sincerely,

John Cullen

John B. Cullen
Director

dlg

cc: Honorable Robert Presley
Lee D. Kemper, CWDA Executive Director
Clark G. Channing, Merced County Administrator

county of ventura

PUBLIC SOCIAL SERVICES AGENCY
James E. Isom
Director

September 18, 1987

The Honorable George Deukmejian
Governor, State of California
State Capitol
Sacramento, CA. 95814

Dear Governor Deukmejian,

RE: SB 243 (Presely) - RECOMMEND SIGANTURE

The Ventura County Public Social Services Agency recommends your signature on SB 243, by Senator Robert Presley, which would more clearly define the basis for making a child a dependent of the Juvenile Court under WIC 300, clarify local child welfare agency and judicial procedures, streamline the permanency planning process for children who are unable to return to their parents, and ensure the appointment of legal counsel for children and parents brought into Juvenile Court due to an allegation of child abuse or neglect.

Under current law, WIC 300 is broadly focused on the actions of the parent or guardian rather than on the harm to the child. As a result, it is widely open to interpretation by the courts, individual child protection workers and local child protection agencies. SB 243 proposes clearer standards for dependency which are focused on the harm to the child and the action or inaction of the parent, guardian or caretaker which contributed to the child's condition. It is our Agency's view that State law should be more specific about when an authoritative intervention by government is appropriate to protect children. We recommend that the language of SB 243 is a balanced approach which ensures a child can be protected from harm while the legal rights of parents and guardians are equitably respected.

SB 243 represents the combined efforts of a task force established by State law which includes representatives of the Attorney General, Public Defenders, The ACLU, County Welfare Departments, the State Department of Social Services, Judicial Counsel, the Juvenile Courts, and advocates for children and parents. We therefore recommend your approval of the important reforms included in SB 243.

Sincerely,

JAMES E. ISOM
Director

c: Honorable Robert Presely ✓
Lee Kemper, CWDA Exec. Director

TRINITY COUNTY

WEAVERVILLE, CALIFORNIA 96093
Jeannie Nix-Temple, Director
TRINITY COUNTY WELFARE DEPARTMENT
P.O. Box 218 Phone (916) 623-1266

September 18, 1987

The Honorable George Deukmejian
Governor, State of California
State Capitol
Sacramento, CA. 95814

RE: SB 243 (Presley) - RECOMMEND SIGNATURE

Dear Governor Deukmejian:

The Trinity County Welfare Department recommends your signature on SB 243, by Senator Robert Presley, which would more clearly define the basis for making a child a Dependent of the Juvenile Court under Welfare and Institutions Code Section 300, clarify local child welfare agency and judicial procedures, streamline the permanency planning process for children who are unable to return to their parents, and ensure the appointment of legal counsel for children and parents brought into Juvenile Court due to an allegation of child abuse or neglect.

Under current law, Welfare and Institutions Code 300 is broadly focused on the actions of the parent or guardian rather than on the harm to the child. As a result, it is widely open to interpretation by the Courts, individual child protection workers and local child protection agencies. SB 243 proposes clearer standards for Dependency which are focused on the harm to the child and the action or inaction of the parent, guardian, or caretaker which contributed to the child's condition. It is our Department's view that state law should be more specific about when an authoritative intervention by government is appropriate to protect children. We recommend that the language of SB 243 is a balanced approach which ensures a child can be protected from harm while the legal rights of parents and guardians are equitably respected.

SB 243 represents the combined efforts of a Task Force established by state law which includes representatives of the Attorney General, public defenders, the ACLU, County Welfare Departments, the State Department of Social Services, Judicial Counsel, the Juvenile Courts and advocates for children and parents. The Trnity County Welfare Department recommends your approval of the important reforms included in SB 243.

Sincerely,

TRINITY COUNTY WELFARE DEPARTMENT

Jeannie Nix-Temple

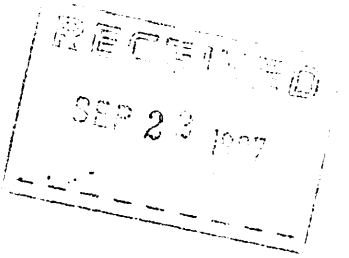
Jeannie Nix-Temple, Director

Jamie Baudizzon, Supervisor
Division of Social Services

JNT:JB:pjd

DEPARTMENT OF SOCIAL SERVICES

LOCATION: MOTHER LODE ACADEMY, RIDGE ROAD • SUTTER CREEK, CALIF. • PHONE (209) 223-6550
MAIL: 108 COURT STREET • JACKSON, CA 95642-2379



September 18, 1987

The Honorable George Deukmejian
Governor, State of California
State Capitol
Sacramento, CA 95814

Dear Governor Deukmejian:

RE: SB 243 (Presley) - RECOMMEND SIGNATURE

The Amador County Department of Social Services recommends your signature on SB 243, by Senator Robert Presley, which would more clearly define the basis for making a child a dependent of the juvenile court under WIC 300, clarify local child welfare agency and judicial procedures, streamline the permanency planning process for children who are unable to return to their parents, and ensure the appointment of legal counsel for children and parents brought into juvenile court due to an allegation of child abuse or neglect.

