Child Abuse and Maltreatment/Neglect: Identification and Reporting

New York State Mandatory Training

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New York State

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If you studied the course online, did all the links work? If not please note the page and link on a separate sheet of paper and send it in with your answer sheet so we can fix it.					

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Objectives

Upon completion of this course, the learner will be able to:

- Discuss the scope of the problem of child abuse.
- Identify the legal definitions of child abuse and maltreatment/neglect in New York State.
- Describe possible indicators, physical and behavioral, of child abuse and maltreatment/neglect.
- Describe the perpetrators of child abuse and maltreatment/neglect.
- Evaluate situations to determine whether there is reasonable cause to suspect child abuse or maltreatment/neglect.
- State the criteria for reporting child abuse or maltreatment/neglect.
- Describe the reporting procedure.
- Describe the legal framework for the New York State Child Protective System.
- State how the New York State Infant Abandonment Law impacts mandated reports.

Introduction

In 2013, the United States, one of the most educated and affluent countries in the world, continued to struggle with child abuse/neglect/maltreatment. Nationally, there were 678,932 victims of abuse and neglect. With a total child population in 2013 of 74,399,940 children, the resulting rate of victimization is 9.1 victims per 1,000 children in the population. On a modestly hopeful note, the number of victims decreased 3.8 percent from 2009 to 2013 (USDHHS-ACF,2015).

Although New York State was a leader in the prevention of child cruelty, going back to the 1800s, it was Chapter 544 of the laws of 1988 that required select professionals to complete 2 hours of coursework regarding the identification and reporting of child abuse and maltreatment/neglect, utilizing the curriculum developed by the New York State Education Department. In 2005, the responsibility for approval of the content of the course was transferred to the New York State Office of Children and Family Services.

Who Are the Mandated Reporters?

Ken Hammond, USDA

The New York State Office of Children and Family Services (NYS-OCFS) (NYS-OCFS, 2011), reporting on two separate studies, a National Incidence Study conducted during the 1980s, and a 1999 University of Rochester study, found that professionals only reported about half of all maltreatment incidents that they knew about. Some of the reasons for not reporting were:

- Confusion or misunderstanding about reporting laws and procedures;
- Lack of knowledge or awareness of warning signs/clues.
- Lack of clarity about abuse/neglect as defined in State Law; and
- Influence of professional beliefs, values and experiences.

Mandated reporters of child abuse are identified in New York State Social Service Law, Article 6, Title 6, Section 413 as:

- All persons credentialed by the NYS Office of Alcoholism and Substance Abuse Services
- Alcoholism counselor
- Child care or foster care workers
- Chiropractor
- Christian Science practitioner
- Coroner
- Day care center worker
- Dentist
- Dental hygienist
- District attorney or assistant district attorney
- Director of children's overnight camp, summer day camp or traveling summer day camp
- Emergency medical technician
- Employee or volunteer in a residential care facility for children
- Hospital personnel engaged in the admission, examination, care or treatment of persons
- Intern
- Investigator employed in the Office of the District Attorney
- Law enforcement officials
- Licensed creative arts therapist
- Licensed marriage and family therapist
- Licensed mental health counselor
- Licensed psychoanalyst
- Medical examiner
- Mental health professional
- Optometrist
- Osteopath
- Peace officer
- Physician
- Podiatrist
- Provider of family or group family day care
- Police officer
- Psychologist
- Registered nurse
- Registered physician assistant
- Resident
- School-age child care worker
- School official, including (but not limited to): school teachers, guidance counselors, school psychologists, school social workers, school nurses, school administrators, or other school personnel required to hold a teaching or other administrative license or certificate)
- Social services worker
- Social Worker
- Substance abuse counselor
- Surgeon

The above professionals are required to report when they have reasonable cause to suspect that a child has been abused or maltreated/neglected.

Because the laws of the state change based on the needs of its residents, the New York State legislature may include additional professionals over time. Please contact the New York State Education Department, Office of the Professions to check if your profession is included as a mandated reporter of child abuse, maltreatment/neglect.

Penalties for Failure to Report

Failure to report child abuse or maltreatment/neglect on the part of mandated reporters is addressed in New York State Social Service Law, Section 420:

- Any person, official or institution required by law to report a case of suspected child abuse or maltreatment/neglect who willfully fails to do so shall be guilty of a Class A misdemeanor;
- Any person, official or institution required by this title to report a case of suspected child abuse or maltreatment/neglect who knowingly and willfully fails to do so shall be civilly liable for the damages proximately caused by such failure.

Protection from Retaliatory Personnel Action

Section 413 of the Social Services Law specifies that no medical or other public or private institution, school, facility or agency shall take any retaliatory personnel action against an employee who made a report of child abuse or maltreatment to the State Central Register (SCR). Furthermore, no school, school official, child care provider, foster care provider, or mental health facility provider shall impose any conditions, including prior approval or prior notification, upon a member of their staff mandated to report suspected child abuse or maltreatment.

Immunity From Liability

Mandated reporters are provided immunity from liability under New York State Social Service Law, Section 419:

Any person, official or institution participating in good faith in making of a report, the taking of photographs, or the removal or keeping of a child they suspect may be abused or maltreated/neglected, shall have immunity from any liability, civil or criminal, that might result from such actions. For the purpose of any proceeding, civil or criminal, the good faith of any such person, official or institution required to report cases of child abuse or maltreatment/neglect shall be presumed, provided such person, official or institution was acting in the discharge of their duties and within the scope of their employment, and that such liability did not result from the willful misconduct or gross negligence of such person, official or institution

Abuse and Maltreatment/Neglect Have Many Presentations

Case #1: Corey

Corey is an 8 year old boy who was brought into the emergency department where you work, by EMS personnel after he was hit by a softball during physical education class at school. Corey lost consciousness for several minutes. During the physical exam, you note that he has bilateral bruises to his shoulders, arms and abdomen. Crying, Corey reports that he was "beaten up" by classmates. When his father arrives at the ED, Corey becomes visibly fearful and stops crying. The father is clearly angry; he begins to shout at Corey about having to leave work early during an important business meeting; he was shouting at Corey about not paying attention to the game, about being a lousy ball player and acting like a baby. As the physician in the ED, you note the dad's behavior and how Corey is responding to it.

Case #2: Juanita

You are a family nurse practitioner working in a primary care office. Juanita's mother comes to the office in follow-up to the hypertension noted at the last visit. She brings 9-year old Juanita with her to the appointment, as she usually does. Today you note that Juanita is withdrawn and has bruises on her face and arms. She looks like she's been crying. Juanita is typically a chatty girl who usually engages you in talking about her love of dancing, often showing off her latest moves for the staff. Her mother appears irritable and distracted. You ask her what's wrong and she says she's fine. You mention that Juanita is so quiet and looks upset today, to which she replies that Juanita has been "bad". What would you do if you were the nurse practitioner this situation?

Case #3: Sam

Twelve year old Sam comes to school wearing only a short sleeved t-shirt and jeans on days when the temperature is in the 30s. Sam is a quiet, slender young man. He often seems nervous; he is easily startled. Sam is a C student. He never seems to be paying much attention during class; he looks preoccupied. Sam doesn't make much eye contact. He spends most of his time alone; he doesn't really have any friends at school. Indeed, often Sam is the focus of harassment and teasing from his classmates. About 2 weeks ago Sam came to class limping. He said he sprained his left ankle. The ankle didn't get better after a week, so you sent a note home to have Sam's family get medical attention for Sam. That was last week and there has been no change. As the teacher in this 7th grade classroom you wonder if Sam might be really injured.

Case #4: Alicia and Martin

The visiting nurse comes to the home to follow-up on 10 week old Alicia. The baby was born to a 19 year old mother with a history of cocaine addiction. Alicia weighed 6 lbs. 2 oz. at birth and was not drug addicted. Today, the first day you have been able to get into the home since the referral was made 6 weeks ago, you note that Alicia weighs 4 lbs. 6 oz. The mom tells the nurse that she ran out of formula yesterday and hasn't had a chance to get to the store yet today. Alicia is fretful, but does not cry. Also, during the home visits the nurse notes that 3 year old Martin has circular burn marks on his arms and legs. He is a lethargic child who cries frequently and is very shy and fearful of adults. The nurse examines Martin and finds that he also has a patterned bruise on his back which looks much like a wooden spoon.

Case #5: Tisha

5 year old Tisha has been to see her primary care provider almost weekly for the past month. Each week Tisha has complained to her mother that her stomach hurts, so her mother brings her in to be examined. Tisha's only symptom is abdominal pain. She has no nausea, vomiting or diarrhea. She is well nourished and developmentally appropriate for her age; she clearly has been well cared for. Multiple diagnostic tests have been run over the past month. As the family nurse practitioner in this practice, you must inform Tisha's mother that Tisha has tested positive for syphilis.

Case #6: Leah and Tisha

As a clinical social worker, you are Leah's therapist. Leah is step-mother to 5 year old Tisha, having been married to Tisha's father, Michael, for the last 6 months. The whirlwind relationship has been the frequent topic of your sessions. Leah has also talked about her role as a step-mother and her discomfort with it. She thinks that Michael and Tisha are too close; it makes her uncomfortable. Leah reports that she thinks Michael is too protective of Tisha, not really allowing her to play with other children when she is staying at their house, even limiting her contact and relationship with Tisha. In the last session with Leah, she told you that she fears that Michael is sexually abusing Tisha: she saw him leave Tisha's room early in the morning, when he thought she was sleeping; she saw him toss a condom in the trash. As the therapist, what should you do?

Case #7: Marcus, Amber and Isaiah

Sometimes, the Shaw children come to school appearing to be hungry. You are the school nurse who comes to this school most afternoons, usually getting to the school at lunchtime. You note that the Shaw children often don't have any lunch. When they do bring a lunch, it is often not enough food. Other than this, the children seem well-groomed and well-behaved. The children are generally quiet, rather private. As the nurse, you begin talking to them and learn that their father does seasonal work and is often between jobs. How would you handle this if you were the school nurse?

Case #8: Tim

At a residential treatment center for boys age 13-16, recently some of the boys have alleged that they were sexually abused by staff. The internal investigations at the facility have never supported these claims. One of the registered nurses, Jean, suspects that what she is being told by the boys is correct; she has noted how some of the aides, mostly males, treat the boys so roughly on the one hand and then at other times are often way too familiar. She has often felt uncomfortable with their behavior. 15 year old Tim showed Jean his bloody underwear. He also told Jean that one of the aides, Joe, was forcing him to have sexual relations with some of the other aides and that Joe was making money on it. Jean complains to the facility administration about these allegations, but was told that an internal investigation has occurred and there is no evidence that these allegations are based in fact.

These situations are real, or at least they could be real; several are based on real situations. If you were faced with these situations, what would you do? Do you know what child abuse looks like? Would you recognize child abuse if signs and symptoms were presented to you? Would you know what to do ethically if you suspect child abuse? Do you know what you must do legally if you suspect child abuse? What if you are not sure? Do you know what you might face legally if you did not report your suspicions? Would you face repercussions if you did report? How should you proceed?

The Disturbing Statistics

The National Child Abuse and Neglect Data System (NCANDS) is a federally sponsored effort that collects and analyzes annual data on child abuse and neglect. The data are submitted voluntarily by the States, the District of Columbia and the Commonwealth of Puerto Rico. *State laws determine what is considered abuse, maltreatment or neglect in each state and these laws can vary from state to state. The information that is collected in each state also varies.*

The reader is requested to remember that the data presented here are provided voluntarily by each state and compiled by NCANDS. The first report from NCANDS was based on data for 1990; the most recent report, *Child Maltreatment 2013*, published in 2015, reports on data collected from October 1, 2012 through September 30, 2013. Most of the statistics in this course come from the US Department of Health and Human Services, Administration for Children and Families' *Child Maltreatment 2013* (USDHHS-ACF, 2015).

The National Picture

Nationwide, an estimated 679,000 children were victims of abuse and neglect in 2013, a victimization rate of 9.1 for every 1,000 children in the country, according to *Child Maltreatment 2013*. A child was counted each time he or she was found to be a victim (USDHHS-ACF, 2015).

The 2013 victimization rate continues a trend towards lower rates. All of the factors that contribute to this reduction are not clear. The decrease can partially be attributed to several factors, including the increase in the number of children who received an unsubstantiated disposition, the increase in the number of children who received an alternative CPS response, and the decrease in the number of children who received a substantiated or indicated disposition.

