8. Sex Abuse

8.0 PURPOSE: The purpose of this section is to provide standard protocols for the handling of specified reports of sexual abuse cases.

8.1 AUTHORITY:

Federal and State Statutes and Administrative Rules:

A.	45 CFR 1340.14	Reporting by mandated and non mandated persons to a child protective agency or constituted authority
B.	CHAP 346-14, HRS	Establishment and administering of programs, standards and adoption of rules for protection of abused and neglected children
C.	CHAP 350-1, HRS	Review of who must report, how reports are to be submitted, confidentiality of reports
D.	CHAP 350-2, HRS	Action on reporting
E.	CHAP 350-3, HRS	Immunity from liability
F.	CHAP 587-21, HRS	Investigative process
G.	CHAP 587-22, HRS	Protective Custody by police officers without a court order
H.	CHAP 587-23, HRS	Authorization for color photographs, x-rays and radiological exam
I.	CHAP 587-24, HRS	Temporary foster custody without court order
J.	ACT 302, SLH '96	Child protective and diversion services
K.	HAR 920.1-7	Authorization for services
L.	HAR 920.1-8	Confidentiality
M.	HAR 920.1-11	Verification of reports

N.	HAR 920.1-12	Registration of reports
O.	HAR 920.1-15	Social assessment
P.	HAR 920.1-16	Disposition
Q.	HAR 920.1-17	Foster custody
R.	HAR 920.1-18	Casework services
S.	HAR 920.1-21	Risk assessment

8.2 SEX ABUSE

8.2.1 Intake

When assessing sex abuse reports, acceptance of report should be considered unless there is clear information that the report is inappropriate. Disclosure of sex abuse comes in stages; what is initially reported may be only the "tip of the iceberg."

A. Assessment of child sex abuse report

Working agreements have been established with Children's Advocacy Centers (CAC) on each island for the department and law enforcement to conduct joint child interviews wherever possible at the CAC. This coordinated, investigative interview is to insure that the child is seen in a timely manner, in a child friendly environment, by an identified team (police and CWS social worker) who will gather the necessary information which will eliminate the need for re-interviewing of the child by varied individuals:

1. The CWS social worker or police counterpart will establish contact to inform each other of the sex abuse report and to plan contact with the child;

2. The team (CWS social worker and police if possible) shall schedule a full interview at the CAC where the interview shall be videotaped. If there is more than one child victim, each child shall be interviewed separately to determine:

   a. the likelihood of harm or threatened harm

including psychological harm;

b. whether or not siblings were victims or witnesses to the harm or threatened harm of the identified child;

c. whether or not siblings are vulnerable to risk of abuse.

3. CWS social worker shall do a screening interview only for immediate safety concerns and those questionable reports where there has been no disclosure or what is being reported is "red flag" behavior by the child. If a screening interview is held, this should be done away from the family home and minimal information should be gathered to assess child's immediate safety. The CWS social worker shall ensure privacy, confidentiality, freedom from influence by others and safety. The specific details of the sex abuse shall be handled as part of the full interview at CAC.

4. If the alleged victim is a young child or a developmentally delayed child and disclosure is not made during the CAC interview, consider a referral for play therapy so that additional information may be obtained during the 60 day assessment period to determine whether harm occurred or not.

5. Siblings should be considered at risk of harm if not reported as harmed. They should be interviewed separately wherever possible and before the interviews of their parents or caretakers (See B.1-3).

   Further information is needed to assess the sibling's acceptance of the abuse or harm and their feelings toward the child victim. This information will assist in the development of the case plan which should focus on comprehensive treatment services for the family unless the non-abusive spouse or caretaker has taken steps to sever that relationship with no plan to reunite with the offender.

   a. Level of acceptance or denial of the harm: Siblings may make it difficult to support and believe the child victim, thus alienating the child victim from emotionally and physically participating in family activities;

b. Feelings toward child victim - to what degree are siblings, supportive vs. angry and resentful, blaming her/him for alleged offender's removal from the home, loss of father's physical presence, loss of father's employment/earnings, loss of home, public embarrassment. Siblings may reject the child victim for allowing the abuse to occur, for "seducing their father/caretaker."