Under current law, WIC 300 is broadly focused on the actions of the parent or guardian rather than on the harm to the child. As a result, it is widely open to interpretation by the courts, individual child protection workers and local child protection agencies. SB 243 proposes clearer standards for dependency which are focused on the harm to the child and the action or inaction of the parent, guardian or caretaker which contributed to the child's condition. It is our department's view that state law should be more specific about when an authoritative intervention by government is appropriate to protect children. We recommend that the language of SB 243 is a balanced approach which ensures a child can be protected from harm while the legal rights of parents and guardians are equitably respected.

SB 243 represents the combined efforts of a Task Force established by state law which includes representatives of the Attorney General, public defenders, the ACLU, county welfare departments, the State Department of Social Services, Judicial Counsel, the Juvenile Courts, and advocates for children and parents. The Amador County Department of Social Services recommends your approval of the important reforms included in SB 243.

Sincerely,

Director
Department of Social Services

cc: Honorable Robert Presley
Lee D. Kemper, CWDA Executive Director

JAMES SEMMES
DIRECTOR

P. O. Box 930
EL CENTRO, CALIF. 92244 - 0930

Imperial County
Welfare Department

TELEPHONE:
(619) 353-1400

REFER REPLY TO

September 21, 1987

The Honorable George Deukmejian
Governor, State of California
State Capitol
Sacramento, CA 95814

Dear Governor Deukmejian:

RE: SB 357 (Presley) - RECOMMEND SIGNATURE

The Imperial County Welfare Department recommends your signature on SB 357, by Senator Robert Presley, which would, among other provisions, extend for two years the existing 95% state, 5% county fiscal sharing ratio for foster care payments.

Since 1982, California's child protection efforts have become highly state-mandated. As a part of these mandates, California has established its commitment in state law to provide all children the care and protection they need to grow safely. Reliable, stable foster care is often a critical component of that state protection.

The current sunset date for the "95-5" state-county foster care sharing ratio is June 30, 1988. If this sharing ratio is permitted to expire, the majority of costs for protecting children in foster care will be shifted to county governments. We estimate the new costs to Imperial County would be approximately $320,000. Our county is simply not in the position to assume these costs, and the stability of the foster care program and the placements of children could be in great jeopardy should such a cost shift occur.

Imperial County recommends your signature on SB 357 to ensure appropriate protection for children in need of foster care.

Sincerely,

JAMES SEMMES
County Welfare Director

cc: Honorable Robert Presley
Lee D. Kemper, CWDA Executive Director
CAO

JAMES SEMMES
DIRECTOR

P. O. Box 930
EL CENTRO, CALIF. 92244 - 0930

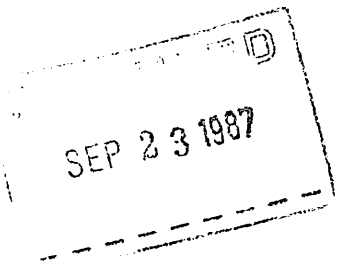
Imperial County Welfare Department

TELEPHONE:
(619) 353-1400

REFER REPLY TO

Paula

September 21, 1987



The Honorable George Deukmejian
Governor, State of California
State Capitol
Sacramento, CA 95814

Dear Governor Deukmejian:

RE: SB 243 (Presley) - RECOMMEND SIGNATURE

The Imperial County Welfare Department recommends your signature on SB 243, by Senator Robert Presley, which would more clearly define the basis for making a child a dependent of the juvenile court under WIC 300, clarify local child welfare agency and judicial procedures, streamline the permanency planning process for children who are unable to return to their parents, and ensure the appointment of legal counsel for children and parents brought into juvenile court due to an allegation of child abuse or neglect.

Under current law, WIC 300 is broadly focused on the actions of the parent or guardian rather than on the harm of the child. As a result, it is widely open to interpretation by the courts, individual child protection workers and local child protection agencies. SB 243 proposes clearer standards for dependency which are focused on the harm to the child and the action or inaction of the parent, guardian or caretaker which contributed to the child's condition. It is our department's view that state law should be more specific about when an authoritative intervention by government is appropriate to protect children. We recommend that the language of SB 243 is a balanced approach which ensures a child can be protected from harm while the legal rights of parents and guardians are equitably respected.

