Identification and Reporting of Child Abuse in NYS

The New York State Nurses Association (NYSNA) has been approved by the New York State Education Department (NYSED) to provide this course for all mandated licensed healthcare providers, certified teachers and social workers. This program is designed as a distance learning self-study program which will meet the New York State child abuse recognition and reporting requirements.

Upon successful completion of this course, results are forwarded electronically to the NYSED, Licensing Division **everyday at 4 p.m**. There is no need for you to send in the certificate - the information will be submitted to the NYSED Licensing Division for you. This saves valuable time and provides a secure and efficient record of course completion. **Please understand the NYSED requires a minimum of 3 business days to update your state record.**

The New York State Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This course has been awarded 3.25 contact hours.

All American Nurses Credentialing Center's *(*ANCC) accredited organizations' contact hours are recognized by all other ANCC accredited organizations. Most states with mandatory continuing education requirements recognize the ANCC accreditation/approval system. Questions about the acceptance of ANCC contact hours to meet mandatory regulations should be directed to the professional licensing board within that state.

NYSNA has been granted provider status by the Florida State Board of Nursing as a provider of continuing education in nursing (Provider number 50-1437).

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

How to Take This Course

Please take a look at the steps below; these will help you to progress through the course material, complete the course examination and receive your certificate of completion.

1. **REVIEW THE OBJECTIVES**

   The objectives provide an overview of the entire course and identify what information will be focused on. Objectives are stated in terms of what you, the learner, will know or be able to do upon successful completion of the course. They let you know what you should expect to learn by taking a particular course and can help focus your study.

2. **STUDY EACH SECTION IN ORDER**

   Keep your learning "programmed" by reviewing the materials in order. This will help you understand the sections that follow.

3. **COMPLETE THE COURSE EXAM**

   After studying the course, click on the "Course Exam" option located on the course navigation toolbar. Answer each question by clicking on the button corresponding to the correct answer. All questions must be answered before the test can be graded; there is only one correct answer per question. You may refer back to the course material by minimizing the course exam window.

4. **GRADE THE TEST**

   Next, click on "Submit Test." You will know immediately whether you passed or failed. If you do not successfully complete the exam on the first attempt, you may take the exam again. If you do not pass the exam on your second attempt, you will need to purchase the course again.

5. **FILL OUT THE EVALUATION FORM**

   Upon passing the course exam you will be prompted to complete a course evaluation. You will have access to the certificate of completion **after you complete the evaluation**. Be sure to print the certificate and keep it for your records.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Course Introduction

It shouldn't hurt to be a child. Child abuse and neglect are seen in many areas of clinical practice. The content for this course uses the hospitalized child as a specific model. It is important when reviewing the information that professionals realize that the indicators of child abuse, maltreatment and neglect can be applied to all practice settings in which professionals interact with children and their families/caregivers. As child abuse is not limited to one setting, neither is its identification or reporting.

Chapter 544 of the laws of 1988, as amended, established a requirement for certain professions (see list below) to provide documentation of having completed two hours of coursework or training regarding the identification and reporting of child abuse and maltreatment. The law further states that the coursework or training must be obtained from a provider approved for this purpose by the New York State Education Department. The New York State Nurses Association (NYSNA) has been approved as a provider and this course meets the training requirements of chapter 544 of the laws of 1988.

In addition, Chapter 394 was amended to provide information for persons in the normal course of their employment, or who travel to locations where children reside, on recognizing signs of an unlawful (clandestine) methamphetamine laboratory. While a specific curriculum has not yet been developed to address this amendment, pursuant to this recently enacted legislation content has been added to this course on how to recognize these illegal labs.

In 2005, the New York State Office of Children and Family Services revised and published the Summary Guide for Mandated Reporters in NYS. This helpful booklet can be downloaded and used as an overview of the material in this course as well as a handy reference on the identification and reporting of child abuse, including how to report suspected child abuse to the New York State Central Register (SCR) of child abuse and maltreatment. A copy of the booklet can be obtained at: http://www.ocfs.state.ny.us/main/publications/pub1159.pdf.

Regardless of the mandated reporter's professional discipline or location of provided services, it is important to understand the responsibility of all professionals to be able to recognize child abuse/neglect and to engage in appropriate interventions.

Mandated Reporters

- Alcoholism counselor
- Any child care worker
- Any employee or volunteer in a residential care facility for children
- Any other child care or foster care worker
- Any other law enforcement official

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

- Christian Science Practitioner
- Chiropractor
- Coroner
- Day care center worker
- Dental hygienist
- Dentist
- District attorney or assistant district attorney
- Emergency medical technician
- Hospital personnel engaged in the admission, examination, care, or treatment of persons
- Intern
- Investigator employed in the Office of the District Attorney
- Medical Examiner
- Mental health professional
- Optometrist
- Osteopath
- Peace officer
- Physician
- Podiatrist
- Police officer
- Provider of family or group family day care
- Psychologist
- Registered Nurse
- Registered physician assistant
- Resident
- School official
- Social service worker
- Social workers
- Substance abuse counselor
- Surgeon

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Objectives

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

- Define what constitutes "abuse," "maltreatment," and "neglect" according to the New York State Family Court Act and Social Services Law.
- Distinguish among various behavioral and environmental characteristics of abusive parents or caregivers.
- Participants will learn what equipment and chemicals may be signs of a clandestine methamphetamine lab.
- Participants will learn what drug-endangered children are and to whom to report child endangerment.
- Identify physical and behavioral indicators of physical abuse, maltreatment and neglect.
- Contrast the physical and behavioral indicators of sexual abuse.
- Identify the professional's role in child abuse identification and reporting.
- Describe the actions in caring for abused/maltreated children and their families/caregivers.
- Describe situations in which mandated reporters must report suspected cases of child abuse or maltreatment.
- Describe what constitutes "reasonable cause to suspect" that a child has been abused or maltreated.
- Outline the proper procedure for making a report of suspected child abuse.
- List what actions certain mandated reporters might take to protect a child in addition to filing a child abuse report.
- Describe the legal protections afforded mandated reporters and the consequences for failing to report.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

About the Authors

This course was designed by a team of experts in the Nursing Advocacy and Information Program of the New York State Nurses Association.

The course was updated in June 2007 by **Cheryl J. Collins, RN, LMHC.** Ms. Collins is a nurse and mental health counselor who has worked in the addictions field for the past fifteen years. She co-founded a community based 350-hour training program for Credentialed Alcohol and Substance Abuse Counselors and currently teaches several classes within that curriculum. Ms. Collins is self-employed, developing courses for several human service agencies in the Capital District of New York and in Florida where she currently resides.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Historical Factors Related to Child Abuse and Maltreatment

Accounts of the abuse and maltreatment of children have strong historical roots. Children were considered to be the property of the parents or caregivers. Indeed, childhood is a relatively new concept. Until approximately the 18th century, children were seen as small adults. Children, as property of their parents or caregivers, did not have rights. The old saying, "Spare the rod and spoil the child' gives an indication of the prevailing perspective. Child begging and mutilation, as well as infanticide were not uncommon. Indeed in many parts of the world today these actions persist to impact the lives of children. Home imprisonment throughout history was not uncommon; child labor has long been a problem (and remains so in many parts of the world) and the industrial revolution in the Western countries only created yet another means for children to be in servitude.