It is possible that the lower rate of victimization in 2013 is related to States' use of an "alternative response", as mentioned previously. This alternative approach may be called alternative response, family assessment response (FAR), or differential response (DR). Cases assigned this response often include early determinations that the children have a low-risk of maltreatment. This response usually includes the voluntary acceptance of CPS services and the mutual agreement of family needs. Such cases do not usually make a specific determination of the allegation of maltreatment. However, in cases where services are required by the agency rather than provided solely on a voluntary basis, some States also use the concept of a victim.

Child neglect continues to comprise the largest portion of cases of child maltreatment. According to the federal report *Child Maltreatment 2013*, of those substantiated reports, figures for the US include:

Neglect	79.5%
Physical abuse	18.0%
Sexual abuse	9.0%
Psychological maltreatment	8.7%
Medical neglect	2.3%
Other types	10.0%

"Other types of maltreatment" include, for example, abandonment, threats of harm, or congenital drug addiction, parent's drug/alcohol use. States may code any condition that does not fall into one of the main categories-physical abuse, neglect, medical neglect, sexual abuse, and psychological or emotional maltreatment as "other." These maltreatment type percentages total more than 100 percent because children who were victims of more than one type of maltreatment were counted for each maltreatment (USDHHS-ACYF, 2015).

Child fatalities are the most tragic consequence of maltreatment. While the number of child deaths decreased since 2009, there were still 1,520 children who died from abuse and neglect in 2013 (USDHHS-ACYF, 2015).

Characteristics of Child Victims

Generally, the rate of victimization was inversely related to the age group of the child; the youngest children had the highest rate of victimization. Children younger than 1 year are at the most risk for abuse with the highest rate of victimization at 23.1 per 1,000 children in the population of the same age (USDHHS-ACYF, 2015). Children younger than 4 years are the most vulnerable for many reasons, including their dependency, small size, and inability to defend themselves. Of the children abused, 50.9 percent were female, 48.7 percent were male (USDHHS-ACYF, 2015).

The majority of victims comprised three races or ethnicities—White (44.0%), Hispanic (22.4%), and African-American (21.2%). African-American children had the highest rates of victimization at 14.6 per 1,000 children in the population of the same race or ethnicity. Hispanic and White children had lower rates of victimization at 8.5 and 8.1 per 1,000 children in the population of the same race or ethnicity (USDHHS-ACYF, 2015).

Thirteen percent (12.6%) of victims were reported as having a disability. Children with the following risk factors were considered as having a disability: intellectual disability, emotional disturbance, physical disability, behavioral problems, or another medical problem. visual or hearing impairment, learning disability, physical disability, behavioral problems, or another medical problem. Children with risk factors may be undercounted as not every child receives a clinical diagnostic assessment. Four percent (4.1%) of victims were reported as having a medical condition not classified in NCANDS, 3.0 percent of victims had behavior problems, 2.4 percent of victims were emotionally disturbed. A victim could have been reported with more than one type of disability, but was counted only once in each disability category (USDHHS-ACYF, 2015).

It is a myth that strangers are the big danger for the nation's children. The great majority of perpetrators of child abuse and neglect/maltreatment continue to be parents of the child. One or both parents maltreated 91.4% of victims. For 13% of victims, the perpetrator was not a parent. The largest group in that category are male relatives, male partner of parent, or "other". The numbers exceed 100% because child victims may have been victimized multiple times by the same perpetrator, or by different combinations of perpetrators (USDHHS-ACYF, 2015).

In 2013, a nationally estimated 1,520 children died from abuse and neglect at a rate of 2.04 per 100,000 children in the population. The number of child deaths decreased by 12.7 percent from 2009 to 2013. Only the 49 states that reported fatality data in both 2009 and 2013 were included in this calculation.

The vulnerability of the youngest victims also is demonstrated by the rates of child fatalities. Nearly three-quarters (73.9%) of all child fatalities were younger than 3 years and the child fatality rate mostly decreased with age. Children who were younger than 1 year old died from maltreatment at a rate of 18.09 per 100,000 children in the population younger than 1 year. This is nearly 3 times the fatality rate for children who were 1 year old (6.58 per 100,000 children in the population of the same age). Children who were older than 5 years died at a rate of less than 1.00 per 100,000 in the population. Boys had a higher child fatality rate than girls; 2.36 per 100,000 boys in the population, compared to 1.77 per 100,000 girls in the population (USDHHS-ACYF, 2015).

More than 85 percent (86.8%) of child fatalities were of White (39.3%), African-American (33.0%), and Hispanic (14.5%) descent. Using the number of victims and the population data to create rates highlights some racial disparity. The rate of African-American child fatalities (4.52 per 100,000 African-American

children) is approximately three times greater than the rates of White or Hispanic children (1.53 per 100,000 White children and 1.44 per 100,000 Hispanic children) (USDHHS-ACYF, 2015).

Reporters of Child Maltreatment

In 2013, of all the reports of child abuse, 61.6% were made by professionals (USDHHS-ACYF, 2015):

- Teachers (17.5%),
- Legal and law enforcement personnel (17.5%),
- Social services staff (11.0%),
- Medical personnel (9.0%),
- Mental health personnel (5.5%),
- Child daycare providers (0.7%), and
- Foster care providers (0.5%).

Almost 19 percent (18.6%) of reports were made by non-professionals (USDHHS-ACYF, 2015):

- Unclassified sources (19.8%),
- Other relatives (6.9%),
- Parents (6.7%), and
- Friends and neighbors (4.7%).

Examining 5 years of report source data shows that the distributions have been stable. The categories of professional, nonprofessional, and unclassified have fluctuated less than two percentage points across the years. The slight changes from 2009 to 2013 indicate better reporting as the percentages of unclassified decreased and the percentages of professionals increased (USDHHS-ACYF, 2015).

In New York State

The following statistics for New York State also come for the national Child Maltreatment-2013 study. In 2013, 205424 children received an investigation or alternative response, or a rate of 48.4 per 1,000 children. There were 64,578 children in the state that were victims of child abuse-a victimization rate of 15.2 for every 1,000 children. This is a 16.8 percent reduction in victims from 2009.

Consistent with national data, the youngest children are victimized most frequently. Children under 1 year of age have the highest rate of victimization. Among boys, 32,315 were victims of abuse; 32,103 girls were victims of abuse; 160 victim's gender was not identified. New York State victims by race or ethnic origin data are also consistent with national data:

Race/Ethnicity	Number of Child Victims
African-American	1,241
American Indian/Alaska Native	207
Asian	1,192
Hispanic	16,230
Multiple Races	1,898
Pacific Islander	19
White	20,794
Unknown	5,997

The 64,578 child victims in New York State in 2013 were determined to have suffered 102,125 maltreatment types, so that as indicated previously most children experience more than one type of abuse or maltreatment.

Maltreatment Type	Number of Victims	Percent
Neglect	69,666	5.8
Medical Neglect	3,728	107.9
Other	19,111	29.6
Physical Abuse	6,810	10.5
Psychological Abuse	574	0.9
Sexual Abuse	2,237	3.5

In 2013, there were determined to be 51,985 perpetrators of child abuse/maltreatment in New York State, with a total of 98,122 total relationships with the child (one perpetrator may hold several relationships with the child):

Perpetrator by Relationship to Child	Number of Child Victims
Parent	85,619
Step-parent	222
Legal Guardian	302
Unmarried Partner	39
Other Relatives	5,512
Foster Parents	346
Group Homes/Residential Facility Staff	139
Day Care Providers	329
Other Professionals	3
Other	1,572
Unknown	3,911

In 2014, there were 96 children in New York State who were substantiated to have died as a result of abuse or neglect; 221 fatalities were investigated after being reported to the State Central Register (SCR), “the child abuse reporting hotline”.

In a New York State report examining child fatality data for 2010 – 2014, two overall conclusions were identified (NYS-OCFS, 2015):

- The number of total child fatalities reviewed by the State Office of Children and Family Services (OCFS) annually increased by 7 percent between 2010 and 2014, a fact attributable to more robust reporting initiatives and an expansion of SCR intake categories. Included now are cases in which unsafe sleep practices may have caused death, and since 2013, the SCR accepts reports involving death of an “otherwise healthy child” to rule out child abuse; and
- The number of fatalities substantiated (or confirmed) as having been caused by abuse or maltreatment fluctuated and then decreased between 2012 and 2014 by 25 percent.

Ken Hammond, USDA

Legal Definitions Related to Child Maltreatment

Child abuse and neglect are defined by both Federal and State laws.

Federal Definitions

The Child Abuse Prevention and Treatment Act (CAPTA) is the Federal legislation that provides minimum standards for the definition of child abuse and neglect that States must incorporate in their statutory definitions.

Under CAPTA, child abuse and neglect means, at a minimum:

- Any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or
- An act or failure to act which presents an imminent risk of serious harm.

The term sexual abuse includes:

The employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or the rape, and in cases of caretaker or interfamilial relationships, statutory rape, molestation, prostitution or other form of sexual exploitation of children, or incest with children.

New York State Legal Definitions

While the Federal CAPTA law provides for the minimum standards needed for State laws, it is important for professionals to know the specific legal definitions in the States in which one practices.

Social Services Law of New York State define the following:

A **child** is an unemancipated person who is under eighteen years of age.

In New York State a child is also defined as a child residing in a group residential care facility under the jurisdiction of the New York State Office of Children and Family Services (OCFS), Division for Youth (DFY), Office of Mental Health (OMH), Office of Mental Retardation and Developmental Disabilities (OMRDD), or the State Education Department (SED).

A child with a handicapping condition who is 18 years or older (up to age 21) who is defined as an abused child in residential care and who is in residential care in one of the following facilities:

- New York State School for the Blind (Batavia, NY);
- New York State School for the Deaf (Rome, NY);
- A private residential school which has been designed for special education;
- A special act school district; or
- A state supported school for the deaf or blind which has a residential component.

Based on the definition above, all of the children involved in cases 1-6 are defined as a "child", even Tim, who is 15 years old and resides in a residential treatment facility under the jurisdiction of the Division for Youth also meets the definition of "child".

Abuse

Abuse constitutes the most serious harm committed against children. In New York State, the Family Court Act, Section 1012.(e). defines an abused child as one whose parent or other person legally responsible for her/his care:

- Inflicts or allows to be inflicted upon the child, physical injury by other than accidental means;
- Creates or allows to be created a substantial risk of physical injury to such a child by other than accidental means which would be likely to cause death, serious or protracted disfigurement or protracted impairment of physical or emotional health or protracted loss of impairment of the function of any bodily organ;
- Commits or allows to be committed a sex offense against a child;
- Allows, permits, or encourages a child to engage in any act described in article 263 of the penal Law such as obscene sexual performance, sexual conduct, prostitution);
- Commits any of the acts described in section 255.5 of the penal law such as incest

Maltreatment/Neglect

In New York State, the term **maltreatment** is used in Social Services Law and in Family Court Act, the term used is **neglect**.

Maltreatment/Neglect includes a child's physical, mental or emotional impairment, or imminent danger of impairment by the parent's or legal guardian's failure to exercise a minimum degree of care:

- In supplying the child with food, clothing, shelter or education, or medical, dental optometrical or surgical care, though financially able to do so or offered financial or other reasonable means to do so; or
- In providing the child with proper supervision or guardianship, by unreasonably inflicting or allowing to be inflicted harm, or a substantial risk thereof, including the use of excessive corporal punishment; or

- By misusing drugs or alcohol to the extent that he or she loses self-control of his/her actions, or
- By any other acts of similarly serious nature requiring the aid of the court; or
- By abandoning the child.

Additionally, a maltreated/neglected child is one who:

- Is less than 18 years of age and is defined as a neglected child by the Family Court Act.
- Has had serious physical injury inflection upon her/him by other than accidental means.
- Is 18 years of age or older, is neglected and resides in one of the special residential care institutions listed above under the definition of the child.

According to the Family court Act Section 1012, a "person legally responsible" includes the child's custodian, guardian, any other person responsible for the child's care, at the relevant time. A custodian may include any person continually or at regular intervals, found in the same household as the child when the conduct of such person causes or contributes to the abuse or neglect of the child.

Recognizing Child Abuse

The first step in helping abused or neglected children is learning to recognize the signs of child abuse and neglect. The presence of a single sign does not prove child abuse is occurring; however, when these signs appear with significant injury, or they occur repeatedly or in combination, the professional must take a closer look at the situation and consider the possibility of child abuse. Special attention should be paid to injuries that are unexplained or are inconsistent with the parent or caretaker's explanation and/or the child's developmental age.