SB 243 represents the combined efforts of a Task Force established by state law which includes representatives of the Attorney General, public defenders, the ACLU, county welfare departments, the State Department of Social Services, Judicial Counsel, the Juvenile Courts, and advocates for children and parents. The Imperial County Welfare Department recommends your approval of the important reforms included in SB 243.

Sincerely,

JAMES SEMMES
County Welfare Director

cc: Honorable Robert Presley
Lee D. Kemper, CWDA Executive Director
CAO

DEPARTMENT OF PUBLIC WELFARE

COUNTY OF HUMBOLDT

929 KOSTER STREET EUREKA, CALIFORNIA 95501

INCOME MAINTENANCE & MEDICAL (707) 445-6103 | FOOD STAMPS (707) 445-6104 | SOCIAL SERVICES (707) 445-6174 | ADMINISTRATION (707) 445-6023

The Honorable George Deukmejian
Governor, State of California
State Capitol
Sacramento CA 95814

September 22, 1987

RE: SB 243 (Presley) - RECOMMEND SIGNATURE

Dear Governor Deukmejian:

The Humboldt County Department of Social Services recommends your signature on SB 243, by Senator Robert Presley, which would more clearly define the basis for making a child a dependent of the juvenile court under WIC 300, clarify local child welfare agency and judicial procedures, streamline the permanency planning process for children who are unable to return to their parents, and ensure the appointment of legal counsel for children and parents brought into juvenile court due to an allegation of child abuse or neglect.

Under current law, WIC 300 is broadly focused on the actions of the parent or guardian rather than on the harm to the child. As a result, it is widely open to interpretation by the courts, individual child protection workers and local child protection agencies. SB 243 proposes clearer standards for dependency which are focused on the harm to the child and the action or inaction of the parent, guardian or caretaker which contributed to the child's condition. It is our department's view that state law should be more specific about when an authoritative intervention by government is appropriate to protect children. We recommend that the language of SB 243 is a balanced approach which ensures a child can be protected from harm while the legal rights of parents and guardians are equitably respected.

SB 243 represents the combined efforts of a Task Force established by state law which includes representatives of the Attorney General, public defenders, the ACLU, county welfare departments, the State Department of Social Services, Judicial Counsel, the Juvenile Courts, and advocates for children and parents. The Humboldt County Department of Social Services recommends your approval of the important reforms included in SB 243.

Sincerely,

John Frank

John Frank, Director
Humboldt County Dept. of Social Services

JF:sd

cc: Honorable Robert Presley
cc: Lee D. Kemper, CWDA Executive Director
cc: Robt. Hendrix, Humboldt County Admin. Ofcr.

COUNTY OF KINGS
BOARD OF SUPERVISORS

GOVERNMENT CENTER HANFORD, CALIFORNIA 93230
209 – 582-3211 EXT. 2362

September 22, 1987

The Honorable George Deukmejian
Governor, State of California
State Capital
Sacramento, CA. 95814

Dear Governor Deukmejian:

RE: SB 243 (Presley) - RECOMMEND SIGNATURE

The Kings County Board of Supervisors recommends your signature on SB 243, by Senator Robert Presley, which would more clearly define the basis for making a child a dependent of the juvenile court under WIC 300, clarify local child welfare agency and judicial procedures, streamline the permanency planning process for children who are unable to return to their parents, and ensure the appointment of legal counsel for children and parents brought into juvenile court due to an allegation of child abuse or neglect.

Under current law, WIC 300 is broadly focused on the actions of the parent or guardian rather than on the harm to the child. As a result, it is widely open to interpretation by the courts, individual child protection workers and local child protection agencies. SB 243 proposes clearer standards for dependency which are focused on the harm to the child and the action or inaction of the parent, guardian or caretaker which contributed to the child's condition. It is our department's view that state law should be more specific about when an authoritative intervention by government is appropriate to protect children. We recommend that the language of SB 243 is a balanced approach which ensures a child can be protected from harm while the legal rights of parents and guardians are equitably respected.

SB 243 represents the combined efforts of a Task Force established by state law which includes representatives of the Attorney General, public defenders, the ACLU, county welfare departments, the State Department of Social Services, Judicial Counsel, the Juvenile Courts, and advocates for children and parents. The Kings County Board of Supervisors recommends your approval of the important reforms included in SB 243.