The Society for Prevention of Cruelty to Children (SPCC) was founded in New York City in 1875. To a significant degree it was the case of Mary Ellen McCormack that spurred its creation. In 1873, Mary Ellen McCormack, a 9 year old orphan, lived in New York City with Francis and Mary Connolly. She was physically abused almost daily by Mrs. Connolly, who often used a raw-hide whip. Mary Ellen had few clothes, no bed, and was not allowed to leave the house. A social worker, Etta Wheeler, learned of the child's horrible situation; she saw the conditions under which the child lived and she saw Mary Ellen herself, an undernourished and uncared for child whose body bore the marks of repeated beatings. Despite efforts to intervene on her behalf, Ms. Wheeler found that the law, as well as charitable institutions, was unable to protect the girl. Finally it was the Society for the Prevention of Cruelty to Animals who intervened to protect Mary Ellen as an abused member of the animal kingdom. On April 9, 1874, Mary Ellen McCormack, a fresh gash on her face, was brought into a New York courtroom to tell her story to the Judge Abraham Lawrence. This was the beginnings of the children's rights movement.

Almost a century later in 1969, a child named Roxanne died. Her death was instrumental in the creation of New York State's comprehensive Child Protection Laws.

In 1987, the beating death of 6-year-old Lisa Steinberg in New York City reminded New Yorkers very vividly that child abuse was not a crime of the past but continued to exist and was continuing to increase at alarming rates. This situation was particularly disturbing because there had been indications that the child was being abused, but this was not reported. It was a toll collector for the New York State Thruway Authority who finally called the police when the bruised child was observed in the back seat of the car. The death of Lisa Steinberg led to the NYS requirement that all professionals mandated to report child abuse and maltreatment must complete an educational program on the identification and reporting of child abuse and maltreatment in order to be licensed or certified.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Legal Definitions

The following are the definitions provided in the New York State Laws:

Abuse

Abuse encompasses the most serious harms committed against children. An abused child is defined as one who is under eighteen years of age whose parent or other person legally responsible for his/her care:

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

In New York State, an abused child can also mean:

- A child residing in a group residential care facility under the jurisdiction of the New York State Office of Children and Family Services (OCFS), Division for Youth (DFY), Office of Mental Health (OMH), Office of Mental Retardation and Developmental Disabilities (OMRDD), or the State Education Department (SED). The definition of an abused child in these settings is virtually identical.

OR

- A child with a handicapping condition who is 18 years or older who is defined as an abused child in residential care and who is in residential care in one of the following facilities: NYS School for the Blind (Batavia), NYS School for the Deaf (Rome), a private residential school which has been designed for special education, a special act school district or a state supported school for the deaf or blind which has a residential component.

Maltreatment

Maltreatment means that a child's physical, mental, or emotional condition has been impaired or placed in imminent danger of impairment, by the parent's or legal guardian's failure to exercise a minimum degree of care.

A maltreated child includes a child:

- Less than eighteen years of age defined as a neglected child by the Family Court Act.
- Who has had serious physical injury inflicted upon him/her by other than accidental means.
- Eighteen years of age or older, who is neglected and resides in one of the special residential care institutions previously listed.

Neglect

A neglected child is defined as a child less than eighteen years of age whose physical, mental, or emotional condition has been impaired or is in imminent danger of becoming impaired as a result of the

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

failure of his/her parents or other person legally responsible for his/her care to exercise a minimum degree of care:

- In supplying the child with adequate food, clothing, shelter, or education, or medical, dental, optometric or surgical care, though financially able to do so or offered financial or other reasonable means to do so.
- In providing the child with proper supervision or guardianship, by unreasonably inflicting or allowing to be inflicted harm, or a substantial risk thereof, including the infliction of excessive corporal punishment.
- By misusing a drug, drugs, or alcohol to the extent that he or she loses self-control of his/her actions.
- By any other acts of similarly serious nature requiring the aid of the court.
- Whom his/her parents or other person legally responsible for the child's care has abandoned.
- Poverty or other financial inability to provide for the child is not maltreatment.

In New York State an emotionally neglected child is defined in the Family Court Act as:

- A state of substantially diminished psychological/intellectual functioning in relation to such factors as failure to thrive, control of aggression/self-destructive impulses, ability to think and reason, or acting out and misbehavior.
- Impairment clearly attributable to the unwillingness or inability of the parent or other person legally responsible for the child to exercise a minimum degree of care to the child.

In New York State a neglected child in residential care (including facilities operated by the Department of Social Services [DSS], Division for Youth [DFY], Office of Mental Health [OMH], Office of Mental Retardation and Developmental Disabilities [OMRDD], or the State Education Department [SED]) means a child whose custodian impairs, or places in danger of impairment, the child's physical, mental or emotional condition:

- By intentionally administering to the child any prescription drug not ordered.
- Failing to adhere to standards for the provision of food, clothing, shelter, education, medical, dental, optometric or surgical care, or the use of isolation or restraint.
- Failing to adhere to standards for the supervision of children by inflicting or allowing to be inflicted physical harm or risk of harm.
- Failing to conform to applicable state regulations for appropriate custodial conduct.

Definition of Person Legally Responsible

A legal caregiver or person legally responsible is a:

- Parent
- Guardian
- Foster parent
- Custodian
- Any other person responsible for the child's care at the relevant time.

It is important to emphasize that abuse or maltreatment can result from the acts of the parent or person legally responsible for a child's care, and suspected incidents should be reported accordingly. In accordance with Sec. 1012(g) of the Family Court Act:

> "*Person legally responsible*" includes the child's custodian, guardian, or any other person responsible for the child's care at the relevant time. Custodian may include any person continually or at regular intervals found in the same household as the child when the conduct of such persons causes or contributes to the abuse of neglect of the child.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

TEST YOURSELF QUESTION #1:

Under New York State law, is it possible for an individual over 18 years of age, who has a disability and resides in a New York state-approved residential care facility, to be classified as an abused child?

a. No, since the person is over the age limit.
b. No, since the person is considered a ward of the state.
c. Yes, this person can be included in this classification.
d. Yes, but only if mentally compromised.

Please turn to page 50 for answer.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Key Assessment Factors

Characteristics of abusive parents or caregivers can be identified by careful assessment that includes:

- Parent/Caregivers History
- Parent/Child History
- Environmental Factors

It is important to remember that child abuse and neglect is a family problem. It is a disease of parenting; it is deviant parenting. Child abuse should receive the same logical, step-wise diagnostic work-up, treatment, and management as any other serious condition. The challenge is to recognize the potential for child abuse early and to intervene on a primary, rather than secondary, level.

American culture, on the whole, accepts and condones the use of physical discipline as normal practice in the adult-child relationship. There is definitely room for learning in parenting styles. However, the message from the caregiver to the child must be "it is safe, you can trust me, come out, experiment, you will not be destroyed."