The following are some signs often associated with particular types of child abuse/maltreatment: physical abuse, neglect, sexual abuse, and emotional abuse. It is important to note, however, these types of abuse are more typically found in combination than alone. A physically abused child, for example, is often emotionally abused as well, and a sexually abused child also may be neglected.

The list that follows contains some common indicators of abuse or maltreatment. This list is not all-inclusive, and some abused or maltreated children may not show any of these signs and symptoms.

Physical Abuse

Physical Indicators

Physical abuse is often the most obvious form of abuse. It is any non-accidental injury to a child by a parent or caretaker. The mandated professional should pay close attention to any frequent injuries that are "accidental" or "unexplained", or that are developmentally unlikely or any explanation that seems unlikely.

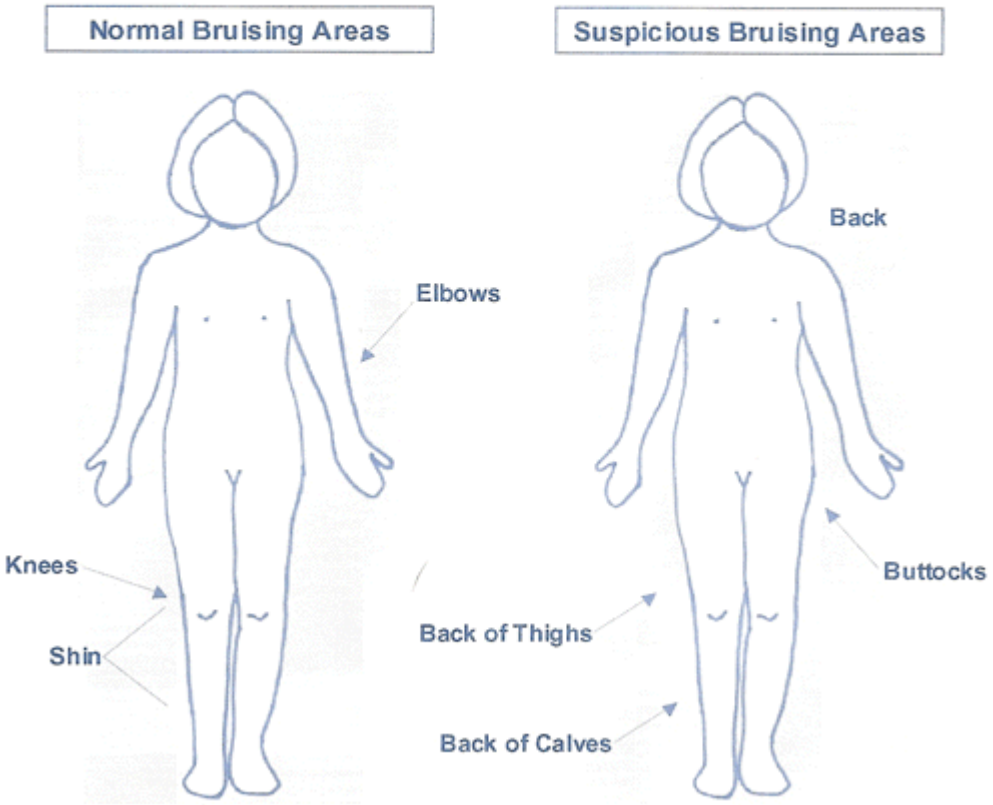
Physical abuse may present as (NYS-OCFS, 2011; CDC, 2015)

Frequent and unexplained bruises

- On face, lips or mouth;
- On torso, back, buttocks, thighs;
- May be in various stages of healing;
- On several different surface areas of the body;
- May appear in distinctive patterns reflecting the shape of the article used such as grab marks or human bite marks, electric cord, belt buckle, etc.;

- Fading bruises or other marks noticeable after an absence, weekend or vacation from school or day care.

Normal and Suspicious Bruising Areas



- Burns
  - Cigar or cigarette burns, especially on the soles, palms, back and buttocks;
  - Immersion burns (sock-lick, glove-like, or doughnut shaped on buttocks or genitalia from having feet, hand buttock/genitals immersed in scalding water);
  - Distinctive patterned burn impressions from appliances or instruments such as steam irons, curling irons, etc.;
  - Rope burns on arms, legs, neck or torso.

Steam Iron Injury

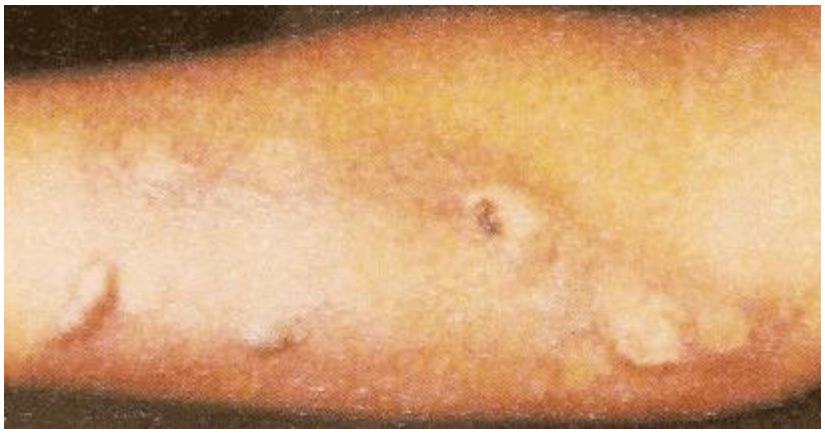


Photo courtesy of NYS-OCFS

Handprint Injury

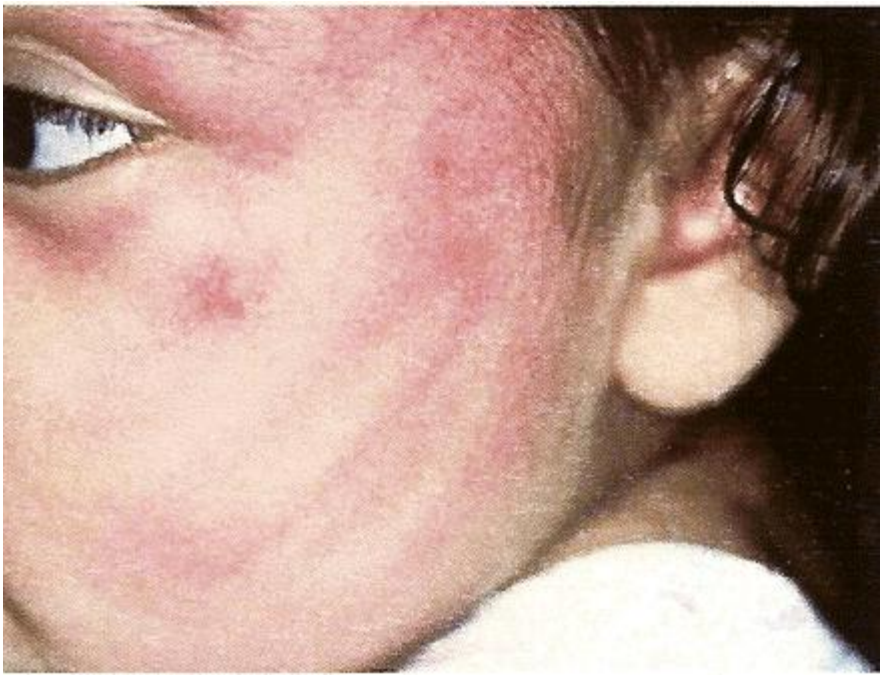


Photo courtesy of NYS-OCFS

Looped Cord Injury

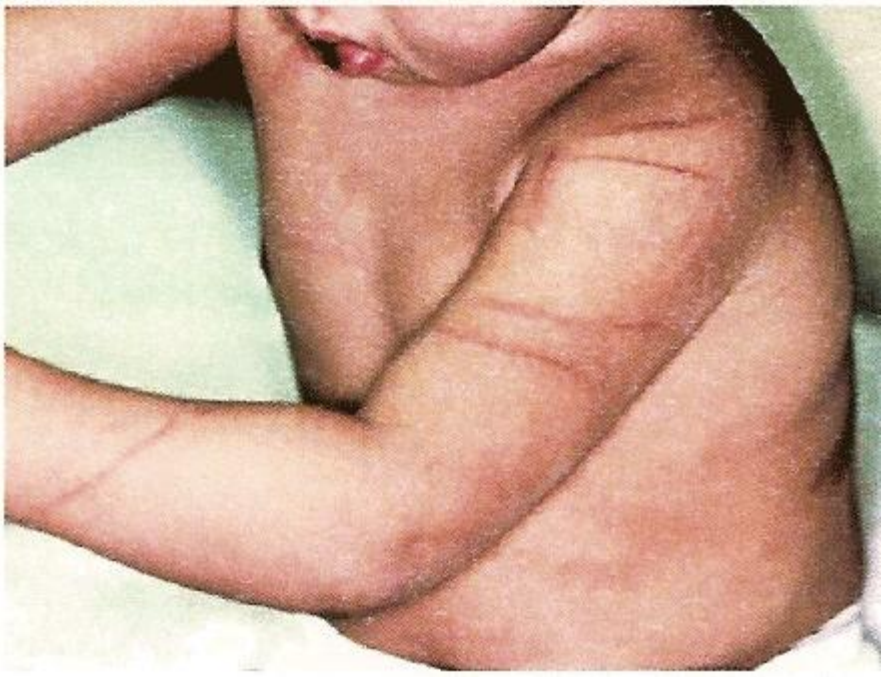


Photo courtesy of NYS-OCFS

- Cuts;
- Welts;
- Swelling;
- Sprains;
- Fractures
    - To skull, nose, facial structures;
    - In various stages of healing;
    - Multiple or spiral fractures
    - Swollen or tender limbs.
- Lacerations or abrasions
    - To mouth, lips, gums, eyes;
    - To external genitalia;
    - On backs of arms, legs or torso;
    - Human bite marks.
- Injuries to the eyes or both sides of the head or body (accidental injuries typically only affect one side of the body;

Child's Behavior - Possible Indicators of Physical Abuse

The following behavioral signs do not necessarily mean that a child is abused or maltreated, but should be considered in light of other indicators. These behavioral indicators are often general, potentially pointing to a problem that may or may not relate to abuse/maltreatment.

- Wary of adult contacts; may shrink at the approach of adults;
- Apprehensive when other children cry;
- May be overly afraid of the parent's reaction to misbehavior;
- Shows sudden changes in behavior or school performance;
- Has not received help for physical or medical problems brought to the parents'

attention;
- Has learning problems (or difficulty concentrating) that cannot be attributed to specific physical or psychological causes;
- Is always watchful, vigilant, as though preparing for something bad to happen;
- Lacks adult supervision;
- Is overly compliant, passive, withdrawn or emotionless behavior;
- Destructive, aggressive or disruptive behavior;
- Behavior extremes, such as appearing overly compliant and passive or very demanding and aggressive or withdrawn;
- Comes to school or other activities early, stays late, and does not want to go home;
- Uncomfortable with physical contact;
- Low self esteem;
- Lags in physical, emotional, or intellectual development;
- Seems frightened of the parents and protests or cries when it is time to go home;
- Is either inappropriately adult (parenting other children, for example) or inappropriately infantile (frequently rocking or head-banging, for example);
- Has attempted suicide;
- Reports a lack of attachment to the parent;
- Reports injury by parent;
- Wears long sleeved or similar clothing to hide injuries;
- Seeks affection from any adult.

Parent's Behavior - Possible Indicators of Physical Abuse

- Shows little concern for the child;
- Denies the existence of-or blames the child for-the child's problems in school or at home;
- Takes an unusual amount of time to obtain medical care for the child;
- Attempts to conceal the child's injury;
- Takes the child to a different healthcare provider or hospital for each injury;
- Offers an inadequate or inappropriate explanation for the child's injury;
- Offers conflicting, unconvincing, or no explanation for the child's injury;
- Disciplines the child too harshly considering the child's age or what s/he has done wrong
- Asks teachers or other caretakers to use harsh physical discipline if the child misbehaves;
- Sees the child as entirely bad, worthless, or burdensome;
- Demands a level of physical or academic performance the child cannot achieve;
- Looks primarily to the child for care, attention, and satisfaction of emotional needs;
- Describes the child as "evil," or in some other very negative way;
- Has a history of abuse as a child;
- Is unduly protective of the child or severely limits the child's contact with other children especially of the opposite sex;
- Is secretive and isolated;
- Is jealous or controlling with family members;
- Constantly blames, belittles, or berates the child;
- Is unconcerned about the child and refuses to consider offers of help for the child's problems;
- Overtly rejects the child;
- Appears to be indifferent to the child;
- Seems apathetic or depressed;
- Behaves irrationally or in a bizarre manner;
- Has poor impulse control;

- Is abusing alcohol or other drugs.