6. Child victims **are not to be subjected to polygraph exams** during the course of the investigation. This gives the message that they are not to be believed and must "prove" themselves.

7. If the non-abusive parent is assessed as supportive, obtain parental consent for child's(ren's) interview at CAC;

8. If an assessment of the non-abusive parent has not been done, request police assistance in taking the child into custody for purposes of the interview at CAC.

9. The CWS social worker shall call/contact parents or caretakers to immediately notify them of the child's whereabouts and to arrange for an interview as soon as possible. Interview the non-abusive spouse first, preferably in the CWS social workers office to assess or gather information:

   a. likelihood that sexual abuse occurred;
   b. ability to protect and support the child rather than blame or find fault;
   c. the causes or dynamics leading to the sexual abuse;
   d. level of dependency on the offender;
   e. quality of relationship with the victim;
   f. number and severity of other problems;
   g. willingness and ability to keep the alleged perpetrator out of the home until further notice;
   h. willingness to participate in intensive home based services or other support services for immediate help and assistance with filing of temporary restraining order, child care, rent assistance, etc., and preparation for civil or possible criminal court

intervention;

i. willingness to participate in treatment with child and other family members.

10. Prior to interviewing the alleged maltreater, the CWS social worker and law enforcement investigator should make contact to decide the particulars of the interview: who will do it, when and the location of the interview. The interview should follow that of the non-abusive spouse to prevent intimidation, collusion or other manipulation of information and to assess:

    a. willingness to disclose the type of abuse and period of time the abuse occurred;
    b. acknowledgement of the seriousness of the behavior,
    c. the degree of shame/guilt for the behavior;
    d. number and severity of the offender's other problems (substance abuse, mental illness, mental retardation, violent behavior, etc.);
    e. willingness to change abusive patterns;
    f. willing to leave the home;
    g. willingness to be evaluated and participate in treatment;
    h. willingness to adhere to a visitation schedule based on input from family, CWS social worker and treatment provider;
    i. acceptance of Family Court intervention to reinforce these conditions.

8.2.2 Videotaping child Interviews

Videotaping is a tool used to record a child's verbal and non-verbal statements of abuse in a first interview conducted for police and child protection purposes.

Unless inter-agency procedures are in place with the CAC and police, the following protocol shall be followed:

GOAL: The goal is to use videotaping as one tool in recording a child's verbal and non-verbal statements of abuse in a first interview conducted for police and child protective services' purposes.

OBJECTIVES:

1. Reduce the need for repeated and exhaustive interviews of the child victim;
2. Provide a record and documentation of the disclosure of the abuse;
3. Utilize as an ongoing training method in demonstrating the significance of a child victim's first report of abuse in a child protection context.

JUSTIFICATION:

While many children and adolescents may be more proficient in verbal skills and more determined to seek immediate protection, time delays, emotional reconsideration, dependency on the family unit, and adversarial court proceedings, are a few examples leading to retractions. Videotaping is one measure of anticipating and dealing with retractions and other "flight" patterns.

1. To reduce the need for multiple interviews by varied agency personnel to document information for civil or criminal proceedings;

2. To act as a psychological catharsis. Having made a permanent record, the child may feel more comfortable about the situation and not have to dwell on it unnecessarily;

3. To aid in psycho-therapy to focus on the issue of child abuse and to offer background to a therapist.

TARGET GROUP:

This target group will be all victims of sexual abuse under the age of 18 years reported to Child Protective Services.

Process:

1. Law enforcement and DHS shall make every attempt to coordinate the videotaping interview and plan the strategy of the interview together, e.g., who is to be the lead interviewer, who may be present, sensitive questions, etc.