An abusive/neglecting parent does not fit a simple mold. Child abuse/neglect covers a broad continuum of behaviors. Abuse/neglect can run the gamut from an isolated explosive episode to psychotic behavior. However, most abusive parents are not psychotic; they are frequently adults who were abused/maltreated children. Their parenting model was an abusive one. They know no other way of acting. We all essentially parent the way we were parented. Each of us has the potential to abuse. We are saved by our coping mechanisms, our own positive experiences as children and as adults, our own thoughtful examination of and response to parenting and/or our intact social supports such as spouses, family and friends.

It should be noted that these indicators are clues but not conclusive proof. They may exist in situations where a child is not suspected to be abused or maltreated. However, they are useful to remember when dealing with the parent/caregiver or child. Clues rarely appear as single entities. Typically, several clues will appear regarding the child and his/her family. Except for the obvious, single clues should be treated as "flags" which indicate that the professional needs to look further, more closely, and methodically.

Parent/Caregiver History

Items in the personal history of the parent/caregiver that should be seen as "red flags" include:

- Parent was abused or neglected as a child.
- Lack of friendships or emotional support:
    - Isolated from supports such as friends, relatives, neighbors, community groups
    - Lack of self-esteem, feelings of worthlessness
- Marital problems of the parents (and grandparents):
    - May include intimate partner violence
- Physical or mental health problems or irrational behavior.
- Life crisis:
    - Financial debt
    - Unemployment/underemployment
    - Housing problems
    - Other significant life stressors
- Alcohol/substance abuse of parents or grandparents.
- Adolescent parents.

Parent/Child History

Items in the history between the parent and child that should be seen as "red flags" include:

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

- Parents have unrealistic expectations of child's physical and emotional needs. (Note: Mentally/developmentally disabled children are particularly vulnerable.)
- Parent's unrealistic expectations for child to meet parent's emotional needs:
  - Role reversal
  - Children viewed as "miniature adults"
- Absence of nurturing child-rearing skills:
  - Violence/corporal punishment is accepted as unquestioned child-rearing practice within the parent's culture
  - Violence is accepted as a normal means of personal interaction
- Delay or failure in seeking health care for child's injury, illness, routine checkups, immunizations, etc.
- Parent views child as bad, evil, different, etc.

<u>Environmental Factors</u>

Environmental factors that should be seen as “red flags” include:

- Lack of social support. (Note: there may be an inability to ask for and receive the kind of help and support parents need for themselves and their children.)
- Homelessness.

<u>Behaviors of Parent/Caregivers of Abused Children</u>

Behaviors of parent/caregivers of abused children that should be seen as “red flags” include:

- Contradictory histories.
- Cannot explain the child's injury or condition.
- Reluctant to give information.
- Blame the child's injury on siblings or others.
- Hospital "shop," delay in getting care.
- Refuse to give consent for diagnostic workup.
- Exhibit loss of control.
- Overreact or under react to child's condition.
- Complain about issues unrelated to child's condition.
- Have unrealistic expectations of the child.
- Cannot be located.
- Present a history of family discord.

Both the abusing and non-abusing parent are ultimately responsible.

TEST YOURSELF QUESTION #2:

Family histories can reveal clues that suggest further investigation is warranted if child abuse is suspected. Which of the following is such a clue?

a. Grandparents were divorced.
b. Single parent family.
c. Parent who stutters.
d. Parent was abused as a child.

Please turn to page 50 for answer.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Methamphetamine and Children at Risk

Thousands of children are neglected every year after living with parents, family members, or caregivers who are using or cooking methamphetamine (meth). Children who reside in or near meth labs are at great risk of being harmed by toxic ingredients and noxious fumes. They are known as ***drug-endangered children*.** These children are often malnourished and are suffering the effects of physical and/or sexual abuse. Some of these children have dangerous chemicals or traces of illicit drugs in their systems. Others suffer burns to their lungs or skin from chemicals or fire. Some have died in explosions and fires. Many have behavior problems as a result of neglect. Children who live at or visit drug-production sites or who are present during drug production face a variety of health and safety risks, including:

- inhalation, absorption, or ingestion of toxic chemicals, drugs, or contaminated foods that may result in nausea, chest pain, eye and tissue irritation, chemical burns, and death.
- fires and explosions.
- abuse and neglect.
- hazardous lifestyle (presence of booby traps, firearms, code violations, poor ventilation).

Understanding what to look for, identifying symptoms of methamphetamine use, and recognizing signs of a clandestine methamphetamine laboratory are critical in assessing a child's environment.

Methamphetamine

What is Methamphetamine?

Methamphetamine is a potent central nervous system stimulant. Meth can be smoked, snorted, injected or administered orally. Users refer to meth as “crank,” “speed,” “crystal,” or “ice.”

What Does Methamphetamine Look Like?

Meth is available as a crystalline powder or in rock-like chunks. Meth varies in color and may be white, yellow, brown, or pink. The following images of methamphetamine are courtesy of the United States Drug Enforcement Administration. Additional images may be viewed on their Web site at http://www.usdoj.gov/dea/photo_library3.html#meth.

Signs of Methamphetamine Use

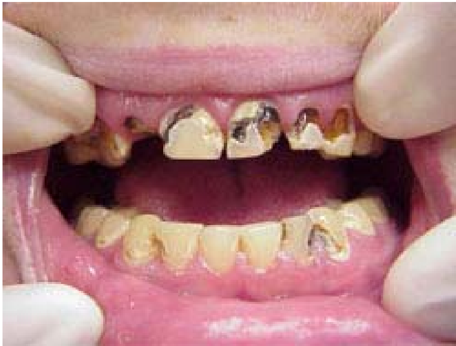
Users who smoke or inject meth will experience an intense sensation, called a “rush” or “flash” that lasts only a few minutes and is described as extremely pleasurable. This is followed by a state of high agitation that in some individuals can lead to violent behavior. Snorting or swallowing meth produces a “high” but not a “rush.” The user may exhibit dilated pupils, sweating, dry mouth, flushed skin, and tremors. They often experience increased wakefulness and insomnia, decreased appetite, irritability, anxiety, nervousness, and convulsions. They may also exhibit aggressive and psychotic behavior, irritability, anxiety, paranoia, and auditory hallucinations.

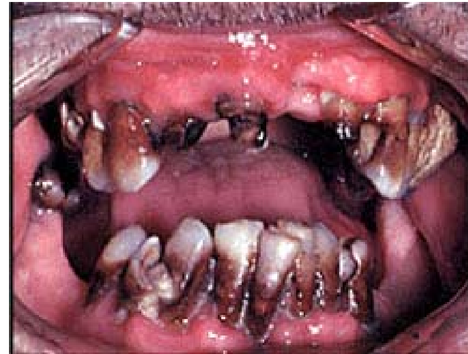
Long term effects of methamphetamine use include accelerated aging of the skin, hair, and body physique, wearing down of tooth enamel, including decay.

“Meth Mouth” photos courtesy of:

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Sharlee Shirley, RDH, MPH; Jim Cecil, DMD, MPH, University of Kentucky, School of Dentistry





This series of photos graphically illustrates the deterioration of a methamphetamine user over the course of 10 years.

Please visit http://www.drugfree.org/Portal/DrugIssue/MethResources/faces/index.html to view additional images of the effects of methamphetamine use.