Sincerely,

Leslie K. Brown, Chairman
Kings County Board of Supervisors

cc: Honorable Robert Presley
Lee D. Kemper, CWDA Executive Director

Exhibit F:
AB 1762 (1989-90 Regular Session)

A.B. No. 1762—Mojonnier.

An act to add Section 68554 to the Government Code, to amend Section 1513 of the Probate Code, and to amend Sections 317, 355.1, 358, and 361.5 of the Welfare and Institutions Code, relating to minors.

1989

Mar. 9—Read first time. To print.
Mar. 10—From printer. May be heard in committee April 9
Mar 16—Referred to Com. on JUD
May 3—In committee: Set, first hearing. Hearing canceled at the request of author
May 10—In committee: Hearing postponed by committee.

1990

Jan. 10—In committee: Set, second hearing. Hearing canceled at the request of author.
Jan. 30—From committee: Filed with the Chief Clerk pursuant to Joint Rule 56. Died pursuant to Art. IV, Sec. 10(a) of the Constitution

A.B. No. 1763—Mojonnier.

An act to amend Sections 300, 311, 361, and 361.3 of the Welfare and Institutions Code, relating to minors.

1989

Mar. 9—Read first time. To print.
Mar. 13—From printer. May be heard in committee April 12
Mar. 27—Referred to Com. on PUB. S

1990

Jan 4—Withdrawn from committee. Re-referred to Com. on JUD
Jan. 30—From committee: Filed with the Chief Clerk pursuant to Joint Rule 56. Died pursuant to Art. IV, Sec. 10(a) of the Constitution.

39—APH—1774

ASSEMBLY BILL No. 1762

Introduced by Assembly Member Mojonnier

March 9, 1989

An act to add Section 68554 to the Government Code, to amend Section 1513 of the Probate Code, and to amend Sections 317, 355.1, 358, and 361.5 of the Welfare and Institutions Code, relating to minors.

LEGISLATIVE COUNSEL'S DIGEST

AB 1762, as introduced, Mojonnier. Minors.

(1) Existing law requires the Judicial Council to establish judicial training programs regarding family law for judges. Existing law also requires the Judicial Council to establish and maintain an ongoing program to provide training for the judicial branch relating to the handling of child sexual abuse cases.

This bill would require the Judicial Council to establish training programs for newly appointed or elected judges who perform duties related to children which training programs shall include a minimum of 40 hours of instruction related to the handling of cases involving child abuse and neglect.

(2) Existing law provides for the establishment of guardianships of the person or of the estate where the proposed guardian is a relative, an investigation concerning the proposed guardianship is to be conducted by a probate court investigator. Where the proposed guardian is a nonrelative, the investigation is to be conducted by a county agency designated to investigate potential dependency.

This bill would provide that the investigations shall be conducted by the county agency designated to investigate potential dependency no matter whether the proposed guardian is a relative or a nonrelative.

(3) Existing law provides for the appointment of counsel for a minor or a parent or guardian of the minor under specified circumstances in dependency proceedings.

This bill would authorize the court to appoint counsel for a relative of the minor who has been providing a substantial portion of the minor's care and who is seeking to have the minor placed in his or her home.

(4) Existing law provides that where a court finds, based on competent professional evidence, that an injury, injuries, or detrimental condition sustained by a minor, of such a nature as would ordinarily not be sustained except as the result of the unreasonable or neglectful acts of omissions of either parent, the guardian, or other person who has the care or custody of the minor, that evidence shall be prima facie evidence that the minor is a person coming within the jurisdiction of the juvenile court based on specified provisions.

This bill would provide that where the court finds, based upon competent professional evidence, that either the parent or guardian of the minor is unable to provide the basic necessities of life for himself or herself because of his or her substance abuse, that evidence shall be prima facie evidence that the minor is a person coming within the dependency jurisdiction of the juvenile court based on specified provisions.

(5) Under existing law, if the court finds that a minor is a person coming within the dependency jurisdiction of the court based on specified provisions, before determining the appropriate disposition of the minor, the court shall receive in evidence the social study of the minor made by the probation officer, any study or evaluation made by a child advocate appointed by the court, and such other relevant and material evidence as may be offered.

This bill would provide that the court shall also receive in evidence any reports by the relatives or other persons who have provided a substantial portion of the minor's care during the preceding 6 months.

(6) Existing law authorizes a court, whenever a minor is removed from a parent's or guardian's custody, to order reunification services for the minor and his or her parent or guardian.

This bill would also authorize the court to order reunification services for any person cohabitating with the minor's parent or guardian who substantially affects the minor's life.

(7) Because this bill would impose additional duties on local agencies and officials, it would create a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates which do not exceed $1,000,000 statewide and other procedures for claims whose statewide costs exceed $1,000,000.