2. Law Enforcement and DHS shall provide blank tapes for taping purposes. One tape shall be for

the police and the other for DHS with both agencies providing blank tapes for this purpose.

3. For CPS cases with a videotaped interview with the child(ren) **and** a court petition, the DHS worker shall:

   a. reference the videotaped interview where appropriate in the court report, and
   b. submit the videotape as an Exhibit with the petition and court report to the Family Court worker per consultation with the Deputy Attorney General (DAG) and/or upon request of Family Court.

NOTE: Custody of the videotape, once submitted to Family Court, becomes the property of Family Court. If the DAG or Court requests that the videotape be submitted with the court petition and court report make a copy of the tape for casework purposes and submit the original tape to court.

4. On every CPS case which includes a videotaped interview by the child, the videotape will be transferred to the case management unit with the case record. Tapes are to be kept in a locked cabinet at all times when not in use.

5. The assigned CWS social worker will be responsible for coordinating and arranging all reviews of the videotapes. This includes setting up the equipment and insuring that the assigned worker/representative remains present during the review.

   Persons acting in the best interest of the child may review the tape (e.g., non-offending caretaker, GAL, therapist, DAG).

   The alleged offender may review the videotape in accordance with a court order or when deemed appropriate by the DHS worker in consultation with the therapists working with the victim, offender and other family members.

6. DHS 1523 form shall be completed for all parties who review the tape. This form shall be rubber banded around the videotape.

7. At the point of case closing, the active worker will physically incorporate the tape as part of the case record (place videotape in manila envelope and secure onto case folder (top of inside left hand folder cover) and route to Closed Files with a memo noting to return the tape to the unit for reuse once the expungement deadline has been met. Prior to reuse, erase all contents on tape.

8.2.3 Medical Examinations

Each section, through interagency collaboration (i.e., Sex Abuse Treatment Center, the Children's Justice Act Grant Task Force, the Children's Advocacy Center or the Child Welfare Advisory Council), has developed protocols for medical examinations. These consist of two types:

A. Cases in which the sexual abuse occurred within the last 72 hours of the child abuse report wherein medical-legal evidence would be available in supporting the allegation of sexual abuse, or cases in which sexual abuse occurred more than 72 hours prior to the child abuse report and penetration was disclosed;

B. Cases in which sexual abuse occurred more than 72 hours prior to the child abuse report but no penetration was disclosed.

When in doubt as to whether or not a medical exam is warranted, seek medical consultation from the Multidisciplinary Team medical consultant. Schedule a medical examination for all children reported as sexually abused (digital or vaginal penetration, anal penetration, testing for sexually transmitted diseases and pregnancy, injury resulting from sexual abuse):

1. At least one general acute care hospital has been identified to perform examinations for child sexual abuse victims:

   Oahu: Kapiolani Medical Center for Women and Children

Maul:	Maui Memorial Hospital
Kauai:	Wilcox Hospital
E. Hawaii:	Hilo Hospital
W. Hawaii:	Kona Hospital

2. Appropriate forms for the 72 hour medical-legal exams as well as for the post 72 hour exams are available at the hospital (for the island of Hawaii, the SANE exam must be accessed through the police department).

3. For families with medical coverage through QUEST, CHAMPUS, HMSA or other private insurance, tap that available resource.

4. For families without medical coverage, the CWS social worker shall assist family in accessing medical assistance through QUEST. A purchase order may be issued to cover the cost of the examination if no other resource is available.

8.2.4 Expedited Sentencing Program

The Expedited Sentencing Program (706-606.3, HRS) was enacted into law during the 1993 Legislative session. Its intent was to provide prosecutors and the legal system with an option in intrafamilial child sex abuse cases which would balance the needs of the child victim with community safety. Participation in the program is based on certain conditions being met:

1. Maltreater admits wrongdoing;
2. Maltreater moves out of the home;
3. Maltreater participates in an assessment and recommended treatment;
4. Maltreater does not have a prior sentence under this section and has not received a prior conviction for felony sexual assault;
5. Prosecuting attorney agrees to the maltreater's participation.

