Child Abuse Assessment and Reporting
(7 hours/units)

Table of Contents:

1. Definitions

Child abuse is the physical, psychological or sexual maltreatment of children. *The Centers for Disease Control and Prevention (CDC)* defines child maltreatment as "any act or series of acts or commission or omission by a parent or other caregiver that results in harm, potential for harm, or threat of harm to a child". Most child abuse occurs in the home, with a lesser amount occurring in the organizations, schools or community organizations. Currently, there are four widely recognized and identifiable categories of child abuse including neglect, physical abuse, psychological/emotional abuse, and sexual abuse. *The Mental Health Journal* defines child as "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, an act or failure to act which presents an imminent risk of serious harm."

2. Assessing Child Abuse

Psychological and Emotional Abuse

Psychological abuse is also referred to as emotional abuse and is a form of abuse characterized by a person subjecting or exposing another to behavior that is psychologically harmful. It involves the willful infliction of mental or emotional anguish by threat, humiliation, or other verbal and non-verbal conduct. It is often associated with situations of power imbalance, such as abusive relationships and child abuse. Psychological abuse may occur as bullying of individuals by groups, often children, or it may be by one partner in a relationship. In domestic abuse psychological abuse nearly always precedes physical violence when this occurs, and also accompanies it. Modern technology had led to new forms of abuse, by text messaging and online cyber-bullying. Methods of abuse include causing fear by intimidation, threatening physical harm to self, partner, children, or partner's family or friends, destruction of pets and property, forcing isolation from family, friends, or school or work. More subtle tactics include putdowns, hiding objects such as keys, then putting them back without the victim seeing, and denial that previous incidents actually happened *(American Psychiatric Association, Definitions of Crisis Behavior & A Mental Disorder by DSM-5 Diagnostic & Statistical Manual of APA, & Crisis Management: NCTSN The National Child Traumatic Stress Network, Child Psychical Abuse Fact Sheet; Child Sexual Abuse Fact Sheet)*

Methods of Manipulative Control

- Positive reinforcement

Carrying on the desired behavior brings rewards which may be in the form of praise, money, gifts, attention, approval or smiles. In abusive relationships however it serves to lure a victim into a relationship, being used more in the early stages, and keep them from leaving when used in the cycle of abuse. Abusers themselves receive positive reinforcement for their behavior through the benefits obtained by their behavior.

- Negative reinforcement

In negative reinforcement, also called aversive conditioning, unpleasant behavior by the manipulator ceases when the victim complies. Such behaviors include nagging, whining, crying, playing the victim and blaming others. This tends to cause anger resentment and frustration in the victim and can lead to a downward spiral anxiety, depression and low self esteem *(Bancroft, Lundy. Why does he do that? Inside the minds of angry and controlling men Berkley Publishing Group).*

- Intermittent or partial reinforcement

Positive reinforcement occurring on an intermittent basis tends to lead to addiction to a relationship. It is the basis on which the gambling industry works, with slot machines paying out small amounts often enough to keep the player hooked, but not enough to show a profit, while the potential jackpot remains elusive. Unpredictable patterns of aggressive behavior, as by an aggressive manager at work, cause anxiety and keep victims striving to please *(Bancroft, Lundy. Why does he do that? Inside the minds of angry and controlling men Berkley Publishing Group).*

- Punishment

Punishment following failure of the victim to comply with the manipulators wishes is often less effective initially than negative reinforcement *(Bancroft, Lundy. Why does he do that? Inside the minds of angry and controlling men Berkley Publishing Group).*

- Traumatic one-trial learning

A single extremely frightening experience can have long term effects on the victim, creating long term fear and anxiety. In abusive relationships fits of violent rage, sometimes including physical assault, can leave the victim too frightened and disorientated to leave the relationship or stand up for themselves *(Bancroft, Lundy. Why does he do that? Inside the minds of angry and controlling men Berkley Publishing Group).*

Loss of control

Abusers may blame the victim's actions for causing them to lose control of their temper. It is often apparent however that they do not behave in that way with other people. When abusers smash up property in apparently random acts it often turns out that they avoid damaging their own belongings, and if law officers, called by alarmed neighbors, arrive the "uncontrollable rage" will be instantly switched off. At this point the abuser, who is calm, will often pass the blame to the victim, who is likely to be visibly disturbed. Abuse therapists find that anger is usually only one of many abusive tactics employed against a victim. Anger results from abusive attitudes and the abuser's sense of entitlement rather than being a cause of these. Anger management courses are unlikely to stop abuse because they do not address the abuser's attitudes *(Bancroft, Lundy. Why does he do that? Inside the minds of angry and controlling men Berkley Publishing Group).*

Physical Abuse

Physical abuse is abuse involving contact intended to cause feelings of intimidation, pain, injury, or other physical suffering or harm.

There are several indicators that strongly suggest a child is being abused:

- Frequent physical injuries that are attributed to the child's being clumsy or accident-prone
- Injuries that do not seem to fit the explanation given by the parents or child
- Conflicting explanations provided by child and/or caregivers, explanations that do not fit the injuries, or injuries attributed to accidents that could not have occurred given the child's age (for example, an immersion burn on a child too young to walk or crawl)
- Habitual absence from or lateness to school without a credible reason. Parents may keep a child at home until physical evidence of abuse has healed. One should also be suspicious if a child comes to school wearing long-sleeved or high-collared clothing on hot days, since this may be an attempt to hide injuries
- Awkward movements or difficulty walking; this may suggest that the child is in pain or suffers from the aftereffects of repeated injuries

If you are a counselor, parent, teacher, or anyone else concerned about a child whom you suspect is being abused, the best way to begin is by talking to the child.

- Start with open-ended questions. Don't assume that the child is being abused. There may be many explanations for why a child is behaving in a particular way or for how a child was injured. Some children have conditions, such as osteogenesis imperfecta or blood clotting disorders that make them more vulnerable to bruising and/or broken bones.
- If the child has a visible injury, ask how the child was injured. Ask open-ended follow-up questions to look for inconsistencies if the explanation for the injury seems implausible or doesn't match the injuries.

There are many reasons why children don't tell about physical abuse, including:

- Fear that their parents will be mad at them or will hurt them worse for telling
- Desire not to get their parents into trouble
- Fear of being removed from their homes
- A belief that it's okay for their parents to hurt them
- Fear of not being believed
- Shame or guilt
- Belief that they deserve the abuse for their "bad" behavior

Forms of physical abuse include:

- striking

- punching
- pushing, pulling
- slapping
- Whipping
- striking with an object
- locking in or out of a room or place/false imprisonment
- excessive pinching
- kicking
- having someone fall
- kneeing
- strangling
- head butting
- drowning
- sleep deprivation
- exposure to cold, freezing
- exposure to heat or radiation, burning
- exposure to electric shock
- placing in "stress positions" (tied or otherwise forced)
- cutting or otherwise exposing somebody to something sharp
- exposure to a dangerous animal
- throwing or shooting a projectile
- exposure to a toxic substance
- infecting with a disease
- withholding food or medication
- assault
- bodily harm
- humiliation
- torture

(Source: NCTSN The National Child Traumatic Stress Network, Child Psychical Abuse Fact Sheet; Child Sexual Abuse Fact Sheet)

Neglect

The National Child Abuse and Neglect Data System (NCANDS) defines neglect as “a type of maltreatment that refers to the failure by the caregiver to provide needed, age-

appropriate care although financially able to do so or offered financial or other means to do so" *(USDHHS)*. Health care professionals, school officials, and relatives are the most frequent to report neglect.
Types of neglect include:

- Physical neglect
- Educational neglect
- Emotional/Psychological neglect
- Medical neglect

Sexual Abuse

Child sexual abuse is any interaction between a child and an adult (or another child) in which the child is used for the sexual stimulation of the perpetrator or an observer. Sexual abuse can include both touching and non-touching behaviors. Touching behaviors may involve touching of the vagina, penis, breasts or buttocks, oral-genital contact, or sexual intercourse. Non-touching behaviors can include voyeurism (trying to look at a child's naked body), exhibitionism, or exposing the child to pornography. Abusers often do not use physical force, but may use play, deception, threats, or other forms of coercion to engage children and maintain their silence. Abusers frequently employ persuasive and manipulative tactics to keep the child engaged. These tactics—referred to as "grooming"—may include buying gifts or arranging special activities, which can further confuse the victim *(Source: NCTSN The National Child Traumatic Stress Network; Child Sexual Abuse Fact Sheet)*

Children of all ages, races, ethnicities, and economic backgrounds are vulnerable to sexual abuse. Child sexual abuse affects both girls and boys in all kinds of neighborhoods and communities, and in countries around the world.

Children who have been sexually abused may display a range of emotional and behavioral reactions, many of which are characteristic of children who have experienced other types of trauma. These reactions include:

- An increase in nightmares and/or other sleeping difficulties
- Withdrawn behavior
- Angry outbursts
- Anxiety
- Depression
- Not wanting to be left alone with a particular individual(s)
- Sexual knowledge, language, and/or behaviors that are inappropriate for the child's age

(Source: NCTSN The National Child Traumatic Stress Network; Child Sexual Abuse Fact Sheet)

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Approximately 15% to 25% of women and 5% to 15% of men were sexually abused when they were children. Most sexual abuse offenders are acquainted with their victims; approximately 30% are relatives of the child, most often fathers, uncles or cousins; around 60% are other acquaintances such as friends of the family, babysitters, or neighbors; strangers are the offenders in approximately 10% of child sexual abuse cases. Most child sexual abuse is committed by men; women commit approximately 14% of offenses reported against boys and 6% of offenses reported against girls. Most offenders who abuse pre-pubescent children are pedophiles, however a small percentage do not meet the diagnostic criteria for pedophilia *(Centers for Disease Control and Prevention. (2005). Adverse Childhood Experiences Study: Data and Statistics. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control)* Under the law, "child sexual abuse" is an umbrella term describing criminal and civil offenses in which an adult engages in sexual activity with a minor or exploits a minor for the purpose of sexual gratification. *The American Psychiatric Association* states that "children cannot consent to sexual activity with adults", and condemns any such action by an adult: "An adult who engages in sexual activity with a child is performing a criminal and immoral act which never can be considered normal or socially acceptable behavior." Incest between a child or adolescent and a related adult has been identified as the most widespread form of child sexual abuse with a huge capacity for damage to a child. One researcher stated that more than 70% of abusers are immediate family members or someone very close to the family. Another researcher stated that about 30% of all perpetrators of sexual abuse are related to their victim, 60% of the perpetrators are family acquaintances, like a neighbor, babysitter or friend and 10% of the perpetrators in child sexual abuse cases are strangers. A Child sexual abuse offense where the perpetrator is related to the child, either by blood or marriage, is a form of incest described as interfamilial child sexual abuse. The most-often reported form of incest is father-daughter and stepfather-daughter incest, with most of the remaining reports consisting of mother/ stepmother-daughter/son incest. Father-son incest is reported less often, however it is not known if the prevalence is less, because it is under-reported by a greater margin. Prevalence of parental child sexual abuse is difficult to assess due to secrecy and privacy; some estimates show 20 million Americans have been victimized by parental incest as

children *(Centers for Disease Control and Prevention), Adverse Childhood Experiences Study: Data and Statistics. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control)*

Child sexual abuse includes a variety of sexual offenses, including:

- *Sexual assault* : Offenses in which an adult touches a minor for the purpose of sexual gratification; for example, rape (including sodomy), and sexual penetration with an object. Most U.S. states include, in their definitions of sexual assault, any penetrative contact of a minor's body, however slight, if the contact is performed for the purpose of sexual gratification.
- *Sexual molestation*: Offenses in which an adult engages in non-penetrative activity with a minor for the purpose of sexual gratification; for example, exposing a minor to pornography or to the sexual acts of others.
- *Sexual exploitation* : Offenses in which an adult victimizes a minor for advancement, sexual gratification, or profit; for example, prostituting a child, and creating or trafficking in child pornography.
- *Sexual grooming*: Defines the social conduct of a potential child sex offender who seeks to make a minor more accepting of their advances, for example in an online chat room.

(Source: NCTSN The National Child Traumatic Stress Network, Child Psychical Abuse Fact Sheet; Child Sexual Abuse Fact Sheet)

Children who received supportive responses following disclosure had less traumatic symptoms and were abused for a shorter period of time than children who did not receive support. Studies have revealed that children need support and stress-reducing resources after disclosure of sexual abuse. Negative social reactions to disclosure are harmful to the survivor's well being. One study reported that children who received an inappropriate reaction from the first person they told, especially if the person was a close family member, had worse scores as adults on general trauma symptoms, post traumatic stress disorder symptoms, and dissociation. Another study found that in most cases when children did disclose abuse, the person they talked to did not respond effectively, blamed or rejected the child, and took little or no action to stop the abuse. Although hearing a victim's disclosure is potentially uncomfortable, for the sake of the victim's well-being, it is important to be able to respond effectively. Showing that you understand and take seriously what the child is saying is an important first step provides guidelines for both what to say to the victim and what to do following the disclosure. According to Dr. Don Brown, "A minimization of the trauma and its effects is commonly injected into the picture by parental caregivers to shelter and calm the child. It has been commonly assumed that focusing on children's issues too long will negatively impact their recovery. Therefore, the parental caregiver teaches the child to mask his or her issues." (*Child Welfare Committee, National Child Traumatic Stress Network & National Children's*

Alliance. CAC Directors' Guide to Mental Health Services for Abused Children. Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress.)

Child Abuse and the Investigative Process

(Source: Child Welfare Committee, National Child Traumatic Stress Network & National Children's Alliance. *CAC Directors' Guide to Mental Health Services for Abused Children.* Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress.)

When they participate in the investigative process, mental health professionals must have specialized training in the dynamics of child abuse. It is important to know how to question children to increase the likelihood of eliciting factual information. This section focuses on how children talk about abuse: why they often don't tell, when they do tell, and why they may delay their disclosure.

When mental health professionals begin working with child abuse victims, they may have some preconceived and often inaccurate notions about children's reactions to traumatic stress. They may expect children to act depressed, traumatized, and/or frightened, and to be hoping to be saved from the abuser and the trauma-related environment. Yet sometimes children apparently long to be with their abuser, appear to be extremely attached to the offender, or exhibit little or no emotion as they disclose abuse. Without an accurate understanding of how children recall traumatic events, mental health professionals may misinterpret children's behavior and statements, thus putting them at continued risk for traumatization.

Mental health professionals who work with children immediately following a report of abuse are interacting with them at a critical moment. Understanding how trauma affects a child's overall behavior and recollection of the event enables mental health professionals to conduct a more accurate investigation and can assist investigators in providing the child with a framework for future healing. If investigators misinterpret the manifestation of trauma in the child's presentation as evidence of a false report, this can have devastating effects on the child's overall health and well-being. In addition, if a case is deemed unfounded based on this misinterpretation, it places the victims and other children at risk of potential future abuse by the offender. Mental health professionals need to understand that a child's disclosure or non-disclosure does not occur in a vacuum. In the child's mind, the investigative process may be perceived as part of the continuum of traumatic events. Thus, the investigation itself, if not handled in a trauma-informed manner, can induce additional traumatic stress. The child's ability to disclose may also be influenced by the family, by the initial response regarding the abuse allegations, and by the offender and the child's community network. The child's developmental stage affects how the child copes with traumatic stress and subsequent disclosure. And because traumatic stress can impede the child's development, this can also affect the disclosure

process. Finally, feelings of fear, shame, responsibility, and embarrassment affect not only the child's response to traumatic stress but the entire investigative process.

How Trauma Affects Children's Ability to Recount Events

Overall, it is important for investigators to take into account the effects of traumatic stress on children and on their ability to recount the abusive event. The sexual abuse of children may occur over a long period of time, and may include any or all of the following: threats of harm, use of force, violations of trust, physical pain, or penetration. These factors make it less likely that the child will tell someone about the abuse. Children may not disclose the abuse because they are afraid of the offender or feel shame about the abuse. Many will be incapable of telling their story due to the effects of traumatic stress on their state of mind and conscious memory of the incident. Children who have experienced traumatic stress may have memory loss, be unable to disclose details of the abuse, or incorporate fantastic elements into their disclosure statements (Everson; Dalenberg, et al).

Memory loss

It is important for investigators to distinguish between children's resistance to questioning and the trauma-related behaviors that affect their ability to respond to inquiries. Inability to respond to questions or to give details of the trauma should not be misinterpreted as indicators of a false allegation. Many studies have documented the phenomenon of memory loss (sometimes referred to as "event amnesia") in survivors of many types of trauma (Briere & Conte; Williams; Loftus, et al.; Chu, et al.). Recent research supports the existence of brain mechanisms that can account for this phenomenon. One recent paper in *Science* (Depue et al.) identified a mechanism in which the brain's prefrontal regions orchestrate suppression of emotional memories via a two-phase process. Whether memories of traumatic events are "repressed," "dissociated," "suppressed," "compartmentalized," or "isolated" remains a matter of semantic debate. As discussed here, memory loss does not necessarily mean repressed memory or amnesia, but rather a child's inability to remember *at the moment of questioning* what may have occurred. Understanding this difference will help professionals to be sensitive to pacing when questioning children about traumatic events. It is critical to give children the time they need to respond as they are able to remember, and not to expect disclosure of all details at one time. Several theories have been proposed to explain why children may experience memory loss when asked to recount abusive situations. One possible explanation, according to Freyd (2006), is that because most children are abused by trusted and loved adults, the abuse and betrayal must be forgotten in order for the child to preserve essential attachments to the abuser. The child may not be able to recall the abuse until he/she gets older, or even enters adulthood, and is no longer emotionally tied to the offender.

Memory is sustained in the brain by a process of rethinking or rehearsing of events, often within the context of a relationship. Many child abuse victims do not have adults nearby with whom they can safely discuss what has happened to them. Without adults they can trust to help them process and understand traumatic events, children are less able to create a coherent account of the event within their sustained memory. On the other hand, victims of non-abusive trauma, such as those exposed to natural disasters or accidents, are more likely to discuss a traumatic event with a supportive adult. Such discussion can facilitate processing of the trauma and aid in creating a coherent account of the event (Epstein & Bottoms). However, disclosing abuse to an adult does not always help the child remember. Even adults with good intentions (but without trauma-specific training) may tell a child: "Forget about it" and/or "Don't tell anyone else."
The child's ability to remember traumatic abuse can also be affected if the offender warned the child not to tell or told the victim to forget what happened (Epstein & Bottoms).

Incomplete disclosure of details of abuse

Sometimes a child can clearly relate to investigators the events preceding and following an abusive event but is unable to give a full account of the abuse itself. Again, there may be several reasons for incomplete disclosure of the details of abuse. Sometimes during an abusive event, dissociation may occur. This is an unconscious defense mechanism by which a person's emotional or mental response separates from consciousness. This survival mechanism may occur during the first event or during subsequent events in a situation of chronic trauma. It is especially common in situations where child victims do not have control over their bodies. Investigators may have observed children who suddenly stop talking during an interview in which they have been disclosing abuse. This can be due to the child's feelings of embarrassment or shame. Or, the child may be experiencing a flashback of the incident. When this occurs, the child may appear to look "spaced out" or "not present." Some children may say they don't remember as a way of avoiding the issue of their abuse. This information is important to consider during the forensic interview of the child. By framing questions regarding what the child remembers at that moment (versus asking the child to tell everything that happened), over time the child may remember and be able to tell more of his/her abusive experience.

Fantastic statements

At the opposite extreme from nondisclosure are unbelievable or "fantastic statements." These may sometimes crop up during interviews with children about their abuse. Although there are certainly cases where false allegations are made and children do not tell the truth, a child's inability to recount the event or the making of fantastic statements could also be attributed to the trauma he/she has experienced. It has been shown that

children aged 4-9 whose abuse was severe and violent are more likely to incorporate bizarre and impossible details into their abuse accounts (Davis & Bottoms) than are children whose abuse was less traumatic. Some children may incorporate details of what they wished could have happened, such as, “Then I jumped out the window and ran away.”

Other dynamics affecting disclosure of abuse

Children who have been sexually abused may have complicated relationships with their abusers. A child may express a desire to be with the abuser, exhibit extreme attachment to the abuser, or display no emotion during disclosure. All of these behaviors can be symptoms of traumatic stress.

Children are dependent upon adults around them and often are not able to make sense of an abusive situation. Roland Summit described what he called the Child Sexual Abuse Accommodation Syndrome (CSAAS) as one way in which children cope with abuse: “The child ‘accommodates’ to the abuse to reduce both internal conflict and conflict with the offender, as well as to preserve a relationship with the non-offending caretaker. The child will therefore often return to the offender, regardless of the severity or duration of the abuse. In other words, the child accepts or submits to the abuse, then learns to live with it, because (s)he concludes that there is no other choice and no hope of escape.” Although this theory has not been proven in a scientific sense, it does describe a phenomenon in which children seem to accommodate to abusive situations because “that’s the way life is.”

There is no question that in some cases strong bonds form between abusers and their victims. A variety of psychodynamic theories have been advanced which explain that this is an adaptive response in which victims identify their survival with the well-being of the victimizer. There are various names for this process (e.g., Stockholm syndrome, traumatic attachment, anxious attachment, Lima syndrome, capture bonding, etc.), which has been best described in adults caught in prolonged hostage situations and in domestic violence.

At times during the investigative interview, children may present with a flat affect or appear to be very matter-of-fact. When the child reveals little or no emotion, it can be difficult for those who interact with the child to believe that the incident occurred. If children have had to tell their story multiple times, they may become desensitized to the feelings when asked yet again to describe their abusive experience. If a child dissociated during the abusive events, the report of the experience may be delivered with the affect of an observer rather than with that of a traumatized person. In the case of observed flat affect, investigators should seriously consider the possibility that the child is suffering from depression. This is more likely if children have been abused by someone they know or have experienced chronic traumatic stress. Lanktree et al., studied a sample of child and adolescent psychiatric outpatients with sexual abuse histories, and found that they

were four times more likely to be suffering from major depression than were patients with no molestation history.

It can be difficult to separate signs of false abuse allegations from some trauma-related symptoms. If investigators are having difficulty with these determinations, it may prove helpful to consult with a mental health professional for guidance.

Crisis Intervention during the Investigative Process

When families are involved in allegations of child abuse, emotions run high and anxiety levels rise, regardless of whether the allegations are true or false. The allegation alone can cause stress in families. Parents and caregivers may fear the child will be removed from their home; that the child truly was a victim of abuse; or that they and the child will suffer social stigma attached to child abuse. They also may be worried about the potential financial, social, and personal losses associated with abuse allegations and resulting legal proceedings. These stressors on families should be anticipated in almost all child abuse investigations. If abuse allegations are proven to be true, families will experience additional severe stressors during the investigation process. It is important to create safeguards for families should the stress escalate to crisis mode. Services may then need to focus on stabilizing the parent/caregiver and child.

If a crisis develops during the interviewing process, it may be necessary to interrupt the forensic interview so that an assessment can be made about whether to proceed. This is a critical step to prevent additional system-induced stress for the child. Such assessments should be made by a team consisting of the investigator, the interviewer, the child welfare worker, and any mental health professional involved with the child. The forensic interview should be terminated if the child 1) says he/she is unwilling to continue; 2) becomes too emotionally upset to continue; or 3) expresses anything that is considered a real or perceived threat to his/her safety or well-being by the alleged perpetrator. When these crises occur, the child may need to be referred for mental health treatment. The interview process may then need to be completed over several sessions.

Children who are victims of child abuse and their families may suffer psychological crises resulting from traumatic stress. Family members may exhibit disorganized thinking and impulsiveness. They may become outwardly hostile, or distance themselves emotionally from others. Some families develop an extreme dependence on investigators during this process, while others are resistant and may appear to lack motivation to cooperate with the investigation. It is important to recognize that the presence of these characteristics does not mean that the family is truly uncooperative. It may simply mean that they need additional time and/or assistance to cope with the crisis situation. Such psychological states may be temporary and do not necessarily indicate a mental illness, but they should be addressed, if possible, before the investigation proceeds. However, if a child or parent/caregiver displays violent, suicidal, and/or homicidal behavior, then

psychiatric assessment and even hospitalization may be needed to rule out significant mental health concerns and/or to help the client become emotionally stable.

The investigation may be impeded if the child or family is pressured to provide information or is treated in a punitive manner. If the investigation is thwarted due to these factors, the safety of the child takes precedence until the barriers have been identified and resolved, at which time the investigation can be completed.

Comprehensive trauma assessments conducted by mental health professional's use standardized measures that are shown to be reliable (consistent over time) and valid (measure what they are supposed to be measuring). They include some measures that are specific to trauma, such as assessing for PTSD symptoms and other common trauma reactions (e.g., dissociation and sexual reactivity). Some common trauma-specific measures include:

- The UCLA PTSD Reaction Index for DSM-IV (parent, child, and adolescent versions) (Steinberg, et al.)
- The Child PTSD Symptom Scale (CPSS) (Foa, et al.)
- Trauma Symptom Checklist for Children: Professional Manual (Briere)
- Trauma Symptom Checklist for Young Children: Professional Manual (Briere)
- Child Sexual Behavior Inventory: Professional Manual (Friedrich)

Child Protective Service investigation of child sexual abuse may add to an already distressing situation by creating an adversarial relationship between the family and the community system. This relationship, coupled with the crisis the family is experiencing, can result in negative outcomes for the child, the family, and the investigation.

Conducting interviews in a neutral, fact-finding manner in a child-friendly setting can help redefine these relationships. When approached from a supportive rather than an adversarial position, the investigation can enable the mental health professionals to join with the non-offending caregiver in a partnership for the protection of the child. When interacting with a caregiver, mental health professionals should model the behaviors they would like the caregiver to exhibit toward the child. One of the primary purposes of such interventions is to empower the caregiver to become a protective resource for the child. The aim is to help the non-offending caregiver make the shift from passive caregiver to an active, protective caregiver. To enable this shift, mental health professionals must be supportive. They must clearly communicate and model their expectations for the caregiver's becoming a protective resource for the child. This positive and supportive approach to the caregiver is preferred to the shaming and blaming that some mental health professionals in the past have conveyed to the non-offending caregiver during the investigation of abuse. This approach is also consistent with the CAC mandate to reduce secondary trauma resulting from the investigation *(Ralston & Sosnowski)*.