<u>What is a Clandestine Laboratory?</u>

The clandestine drug laboratory or clan lab is a mini-chemical lab designed for one purpose: to manufacture illegal drugs quickly and cheaply. Clandestine lab chemists can produce LSD, synthetic heroin and other drugs, but their drug of choice is methamphetamine.

These homemade drugs are dangerous, but the labs are equally dangerous and can be located in any neighborhood. Toxic chemicals, explosions, fires, booby traps, and armed criminals - are all common dangers of clandestine labs.
Clandestine labs can be found in:

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

- Rural rentals with absentee landlords (homes, barns, mobile homes or outbuildings).
- Urban home or apartment rentals with absentee landlords.
- Trailers and motor homes.
- Motel rooms.
- Houseboats.
- Mini-storage units. These are used to store chemicals, drugs, lab equipment and weapons.

Why Should I Be Concerned?

Methamphetamine users are not the only persons poisoned by this drug. The manufacture of it is extremely dangerous and involves many common household chemicals. These chemicals, alone and in an array of combinations, can be toxic and even lethal. When mixed, these chemicals can damage the central nervous system, liver and kidneys. They can also burn or irritate the skin, eyes, nose, and throat.

The chemicals and their fumes can permeate the wall, carpets, plaster, and wood in meth labs and the surrounding soil, making this a danger to anyone who enters. These chemicals are known to cause cancer, short-term and permanent brain damage, immune system problems, and respiratory problems.

Many clandestine meth lab operators are untrained in the use of dangerous chemicals. This results in fires and explosions that can injure and kill not only the meth producers but innocent bystanders, children, neighbors, law enforcement officials, firemen, and home healthcare providers. Some meth lab operators experiment with other chemical mixtures, producing unknown toxic and hazardous chemical waste and fumes that may kill several innocent people.

In addition, meth use increases the cost to society for medical and emergency room use. It also contributes to the domestic violence, child abuse, automobile accidents, and the spread of infectious diseases such as Hepatitis C and HIV.

Potential Health Effects

Types	Common Chemicals	Symptoms/Health Effects
Solvents	Acetone, ether/starting fluid, Freon, hexane, methanol, toluene, white gas, xylene	Irritation to skin, eyes, nose and throat; headache; dizziness; depression; nausea; vomiting; visual disturbances; cancer
Corrosives/irritants (acids/bases)	Anhydrous ammonia, iodine crystals, hydrochloric acid (*muriatic acid),* phosphine, sodium hydroxide *(lye),* sulfuric acid *(drain cleaner)*	Cough; eye, skin and respiratory irritation; burns and inflammation; gastrointestinal disturbances; thirst; chest tightness; muscle pain; dizziness; convulsions
Metals/salts	Iodine, lithium metal, red phosphorus, yellow phosphorus, sodium metal	Eye, skin, nose and respiratory irritation; chest tightness; headache; stomach pain; birth defects; jaundice; kidney damage

External Signs of a Meth Lab

Any single activity may or may not be sole proof that drug dealing or methamphetamine production is occurring. However, a combination of the following may be reason for concern:

- Frequent visitors at all times of the day or night.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

- Occupants appear unemployed, yet seem to have plenty of money and pay bills with cash.
- Occupants display paranoid or odd behavior.
- Windows blackened or curtains always drawn.
- Chemical odors coming from the house, garbage or detached buildings.
- Garbage contains numerous bottles, container, and materials such as those listed in the section below.
- Coffee filters, bed sheets or other material stained from filtering red phosphorus or other chemicals.

Common household cleaning chemicals and products, including over-the-counter medications, are frequently used in meth production.

Large Quantities of Common Chemicals Used in Meth Production	
Chemical Name	**Commonly found in:**
Alcohol	Isopropyl or rubbing
Toluene	Brake cleaner
Ether	Engine starter
Sulfuric Acid	Drain cleaner
Red Phosphorus	Matches/road flares
Salt	Table/rock
Iodine	Teat dip or flakes/crystals
Lithium	Batteries
Trichloroethane	Gun scrubber
MSM	Cutting agent
Sodium or Potassium Metal	
Methanol/Alcohol	Gasoline additives
Muriatic Acid	
Anhydrous Ammonia	Farm fertilizer
Sodium Hydroxine	Lye
Pseudoephdrine/Ephedrine	Cold tablets (Sudafed)
Acetone	Nail polish remover
Calcium bentonite or silica gel	Kitty Litter
Ammonium Sulphate Fertilizer	Used to make Anhydrous Ammonia
Liquid Propane	
Carbon dioxide	Dry Ice
Drierite	Used to remove water

The equipment in meth production is common in name or type, but uncommon in the large quantities needed to produce meth.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Common Equipment Used in Meth Production		
• Pyrex or Corning dishes • Jugs/bottles • Paper towels • Coffee filters • Thermometer • Cheesecloth • Funnels • Blenders	• Rubber tubing/gloves • Pails/buckets • Gas cans • Tape clamps • Internet documents/notes • Strainers • Aluminum foil • Propane cylinders	• *"How to Make Methamphetamine"* books • Hotplates • Plastic storage containers/ice chests • Measuring cups • Scales • Towels/bed sheets • Laboratory beakers/glassware • Mop pail

Children Affected by Meth Labs

According to the El Paso Intelligence Center (EPIC) National Clandestine Laboratory Seizure System, there were 1,660 children affected by or injured or killed at methamphetamine labs during calendar year 2005. A child affected by labs includes children who were residing at the labs but may not have been present at the time of the lab seizure as well as children who were visiting the site.

Number of Children Affected by Labs, 2002–2005

	2002	2003	2004	2005
Child injured	11	25	13	11
Child killed	2	1	3	2
Children affected	3,660	3,682	3,088	1,647
Total injured/killed/affected	**3,673**	**3,708**	**3,104**	**1,660**

Source: Office of National Drug Control Policy, March 2, 2007

How Do We Respond?

In October 2003, the Office of National Drug Control Policy announced a National Drug Endangered Children (DEC) (http://www.whitehousedrugpolicy.gov/news/press03/100603.html) initiative to assist with coordination between existing state programs. This initiative created a standardized training program to extend DEC to states where such a program does not yet exist.

On February 27, 2007 the Drug Endangered Children Act of 2007 (HR 1199) (http://thomas.loc.gov/cgi-bin/query/z?c110:H.R.1199:) was introduced in the House of Representatives. If passed, the bill would provide $20 million in DEC grants for fiscal years 2008 and 2009.

A variety of agencies are called upon to respond when drug laboratories are identified, including HAZMAT, law enforcement, and fire officials. When children are found at the laboratories; however, additional agencies and officials should be called in to assist, including emergency medical personnel, social services, and physicians.

Although coordination among child welfare services, law enforcement, medical services, and other agencies may vary across jurisdictions, interagency protocols developed to support drug-endangered children should generally address:

- staff training, including safety and cross training.
- roles and responsibilities of agencies involved.
- appropriate reporting, cross-reporting, and information sharing.
- safety procedures for children, families, and responding personnel.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

- interviewing procedures.
- evidence collection and preservation procedures.
- medical care procedures.