As soon as the assessment (investigation) is completed, a civil/criminal coordination meeting should be scheduled by the CAC Program Director in intrafamilial cases to discuss the appropriateness of Expedited Sentencing. The CWS social worker shall coordinate with the police, prosecutor and Judiciary - Adult/Juvenile Probation in the completion of the assessment and recommended treatment. Every effort shall be made to share the

cost among the key agencies involved.

8.2.5 Evaluation

Following the initial interview of the child and parents, further assessment and/or evaluation is needed (refer to charts 1 and 2 at the end of the procedures section taken from the National Center on Child Abuse and Neglect, Child Sexual Abuse; Intervention and Treatment Issues, the Use Manual Series. 1993).

A. The Child

The child victim may be at greater risk for emotional abuse than additional sexual abuse immediately after disclosure:

1. The child may be disbelieved by her/his mother, siblings, and/or extended family;
2. The child may be blamed for the sexual abuse (She/he may be told she/he was seductive. The child may believe she/he allowed it because she/he got special favors from the offender).
3. The child may be rejected by her/his family (Mother is angry at her/him. The child's siblings are angry because she/he has caused them embarrassment and loss of their father).
4. The child may be blamed for the consequences of disclosure (Because she/he told, the father is going to have to leave the home, going to lose his job, going to jail, mother divorcing the father, family has to go an public assistance, etc.).
5. The child may be pressured to recant.

B. The Maltreater

1. The following areas need to be evaluated:

   a. past sexual victimization of children;
   b. possible future victimization of children;
   c. the extent of deviant arousal patterns, fantasy and planning, denial, remorse, empathy, functioning level;
   d. other dysfunctional behaviors and problems;
   e. whether or not outpatient treatment is feasible.

2. The psychosexual assessment:

For alleged maltreaters, a psychosexual assessment shall be completed prior to referral for treatment. This evaluation may include:

a. clinical interview: focus on sexual behavior and fantasies, psychopathy;
b. police report: description of the victim's version of the offense to confirm whether the offender is admitting to the offense with some minimization;
c. MMPI-2: validity scales and illuminating issues that are not directly related to sexual offending;
d. Multiphasix Sex Inventory: validity scales complement and confirm the MMPI's validity scales;
e. Demographic Questionnaire: Correlation with risk and re-offense;
f. Goals of Treatment (revised): developed by Dr. Gene Abel. It has non-obvious correlations with treatment outcome and recidivism;
g. Sexual Interest Cardsort: Gene Abel and Judith Becker's instrument taps a broad range of sexually deviant interests;
h. Cognitions Scale (revised): designed by Dr. Abel and Dr. Becker, this tool focuses specifically on the fantasies of child molesters and is useful in detecting the scope of potential pedophilia.

3. For those denying sexual abuse:

A polygraph or penile plethysmograph should also be administered with the above mentioned tests or reports either voluntarily or by order of the court. If the alleged offender refuses to consent or participate, discuss with evaluator and proceed with the appropriate tests a-h above, noting client's refusal to complete the comprehensive testing.

4. Payment of assessment:

Discuss the assessment with the maltreater and the evaluator. Be clear on who is responsible for payment. Cost of assessments should be covered by alleged offender, QUEST, or other medical/private resource available to the client. Otherwise, payment can be

made through purchase order ($85/hr. not to exceed 4 hours). If the evaluation exceeds this amount, the client shall pay the difference and the evaluator shall be made aware of and agree to this arrangement.

5. Evaluators:

Providers for incest maltreater assessment should be limited to those who have expressed an interest and willingness to do these evaluations, have received training through the Department of Safety or comparable expert, have experience working with sex offenders and follow and abide by the Sex Offender Treatment Team's integrated treatment model (SOTT).

8.2.6 Basic Principles

Basic principles are accepted in order for treatment services to be effective:

A. Child sex abuse is an assaultive behavior that harms children. Police shall be involved in the investigative process based on established protocols with the Children's Advocacy Center.