During the assessment period, mental health professionals should strive to engage the caregiver in the investigative process. They can accomplish this by defining the caregiver as the expert about the child and themselves as the experts about abuse. Their common goal is to join in a partnership for the protection of the child. By setting this tone, and engaging caregivers, mental health professionals can help prepare the caregiver for the required protective role. In addition, the caregiver will be a valuable source of information about the family's and child's histories across multiple domains (e.g., medical, mental health, abuse, trauma, substance abuse, employment, education, and legal histories).

The assessment process also includes eliciting information regarding how the family functions: its rules, methods of discipline, and interpersonal boundaries. It will be helpful for the interviewer to ascertain from the caregiver the child's previous exposure to sexual information and material, names that the family has given for sexual parts, and the initial indicator of abuse. Also important: eliciting information about the caregiver's response to the initial indicator of abuse, the child's perception of the caregiver's concern, what the child was told about the interview, and the caregiver's desired outcome. This history-gathering process provides foundational information to help understand the child's behavioral and verbal responses during the forensic interview; and it allows the interviewer to assess the caregiver's willingness and ability to be a protective resource for the child (Ralston & Sosnowski). The caregiver can also be invited to play a positive role in the forensic interview by being the one to give the child permission to talk to the interviewer. With young children the caregiver also assures the child that the caregiver will be waiting for him/her following the interview.

After the child is interviewed, the caregiver (without the child present) is given feedback. Forensic interviewers are often trained mental health professionals and bring specialized training to this critical portion of the forensic interview. The interviewer shares his/her professional opinion regarding risk to the child and reports any alleged offenders as identified by the child. The forensic interviewer and/or the mental health professional then help the caregiver manage the feedback so he/she will be better able to help the child cope with what has happened.

All of these approaches are designed to identify barriers to the caregiver's ability and willingness to be a protective resource for the child, and to develop interventions designed to reduce or remove those barriers (Ralston & Sosnowski, 2004). Barriers associated with the parent/caregiver's own abilities to be protective (such as limited cognitive abilities, mental health issues, medical conditions, abuse history, or substance abuse) must be identified; and interventions to address and overcome these barriers provided. External barriers to provision of protection may include lack of financial resources, lack of a support system, lack of transportation, and a history of domestic violence. Finally, any child characteristics that may be barriers to the caregiver's ability

or willingness to be a protective resource must be identified. Some of these barriers might include the caregiver's inability to manage the behavioral consequences of the child's abuse, the child's mental health or medical problems, and sexual reactivity of the child. Although symptom reduction is the target of treatment, it is common for children to experience elevations in certain symptoms as they work through other issues related to the trauma. For instance, as a sexually abused child works through a narrative and processes feelings related to the trauma, he/she might demonstrate more sexual reactivity, a common outcome of sexual abuse. Provision of interventions to address this behavior are essential, which, if left untreated, may result in a child's sexually acting out with others.

The child abuse literature suggests that the child's ability to recount the events, to testify in court, and to recover from the abuse are enhanced by the involvement of a supportive and protective non-offending caregiver. When child protection and law enforcement responses are experienced as adversarial and/or ambivalent, the caregiver may become confused or angry. The literature also clearly shows that the non-offending caregiver's response to child sexual abuse is critical to the psychological outcome for the child victim.

3. Statistics

Recently a study conducted by the *Center for Disease Control and Prevention* found that 1 in 50 infants in the United States are victims of nonfatal neglect or abuse. In the US, neglect is defined as the failure to meet the basic needs of children including housing, clothing, food and access to medical care. Researchers found over 91,000 cases of neglect over the course of one year with their information coming from a database of cases verified by protective services agencies *(Source: Centers for Disease Control and Prevention)*.

Child sexual abuse occurs frequently in Western society. The rate of prevalence can be difficult to determine. In the UK it is estimated at about 8% for boys and 12% for girls. The estimates for the United States vary widely. A literature review of 23 studies found rates of 3% to 37% for males and 8% to 71% for females, which produced an average of 17% for boys and 28% for girls, while a statistical analysis based on 16 cross-sectional studies estimated the rate to be 7.2% for males and 14.5% for females. The US *Department of Health and Human Services* reported 83,600 substantiated reports of sexually abused children in 2005.Including incidents which were not reported would make the total number even larger. Surveys have shown that one fifth to one third of all women reported some sort of childhood sexual experience with a male adult. One study found that professionals failed to report approximately 40% of the child sexual abuse cases they encountered. A study by Lawson & Chaffin indicated that many children who were sexually abused were "identified solely by a physical complaint that was later diagnosed as a venereal disease...Only 43% of the children who were diagnosed with venereal disease made a verbal disclosure of sexual abuse during the initial interview." It

has been found in the epidemiological literature on CSA that there is no identifiable demographic or family characteristic of a child that can be used to bar the prospect that a child has been sexually abused *(Centers for Disease Control and Prevention). Adverse Childhood Experiences Study: Data and Statistics. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control)*

In US schools, according to the *US Department of Education,* "nearly 9.6% of students are targets of educator sexual misconduct sometime during their school career." In studies of student sex abuse by male and female educators, male students were reported as targets in ranges from 23% to 44%. In U.S. school settings same-sex (female and male) sexual misconduct against students by educators "ranges from 18-28% of reported cases, depending on the study" Significant under reporting of sexual abuse of boys by both women and men is believed to occur due to sex stereotyping, social denial, the minimization of male victimization, and the relative lack of research on sexual abuse of boys. Sexual victimization of boys by their mothers or other female relatives is especially rarely researched or reported. Sexual abuse of girls by their mothers, and other related and/or unrelated adult females is beginning to be researched and reported despite the highly taboo nature of female-female child sex abuse. In studies where students are asked about sex offenses, they report higher levels of female sex offenders than found in adult reports. This under-reporting has been attributed to cultural denial of female-perpetrated child sex abuse, because "males have been socialized to believe they should be flattered or appreciative of sexual interest from a female" and because female sexual abuse of males is often seen as 'desirable' and/or beneficial by judges, mass media pundits and other authorities *(Centers for Disease Control and Prevention, Adverse Childhood Experiences Study: Data and Statistics. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control)*

The *Ministry of Women and Child Development* published the "Study on Child Abuse: India." It sampled 12447 children, 2324 young adults and 2449 stakeholders across 13 states. It looked at different forms of child abuse: Physical Abuse, Sexual Abuse and Emotional Abuse and Girl Child Neglect in five evidence groups, namely, children in a family environment, children in school, children at work, children on the street and children in institutions. The study's main findings included: 53.22% of children reported having faced sexual abuse. Among them 52.94% were boys and 47.06% girls. Andhra Pradesh, Assam, Bihar and Delhi reported the highest percentage of sexual abuse among both boys and girls, as well as the highest incidence of sexual assaults. 21.90% of child respondents faced severe forms of sexual abuse, 5.69% had been sexually assaulted and 50.76% reported other forms of sexual abuse. Children on the street, at work and in institutional care reported the highest incidence of sexual assault. The study also reported that 50% of abusers are known to the child or are in a position of trust and responsibility and most children had not reported the matter to anyone (*Ministry of Women and Child Development* “Study on Child Abuse: India”)

4. Mandated Reporters

The criteria in identifying suspected child abuse and when a mandatory reporter should report varies among states. Typically, a report must be made when the reporter, in his or her official capacity, *suspects* that a child has been abused. Another standard frequently used is when the reporter has knowledge of, or observes a child being subjected to, conditions that would reasonably result in harm to the child *(Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse')*

State Reporting Laws

All 50 States and the District of Columbia have statutes that protect children from abuse and neglect by their parents or others. There are criminal statutes prohibiting certain acts (or failures to act), violation of which may lead to imprisonment. There are also civil statutes that prohibit abuse and neglect. If these statutes are violated, the court may impose requirements that parents accept certain kinds of help (such as substance abuse treatment, parenting classes, or anger management training), that their children be removed from the home, or that their parental rights be terminated *(Source: SAMHSA)*

Most States define abuse as an act or failure to act that result in non-accidental physical injury or sexual abuse of a child. Neglect generally includes the denial of adequate food, shelter, supervision, clothing, or medical care when such resources or services are available. Each state defines abuse and neglect differently, and the conditions considered to be neglect or abuse in one state may not be the same in others. Because state law often requires that treatment providers report suspected abuse and neglect, treatment staff should become familiar with their state's definitions of abuse and neglect. Staff can contact the State's CPS agency for information on current laws. (If the abuse occurred in another state, or if the perpetrator is currently living in another state, it is wise to check on the laws in the other state to ensure compliance. At times, there may be a need to report in both states.) Readers can also find state statutory child abuse and neglect definitions on the Internet at http://www.calib.com/nccanch/services/statutes.htm. Federal definitions of these terms appear in the Child Abuse Prevention and Treatment Act, 42 U.S.C. §5106(g). In some cases, the CPS agency can be consulted regarding whether or not a report must be made in a particular situation without divulging confidential (i.e., identifying) information. Consultation with the CPS agency must be done with great care, and this communication can be noted in the client's chart *(Source: SAMHSA)*.

Although each state's laws are different, the following conditions are reportable in most states:

- The child has been seriously physically injured by a parent or other adult by other than accidental means.
- The child appears injured or ill to the point that a reasonable person would seek medical attention, but the parent has not sought medical attention,

refuses to consider it, or fails to follow medical advice, putting the child at risk.

- An adult has sexually touched (or made the child sexually touch the adult), abused, or exploited the child.
- The child is not registered for or attending school, and the parent refuses to remedy the situation (home schooling must be adequately documented).

Although the behaviors outlined above are the most blatant examples of child abuse or neglect, other parental behaviors or practices may put children at risk. For example, the following may also constitute child abuse or neglect:

- Leaving a young child alone and unsupervised
- Inappropriate punishment that puts a child at risk (e.g., locking a young child out of the house as a punishment)
- Depriving a young child of food for an extended period of time
- Treating one child, the "bad one," far more harshly than others

Whether behaviors like these are reportable depends, in part, on how State statutes define abuse and neglect, the seriousness of the behavior or incident, its impact on the child, and the counselor's perception of the client's overall behavior with the child and of the client's willingness to correct inappropriate behavior *(Source: SAMSHA)*.

Mandated reporters are those who, in the course of their work and because they have regular contact with children, are required to make a suspected child abuse report whenever physical, sexual or other types of abuse has been observed or is suspected, or when there is evidence of neglect, knowledge of an incident, or an imminent risk of serious harm. Abuse occurs when a victim has suffered physical injury inflicted other than by accidental means, has injuries, or is in a condition resulting from mistreatment, such as malnutrition, sexual molestation or exploitation, deprivation of necessities, emotional abuse or cruelty. Neglect may be defined as abandonment, denial of proper care and attention physically, emotionally, or morally, or living under conditions, circumstances or associations injurious to well-being *(Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse')*.

Mandated reporters also include persons who have assumed full or intermittent responsibility for the care or custody of a child, dependent adult, or elder, whether or not they are compensated for their services. The report must be made to a "child protective agency." Including a county welfare or probation department or a police or sheriff's department. Exceptions are reports by commercial print and photographic print processors, which are made to the law enforcement agency having jurisdiction. The mandated reporter must report the known or suspected incidence of child abuse to a child

protective agency immediately or as soon as practically possible by telephone *(Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse').*

Mandated reporters may not make an anonymous report. Mandated reporters, however, are not legally required to tell involved individuals that a report is about to be made. The law does not require mandated reporters to tell the parents that a report is being made. A client's self-report does not negate the therapist's mandate to report. The role of a mandated reporter is to report and not investigate the allegation(s). Any attempts to investigate may have a negative clinical impact on the child and family. If a mandated reporter learns about suspected child abuse from a third party (hearsay), and reasonable suspicion exists, the therapist must make a report if the information was revealed to the therapist within their professional capacity *(Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse').*

The identity of all reporters is considered confidential and is disclosed only between child protective agencies. Mandated reporters have immunity from criminal and civil liability for reporting as required. Any other person who reports a known or suspected case of child abuse is also protected from civil and criminal liability, unless it can be proven that the person deliberately made a false report. The Child Abuse Reporting Law takes precedence over laws governing the psychotherapist-patient privilege. A failure to report known or suspected child abuse when mandated to do so is considered a misdemeanor and is punishable by a term in jail not to exceed six months or by a fine not to exceed $1,000 or by both *(Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse').*

RAINN maintains a database of mandatory reporting regulations regarding children and the elderly by state, including who is required to report, standards of knowledge, definitions of a victim, to whom the report must be made, information required in the report, and regulations regarding timing and other procedures.

Summary of State Laws

Alabama

Professionals Required to Report: Doctors, medical examiners, dentists, nurses, or pharmacists, school teachers or officials, law enforcement officials, daycare workers or social workers, members of the clergy, and any other person called upon to render aid or medical assistance to a child

Reporting by Other Persons: Any other person who has reasonable cause to suspect that a child is being abused or neglected may report.

Standards for Making a Report: A report must be made when the child is known or suspected of being a victim of abuse or neglect.

Privileged Communications: Only the clergy-penitent and attorney-client privileges are permitted.

Inclusion of Reporter's Name in Report: Not specifically required by statute
Disclosure of Reporter Identity. The department will not release the identity of the reporter except under court order when the court has determined that the reporter knowingly made a false report.

Alaska

Professionals Required to Report: Health practitioners, administrative officers of institutions, school teachers and administrators, childcare providers, paid employees of domestic violence and sexual assault programs, and crisis intervention and prevention programs; paid employees of organizations that provide counseling or treatment to individuals seeking to control their use of drugs or alcohol, peace officers; officers of the Department of Corrections, persons who process or produce visual or printed matter, either privately or commercially, members of a child fatality review team or the multidisciplinary child protection team

Mandated reporters may report cases that come to their attention in their non-occupational capacities: Any other person who has reasonable cause to suspect that a child has been harmed may report.

Standards for Making a Report: When, in the performance of their occupational duties, they have reasonable cause to suspect that a child has suffered harm as a result of abuse or neglect, when they have reasonable cause to suspect that visual or printed matter depicts a child engaged in the unlawful exploitation of a minor.

Privileged Communications: Neither the physician-patient nor the husband-wife privilege is recognized.

Inclusion of Reporter's Name in Report: Not specifically required by statute
disclosure of reporter identity not addressed in statutes reviewed

Arizona

Professionals Required to Report: Physicians, physician's assistants, optometrists, dentists, behavioral health professionals, nurses, psychologists, counselors or social workers, peace officers, members of the clergy, priests, or Christian Science practitioners parents, stepparents, or guardians, school personnel or domestic violence victim advocates, and any other person who has responsibility for the care or treatment of the minor.

Reporting by Other Persons: Any other person who reasonably believes that a minor is a victim of abuse or neglect may report.

Standards for Making a Report: When they reasonably believe that a minor is a victim of abuse or neglect

Privileged Communications: Only the attorney-client and the clergy-penitent privileges are recognized.

Inclusion of Reporter's Name in Report: Not specifically required by statute

Disclosure of Reporter Identity: Not addressed in statutes reviewed

Arkansas

Professionals Required to Report: Physicians, surgeons, osteopaths, resident interns, coroners, dentists, nurses, or medical personnel, teachers, school officials or counselors, daycare center workers, childcare workers, foster care workers, social workers, foster parents, or department employees, mental health professionals, domestic violence shelter employees or volunteers, law enforcement personnel, peace officers, prosecuting attorneys, domestic abuse advocates, judges, Court Appointed Special Advocate (CASA) program staff or volunteers, juvenile intake or probation officers, any members of clergy, including ministers, priests, rabbis, accredited Christian Science practitioners, or other similar functionary of a religious organization

Reporting by Other Persons: Any other person with reasonable cause to suspect child maltreatment may report.

Standards for Making a Report: When they have reasonable cause to suspect child maltreatment. When they have observed the child being subjected to conditions or circumstances that would reasonably result in child maltreatment.

Privileged Communications: No privilege is granted except the attorney-client and clergy-penitent (including a Christian Science practitioner).
Inclusion of Reporter's Name in Report: Not specifically required in statute

Disclosure of Reporter Identity: The identity of the reporter shall not be disclosed unless a court determines that the reporter knowingly made a false report.

California

Professionals Required to Report: Penal Code 11166; 11165.7: Teachers, teacher's assistants, administrative officers, certificated pupil personnel employees of any public or private school administrators and employees of public or private day camps, youth centers, youth recreation programs, or youth organizations, employees of childcare institutions, including, but not limited to, foster parents, group home personnel, and personnel of residential care facilities. Social workers, probation officers, or parole

officers. Any person who is an administrator or a counselor in a child abuse prevention program in any public or private school. District attorney investigators, peace officers, firefighters, except for volunteer firefighters. Physicians, surgeons, psychiatrists, psychologists, dentists, licensed nurses, dental hygienists, optometrists, marriage counselors, family and child counselors and clinical social workers. Emergency medical technicians I or II or paramedics, state or county public health employees, coroners or medical examiners, commercial film and photographic print processors, child visitation monitors, animal control officers or humane society officers, clergy members, which includes priests, ministers, rabbis, religious practitioners, or similar functionary of a church, temple, or recognized denomination or organization. Any custodian of records of a clergy member. Employees or volunteers of Court Appointed Special Advocate programs

Reporting by Other Persons: Penal Code 11166: Any other person who reasonably suspects that a child is a victim of abuse or neglect may report.

Standards for Making a Report: Penal Code 11166; 11165.7
When in his or her professional capacity, he or she has knowledge of or observes a child whom the reporter knows or reasonably suspects is the victim of abuse or neglect. Commercial film and photographic print processors when they have knowledge of or observe any film, photograph, videotape, negative, or slide depicting a child under the age of 16 years engaged in an act of sexual conduct.

Privileged Communications: Penal Code 11166: Only the clergy-penitent privilege is permitted.

Inclusion of Reporter's Name in Report: Penal Code 11167: Reports of mandated reporters shall include: The name, business address, and telephone number of the mandated reporter; The capacity that makes the person a mandated reporter; Reports of other persons do not require the reporter's name.

Disclosure of Reporter Identity: Penal Code 11167: The identity of the reporter shall be confidential, and shall be disclosed only to agencies investigating the report, when the person waives confidentiality, and/or by court order

Colorado

Professionals Required to Report: Physicians, surgeons, physicians in training, child health associates, medical examiners, coroners, dentists, osteopaths, optometrists, chiropractors, podiatrists, nurses, hospital personnel, dental hygienists, physical therapists, pharmacists, registered dieticians, public or private school officials or employees, social workers, Christian Science practitioners, mental health professionals, psychologists, professional counselors, marriage and family therapists, veterinarians, peace officers, firefighters, or victim's advocates, commercial film and photographic print

processors, counselors, marriage and family therapists, or psychotherapists, clergy members, including priests; rabbis; duly ordained, commissioned, or licensed ministers of a church; members of religious orders; or recognized leaders of any religious bodies, and workers in the state department of human services

Reporting by Other Persons: Any other person may report known or suspected child abuse or neglect.

Standards for Making a Report: When they have reasonable cause to know or suspect child abuse or neglect, when they have observed a child being subjected to circumstances or conditions that would reasonably result in abuse or neglect. Commercial film and photographic print processors when they have knowledge of or observe any film, photograph, videotape, negative, or slide depicting a child engaged in an act of sexual conduct.

Privileged Communications: 19-3-304; 19-3-311, the clergy-penitent privilege is permitted. The physician-patient, psychologist-client, and husband-wife privileges are not allowed as grounds for not reporting.

Inclusion of Reporter's Name in Report: 19-3-307, the report shall include the name, address, and occupation of the person making the report.

Disclosure of Reporter Identity: 19-1-307, the identity of the reporter shall be protected.

Connecticut

Professionals Required to Report: 17a-101, physicians or surgeons, nurses, medical examiners, dentists, dental hygienists, physician assistants, pharmacists, or physical therapists, psychologists or other mental health professionals, school teachers, principals, guidance counselors, or coaches, social workers, police officers, juvenile or adult probation officers, or parole officers, members of the clergy, alcohol and drug counselors, marital and family therapists, professional counselors, sexual assault counselors, or battered women's counselors, emergency medical services providers, any person paid to care for a child in any public or private facility, child daycare center, group daycare home, or family daycare home that is licensed by the State Employees of the Department of Children and Families and the Department of Public Health who are responsible for the licensing of child daycare center, group daycare homes, family daycare homes, or youth camps, the Child Advocate and any employee of the Office of Child Advocate.

Reporting by Other Persons: 17a-103, any mandated reporter acting outside his or her professional capacity or any other person having reasonable cause to suspect that a child is being abused or neglected may report.

Standards for Making a Report: 17a-101a, when, in the ordinary course of their employment or profession, they have reasonable cause to suspect or believe that a child has been abused or neglected.

Inclusion of Reporter's Name in Report: 17a-101d; 17a-103, the reporter is not specifically required by statute to include his or her name in the report. The Commissioner shall use his or her best efforts to obtain the name and address of the reporter.

Disclosure of Reporter Identity: 17a-28, the identity of the reporter shall not be released to the subject of the report unless there is reasonable cause to believe that the reporter knowingly made a false report.

Delaware

Professionals Required to Report: Tit. 16, 903, physicians, dentists, interns, residents, osteopaths, nurses, or medical examiners, school employees, social workers or psychologists.

Reporting by Other Persons: Tit. 16, 903, any person who knows or in good faith suspects child abuse or neglect shall make a report.

Standards for Making a Report: Tit. 16, 903, when they know or in good faith suspect child abuse or neglect.

Privileged Communications: Tit. 16, 909, only the attorney-client and clergy-penitent privileges are recognized.

Inclusion of Reporter's Name in Report: Tit. 16, 905, although reports may be made anonymously, the division shall request the name and address of any person making a report.

Disclosure of Reporter Identity: Not addressed in statutes reviewed.

Florida

Professionals Required to Report: 39.201, physicians, osteopaths, medical examiners, chiropractors, nurses, or hospital personnel, other health or mental health professionals, practitioners who rely solely on spiritual means for healing, school teachers or other school officials or personnel, social workers, daycare center workers, or other professional childcare, foster care, residential, or institutional workers, law enforcement officers or judges.

Reporting by Other Persons: 39.201, any person who knows or has reasonable cause to suspect that a child is abused, abandoned, or neglected shall report.

Standards for Making a Report: 39.201, when they know or have reasonable cause to suspect that a child is abused, abandoned, or neglected.

Privileged Communications: 39.204, only the attorney-client and clergy-penitent privileges are permitted.

Inclusion of Reporter's Name in Report: 39.201, the professionals who are mandated reporters are required to provide their names to hotline staff.

Disclosure of Reporter Identity: 39.201; 39.202, the names of reporters are held confidential and may be released only: To the department, the central abuse hotline, law enforcement, or the appropriate State attorney (if the reporter consents to release in writing).

Georgia

Professionals Required to Report: 19-7-5; 16-12-100, physicians, hospital and medical personnel, podiatrists, dentists, or nurses, school teachers, administrators, guidance counselors, school social workers, or psychologists, counselors, social workers, or marriage and family therapists, child welfare agency personnel (including any child-caring institution, child-placing agency, maternity home, family daycare home, group daycare home, and daycare center), child-counseling personnel, or child service organization personnel, law enforcement personnel, persons who process or produce visual or printed matter.

Reporting by Other Persons: 19-7-5, any other person who has reasonable cause to believe that a child has been abused may report.

Standards for Making a Report: 19-7-5; 16-12-100, when they have reasonable cause to believe that a child has been abused, when they have reasonable cause to believe that the visual or printed matter submitted for processing or producing depicts a minor engaged in sexually explicit conduct.

Privileged Communications: 19-7-5, no privileged communications are permitted for mandatory reporters.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 49-5-41, any release of records shall protect the identity of any person reporting child abuse.

Hawaii

Professionals Required to Report: 350-1.1, physicians, physicians in training, psychologists, dentists, nurses, osteopathic physicians and surgeons, optometrists, chiropractors, podiatrists, pharmacists, and other health-related professionals, medical examiners or coroners. employees or officers of any public or private school; childcare

employees; employees or officers of any licensed or registered childcare facility, foster home, or similar institution. Employees or officers of any public or private agency or institution, or other individuals, providing social, medical, hospital, or mental health services, including financial assistance. Employees or officers of any law enforcement agency, including, but not limited to, the courts, police departments, correctional institutions, and parole or probation offices. Employees of any public or private agency providing recreational or sports activities.

Reporting by Other Persons: 350-1.3, any other person who becomes aware of facts or circumstances that cause the person to believe that child abuse or neglect has occurred may report.

Standards for Making a Report: 350-1.1, when, in their professional or official capacity, they have reason to believe that child abuse or neglect has occurred or that there exists a substantial risk that child abuse or neglect may occur in the reasonably foreseeable future.

Privileged Communications: § 350-5, the physician-patient, psychologist-client, husband-wife, and the victim-counselor privileges are not grounds for failing to report.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 350-1.4, every reasonable good faith effort shall be made by the department to maintain the confidentiality of the name of a reporter who requests that his or her name be confidential.

Idaho

Professionals Required to Report: 16-1619, physicians, residents on hospital staffs, interns, nurses, or coroners, school teachers or daycare personnel, social workers or law enforcement personnel.

Reporting by Other Persons: 16-1619, any person who has reason to believe that a child has been abused, abandoned, or neglected is required to report.

Standards for Making a Report: 16-1619, when they have reason to believe that a child has been abused, abandoned, or neglected. When they observe a child being subjected to conditions or circumstances which would reasonably result in abuse, abandonment, or neglect.