Pediatric Abusive Head Trauma

Shaken Baby Syndrome/Abusive Head Trauma (SBS/AHT) is a term used to describe the constellation of signs and symptoms resulting from violent shaking or shaking and impacting of the head of an infant or small child (NCSBS, Nd). The American Academy of Pediatrics (AAP) describes SBS as a subset of AHT with injuries having the potential to result in death or permanent neurologic disability. They further clarify that "The use of broad medical terminology that is inclusive of all mechanisms of injury, including shaking, is required…The American Academy of Pediatrics supports prevention efforts that reduce the frequency of AHT and recognizes the utility of maintaining the use of the term "shaken baby syndrome" for prevention efforts." (NCSBS, Nd).

Shaken infant syndrome has been the most widely used and recognized term, although shaking alone may not account for all injuries. In 2009, the American Academy of Pediatrics, in a policy statement (Christian, et al., 2009), stated,

> " Shaken baby syndrome is a term often used by physicians and the public to describe abusive head trauma inflicted on infants and young children. Although the term is well known and has been used for a number of decades, advances in the understanding of the mechanisms and clinical spectrum of injury associated with abusive head trauma compel us to modify our terminology to keep pace with our understanding of pathologic mechanisms. Although shaking an infant has the potential to cause neurologic injury, blunt impact or a combination of shaking and blunt impact cause injury as well. Spinal cord injury and secondary hypoxic ischemic injury can contribute to poor outcomes of victims. The use of broad medical terminology that is inclusive of all mechanisms of injury, including shaking, is required. The American Academy of Pediatrics recommends that pediatricians develop skills in the recognition of signs and symptoms of abusive head injury, including those caused by both shaking and blunt impact, consult with pediatric subspecialists when necessary, and embrace a less mechanistic term, **abusive head trauma** (AHT), when describing an inflicted injury to the head and its contents."

According to the CDC (2012a), pediatric abusive head trauma is defined as an injury to the skull or intracranial contents of an infant or young child (< 5 years of age) due to inflicted blunt impact and/or violent shaking.

According to the National Center on Shaken Baby Syndrome (NCSBS, nd), approximately 1,300 U.S. children experience severe or fatal head trauma from child abuse every year. Abusive head injuries are the most common cause of death in child abuse (Case & NCSBS, nd). Estimates of the incidence of abusive head trauma vary, but most range from 20 to 30 cases per 100,000 children under 1 year of age (CDC, 2015a).

Approximately 20% of cases of abusive head trauma are fatal in the first few days after injury and the majority of the survivors are left with handicaps ranging from mild - learning disorders, behavioral changes - to moderate and severe, such as profound mental and developmental retardation, paralysis, blindness, inability to eat or existence in a permanent vegetative state (NCSBS, nd). Dias, et al. (2005) reported that 13 to 30% of pediatric abusive head trauma cases result in mortality and significant neurologic impairments occur in at least one half of the survivors. The NCSBS (nd) reported that more than 80% of victims of shaken baby syndrome have lifetime impairments and 25% die from their injuries.

Medical costs associated with initial and long-term care for children who are victims of AHT can range from $300,000 to more than $1,000,000 (NCSBS, nd). Additional costs associated with loss of societal productivity and occupational revenue and with prosecution and incarceration of a perpetrator are unknown (Dias, et al., 2005). The total societal economic impact is estimated to be 16.8 billion dollars (NCSBS, nd).

Parents and their partners are responsible for nearly three fourths of cases, with fathers or stepfathers (37% of cases) and boyfriends (21% of cases) accounting for the majority of cases and mothers accounting for an additional 13%. The average age of the victims is 5 to 9 months, and almost all are less than 36 months of age (Dias, et al., 2005; CDC, nd).

The incidence rate decreases with increasing age; those 1 year of age or younger have a substantially higher incidence. The peak incidence and rapid decrease with age are thought to be related to episodes of prolonged, inconsolable, and unpredictable crying that are developmentally normal for infants (CDC, 2015a). Episodes of crying that can trigger shaking behavior among parents and caregivers are known to increase in the first month after birth, peak in the second month, and decrease thereafter. While the majority of victims are under 2 years of age and the peak incidence is typically found from 2-3 months, injuries consistent with abusive head trauma have been found in children as old as 5 years of age (CDC, 2015a).

Serious traumatic brain injury in young children is largely the result of abuse and results in significant morbidity and mortality. Among United States children, abuse is the third leading cause of all head injuries, after falls and motor vehicle crashes. For children in the first year of life, the majority of serious head injuries result from abuse. Estimates of the incidence of abusive head trauma vary, but most range from 20 to 30 cases per 100,000 children under 1 year of age.

Maltreatment/Neglect

Maltreatment/neglect includes a parent or caretaker's failure to give the child food, clothing, hygiene, shelter, medical care and supervision. Maltreatment/Neglect may be difficult to identify correctly. What appears as maltreatment/neglect may be the result of poor parental or caretaker judgment. Or it may be the result of poverty rather than neglect.

Maltreatment/neglect is a term used to encompass many situations. What they all have in common is that maltreatment/neglect is often determined by a lack of action-an act of omission-regarding a child's needs. Most commonly, maltreatment/neglect is related to a failure to meet a child's physical needs (including food, clothing, shelter, supervision, and medical needs), but it also can refer to a failure to meet a child's educational and emotional needs. Maltreatment/neglect can range from a caregiver's momentary inattention to willful deprivation. Single incidents can have no harmful effects or, in some cases, they can result in death. Chronic patterns of maltreatment/neglect may result in severe developmental delays or severe emotional disabilities.

Physical Indicators of Maltreatment/Neglect

- Consistent hunger;
- Obvious malnourishment, listlessness or fatigue;
- Poor hygiene; is consistently dirty or malodorous;
- Lacks sufficient clothing; inappropriate dress for age or season;
- Consistent lack of supervision, especially in dangerous activities or long periods;
- Abandonment;

- Child may frequently go to neighbors saying parents told them to stay away;
- Unattended physical problems or medical or dental needs, immunizations or glasses;
- Delayed physical development;
- Abuses alcohol or other drugs.

Child's Behavior - Possible Indicators of Maltreatment/ Neglect

- Begging or stealing food or money;
- Extended stays in school (early arrival and late departure);
- Frequent tardiness to school; " Infrequent school attendance;
- Constant fatigue, falling asleep in class;
- Alcohol and drug abuse;
- States there is no caretaker.

Parent's Behavior - Possible Indicators of Maltreatment/Neglect

- Misuses alcohol or other drugs;
- Has disorganized, chaotic or upsetting home life;
- Is apathetic, feels nothing will change;
- Is isolated from friends, relatives and neighbors;
- Has long-term chronic illness;
- Cannot be found;
- Has history of neglect as a child;
- Exposes child to unsafe living conditions;
- Evidences limited intellectual capacity.

Emotional Abuse

Physical Indicators of Emotional Abuse

- Conduct disorders (fighting in school, anti-social behavior, destructive, etc.);
- Habit disorders (rocking, biting, sucking fingers, pulling out hair, etc.);
- Anxiety disorders, speech disorders, sleep problems, inhibition of play; phobias, hysterical reactions, compulsions, hypochondria;
- Lags in physical development;
- Failure to thrive.

Child's Behavior - Possible Indicators of Emotional Abuse

- Overly adaptive behavior, such as inappropriately adult or inappropriately infantile;
- Developmental delays (mental and emotional);
- Extremes of behavior (compliant, passive, aggressive, demanding);
- Self-mutilation;
- Suicide attempts or gestures.

Parent's Behavior - Possible Indicators of Emotional Abuse

- Treats children in the family unequally;
- Doesn't seem to care much about the child's problems;
- Blames or belittles the child;
- Is cold and rejecting;

- Inconsistent behavior toward child.
- Verbally terrorizes the child;
- Continually and severely criticizes the child,
- Failure to express any affection or nurturing.
- Humiliation,
- Engages in actions intended to produce fear or extreme guilt in a child.

Sexual Abuse

Sexual abuse can include promoting prostitution, fondling, intercourse, or using the child for pornographic materials. Consider the possibility of sexual abuse when the **child** exhibits some of the following (CWIG, 2008):

Physical Indicators of Sexual Abuse

- Has difficulty walking or sitting;
- Reports nightmares or bedwetting;
- Experiences a sudden change in appetite; or complains frequently of abdominal discomfort of pain;
- Becomes pregnant, particularly in early adolescent years;
- Contracts a sexually transmitted disease, including venereal oral infections in pr-adolescent age group;
- Has sudden, unusual difficulty with toilet habits;
- Experiences pain or itching, bruises or bleeding in the genital area;
- Has torn, stained, or bloody clothing.

Child's Behavior - Possible Indicators of Sexual Abuse

- Suddenly refuses to change for gym or to participate in physical activities;
- Demonstrates bizarre, sophisticated, or unusual sexual knowledge or behavior, particularly given the child's age;
- Sexual victimization of other children;
- Exhibits withdrawal, fantasy or infantile behaviors;
- Poor peer relationships;
- Aggressive or disruptive behavior, delinquency, running away or school truancy;
- Any sudden change in behavior;
- Self-injurious behaviors;
- Suicide attempts;
- Reports sexual abuse by caretaker;
- Exaggerated fear of closeness or physical contact.

Parent's Behavior - Possible Indicators of Sexual Abuse

- Very protective or jealous of child;
- Encourages or forces child to engage in prostitution;
- Encourages or forces sexual acts in the presence of caretaker;
- Misuses alcohol or other drugs;
- Is geographically isolated and/or lacking in social and emotional contacts outside the family;
- Has low self-esteem.

Case Studies: Identifying Abuse

Case #1: Corey

Corey is an 8 year old boy who was brought into the emergency department where you work, by EMS personnel after he was hit by a softball during physical education class at school. Corey lost consciousness for several minutes. During the physical exam, you note that he has **bilateral bruises to his shoulders, arms and abdomen**. Crying, **Corey reports that he was "beaten up" by classmates. When his father arrives at the ED, Corey becomes visibly fearful and stops crying. The father is clearly angry; he begins to shout at Corey about having to leave work early during an important business meeting; he was shouting at Corey about not paying attention to the game, about being a lousy ball player and acting like a baby**. As the physician in the ED, you note the dad's behavior and how Corey is responding to it.

- Corey has bilateral bruises on his shoulders and arms. Accidental injuries tend to occur on one side or another, not usually on both shoulders or both arms.
- Corey's explanation that he was "beaten up" by classmates is not consistent with what EMS personnel describe about the injury during physical education class.
- Corey is fearful when his father appears.
- Corey stops crying when his father appears.
- Corey's father is angry and not concerned about his son's injury.
- Corey's father belittles Corey about his ability to play softball.
- Corey's father uses shame (ie. "acting like a baby") because Corey had been crying

Case #2: Juanita

You are a family nurse practitioner working in a primary care office. Juanita's mother comes to the office in follow-up to the hypertension noted at the last visit. She brings 9-year old Juanita with her to the appointment, as she usually does. Today you note that **Juanita is withdrawn and has bruises on her face and arms. She looks like she's been crying. Juanita is typically a chatty girl who usually engages you in talking about her love of dancing, often showing off her latest moves for the staff**. Her mother appears irritable and distracted. You ask her what's wrong and she says she's fine. You mention that Juanita is so quiet and looks upset today, to which **she replies that Juanita has been "bad"**. What would you do if you were the nurse practitioner this situation?

- She has bruises on her face and arms.
- Juanita has had a change in behavior, from outgoing and engaging to withdrawn and tearful.
- Ms. Flores says Juanita has been "bad".

Case #3: **Sam**

Twelve year old **Sam comes to school wearing only a short sleeved t-shirt and jeans on days when the temperature is in the 30s. Sam is a quiet, slender young man. He often seems nervous; he is easily startled**. Sam is a C student. **He never**

seems to be paying much attention during class; he looks preoccupied. Sam doesn't make much eye contact. He spends most of his time alone; he doesn't really have any friends at school. Indeed, often Sam is the focus of harassment and teasing from his classmates. About 2 weeks ago Sam came to class limping. He said he sprained his left ankle. The ankle didn't get better after a week, so you sent a note home to have Sam's family get medical attention for Sam. That was last week and there has been no change. As the teacher in this 7th grade classroom you wonder if Sam might be really injured.