Actions of the responding agencies should include taking children into protective custody and arranging for child protective services, immediately testing the children for methamphetamine exposure, conducting medical and mental health assessments, and ensuring short and long-term care.

For further information on recognizing clandestine meth labs please visit www.elearnonline.net for the online course, *Clandestine Methamphetamine Labs: What's Cooking in Your Neighborhood?*, or refer to the New York State Office of Alcoholism and Substance Abuse Services Web site at http://www.oasas.state.ny.us/meth/.

TEST YOURSELF QUESTION #3:

It is necessary for healthcare workers to be aware of the signs of a clandestine methamphetamine lab because:

A. Methamphetamine labs are found only in rural areas or inner city projects.
B. It is considered a danger to children, therefore is inclusive in the definition of child abuse.
C. Methamphetamine users or cookers are the only ones in danger of "poisoning."
D. Children are at risk only when methamphetamine is being cooked.

Please turn to page 50 for answer.

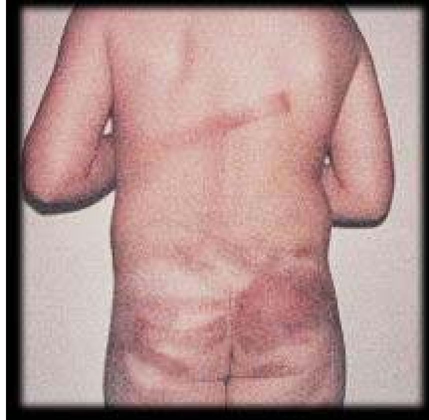
© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Assessing Physical Symptoms

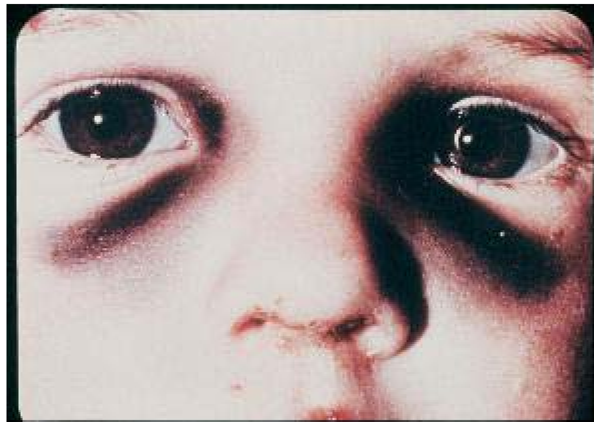
Special attention should be paid to injuries that are unexplained or are inconsistent with the parent(s)/caregiver's explanation and/or the developmental stage of the child. This section will describe physical and behavioral signs that could indicate abuse.

Bruises, welts, and bite marks:

- On face, lips, mouth, neck, wrists, and ankles
- On torso, back, buttocks, and thighs



- Both eyes or cheeks - always of suspicious origin because only one side of the face is usually injured as the result of an accident.



- Clustered, forming regular patterns reflecting shape of article used to inflict, i.e., electric cord, belt buckle, etc.
- Grab marks on arms or shoulders

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

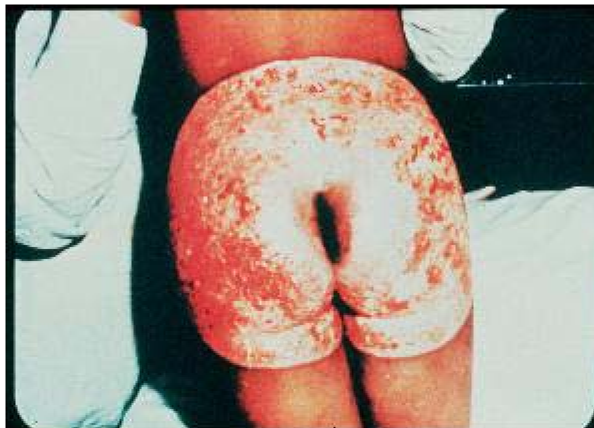
- On several different surface areas
- Evidence of human bite - human bite compresses the flesh, animal bite tears flesh and has narrower teeth imprint
- In various stages of healing
- Regularly appear after absence, weekend, or vacation

Lacerations or abrasions:

- To mouth, lips, gums, eyes
- To external genitalia
- On backs or arms, legs or torso

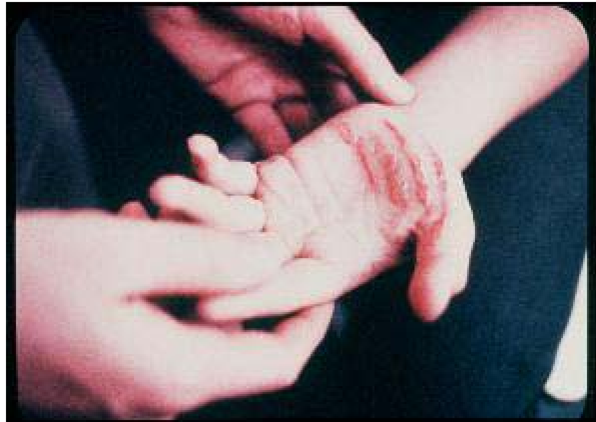
Burns:

- Cigar, cigarette burns, especially on soles, palms, back, or buttocks
- Immersion burns by scalding water (sock-like, glove-like, doughnut- shaped on buttocks or genitalia - "dunking syndrome")

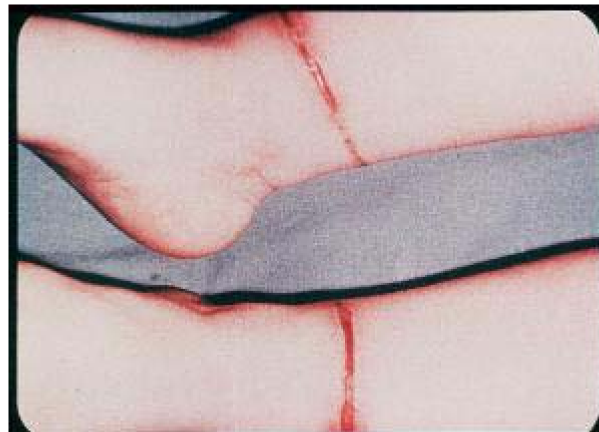


- Patterned burn, for example electric burner, iron, etc.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

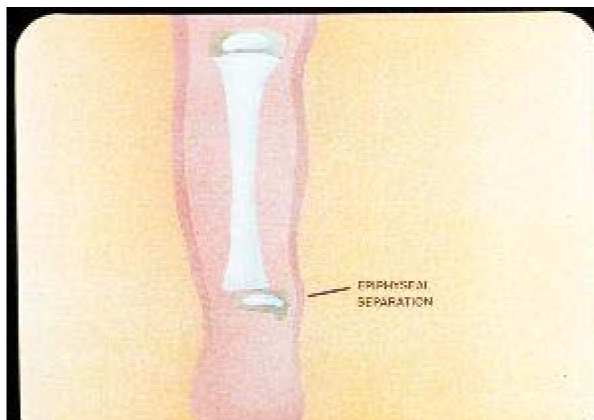


- Rope burns on arms, legs, neck, or torso



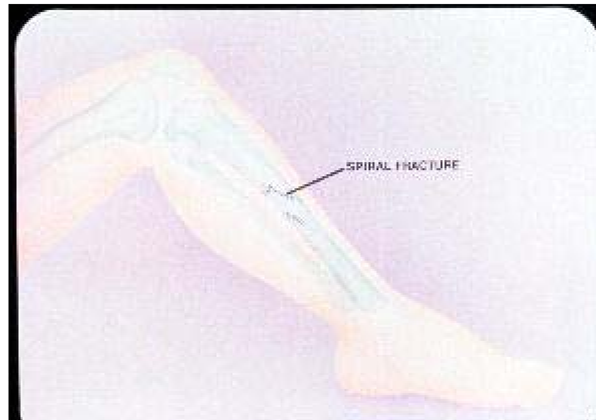
Fractures:

- To skull, nose, facial structure
- Skeletal trauma accompanied by other injuries, such as dislocations



- Multiple or spiral fractures

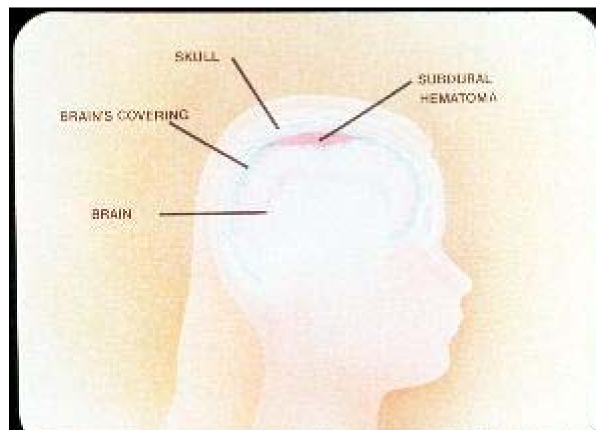
© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.



- In various stages of healing
- Fracture "accidentally" discovered in the course of an exam

Head Injuries

- Absence of hair and/or hemorrhaging beneath the scalp due to vigorous hair pulling
- Subdural hematoma (a hemorrhage beneath the outer covering of the brain, due to severe hitting or shaking)



- Retinal hemorrhage or detachment, due to shaking
- Shaken baby syndrome/Whiplash shaken infant syndrome

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

- Eye injury
- Jaw and nasal fracture
- Tooth or frenulum injury

Symptoms suggestive of parentally - induced or fabricated illnesses:

- Sometimes know as Munchausen Syndrome by Proxy (MSP) - an example might be repeatedly causing a child to ingest quantities of laxatives sufficient to cause diarrhea, dehydration, and hospitalization

TEST YOURSELF QUESTION #4:

Physical signs that almost always indicate child abuse are:

a. Bruises
b. Lacerations
c. Persistent diaper rash
d. Injuries to both eyes or cheeks

Please turn to page 50 for answer.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Assessing Behavioral Symptoms

- Wary of contact with other adults
- Apprehensive when other children cry
- Exhibits behavioral extremes:
  - Aggressiveness
  - Destructiveness
  - Withdrawal
  - Emotionless behavior
  - Extreme mood changes
- Is afraid to go home, has repeated incidents of running away
- Fear of parents
- Reports injury by parents
  - Sometimes blames self, e.g. "I was bad and I was punished"
- Has habit disorders
  - Self-injurious behaviors
  - Psychological reactions (obsessions, phobias, compulsions, hypochondria)
- May wear long sleeves or other concealing clothing to hide physical indicators of abuse
  - Often inappropriate for season
- Manifests low self-esteem
- Attempts Suicide

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Maltreatment and Neglect

Just as when observing for physical abuse, professionals must be alert and aware for physical and behavioral signs of possible maltreatment and neglect. Remember that not all of these symptoms are present in all abusive/neglectful situations. Look for patterns, clues, or a combination of indicators.

Physical Indicators

- Obvious malnourishment
- Failure to thrive (physically or emotionally)
- Drug withdrawal symptoms in newborns
- Lags in physical development
- Poor hygiene/inappropriate seasonal dress, consistent hunger
- Speech disorders
- Chronic lack of supervision, especially in dangerous activities or for long periods
- Unattended physical problems/medical needs
- Untreated need for glasses, dental care
- Chronic truancy
- Abandonment

Behavioral Indicators

- Begging for, or stealing food
- Extended stays at school (early arrival or late departure)
- Constant fatigue/listlessness
- Alcohol or drug use/abuse
- Delinquency (e.g., thefts)
- Runaway behavior
- Habit disorders (sucking, biting, rocking, head banging)
- Conduct disorders (antisocial, destructive)
- Neurotic traits (sleep disorders, inhibited play)
- Psychological reactions (hysteria, phobias, hypochondria)
- Behavioral extremes (compliant, passive, aggressive, demanding)
- Lags in mental and/or emotional development
- Suicide attempts

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Sexual Abuse

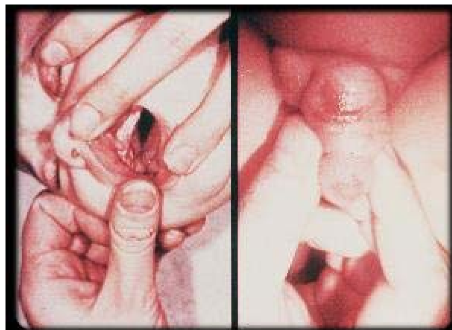
Because most sexual abuse cases do not present overtly apparent physical evidence or indicators, identification and recognition are often very difficult. To compound the problem of detection and identification, the many legitimate fears which child victims of sexual abuse experience make it extremely difficult for them to report the abuse, even to a very trusted adult or friend since their trust has been so violated.

The fact that the vast majority of child molesters are family members or friends of the child or his/her family makes disclosure of the abuse very difficult for the child. Victims of child sexual abuse experience the fear of betraying a loved one and possibly losing affections forever if they disclose the abuse. Child victims fear the overwhelming shame and guilt that such disclosure may cause, and they fear that family members and other significant people in their lives will blame them for the abuse. They also fear the common threats of being hurt or even killed if they disclose the abuse. Even after disclosing sexual abuse, a child may retract the disclosure as the family system may begin to place pressure. For these and other reasons, sexually abused children often decide to live in quiet and devastating isolation with their "secret" rather than risk the realization of their fears.

It is very important to keep in mind that the overwhelming majority of child sexual abuse occurs within the child's immediate or extended family. Most perpetrators of child sexual abuse are known to the child before the abuse. They are usually trusted family members who have easy physical access to their child victims, not the stereotypical strangers in raincoats who wait for children on street corners with lures of candy or money. Child sexual abuse is not a problem uniquely found in only certain geographic areas or among people of certain economic conditions, races, or occupations. There is absolutely no profile of a child molester or of the typical victim. Do not assume that because an alleged offender has an unparalleled reputation for good works in the community or holds a certain job, he or she could not also be a child molester.