Privileged Communications:, 16-1619; 16-1620, any privilege between a husband and wife and any professional and client, except for the clergy-penitent or attorney-client privilege, shall not be grounds for failure to report.

Inclusion of Reporter's Name in Report: Not addressed in statutes reviewed.

Disclosure of Reporter Identity: Not addressed in statutes reviewed.

Illinois

Professionals Required to Report: Ch. 325, 5/4; Ch. 720, 5/11-20.2, physicians, hospital administrators and personnel, surgeons, physician assistants, osteopaths, chiropractors, genetic counselors, dentists, coroners, medical examiners, emergency medical technicians, nurses, acupuncturists, respiratory care practitioners, or home health aides. School personnel, directors or staff of nursery schools or child daycare centers, recreational program or facility personnel, childcare workers, or homemakers. Substance abuse treatment personnel, crisis line or hotline personnel, social workers, domestic violence program personnel, psychologists, psychiatrists, or counselors, social services administrators, foster parents, or field personnel of the Illinois Department of Public Aid, Public Health, Human Services, Corrections, Human Rights, or Children and Family Services, truant officers, law enforcement officers, probation officers, funeral home directors or employees, clergy members, commercial film and photographic print processors.

Reporting by Other Persons: Ch. 325, 5/4, any other person who has reasonable cause to believe that a child is abused or neglected may report.

Standards for Making a Report: Ch. 325, 5/4; Ch. 720, 5/11-20.2, when they have reasonable cause to believe that a child known to them in their professional capacity may be abused or neglected, commercial film and photographic print processors when they have knowledge of or observe any film, photograph, videotape, negative, or slide that depicts a child engaged in any sexual conduct.

Privileged Communications: Ch. 325, 5/4; Ch. 735, 5/8-803, the privileged quality of communication between any professional person required to report and his patient or client shall not apply to situations involving abused or neglected children and shall not constitute grounds for failure to report. A member of the clergy shall not be compelled to disclose a confession or admission made to him or her apart of the discipline of the religion.

Inclusion of Reporter's Name in Report: Ch. 325, 5/7.9, the report shall include the name, occupation, and contact information of the person making the report.

Disclosure of Reporter Identity: Ch. 325, 5/11.1a, any disclosure of information shall not identify the person making the report.

Indiana

Professionals Required to Report: 31-33-5-2. Any staff member of a medical or other public or private institution, school, facility, or agency.

Reporting by Other Persons: 31-33-5-1. Any person who has reason to believe that a child is a victim of abuse or neglect must report.

Standards for Making a Report: 31-33-5-1; 31-33-5-2. When they have reason to believe that a child is a victim of abuse or neglect.

Privileged Communications: 31-32-11-1. The following privileges are not permitted, and shall not be grounds for failing to report:

- Husband-wife privilege
- Health care provider-patient privilege
- Therapist-client privilege between a certified social worker, certified clinical social worker, or certified marriage and family therapist and a client of any of these professionals
- Any privilege between a school counselor or psychologist and a student

Inclusion of Reporter's Name in Report: 31-33-7-4. The written report must include the name and contact information for the person making the report.

Disclosure of Reporter Identity: 31-33-18-2. The identity of the reporter is protected whenever the report is made available to the subject of the report.

Iowa

Professionals Required to Report: 232.69; 728.14. Health practitioners, Social workers, school employees, certified para-educators, coaches, or instructors employed by community colleges, employees or operators of health care facilities, childcare centers, Head Start programs, family development and self-sufficiency grant programs, substance abuse programs or facilities, juvenile detention or juvenile shelter care facilities, foster care facilities, or mental health centers, employees of Department of Human services institutions, peace officers, counselors, or mental health professionals, commercial film and photographic print processors.

Reporting by Other Person: 232.69. Any other person who believes that a child has been abused may report.

Standards for Making a Report: 232.69; 728.14. When, in the scope of professional practice or their employment responsibilities, they reasonably believe that a child has been abused. A commercial film and photographic print processor who has knowledge of or observes a film, photograph, videotape, negative, or slide that depicts a minor engaged in a prohibited sexual act or in the simulation of a prohibited sexual act.

Privileged Communications: 232.74. The husband-wife or health practitioner-patient privilege does not apply to evidence regarding abuse to a child.

Inclusion of Reporter's Name in Report: 232.70. The report shall contain the name and address of the person making the report.

Disclosure of Reporter Identity: 232.71B. The department shall not reveal the identity of the reporter to the subject of the report.

Kansas

Professionals Required to Report: 38-1522. Physicians, dentists, optometrists, nurses, chief administrative officers of medical care facilities, or emergency medical services personnel, teachers, school administrators, or other school employees, licensed childcare providers, Psychologists, clinical psychotherapists, marriage and family therapists, social workers, clinical marriage and family therapists, professional counselors, or alcohol and drug abuse counselors, firefighters, mediators, law enforcement officers, or juvenile intake and assessment workers.

Reporting by Other Persons: 38-1522. Any other person who has reason to suspect that a child has been injured as a result of maltreatment may report.

Standards for Making a Report: 38-1522. When they have reason to suspect that a child has been injured as a result of maltreatment, When they know of the death of a child.

Privileged Communications: Not addressed in statutes reviewed.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 38-1507. Authorized disclosures of information shall not identify a reporter of a child in need of care.

Kentucky

Professionals Required to Report: 620.030. Physicians, osteopathic physicians, nurses, coroners, medical examiners, residents, interns, chiropractors, dentists, optometrists, emergency medical technicians, paramedics, or health professionals, teachers, school personnel, or child-caring personnel, social workers or mental health professionals, peace officers.

Reporting by Other Persons: 620.030. Any person who knows or has reasonable cause to believe that a child is dependent, neglected, or abused shall immediately report.
Standards for Making a Report: 620.030. When they know or have reasonable cause to believe that a child is dependent, neglected, or abused.

Privileged Communications: 620.050. Neither the husband-wife nor any professional-client/patient privilege, except the attorney-client and clergy-penitent privilege, shall be a

ground for refusing to report.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 620.050. The identity of the reporter shall not be disclosed except: To law enforcement officials, the agency investigating the report, or to a multidisciplinary team, under court order, after a court has found reason to believe the reporter knowingly made a false report.

Louisiana

Professionals Required to Report: Children's Code art. 603. Physicians, surgeons, physical therapists, dentists, residents, interns, hospital staff members, podiatrists, chiropractors, licensed nurses, nursing aides, dental hygienists, emergency medical technicians, paramedics, optometrists, coroners, or medical examiners, psychiatrists, psychologists, marriage or family counselors, or social workers, members of the clergy, including priest, rabbis, deacons or ministers, christian science practitioners, or other similar functionary of a religious organization, teachers, childcare providers, school principals, teacher's aides, school staff members, foster home parents, or group home or other childcare institutional staff members, personnel of residential home facilities, daycare providers, or any individuals who provide such services to children, police officers, law enforcement officials, or probation officers, commercial film or photographic print processors, mediators.

Reporting by Other Persons: Children's Code art. 609. Any other person who has cause to believe that a child's health is endangered as a result of abuse or neglect may report.

Standards for Making a Report: Children's Code art. 609; 610. When they have cause to believe that a child's health is endangered as a result of abuse or neglect, commercial film or photographic print processors when they have knowledge of or observe any film, photograph, videotape, negative, or slide depicting a child that constitutes child pornography.

Privileged Communications: Children's Code art. 603. Only the clergy-penitent privilege is permitted. No claim to privilege by other professionals is permitted.

Inclusion of Reporter's Name in Report: Children's Code art. 610. The report must include the name and address of the reporter.

Disclosure of Reporter Identity: Rev. Stat. 46:56. The identity of the reporter shall not be released unless a court finds that the reporter knowingly made a false report.

Maine

Professionals Required to Report: Tit. 22, 4011-A. Allopathic and osteopathic physicians, emergency medical services persons, medical examiners, podiatrists, physicians' assistants, dentists, dental hygienists and assistants, chiropractors, nurses, home health aides, medical or social service workers, teachers, guidance counselors, school officials, children's summer camp administrators or counselors, or childcare personnel, social workers, psychologists, or mental health professionals, Court Appointed Special Advocates, guardians ad litem, homemakers, law enforcement officials, fire inspectors, municipal code enforcement officials, or chairs of licensing boards that have jurisdiction over mandated reporters, commercial film and photographic print processors, clergy members acquiring the information as a result of clerical professional work except for information received during confidential communications, humane agents employed by the Department of Agriculture, Food and Rural Resources.

Reporting by Other Persons: Tit. 22, 4011-A. Any other person who knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected may report.

Standards for Making a Report: Tit. 22, 4011-A. When the person knows or has reasonable cause to suspect that a child is or is likely to be abused or neglected.

Privileged Communications: Tit. 22, 4011-A. A member of the clergy may claim privilege when information is received during a confidential communication. The husband-wife and physician and psychotherapist-patient privileges cannot be invoked as a reason not to report.

Inclusion of Reporter's Name in Report: Tit. 22, 4012. The report shall include the name, occupation, and contact information for the person making the report.

Disclosure of Reporter Identity: Tit. 22, 4008. The identity of the reporter is protected in any release of information to the subject of the report.

Maryland

Professionals Required to Report: Fam. Law 5-704. Health practitioners, educators or human service workers, police officers.

Reporting by Other Persons: Fam. Law 5-705. Any other person who has reason to believe that a child has been subjected to abuse or neglect must report.

Standards for Making a Report: Fam. Law 5-704; 5-705. When, acting in a professional capacity, the person has reason to believe that a child has been subjected to abuse or

neglect.

Privileged Communications: Fam. Law 5-705. Only the attorney-client and clergy-penitent privileges are permitted.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: Not addressed in statutes reviewed.

Massachusetts

Professionals Required to Report: Ch. 119, 51A. Physicians, hospital personnel, medical examiners, emergency medical technicians, dentists, nurses, chiropractors, optometrists, or psychiatrists, teachers, educational administrators, daycare workers or persons paid to care for or work with children in facilities that provide daycare or residential services, family daycare systems and childcare food programs, or school attendance officers psychologists, social workers, licensed allied mental health and human services professionals, drug and alcoholism counselors, clinical social workers, or guidance or family counselors, probation officers, clerk or magistrates of district courts, parole officers, foster parents, firefighters or police officers, priests, rabbis, clergy members, ministers, leaders of any church or religious body, accredited christian science practitioners, persons performing official duties on behalf of a church or religious body, leader of any church or religious body, or persons employed by a church or religious body to supervise, educate, coach, train, or counsel a child on a regular basis.

Reporting by Other Persons: Ch. 119, 51A. Any other person who has reasonable cause to believe that a child is suffering from abuse or neglect may report.

Standards for Making a Report: Ch. 119, 51A. When, in his or her professional capacity, the person has reasonable cause to believe that a child is suffering injury from abuse or neglect that inflicts harm or a substantial risk of harm.

Privileged Communications: Ch. 119, 51A. A clergy member shall report all cases of abuse, but need not report information gained in a confession or other confidential communication. Any other privilege relating to confidential communications shall not prohibit the filing of a report.

Inclusion of Reporter's Name in Report: Ch. 119, 51A. Reports shall include the name of the reporter.

Disclosure of Reporter Identity: Not addressed in statutes reviewed

Michigan

Professionals Required to Report: Physicians, physician assistants, dentists, dental hygienists, medical examiners, nurses, persons licensed to provide emergency medical care, or audiologists, school administrators, counselors, or teachers, regulated childcare providers, psychologists, marriage and family therapists, licensed professional counselors, social workers, or social work technicians, law enforcement officers, members of the clergy, department employees, including eligibility specialists, family independence managers, family independence specialists, social services specialists, social work specialists, social work specialist managers, or welfare services specialists.

Reporting by Other Persons: 722.624. Any other person, including a child, who has reasonable cause to suspect child abuse or neglect, may report.

Standards for Making a Report: 722.623. When they have reasonable cause to suspect child abuse or neglect.

Privileged Communications: 722.631. Only the attorney-client or clergy-penitent privilege can be grounds for not reporting.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 722.627. The identity of the reporter is protected in any release of information to the subject of the report.

Minnesota

Professionals Required to Report: 626.556, Subd. 3. A professional or professional's delegate who is engaged in the practice of the healing arts, hospital administration, psychiatric treatment, childcare, education, psychological treatment, social services, or law enforcement, members of the clergy.

Reporting by Other Persons: 626.556, Subd. 3. Any other person may voluntarily report if the person knows, has reason to believe, or suspects that a child is being neglected or subjected to sexual or physical abuse.

Standards for Making a Report: 626.556, Subd. 3 When they know or have reason to believe that a child is being neglected or sexually or physically abused.

Privileged Communications: 626.556, Subd. 3 & 8. A member of the clergy is not required by this subdivision to report information that is otherwise privileged under 595.02, subdivision 1, paragraph (c). No evidence relating to the neglect or abuse of a child or to any prior incidents of neglect or abuse involving any of the same persons

accused of neglect or abuse shall be excluded in any proceeding on the grounds of privilege set forth in section 595.02, subdivision 1, paragraph (a) [husband-wife], (d) [medical practitioner patient], or (g) [mental health professional-client].

Inclusion of Reporter's Name in Report: 626.556, Subd. 7. The report must include the name and address of the reporter.

Disclosure of Reporter Identity: 626.556, Subd. 11. The name of the reporter shall be kept confidential while the report is under investigation. After the investigation is complete, the subject of the report may compel disclosure of the name only upon the reporter's consent or a finding by the court that the report was false and made in bad faith.

Mississippi

Professionals Required to Report: 43-21-353. Physicians, dentists, interns, residents, or nurses, public or private school employees or childcare givers, psychologists, social workers, or child protection specialists, attorneys, ministers, or law enforcement officers.

Reporting by Other Persons: 43-21-353. All other persons who have reasonable cause to suspect that a child is abused or. neglected must report.

Standards for Making a Report: 43-21-353. When they have reasonable cause to suspect that a child is abused or neglected.

Privileged Communications: Not addressed in statutes reviewed.

Inclusion of Reporter's Name in Report: 43-21-353. The department's report shall include the name and address of the reporter, if known, and whether he or she is a material witness to the abuse.

Disclosure of Reporter Identity: 43-21-353. The identity of the reporting party shall not be disclosed to anyone other than law enforcement officers or prosecutors without an order from the appropriate youth court.

Missouri

Professionals Required to Report: 210.115; 568.110; 352.400. Physicians, medical examiners, coroners, dentists, chiropractors, optometrists, podiatrists, residents, interns, nurses, hospital and clinic personnel, or other health practitioners, daycare center workers or other childcare workers, teachers, principals, or other school officials, psychologists, mental health professionals, social workers, ministers, which includes clergyperson, priest, rabbi, christian science practitioner, or other person serving in a similar capacity for any religious organization, juvenile officers, probation, parole officers, or peace

officers, law enforcement officials, or jail or detention center personnel, other persons with responsibility for the care of children, commercial film and photographic print processors, computer providers, installers, or repair persons, or Internet service providers.

Reporting by Other Persons: 210.115. Any other person who has reasonable cause to suspect that a child has been subjected to abuse may report.

Standards for Making a Report: 210.115; 568.110.When they have reasonable cause to suspect that a child has been subjected to abuse or neglect, when they observe a child being subjected to conditions or circumstances that would reasonably result in abuse or neglect, commercial film and photographic print processors when they have knowledge of or observe any film, photograph, videotape, negative, slide, or computer-generated image or picture depicting a child engaged in an act of sexual conduct.

Privileged Communications: 210.140. Only the attorney-client or clergy-penitent privilege may be grounds for failure to report.

Inclusion of Reporter's Name in Report: 210.130. The report must include the name, address, occupation, and contact information for the person making the report.

Disclosure of Reporter Identity: 210.150. The names or other identifying information of reporters shall not be furnished to any child, parent, guardian, or alleged perpetrator named in the report.

Montana

Professionals Required to Report: 41-3-201. Physicians, residents, interns, members of hospital staffs, nurses, osteopaths, chiropractors, podiatrists, medical examiners, coroners, dentists, optometrists, or any other health professionals, school teachers, other school officials, employees who work during regular school hours, operators or employees of any registered or licensed day-care or substitute care facility, or any other operators or employees of child care facilities, mental health professionals or social workers, christian science practitioners or religious healers, foster care, residential, or institutional workers, members of clergy, guardians ad litem or court appointed advocates authorized to investigate a report, peace officers or other law enforcement officials.

Reporting by Other Persons: 41-3-201. Any other person who knows or has reasonable cause to suspect that a child is abused or neglected may report.

Standards for Making a Report: 41-3-201. When they know or have reasonable cause to suspect, as a result of information they receive in their professional or official capacity, that a child is abused or neglected.

Privileged Communications: 41-3-201. A person listed as a mandated reporter may not refuse to make a report as required in this section on the grounds of a physician-patient or similar privilege. A member of the clergy or priest is not required to make a report under this section if the communication is required to be confidential by canon law, church doctrine, or established church practice.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 41-3-201. The identity of the reporter shall not be disclosed in any release of information to the subject of the report.

Nebraska

Professionals Required to Report: 28-711. Physicians, medical institutions, nurses, school employees, social workers.

Reporting by Other Persons: 28-711. All other persons who have reasonable cause to believe that a child has been subjected to abuse or neglect must report.

Standards for Making a Report: 28-711. When they have reasonable cause to believe that a child has been subjected to abuse or neglect. When they observe a child being subjected to conditions or circumstances that reasonably would result in abuse or neglect.

Privileged Communications: 28-714. The physician-patient, counselor-client, and husband-wife privileges shall not be grounds for failing to report.

Inclusion of Reporter's Name in Report: 28-711. The initial oral report shall include the reporter's name and address.

Disclosure of Reporter Identity: 28-719. The name and address of the reporter shall not be included in any release of information.

Nevada

Professionals Required to Report: 432B.220. Physicians, dentists, dental hygienists, chiropractors, optometrists, podiatrists, medical examiners, residents, interns, nurses, or physician assistants, emergency medical technicians, other persons providing medical services, or hospital personnel, coroners, school administrators, teachers, counselors, or librarians, any persons who maintain or are employed by facilities or establishments that provide care for children, children's camps, or other facilities, institutions, or agencies furnishing care to children, psychiatrists, psychologists, marriage and family therapists, alcohol or drug abuse counselors, athletic trainers, or social workers, clergymen,

practitioners of christian science, or religious healers, unless they have acquired the knowledge of the abuse or neglect from the offenders during confessions, persons licensed to conduct foster homes, officers or employees of law enforcement agencies or adult or juvenile probation officers, attorneys, unless they have acquired the knowledge of the abuse or neglect from clients who are, or may be, accused of the abuse or neglect, any person who is employed by or serves as a volunteer for an approved youth shelter, any adult person who is employed by an entity that provides organized activities for children, any person who maintains, is employed by, or serves as a volunteer for an agency or service that advises persons regarding abuse or neglect of a child and refers them to services.

Reporting by Other Persons: 432B.220. Any other person may report.

Standards for Making a Report: 432B.220. When, in their professional capacity, they know or have reason to believe that a child is abused or neglected, when they have reasonable cause to believe that a child has died as a result of abuse or neglect.

Privileged Communications: 432B.220; 432B.250. The clergy-penitent privilege applies when the knowledge is gained during religious confession. The attorney-client privilege applies when the knowledge is acquired from a client who is or may be accused of abuse. Any other person who is required to report may not invoke privilege for failure to make a report.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 432B.290. The identity of the reporter is kept confidential.

New Hampshire

Professionals Required to Report: 169-C:29. Physicians, surgeons, county medical examiners, psychiatrists, residents, interns, dentists, osteopaths, optometrists, chiropractors, nurses, hospital personnel, or christian science practitioners, teachers, school officials, nurses, or counselors, daycare workers or any other child or foster care workers, social workers, psychologists or therapists, priests, ministers, or rabbis, law enforcement officials.

Reporting by Other Persons: 169-C:29. All other persons who have reason to suspect that a child has been abused or neglected must report.
Standards for Making a Report: 169-C:29. When they have reason to suspect that a child has been abused or neglected.

Privileged Communications: 169-C:32. Only the attorney-client privilege is permitted.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: Not addressed in statutes reviewed.

New Jersey

Professionals Required to Report: None specified in statute.

Reporting by Other Persons: 9:6-8.10. Any person having reasonable cause to believe that a child has been subjected to child abuse or acts of child abuse shall report.

Standards for Making a Report: 9:6-8.10. When they have reasonable cause to believe that a child has been subjected to abuse.

Privileged Communications: Not addressed in statutes reviewed.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 9:6-8.10a. The identity of the reporter shall not be made public. Any information that could endanger any person shall not be released.

New Mexico

Professionals Required to Report: 32A-4-3. Physicians, residents, or interns, law enforcement officers or judges, nurses, teachers or school officials, social workers, members of the clergy.

Reporting by Other Persons: 32A-4-3. Every person who knows or has a reasonable suspicion that a child is an abused or a neglected child shall report the matter immediately.

Standards for Making a Report: 32A-4-3. When they know or have a reasonable suspicion that a child is abused or neglected.

Privileged Communications: 32A-4-3; 32A-4-5. A clergy member need not report any information that is privileged. The report or its contents or any other facts related thereto or to the condition of the child who is the subject of the report shall not be excluded on the ground that the matter is or may be the subject of a physician patient privilege or similar privilege or rule against disclosure.

Inclusion of Reporter's Name in Report: Not specifically required in statute

Disclosure of Reporter Identity: 32A-4-33. Any release of information to a parent, guardian, or legal custodian shall not include identifying information about the reporter.

New York

Professionals Required to Report: Soc. Serv. Law 413. Physicians, physician assistants, surgeons, medical examiners, coroners, dentists, dental hygienists, osteopaths, optometrists, chiropractors, podiatrists, residents, interns, nurses, hospital personnel, emergency medical technicians, or christian science practitioners, school officials, social workers, social services workers, daycare center workers, providers of family or group family daycare, employees or volunteers in a residential care facility, or any other childcare or foster care worker, psychologists, therapists, mental health professionals, substance abuse counselors, or alcoholism counselors, police officers, district attorneys or assistant district attorneys, investigators employed in the office of a district attorney, or other law enforcement officials.

Reporting by Other Persons: Soc. Serv. Law 414. Any other person who has reasonable cause to suspect that a child is abused or maltreated may report.

Standards for Making a Report: Soc. Serv. Law 413. When they have reasonable cause to suspect that a child coming before them in their professional or official capacity is an abused or maltreated child. Where the parent, guardian, custodian, or other person legally responsible for the child comes before the reporter and states from personal knowledge facts, conditions, or circumstances that, if correct, would render the child an abused or maltreated child.

Privileged Communications: Not addressed in statutes reviewed.

Inclusion of Reporter's Name in Report: Soc. Serv. Law 415. The report shall include the name and contact information for the reporter.

Disclosure of Reporter Identity: Soc. Serv. Law 422-a. Any disclosure of information shall not identify the source of the report.

North Carolina

Professionals Required to Report: 7B-301. Any institution

Reporting by Other Persons: 7B-301. All persons who have cause to suspect that any juvenile is abused, neglected, or dependent, or has died as the result of maltreatment, shall report.

Standards for Making a Report: 7B-301. When they have cause to suspect that any juvenile is abused, neglected, or dependent, or has died as the result of maltreatment.

Privileged Communications: 7B-310. No privilege shall be grounds for failing to report. Only the attorney-client privilege shall be grounds for excluding evidence of abuse in any judicial proceeding.

Inclusion of Reporter's Name in Report: 7B-301. The report must include the name, address, and telephone number of the reporter.

Disclosure of Reporter Identity: 7B-302. The department shall hold the identity of the reporter in strictest confidence.

North Dakota

Professionals Required to Report: 50-25.1-03. Physicians, nurses, dentists, optometrists, medical examiners or coroners, or any other medical or mental health professionals or religious practitioners of the healing arts, school teachers, administrators, or school counselors, addiction counselors or social workers, daycare center or any other childcare workers, police or law enforcement officers, members of the clergy.

Reporting by Other Persons: 50-25.1-03. Any other person who has reasonable cause to suspect that a child is abused or neglected may report.

Standards for Making a Report: 50-25.1-03. When they have knowledge of or reasonable cause to suspect that a child is abused or neglected if the knowledge or suspicion is derived from information received by that person in that person's official or professional capacity.

Privileged Communications: 50-25.1-03; 50-25.1-10. A member of the clergy is not required to report such circumstances if the knowledge or suspicion is derived from information received in the capacity of spiritual adviser. Any privilege of communication between husband and wife or between any professional person and the person's patient or client, except between attorney and client, cannot be used as grounds for failing to report.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 50-25.1-11. The identity of the reporter is protected.

Ohio

Professionals Required to Report: 2151.421. Physicians, residents, interns, podiatrists, dentists, nurses, other health care professionals, speech pathologists, audiologists, coroners, licensed school psychologists; administrators or employees of child daycare centers, residential camps, or child day camps; school teachers, employees, or authorities licensed psychologists, marriage and family therapists, social workers, professional counselors, or agents of county humane societies, persons rendering spiritual treatment through prayer in accordance with the tenets of a well recognized religion, CEU Superintendent, board member, or employee of a county board of mental retardation; investigative agent contracted with by a county board of mental retardation; or employee of the department of mental retardation and developmental disabilities Attorneys.

Reporting by Other Persons: 2151.421. Any other person who suspects that a child has suffered or faces a threat of suffering from abuse or neglect may report.

Standards for Making a Report: 2151.421. When a mandated person is acting in an official or professional capacity and knows or suspects that a child has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child.

Privileged Communications: 2151.421. The attorney-client or physician-patient privilege is waived if the client or patient is a child who is suffering or faces the threat of suffering any physical or mental injury. The physician-patient privilege shall not be a ground for excluding evidence regarding a child's injuries, abuse, or neglect, or the cause of the injuries, abuse, or neglect in any judicial proceeding resulting from a report.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 2151.421. The name of the person who made the report shall not be released.