This bill would provide that, if the Commission on State Mandates determines that this bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to those statutory procedures and, if the statewide cost does not exceed $1,000,000, shall be made from the State Mandates Claims Fund.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 68554 is added to the Government Code, to read:

68554. The Judicial Council shall establish judicial training programs for newly appointed or elected judges who perform duties related to children. The training shall include a minimum of 40 hours of instruction related to the handling of cases involving child abuse and neglect.

SEC. 2. Section 1513 of the Probate Code is amended to read:

1513. (a) Unless waived by the court, a court investigator, probation officer, or domestic relations investigator shall make an investigation and file with the court a report and recommendation concerning each proposed guardianship of the person or guardianship of the estate. ~~Investigations where the proposed guardian~~

~~is a relative shall be made by a probate court investigator.~~ Investigations ~~where the proposed guardian is a nonrelative~~ shall be made by the county agency designated to investigate potential dependency. The report for the guardianship of the person shall include, but need not be limited to, an investigation and discussion of all of the following:

(1) A social history of the guardian.

(2) A social history of the proposed ward, including, to the extent feasible, an assessment of any identified developmental, emotional, psychological, or educational needs of the proposed ward and the capability of the petitioner to meet those needs.

(3) The relationship of the proposed ward to the guardian, including the duration and character of the relationship, where applicable, the circumstances whereby physical custody of the proposed ward was acquired by the guardian, and a statement of the proposed ward's attitude concerning the proposed guardianship, unless the statement of the attitude is affected by the proposed ward's developmental, physical, or emotional condition.

(4) The anticipated duration of the guardianship and the plans of both natural parents and the proposed guardian for the stable and permanent home for the child. The court may waive this requirement for cases involving relative guardians.

(b) The report shall be read and considered by the court prior to ruling on the petition for guardianship, and shall be reflected in the minutes of the court. The person preparing the report may be called and examined by any party to the proceeding.

(c) If the investigation finds that any party to the proposed guardianship alleges the minor's parent is unfit, as defined by Section 300 of the Welfare and Institutions Code, the case shall be referred to the county agency designated to investigate potential dependencies. Guardianship proceedings shall not be completed until the investigation required by Sections 328 and 329 of the Welfare and Institutions Code is completed and a report

is provided to the probate court.

(d) The report required by this section shall be confidential and shall only be made available to persons who have been served in the proceedings or their attorneys. The county clerk shall make provisions for the limitation of the report exclusively to persons entitled to its receipt.

(e) This section does not apply to guardianships resulting from a permanency plan for a dependent child pursuant to Section 366.25 of the Welfare and Institutions Code.

SEC. 3. Section 317 of the Welfare and Institutions Code is amended to read:

317. (a) When it appears to the court that a parent or guardian of the minor desires counsel but is unable to afford and cannot for that reason employ counsel, the court may appoint counsel.

(b) When it appears to the court that a parent or guardian of the minor is unable to afford and cannot for that reason employ counsel, and the minor has been placed in out-of-home care, or the petitioning agency is recommending that the minor be placed in out-of-home care, the court shall appoint counsel, unless the court finds that the parent or guardian has made a knowing and intelligent waiver of counsel.

(c) *When it appears to the court that a relative of the minor, who has been providing a substantial portion of the minor's care and who is seeking to have the minor placed in his or her home, desires counsel but is unable to afford and for that reason cannot employ counsel, the the court may appoint counsel.*

(d) In any case in which it appears to the court that the minor would benefit from the appointment of counsel the court shall appoint counsel for the minor. Counsel for the minor may be a county counsel, district attorney, public defender, or other member of the bar, provided that the counsel does not represent another party or county agency whose interests conflict with the minor's. The fact that the district attorney represents the minor in a proceeding pursuant to Section 300 as well as

conducts a criminal investigation or files a criminal complaint or information arising from the same or reasonably related set of facts as the proceeding pursuant to Section 300 is not in and of itself a conflict of interest. The court shall determine if representation of both the petitioning agency and the minor constitutes a conflict of interest. If the court finds there is a conflict of interest, separate counsel shall be appointed for the minor. The court may fix the compensation to be paid by the county for the services of appointed counsel, if counsel is not a county counsel, district attorney, or public defender.

~~(d)~~

(e) The counsel appointed by the court shall represent the parent, guardian, or minor at the detention hearing and at all subsequent proceedings before the juvenile court. Counsel shall continue to represent the parent or minor unless relieved by the court upon the substitution of other counsel or for cause. The representation shall include representing the parent or the minor in termination proceedings and in those proceedings relating to the institution or setting aside of a legal guardianship.