Physical Indicators

- Difficulty in walking, sitting
- Torn, stained, bloody clothing or underwear
- Genital pain, itching
- Bruises, bleeding, or any injury in genital, vaginal or anal areas
- Bruising, injury to the hard or soft palate



- Sexually transmitted diseases, especially in preteens, including venereal oral infections.
- Pregnancy, especially in early adolescent years
- Painful urination or urinary tract infections
- Presence of foreign bodies in vagina or rectum

Remember, the lack of physical evidence makes identification and recognition difficult. Since the vast majority of child molesters are family members or friends, admitting the abuse is very difficult for the child.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Behavioral Indicators

- Low self esteem
- Refusal to participate in/or change for gym
- Infantile behavior
- Withdrawn/elaborate fantasy life
- Sexually suggestive, inappropriate, or promiscuous behavior or verbalization
- Expressing age-inappropriate knowledge of sexual relations
- Sexual victimization of other children
- Prostitution
- Extreme fear of being touched
- Poor peer relationships
- Delinquent, truancy, running away
- Self-injurious activities/suicide

Components of a Sexual Abuse Examination

- Full history and physical examination
- Psychosocial/developmental evaluation
- X-rays and photographs as indicated
- Genital examination
- Appropriate specialty examinations
- Daycare and school reports

TEST YOURSELF QUESTION #5:

Children are most often physically abused by:

a. Strangers
b. Other children
c. Their teachers
d. Their relatives

Please turn to page 50 for answer.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Hospitalization and the Abused Child

In instances where an abused child is hospitalized, in addition to the treatment of injuries, hospitalization can provide benefits for the abused child and family.

- Respite for all involved parties
- Exposure to predictable and trustworthy adults
- Opportunity for the child to develop a positive self image
- Interaction of the child and parent in a controlled environment
- Opportunity for parents to form relationships with supportive professionals

During hospitalization caregivers must adhere to professional responsibilities:

- The child's safety is the healthcare worker's responsibility
- Parents should be told that New York State law requires that, when the cause of a child's injuries cannot be explained, the child and family is referred to the child protection agency for investigation
- Parents should be informed that the cause of the child's injuries is uncertain and that further studies and evaluation are necessary

The following information can be very useful in dealing with an abused child. Although developed for nurses, the guidelines and principles can be adapted easily by other professionals to fit their own situations.

<u>Assessment</u>

Key Points

- Physical and emotional trauma to child
- Relationship of parents/caregiver and child

Objectives: Outcomes of Care

- Physiological and psychosocial well-being of child
- Freedom from further abuse/neglect
- Positive parent-child interactions

<u>Intervention: Specific Professional Actions</u>

- Verify that the case has been reported to appropriate agencies according to state law.
- Promote a trusting relationship with the child:
    - Insure consistent professional care givers.
    - Provide a non-threatening atmosphere.
    - Provide frequent contact (note that cuddling/holding may not be appropriate).
- Integrate the child into a normal daily routine as tolerated.
- Observe closely all interactions between the parents/caregivers and the child.
- Remove the parent/caregiver from the unit if she or he is attempting to harm the child.
- Participate in multidisciplinary treatment meetings regarding the child's progress and status.
- Allow the parents/caregivers to verbalize; listen non-judgmentally.
- Avoid asking threatening questions about any specific incident of abuse.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Teaching and Discharge

- If the child is to be discharged in the custody of parents/caregivers, provide guidance in:
    - Specific stages of growth and development to foster realistic expectations of behavior at home.
    - Appropriate child-rearing practice within the framework of the individual family's cultural background.
    - Proper use and methods of discipline (consistency, positive reinforcement).
- If the child is to be placed outside of the home, assist the parents in accepting that the decision has been made for the benefit of the child/family.
- Encourage parents to comply with professional guidance/treatment.
- Collaborate with other healthcare professionals in discharge planning.

Documentation

- All objective evidence of abuse/neglect
- Child's responses to professional interventions
- Behavior of parent/caregiver with child
    - Time, number, and length of visits and their effects on the child
    - Parent/caregiver's response to child (e.g., eye contact, ignoring child, physical contact)
    - Child's response to parent (e.g., crying, no eye contact, clinging, avoidance)
- Parents/caregivers level of comprehension of all instructions/teaching

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Who Is Mandated to Report

Social Service Law

Section 413 of Social Services Law in New York State identifies professionals and officials who are required to report cases of suspected child abuse or maltreatment.

The following persons and officials are required to report or cause a report to be made in accordance with this title 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, or when they have reasonable cause to suspect that a child is an abused or maltreated child where the parent, guardian, custodian or other person legally responsible for such child comes before them in their professional or official capacity and states from personal knowledge facts, conditions or circumstances which, if correct, would render the child an abused or maltreated child: any physician; surgeon; medical examiner; coroner; dentist; osteopath; optometrist; chiropractor; podiatrist; resident; intern; psychologist; registered nurse; hospital personnel engaged in the admission, examination, care or treatment of persons; a Christian Science practitioner; school official; social service worker; day care worker; provider of family or group family day care; employee or volunteer in a residential care facility defined in subdivision seven of section four hundred twelve of this chapter or any other child care or foster care worker; mental health professional; peace officer; police officer; district attorney or assistant district attorney; or other law enforcement official.

In August 2007, the above law was amended related to the reporting obligations for individuals employed as social service workers as follows:

Social service workers are required to report or cause a report to be made in accordance with this title when they have reasonable cause to suspect that a child is an abused or maltreated child where a person comes before them in their professional or official capacity and states from personal knowledge facts, conditions or circumstances which, if correct, would render the child an abused or maltreated child.

Mandated Reporters

Mandated Reporter - An individual who is legally required to report whenever he or she has reasonable cause to suspect that a child whom the reporter sees in his/her professional or official capacity is abused or maltreated; or has reasonable cause to suspect that a child is abused or maltreated where the parent or person legally responsible for such child comes before them in his/her professional or official capacity and states from personal knowledge, facts, conditions, or circumstances which, if correct, would render the child abused or maltreated (New York State Education Department, 1990).

According to the Section 413 of Social Services Law, the following persons are mandated child abuse reporters in New York State:

Physician	**Surgeon**
Medical Examiner	**Coroner**
Dentist	**Osteopath**
Optometrist	**Chiropractor**
Podiatrist	**Resident**
Intern	**Psychologist**
Registered Nurse	**Dental Hygienist**

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Psychiatrist	**School Official**
Social Service Worker	**Day Care Center Worker**
Peace Officer	**Mental Health Professional**
Police Officer	**Christian Science Practitioner**
Teacher	
Hospital personnel engaged in the admission, examination, care, or treatment of persons	
Employer or volunteer in a Residential Care Facility	
Provider of family or group family day care	
Any other Child Care of Foster Care Worker	
District Attorney or Assistant District Attorney	
Investigator Employed in the office of the DA or other Law Enforcement Official	

Whenever such person is required to report under this title in his or her capacity as a member of the staff of a medical or other public or private institution, school, facility or agency, he or she shall immediately notify the person in charge of such institution, school, facility or agency, or his or her designated agent, who then also shall become responsible to report or cause reports to be made. However, nothing in this section or title is intended to require more than one report from any such institution, school or agency. At the time of the making of a report, or at any time thereafter, such person or official may exercise the right to request, pursuant to paragraph (A) of subdivision four of section four hundred twenty-two of this article, the finding of an investigation made pursuant to this title or section 45.07 of the mental hygiene law.