Oklahoma

Professionals Required to Report: Tit. 10, 7103-7104; Tit. 21, § 1021.4. Physicians, surgeons, residents, interns, dentists, osteopaths, nurses, or other health care professionals, teachers, commercial film and photographic print processors.

Reporting by Other Persons: Tit. 10, 7103. Any person who has reason to believe that a child is a victim of abuse or neglect must report.

Standards for Making a Report: Tit. 10, 7103-7104; Tit. 21, 1021.4. When they have reason to believe that a child is a victim of abuse or neglect, when a health care professional treats the victim of what appears to be criminally injurious conduct, including, but not limited to, child physical or sexual abuse, when a health care professional attends the birth of a child who tests positive for alcohol or a controlled dangerous substance, when any commercial film and photographic print processor has knowledge of or observes any film, photograph, video tape, negative, or slide, depicting a child engaged in an act of sexual conduct.

Privileged Communications: Tit. 10, 7103. No privilege shall relieve any person from the requirement to report.

Inclusion of Reporter's Name in Report: Tit. 10, 7108. Reports may be made anonymously.

Disclosure of Reporter Identity: Tit. 10, 7109. The department shall not release the identity of the person who made the initial report unless a court orders the release of information for good cause shown.

Oregon

Professionals Required to Report: 419B.005. Physicians, interns, residents, optometrists, dentists, emergency medical technicians, naturopathic physicians, or nurses, employees of the Department of Human Resources, State Commission on Children and Families, Childcare Division of the Employment Department, the Oregon Youth Authority, a county health department, a community mental health and developmental disabilities program, a county juvenile department, a licensed child-caring agency, or an alcohol and drug treatment program, school employees, childcare providers, psychologists, members of clergy, social workers, foster care providers, counselors, or marriage and family therapists, peace officers, attorneys, firefighters, or court appointed special advocates, members of the legislative assembly.

Reporting by Other Persons: 419B.015: Any person may voluntarily make a report.

Standards for Making a Report: 419B.010. When any public or private official has reasonable cause to believe that any child with whom the official comes in contact has suffered abuse.

Privileged Communications: 419B.010. A psychiatrist, psychologist, member of the clergy, or attorney shall not be required to report if such communication is privileged under law. An attorney is not required to make a report of information communicated to the attorney in the course of representing a client, if disclosure of the information would be detrimental to the client.

Inclusion of Reporter's Name in Report: Not specifically required in statute

Disclosure of Reporter Identity: 419B.035. The name, address, and other identifying information about the person who made the report may not be disclosed.

Pennsylvania

Professionals Required to Report: Ch. 23, 6311. Physicians, osteopaths, medical examiners, coroners, funeral directors, dentists, optometrists, chiropractors, nurses, hospital personnel, or christian science practitioners, members of the clergy, school administrators, teachers, or school nurses, social services workers, daycare center workers, or any other childcare or foster care workers, or mental health professionals, peace officers or law enforcement officials.

Reporting by Other Persons: Ch. 23, 6312. Any person who has reason to suspect that a child is abused may report.

Standards for Making a Report: Ch. 23, 6311. When, in the course of their employment, occupation, or practice of their profession, they have reasonable cause to suspect, on the basis of their medical, professional, or other training and experience, that a child coming before them is an abused child.

Privileged Communications: Ch. 23, 6311. Except for confidential communications made to an ordained member of the clergy that are protected under 42 Pa.C.S. 5943 (relating to confidential communications to clergymen), the privileged communication between any professional person required to report and the patient or client of that person shall not apply to situations involving child abuse and shall not constitute grounds for failure to report.

Inclusion of Reporter's Name in Report: Ch. 23, 6313. Mandated reporters must make a written report that includes their name and contact information.

Disclosure of Reporter Identity: Ch. 23, 6340. The release of the identity of the mandated reporter is prohibited unless the secretary finds that the release will not be detrimental to the safety of the reporter.

Rhode Island

Professionals Required to Report: 40-11-6. Any physician or duly certified registered nurse practitioner.

Reporting by Other Persons: 40-11-3(a). Any person who has reasonable cause to know or suspect that a child has been abused or neglected must report.

Standards for Making a Report: 40-11-3(a); 40-11-6. When they have reasonable cause to know or suspect that a child has been abused or neglected. When any physician or nurse practitioner has cause to suspect that a child brought to them for treatment is an abused or neglected child or when they determine that a child under the age of 12 years is suffering from any sexually transmitted disease.

Privileged Communications: 40-11-11. The privileged quality of communication between husband and wife and any professional person and his or her patient or client, except that between attorney and client, shall not constitute grounds for failure to report.

Inclusion of Reporter's Name in Report: Not specifically required in statute

Disclosure of Reporter Identity: Not addressed in statutes reviewed

South Carolina

Professionals Required to Report: 20-7-510. Physicians, nurses, dentists, optometrists, medical examiners, or coroners, any other medical, emergency medical services, or allied health professionals, school teachers or counselors, principals, or assistant principals, childcare workers in any childcare centers or foster care facilities, mental health professionals, social or public assistance workers, or substance abuse treatment staff, members of the clergy including christian science practitioners or religious healers, police or law enforcement officers, judges, funeral home directors or employees, persons responsible for processing films or computer technicians.

Reporting by Other Persons: 20-7-510. Any other person who has reason to believe that a child's physical or mental health or welfare has been or may be adversely affected by abuse and neglect may report.

Standards for Making a Report: 20-7-510. When in their professional capacity they have received information which gives them reason to believe that a child has been or may be abused or neglected.

Privileged Communications: 20-7-550. The privileged quality of communication between husband and wife and any professional person and his patient or client, except that between attorney and client or clergy member, including Christian Science Practitioner or religious healer, and penitent, does not constitute grounds for failure to report.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 20-7-510. The identity of the person making a report pursuant to this section must be kept confidential by the agency or department receiving the report and must not be disclosed.

South Dakota

Professionals Required to Report: 26-8A-3. Physicians, dentists, osteopaths, chiropractors, optometrists, nurses, coroners, teachers, school counselors or officials, child welfare providers, mental health professionals or counselors, psychologists, social workers, chemical dependency counselors, employees or volunteers of domestic abuse shelters, or religious healing practitioners, parole or court services officers or law enforcement officers, any safety-sensitive position, as defined in 23-3-64

Reporting by Other Persons: 26-8A-3. Any person who knows or has reasonable cause to suspect that a child has been abused or neglected may report.
Standards for Making a Report: 26-8A-3. When they have reasonable cause to suspect that a child has been abused or neglected.

Privileged Communications: 26-8A-15. The following privileges may not be claimed as a reason for not reporting: Physician-patient, husband-wife, school counselor-student, social worker-client.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 26-8A-11.1. The name of the reporter is not disclosed unless: The report is determined to be unsubstantiated within 30 days, the subject of the report requests disclosure of the reporter's identity. A hearing is held to determine whether the report was made with malice and without reasonable foundation and that release of the name will not endanger the life or safety of the reporter.

Tennessee

Professionals Required to Report: 37-1-403; 37-1-605. Physicians, osteopaths, medical examiners, chiropractors, nurses, hospital personnel, or other health or mental health professionals, school teachers, other school officials or personnel, daycare center workers, or other professional childcare, foster care, residential, or institutional workers, social workers, practitioners who rely solely on spiritual means for healing, judges or law enforcement officers, neighbors, relatives, or friends.

Reporting by Other Persons: 37-1-403; 37-1-605. Any person who has knowledge that a child has been harmed by abuse or neglect must report.
Standards for Making a Report: 37-1-403; 37-1-605. When they have knowledge that a child has been harmed by abuse or neglect, when they are called upon to render aid to any

child who is suffering from an injury that reasonably appears to have been caused by abuse, when they know or have reasonable cause to suspect that a child has been sexually abused.

Privileged Communications: 37-1-411. The following privileges may not be claimed: Husband-wife, Psychiatrist-patient or psychologist-patient

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 37-1-409. The name of the reporter shall not be released, except as may be ordered by the court.

Texas

Professionals Required to Report: Fam. Code 261.101. A professional, for purposes of the reporting laws, is an individual who is licensed or certified by the state or who is an employee of a facility licensed, certified, or operated by the state and who, in the normal course of official duties or duties for which a license or certification is required, has direct contact with children, teachers or daycare employees, nurses, doctors, or employees of a clinic or health care facility that provides reproductive services, juvenile probation officers or juvenile detention or correctional officers.

Reporting by Other Persons: Fam. Code 261.101. A person who has cause to believe that a child has been adversely affected by abuse or neglect shall immediately make a report.

Standards for Making a Report: Fam. Code 261.101. When they have cause to believe that a child has been adversely affected by abuse or neglect.

Privileged Communications: Fam. Code 261.101: No privilege may be claimed to exempt a person from the duty to report.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: Fam. Code 261.201. The identity of the reporter is confidential and may not be disclosed to the subject of the report.

Utah

Professionals Required to Report: 62A-4a-403. Any person licensed under the Medical Practice Act or the Nurse Practice Act.

Reporting by Other Persons: 62A-4a-403. Any person who has reason to believe that a child has been subjected to abuse or neglect must report.

Standards for Making a Report: 62A-4a-403. When they have reason to believe that a child has been subjected to abuse or neglect, when they observe a child being subjected to conditions or circumstances that would reasonably result in sexual abuse, physical abuse, or neglect.

Privileged Communications: 62A-4a-403. The requirement to report does not apply to a clergyman or priest, without the consent of the person making the confession, with regard to any confession made to him in his professional character in the course of discipline enjoined by the church to which he belongs.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 62A-4a-412. The name and contact information of the reporter shall be deleted prior to any release of records to the subject of the report.

Vermont

Professionals Required to Report: Tit. 33, 4913. Physicians, surgeons, osteopaths, chiropractors, physician's assistants, hospital administrators, nurses, medical examiners, dentists, psychologists, or other health care providers, school superintendents, school teachers, school librarians, daycare workers, school principals, school guidance counselors, mental health professionals, or social workers, probation officers, police officers, camp owners, camp administrators or counselors, members of the clergy.

Reporting by Other Persons: Tit. 33, 4913. Any other person who has reasonable cause to believe that a child has been abused or neglected may report.

Standards for Making a Report: Tit. 33, 4913. When they have reasonable cause to believe that a child has been abused or neglected.

Privileged Communications: Tit. 33, 4913. A member of the clergy is not required to report if the knowledge comes from a communication that is required to be kept confidential by religious doctrine.

Inclusion of Reporter's Name in Report: Tit. 33, 4914. Reports shall contain the name and address of the reporter.

Disclosure of Reporter Identity. Tit. 33, 4913. The name of the person making the report shall be confidential unless: The person making the report requests disclosure.
A court determines that the report was not made in good faith.

Virginia

Professionals Required to Report: 63.2-1509. Persons licensed to practice medicine or any of the healing arts, hospital residents or interns, nurses, or duly accredited christian science practitioners, teachers or other persons employed in public or private schools, kindergartens, or nursery schools; persons providing childcare full-time or part-time for pay on a regularly planned basis, social workers, mental health professionals, or any person responsible for the care, custody, and control of children, probation officers, law enforcement officers, mediators, or court-appointed special advocates.

Reporting by Other Persons: 63.2-1510. Any person who suspects that a child is abused or neglected may report.

Standards for Making a Report: 63.2-1509. When, in their professional or official capacity, they have reason to suspect that a child is abused or neglected.

Privileged Communications: 63.2-1519. The physician-patient or husband-wife privilege is not permitted.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: Not addressed in statutes reviewed.

Washington

Professionals Required to Report: 26.44.030. Practitioners, county coroners or medical examiners, pharmacists, or nurses, professional school personnel or childcare providers Social service counselors or psychologists, employees of the State Department of Social and Health Services, juvenile probation officers, law enforcement officers, personnel of the Department of Corrections, or placement and liaison specialists, responsible living skills program staff, HOPE center staff, State family and children's ombudsman, or any volunteer in the ombudsman's office, any adult with whom a child resides.

Reporting by Other Persons: 26.44.030. Any person who has reasonable cause to believe that a child has suffered abuse or neglect may report.

Standards for Making a Report: 26.44.030. When they have reasonable cause to believe that a child has suffered abuse or neglect.

Privileged Communications: 26.44.060. Making a report shall not be considered a violation of any of the following privileges: clergy-penitent, physician or optometrist-patient, psychologist-client.

Inclusion of Reporter's Name in Report: 26.44.030. The department shall make reasonable efforts to learn the name, address, and telephone number of the reporter.

Disclosure of Reporter Identity: 26.44.030. The department shall provide assurances of appropriate confidentiality of information in the report.

West Virginia

Professionals Required to Report: 49-6A-2. Medical, dental, or mental health professionals; emergency medical services personnel, school teachers or other school personnel; childcare workers or foster care workers, christian science practitioners or religious healers, social service workers, peace officers or law enforcement officials, circuit court judges, family law masters, employees of the division of juvenile services, or magistrates, members of the clergy.

Reporting by Other Persons: 49-6A-2. Any person who has reasonable cause to suspect that a child is abused or neglected may report.

Standards for Making a Report: 49-6A-2. When they have reasonable cause to suspect that a child is abused or neglected. When they observe the child being subjected to conditions that are likely to result in abuse or neglect. When they believe that a child has suffered serious physical abuse or sexual abuse or sexual assault.
Privileged Communications: 49-6A-7. The privileged quality of communications between husband and wife and between any professional person and his patient or his client, except that between attorney and client, cannot be invoked in situations involving suspected or known child abuse or neglect.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: Not addressed in statutes reviewed.

Wisconsin

Professionals Required to Report: 48.981. Physicians, coroners, medical examiners, nurses, dentists, chiropractors, optometrists, acupuncturists, other medical or mental health professionals, physical therapists, dietitians, occupational therapists, speech language pathologists, audiologists, or emergency medical technicians, school teachers, administrators or counselors, childcare workers in daycare centers, group homes, or residential care centers, or daycare providers, alcohol or other drug abuse counselors, marriage and family therapists, or professional counselors, social workers, public assistance workers, first responders, police or law enforcement officers, mediators, or court appointed special advocates, members of the clergy or a religious order, including

brothers, ministers, monks, nuns, priests, rabbis, or sisters.

Reporting by Other Persons: 48.981. Any person, including an attorney, who has reason to suspect that a child has been abused or neglected or who has reason to believe that a child has been threatened with abuse or neglect and that abuse or neglect of the child will occur may report.

Standards for Making a Report: 48.981. When, in the course of their professional duties, they have reasonable cause to suspect that a child has been abused or neglected. When, in the course of their professional duties, they have reason to believe that a child has been threatened with abuse or neglect or that abuse or neglect will occur.

Privileged Communications: 48.981. A member of the clergy is not required to report child abuse information that he or she receives solely through confidential communications made to him or her privately or in a confessional setting.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 48.981. The identity of the reporter shall not be disclosed to the subject of the report.

Wyoming

Professionals Required to Report: None specified in statute.

Reporting by Other Persons: 14-3-205. All persons must report.

Standards for Making a Report: 14-3-205. When they know or have reasonable cause to believe or suspect that a child has been abused or neglected. When they observe any child being subjected to conditions or circumstances that would reasonably result in abuse or neglect.

Privileged Communications: 14-3-210. Only the clergy-penitent and attorney-client privileges are permitted.

Inclusion of Reporter's Name in Report: 14-3-206. The reporter is not specifically required to provide his or her name in the written report. If photographs or x-rays of the child are taken, the person taking them must be identified.

Disclosure of Reporter Identity: Not addressed in statutes reviewed.

Typical Minimum Reporting Requirements

Typically, minimum requirements for what must be reported include:

- A description of how the reporter learned of the injuries or neglect and of any actions taken to assist
- Information on previous injuries, assaults, neglect or financial abuses
- The date, time, nature, and extent of the abuse or neglect* The date of the report
- The perpetrator's name, address, and relationship to the (possible) victim
- The reporter's name, agency, position, address, telephone number, and signature

Abuse or neglect suspected at an institution or facility

Mandated reporters are required to file a report whenever there is reasonable cause to suspect or believe any resident of a care facility has been abused or neglected by a staff member of a public or private institution or facility that provides care. Whenever the results of an investigation leads to the conclusion that there is reasonable cause to believe that that there has been abuse or neglect perpetrated by staff, then the institution, school or facility must provide records concerning the investigation to the appropriate investigating agency and/or to the agency that licensed the facility. An institution may suspend employee(s) during an investigation, or, at the conclusion of an investigation, may impose penalties in addition to any separate penalties resulting from civil litigation or criminal prosecution. Employers may not discharge, discriminate or retaliate against an employee for making a good faith report or for testifying at an abuse or neglect proceeding *(Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse').*

Anonymity and immunity

Mandated reporters are usually required to identify themselves by name when making a report, but may request anonymity to protect their privacy. A mandated reporter who knowingly makes a false report will ordinarily have their identity disclosed to the appropriate law enforcement agency, and their identity may be disclosed to the alleged perpetrator of the reported abuse or neglect. A mandated reporter may be subject to penalties, though immunity from civil or criminal liability is granted to reporters who report in good faith. Immunity is also granted to reporters who, in good faith, have not reported. However, failure to report suspected abuse or neglect could result in fines or other sanctions, such as participation in a training program. Failure to act may result in even stiffer penalties, such as civil litigation or criminal prosecution with the prospect of potential imprisonment *(Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse').*

Conflicts

Conflicts between a mandated reporter's duties and privileged communication statutes are common. It has been argued that the category of "mandatory reporters" should be expanded to members of the clergy; however in some more traditional denominations the conflict this creates with the "confessional" makes this unworkable. When such conflicts arise, professionals often choose not to report; e.g., in a large number of cases involving clergy, numerous alleged child sexual assaults have gone unreported *(Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse')*.

Informing family members and guardians

Mandated reporters typically are not obligated to inform parents, siblings or offspring that a report has been made. In many circumstances, however, it may be necessary and/or beneficial to do so. When a report is made at a care giving facility, the person in charge of a hospital, school or other institution is generally required to notify family members, or other caregiver(s) responsible for the (possible) victim, that a report has been made. Healthcare professionals or members of the clergy, however, often must to talk with family members or guardians to offer support and guidance, or to assess the cause of an injury. In cases of serious physical abuse or sexual abuse, it may be unwise to advise caregivers before a case is reported, as it may put a victim at greater risk and/or interfere with a criminal investigation *(Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse')*.

Investigation of reports

Law enforcement or public health agencies are responsible for immediately evaluating and classifying all reports of suspected abuse, neglect, or imminent risk. When reports contain sufficient information to warrant an investigation, authorities must make efforts within a reasonable time frame to begin an effective investigation, often within hours, particularly when there is an imminent risk of physical harm or another emergency; investigations must also be completed within a reasonable or specified time frame. The investigation also must also include a determination of whether the report was warranted or unfounded *(Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse')*.

Agencies must coordinate activities to minimize impacts upon the (possible) victim. Consent to interview(s) of the (possible) victim often must be obtained from caregivers, family members or guardians, unless there is reason to believe such person is the alleged perpetrator. In cases where serious abuse or neglect is substantiated, local law enforcement, prosecutors or other public offices must be notified, and a copy of the investigation report must be sent *(Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse')*.

Professionals responsible for mandated reporting

In many US states, mandatory reporting requirements apply to all people in the state. In other states, mandated reporting requirements generally apply to staff members of a public or private institution or caregiving facility, as well as to a variety of public safety employees and medical professionals, or a public or private school responsible for the safety and well being of vulnerable persons. These generally include, but are not limited to the following:

- Adult protective service employees
- Child advocates
- Child protective service employees
- Chiropractors
- Clergy
- Commercial Film and Photographic Print Processors
- Dentists and dental hygienists
- Emergency medical service providers
- Marital and family therapists
- Medical examiners
- Mental health professionals
- Nurses
- Ombudsmen
- Optometrists
- Parole officers
- Pharmacists
- Physical therapists
- Physician assistants
- Physicians
- Podiatrists
- Police officers
- Probation officers
- Psychologists
- Public health service providers responsible for the licensing or monitoring of child day care centers, long term care and nursing facilities, group day care homes, family day care homes, and youth camps
- Professional counselors

- Resident medical interns
- School teachers, coaches, guidance counselors, paraprofessionals, and principals
- Sexual assault and battered women's counselors
- Social workers
- Substance abuse rehabilitation counselors

Training is typically offered wherever mandated reporting laws are enforced, entailing matters such as recognition of abuse and neglect, what must be reported, how to report it, anonymity, immunity and penalties *(Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse').*

5. The Effects of Child Abuse

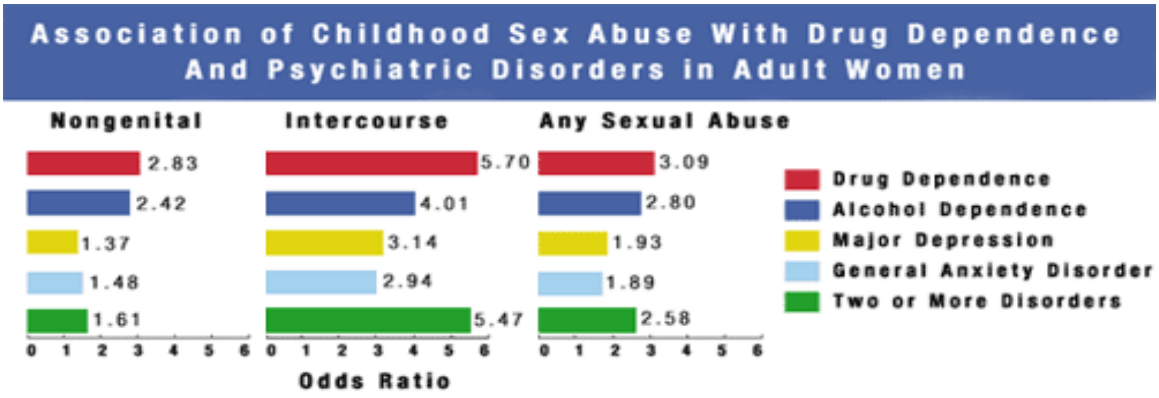
Children with a history of neglect or physical abuse are at risk of developing psychiatric problems or a disorganized attachment style. Disorganized attachment is associated with a number of developmental problems, including dissociative, anxiety, depressive, and acting-out symptoms. A recent study found that 80% of abused and maltreated infants exhibited symptoms of disorganized attachment *(Dinwiddie S, Heath AC, Dunne MP, et al. "Early sexual abuse and lifetime psychopathology: a co-twin-control study." Psychological Medicine).*

Victims of childhood abuse may also suffer from physical health problems later on in life such as chronic head, abdominal, pelvic, or muscular pain with no identifiable reason. Although the majority of childhood abuse victims realize that their abuse is or may be the cause of health problems in their adult life, for the majority their abuse was not directly associated with those problems, indicating that sufferers were most likely diagnosed with other possible causes for their health problems, instead of their childhood abuse *(Dinwiddie S, Heath AC, Dunne MP, et al, "Early sexual abuse and lifetime psychopathology: a co-twin-control study." Psychological Medicine).*

The effects of child abuse can vary. According to a recent study, childhood emotional and sexual abuse was strongly related to adult depressive symptoms, while exposure to verbal abuse and witnessing of domestic violence had a moderately strong association and physical abuse a moderate association. For depression, experiencing more than two kinds of abuse produced stronger symptoms. Sexual abuse was particularly deleterious in its interfamilial form, for symptoms of depression, anxiety, dissociation, and limbic irritability. Childhood verbal abuse had a stronger association with anger-hostility than any other type of abuse studied, and was second only to emotional abuse in its relationship with dissociative symptoms. More generally, in the case of 23 of the 27 illnesses listed in the questionnaire of a French INSEE survey, some statistically significant correlations were found between repeated illness and family traumas encountered by the child before the age of 18 years. These relationships show that inequality in terms of illness and suffering is not only social. It has also its origins in the family, where it is associated with the degrees of lasting affective problems (lack of affection, parental discord, the prolonged absence of a parent, or a serious illness

affecting either the mother or father) that individuals report having experienced in *childhood (Julia Whealin, Ph.D. "Child Sexual Abuse". National Center for Post Traumatic Stress Disorder, US Department of Veterans Affairs).*

Child sexual abuse can result in both short-term and long-term harm, including psychopathology in later life. Psychological, emotional, physical, and social effects include depression, post-traumatic stress disorder, anxiety, eating disorders, poor self-esteem, dissociative and anxiety disorders; general psychological distress and disorders such as somatization, neurosis, chronic pain, sexualized behavior, school/learning problems; and behavior problems including substance abuse, destructive behavior, criminality in adulthood and suicide. A specific characteristic pattern of symptoms has not been identified and there are several hypotheses on the causality of these associations *(Dinwiddie S, Heath AC, Dunne MP, et al,. "Early sexual abuse and lifetime psychopathology: a co-twin-control study." Psychological Medicine).*



A study funded by the *USA National Institute of Drug Abuse* found that, "Among more than 1,400 adult females, childhood sexual abuse was associated with increased likelihood of drug dependence, alcohol dependence, and psychiatric disorders. The associations are expressed as odds ratios: for example, women who experienced non genital sexual abuse in childhood were 2.93 times more likely to suffer drug dependence as adults than were women who were not abused."