- Sam wears a short-sleeved t-shirt even during cold weather; this is inappropriate attire for the season.
- Sam's family did not seek the medical attention that you, as the teacher, suggested because of Sam's limping and apparent injury to his left ankle.
- Sam seems nervous and is easily startled.
- Sam is preoccupied during class and doesn't pay much attention to the class work.
- Sam doesn't make eye contact and is isolated at school; he is often teased at school.
- Sam's ankle is injured and Sam's family has not sought medical attention for the injury.

Case #4: Alicia and Martin

The visiting nurse comes to the home to follow-up on 10 week old Alicia. The baby was born to a 19 year old mother with a history of cocaine addiction. Alicia weighed 6 lbs. 2 oz. at birth and was not drug addicted. Today, the first day you have been able to get into the home since the referral was made 6 weeks ago, you note that Alicia weighs 4 lbs. 6 oz. **The mom tells the nurse that she ran out of formula yesterday and hasn't had a chance to get to the store yet today**. Alicia is fretful, but does not cry. Also, during the home visits the nurse notes that 3 year old Martin has circular burn marks on his arms and legs. **He is a lethargic child who cries frequently and is very shy and fearful of adults**. The nurse examines Martin and finds that he also has a patterned bruise on his back which looks much like a wooden spoon.

- Alicia has lost significant weight since birth. Although some weight loss is not uncommon, by 10 weeks, she should have gained more weight.
- The home is lacking formula for Alicia.
- Martin has circular burn marks on his arms and legs; the nurse notes that they look like cigarette burns.
- Martin has a patterned bruise on his back which looks like a wooden spoon.
- Martin is lethargic, cries frequently and seems fearful of adults.

Case #5: Tisha

5 year old Tisha has been to see her primary care provider almost weekly for the past month. **Each week Tisha has complained to her mother that her stomach hurts, so her mother brings her in to be examined**. Tisha's only symptom is abdominal pain. She has no nausea, vomiting or diarrhea. She is well nourished and developmentally appropriate for her age; she has clearly has been well cared for. Multiple diagnostic tests have been run over the past month. As the family nurse

practitioner in this practice, you must inform Tisha's mother that **Tisha has tested positive for syphilis** .

- Tisha has frequent complaints about abdominal pain; these complaints often happen on Mondays, after spending the weekend with her father.
- Five year old Tisha has tested positive for a sexually transmitted disease.

Case #6: Leah and Tisha

As a clinical social worker, you are Leah's therapist. Leah is step-mother to 5 year old Tisha, having been married to Tisha's father, Michael, for the last 6 months. The whirlwind relationship has been the frequent topic of your sessions, **particularly Michael's controlling nature**. Leah has also talked about her role as a step-mother and her discomfort with it. **She thinks that Michael and Tisha are too close; it makes her uncomfortable**. Leah reports that she thinks **Michael is too protective of Tisha, not really allowing her to play with other children when she is staying at their house, even limiting her contact and relationship with Tisha. In the last session with Leah, she told you that she fears that Michael is sexually abusing Tisha: she saw him leave Tisha's room early in the morning, when he thought she was sleeping; she saw him toss a used condom in the trash**. As the therapist, what should you do?

- Tisha's father is seen leaving Tisha's room and then throwing a used condom in the trash.
- Michael has a controlling nature.
- Leah is uncomfortable with the closeness between Michael and Tisha and his limitation of Tisha's playing with other children and even Tisha's getting close to Leah.
- Leah fears that Michael is sexually abusing Tisha.

Case #7: Marcus, Amber and Isaiah

Sometimes, **the Shaw children come to school appearing to be hungry**. You are the school nurse who comes to this school most afternoons, usually getting to the school at lunchtime. You note that **the Shaw children often don't have any lunch. When they do bring a lunch, it is often not enough food**. Other than this, the children seem well-groomed and well-behaved. The children are generally quiet, rather private. As the nurse, you begin talking to them and **learn that their father does seasonal work and is often between jobs**. How would you handle this if you were the school nurse?

- The children appear to be hungry when they come to school.
- The children often don't have any lunch, or if they bring lunch it is not enough.
- The Shaw children, normally quiet and private, when they speak with the nurse provide information about their father's underemployment/unemployment.

Case #8: Tim

At a residential treatment center for boys age 13-16, recently **some of the boys have alleged that they were sexually abused by staff**. The internal investigations at the facility have never supported these claims. One of the registered nurses, Jean, suspects that what she is being told by the boys is correct; **she has noted how some of the aides, mostly males, treat the boys so roughly on the one hand and then at other times are often way too familiar. 15 year old Tim showed Jean his bloody underwear. He also told Jean that one of the aides, Joe, was forcing him to have sexual relations with some of the other aides and that Joe was making money on it**. Jean complains to the facility administration about these allegations, but was told that an internal investigation has occurred and there is no evidence that these allegations are based in fact.

- Some of the boys at the residential treatment center have reported that they have been sexually abused by staff members.
- Tim showed his bloody underwear to the nurse, Jean.
- Jean felt uncomfortable with the way some male staff interacted with the boys, either to rough or too familiar.
- Tim told Jean that an aide, Joe, was forcing him to have sex and that Joe was making money since he was taping the sexual activity and then selling the tapes.

Risk Factors Contributing to Child Abuse and Maltreatment

There are many risk factors for how child abuse occurs. These include risk factors within the child, within the parent and in society in general. According to national report *Child Maltreatment 2013*, poverty and low socio-economic status have been identified in research as a risk factor for child maltreatment (USDHHS-ACFY, 2015). Domestic violence or intimate partner violence within the family also is a risk factor of child maltreatment. When anger is used as a means of power and control, all members of the family are at risk.

Child Risk Factors

- Premature birth,
- Birth anomalies,
- Low birth weight,
- Exposure to toxins in utero
- Temperament: difficult or slow to warm up
- Physical/cognitive/emotional disability, chronic or serious illness
- Childhood trauma
- Anti-social peer group
- Age
- Child aggression, behavior problems, attention deficits

Parental/Family Risk Factors

- Poverty
- Parental substance abuse
- Parental impulsivity
- Parental low self-esteem

- A lack of social support for the family.
- Parental immaturity
- Parents' unrealistic expectations
- Unmet emotional needs
- The stress of caring for children
- Economic crisis
- Domestic/intimate partner violence
- Lack of parenting knowledge/skills
- Lack of communication skills
- Inaccurate knowledge and expectations about child development
- Difficulty in managing relationships
- Depression, anxiety or other mental health problems
- Personality Factors
- External locus of control
- Low tolerance for frustration
- Feelings of insecurity
- Lack of trust
- Insecure attachment with own parents
- Childhood history of abuse
- Family structure - single parent with lack of support, high number of children in household
- Social isolation, lack of support
- Separation/divorce, especially high conflict divorce
- High general stress level
- Poor parent-child interaction, negative attitudes and attributions about child's behavior

Community Risk Factors

- Low socioeconomic status
- Stressful life events
- Social isolation/lack of social support
- Dangerous/violent neighborhood
- Community violence
- Poverty
- Lack of access to medical care, health insurance, adequate child care, and social services

Societal Risk Factors

- Homelessness
- Exposure to racism/discrimination
- Poor schools
- Exposure to environmental toxins
- Narrow legal definitions of child maltreatment
- Social acceptance of violence (as evidenced by music lyrics, television, film and video games)
- Political and religious views that value noninterference in families.

Protective Factors for Child Abuse and Maltreatment

Child abuse prevention programs have long focused on reducing particular risk factors. However, increasingly, prevention services are also recognizing the importance of promoting protective factors: conditions in families and communities that research has shown to increase the health and well-being of children and families. These factors help parents who might otherwise be at risk of abusing or neglecting

their children to find resources, supports, or coping strategies that allow them to parent effectively, even under stress.

Child Protective Factors

Resilience is a concept that has been identified as an important protective factor among children who have been abused or maltreated. Research has identified that resilience was found to be related to personal characteristics that included a child's ability to: recognize danger and adapt, distance oneself from intense feelings, create relationships that are crucial for support, and project oneself into a time and place in the future in which the perpetrator is no longer present.

Additional protective factors include (CDC, 2015; NYS-OCFS, 2011)

- Good health, history of adequate development
- Above-average intelligence
- Hobbies and interests
- Good peer relationships
- Personality factors such as an easy-going temperament
- Positive disposition
- Active coping style
- Positive self-esteem
- Good social skills
- Internal locus of control
- A balance between help seeking and autonomy

Parental/Family Protective Factors

Resilience is also a protective factor for parents. Parents who are emotionally resilient have a positive attitude, creatively problem solve, effectively address challenges, and are less likely to direct anger and frustration at their children (USDHHS-ACF, 2015, CDC, 2015, NYS-OCF, 2011).

- Secure attachment with children; positive and warm parent-child relationship
- Supportive family environment
- Parents have come to terms with own history of abuse
- Household rules/structure; parental monitoring of child
- Extended family support and involvement, including caregiving help
- Stable relationship with parents
- Parents have a model of competence and good coping skills
- Family expectations of pro-social behavior
- High parental education

Community Protective Factors

- Mid to high socioeconomic status
- Access to health care and social services
- Consistent parental employment
- Adequate housing
- Family religious faith participation
- Good schools
- Supportive adults outside of family who serve as role models/mentors to child

Societal Protective Factors

- Families with two married parents encounter more stable home environments, fewer years in poverty, and diminished material hardship
- Supportive institutions in the society such as good child care and healthcare

The Consequences of Child Abuse

While physical injuries may or may not be immediately visible, abuse and neglect can have consequences for children, families, and society that last lifetimes, if not generations.

The impact of child abuse and neglect is often discussed in terms of physical, psychological, behavioral, and societal consequences. In reality, however, it is impossible to separate them completely. Physical consequences (such as damage to a child's growing brain) can have psychological implications (cognitive delays or emotional difficulties, for example). Psychological problems often manifest as high-risk behaviors. Depression and anxiety, for example, may make a person more likely to smoke, abuse alcohol or illicit drugs, or overeat. High-risk behaviors, in turn, can lead to long-term physical health problems such as sexually transmitted diseases, cancer, and obesity. In additional to the human consequences, all of these consequences also have an economic impact on a society.

In the landmark Adverse Childhood Experiences (ACE) Study (1998) and successive research since then, it was identified that childhood experiences, both positive and negative, have a tremendous impact on future violence victimization and perpetration, and lifelong health and opportunity. As such, early experiences are an important public health issue. Much of the foundational research in this area has been referred to as Adverse Childhood Experiences (ACEs). Some examples of these adverse experiences include emotional, physical, sexual abuse, emotional and physical neglect, mother treated violently, household substance abuse, household mental illness, parental separation/divorce, incarcerated household member.

The Adverse Childhood Experiences (ACE) Study referred to previously also determined that these adverse experiences have been linked to:

- risky health behaviors (for example, tobacco smoking, drug use, alcohol use, unsafe sexual behavior, etc.),
- chronic health conditions (for example, obesity, diabetes, depression, suicide, sexually transmitted diseases, heart disease, cancer, stroke, chronic obstructive pulmonary disease, broken bones, etc.),
- low life potential (for example, impact on high school graduation rates, academic performance and achievement, poor occupational options, unemployment, lost time from work, etc.) , and
- early death.

As the number of ACEs increases, so does the risk for these outcomes.

Not all abused and neglected children will experience long-term consequences. Outcomes of individual cases vary widely and are affected by a combination of factors, including (CDC, 2015):

- The child's age and developmental status when the abuse or neglect occurred;
- The type of abuse (physical abuse, neglect, sexual abuse, etc.);
- Frequency, duration, and severity of abuse;
- Relationship between the child victim and the abuser.

Physical Health Consequences

The immediate physical effects of abuse or neglect can vary greatly; the effects may be relatively minor (bruises or cuts) or severe (broken bones, hemorrhage, or even death). In some cases the physical effects are temporary; however, the pain and suffering they cause a child should never be discounted. The long-term impact of child abuse and neglect on physical health is just beginning to be explored. Below are some outcomes researchers have identified (NINDS, 2015; USDHHS-ACF, 2007):

- **Pediatric Abusive Head Trauma/Shaken baby syndrome.** Shaken baby syndrome is a type of inflicted traumatic brain injury that happens when a baby is violently shaken. A baby has weak neck muscles and a large, heavy head. Shaking makes the fragile brain bounce back and forth inside the skull and causes bruising, swelling, and bleeding, which can lead to permanent, severe brain damage or death. The characteristic injuries of shaken baby syndrome are subdural hemorrhages (bleeding in the brain), retinal hemorrhages (bleeding in the retina), damage to the spinal cord and neck, and fractures of the ribs and bones. These injuries may not be immediately noticeable. Symptoms of shaken baby syndrome include extreme irritability, lethargy, poor feeding, breathing problems, convulsions, vomiting, and pale or bluish skin. Shaken baby injuries usually occur in children younger than 2 years old, but may be seen in children up to the age of 5 (NINDS, 2015).