~~(e)~~

(f) The counsel for the minor shall be charged in general with the representation of the minor's interests. To that end, counsel shall make such further investigations as he or she deems necessary to ascertain the facts, including the interviewing of witnesses, and he or she shall examine and cross-examine witnesses in both the adjudicatory and dispositional hearings; he or she may also introduce and examine his or her own witnesses, make recommendations to the court concerning the minor's welfare, and participate further in the proceedings to the degree necessary to adequately represent the minor. In any case in which the minor is four years of age or older, counsel shall interview the minor to determine the minor's wishes and to assess the minor's well-being. In addition, counsel shall investigate the interests of the minor beyond the scope of the juvenile proceeding and report to the court other

interests of the minor that may need to be protected by the institution of other administrative or judicial proceedings. The court shall take whatever appropriate action is necessary to fully protect the interests of the minor.

~~(f)~~

(g) Notwithstanding any other provision of law, counsel shall be given access to all records relevant to the case which are maintained by state or local public agencies. Counsel shall be given access to records maintained by hospitals or by other medical or nonmedical practitioners or by child care custodians, in the manner prescribed by Section 1158 of the Evidence Code.

SEC. 4. Section 355.1 of the Welfare and Institutions Code is amended to read:

355.1. (a) Where the court finds, based upon competent professional evidence, that an injury, injuries, or detrimental condition sustained by a minor, of such a nature as would ordinarily not be sustained except as the result of the unreasonable or neglectful acts or omissions of either parent, the guardian, or other person who has the care or custody of the minor, that evidence shall be prima facie evidence that the minor is a person described by subdivision (a), (b), or (d) of Section 300.

(b) *Where the court finds, based upon competent professional evidence, that either the parent or guardian of the minor is unable to provide the basic necessities of life for himself or herself because of his or her substance abuse, that evidence shall be prima facie evidence that the minor is a person described by subdivision (a), (b), or (d) of Section 300.*

(c) Proof that either parent, the guardian, or other person who has the care or custody of a minor who is the subject of a petition filed under Section 300, has physically abused, neglected, or cruelly treated another minor shall be admissible in evidence.

~~(e)~~

(d) The presumption created by subdivision (a) *or (b)* constitutes a presumption affecting the burden of

producing evidence.

~~(d)~~

(e) Testimony by a parent, guardian, or other person who has the care or custody of the minor made the subject of a proceeding under Section 300 shall not be admissible as evidence in any other action or proceeding.

SEC. 5. Section 358 of the Welfare and Institutions Code is amended to read:

358. (a) After finding that a minor is a person described in Section 300, the court shall hear evidence on the question of the proper disposition to be made of the minor. Prior to making a finding required by this section, the court may continue the hearing on its own motion, the motion of the parent or guardian, or the motion of the minor, as follows:

(1) If the minor is detained during the continuance, and the probation officer is not alleging that subdivision (b) of Section 361.5 is applicable, the continuance shall not exceed 10 judicial days. The court may make such order for detention of the minor or for the minor's release from detention, during the period of continuance, as is appropriate.

(2) If the minor is not detained during the continuance, the continuance shall not exceed 30 days after the date of the finding pursuant to Section 356. However, the court may, for cause, continue the hearing for an additional 15 days.

(3) If the probation officer is alleging that subdivision (b) of Section 361.5 is applicable, the court shall continue the proceedings for a period not to exceed 30 days. The probation officer shall notify each parent of the content of subdivision (b) of Section 361.5 and shall inform each parent that if the court does not order reunification a permanency planning hearing will be held, and that his or her parental rights may be terminated within the time frames specified by law.

(b) Before determining the appropriate disposition, the court shall receive in evidence the social study of the minor made by the probation officer, *any reports by relatives or other persons who have provided a*

substantial portion of the minor's care during the preceding six months, any study or evaluation made by a child advocate appointed by the court, and such other relevant and material evidence as may be offered. In any judgment and order of disposition, the court shall specifically state that the social study made by the probation officer and the study or evaluation made by the child advocate appointed by the court, if there be any, has been read and considered by the court in arriving at its judgment and order of disposition.

(c) If the court finds that a minor is described by subdivision (h) of Section 300 or that subdivision (b) of Section 361.5 may be applicable, the court shall conduct the dispositional proceeding pursuant to subdivision (c) of Section 361.5.