Long term negative effects on development leading to re-victimization in adulthood are also associated with child sexual abuse. Studies have established a causal relationship between childhood sexual abuse and certain specific areas of adult psychopathology, including suicidality, antisocial behavior, PTSD, anxiety and alcoholism. Adults with a history of abuse as a child, especially sexual abuse, are more likely than people with no history of abuse to become frequent users of emergency and medical care services. A study comparing middle-aged women who were abused as children with non-abused counterparts found significantly higher health care costs for the former *(Dinwiddie S, Heath AC, Dunne MP, et al, "Early sexual abuse and lifetime psychopathology: a co-twin-control study." Psychological Medicine).*

Sexually abused children suffer from more psychological symptoms than children who have not been abused; studies have found symptoms in 51% to 79% of sexually abused children. The risk of harm is greater if the abuser is a relative, if the abuse involves intercourse or attempted intercourse, or if threats or force are used. The level of harm may also be affected by various factors such as penetration, duration and frequency of abuse, and use of force *(Dinwiddie S, Heath AC, Dunne MP, et al. "Early sexual abuse and lifetime psychopathology: a co-twin-control study." Psychological Medicine).*

The social stigma of child sexual abuse may compound the psychological harm to children, and adverse outcomes are less likely for abused children who have supportive family environments. Young children who are abused sexually by adult females may incur double traumatization due to the widespread denial of female-perpetrated child sexual abuse by non-abusing parents, professional caregivers and the general public.Turner and Maryanski in *Incest: Origins of the Taboo,* suggest that mother-son incest causes the most serious damage to children in comparison to mother-daughter, father-daughter and father-son child incest. Crawford asserts that our socially repressed view of female and maternal sexuality conceals both the reality of female sexual pathologies and the damage done by female sexual abuse to children (*Incest: Origins of the Taboo)*

Child abuse, including sexual abuse, especially chronic abuse starting at early ages, has been found to be related to the development of high levels of dissociative symptoms, which includes amnesia for abuse memories. The level of dissociation has been found to be related to overwhelming sexual and physical abuse. When severe sexual abuse (penetration, several perpetrators, lasting more than one year) had occurred, dissociative symptoms were even more prominent. Child sexual abuse independently predicts the number of symptoms for PTSD a person displays, after controlling for possible confounding variables, according to *Widom,* who wrote "sexual abuse, perhaps more than other forms of childhood trauma, leads to dissociative problems ... these PTSD findings represent only part of the picture of the long-term psychiatric sequel associated with early childhood victimization ... antisocial personality disorder, alcohol abuse, and other forms of psychopathology." Children may develop symptoms of post traumatic stress disorder resulting from child sexual abuse, even without actual or threatened injury or violence (*Incest: Origins of the Taboo).*

Because child sexual abuse often co-occurs with other potentially confounding variables, such as poor family environment and physical abuse, some scholars argue it is important to control for those variables in studies which measure the effects of sexual abuse. In a review of related literature, *Martin and Fleming,* state "The hypothesis advanced in this paper is that, in most cases, the damage caused by child sexual abuse is due to the child's developing capacities for trust, intimacy, agency and sexuality, and that many of the mental health problems of adult life associated with histories of child sexual abuse are second-order effects." Other studies have found an independent association of child sexual abuse with adverse psychological outcomes. *Kendler et al.,* found that most of the relationship between severe forms of child sexual abuse and adult psychopathology in

their sample could not be explained by family discord, because the effect size of this association decreased only slightly after they controlled for possible confounding variables. Their examination of a small sample of CSA-discordant twins also supported a causal link between child sexual abuse and adult psychopathology; the CSA-exposed subjects had a consistently higher risk for psychopathologic disorders than their CSA non-exposed twins *(Dinwiddie S, Heath AC, Dunne MP, et al. "Early sexual abuse and lifetime psychopathology: a co-twin-control study." Psychological Medicine).*

Injuries such as internal lacerations and bleeding can result from abuse depending on the age and size of the child as well as the severity of the abuse. In severe cases, damage to internal organs may occur, which, in some cases, may cause death. *Herman-Giddens et al* identified six certain and six probable cases of death due to child sexual abuse in North Carolina between 1985–1994. The victims ranged in age from 2 months to 10 years. Causes of death included trauma to the genitalia or rectum and sexual mutilation. Child sexual abuse may cause infections and sexually transmitted diseases. Depending on the age of the child, due to a lack of sufficient vaginal fluid, chances of infections are higher. Vaginitis has also been reported *(Dinwiddie S, Heath AC, Dunne MP, et al. "Early sexual abuse and lifetime psychopathology: a co-twin-control study." Psychological Medicine).*

Research has revealed that traumatic stress, including stress caused by sexual abuse, can produce identifiable changes in brain functioning and development. Various studies have suggested that severe child sexual abuse may have a negative effect on brain development. *Ito et al.* found "reversed hemispheric asymmetry and greater left hemisphere coherence in abused subjects;" *Teicher et al.* found that an increased likelihood of "ictal temporal lobe epilepsy-like symptoms" in abused subjects; *Anderson et al. (2002)* recorded abnormal transverse relaxation time in the cerebellar vermis of adults sexually abused in childhood; *Teicher et al.* found that child sexual abuse was associated with a reduced corpus callosum area; various studies have found an association of reduced volume of the left hippocampus with child sexual abuse; and *Ito et al.* found increased electrophysiological abnormalities in sexually abused children *(Ito Y, Teicher MH, Glod CA, et al: "Preliminary evidence for aberrant cortical development in abused children: a quantitative EEG study," The Journal of Neuropsychiatry and Clinical Neurosciences).*

Some studies indicate that sexual or physical abuse in children can lead to the over excitation of an undeveloped limbic system. *Teicher et al.* used the "Limbic System Checklist-33" to measure ictal temporal lobe epilepsy-like symptoms in 253 adults. Reports of child sexual abuse were associated with a 49% increase to LSCL-33 scores, 11% higher than the associated increase of self-reported physical abuse. Reports of both physical and sexual abuse were associated with a 113% increase. Male and female victims were similarly affected. *Navalta et al.,* found that the self-reported math Scholastic Aptitude Test scores of their sample of women with a history of repeated child sexual abuse were significantly lower than the self-reported math SAT scores of their non-abused sample. Because the abused subjects verbal SAT scores were high, they hypothesized that the low math SAT scores could "stem from a defect in hemispheric

integration." They also found a strong association between short term memory impairments for all categories tested (verbal, visual, and global) and the duration of the abuse (*Navalta et al.)*

6. Treatment

A variety of treatment is available to victims of child abuse. Some of the treatment modalities that have strong research support include Trauma- Focused Cognitive Behavioral Therapy (TF-CBT) (Cohen et al.) to treat sexually abused children. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a conjoint child and parent/caregiver psychotherapy model for children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based hybrid treatment model that incorporates trauma sensitive interventions with cognitive behavioral, family, and humanistic principles. Essential components include:

P - Psychoeducation

P - Parenting skills

R - Relaxation techniques such as focused breathing, progressive muscle relaxation, and teaching children to control their thoughts (thought stopping).

A - Affective expression and regulation: Helping children and parents/caregivers learn to control their emotional reactions to reminders by expanding their emotional vocabulary, enhancing their skills in identifying and expressing emotions, and encouraging self-soothing activities.

C - Cognitive coping and processing or cognitive reframing: Helping children learn to think in new and healthier ways about the abuse and their role in it.

T - Trauma narrative: Gradual exposure exercises including verbal, written, and/or symbolic recounting (e.g., utilizing dolls, art, puppets) of abusive events so children learn how to discuss the events when they choose in ways that do not produce overwhelming emotions.

I - In vivo exposure: Gradual exposure to non-threatening trauma reminders in children's environment (e.g., basement, darkness, school) so they learn they can control their emotional reactions to things that remind them of the trauma.

C - Conjoint parent/caregiver/child sessions, typically toward the end of the treatment, including psychoeducation, sharing the trauma narrative, anxiety management, and correction of cognitive distortions. Family works to enhance communication and create opportunities for therapeutic discussion regarding

the trauma.

E - Enhancing personal safety and future growth: Training and education on personal safety skills and healthy sexuality/interpersonal relationships; encouraging the utilization of skills learned to manage future stressors and/or trauma reminders.

Abuse Focused Cognitive-Behavioral Therapy (AF-CBT) (*Kolko &Swenson*) to treat physical abuse. CACs also would be well advised to include Parent-Child Interaction Therapy (PCIT) in their therapeutic menu. PCIT was developed for families with young children experiencing behavioral and emotional problems. PCIT is a parent/caregiver-mediated service shown to be effective with physically abusive parents/caregivers in cases where the abuse is related to efforts to discipline the child *(Chaffin)*.

Abuse focused cognitive behavioral therapy was designed for children who have experienced physical abuse. It targets externalizing behaviors and strengthens prosocial behaviors. Offending parents are included in treatment, to improve parenting skills/ practices. AF-CBT is a treatment based on principles derived from learning and behavioral theory, family systems, cognitive therapy, and developmental victimology. It integrates specific techniques to target school-aged abused children, their offending caregivers, and the larger family system. Through training in specific intrapersonal and interpersonal skills, AF-CBT seeks to promote the expression of appropriate/prosocial behavior, and to discourage the use of coercive, aggressive, and violent behavior. Essential components include:

- Educate individuals and families about relevance of CBT model and physical abuse.

- Establish agreement with family to refrain from using physical force and to discuss any incidents involving the use of force within the family.

- Review the child's exposure to emotional abuse in the family and provide education about the parameters of abusive experiences (causes, characteristics, and consequences) to help child and caregiver to better understand the context in which they occurred.

- Identify and address cognitive contributors to abusive behavior in caregivers (e.g., misattributions/high expectations) and/or their consequences in children (e.g., views supportive of aggression, self-blame) that could maintain any physically abusive or aggressive behavior.

- Teach affect-management skills.

- Teach caregivers behavioral strategies to reinforce and punish children's behavior as alternatives to physical discipline.

- Teach prosocial communication and problem-solving skills to the family and help them establish these skills as everyday routines.

Child-parent psychotherapy was designed to improve the child-parent relationship following the experience of domestic violence. It targets trauma-related symptoms in infants, toddlers, and preschoolers, including PTSD, aggression, defiance, and anxiety. It is supported by two studies of one sample *(Cohen, J.A.; Mannarino, A.P.; Murray, L.K.; Igelman, R.. "Psychosocial Interventions for Maltreated and Violence-Exposed Children". Journal of Social Issue).*

The initial approach to treating a person who has been a victim of sexual abuse involves the following considerations:

- Age at the time of presentation
- Circumstances of presentation for treatment
- Co-morbid conditions

The goal of treatment is not only to treat current mental health issues, but to focus on prevention as well.

Children often present for treatment in one of several circumstances, including criminal investigations, custody battles, problematic behaviors, and referrals from CPS.

The three major modalities for therapy with children and teenagers are family therapy, group therapy, and individual therapy. Which course is used depends on a variety of factors that must be assessed on a case by case basis. For instance, treatment of young children generally requires strong parental involvement, and can benefit from family therapy. Adolescents tend to be more independent, can benefit from individual or group therapy. The modality also shifts during the course of treatment, for example group therapy is rarely used in the initial stages, as the subject matter is very personal and/or embarrassing.

Variables impacting both the pathology and response to treatment include the type and severity of the sexual act, its frequency, the age at which it occurred, and the child's family of origin. Adults with a history of sexual abuse often present for treatment with a secondary mental health issue, which can include substance abuse, eating disorders, personality disorders, depression, and conflict in romantic or interpersonal relationships.

Treatment can be varied and depends on the person's specific issues. For example, a person with a history of sexual abuse suffering from severe depression would be treated for depression. However, there is often an emphasis on cognitive restructuring due to the nature of the trauma. Some newer techniques such as Eye Movement Desensitization and Reprocessing (EMDR) have been shown to be effective. Sexual abuse is associated with many sub-clinical behavioral issues as well, including re-victimization in the teenage years, a bipolar-like switching between sexual compulsion and shut-down, and distorted thinking on the subject of sexual abuse (for instance, that it is common and happens to

everyone). When first presenting for treatment, the patient can be fully aware of their abuse as an event, but their appraisal of it is often distorted, such as believing that the event was unremarkable (a form of isolation). Frequently, victims do not make the connection between their abuse and their present pathology *(Julia Whealin, Ph.D., "Child Sexual Abuse". National Center for Post Traumatic Stress Disorder, US Department of Veterans Affairs).*

Many resources exist to help CACs and their mental health partners identify efficacious and evidence-supported practices. Some of these resources include:

- *Child Physical and Sexual Abuse: Guidelines for Treatment* (Saunders et al., 2004), available through the Medical University of South Carolina (*http://academicdepartments.musc.edu/ncvc/resources_prof/reports_prof.htm*)
  n California Evidence-Based Clearinghouse for Child Welfare *(www.cachildwelfareclearinghouse.org)*
- The Center for the Study and Prevention of Violence at the University of Colorado at Boulder makes available the Blueprints project online (*www.colorado.edu/cspv/blueprints*)
- *Closing the Quality Chasm in Child Abuse Treatment: Identifying and Disseminating Best Practices—The Findings of the Kauffman Best Practices Project to Help Children Heal From Child Abuse,* available from the Chadwick Center (*http://www.chadwickcenter.org/Documents/Kaufman%20Report/ChildHosp-NCTAbrochure.pdf*)
- Substance Abuse and Mental Health Services Administration's National Registry of Effective Programs and Practices (NREPP) (*http://nrepp.samhsa.gov/*)

Practitioners should seek out opportunities to acquire training on evidence-based practices. Treatment developers frequently offer training in these interventions at national meetings and conferences or may contract with organizations to provide training. The NCTSN and the American Professional Society on the Abuse of Children (*http://www.APSAC.org*) are good information sources for training opportunities.

7. Substance Abuse

Because many parents who abuse substances also neglect or abuse their children, it is common for clients in substance abuse treatment to have contact with some part of the child protective services (CPS) system. While the organizational roles and titles will vary, a CPS agency is the part of a State's child welfare system responsible for investigating and processing child abuse and neglect cases. For convenience, the term "CPS agencies" is used in this chapter to refer to all aspects of social services related to child welfare.

Some substance-abusing parents will be drawn into the CPS system during treatment; others will be compelled into substance abuse treatment by a CPS agency. In either case,

it is critical that treatment providers become familiar with the laws governing the child protective system, including

- How child abuse and neglect are defined
- Whether, when, and how a counselor must report a parent or other primary caretaker--or a parent who was maltreated in childhood--to a CPS agency or police
- What happens after a report is made
- How State-mandated family preservation services operate
- How welfare reform will affect clients in treatment

Complicating the picture are the Federal law and regulations governing confidentiality of information about clients in substance abuse treatment (42 U.S.C. §290dd-2; 42 Code of Federal Regulations [C.F.R.], Part 2), which restrict the circumstances under which programs can make disclosures about clients, as well as the information they can disclose.

Clinical Concerns

Counselors may be concerned that compliance with the mandatory reporting law will damage the client-counselor relationship or trigger relapse. A recent study shows that neither is likely to occur: Most clients stay in treatment after a report, and many are able to overcome the negative feelings that often result. There are ways to limit the potential damage to the therapeutic relationship. The first is to inform the client about the mandatory reporting law at the time of admission. This practice is actually required by the Federal confidentiality regulations. §2.22 of the regulations require that substance abuse treatment programs give all clients a notice describing the confidentiality rules, as well as their exceptions (which include mandatory child abuse reporting), upon admission or as soon thereafter as possible. (The regulations contain a sample notice at §2.22(d) that may be used for this purpose.) This practice is also endorsed by the American Psychological Association and the Code of Ethics for Social Workers.

A second way to limit damage is to provide the client an opportunity to self-report. Self-reporting "affords the individual an opportunity to assume responsibility for his or her own actions and allows for at least some control in what otherwise might be a powerless situation". If the client makes the report from the counselor's office, the counselor can provide appropriate support. Counselors should be aware, however, that although this might preserve the therapeutic relationship, it may not fulfill the counselor's statutorily imposed duty to make a report. Sometimes it is possible to minimize damage to the relationship by completing the report (both oral and written) in the client's presence.

If there is imminent risk to a child, the counselor may not have time to engage the parent in the process. For example, if a counselor learns that the client has scalded his child and tied him to the bed, it would be appropriate to contact a CPS agency immediately.

Similarly, if there is a risk that the client will continue his behavior and seek to cover his tracks, the counselor would probably not involve him in the report or inform him until after it has been made.

Although counselors may sometimes be tempted to use the threat of reports to coerce clients into complying with treatment requirements, counselors must remember that the purpose of the reporting laws is to protect children--*not* to provide counselors with a bargaining chip in the treatment process.

Reporting may advance a client's recovery by providing an appropriate limit-setting example, increasing the parent's sense of responsibility for harmful behavior, and giving the family an opportunity to change. Parents may be relieved after a report has been made that external control has been introduced into a situation that frightens them as much as it does the children. Reporting may also open a dialog with the client concerning family relationships and any personal history of abuse, if one exists. Whether these positive results occur appears to depend on when the report is made (earlier in treatment is more likely to affect the relationship negatively), how much support the counselor offers when the report is made, and how well the counselor deals with the client's anxiety and anger.

The National Center on Child Abuse and Neglect offers the following guidance: The law does not require mandated reporters to tell the parents that a report is being made; however, in the majority of cases, advising the client is therapeutically advisable. First, the therapist is employing clinical leverage by using authority to set a firm and necessary limit... Second, if the therapist does not mention the report, there is secrecy and tension, which may result in the clients' feelings of suspicion, isolation, or betrayal. In some cases, reporting may elicit an extreme response from the clients... It can be very beneficial to give clients the opportunity to make the reports themselves in the therapist's presence *(Peterson and Urquiza).*

Although the manner in which the counselor makes the report may affect the counselor-client relationship, the importance of that relationship must not override the counselor's responsibility to fulfill the statutorily imposed obligation to report when a report is necessary to protect a child. If a client has a history of violence, the counselor must also consider her own safety when deciding how much to include the client in the reporting process.

Parental Substance Abuse as Child Abuse and Neglect

The differences in the ways States define child abuse and neglect are particularly striking in the area of parental substance abuse. In some States, parental substance abuse, by itself, may constitute child abuse or neglect. In others, something more must be shown. For example, in South Carolina, giving birth to a drug-exposed infant is a criminal offense; a conviction may send the mother to prison (*State* v. *Whitner*, 328 S.C. 1, 492;

S.E. 2d 777, *cert. denied,* 118 S. Ct.). In other States, like New York, "[a] report which shows only a positive toxicology for a controlled substance [in the newborn] generally does not in and of itself prove that a child has been [neglected]" (*Nassau County Department of Social Services* v. *Denise J.*, 87 N.Y. 2d 73, 661 N.E. 2d 138, 637 NYS 2d 666).

New York offers a particularly interesting approach to the question of parental substance abuse, as it distinguishes among three kinds: (1) those parents who misuse substances but not to the extent that they become intoxicated, unconscious, or their judgment is impaired; (2) those parents who misuse substances but are in treatment; and (3) those parents not in treatment who misuse substances to the extent that they become intoxicated, unconscious, or their judgment is impaired.

In New York, a CPS agency that brings a neglect proceeding against a parent who uses substances must show, at a minimum, that the parent "repeatedly misuses a drug or drugs or alcoholic beverages, to the extent that it has or would ordinarily have the effect of producing a substantial state of stupor, unconsciousness, intoxication, hallucination, disorientation or incompetence, or a substantial impairment of judgment or a substantial manifestation of irrationality...." Substance abuse below that level is not prima facie evidence of neglect. When a parent is in treatment, the State may not use "such drug or alcoholic beverage misuse [as] *prima facie* evidence of neglect" even if it results in "a substantial state of stupor" (§1046(b)(iii) of the Family Court Act).

Similarly, for a court to rule that a child is neglected because of the substance abuse of a parent who is not in treatment, the court need find only that the parent's substance abuse results in loss of self-control of his actions. On the other hand, if the parent is voluntarily and regularly participating in treatment, the court cannot make a ruling of neglect unless it finds (1) that the substance abuse results in the loss of self-control and (2) that there is sufficient evidence that the "child's physical, mental or emotional condition has been impaired or is in imminent danger of becoming impaired" (§1012(f) of the Family Court Act). The wide variation in the way States define child abuse and neglect makes it imperative that providers be familiar with their States' statutes.

CPS Agency Investigation and Potential Outcomes

Once a professional, relative, or neighbor has made a report about a child, the State or local CPS agency is supposed to take action and investigate the complaint. If the complaint is unfounded or unsubstantiated, it is dismissed, and there are no further consequences. If, on the other hand, an initial investigation substantiates the complaint, the CPS agency has a number of options:

1. It may reach an agreement with the family (without filing any court action) regarding what changes are needed and what services will help the family achieve those changes. It will then develop a service plan

outlining the remedial steps the family has agreed to take and establishing a timetable for the family to complete those steps.

2. A CPS agency can bring a neglect or abuse petition against the parent or guardian in a family or trial-level court. After a trial or fact-finding hearing, the court may take one of the following actions:
    a. Dismiss the petition (setting the parent free from further obligation)
    b. Issue an order requiring the parent to comply with all or part of the CPS agency's service plan, an order the court may review periodically to assess the parent's compliance (If the parent fails to comply with the court's order, the court may, after a hearing, either give the parent another chance or, if the case has been pending for some time, the parent has made little progress, or her behavior is particularly egregious, remove the child and begin proceedings to terminate parental rights.)
    c. Issue an order for the child's removal
3. If the situation is life threatening, a CPS agency can remove the child (and any siblings) immediately and schedule a prompt court hearing at which the parent or guardian may contest the removal. If the court finds the removal unnecessary, the child may be returned, but the parent may still be required to comply with a service plan.
4. A CPS agency can refer the case to criminal justice officials.

The majority of child abuse or neglect reports will not result in full-fledged court cases. Of those that do result in court action, most are brought in a family court, where hearings are closed to the public and files are sealed. Only rarely will a report result in criminal charges against the parent.

Whatever is reported to the CPS agency or whatever action that agency takes, if the parent contests the charges or objects to the CPS agency's proposals, she is entitled to a hearing and to be represented by an attorney. In this country, parents may not have their children permanently removed or their parental rights terminated or be punished or be required to go into substance abuse treatment without a court proceeding. (Of course, parents may find themselves coerced into agreeing to enter treatment to retain their children.) In cases where a child has been removed from a home against the parent's wishes, a hearing must be held within a specified time, or the child must be returned. The focus in any initial hearing will be placement of the child during a CPS agency investigation or during any trial.

Clinical Issues

The counselor's role can be critical for a client involved in a child abuse or neglect investigation or proceeding. Getting the client to sign a consent form allowing communication and joint service planning can be an important first step. The counselor can help a client understand what is happening, help her stay focused on what needs to be accomplished, and provide support and encouragement. However, to offer the client sound assistance the counselor needs some basic information:

- Is this the first time the client has had a case with a CPS agency?
- What are the charges against the client (e.g., abuse, neglect)? What precisely is the client charged with doing or not doing?
- Has a child ever been removed from the client's home?
- Does the client have a lawyer representing him? (The counselor should ask the client to sign a consent form permitting the counselor to communicate with the lawyer.)
- At what stage is the client's case? Has the client agreed to a service plan? Is he subject to a court order?
- What actions must the client take to comply with the service plan or court order? Is there a timetable?
- What are the likely outcomes of the proceeding and is termination of parental rights a possibility?
- What is the client's view of the CPS agency and of the entire situation?

Although some might think the last question strange, soliciting the client's view of the CPS agency will help to maintain the counselor-client relationship as the investigation unfolds. Clients have often had negative experiences with CPS agencies or other social service agencies that have intervened in their lives, especially if cross-cultural issues are involved. If a counselor acts on the assumption that the client thinks a CPS agency is acting in her best interest, the counselor may well alienate the client and close the door on what could be an opportunity for developing a therapeutic alliance. In other words, if the counselor characterizes the CPS agency's intentions as beneficent and its intervention as beneficial, the client may well view the counselor as naive at best, and possibly part of the "enemy camp." It is best to begin a dialog with the client about the role of the CPS organization. Perhaps the safest approach is for the counselor to take the position that whether or not the CPS agency's intentions are benign or its intervention is welcome, it is a force with which the client must deal.

It is important, however, for the counselor to help the client move past denial, hurt, and anger into a working relationship with the CPS agency. She should not align or over-identify with the client against the CPS agency. The counselor should make it clear that his major role in this situation will be to work with the client to ensure that the client understands and complies with the CPS agency's or the court's requirements regarding substance abuse treatment. To this end, the counselor should obtain a copy of the service

plan and review it with the client. The terms and requirements of the service plan can often be integrated effectively into counseling objectives. In fact, the CPS system may have information for the treatment provider on the client's substance abuse history and other relevant clinical information. Collateral information from CPS agencies on substance abuse evaluations can be invaluable in raising the quality of the evaluation, providing accurate information, and making better treatment decisions. (For guidelines on maintaining client confidentiality and the legal requirements involved, please see Appendix B.) Frequently clients do not understand the severity of their situation and may minimize or withhold information. This may be due to drug-related cognitive impairments, low IQ, naiveté regarding the legal system, or the same denial and rationalization that sustained their addictions.

Alcohol and drug counselors working with parents during CPS agency investigations or court proceedings may find that the CPS agency and others view them as a good source of information. It is important to keep two things in mind. First, substance abuse treatment programs and the child welfare system (including both the courts and the CPS agency) have different concerns, goals, and measures of success. Once the counselor has made the initial report, her concern must turn to the client's progress toward recovery. While the child protective system is also concerned with the client's recovery, its focus is on the child's safety and stability. These differences in primary focus mean that while the alcohol and drug counselor can help the client achieve recovery (and thereby successfully end the involvement of the CPS agency), she cannot change either the client or the situation. Sometimes, the treatment system's interest in the client's recovery conflicts with the CPS agency's interest in protection of and permanency planning for the child. For example, the counselor's goal of having the client reduce his substance abuse (and allowing sufficient time for that to happen) may conflict with the CPS agency's goal of finding a permanent placement for a child who has been in foster care for many months.

Counselors must keep in mind that they may communicate with or respond to requests for information only when the proposed communication conforms to one of the Federal regulations' narrow exceptions permitting a disclosure. If a counselor fails to abide by Federal confidentiality rules, an unpleasant and expensive lawsuit may be brought against the program and possibly the counselor. Moreover, if word spreads that the program fails to protect information about its clients, it may have a difficult time in retaining its clients' confidence and in attracting new clients into its treatment services (as well as the possibility of professional sanctions and relicensing difficulties).