  The majority of infants who survive severe shaking will have some form of neurological or mental disability, such as blindness, learning disabilities, paralysis, cerebral palsy or mental retardation, which may not be fully apparent before 6 years of age. Children with shaken baby syndrome may require lifelong medical care (NINDS, 2015).

- **Impaired brain development**. Child abuse and neglect have been shown, in some cases, to cause important regions of the brain to fail to form properly, resulting in impaired physical, mental, and emotional development. In other cases, the stress of chronic abuse causes a "hyperarousal" response by certain areas of the brain, which may result in hyperactivity, sleep disturbances, and anxiety, as well as increased vulnerability to post-traumatic stress disorder, attention deficit/hyperactivity disorder, conduct disorder, and learning and memory difficulties.

- **Poor physical health**. The ACE studies have consistently identified a relationship between early adverse experiences and later serious physical and mental health disorders, as described above. A study of 700 children who had been in foster care for 1 year found more than one-quarter of the children had some kind of recurring physical or mental health problem (National Survey of Child and Adolescent Well-Being). A study of 9,500 HMO participants showed a relationship between various forms of household dysfunction (including childhood abuse) and long-term health problems such as sexually transmitted diseases, heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease.

- **Death**

Psychological Consequences

The immediate emotional effects of abuse and neglect-isolation, fear, and an inability to trust-can translate into lifelong consequences including low self-esteem, depression, and relationship difficulties. Researchers have identified links between child abuse and neglect and the following (USDHHS-ACF, 2007):

- **Poor mental and emotional health**. The ACE studies have consistently pointed to early adverse experiences as impact mental and physical health. In another one long-term study, as many as 80 percent of young adults who had been abused met the diagnostic criteria for at least one psychiatric disorder at age 21. These young adults exhibited many problems, including

depression, anxiety, eating disorders, and suicide attempts. Other psychological and emotional conditions associated with abuse and neglect include panic disorder, dissociative disorders, attention-deficit/hyperactivity disorder, post-traumatic stress disorder, and reactive attachment disorder.

- **Cognitive difficulties**. The National Survey of Child and Adolescent Well-Being recently found children placed in out-of-home care due to abuse or neglect tended to score lower than the general population on measures of cognitive capacity, language development, and academic achievement.

- **Social difficulties**. Children who are abused and neglected by caretakers often do not form secure attachments to them. These early attachment difficulties can lead to later difficulties in relationships with other adults as well as with peers.

Behavioral Consequences

Not all victims of child abuse and neglect will experience behavioral consequences; however, child abuse and neglect appear to make the following more likely (USDHHS-ACF, 2007):

- **Difficulties during adolescence**. Studies have found abused and neglected children to be at least 25 percent more likely to experience problems such as delinquency, teen pregnancy, low academic achievement, drug use, and mental health problems.
- **Juvenile delinquency and adult criminality**. A National Institute of Justice study indicated being abused or neglected as a child increased the likelihood of arrest as a juvenile by 59 percent. Abuse and neglect increased the likelihood of adult criminal behavior by 28 percent and violent crime by 30 percent.
- **Alcohol and other drug use/abuse**. Research consistently reflects an increased likelihood that abused and neglected children (ACE research) will smoke cigarettes, abuse alcohol, or take illicit drugs. According to the National Institute on Drug Abuse, as many as two-thirds of people in drug treatment programs reported being abused as children.
- **Abusive behavior**. Abusive parents often have experienced abuse during their own childhoods. It is estimated approximately one-third of abused and neglected children will eventually victimize their own children.

Societal Consequences

According to Gelles & Perlman (2012), the cost of child abuse and neglect is conservatively estimated to cost 80 billion dollars in 2012. While child abuse and neglect almost always occur within the family, the impact does not end there. Society as a whole pays a price for child abuse and neglect, in terms of both direct and indirect costs (USDHHS-ACFS, 2012; Gelles & Perlman, 2012).

- **Direct costs**. Direct costs include those associated with maintaining a child welfare system to investigate allegations of child abuse and neglect, as well as expenditures by the judicial, law enforcement, health, and mental health systems to respond to and treat abused children and their families. Direct costs are estimated to total $33 billion.

- **Indirect costs**. Indirect costs represent the long-term economic consequences of child abuse and neglect. These include early intervention, juvenile and adult criminal justice systems and activity, mental illness, substance abuse, and domestic violence. They can also include loss of productivity due to unemployment and underemployment, adult homelessness, the cost of special education services, and increased use of the health care system. These costs are estimated to be $47 million.

Estimating the cost of child abuse and neglect/maltreatment can be difficult, and estimates vary depending on the source and what is included in the estimates. According to Fang, et al. (2012), the estimated average lifetime cost per victim of nonfatal child maltreatment is $210,012 in 2010 dollars, including $32,648 in childhood health care costs; $10,530 in adult medical costs; $144,360 in productivity losses; $7,728 in child welfare costs; $6,747 in criminal justice costs; and $7,999 in special education costs. The estimated average lifetime cost per death is $1,272,900, including $14,100 in medical costs and $1,258,800 in productivity losses. The total lifetime economic burden resulting from new cases of fatal and nonfatal child maltreatment in the United States in 2008 is approximately $124 billion. In sensitivity analysis, the total burden is estimated to be as large as $585 billion.

Talking with Children

In some cases, a child will disclose that he or she has been sexually abused. If a child discloses abuse, try to stay calm and, above all else, believe the child. Children rarely lie about sexual abuse. Here are some things you should do (PCA-NY, ND):

- Allow the child to talk, but don't press. Don't ask the child to repeat the details over and over.
- Praise the child for telling you.
- Reassure the child that he or she is not to blame.
- Show love and respect for the child.
- Protect the child immediately from the suspected offender.

Whenever discussing potential abuse with a child, some basic considerations include the following:

Do:

- Find a private place to talk.
- Remain calm.
- Be honest, open and up front with the child.
- Use age-appropriate language.
- Remain supportive to the child.
- Listen to the child.
- Stress that it is ***NOT*** the child's fault.
- Report the situation immediately.

Don't:

- Overreact.
- Make judgments
- Make promises
- Interrogate the child or try to investigate. This is especially important in sexual abuse cases.

Reporting Child Abuse and Maltreatment

As previously stated, mandated reporters fail to report child abuse and maltreatment because they feel they cannot identify abuse correctly and they feel they do not know the correct procedure for reporting. Additionally, people sometimes fear that reporting child abuse or maltreatment will destroy a family. The truth, however, is that reporting should lead to getting help for the family by protecting the child from further suffering and harm and by assisting the family in facing and overcoming its problems. Professionals can all help end child abuse by their efforts to become more aware of the signs of child abuse and maltreatment and reporting suspected cases.

It is important for everyone to know the signs that may indicate maltreatment and how to report it. We all share a responsibility to help keep children safe as we take steps to prevent abuse from occurring in the first place.

Professionals Mandated to Report

New York State has identified select professionals, who bring specific skills to the process, to be in the very important role of mandated reporter of child abuse or maltreatment. The complete current list can be found in Section 413 of the New York Social Services Law. These mandated professionals are:

- Alcoholism counselor
- Child care or foster care workers
- Chiropractor
- Christian Science practitioner
- Coroner
- Day care center worker
- Dentist
- Dental hygienist
- District attorney or assistant district attorney
- Emergency medical technician
- Employee or volunteer in a residential care facility for children
- Hospital personnel engaged in the admission, examination, care or treatment of persons
- Intern
- Investigator employed in the Office of the District Attorney
- Law enforcement officials
- Licensed creative arts therapist
- Licensed marriage and family therapist
- Licensed mental health counselor
- Licensed psychoanalyst
- Medical examiner
- Mental health professional
- Optometrist
- Osteopath
- Peace officer
- Physician
- Podiatrist
- Provider of family or group family day care
- Police officer
- Psychologist
- Registered nurse
- Registered physician assistant
- Resident
- School official (As of July 3, 2007, this includes, but is not limited to: school teachers, guidance counselors, school psychologists, school social workers, school nurses, school administrators, or other school personnel required to hold a teaching or other administrative license or certification.)
- Social services worker
- Social Worker
- Substance abuse counselor
- Surgeon

The Role of the Mandated Reporter

By identifying certain professionals as mandated reporters of child abuse and maltreatment, the State of New York is attempting to ensure that this select group of individuals will do so as part of their professional responsibilities. The role of the mandated reporter is to: **report suspected incidents of child abuse or maltreatment/neglect while acting in their professional capacity**.

When a mandated reporter has reasonable cause to suspect that a child whom the reporter sees in his/her professional or official capacity is abused or maltreated, the professional must report the abuse, maltreatment or neglect.

Additionally, a mandated reporter must report when s/he has **reasonable cause to suspect** that a child is abused or maltreated where the parent or person legally responsible for the child comes before them in his/her professional or official capacity and states from personal knowledge facts, conditions, or circumstances which, if correct, would render the child abused or maltreated.

Reflecting changes to the child abuse reporting laws, which came into effect on July 3, 2007, **whenever** a mandated reporter suspects child abuse or maltreatment while acting in her/his professional capacity as a staff member of a medical or other public or private institution, school, facility or agency, he or she must report the child abuse **personally**, as required by law and then immediately notify the person in charge of that school, facility institution or her/his designated agent that a report was made. The mandated reporter must include, to the best of the reporter's ability, the names, titles and contact information for each staff person in the institution who has direct knowledge of the allegations in the report. The law does not require more than one report from the institution, school, facility or agency on any one incident of suspected abuse or maltreatment. The person in charge of the institution, school, facility or agency, or the designated agent, is then responsible for all subsequent administrative actions in support of the report.

The 2007 changes made by the New York State Legislature clarified that **reporting internally to the person in charge does not discharge the mandated reporter's obligation to report to the State Central Register.** Additionally, the revised law states that any person in charge of a medical or other public or private institution, school, facility or agency may not prevent the staff member, who is a mandated reporter, from making a report. The revised law specifically states that no retaliatory personnel actions can be taken against mandated reporters by the institution. Additionally, 2007 revision to the law stated that no school, school official, child care provider, foster care provider, residential care facility provider, hospital, medical institution provider, or mental health facility provider may impose additional conditions about reporting, such as prior approval or prior notification, upon any staff members who are mandated reporters of child abuse and maltreatment.

Also in 2007, Chapter 513 of the Laws of 2007, also known as Xctasy's Law amended Section 413 of the Social Services Law. Mandated reporters' responsibility to report applies when a child, parent, guardian, custodian other person legally responsible for the child, or any other person appearing before the social services worker comes before the mandated reporter in his or her professional or official capacity and states facts, conditions or circumstances based on personal knowledge sufficient to give the social services worker a reasonable cause to suspect child abuse or maltreatment. This change only affects social services workers; the reporting standard did not change for other mandated reporters.

Social services workers are identified by the New York State Office of Children and Family Services (OCFS) as the following:

- Professional and paraprofessional staff of local social services districts. This would include child welfare staff, all professional and paraprofessional local district staff, regardless of their function or area of responsibility, who provide services to children and/or families. For example, public assistance staff, adult protective services workers and Medicaid staff would be included.
- Professional and paraprofessional staff that provide services to children and/or families, who work for organizations or entities that have contracts-as well as individuals who have contracts or subcontracts- with local social services districts, as well as providing services related to foster care, adoption, or preventive services.
- OCFS regional office staff that have responsibilities for inspections or investigation of complaints at residential facilities and day care programs, other than those staff whose sole responsibility is to inspect facilities and investigate complaints related to physical plant or building safety issues.

Reasonable Cause to Suspect: Certainty is not required

Do you as a mandated reporter have to be certain that abuse, maltreatment or neglect has actually occurred? Do you need to have proof before you report your suspicions?

In New York State, a mandated reporter can have "reasonable cause" to suspect that a child is abused or maltreated, if, considering what physical evidence s/he observes or is told about, and from his/her own training and experience, it is possible that the injury or condition was caused by non-accidental means. **The mandated reporter need not be absolutely certain that the injury or condition was caused by neglect or by non-accidental means**; the reporter should only be able to entertain the possibility that it could have been neglect or non-accidental in order to possess the necessary "reasonable cause".