B. The maltreater shall be removed from the home. Children need the protection and safety of their family, their extended families, friends, and community (such as the school, church, or others). To remove children further traumatizes them and increases chances that the children will recant. Removal of the offender:

1. increases the child's safety;
2. reduces the offender's power and control over household members;
3. demonstrates the severity of the offender's actions;
4. identifies and places responsibility for the situation in the family with the offender, not the victim;
5. enables the non-offending spouse, with support such as counseling, intensive home based services and other services to strengthen her parenting abilities so she can be protective and assertive.

However, there are cases in which, to protect the child, to prevent her/his psychological abuse, or to relieve the victim of the experience of family turmoil, the child needs to be placed

outside of the family home.

This is usually least desirable for the child victim as there is great risk of becoming identified and scapegoated as the person who caused the family problem.

However, it may be necessary particularly if the non-abusive spouse is unsupportive and there is enormous pressure by the maltreater and other family members to withdraw the complaint of sexual abuse.

If the child is removed, serious consideration should be given to the removal of the maltreater as well for the reasons cited above in 9.7.6, 2) a-d.

Consideration must also be given to the removal of all children in the home, depending on the circumstances of the case and the willingness and ability of the non-offending parent to assure their safety.

C. A petition to Family Court shall be initiated in order to mandate treatment particularly for the maltreater where expedited sentencing is not being considered. Because of the misuse of power and control, and the abusive behavior to the child by the maltreater, often over a period of time, intervention must be authoritative yet supportive. **Exceptions: a) Instances where the non-abusive spouse has divorced the maltreater or relocated with her children and has taken steps to obtain needed therapy for her family; b) maltreater has admitted to sexual abuse and is awaiting criminal prosecution and has moved out of the home; c) the maltreater no longer has access to the child(ren) and the child's legal caregivers are protective and able to prevent any contact between the maltreater and the child(ren).**

D. Treatment services shall be provided through available resources, e.g., QUEST, public and private resources. Families with no resources shall be referred to purchase of service treatment services as slots/funding are available. Alleged maltreaters adjudicated and/or criminally prosecuted shall be held accountable for payment of their treatment through their respective court orders and/or through the purchase of service - restitution criteria.

E. Information shall be shared with key agencies (Department of Public Safety, Judiciary - Adult/Juvenile Probation, Purchase of Service Providers, Police, Prosecutors Office) to insure child and community safety. Information shared may be part of the Children's Advocacy Centers civil-criminal case conference, CPS Multidisciplinary Team meeting, and/or case planning such as reunification, visitation, and termination of jurisdiction.

8.2.7 Treatment

It is important that all family members participate in treatment to understand why and how the abuse occurred and what steps need to be taken to assure that further abuse does not reoccur. Treatment modalities include individual, conjoint, family (when re-entry of the maltreater is agreed upon by all the family members) and group treatment. Refer to the section's copy of the request for proposal (RFP) for the specifics of the treatment model.

If, following the evaluation, the maltreater enters treatment but continues to deny any wrongdoing after **one cycle of treatment, he shall be terminated from treatment.** If treatment is court ordered, notify the court of termination and the reasons why. The CWS social worker need not place the maltreater into another treatment program. However, the child victim and non-abusive caretaker and siblings, if appropriate, shall continue to be supported in treatment particularly if the non-abusive caretaker is contemplating reuniting with her spouse. It should be stressed how this jeopardizes the child's safety when the maltreater fails to admit, to take responsibility, to demonstrate empathy and to apologize to the victim and the family. If there is no reunification planned, and the maltreater continues to deny wrongdoing, discuss with non-abusive caretaker terminating the maltreaters parental rights.

If the maltreater is active with Adult/Juvenile Probation, the lead for treatment shall be initiated by that agency with the Department providing services to the child victim, non-abusive spouse and siblings. Coordination and sharing of information with that agency shall continue to insure that the child/family's needs are met.