The following discussion about communicating with parts of the child welfare and legal systems relies heavily on four exceptions to the Federal regulations that permit disclosures:

- Proper written consent from the client (§2.31)
- Proper written criminal justice system consent from the client (§2.35)
- Court orders (§§2.64-2.66)

- Qualified service organization agreements (§§2.11, 2.129(c)4))

All professionals who work in the field of substance abuse treatment are aware that their clients have serious problems that may involve procuring and using illicit drugs. Abuse of such illicit substances interferes with their lawful behavior and, when they are parents, interferes with responsible parenting. Treatment providers, therefore, will often need to interact with the legal and child protective systems. The way in which counselors interact with these agencies will vary from case to case. The counselor may have to contact a CPS agency to report a client suspected of child abuse, or the legal system may contact the counselor for information about a client's participation in a treatment program. Whatever the nature of the interaction with CPS agencies or the legal system, counselors need to be aware of their legal responsibilities.

The following subsections discuss how the counselor should deal with various agencies. In all of these circumstances, the Consensus Panel recommends that counselors (1) ask for their supervisor's guidance on what boundaries to keep, (2) consult their client, (3) use common sense, and (4) consult State law (or a lawyer familiar with State law).

Communicating With a CPS Agency

Even if a CPS agency has sent the program a Request for Information Release that the client has already signed, if the form does not comply with §2.31 of the Federal confidentiality regulations, the counselor may not release any information. Even if the form complies with the Federal requirements, the counselor should remember that a signed consent form does not require her to disclose any information. The counselor should still evaluate the appropriateness of the request in the context of its impact on the client's treatment.

First, after getting the client's written consent to do so, the counselor should consult with the client's lawyer. (Some clients may not be aware that they have the right to an attorney when custody of their children is being questioned.) The counselor should ask the lawyer whether she has objections to the program's making a disclosure and whether she thinks it is in the client's interest for the program to disclose the requested information. The lawyer may be pleased to know that the Federal confidentiality regulations provide a way to limit the kind of information disclosed. If the lawyer has no objections, the counselor can simply have the client sign a valid consent form, making sure to limit the scope of the disclosure as appropriate (and as the regulations require). If the lawyer does have an objection, then it is best to let her take the lead.

If the client has signed a proper consent form authorizing the counselor to communicate with the caseworker at the CPS agency, how much information should the counselor disclose and how active a role should he take? In some cases, disclosing information to the CPS agency or court will benefit the client. It may also help the client if the counselor

participates in developing a service plan for the family. However, it is up to the client and the lawyer, not the counselor, to determine whether communication or cooperation with a CPS agency will benefit the client. Therefore, it is essential that the counselor communicate with the client's attorney *before* taking it upon himself to communicate with a CPS agency.

Counselors should avoid using a standard report form in communicating with a CPS agency, unless the form calls for a limited amount of relevant, objective data. Each case is different, and a one-size-fits-all approach may hurt the client. It is best to think through each case on its own terms--with the help of the client's lawyer and with appropriate supervision. Sometimes, however, CPS agencies only need to know whether the client is participating in treatment, what the program's expectations are, if the client's participation has been satisfactory, the extent of drug involvement, and whether the client has complied with specific directives the treatment provider may have made.

Responding to Lawyers' Inquiries

If a lawyer calls to find out about a client's treatment history or current treatment, unless the client has consented in writing to the counselor's communicating with the lawyer, the counselor must tell the lawyer, "I'm sorry. I can't respond to that question right now. Can I have your telephone number and call you back at another time?" This is because the Federal confidentiality regulations prohibit any other response without the client's written consent. The regulations view any response indicating that the person in question is the counselor's client as a disclosure that the person is in fact in substance abuse treatment. This applies even if the lawyer already knows that the client is in treatment.

A firm but polite tone is best. If confronted by what could be characterized as "stonewalling," a lawyer may be tempted to subpoena the requested information and more. The counselor will not want to provoke the lawyer into taking action that will harm the client. Even if the counselor has the client's written consent to speak with the lawyer, she may find it helpful to consult with the client before having a conversation about him. The lawyer can be told, "I'm sure you understand that I am professionally obligated to speak with this person before I speak with you." It will be hard for any lawyer to disagree with this statement.

The counselor should then speak with the client to ask whether the client knows what information the caller is seeking and whether the client wants her to disclose that or any other information. She should leave the conversation with a clear understanding of the client's instructions--whether she should disclose the information and, if so, how much and what kind. It may be that the lawyer is representing the client and the client wants the counselor to share all the information she has. On the other hand, the lawyer may represent the CPS agency, the prosecuting attorney, or some other party with whom the

client is not anxious to share information. There is nothing wrong with refusing to answer a lawyer's questions.

If the lawyer represents the client and the client asks the counselor to share all information, the counselor can speak freely with the lawyer once the client signs a proper consent form. However, if the counselor is answering the questions from a lawyer who does *not* represent the client (but the client has consented in writing to the disclosure of *some* information), the counselor should listen carefully to each question, choose her words with care, limit each answer to the question asked, and take care not to volunteer information not called for. If the lawyer asking for information represents the prosecuting attorney, the counselor should consult both the client and his lawyer, as well as the program's legal counsel before responding to any questions.

Responding to Subpoenas

Subpoenas come in two forms. One is an order requiring a person to testify, either at a deposition out of court or at a trial. The other--known as a *subpoena duces tecum*--requires a person to appear with the records listed in the subpoena. (Depending on the State, a subpoena can be signed by a judge or filled out by a lawyer and stamped by a court clerk.) Unfortunately, it can neither be ignored nor automatically obeyed.

When a subpoena is received, the counselor should call the client about whom he is asked to testify or whose records are sought and ask what the subpoena is about. It may be that the subpoena has been issued by or on behalf of the client's lawyer, with her consent. However, it is equally possible that the subpoena has been issued by or on behalf of the CPS agency's lawyer (or the lawyer for another adverse party). If that is the case, the counselor's best option is to consult with the client's lawyer (if the client has signed a consent form) to find out whether the lawyer will object (i.e., ask the court to "quash" the subpoena) or whether the counselor should simply obtain the client's written consent to testify or turn over her records. An objection can be based on a number of grounds and can be raised by any party, as well as by the person whose treatment information is sought. Often, the counselor may assert the client's privilege for her.

Communicating With the Court

Sometimes, the court hearing a client's case will ask a treatment program to write a report about his progress in treatment. Or a client's lawyer may ask an agency to submit a letter to the court to support a disposition she is advocating. In any letter it submits, the agency should limit itself to reporting factual information, such as client attendance and urine toxicology screen results; it should not speculate on the future of the client or the client's family. Nor should it offer an opinion as to where the child should be placed. Of course, any information the agency releases in the form of a letter-report must be limited to the kind and amount of information the client agreed to have released when he signed the

consent form. Moreover, the agency should consult with the client's attorney to ensure the letter covers the areas of concern and will do no damage.

What should a counselor do if the client is continuing to abuse the child, the counselor knows this, and the counselor is asked to submit a report? First, if a counselor believes that her client is continuing to abuse a child and that the child's life or health is in danger, the counselor can make another "initial" report to the CPS agency (even when no report has been requested).

Second, if the client's lawyer has asked the counselor to write a report for the court and the counselor believes that the client is continuing to have difficulty meeting his parenting responsibilities (but that active abuse that would require another report is not present), the counselor can explain why she doesn't want to write a report, so long as the client has signed a consent form permitting the counselor to talk to the lawyer.

Third, if the court has asked the program for a report, the counselor can state in the beginning of the report that it will be limited to factual matters related to the client's progress and compliance with substance abuse treatment. The only circumstance in which a counselor could voluntarily inform a court of his opinion that there was ongoing abuse would be when the client's signed consent form would permit this kind of communication.

Finally, if the court insists on a report (or testimony) on the subject of the client's parenting and the client has not consented to such communications, the program must explain that in order for the counselor to report (or testify) on this issue, the court must issue an order under subpart E of the Federal regulations. Note that if the report or testimony will include "confidential communications" it can only be done if the disclosure

- Is necessary to protect against a threat to life or of serious bodily injury
- Is necessary to investigate or prosecute an extremely serious crime (including child abuse)
- Is in connection with a proceeding at which the client has already presented evidence concerning confidential communications (for example, "I told my counselor...") (§2.63)

Responding to inquiries by law enforcement

If a client faces criminal child abuse or neglect charges, a police officer, detective, or probation officer may pay the counselor a visit. If any of these officials asks a counselor to disclose information about a client or her treatment records, the counselor should handle the matter in the same way he would handle it with a lawyer. The counselor should tell the officer, as he might a lawyer, "I can't tell you if I have a client with that name. I'll have to check my records." Of course, if the client was mandated into treatment

in lieu of prosecution or incarceration and has signed a criminal justice system consent form authorizing communication with the mandating agency, program staff may be obligated to speak with someone from that agency. (See discussion in Appendix B.)
If the officer's inquiry has come unexpectedly, the counselor should determine from the client whether she knows the subject of the officer's inquiry; whether she wants the counselor to disclose information and, if so, how much and what kind; and whether there are any particular areas the client would prefer she *not* discuss with the officer. Again, the counselor must obtain written consent from the client before he speaks with the officer. If the client has a criminal case pending against her, it is best to check with her lawyer, too.

Maintaining Working Relationships with CPS Agencies and Others

While a treatment program and a CPS agency may have conflicts regarding certain clients' cases, the program needs to maintain a good working relationship with the CPS agency and other agencies involved in the child protection system. It is possible, outside the context of any individual case, for treatment programs, CPS agencies, and others to work together to develop common approaches to improve family functioning, reduce substance use, and keep children safe. Many States have coordinating committees to exchange information among diverse agencies about goals and strategies to promote understanding of each agency's perspectives, needs, and legal constraints.

8. Legal and Ethical Considerations

Subpoenas and Court Orders

Mental health professionals should be informed about the possibility of being served with a subpoena or court order to provide information about the nature of the treatment and the sequelae of traumatic stress following the child’s abuse. They should share this potentiality with their clients. Mental health professionals should be aware of how information can be released upon receipt of a subpoena. A court order may be necessary in order to release specific types of mental health information.

The mental health professional should also communicate clearly to families which types of information must be shared without the client’s consent such as suspected child abuse, adult and domestic abuse, and suicidal or homicidal threats. Certain safety issues found in some families dealing with sexual abuse fall in this category including re-abuse and contact with the alleged perpetrator when such contact has been disallowed by CPS.

Implications of Mental Health Treatment for the Juvenile and Criminal Justice Systems

Traumatized children and their families are often involved with multiple service systems, including law enforcement, child welfare, the courts, schools, primary care, and mental

health. When different systems have different and potentially competing priorities, there is a risk that children and their families will receive mixed or confusing messages—or simply fall through the cracks. The challenge faced by each type of court (whether juvenile, civil, family, or criminal) is to collaborate with mental health professionals in a manner that minimizes re-traumatizing the child or family. At the same time, the court must meet its obligations to remain objective and unbiased. Aside from the clinical benefits associated with traditional psychotherapy, mental health treatment/involvement has direct implications for child and family participation in the legal system.

Role Clarity

Whenever possible, the forensic interviewer should not be the treating mental health professional for a child he/she interviewed. Conversely, a mental health professional who has treated a child or who has a therapeutic relationship with a child should not conduct a forensic interview with that child.

Psychotherapy and Court Proceedings

Mental health professionals can help promote the child's safety, permanency, and well-being by alleviating symptoms, helping to improve psychosocial functioning, and working to prepare the child for periods of heightened distress in response to court activity. Treatment may bolster the child's capacity to participate meaningfully in the legal process and may make a profound contribution to the future well-being and development of victimized children.

In addition to direct interventions to ameliorate such symptoms as depression and PTSD, quality mental health care provides an opportunity for children to master effective techniques for coping with anticipatory anxiety related to legal proceedings and to address unwarranted feelings of guilt or responsibility for their abuse. Particularly for abused children contending with PTSD symptoms, treatment may involve the development of a "trauma narrative" *(Deblinger & Runyon, 2005)*. The narrative allows them to recall and consider their experiences over time in a manner that is less overwhelming.

Some attorneys advise against children's participating in therapy prior to a court appearance, concerned that therapy may result in a child's testimony appearing too polished or rehearsed. Research indicates, however, that therapy is beneficial because it helps children learn effective coping strategies that tend to reduce anxiety and distress and improve their ability to participate in the legal process *(Cohen, et al., 2006)*.

Prosecuting attorneys may need to be given information on the functions of therapy to help dissuade them from dispensing inappropriate advice to families. As cases extend for months and years, the legal system bears witness to despair, victimization, and family

dysfunction—none of which it can effectively address. Since implementation of The Adoption and Safe Families Act in 1997, courts face an increased responsibility to ensure safety, permanency, and well-being for children in the child welfare system. The courts are unlikely to meet this mandate unless they develop close collaboration with mental health and prevention systems and providers *(Lederman & Osofsky)*.

Mental health providers may assist courts in developing recommendations for treatment and best practice models that draw upon available evidence for the effectiveness of particular interventions to help further the courts' efforts to act in the "best interests of the child"(Goldstein et al.). Clinicians may also serve as consultants to courts, providing an important developmental perspective on child trauma, maltreatment, and their potential manifestations in the legal context including recommendations regarding treatment, placement, permanency, and competence to provide testimony *(Office for Victims of Crime,; Osofsky et al.; Cohen & Youcha)*. Faced with decisions about custody, placement, parental rights, and culpability for abuse, courts are increasingly challenged to act "in the best interest of the child" while facing choices that may represent only a "least detrimental alternative."

Given the potential benefits to the child and family, as well as to the legal process, mental health treatment for child victims of abuse should be introduced as early as possible. Accurate and timely evaluation of the child sets the stage for recovery. Treatment that utilizes evidence-based interventions allows children a more complete return to the appropriate developmental tasks consistent with their age.

Client Confidentiality and Sharing of Information

Once an investigation is complete, law enforcement and CPS staff may have limited (or no) contact with the family. Mental health professionals, however, may work with the family for months after the investigation is complete, and typically will form strong, trusting relationships with families. The mental health professional is in a unique position to recognize the strengths of—and potential risks for—a family, and to learn what the family's greatest concerns are related to the investigation and its outcome. Thus, the sharing of information between the mental health provider and the team can be beneficial both to the family and to the team's effort to conduct a thorough investigation and successfully resolve the case.

Confidentiality laws, including Health Insurance Portability and $FFRXQWDELOLW (HIP$A) regulations, also extend to clients' mental health records. Mental health professionals are legally and ethically bound to adhere to these laws. Confidentiality should be discussed as treatment begins and proceeds. For example, if the mental health professional is a participant in a weekly case review in which the status and progress of cases are discussed, he or she should explain to the family the purpose of the case review meeting.

Therapy records should include documentation signed by clients indicating that they understand the protection of their private health information.

9. Child Maltreatment

All 50 States, the District of Columbia, and the U.S. Territories have child abuse and neglect reporting laws that mandate certain professionals and institutions to report suspected maltreatment to a child protective services (CPS) agency. Each State has its own definitions of child abuse and neglect that are based on standards set by Federal law. Federal legislation provides a foundation for States by identifying a set of acts or behaviors that define child abuse and neglect. The Child Abuse Prevention and Treatment Act (CAPTA), (42 U.S.C. §5101), as amended by the CAPTA Reauthorization Act of 2010, retained the existing definition of child abuse and neglect as, 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. Most States recognize four major types of maltreatment: neglect, physical abuse, psychological maltreatment, and sexual abuse. Although any of the forms of child maltreatment may be found separately, they can occur in combination.

Who reported child maltreatment?

For 2011, professionals made three fifths (57.6%) of reports of alleged child abuse and neglect. The term professional means that the person had contact with the alleged child maltreatment victim as part of the report source's job. This term includes teachers, police officers, lawyers, and social services staff. Nonprofessionals—including friends, neighbors, and relatives—submitted one fifth of reports (18.2%). Unclassified sources submitted the remainder of reports (24.3%). Unclassified includes anonymous, "other," and unknown report sources. States use the code of "other" for any report source that does not have an NCANDS designated code. The three largest percentages of report sources were from such professionals as teachers (16.0%), legal and law enforcement personnel (16.7%), and social services personnel (10.6%). Who were the child victims? All 52 States submitted data to NCANDS about the dispositions of children who received one or more CPS responses. For FFY 2011, more than 3.7 million (duplicate count) children were the subjects of at least one report. One fifth of these children were found to be victims with dispositions of substantiated (18.5%), indicated (1.0%), and alternative response victim (0.5%). The remaining four fifths of the children were found to be non-victims of maltreatment. The duplicate count of child victims tallies a child each time he or she was found to be a victim. The unique count of child victims counts a child only once regardless of the number of times he or she was found to be victim during the reporting year. For FFY 2011, 51 States reported (unique count) 676,569 victims of child abuse and neglect. The unique victim rate was 9.1 victims per 1,000 children in the population. Using this rate, the national estimate of unique victims for FFY 2011 was 681,000. Comparing 2011 (unique count) victim data to 2010 data, 42 States reported a decreased number of victims. Other victim demographics include:

■ Victims in the age group of birth to 1 year had the highest rate of victimization at 21.2 per 1,000 children of the same age group in the national population.

■ Victimization was split between the sexes with boys accounting for 48.6 percent and girls accounting for 51.1 percent. Fewer than 1 percent of victims were of unknown sex.

■ Eighty-seven percent of (unique count) victims were comprised of three races or ethnicities— African American (21.5%), Hispanic (22.1%), and White (43.9%).

What were the most common types of maltreatment?

As in prior years, the greatest percentage of children suffered from neglect. A child may have suffered from multiple forms of maltreatment and was counted once for each maltreatment type. CPS investigations or assessments determined that for unique victims:

■ more than 75 percent (78.5%) suffered neglect

■ more than 15 percent (17.6%) suffered physical abuse

■ less than 10 percent (9.1%) suffered sexual abuse

How many children died from abuse or neglect?

Child fatalities are the most tragic consequence of maltreatment. For FFY 2011, 51 States reported a total of 1,545 fatalities. Based on these data, a nationally estimated 1,570 children died from abuse and neglect. Analyses are performed on the number of child fatalities for whom case level data were obtained:

■ The overall rate of child fatalities was 2.10 deaths per 100,000 children.

■ Four fifths (81.6%) of all child fatalities were younger than 4 years old.

■ Boys had a higher child fatality rate than girls at 2.47 boys per 100,000 boys in the population. Girls died of abuse and neglect at a rate of 1.77 per 100,000 girls in the population.

■ Nearly 90 percent (86.5%) of child fatalities were comprised of African American (28.2%), Hispanic (17.8%), and White (40.5%) victims.

■ Four fifths (78.3%) of child fatalities were caused by one or more parents.

Who abused and neglected children?

A perpetrator is the person who is responsible for the abuse or neglect of a child. Fifty States reported case level data about perpetrators using unique identifiers. In these States, the total duplicated count of perpetrators was 885,003 and the total unique count of perpetrators was 508,849. For 2011:

■ Four fifths (84.6%) of unique perpetrators were between the ages of 20 and 49 years. ■ More than one-half (53.6%) of perpetrators were women, 45.1 percent of perpetrators were men, and 1.3 percent were of unknown sex.

■ Four fifths (80.8%) of duplicated perpetrators were parents.

■ Of the duplicated perpetrators who were parents, 87.6 percent were the biological parents.

Who received services?

CPS agencies provide services to children and their families, both in their homes and in foster care. Reasons for the provision of services may include 1) preventing future instances of child maltreatment and 2) remedying conditions that brought the children and their family to the attention of the agency. During 2011, for the duplicate count of children:

■ Forty-six States reported approximately 3.3 million children received prevention services.

■ Based on data from 40 States, 1,046,947 duplicate children received post response services from a CPS agency.

■ Three fifths (61.2%) of duplicate victims and nearly one third (30.1%) of duplicate non-victims received post response services.

CPS agencies conduct a response for all screened-in referrals—called reports. The response may be an investigation, which determines whether a child was maltreated or is at-risk of maltreatment and establishes if an intervention is needed. The majority of reports receive investigations. A small, but growing, number of reports are handled by an alternative response, which focuses primarily upon the needs of the family and usually does not include a determination regarding the alleged maltreatment(s).

Screening of Referrals

A referral may be either screened in or screened out. The reasons behind the determination to screen out a referral may include one or more of the following: ■ did not meet the State's intake standard

■ did not concern child abuse and neglect

■ did not contain enough information for a CPS response to occur

■ response by another agency was deemed more appropriate

■ children in the referral were the responsibility of another agency or jurisdiction (e.g., military installation or Tribe)

■ children in the referral were older than 18 years

During FFY 2011 (the most recent analysis as of this writing 2017-2018), CPS agencies across the nation received an estimated 3.4 million referrals. The estimate is based on a national referral rate of 45.8 referrals per 1,000 children in the population. Examining 5 years of referral data reveals that both the reported number and national estimated number of referrals have been increasing since 2007. (See table 2–1, exhibit 2–A, and related notes.)

The national estimate of 3.4 million referrals were estimated to include 6.2 million children. Because the number of referrals has increased since 2007, so too has the

national estimate of the number of children included in referrals increased. For FFY 2010, a national estimate of 5.9 million children were included in referrals to CPS agencies. For FFY 2011, 45 States reported both screened-in and screened-out referrals (table 2–1). Nationally, those States screened in 60.8 percent and screened out 39.2 percent of referrals. These national percentages have remained constant for several years. Reviewing the percentages at the State level, 15 States screened in more than the national screened-in percentage, ranging from 62.6 to 98.6 percent. Twenty-nine States screened out more than the national screened-out percentage, ranging from 39.9 to 75.6 percent. State variations in policy and procedure account for some of the extremes in the percentages. For example, one State counts all calls to the hotline, even misdialed numbers, as a referral. This understandably inflates the State's percentage of screened-out referrals. Readers are encouraged to read State comments in appendix D for additional information.

Report Dispositions

Screened-in referrals, known as reports, commonly receive an investigation response. This response includes assessing the allegation of maltreatment according to State law and policy. The primary purpose of this investigation is twofold: (1) to determine whether the child was maltreated or is at-risk of being maltreated (commonly called a disposition or finding) and (2) to determine the child welfare agency's appropriate services response. For FFY 2011, more than 2 million reports were screened in, had a CPS response, and received a disposition. The national rate of reports that received a disposition was 27.4 per 1,000 children in the national population. An analysis of 5 years' worth of data on reports that received a response and resulted in a disposition reveals slight fluctuations in the number and rate of reports. (See exhibit 2–B and related notes.)

Exhibit 2–B Report Disposition Rates, 2007–2011

Year	States Reporting	Child Population of Reporting States	Reports with a Disposition from Reporting States	Disposition Rate	Child Population of all 52 States	National Estimate of Reports with a Disposition
2007	51	72,896,154	1,870,903	25.7	75,342,238	1,936,000
2008	52	75,411,627	2,024,057	26.8	75,411,627	2,024,000
2009	52	75,512,062	2,000,508	26.5	75,512,062	2,001,000
2010	52	75,022,478	1,987,080	26.5	75,022,478	1,987,000
2011	52	74,810,766	2,047,042	27.4	74,810,766	2,047,000

Report Sources

A report source is defined as the category or role of the person who notified a CPS agency of the alleged child maltreatment. Report sources are grouped into the categories of professional, nonprofessional, and unclassified. Professional report sources are persons who encountered the child as part of their occupation, such as child daycare providers, legal and law enforcement personnel, and medical personnel. State laws

require most professionals to notify CPS agencies of suspected maltreatment. Nonprofessional report sources are persons who did not have a relationship with the child based on their occupation, such as friends, relatives, and neighbors. State laws vary as to whether nonprofessionals must report their observations of possible abuse and neglect. Unclassified includes anonymous, "other," and unknown report sources. States use the code of "other" for any report source that does not have an NCANDS-designated code. According to comments provided by the States, the "other" report source includes religious leader, Temporary Assistance for Needy Families staff, landlord, tribal official or member, camp counselor, and private agency staff. Readers are encouraged to review appendix D, State Commentary for additional information as to what is included in the category of "other" report source. For FFY 2011, professionals submitted three-fifths of reports (57.6%). Education personnel (16.0%), legal and law enforcement personnel (16.7%), medical personnel (8.4%) and social services personnel (10.6%) accounted for the highest percentages of all reports. (See exhibit 2–C and related notes.) Nonprofessionals submitted one-fifth of reports (18.2%). Friends and neighbors (4.4%), other relatives (6.7%), and parents (6.6%) accounted for nearly all of the nonprofessional reporters. Unclassified sources submitted the remainder of reports (24.3%). Examining report source data for 5 years shows that the data have been stable. The professional, nonprofessional, and unclassified categories have fluctuated less than two percentage points within each category across the years. Professionals submitted three-fifths of reports for each year.