The mandated reporter does not have to prove the abuse or maltreatment. It is enough for the mandated reporter to be suspicious, to distrust or doubt what s/he personally observes or is told. Many factors can and should be considered in the formation of that doubt or distrust in potential abuse cases: Physical and behavioral indicators are helpful in forming a reasonable basis of suspicion. Although these indicators are not diagnostic criteria of child abuse, neglect or maltreatment, they illustrate important patterns that may be recorded in the written report when relevant.

Reasonable Cause/When to Report

Case #1: Corey

Does the emergency department physician have reasonable cause to suspect that Corey has been abused? Should a report be made?

The emergency department physician was given conflicting information about how Corey was injured (the EMS personnel reported that Corey had been hit with a softball during practice; Corey reports he was "beat up"). Corey seems so distressed by his father's presence and the father is very angry at Corey and humiliates him, despite the boy's injury and pain. Corey's father seems to have particular anger towards what he perceives as Corey's shortcomings. As the emergency department physician you report Corey to the SCR.

Case #2: Juanita

As the family nurse practitioner who knows this family well, you decide to ask mother and daughter about what happened that upset them both so much. Mom does not respond, but Juanita blurts out that she stole some nail polish and lipstick from the drug store and her mother found out once they got home. Mom uses corporal punishment in dealing with Juanita and she slapped the girl across the face as well as grabbed her arm rather roughly. She ordered Juanita to take the items back to the store and to apologize to the clerk at the store. Juanita, although initially minimizing her actions, began to feel guilt and remorse for her actions. She was still recovering from the incident that had occurred earlier today.

After Juanita confessed her crime to the nurse practitioner, Mom confirmed the story and talked about how upset she was that her daughter had stolen from the store. She was angry because she is a religious woman who lives by a strict moral code and feels betrayed by her daughter for not also living by the values she thought she had instilled in her daughter. As the nurse practitioner, you believe the explanation that the mother and daughter provide you and you encourage them to continue to talk about the incident with each other. You decide this is not a case of potential abuse and you do

not report this to the SCR.

Case #3: Sam

As Sam's teacher and a mandated reporter, do you have reason to suspect that Sam may be the victim of both neglect and abuse in his home?

Sam is often not dressed appropriately for the weather. He is teased by his classmates, largely for his nervousness, anxiety and poor eye contact. His injured ankle has not been treated even though you sent a note home almost two weeks ago.

You decide that you do indeed suspect neglect and possible abuse. You talk to your principal about making a report for neglect and request that the family be evaluated for possible abuse as well.

Case #4: Alicia and Martin

As the visiting nurse you recognize the obvious signs of neglect in the Alicia and the signs of abuse and neglect in Martin. You call the SCR and discuss the immediacy of the need for safety and services (ie. This is the first time you have been in the house in 6 weeks; there is a history of cocaine use; Alicia has lost a significant amount of weight and there is no formula or food in the house; Martin has been abused multiple times and is fearful of adults). You request that immediate action be taken; it is your belief that the children are not safe in the home at this time.

Case #5: Tisha

As the family nurse practitioner in the primary care practice, you must report Tisha to the SCR. In a child as young as Tisha, only 5 years old, a positive lab test for syphilis is a strong indication that the child is being sexually abused. You report the positive result to Tisha's mother, who becomes tearful and angry and agrees to cooperate with the report, because she fears that Tisha has been sexually abused and is very upset that she has not been able to keep her daughter safe. She wants to find out how this could have happened.

Case #6: Leah and Tisha

Does the clinical social worker have a legal obligation to report what the patient, Leah, has told her? The clinical social worker hasn't been treating Tisha, rather it is Leah who is her patient. Is the social worker required to make a report to the State Central Register? Yes. As stated previously, mandated reporter must report when s/he has reasonable cause to suspect that a child is abused or maltreated where the parent or personal legally responsible for the child comes before them in her/his professional or official capacity and states from personal knowledge facts, conditions or circumstances which, if correct, would render the child abused or maltreated. The therapist is in contact with Leah because Leah has sought out the professional's services. Leah lives in the home with her husband and with Tisha. If what Leah saw was true, then it is reasonable to suspect that abuse may be occurring.

The clinical social worker may want to work with Leah, to assist her to make the report, but this does not take the place of the requirement for the clinical social worker, as a mandated reporter to report her suspicions of sexual abuse.

Case #7: Marcus, Amber and Isaiah

The school nurse meets with the teachers of the Shaw children, requesting their perspectives on whether or not the Shaw children are neglected. She learns that they rarely miss school. Amber and Isaiah are average students, but Marcus is in gifted classes. There has never been any suspicion on the part of the teachers that there may be any abuse in the family. Given what the Shaw children have told the nurse, as well as the teachers' reports, the nurse decides to refer the Shaw children for the school breakfast and lunch programs, seeing this as a financial issue, not a case of neglect. The nurse does not report the Shaw children to the SCR, but refers them and their family to the social service office for other potential entitlements.

Case #8: Tim

As the nurse for this residential treatment center and a mandated reporter, Jean knows that she has a legal obligation report her suspicions of child abuse. This legal requirement overrides any loyalty she may feel towards her employer. She also recognizes that reporting may put her job in jeopardy, since the employer has "investigated" and does not believe the allegations of abuse. Given what Tim has told her, the bloody underwear, and her own discomfort/suspicions when observing staff/client interactions, Jean knows that she has a legal responsibility to report. Ethically and professionally, she also recognizes that she must report, despite whatever ramifications there may be from her employer.

Despite the internal investigation that was conducted by the employer, Jean still has a legal responsibility to report her suspicion of sexual abuse. Additionally, the 2007 changes to the child abuse reporting laws also protect the mandated reporter from retaliation for reporting from the employing agency.

How to Report

Suspicion of child abuse and maltreatment/neglect must be immediately reported by telephone, at any time of the day, seven days per week.

A written report must be filed within 48 hours of the oral report. Oral telephone reports should be made to the New York State Central Register of Child Abuse and Maltreatment (SCR) by calling the statewide, toll-free telephone number for mandated reporters:

MANDATED REPORTER EXPRESS LINE

1-800-635-1522

General Public: 1-800-342-3720
Outside NY State: 1-518-474-8740

Outside of New York State or Nationally

If you suspect that a child is being abused or maltreated/neglected, you should call your local Child Protective Services (CPS) agency or the CPS agency in the State in which the abuse occurred. As you identify the appropriate agency for making a report, remember the following:

- Not every State has a toll free hotline, or the hotline may not operate on a 24 hour basis.
- If a toll free (800 or 888) number is available, it may be accessible only from within that State.

Federal agencies have no authority to intervene in individual child abuse and neglect cases.

Each state has its own procedure for reporting child abuse. A listing of phone numbers for the states that have them is available at http://www.childwelfare.gov/pubs/reslist/rl_dsp.cfm?rs_id=5&rate_chno=11-11172 If a number is not listed, or if you need to report suspected abuse in a State other than your own, please call:

Childhelp® USA National Child Abuse Hotline
1-800-4-A-CHILD® (1-800-422-4453)
TDD: 1-800-2-A-CHILD

Childhelp® USA is a non-profit agency which can provide reporting numbers, and has Hotline counselors who can provide referrals.

New York State-Telephone Reporting

Mandated reporters can prepare themselves to make the report by compiling information needed for the report. While having all of the information needed would be ideal, the mandated reporter should not wait to report just because some of the information is missing. To the extent possible, when calling to report child abuse or maltreatment/neglect, attempt to provide the following information:

Information that must be included in the telephone report:

- The names and addresses of the child and his/her parents or other person responsible for his/her care;
- The child's age, gender and race;
- The nature and extent of the child's injuries, abuse or maltreatment/neglect, including any evidence of prior injuries, abuse or maltreatment of the child or his/her siblings;
- Is the child at risk for harm? How?
- The name of the person or persons responsible for causing the injury, abuse, or maltreatment/neglect;
    - Family composition;
- Where is the child now? Where are siblings now?
- The source of the report:
    - The person making the report and where s/he can be reached;
- The actions taken by the reporting source, including the taking of photographs or X-rays, removal or keeping of the child, or notifying the medical examiner or coroner; and
- Any additional information that might be helpful; for example, are there special needs or medications? What are they? Are there concerns for local CPS such as weapons or drugs in the home?

Written Report

The written report is made on form LDSS-2221A. The written report can be accessed at http://www.ocfs.state.ny.us/main/cps/

The written report, signed by the reporter, must be filed with the local child protective service (CPS) within 48 hours of the oral report. You may request the address of the investigative district from the child protective specialist at the time you make the oral report to the State Central Register of Child Abuse and Maltreatment.

A written report that involves a child who is in foster care or in residential care, should be submitted to the New York State Child Abuse and Maltreatment Register, 40 North Pearl Street, Albany, NY 12243.

Mandated reporters may wish to maintain additional careful notes for their own personal records, noting important information such as dates, times, places, names of individuals involved in any aspect of the case.

Mandated reporters may wish to maintain additional careful notes for their own personal records, noting important information such as dates, times, places, names of individuals involved in any aspect of the case. For the purpose of reported suspected cases of child abuse and maltreatment/neglect to the SCR and CPS, it is important to understand the definition of who can be the "subject of the report".

The **Subject of the report** means any

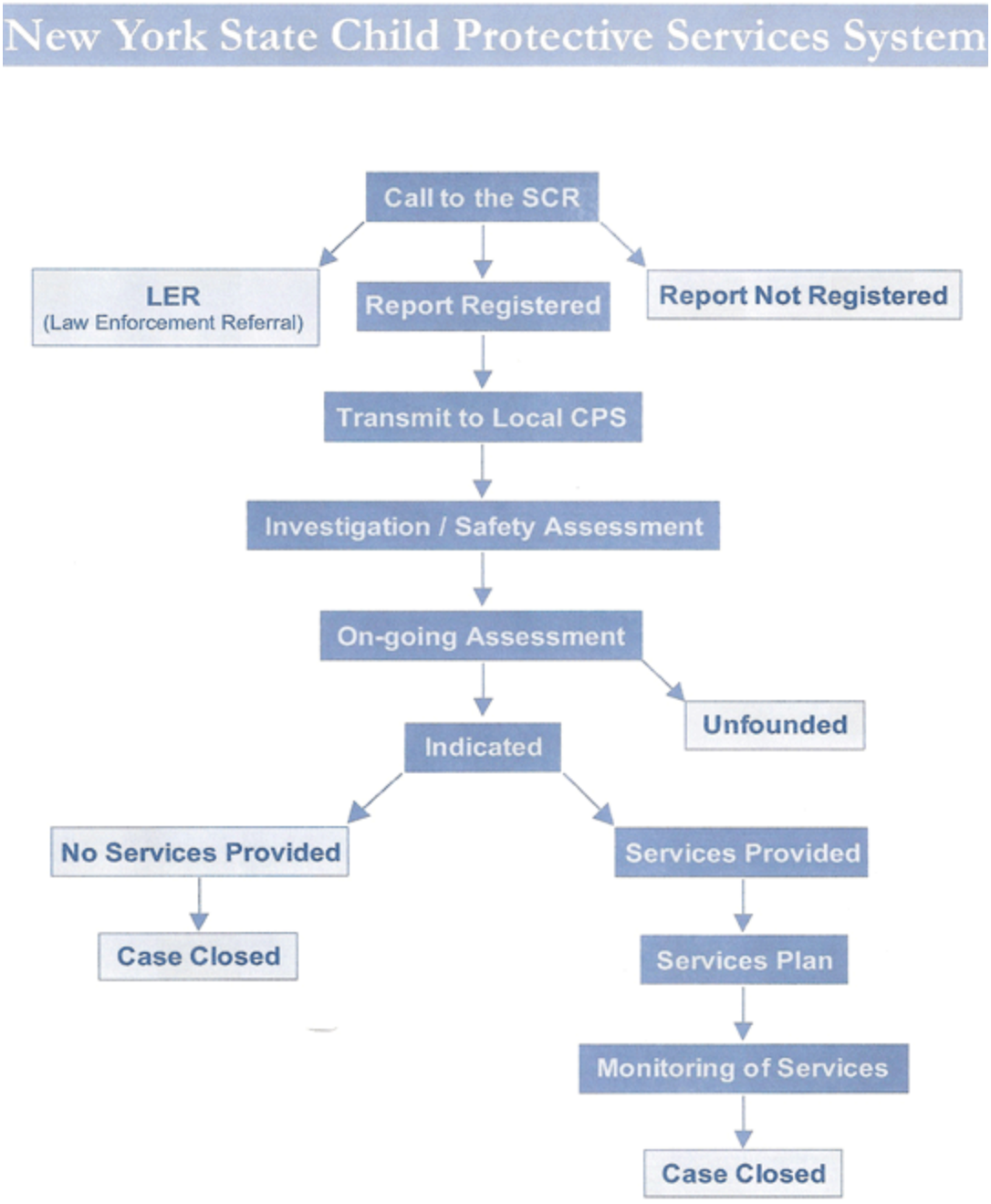
- Parent
- Guardian
- Custodian, or
- Other person 18 years of age or older who is legally responsible for a child reported to the SCR and who is allegedly responsible for causing - or allowing the infliction of - injury, abuse, or maltreatment/neglect of such child.
- The operator of, employee of, or volunteer in
    - Residential care staff, such as a home operated or supervised by an authorized agency, the Division for Youth, or an office of the Department of Mental Hygiene; or
    - A family day-care home, day-care center, group family day-care home, or a day services program and who is allegedly responsible for causing - or allowing the infliction of - injury, abuse or maltreatment/neglect to a child who is reported to the SCR.