SEC. 6. Section 361.5 of the Welfare and Institutions Code is amended to read:

361.5. (a) Except as provided in subdivision (b), whenever a minor is removed from a parent's or guardian's custody, the juvenile court shall order the probation officer to provide child welfare services to the minor and the minor's parents or guardians *or to any person cohabitating with the minor's parent or guardian who substantially affects the minor's life* for the purpose of facilitating reunification of the family within a maximum time period not to exceed 12 months. The court also shall make findings pursuant to subdivision (a) of Section 366. When counseling or other treatment services are ordered, the parent shall be ordered to participate in those services, unless the parent's participation is deemed by the court to be inappropriate or potentially detrimental to the child. Services may be extended up to an additional six months if it can be shown that the objectives of the service plan can be achieved within the extended time period. Physical custody of the minor by the parents or guardians during the 18-month period shall not serve to interrupt the running of the period.

Except in cases where, pursuant to subdivision (b), the court does not order reunification services, the court shall

inform the parent or parents of the provision of Section 366.25 or 366.26 and shall specify that the parent's or parents' parental rights may be terminated.

(b) Reunification services need not be provided to a parent described in this subdivision when the court finds, by clear and convincing evidence, any of the following:

(1) That the whereabouts of the parents is unknown. A finding pursuant to this paragraph shall be supported by an affidavit or by proof that a reasonably diligent search has failed to locate the parent. The posting or publication of notices is not required in such a search.

(2) That the parent is suffering from a mental disability that is described in Section 232 of the Civil Code and that renders him or her incapable of utilizing those services.

(3) That the minor had been previously adjudicated a dependent pursuant to any subdivision of Section 300 as a result of physical or sexual abuse, that following that adjudication the minor had been removed from the custody of his or her parent or guardian pursuant to Section 361, that the minor has been returned to the custody of the parent or parents, guardian, or guardians from whom the minor had been taken originally, and that the minor is being removed pursuant to Section 361, due to additional physical or sexual abuse. However, this section is not applicable if the jurisdiction of the juvenile court has been dismissed prior to the additional abuse.

(4) That the parent of the minor has been convicted of causing the death of another child through abuse or neglect.

(5) That the minor was brought within the jurisdiction of the court under subdivision (e) of Section 300 because of the conduct of that parent.

(c) In deciding whether to order reunification in any case in which this section applies, the court shall hold a dispositional hearing. The probation officer shall prepare a report which discusses whether reunification services shall be provided. When it is alleged, pursuant to paragraph (2) of subdivision (b), that the parent is incapable of utilizing services due to mental disability,

the court shall order reunification services unless competent evidence from mental health professionals establishes that, even with the provision of services, the parent is unlikely to be capable of adequately caring for the child within 12 months.

When paragraph (3), (4), or (5), inclusive, of subdivision (b) is applicable, the court shall not order reunification unless it finds that, based on competent testimony, those services are likely to prevent reabuse or continued neglect of the child or that failure to try reunification will be detrimental to the child because the child is closely and postively attached to that parent. The probation officer shall investigate the circumstances leading to the removal of the minor and advise the court whether there are circumstances which indicate that reunification is likely to be successful or unsuccessful and whether failure to order reunification is likely to be detrimental to the child.

The failure of the parent to respond to previous services, the fact that the child was abused while the parent was under the influence of drugs or alcohol, a past history of violent behavior, or testimony by a competent professional that the parent's behavior is unlikely to be changed by services are among the factors indicating that reunification services are unlikely to be successful. The fact that a parent or guardian is no longer living with an individual who severely abused the minor may be considered in deciding that reunification services are likely to be successful, provided that the court shall consider any pattern of behavior on the part of the parent that has exposed the child to repeated abuse.

(d) If reunification services are not ordered pursuant to paragraph (1) of subdivision (b) and the whereabouts of a parent become known within six months of the out-of-home placement of the minor, the court shall order the probation officer to provide family reunification services in accordance with this subdivision. However, the time limits specified in Section 366.25 are not tolled by the parent's absence.

(e) If the parent or guardian is incarcerated or

institutionalized, the court shall order reasonable services unless the court determines those services would be detrimental to the minor. In determining detriment, the court shall consider the age of child, the degree of parent-child bonding, the length of the sentence, the nature of the treatment, the nature of crime or illness, the degree of detriment to the child if services are not offered and, for minors 10 years of age or older, the minor's attitude toward the implementation of family reunification services, and any other appropriate factors. Services may include, but shall not be limited to, all of the following:

(1) Maintaining contact between parent and child through collect phone calls.

(2) Transportation services, where appropriate.

(3) Visitation services, where appropriate.

(4) Reasonable services to extended family members or foster parents providing care for the child if the services are not detrimental to the child.

An incarcerated parent may be required to attend counseling, parenting classes, or vocational training programs as part of the service plan if these programs are available.