Exhibit 2–C Report Sources, 2007–2011

Report Sources	2007		2008		2009		2010		2011	
	Number	%	Number	%	Number	%	Number	%	Number	%
PROFESSIONAL										
Child Daycare Providers	16,598	0.9	17,471	0.9	15,934	0.8	14,317	0.7	14,638	0.7
Education Personnel	315,698	16.9	337,888	16.7	329,825	16.5	315,359	16.4	327,804	16.0
Foster Care Providers	10,876	0.6	11,420	0.6	11,727	0.6	10,129	0.5	9,386	0.5
Legal and Law Enforcement Personnel	302,419	16.2	326,800	16.1	328,664	16.4	321,068	16.7	342,393	16.7
Medical Personnel	155,414	8.3	165,404	8.2	163,080	8.2	158,194	8.2	171,062	8.4
Mental Health Personnel	79,209	4.2	85,273	4.2	87,880	4.4	89,342	4.6	95,871	4.7
Social Services Personnel	199,366	10.7	228,563	11.3	228,754	11.4	221,659	11.5	216,981	10.6
Total Professionals	**1,079,580**	**57.7**	**1,172,819**	**57.9**	**1,165,864**	**58.3**	**1,130,068**	**58.6**	**1,178,135**	**57.6**
NONPROFESSIONAL										
Alleged Perpetrators	1,195	0.1	1,150	0.1	1,124	0.1	879	0.0	734	0.0
Alleged Victims	10,498	0.6	10,937	0.5	10,285	0.5	8,112	0.4	7,910	0.4
Friends and Neighbors	94,936	5.1	101,229	5.0	97,508	4.9	85,046	4.4	90,655	4.4
Other Relatives	139,196	7.4	146,250	7.2	141,037	7.1	133,975	7.0	138,141	6.7
Parents	117,287	6.3	133,526	6.6	135,375	6.8	131,386	6.8	134,362	6.6
Total Nonprofessionals	**363,112**	**19.4**	**393,092**	**19.4**	**385,329**	**19.3**	**359,398**	**18.6**	**371,802**	**18.2**
OTHER AND UNKNOWN										
Anonymous Sources	147,755	7.9	176,637	8.7	177,367	8.9	173,601	9.0	183,611	9.0
Other	163,525	8.7	161,660	8.0	157,857	7.9	151,874	7.9	168,573	8.2
Unknown	116,931	6.2	119,849	5.9	114,091	5.7	112,652	5.8	144,921	7.1
Total Unclassified	**428,211**	**22.9**	**458,146**	**22.6**	**449,315**	**22.5**	**438,127**	**22.7**	**497,105**	**24.3**
Total	**1,870,903**	**100.0**	**2,024,057**	**100.0**	**2,000,508**	**100.0**	**1,927,593**	**100.0**	**2,047,042**	**100.0**
States Reporting	**51**		**52**		**52**		**51**		**52**	

CPS Response Time

State policy usually establishes guidelines or requirements for initiating a CPS response to a report. The response time is defined as the time between the receipt of a call to the State or local agency alleging maltreatment and face-to-face contact with the alleged victim (when appropriate), or with another person who can provide information on the allegation(s). States have either a single timeframe that applies to responding to all reports or different timeframes for responding to different types of reports. High-priority responses are often stipulated to occur within 1 to 24 hours; lower priority responses may range from 1 to several days. CPS response time is a Federal Performance Measure with the goal to, "Improve States' average response time between maltreatment report and investigation [or alternative response], based on the median of States' reported average response time, in hours, from screened-in reports to the initiation of the investigation." The national median for all reporting States is submitted to the Office of Management and Budget (OMB). The targeted goal is a reduction in response time of 5 percent from the prior year. Individual State data are not reported to OMB, but are presented here for the reader. Based on data from 34 States, the FFY 2011 average response time was 71 hours or 3.0 days; the median response time was 63 hours or 2.6 days. (See table 2–2 and related notes.) The response time data have fluctuated over the past 5 years, due in part, to the number of States that reported data for each year. FFY 2009 had the most States reporting data with 38 States and an average of 69 hours and a median of 59 hours.

CPS Workforce and Caseload

Given the large number and the complexity of CPS responses that are conducted each year, there is ongoing interest in the size of the workforce that performs CPS functions. In most agencies, screening and investigation response (and alternative response for those States with such programs) tasks are conducted by different groups of workers. In many rural and smaller agencies, one worker may perform all or any combination of those functions and may provide additional services. Due to limitations in States' systems and the fact that workers may conduct more than one function in a CPS agency, the data reported in the workforce and caseload tables vary from State-to-State. In some cases a State may report authorized positions, other States may report a "snapshot" or the actual number of workers on a given day. The Children's Bureau will provide technical assistance for the related data fields and endeavor to ensure that these data continue to become more comparable. For FFY 2011, 47 States reported a total workforce of 32,970. This is a decrease from FFY 2010 when 47 states reported 33,638 workers. This decrease is due, in part, to a State that changed its methodology for counting workers to one that the State believes is more accurate. Forty States were able to report on the number of specialized intake and screening workers. The number of investigation and alternative response workers was computed by subtracting the reported number of intake and screening workers from the reported total workforce number. (See table 2–3 and related notes.) Using the data from these 40 States, investigation and alternative response

workers completed an average of 70.7 CPS responses for FFY 2011. This is an increase from FFY 2010 when investigation workers completed an average of 66.7 CPS responses. As CPS agencies realign their workforce to improve the multiple types of CPS responses they provide, the methodologies for estimating caseloads may become more complex and State- or county-specific.

The Child Abuse Prevention and Treatment Act

(CAPTA), (42 U.S.C. §5101), as amended by the CAPTA Reauthorization Act of 2010 (P.L.111–320), retained the existing definition of child abuse and neglect as, 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.

- ➢ Each State defines the types of child abuse and neglect in State statute and policy. Child protective services (CPS) agencies determine the appropriate response for the alleged maltreatment based on those statutes and policies. The most common response is an investigation. The result of an investigation response is a determination (also known as a disposition) about the alleged child maltreatment.

The two most prevalent dispositions are:

- ✓ Substantiated: An investigation disposition that concludes that the allegation of maltreatment or risk of maltreatment was supported or founded by State law or policy.

- ✓ Unsubstantiated: An investigation disposition that determines that there was not sufficient evidence under State law to conclude or suspect that the child was maltreated or at-risk of being maltreated.

Less commonly used dispositions for investigation responses include:

- ❖ Indicated: An investigation disposition that concludes that maltreatment could not be substantiated under State law or policy, but there was reason to suspect that at least one child may have been maltreated or was at-risk of maltreatment. This is applicable only to States that distinguish between substantiated and indicated dispositions.

- ❖ Intentionally false: The unsubstantiated investigation disposition that indicates a conclusion that the person who made the allegation of maltreatment knew that the allegation was not true.

- ❖ Closed with no finding: A disposition that does not conclude with a specific finding because the investigation could not be completed. Reasons for an incomplete response include: the family moved out of the jurisdiction, the family could not be located, or necessary diagnostic or other reports were not received within required time limits.

- ❖ States may also use the category of "other," if none of the above is applicable

State statutes also establish the level of evidence needed to determine a disposition of substantiated or indicated. CPS agencies respond to the safety needs of the children who are the subjects of child maltreatment reports based on these State definitions and requirements for levels of evidence. Some States use an alternative approach, which 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. While in general, families who are assigned to an alternative response do not receive a finding on the allegations, in this report the term disposition is used for the determinations of both investigation and alternative responses. Each State that uses alternative response decides how to map its codes for these programs to the National Child Abuse and Neglect Data System (NCANDS) codes:

- ➢ Alternative Response Victim: The provision of a response other than an investigation that determines that a child was a victim of maltreatment.

- ➢ Alternative Response Non-victim: The provision of a response other than an investigation that did not determine that a child was a victim of maltreatment.

As alternative response programs evolve, there are more variations to the programs. For example, 11 States mention in their commentary (appendix D) that they have a type of alternative response program that does not go through CPS and (appropriately) the data are not reported to NCANDS. Many of these additional programs provide services for families that do not have allegations of maltreating children and do not meet the State's criteria for CPS intervention. The 11 States with these programs are Alabama, California, District of Columbia, Georgia, Hawaii, Iowa, Maine, North Dakota, Pennsylvania, Rhode Island, and South Dakota. Other States commented that an alternative response program

is in-progress and may be implemented in the coming years. Readers are encouraged to review appendix D for more information about these programs.

Ongoing interest in understanding the outcomes of children and their families—as well as advances in State child welfare information systems—has resulted in the ability to assign a unique identifier, within the State, to each child who receives a CPS response. These capabilities enable the types of analyses listed below to be conducted:

- Duplicate count: Counting a child each time that he or she was a subject of a report. This count also is called a report-child pair.

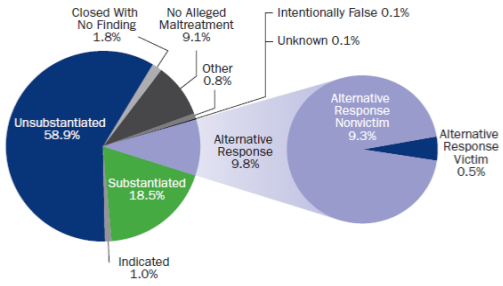
- Unique count: Counting a child once, regardless of the number of reports concerning that child, that received a CPS response in the FFY.

As nearly all States are able to report unique counts, the Child Maltreatment report series is in the process of transitioning from analyses with duplicate counts to analyses with unique counts. For the Child Maltreatment 2011report, basic counts and demographic analyses (age, sex, and race) were conducted with the unique counts. For analyses where events and attributes of the victims were examined—such as disposition type and perpetrator relationship—a duplicate count was used

Children Who Were Subjects of a Report

For FFY 2011, more than 3.7 million (duplicate count) children were the subjects of at least one report. One-fifth of these children were found to be victims with dispositions of substantiated (18.5%), indicated (1.0%), and alternative response victim (0.5%). The remaining four-fifths of the children were found to be non-victims of maltreatment. (See table 3–1, exhibit 3–A, and related notes).

Exhibit 3–A Children Who Received a CPS Response by Disposition, 2011 *(duplicate count)*



Based on data from table 3–1.

For FFY 2011, 18 States reported 361,907 (duplicate count) children who received an alternative CPS response. This is an increase from FFY 2010 when 14 States reported 331,204 (duplicate count) children who received such a response. As States are increasing their usage of alternative response programs, the numbers and percentages of duplicate children with alternative response dispositions also are increasing. A special analysis was conducted for the 18 States that reported (duplicate count) children who received alternative responses to NCANDS. For those States, the (duplicate count) children were categorized by disposition in three groups—alternative response (including dispositions of alternative response victims and alternative response non-victims), victims (including dispositions of substantiated and indicated), and non-victims (including dispositions of unsubstantiated, intentionally false, closed with no finding, no alleged maltreatment, other, and unknown). (See exhibit 3–B and related notes.)

The demographics of the children in these 18 States were analyzed. For most of the demographic analyses, the alternative response group when compared with the non-victims group had remarkably similar percentages. This similarity is logical because children who received an alternative response are deemed to have a low risk of maltreatment and one would expect the group to have similar results as the non-victim group. There is one area of difference between the children who received an alternative response and the children who were determined to be non-victims. The difference is in the race and ethnicity analysis. More than one-half (53.2%) of the children who received an alternative response were White. However, White children comprised less than one-half of victims (45.7%) and non-victims (46.3%). Similarly, only 8.9 percent of children who received an alternative response were Hispanic, while 15.7 percent of victims and 12.2 percent of non-victims were Hispanic. This means that in the 18 States, a slightly higher percentage of White children received alternative responses than other races and a lower percentage of Hispanic children received alternative responses than other races. There have been several studies and articles written about potential racial disparity in the child welfare system. Additional research would be needed to determine the reasons behind the racial disparity in the States with alternative response programs. During FFY 2011, 3 million (unique count) children received either an investigation response or an alternative response. Calculating this unique count of children against the child population results in a national rate of 41.2 children per 1,000 in the population who received a CPS response. (See table 3–2 and related notes.) Five-year trend analyses of the (unique count) child disposition rates reveal slight fluctuations in the rates since 2007. The disposition rate is the rate of all children who received a CPS response. (See exhibit 3–C and related notes.)

Number of Child Victims

In NCANDS, a victim is defined as a child for whom the State determined at least one maltreatment was substantiated or indicated; and a disposition of substantiated, indicated,

or alternative response victim was assigned for a child in a specific report. It is important to note that a child may be a victim in one report and a non-victim in another report. For FFY 2011, 51 States reported (unique count) 676,569 victims of child abuse and neglect. The unique count of child victims counts a child only once regardless of the number of times he or she was found to be a victim during the reporting year. The FFY 2011 unique victim rate was 9.1 victims per 1,000 children in the population. (See table 3–3 and related notes.) Analyses of the number and rate of victimization for the past 5 years show an overall decrease. During FFY 2007, there was a national estimate of 723,000 (unique count) victims of maltreatment. By FFY 2011, the national estimate had decreased to 681,000. Comparing 2011 (unique count) victim data to 2010 data, 31 States reported a decreased number of victims. The decrease may be attributed to several factors, including a decrease in the number of children who received a CPS response and an increase in the number of States with alternative response dispositions. (See exhibit 3–D and related notes.

Exhibit 3–D Child Victimization Rates, 2007–2011 *(unique count)*

Year	States Reporting	Child Population of Reporting States	Unique Victims from Reporting States	Victimization Rate	Child Population of all 52 States	National Estimate of Unique Victims
2007	49	71,886,504	690,849	9.6	75,342,238	723,000
2008	50	74,398,024	704,714	9.5	75,411,627	716,000
2009	50	74,495,280	693,485	9.3	75,512,062	702,000
2010	51	74,157,309	688,157	9.3	75,022,478	698,000
2011	51	73,946,999	676,569	9.1	74,810,766	681,000

Child Victim Demographics

The youngest children are the most vulnerable to maltreatment. Fifty-one States reported more than one-quarter (27.1%) of all FFY 2011 (unique count) victims were younger than 3 years. This equals to 182,742 (unique count) victims who were younger than 3 years. Twenty percent (19.6%) of victims were in the age group 3–5 years.
Children younger than 1 year had the highest rate of victimization at 21.2 per 1,000 children in the population of the same age. Victims with the single-year age of 1, 2, or 3 years old had victimization rates of 12.4, 12.3, and 11.4 victims per 1,000 children of those respective ages in the population. In general, the rate and percent age of victimization decreased with age. (See table 3–4, exhibit 3–E, and related notes.)
Victimization was split between the sexes, with boys accounting for 48.6 percent and girls accounting for 51.1 percent. Fewer than 1 percent of (unique count) victims had an

unknown sex. The FFY 2011 victimization rate for girls was slightly higher at 9.6 per 1,000 girls in the population than boys at 8.7 per 1,000 boys in the population. (See table 3–5 and related notes.)

Eighty-seven percent of (unique count) victims were comprised of three races or ethnicities— African-American (21.5%), Hispanic (22.1%), and White (43.9%). However, victims of African-American, American Indian or Alaska Native, and multiple racial descent had the highest rates of victimization at 14.3, 11.4, and 10.1 victims, respectively, per 1,000 children in the population of the same race or ethnicity. (See table 3–6, exhibit 3–F and related notes.) Analyzing 5 years of race and ethnicity data reveals that the percentage and rate per 1,000 distributions have remained stable for several years. (See table 3–7 and related notes.)

Maltreatment Types

Four-fifths (78.5%) of (unique count) victims were neglected, 17.6 percent were physically abused, and 9.1 percent were sexually abused. Because a victim may have suffered from more than one type of maltreatment, every maltreatment type was counted, which is why the percentages total to more than 100.0. In addition, 10.3 percent of victims experienced such "other" types of maltreatment as "threatened abuse," "parent's drug/alcohol abuse," "safe relinquishment of a newborn," or "lack of supervision." States may code any maltreatment as "other" if it does not fall into one of the NCANDS categories. Readers are encouraged to review State comments about what is included in the "other" maltreatment type category in appendix D. It is important to note that these maltreatment types have been determined by CPS as confirmed. The Child Maltreatment report does not include alleged maltreatments. (See table 3–8 and related notes.)
A crosstab relation analysis was conducted to delve further into the characteristics of (unique count) victims. Selected maltreatment types of victims were analyzed by age to examine the distribution of age within each maltreatment type. Of the children who suffered medical neglect, more than one-third (34.6%) were younger than 3 years. Of the victims who were sexually abused, 26.3 percent were in the age group of 12–14 years and 21.8 percent were in the age group of 15–17 years. (See exhibit 3–G and related notes.)

Risk Factors

Children who were reported with any of the following risk factors were considered to have a disability: mental retardation, emotional disturbance, 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. Eleven percent (11.2%) of (unique count) victims were reported as having a disability. Nearly 4 percent (3.8%) of victims were

reported as having a medical condition not classified in NCANDS, 2.6 percent of victims had behavior problems, and 2.1 percent were emotionally disturbed. A victim could have been reported with more than one type of disability. (See table 3–9 and related notes.) The data were examined to determine if the children had alcohol abuse, drug abuse, and domestic violence caregiver risk factors. This means that the child was exposed to the risk factor behavior in the home. With respect to domestic violence, the caregiver could have been either the perpetrator or the victim of the domestic violence. For the States that reported on the domestic violence caregiver risk factor, 25.1 percent of (unique count) victims and 8.2 percent of (unique count) non-victims were exposed to this behavior. (See tables 3–10 and related notes.) Fewer States reported data on the alcohol and drug abuse caregiver risk factors. Ten percent (9.8%) of (unique count) victims and 5.2 percent of (unique count) non-victims were reported with the alcohol abuse caregiver risk factor and 18.6 percent of victims and 9.4 percent of non-victims were reported with the drug abuse caregiver risk factor. It is important to note that some States are not able to differentiate between alcohol abuse and drug abuse for some or all children. Those States report both risk factors for the same children in both caregiver risk factor categories. (See tables 3–11, 3–12, and related notes.)

Perpetrator Relationship

Victim data were analyzed by relationship of (duplicate count) victims to their perpetrators. Four-fifths (81.2%) of victims were maltreated by a parent either acting alone or with someone else. Nearly two-fifths (36.8%) of victims were maltreated by their mother acting alone. One-fifth (19.0%) of victims were maltreated by their father acting alone. One-fifth (18.9%) of victims were maltreated by both parents. Thirteen percent (12.8%) of victims were maltreated by a perpetrator who was not a parent of the child. (See exhibit 3–H and related notes.)

Federal Standards and Performance Measures

Each year during FFY 2007–2011, three-quarters of (unique count) victims did not have a prior history of victimization. Information regarding first-time victims is a Federal Performance measure. The Community-Based Child Abuse Prevention Program (CBCAP) reports this measure to the Office of Management and Budget (OMB) each year as an average of all States. Individual State data are not reported to OMB, but are presented here for the reader. (See table 3–13 and related note).Through the Child and Family Services Reviews (CFSR), the Children's Bureau established the current national standard for the absence of maltreatment recurrence as 94.6 percent, defined as: "Of all children who were victims of substantiated or indicated abuse or neglect during the first 6 months of the reporting year, what percent did not experience another incident of substantiated or indicated abuse or neglect within a 6-month period?"

The (unique count) of victims are used to determine compliance with this standard. For FFY 2011, the number of States in compliance increased to 26 States, which translates to 51.0 percent that met the standard. The number of States in compliance with the standard has fluctuated during the past 5 years. The fewest number of States in compliance occurred during 2009 with 23 States and the most occurred in 2010 with 27 States. (See table 3–14 and related notes.) Also through the CFSR, the Children's Bureau established a national standard for the absence of maltreatment in foster care as 99.68 percent, defined as: "Of all children in foster care during the reporting period, what percent were not victims of a substantiated or indicated maltreatment by foster parents or facility staff members?"

The number of States in compliance has increased from 20 States that met this standard for FFY 2007 to 24 States for FFY 2011. The (unique count) of children not maltreated in foster care were derived by subtracting the NCANDS count of children maltreated by foster care providers from the Adoption and Foster Care Analysis and Reporting System (AFCARS) count of children placed in foster care. The observation period for this measure is 12 months. (See table 3–15 and related notes.)

Fatalities

The consequences of child abuse and neglect are serious, and a child fatality is the most tragic consequence. The National Child Abuse and Neglect Data System (NCANDS) collects case-level data in the Child File on child fatalities that result from maltreatment. Additional counts of child fatalities, for whom case-level data are not known, are reported through the Agency File and the Summary Data Component (SDC). The determination that a death is due to child maltreatment involves the submission of an initial report of a child fatality to law enforcement or child protective services (CPS). These agencies are dependent upon the public, medical professionals, and hospital staff for such reports. Once an allegation of a suspicious death occurs, close coordination between CPS and law enforcement is necessary, with additional support from the offices of the medical examiner or coroner. District attorneys and the courts make the final determination of the criminal aspect of the investigations. Some deaths may not come to the attention of CPS. Reasons for this include if there were no surviving siblings in the family or if the child had not been the recipient of child welfare services. To expand the knowledge base of the actual number of child fatalities, States are increasingly consulting other data sources for deaths attributed to child maltreatment. The Child and Family Services Improvement and Innovation Act (P.L. 112–34) listed the following additional data sources for child death reporting from which States should be obtaining data: State vital statistics departments, child death review teams, law enforcement agencies, and offices of medical examiners or coroners. States that are able to provide these additional data do so as aggregate data via the Agency File.

Number of Child Fatalities

Fifty-one States reported a total of 1,545 fatalities. Of those 51 States, 45 reported case-level data about 1,258 fatalities and 43 reported aggregate data on 287 fatalities. Fatality rates by State ranged from 0.00 to 4.16 per 100,000 children in the population. (See table 4–1 and related notes.) For FFY 2011, a nationally estimated 1,570 children died from abuse and neglect. The national fatality rate per 100,000 children in the population was 2.10 for FFY 2011, the same as it was for FFY 2010. The number of reported child fatalities due to child abuse and neglect has fluctuated during the past 5 years, from 1,608 in 2007 to a high of 1,685 in 2009, and a low of 1,545 in 2011. Due to the relatively low frequency of child fatalities, the national estimate and national rate are sensitive to which States report data and changes in the child population estimates produced by the U.S. Census Bureau. Some explanations for State data fluctuations may be found in the State commentaries in appendix D. (See table 4–2, exhibit 4–A, and related notes).

Child Fatality Demographics

The youngest children are the most vulnerable to death as the result of child abuse and neglect. Four-fifths (81.6%) of all child fatalities were younger than 4 years old. Rates of child fatalities by age also reveals that the very youngest children are the most vulnerable. Children who were younger than 1 year old died from abuse and neglect at a rate of 16.80 per 100,000 children in the population younger than 1 year old. In general, the child fatality rate decreased with age. Children who were age 17 died at a rate of 0.12 per 100,000 in the population age 17. Boys had a higher child fatality rate than girls at 2.47 boys per 100,000 boys in the population. Girls died of abuse and neglect at a rate of 1.77 per 100,000 girls in the population. (See exhibit 4–C and related notes.)

Nearly 90 percent (86.5%) of child fatalities were comprised of African-American (28.2%), Hispanic (17.8%), and White (40.5%) victims. Examining the rates reveals that African-American children had the highest rate of child fatalities at 3.92 per 100,000 African-American children in the population. Children of multiple races (meaning two or more races) had the second highest fatality rate at 2.90 per 100,000 children in the population. (See exhibit 4–D and related notes.)

Perpetrator Relationship

Four-fifths (78.3%) of child fatalities were caused by one or more parents. Examining this category reveals that the child's mother acting alone perpetrated more than one-fifth (26.4%) and both parents were responsible for one-fifth (22.0%) of child fatalities. Perpetrators without a parental relationship to the child accounted for 13.4 percent of fatalities. Child fatalities with unknown perpetrator relation-ship data accounted for 8.3 percent. (See exhibit 4–E and related notes.)

Maltreatment Types

Because a victim may have suffered from more than one type of maltreatment, and this is especially true for child fatalities, every reported maltreatment type was counted and the percentages total to more than 100.0 percent. Of the children who died, 71.1 percent suffered neglect either exclusively or in combination with another maltreatment type and 47.9 percent suffered physical abuse either exclusively or in combination. (See exhibit 4–F and related notes).

Risk Factors

To the extent possible, the investigations of child fatalities capture caregiver risk factors. The distributions of the risk factors for child fatalities are similar to the distribution of the risk factors for victims. Twenty-eight States reported that 5.7 percent of child fatalities were exposed to caregiver alcohol abuse. Thirty-three States reported 16.7 percent of child fatalities were exposed to domestic violence in the home. Thirty States reported 12.8 percent of child fatalities were exposed to caregiver drug abuse.
It is important to note that some States are not able to differentiate between alcohol abuse and drug abuse. Those States report the same children in both caregiver risk factor categories. (See exhibit 4–G and related notes.)

Prior CPS Contact

Some children who died from abuse and neglect were already known to CPS agencies. In 33 reporting States, the children whose families had received family preservation services in the past 5 years accounted for 8.8 percent of child fatalities. In 37 reporting States, 1.4 percent of child fatalities had been in foster care and had been reunited with their families in the past 5 years. (See table 4–3, table 4–4, and related notes.)

The National Child Abuse and Neglect Data System (NCANDS) defines a perpetrator as a person who has been determined to have caused or knowingly allowed the maltreatment of a child. NCANDS does not collect information about persons who were alleged to be perpetrators and not found to have perpetrated abuse and neglect.

Number of Perpetrators

As States have improved their child welfare information systems, persons who have been determined to be perpetrators have received unique identifiers within child protective services (CPS) agency databases. This enables the below-listed types of analyses to be conducted:

- Duplicated count of perpetrators: Counting a perpetrator each time the perpetrator is associated with maltreating a child. This also is known as a report-child-perpetrator triad. For example, a perpetrator would be counted twice in all of the following situations (1) one child in two separate reports, (2) two children in a single report, and (3) two children in two separate reports.

- Unique count of perpetrators: Identifying and counting a perpetrator once, regardless of the number of children the perpetrator is associated with maltreating or the number of records associated with a perpetrator.

For FFY 2011, 50 States reported 885,003 duplicate count of perpetrators (not shown). Because a perpetrator may have a different relationship with different children in the same report or across multiple reports, the report-child-perpetrator triad (duplicated count) was used for the perpetrator relationship analysis. For example, a perpetrator may be a mother to one victim and a neighbor to a second victim in the same report. That perpetrator would be counted once in the parent category and once in the friend and neighbor category. The maltreatment type analysis also was conducted with the duplicated count of perpetrators. For FFY 2011, 50 States reported 508,849 unique count of perpetrators. A national estimate of 524,000 unique perpetrators was calculated using the average number of victims per perpetrator and the national estimate of victims. Because a perpetrator is associated with one sex or race even across multiple reports, demographic analyses (age, sex, and race) were conducted with the unique perpetrator counts. (See table 5–1 and related notes.