A. Maltreater

Relapse prevention is the treatment model for maltreaters with behavioral conditioning therapy, individual behavioral treatment and psycho-educational group, rounding out the

therapy for maltreaters. Treatment issues include:

1. Sexual arousal to children: understanding sexual and other trauma during' childhood, understanding sex roles and learning how to change deviant arousal patterns;
2. Propensity to act on arousal: e.g., poor impulse control, diminished capacity, superego deficits, and addressing these by taking responsibility for sexual abuse and relapse prevention;
3. Contributing factors: e.g., child behaviors, opportunity to abuse;
4. Preventing future sexual abuse: understanding why the abuse occurred in the first place.

B. Child

Treatment issues to be addressed:

1. Trust, including patterns in relationships;
2. Emotional reactions to sexual abuse - feeling guilty, responsible, altered sense of self,
3. Behavioral reactions to sexual abuse - sexualized behavior, other behavioral problems - e.g., aggression, running away, self harm;
4. Cognitive reactions to sexual abuse - learning what appropriate and inappropriate touching is, understanding the meaning of the abuse dependent on the child's developmental stage;
5. Protection from future victimization - assertiveness and communication skills.

C. Siblings

Siblings, as appropriate, shall be included during the early stages of intervention to assist with:

1. What they understand about the abuse and the events that transpired since disclosure;
2. How they feel about the victim and the offender;
3. How they are functioning in their school and community;
4. Any possible problems that need to be resolved before working on family therapy.

D. Non-abusive parent/caretaker

Treatment issues include:

1. Understanding maltreater and victim dynamics: the adult's sexual activity with the child, believing the child's disclosure, understanding his/her role with the child;
2. Mother-victim relationship: assisting non-abusive parent in developing empathy for the victim, enhancing communication, helping to resolve relationship issues, developing positive experiences;
3. Feelings about the maltreater: trust, anger and betrayal, whether to remain or terminate the relationship;
4. Other personal issues: i.e., substance abuse, dependency, emotional problems.

8.2.8 Visitation

The child and/or family may want visitation or unsupervised visitation when it is not deemed in the child's best interest by the professionals involved in the case, such as the child's therapist, CWS social worker, guardian ad litem, and Adult Probation. The Family Court may also be seeking help from the CWS social worker as to what factors to consider in determining the appropriateness of contact between parents, victim and other children in the family.

A. Guidelines for the CWS social worker regarding visitations between the child and alleged maltreater include:

    1. No contact between the victim and the maltreater if the child is to appear in court, until after her/his testimony;
    2. If the child genuinely does not wish visits, these should not be pushed, particularly with older adolescents;
    3. If the non-abusive parent and/or other family members are unsupportive of the child testifying, there should not be contact until after the child's testimony;
    4. There should be no unsupervised visitation until the child feels safe and the maltreater has been assessed and found not at risk of reoffending, e.g., polygraph completed that is unremarkable, treatment progressing;
    5. If the family and child want visits, these should be based on consultation with all the therapists/agencies involved;
    6. If visits commence, these should be **supervised by the child's support system,** e.g., therapist, guardian ad Litem, family members who believe the child and are protective and supportive; use of the therapist can help

reframe for the maltreater, appropriate interaction between parent and child;

B. Guidelines for visitation between alleged maltreater and other children In the family:

1. The visits must be at the request of the child(ren).
2. The visits should take into account the psychological well being of the victim or victims;
3. The maltreater must be participating in therapy and have acknowledged and taken responsibility for the abuse.
4. Visitation must be approved by the CWS social worker, the therapists for the victim, maltreater and family, and GAL;
5. The safety of the child(ren) must be assured;
6. The visits must be supervised closely at a neutral location;
7. Conditions for the visits must be documented in a written visitation agreement between the parties with penalties for violations of the conditions;
8. Visits will be cancelled if any of the above conditions are not met.