(f) If a court, pursuant to paragraph (2), (3), (4), or (5) of subdivision (b), does not order reunification services, it shall conduct a hearing pursuant to Section 366.25 or 366.26 within 120 days of the dispositional hearing.

(g) Whenever a court orders that a permanency planning hearing shall be held it shall direct the agency supervising the child and the licensed county adoption agency, or the State Department of Social Services when it is acting as an adoption agency in counties which are not served by a county adoption agency, to prepare an assessment which shall include current search efforts for an absent parent or parents; a review of the amount of and nature of any contact between the minor and his or her parents since the time of placement; an evaluation of the minor's medical, developmental, scholastic, mental, and emotional status; a preliminary assessment of the

eligibility and commitment of any identified prospective adoptive parent, particularly the caretaker; and an analysis of the likelihood that the minor will be adopted if parental rights are terminated. In any case involving a minor 10 years of age or older the report shall also indicate the minor's attitude toward placement and termination of parental rights.

SEC. 7. Notwithstanding Section 17610 of the Government Code, if the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code. If the statewide cost of the claim for reimbursement does not exceed one million dollars ($1,000,000), reimbursement shall be made from the State Mandates Claims Fund. Notwithstanding Section 17580 of the Government Code, unless otherwise specified in this act, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution.

O

PROOF OF SERVICE
IN THE SUPREME COURT OF CALIFORNIA

In re N.R.,
Supreme Court Case No: S274943
Appellate Court Case No.: B312001

I, Sean Burleigh, declare and state:

That I am not a party to the within action; that I am an attorney admitted to practice law in the State of California appointed by this Court to represent Appellant.

That on December 14, 2022, I served the following:

Exhibits to Appellant's Judicial Notice Request

Upon the persons or organizations listed below electronically. I utilized service through the true filing electronic system.

Michael Neu, neum@ladlinc.org
Daniel Hoang, Hoangd@ladlinc.org
Samantha Bhuiyan, bhuiyans@clcla.org
Office of County Counsel, dmiller@counsel.lacounty.gov
CAP-LA, capdocs@lacap.com
Superior Court, JuvJoAppeals@lacourt.org
Appellate Court, through truefiling

Upon the persons or organizations listed below, by placing this document in the mail addressed to:

O.R. - Appellant, address on file

I declare under penalty of perjury of the laws of the State of California that the foregoing is true and correct and that this declaration was executed on December 14, 2022 at Tucson, Arizona.

/S/
Sean Burleigh

STATE OF CALIFORNIA
Supreme Court of California

PROOF OF SERVICE

STATE OF CALIFORNIA
Supreme Court of California

Case Name: **IN RE N.R.**
Case Number: **S274943**
Lower Court Case Number: **B312001**

1. At the time of service I was at least 18 years of age and not a party to this legal action.

2. My email address used to e-serve: **saburleigh@gmail.com**

3. I served by email a copy of the following document(s) indicated below:

Title(s) of papers e-served:

Filing Type	Document Title
BRIEF	S274943 AOB
REQUEST FOR JUDICIAL NOTICE	S274943JudicialNoticeRequest
ADDITIONAL DOCUMENTS	S274943JudicialNoticeExhibits

Service Recipients:

Person Served	Email Address	Type	Date / Time
Michael Neu Los Angeles Dependency Lawyers	neum@ladlinc.org	e-Serve	12/14/2022 11:27:20 AM
Samantha Bhuiyan Children's Law Center	bhuiyans@clcla.org	e-Serve	12/14/2022 11:27:20 AM
David Miller Office of the County Counsel 251772	dmiller@counsel.lacounty.gov	e-Serve	12/14/2022 11:27:20 AM
Sarah Vesecky Office of County Counsel Appeals Division 205481	svesecky@counsel.lacounty.gov	e-Serve	12/14/2022 11:27:20 AM
Sean Burleigh Court Added 305449	saburleigh@gmail.com	e-Serve	12/14/2022 11:27:20 AM
Daniel Hoang	Hoangd@ladlinc.org	e-Serve	12/14/2022 11:27:20 AM
CAP-LA	capdocs@lacap.com	e-Serve	12/14/2022 11:27:20 AM
Superior Court	JuvJoAppeals@lacourt.org	e-Serve	12/14/2022 11:27:20 AM

This proof of service was automatically created, submitted and signed on my behalf through my agreements with TrueFiling and its contents are true to the best of my information, knowledge, and belief.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

12/14/2022
Date

/s/Sean Burleigh

Signature

Burleigh, Sean (305449)

Last Name, First Name (PNum)

Law Office of Sean Burleigh

Law Firm