Perpetrator Demographics Four-fifths (84.6%) of (unique count) perpetrators were between the ages of 20 and 49 years. Nearly two-fifths (36.4%) were in the age group of 20–29 years; 32.3 percent were in the age group of 30–39 years; and 15.9 percent were in the group of 40–49 years. While perpetrators younger than 20 years account for less than 6 percent of all perpetrators, 4.4 percent are in the age group of 16–19 years. (See table 5–2, exhibit 5–A, and related notes.) More than one-half (53.6%) of perpetrators were women and 45.1 percent of perpetrators were men; 1.3 percent were of unknown sex. (See table 5–3 and related notes.)

The racial distributions of (unique count) perpetrators were similar to the race of their victims. During FFY 2011, one-fifth (20.2%) of perpetrators were African-American, one-fifth (19.2%) were Hispanic, and 48.4 percent were White. Perpetrators of American Indian or Alaska Native (1.1%), Asian (1.0%), and multiple race (1.0%) descent accounted for 3.1 percent of perpetrators. Race or ethnicity was not reported for 8.9 percent of perpetrators. These proportions have remained consistent for the past few years (not shown). (See table 5–4, exhibit 5–B, and related notes).

Perpetrator Relationship

Four-fifths (80.8%) of (duplicated count) perpetrators were parents, 5.9 percent were relatives other than parents, and 4.4 percent were unmarried partners of parents. Perpetrators with an "other" relationship accounted for 4.5 percent and those with an unknown relationship to their victim accounted for 2.9 percent. According to comments provided by the States, the "other" perpetrator relationship includes sibling, victim's boyfriend or girlfriend, stranger, and babysitter. Readers are encouraged to review appendix D, State Commentary for additional information as to what is included in the category of "other" perpetrator relationship. The remaining relationship categories each accounted for less than 1 percent. (See table 5–5, exhibit 5–C, and related notes.) Of the (duplicated count) perpetrators who were parents, 87.6 percent were the biological parents, 4.1 percent were stepparents and 0.7 percent were adoptive parents. The remaining 7.6 percent were of unknown parental relationship. (See table 5–6 and related notes.)

Maltreatment Types

In most instances, data records associate a perpetrator with one type of maltreatment per child per report. Three-fifths (61.0%) of (duplicated count) perpetrators neglected children, 9.7 percent of (duplicated count) perpetrators physically abused children, and 6.2 percent sexually abused children. Another 15 percent (15.1%) were associated with more than one type of maltreatment. (See exhibit 5–D and related notes.)

the mandate of child protection is not solely to assess if an allegation of maltreatment has merit or not, but also to provide for the safety of children. Child protective services (CPS) agencies promote the safety of children through a broad range of prevention activities and through providing services to children who were maltreated or are at-risk of being maltreated.

The National Child Abuse and Neglect Data System (NCANDS) examines services from two perspectives. One perspective uses aggregated data from States regarding the usage of various funding streams for prevention services. Prevention services are provided to parents whose children are at-risk of abuse and neglect. These services are designed to increase the understanding of parents and other caregivers of the developmental stages of childhood and to improve their child-rearing competencies. Examples include such services as family support, child daycare, education and training, employment, housing, and information and referral. NCANDS also collects case-level data about children who received services that were provided as a result of the response and within 90 days of the completion (meaning a disposition was assigned) of the CPS response. Post response services (also known as post investigation services) address the safety of the child and usually are based on an assessment of the family's situation, including services needs and family strengths. Examples of post response services include both in-home services and foster care services.

Prevention Services

States and local agencies determine who will receive prevention services, what services will be offered, and how the services will be provided. Prevention services may be funded by the State or the following Federal programs.

- ✓ Ection 106 of title I of the Child Abuse Prevention and Treatment Act (CAPTA), as amended [42 U.S.C. 5106 et seq.]—The Child Abuse and Neglect State Grant (Basic State Grant) provides funds to States to improve CPS systems. The grant serves as a catalyst to assist States in screening and investigating child abuse and neglect reports, creating and improving the use of multi-disciplinary teams to enhance investigations, improving risk and safety assessment protocols, training CPS workers and mandated reporters, and improving services to infants with life-threatening conditions.

- ✓ Title II of CAPTA, as amended [42 U.S.C. 5116 et seq.]—The Community-Based Grants for the Prevention of Child Abuse and Neglect program (formerly the Community–Based Family Resource and Support program) provides funding to a lead State agency to develop, operate, expand, and enhance community-based, prevention-focused programs and activities designed to strengthen and support families to prevent child abuse and neglect. This program is administratively known as the Community–Based Child Abuse Prevention Grants (CBCAP).

- ✓ Title IV–B, Subpart 2, Section 430, of the Social Security Act, as amended [42.U.S.C. 629 et seq.] Promoting Safe and Stable Families—This legislation has the goal of keeping families together by funding such services as prevention intervention so that children do not have to be removed from their homes, services to develop alternative placements if children cannot remain safely in the home, and family reunification services to enable children to return to their homes, if appropriate.

- ✓ Title XX of the Social Security Act, [42. U.S.C. 1397 et seq.], Social Services Block Grant SSBG)—Under this grant, States may use funds for such prevention services as child daycare, child protective services, information and referral, counseling, and foster care, as well as other services that meet the goal of preventing or remedying neglect, abuse, or exploitation of children.

Forty-six States reported approximately 3.3 million children received prevention services. The discussion of prevention services counts children by funding source and may include duplication across sources or within sources. Funding sources with the highest levels of States reporting data are the Community-Based Child Abuse Prevention Grants (CBCAP) with 40 States and Promoting Safe and Stable Families with 34 States. Fewer States reported data for the Basic State Grant and the Social Services Block Grant. States

continue to work to improve reporting on these funding sources. (See table 6–1 and related notes.)

While States are able to report the number of children who received prevention services, they continue to work on improving the ability to measure the prevention services that were provided. Some of the difficulties with collecting and reporting these data are listed below:

- ➢ Children and families may receive services under more than one funding stream and may be counted more than once.

- ➢ Some programs count families, while others count children. Statistical methods are used in this report to estimate the number of children.

- ➢ Prevention services are often provided by local community-based agencies, which are not required to report on the number of clients that they serve.

- ➢ Agencies that receive funding through different streams also may report to different agencies. The child welfare agency may have difficulty collecting data from all funders or all funded agencies.

Post response Services

A child and his or her family may receive CPS services prior to the start of an investigation response or alternative response. This report attempts to discuss only those services that were initiated as a result of the investigation or alternative response. Therefore, only those services that continued past or were initiated after the disposition date are included in these analyses. Children who received post response services are counted per response by CPS and may be counted more than once.
States provide data on the start of post response services. For those children who were not already receiving services at the start of the report, the average number of days from receipt of a report to initiation of services was 48 days. (See table 6–2 and related notes.) More than 1 million (1,113,702) duplicate children received post response services from a CPS agency. Three-fifths (61.2%) of duplicate victims and nearly one-third (30.1%) of duplicate non-victims received post response services. (See table 6–3 and related notes. NCANDS classifies children as either having (1) received only in-home services, meaning any service provided to the family while the child remains in the home, or (2) received foster care services and possibly in-home services. Analyzing data from the States that report both foster care and in-home post response services reveals that three-fifths (62.6%) of victims (duplicate count) who received post response services received only in-home services. Two-fifths (37.4 %) of victims (duplicate count) who received post response services were removed from their homes and received foster care services. For non-victims (duplicate count) who received post response services,

87.8 percent received only in-home services and 12.2 percent received foster care services. (See tables 6–4, 6–5; exhibits 6–A, 6–B; and related notes.). States also reported on the number of victims for whom some court action had been undertaken. Court action may include any legal action taken by the CPS agency or the courts on behalf of the child, including authorization to place a child in foster care and filing for temporary custody, protective custody, dependency, or termination of parental rights. In other words, these include children who were removed, as well as other children who may have had petitions while remaining at home. Based on 46 reporting States, 19.0 percent of victims had court actions. (See table 6–6 and related notes.) States were less able to report on the number of victims with court-appointed representatives. Thirty-four States reported that 15.2 percent of victims received court-appointed representatives. These numbers are likely to be an undercount given the statutory requirement in CAPTA, "in every case involving an abused or neglected child which results in a judicial proceeding, a Guardian ad Litem . . . who may be an attorney or a court-appointed special advocate . . . shall be appointed to represent the child in such proceedings. . ." Many States are working to improve the reporting of the
court-appointed representative data element. (See table 6–7 and related notes.)

History of Receiving Services

Two data elements in the Agency File collect information on past histories of victims. Based on data from 23 States, 14.6 percent of victims received family preservation services within the previous 5 years. (See table 6–8 and related notes.) Based on data from 31 States, 5.0 percent of victims were reunited with their families within the previous 5 years

Reports on National Statistics

Child Welfare Outcomes 2007–2010: Report to Congress (Child Welfare Outcomes) is the 11th in a series of annual reports from the U.S. Department of Health and Human Services (HHS), Children's Bureau. This report series is developed in-accordance with section 479A of the Social Security Act (as amended by the Adoption and Safe Families Act of 1997) and provides information pertaining to

State performance on the following national child welfare outcomes:

- ✓ Outcome 1—Reduce recurrence of child abuse and/or neglect
- ✓ Outcome 2—Reduce the incidence of child abuse and/or neglect in foster care
- ✓ Outcome 3—Increase permanency for children in foster care
- ✓ Outcome 4—Reduce time in foster care to reunification without increasing reentry
- ✓ Outcome 5—Reduce time in foster care to adoption
- ✓ Outcome 6—Increase placement stability

- ✓ Outcome 7—Reduce placements of young children in group homes or institutions

The Child Welfare Outcomes reports provide State-level data as well as national trends on the outcome measures. Demographics such as race and ethnicity and age give a broader picture of State and national data. The report series incorporates data from NCANDS and the Adoption and Foster Care Analysis and Reporting System (AFCARS) on 12 original measures, as well as data on 15 additional measures that HHS adopted in 2006 to assess State performance during the second round of the Child and Family Services Reviews (CFSRs). The report also contains State data on the frequency and location of caseworker visits for children in foster care. The most recent report, as well as prior Child Welfare Outcomes reports, are available on the Children's Bureau's website at http://www.acf.hhs.gov/programs/cb/stats_research/index.htm#cw Child Maltreatment 2011 Chapter 7: Reports, Research, and Capacity Building Activities. The Children's Bureau also established a website where users can create their own custom reports using the data from the Child Welfare Outcomes reports. The user's custom reports may be displayed as a table, graph, or map, and can include demographic data. This site allows the data to be available to members of Congress and the public several months prior to the dissemination of the full report. Currently, FFY 2011 data are available. The data site is located at http://cwoutcomes.acf.hhs.gov/data/. For further information about the Child Welfare Outcomes 2007-2010: Report to Congress, contact: Sharon Newburg-Rinn, Ph.D. Social Science Research Analyst
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America's Children in Brief: Key National Indicators of Well-Being, 2012
Each year since 1997, the Federal Interagency Forum on Child and Family Statistics has published a report on the well-being of children and families. Pending data availability, the Forum updates all 41 indicators annually on its Web site (http://childstats.gov) and alternates publishing a detailed report, America's Children: Key National Indicators of Well-Being, with a summary version, which highlights selected indicators. For 2012, the Forum released the condensed version of the report, America's Children in Brief: Key National Indicators of Well-Being, 2012. The America's Children series provides Federal data on children and families available in a nontechnical, easy-to-use format to stimulate discussion among data providers, policymakers, and the public. The Forum fosters coordination and integration among 22 Federal agencies that produce or use statistical data on children and families, and seeks to improve Federal data on children and families. The America's Children series provides accessible compendia of indicators drawn across topics from the most reliable official statistics; it is designed to complement other more specialized, technical, or comprehensive reports produced by various Forum agencies. Indicators are chosen because they are easy to understand, are based on substantial research connecting them to child well-being, cut across important areas of children's

lives, are measured regularly so that they can be updated and show trends over time, and represent large segments of the population. These child well-being indicators span seven domains: family and social environment, economic circumstances, health care, physical environment and safety, behavior, education, and health. For further information about America's Children in Brief: Key National Indicators of Well-Being, 2012 or the Federal Interagency Forum on Child and Family Statistics, contact:
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Research on Child Maltreatment

National Survey of Child and Adolescent Well-Being
The National Survey of Child and Adolescent Well-Being (NSCAW) is a nationally representative, longitudinal survey that focuses on the well-being of children who have encountered the child welfare system. Two cohorts of children and families were included in the project. The NSCAW I core sample of 5,501 children in 36 States represented all children who were investigated for child maltreatment during the 15-month baseline period, which began in October 1999. Children were included whether or not the case was substantiated or founded and whether or not they received child welfare services as a result of the investigation. Children and families were followed for five waves of data collection that ended during 2006. The NSCAW II baseline began in March 2008. The NSCAW II design and protocol are similar to the prior study. Data are collected from 5,873 children, current caregivers, caseworkers, and teachers sampled from the NSCAW I-selected counties using similar measures. NSCAW II data also included administrative data like that provided by the States for NCANDS and AFCARS, to obtain more complete data about reports, services, and placement history. A follow up (called Wave 2) of children and families occurred approximately 18 months after the close of the NSCAW II index investigation. The NSCAW II cohort of children who were approximately 2 months to 17.5 years old at baseline ranged in age from 16 months to 19 years old at Wave 2. Data collection for Wave 2 of the study occurred from October 2009 through January 2011. A report containing results from the second wave of the study titled, NSCAW II WAVE 2 REPORT Child Well-Being was released during July 2012. Data collection for a 36-month follow up (Wave 3) is scheduled for completion during early 2013. The NSCAW data sets are archived for use by the research community, through licensing agreements, at the National Data Archive on Child Abuse and Neglect at Cornell University. The Archive also maintains a bibliography of publications using NSCAW data. The data sets represent an important resource for researchers interested in child maltreatment, child welfare, child development, and services to high-risk children

and families. Study reports, research briefs, and information about NSCAW methods and measures are available at http://www.acf.hhs.gov/programs/opre/abuse_neglect/nscaw/index.html. For more information on accessing the NSCAW data sets, please see http://www.ndacan.cornell.edu.

For additional information about the National Survey of Child and Adolescent Well-Being contact:
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Report of Maltreatment as a Risk Factor for Injury Death:
A Prospective Birth Cohort Study
Emily Putnam-Hornstein (2011) conducted a population-based study using administrative data from vital birth records, child protective services records, and vital death records. The study linked children aged birth through 5 years who were born in California to maltreatment allegations and maltreatment death. The researcher was interested in whether children previously maltreated were at greater risk of death due to maltreatment. The author found that after adjusting for other risk factors, children with previous maltreatment allegations were more than 5 times more likely to die from subsequent maltreatment. The study also concluded that those children died from other causes at a much higher rate than children not reported to child protective services.
An abstract of the article is available online at http://cm.sagepub.com. The full citation for the article is: Putnam-Hornstein, E. (2011) Report of Maltreatment as a Risk Factor for Injury Death: A Prospective Birth Cohort Study. Child Maltreatment, 16(3), 163-174. doi:10.1177/1077559511411179 For further information or to obtain the complete article, contact: Child Maltreatment http://cm.sagepub.com

Capacity Building Activities

Maternal, Infant, and Early Childhood Home Visiting Program
The Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) was created from the Patient Protection and Affordable Care Act (P.L. 111-148), and receives its funding via the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA). HRSA and the Administration for Children and Families (ACF), have partnered to implement the program. The purpose of MIECHV is to respond to the diverse needs of children and families in communities at-risk and to provide an opportunity for collaboration and partnership at the Federal, State, and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs. Grantees from 50 States, the District of

Columbia, six jurisdictions, Indian Tribes, tribal organizations, and Urban Indian organizations received funds to support evidence-based home visiting programs focused on improving the wellbeing of families with young children. In April 2012, HRSA awarded $71.9 million to 10 states to expand their home visiting services. The awards were given to States that have demonstrated successful operations of early childhood systems for pregnant women, parents, caregivers, and children from birth to 8 years of age and are ready to expand home visiting services. Program information and grant opportunities are available on the HRSA MIECHV website at http://mchb.hrsa.gov/programs/homevisiting/. For additional information about MIECHV please contact:
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Community-Based Child Abuse Prevention (CBCAP) Grants

This program provides funding to States to:

- ✓ Support community-based efforts to develop, operate, expand, enhance, and coordinate initiatives, programs, and activities to prevent child abuse and neglect and to support the coordination of resources and activities to better strengthen and support families to reduce the likelihood of child abuse and neglect

- ✓ Foster understanding, appreciation, and knowledge of diverse populations in order to effectively prevent and treat child abuse and neglect

Some of the core features of the program include:

- ❖ Federal, State, and private funds are blended and made available to community agencies for child abuse and neglect prevention activities and family support programs.

- ❖ Has an emphasis on the involvement of all parents in the planning and program implementation of the lead agency and entities carrying out local programs.

- ❖ Interagency collaborations occur with public and private agencies in the States to form a child abuse prevention network to promote greater coordination of resources.

- ❖ Funds are used to support programs such as voluntary home visiting programs, parenting programs, family resource centers, respite, parent mutual support, and other family support programs.

- ❖ Has an emphasis on promoting the increased use and high quality implementation of evidence-based and evidence-informed programs and practices.

- ❖ A focus on the continuum of evaluation approaches, which use both qualitative and quantitative methods to assess the effectiveness of the funded programs and activities.

NCANDS data are used to assess CBCAP's performance on the effectiveness of CBCAP-sponsored primary prevention efforts with regard to:

(A) A reduction of the overall rate of children who become first-time victims each year of the reporting States' population of children (younger than 18 years),

(B)A reduction in the overall rate of adults who become first-time perpetrators each year of the reporting States' population of adults (older than 18 years).

For further information regarding the CBCAP program, contact:
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Office on Child Abuse and Neglect
Children's Bureau, ACYF, ACF, HHS
1250 Maryland Ave., SW, 8th Floor
Washington, DC 20024
202–205–7403
rosie.gomez@acf.hhs.gov

Children's Bureau Training and Technical Assistance Network
The purpose of the Training and Technical Assistance (TTA Network) is to build the capacity of State, local, tribal, and other publicly administered or publicly supported child welfare agencies and family and juvenile courts through the provision of training, technical assistance, research, and consultation on the full array of Federal requirements administered by the Children's Bureau. TTA Network members provide assistance to States and Tribes in improving child welfare systems and conformity with the outcomes and systemic factors defined in the Child and Family Services Reviews (CFSRs) and the results of other monitoring reviews conducted by the Children's Bureau to ensure the safety, permanency, and well-being of children and families. Many State and tribal requests for training and technical assistance are made to Regional Administration for Children and Families (ACF) offices. For a listing of Regional ACF offices and the States they serve, visit the ACF website at http://www.acf.hhs.gov/programs/oro.

To read a PDF booklet titled
Children's Bureau Training and Technical Assistance Network (2010), which was designed to communicate to States and Tribes the specific focus of each TTA Network, please see http://www.acf.hhs.gov/programs/cb/tta/cbttan.pdf

National Data Archive on Child Abuse and Neglect

The National Data Archive on Child Abuse and Neglect (NDACAN) was established by the Children's Bureau to encourage scholars to use existing child maltreatment data sources in their research. As part of the TTA Network, NDACAN acquires data sets from various national data collection efforts and from individual researchers, prepares the data and documentation for secondary analysis, and disseminates the data sets to researchers who qualified to use the data. NDACAN houses the NCANDS's Child Files and Agency Files and licenses qualified researchers to use the data in their work. Please note that NDACAN serves as the repository for the NCANDS data sets, but is not the author of the Child Maltreatment report series. For more information about access to NDACAN, researchers may contact:
John Eckenrode, Ph.D., Director
National Data Archive on Child Abuse and Neglect Bronfenbrenner Center for Translational Research
Beebe Hall
Cornell University
Ithaca, NY 148533
607–255–7799
ndacan@cornell.edu

The National Resource Center for Child Welfare Data and Technology
The National Resource Center for Child Welfare Data and Technology (NRC-CWDT), a service of the Children's Bureau and member of the TTA Network, provides a broad range of technical assistance to State and Tribal child welfare agencies and family and juvenile courts in the use of data and information technology to improve outcomes for children and families. The center helps States, Tribes, and courts improve the quality of data collected, build the capacity to analyze and use data for decisionmaking in daily practice, and develop or improve case management and data collection systems, including Statewide Automated Child Welfare Information Systems (SACWIS). The NRC-CWDT provides technical assistance to IV–E agencies on the Federal reporting requirements—AFCARS, NCANDS, and the National Youth in Transition Database (NYTD). The Center also provides technical assistance for the CFSRs and other Federal policies and initiatives. The NRC-CWDT is operated by the Child Welfare League of America (CWLA) and its partners, Westat, and the National Center for State Courts (NCSC). For further information about the NRC-CWDT, contact:
Debbie Milner, Director

NRC-CWDT
850- 622-1567
dmilner@cwla.org

10. Resources

CHILDHELP USA® National Child Abuse Hotline
Toll-free: 1-800-422-4453 (24 hours)
(This is a national hotline that also reaches Canada, Guam, Puerto Rico, and the U.S. Virgin Islands.) or go to http://www.childhelp.org/get-help. If you need immediate assistance, call 911 or visit the federally funded Child Welfare Information Gateway at: http://www.childwelfare.gov/responding. If you need immediate assistance, call 911.

Prevent Child Abuse America - A not-for-profit organization that has worked for over 25 years with local, state, and national groups to promote healthy parenting and community involvement as effective strategies for preventing child abuse. A network of state chapters offers unique programs and services in order to meet local community needs.

- Prevent Child Abuse California - Aims to prevent child abuse in all its forms by maximizing resources throughout the State of California. General information, ways to help, programs, legislation, and yearly highlights.
- Prevent Child Abuse Illinois - Dedicated exclusively to the prevention of child abuse and neglect and building strong, healthy families. Signs of abuse, prevention programs, special events, parenting tips, community resources, and advocacy.
- Prevent Child Abuse New York - Works so that all children live in families that love, nurture and protect them. Child abuse information, prevention tips, family resources, and member organizations.
- Prevent Child Abuse Texas - Works to prevent child abuse and neglect in all its forms throughout Texas. Advocacy opportunities, conference information, abuse facts and upcoming events.

Organizations and Agencies

Childhelp USA
15757 N. 78th Street
Scottsdale, AZ 85260
Phone: (480) 922-8212
Toll-Free Hotline: 1-800-422-4453
www.childhelpusa.org

The ChildTrauma Academy
5161 San Felipe, Suite 320
Houston, TX 77056

Phone: (713) 818-3967
www.childtrauma.org

Child Welfare League of America
440 First Street NW, Suite 310
Washington, DC 20001-2085
Phone: (202) 638-2952
www.cwla.org

Healthy Families America
Prevent Child Abuse America
200 S. Michigan Avenue, Suite 1700
Chicago, IL 60604
Phone: (312) 663-3520
www.healthyfamiliesamerica.org
HFA is a national program model designed to help expectant and new parents get their children off to a healthy start. Families participate voluntarily and receive home visiting and referrals from trained staff. By providing services to overburdened families, HFA fits into the continuum of services provided to families in many communities.

International Society for Prevention of Child Abuse and Neglect
25 W. 560 Geneva Rd., Suite L2C
Carol Stream, IL 60188
Phone: (630) 221-1311
www.ispcan.org

National Association for Prevention of Child Abuse and Neglect
PO Box K241
Haymarket
NSW 1240
Phone: 02 9211 0224
www.napcan.org.au

National Child Protection Clearinghouse
Australian Institute of Family Studies
300 Queen Street
Melbourne Vic 3000
Phone: 03 9214 7888
www.aifs.org.au/nch/
The NCPC collects, shares, monitors and distributes information on the prevention of child abuse and neglect.

National Clearinghouse on Child Abuse and Neglect
330 C Street, SW
Washington, DC 20447
Toll-free: 1-800-394-3366
nccanch.acf.hhs.gov

National Data Archive on Child Abuse and Neglect
Surge 1 - FLDC
Cornell University
Ithaca, NY 14853
Phone: (607) 255-7799
www.ndacan.cornell.edu

National Resource Center on Child Maltreatment
P.O. Box 441470
Aurora, CO 80044-2470
Phone: (303) 369-8008
www.gocwi.org/nrccm/
NRCCM provides information, training, and technical assistance to state, local, and tribal child protection agencies.

Tribal Court Clearinghouse: Child Abuse & Neglect
The Tribal Law & Policy Institute
8235 Santa Monica Blvd., Suite 211
West Hollywood, CA 90046
Phone: (323) 650-5467
www.tribal-institute.org/lists/child.htm
Information on Indian Child Welfare Act, resources for Tribal Court, law enforcement, and social services personnel regarding child abuse and neglect on reservations, Tribal family resources.

USUHS Radiology Child Abuse Website
Child Abuse Referral and Education (CARE) Network
rad.usuhs.mil/rad/home/peds/pedindex.html
Extremely comprehensive site from the Uniformed Services University of Health Science and the Armed Forces Institute of Pathology, with information for medical personnel attempting to distinguish abuse/neglect related injuries and fatalities from accidental injury, SIDS, etc. Includes sections on injuries to various types of trauma, radiological imaging, Shaken Baby Syndrome, and reporting suspected abuse/neglect cases by military medical personnel.

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[released 05/17/2012]). Here and throughout this report, the term “child population” refers to all people in the U.S. population younger than 18 years.

About the Course Presenter:

Nicole Hiltibran, MA, LMFT, is a graduate from Pepperdine University, where she earned her Masters Degree in Clinical Psychology with an emphasis in Marriage and Family Counseling, and is a Licensed Psychotherapist. Nicole has 25 years of experience serving adults, children, couples and families both in the public sector and private practice. Nicole has written state licensing exams for the California State Board of Behavioral Sciences for 10 years as well as offering continuing education courses to licensed mental health and social work professionals including LMFT’s, LCSW’s, LPCCs, RN’s, and PhD’s.