Abuse and maltreatment/neglect can certainly be caused by persons other than parents or the person who is legally responsible for the child's care, such as neighbors or strangers. Such individuals might not fit the legal definition of the "subject of the report". In these cases, it is the **law enforcement authorities** that should be contacted directly. If a mandated reporter calls the SCR in a situation in which the person allegedly responsible for the abuse or maltreatment/neglect cannot be the subject of a report, and if the SCR believes that the alleged acts or circumstances described by the mandated reporter may constitute a crime or an immediate threat to the child's health or safety, the SCR is required by law to transmit the information contained in the call to the appropriate law enforcement agency, district attorney or other public official empowered to provide necessary aid or assistance.

What Happens After a Report is Made

After taking the report of child abuse or maltreatment/neglect from a mandated reporter, staff at the SCR, based on the information provided will make a determination if the report is to be registered and investigated by the local Child Protective Service (CPS), if it will be referred to law enforcement or if the report is not registered (see Figure 2. The New York State Child Protective Services System).

Figure 2. The New York State Child Protective Services System



New York State has allowed each county to institute voluntary alternative response if desired. Currently some counties are using this alternative response, which in New York State is called the **Family Assessment Response (FAR)** (NYS-OCFS, nd).

Chapter 452 of the Laws of 2007 authorized local departments of social services (LDSS), other than in New York City, to apply to the New York State Office of Children and Family Services (OCFS) to use a family assessment and services approach for a subset of families that are reported to the Statewide Central Register (SCR) for child maltreatment. The family assessment response (FAR) is a child protective response that does not require an investigation and determination of allegations and individual

culpability for families reported to the SCR. It is an alternative approach to providing protection to children by focusing on engaging families in informal and formal support services that meet their needs and increases their ability to care for their children. FAR requires an initial assessment of child safety. If a child is assessed to be in danger, the report may not be handled using a family assessment response. States have found that a family assessment approach is less threatening to and is more engaging of families. It allows the family to have a larger role in determining what services will benefit their children and the LDSS is more likely to be viewed by the family as a helping entity in the future should issues arise that create risk to children (NYS-OCFS, nd).

CPS may take a child into protective custody if it is necessary for the protection from further abuse or maltreatment. Based upon an assessment of the circumstances, CPS may offer the family appropriate services. The CPS caseworker has the obligation and authority to petition the Family Court to mandate services when they are necessary for the care and protection of a child.

After conducting interviews with family members, the alleged child victim, and sometimes other people familiar with the family, the CPS agency makes a determination concerning whether the child is a victim of abuse or neglect, or is at risk of abuse or neglect. This determination is often called a disposition.

CPS has 60 days after receiving the report to determine whether the report is "indicated" or "unfounded". The law requires CPS to provide written notice to the parents or other subjects of the report concerning the rights accorded to them by the New York State Social Services Law. The CPS investigator will also inform the SCR of the determination of the investigation.

The SCR may refer the report to law enforcement. This may occur if the "Subject of the Report" is not someone who meets the legal definition. The perpetrator of the abuse may not be someone who has the legal responsibility for the child. In such cases, referrals to law enforcement agencies are made in order to execute the appropriate legal action. There are situations in which both law enforcement and CPS will be involved, depending on who is the subject of the report and the nature of the injury and if any crimes have been committed.

In some cases, perhaps such as in Case #2 of Juanita, if the nurse practitioner had decided to report the family to the SCR, the report may not have been taken by the SCR staff. This may occur when there is information provided by the mandated reporter that indicates a more appropriate intervention would be family resolution or referral to a community resource.

The Abandoned Infant Protection Act

Like many states in the US, New York State passed a law to help stop people from abandoning newborns in unsafe and dangerous places. Every year newborns are abandoned in public places by their parents, who have no plan or ability to care for them.

The Abandoned Infant Protection Act (AIPA) created an affirmative defense to the criminal charges of Abandonment of a Child and Endangering the Welfare of a Child, when the following conditions are met:

1. The abandoned infant can be no more than 5 days old.
2. The person abandoning the infant must have intended the child be safe and well cared for. They cannot have intended the child any harm.
3. The infant must be left with an appropriate or suitable location. Should the infant be left in a suitable location, and appropriate person must be notified immediately of the child's location so the child can be taken into custody and cared for.

A "suitable location" has been identified by district attorneys in New York State as being:

- Hospitals
- Police stations
- Fire stations
- As long as they are open and staff is present.

An "appropriate person" has been identified as:

- Employees of the suitable location that are trained to deal with emergency situations.
- At a hospital, a doctor, nurse or emergency room personnel would be suitable. Any on-duty police officer at a police station or fire-persons or emergency medical technicians (EMTs) at a fire station would also be appropriate.

The Abandoned Infant Protection Act and Mandated Reporters

While the AIPA offers protection for parents who safely abandon their infants is they meet criteria previously mentioned, AIPA in no way changes the responsibilities of the mandated reporter. Mandated reporter must still report abandonment if s/he learns of the abandonment. Whether or not all of the information is known, the mandated reporter is still obligated to fulfill their responsibilities as a mandated reporter. For example, if the mandated reporter is unsure of the name of the person who abandoned the child, the reporter must still make the report.

The Abandoned Infant Protect Act and Social Services Law/Family Court Act

The AIPA does not change the laws pertaining to child abuse and maltreatment under current New York State legal requirements. Persons who abandon infants under AIPA will still be indicated as subjects of child maltreatment reports and may still have petitions for child neglect brought against them in family court.

Mandated reporters who have any questions about the Abandoned Infant Protection Act should contact the AIPA Informational Hotline operated by the New York State Office of Children and Family Services (OCFS) at 1-866-505-SAFE, or the OCFA Public Information Office at 518-473-7793.

Conclusion

The abuse of children is horrifying, with wide ramifications. The vastness of this problem can feel overwhelming to professionals. But there are interventions that can help. In this course, you learned to identify child abuse in its various forms and how to report it.

Because mandated reporters work in professional capacities in many occupations that interface with children, New Yorkers are counting on you to recognize child abuse and maltreatment/neglect, in all its forms, when you see it. Once identified, New Yorkers are counting on mandated reporters to report their suspicions to the SCR. It is critical that all mandated reporters understand their legal responsibility to report, as well as take on the professional and ethical responsibility to stop the abuse and maltreatment/neglect and end the suffering of children.

In addition to the identification and reporting of child abuse, it is important to consider the wide-ranging health and social consequences of ACEs. It is clear that the goal is to prevent them before they happen.

Resources

Prevent Child Abuse - New York
134 South Swan Street
Albany, NY 12210
(518) 445-1273
www.preventchildabuseny.org

Parent Helpline 800.342.7472

New York State Office of Children and Family Services
http://www.ocfs.state.ny.us/main/

ChildHelp USA
Hotline 800.422.4453

The National Clearinghouse on Child Abuse and Neglect Information (NCCAN) 800.FYI.3366

ChildFind (Registry for missing and Exploited Children)
800.222.1464

Domestic Violence
Hotline 800.799.7253

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Child Abuse and Maltreatment/Neglect: Identification and Reporting

Test

***If you have downloaded the course off the Internet and wish to submit your test online you must return to our website (www.accesscontinuingeducation.com) to do so.**

1. The most common form of child maltreatment, both in the US and in New York State is:

   a.Physical abuse.

   b. Sexual abuse.

   c. Neglect.

   d. Emotional abuse.

2. In New York State, a mandated reporter need not be absolutely certain that an injury or condition was caused by abuse or maltreatment/neglect; the reporter should only be able to entertain the possibility that it could have been neglect or non-accidental in order to possess the necessary "reasonable cause". The mandated reporter does not have to prove the abuse or maltreatment. It is enough for the mandated reporter to be suspicious, to distrust or doubt what s/he personally observes or is told.

   a. True

   b. False

3. Mandated reporters of child abuse and maltreatment/neglect in New York State:

   a. Have immunity from prosecution if they reported in good faith.

   b. Can be charged with a Class A misdemeanor for failing to report.

   c. May be civilly liable for any damages caused by failure to report.

   d. All of the above.

4. More than half of the reports of child abuse and maltreatment/neglect were made by professionals who are required to report their suspicions of abuse or maltreatment/neglect.

   a. True

   b. False

5. According to the US Department of Health and Human Services, Administration for Children and Families' Report-Child Maltreatment-2010, the rate of child victimization has decreased over the last seven years.

   a. True

   b. False

6. Evidence of child maltreatment/neglect includes:

   a. Parental lack of correct information about child development, and child care practices.

   b. Parental lack of communication, problem solving or parenting skills.

   c. Failure to supply the child with food, clothing, shelter, education, healthcare although financially able to do so.

   d. Poverty.

7. Physical abuse should be considered if:

   a. The caretaker explanation for the injury does not fit the physical evidence.

   b. The explanation for the injury is not possible based on the child's developmental stage.

   c. There are repeated or patterned injuries.

   d. All of the above.

The following case relates to questions 8-12.

10 year old Michael was always a talkative, rambunctious and social boy with many friends. Last year his mother married a man who Michael liked very much. For approximately the last 6 months, Michael has been moody, sometimes being withdrawn and socially isolated and at other times, getting into fights at school. He's also been failing exams and his grades have fallen. You see Michael for complaints of a sore throat in the primary care office, accompanied by his step-father. Michael and his step-father hardly speak to one another; Michael avoids interacting with him. During the exam, Michael tells you that he "hates" his step-father and that Michael's mother works the evening shift part-time, which is why his mother is not available for today's urgent visit. When you attempt to examine Michael, he flinches at your touch. A throat culture reveals gonorrhea.

8. Behavioral indicators of possible abuse include all the following EXCEPT:

   a. Lab results indicating gonorrhea.

   b. Sudden change in behavior, and school performance.

   c. Behavioral extremes.

   d. Avoidance of touch.

9. Physical indicators of possible abuse include:

a. Sore throat and lab results indicating gonorrhea.

b. Avoidance of his step-father.

c. Avoidance of touch during the exam.

d. Change in behavior.

10. During the office visit, you are aware that you need to be careful in talking with Michael, so that he feels comfortable telling you about his situation. You make sure you are able to do all the following EXCEPT:

a. Remain calm, be open and honest with Michael.

b. Listen carefully and remain supportive, stressing that it is NOT Michael's fault.

c. Interrogate Michael in an attempt to investigate what is really happening in his life.

d. Report the situation.

11. You know that gonorrhea in a child of Michael's age is often a sign of child sexual abuse, and you note his behavioral changes and what he has told you. As a mandated reporter, you call the State Central Register's Express Line for mandated reporters of child abuse and maltreatment/neglect. You call 1.800.635.1522.

a. True

b. False

12. You follow-up the telephone report with a written report. You identify the "Subject of the Report" as Michael.

a. True

b. False

13. Your report has initiated The New York State Child Protective Services System into action. Using this model, potential actions include all the following EXCEPT:

a. Law enforcement involvement (Michael's step-father could be arrested).

b. Removal of Michael from the home (if he is in imminent danger).

c. Not investigating your report.

d. Services could be offered to the family, such as family therapy, individual child therapy for Michael.

14. The most frequent perpetrators of child abuse and maltreatment/neglect are:

a. Strangers.

b. Caretakers who are not family members.

c. Parents.

d. Family members other than parents.

15. The Abandoned Infant Protection Act protects parents who safely abandon their infants but does not change the responsibility of the mandated reporter to report the abandonment if s/he learns of it.

a. True

b. False