Agency Responsibilities

Any person, institution, school, facility, agency, organization partnership or corporation which employs persons mandated to report suspect incidents of child abuse or maltreatment pursuant to subdivision one of this section shall provide consistent with section four hundred twenty-one of this chapter, all such current and new employees with written information explaining the reporting requirements set out in subdivision one of this section and in sections four hundred fifteen through four hundred twenty of this title. The employers shall be responsible for the costs associated with printing and distributing the written information.

Any state or local government agency or authorized agency which issues a license, certificate or permit to an individual to operate a family day care home or group family day care home shall provide each person currently holding or seeking such a license, certificate or permit with written information explaining the reporting requirements set out in subdivision one of this section and in sections four hundred fifteen through four hundred twenty of this tile.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Handling Disclosures of Abuse

Recognizing Disclosures

Very seldom will a child disclose abuse immediately after the first incident has occurred. Victimized children often experience a great sense of helplessness and hopelessness and think that nobody can do anything to help them. Also, victimized children may try to make every attempt to protect an abusive parent or they may be extremely reluctant to report any abuse for fear of what the abuser may do to them. Typically, a child may not report abuse for months and even years, particularly if the abuser is someone close to the child.

Sometimes an outcry may not be verbal but portrayed in a drawing left behind inadvertently for the teacher, the counselor, or a trusted relative to see. Another form of outcry may be seen in a child who will frequently go to the school nurse complaining of vague, somatic symptoms, often without organic basis, hoping that the nurse will guess what has happened. This way, in their minds, they have not betrayed, nor will they be punished since they did not directly report the abuse. Some children, while totally reluctant to report or discuss the abuse, may be more willing to express their apprehensions and anxieties about the perpetrator or the home situation. In some cases, abused children will make an outcry, which may take the extreme form of a suicide gesture or attempt.

Children may disclose abuse in a variety of ways. They may blurt it out to you, especially after you have created a warm nurturing environment. They may come privately to **talk directly and specifically** about what is going on. But more common ways include:

> ***Indirect Hints:*** "My brother wouldn't let me sleep last night." "My babysitter keeps bothering me." A child may talk in these terms because he/she hasn't learned more specific vocabulary, feels too ashamed or embarrassed to talk more directly, has promised not to tell, or for a combination of these reasons.
>
> ***Appropriate responses*** would be invitations to tell you more, such as "How did that make you feel?" and open-ended questions such as "Can you tell me more?" or "What do you mean?" Gently encourage the child to be more specific. It is important that the child use his/her own language, and that no additional words are given to the child.
>
> ***Disguised Disclosure****:* "What would happen if a girl told someone her mother beat her?" "I know someone who is being touched in a bad way." Here the child might be talking about a friend or sibling, but is just as likely to be talking about her/himself. Encourage the child to tell you what he/she knows about the "other child." It is probable that the child will eventually tell you about whom he/she is talking.
>
> ***Disclosure with Strings Attached:*** "I have a problem, but if I tell you about it, you have to promise not to tell anyone else." Most children are all too aware that some negative consequences will result if they break the secret of abuse. Often the offender uses the threat of these consequences to keep the child silent. Let the child know you want to help him/her. Tell, from the beginning, that there are times when you too may need to get help with the problem. In order to help, it may be necessary to get some special people involved. The fact that the child has chosen this particular moment to disclose is important. Usually they will agree to seek help if you talk about it ahead of time. Assure the child that you will respect his/her need for confidentiality by not discussing the abuse with anyone other than those directly involved in getting help. And, if you can explain the process, it may help with initial fear.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Responding to Disclosures

In school, if a child discloses during a lesson, acknowledge the child's disclosure and continue the lesson. Afterward, find a place where you can talk with the child alone. It is best to present child abuse curricula before a playtime or recess so that you have a natural opportunity to talk with children privately if they come forward.

Before notifying anyone outside of your school or agency, you or another designated person should sit down in a quiet room without interruptions and speak with the child. If a child has chosen you as the person in whom to confide, you should take the time to speak with the child about the problem. If that is not possible, ask the child if she/he would feel comfortable discussing it with someone else. If the child indicates that he wants to tell you, you must make every effort to listen and support the child. She/he may not trust another enough to tell.

Multiple interviews should be avoided. The child will have to share the story with many others. When you speak with the child, sit down together, assure him/her that you are concerned and want to know more and that it's okay to tell you. Go slowly, allowing the child to explain as much as he/she can. Do not suggest in any way that any particular person may have done something to him/her or that the child was touched in any particular way. Let the child talk as much as possible. Explain, in age appropriate language, that the law requires you to make a report if any child discloses abuse and that the law is there to protect them. Describe for them who will be involved, for example, the social worker, principal and the CPS caseworker.

When Talking to the Child

DO:

- Find a private place to talk with the child.
- Sit next to the child, not across a table or desk.
- Use language the child understands; ask the child to clarify words you don't understand.
- Express your belief that the child is telling you the truth.
- Reassure the child that it is not his/her fault, and that he/she is not bad and did nothing to deserve this.
- Determine the child's immediate need for safety.
- Let the child know you will do your best to protect and support him/her.
- Tell the child what you will do, and who will be involved in the process.

DO NOT:

- Disparage or criticize the child's choice of words or language.
- Suggest answers to the child.
- Probe or press for answers the child is unwilling to give.
- Display shock or disapproval of parent(s), child, or the situation.
- Talk to the child with a group of interviewers.
- Make promises to the child, about "not telling" nor about how the situation will work out.

Supporting the Child After the Report Has Been Made

If it is necessary for Child Protective Services or a Law Enforcement official to interview the child at the school or agency, you should cooperate and assist by providing access for such an interview. Unless there are compelling reasons against it, a staff member the child trusts should be present during the interview to provide support for the child. (This situation may also arise when the report did not originate from your school or agency.)

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Reporting Child Abuse, Maltreatment or Neglect

Reportable Situations

- When a mandated reporter suspects that a child whom the reporter sees in his or her professional/official capacity is abused/maltreated.
- When the reporter sees the parent/caregiver in an official capacity and the parent/caregiver reports abuse of a child or children.
- When, as an employee, the mandated reporter suspects abuse or neglect he/she immediately notifies the appropriate authority in the agency or facility where he or she is employed. That person then makes the report. It should be noted that the person in charge may not prevent the staff member from making a report if there is reasonable cause to suspect.

Examples of Reportable Situations

- A school principal calls the State Central Register (SCR) and reports that a 10-year-old pupil, Ed, has told him repeatedly for several weeks that he does not get enough to eat at home. The child appears pale and eats excessively at the school lunch program.
- Mary Lacy brings her four-year-old daughter, Joan, to the emergency room because of a vaginal discharge. The child is diagnosed to have gonorrhea.
- A five-year-old boy, Jason, is continually brought to the school nurse for an advanced case of head lice.
- Nancy, a 12-year-old, comes to school with two bruises. One is on the upper left arm and one is on the lower area of her neck. Nancy states that her mother was upset yesterday and threw her against the refrigerator.
- Three-year-old Amy is brought to the emergency room and is diagnosed to have second-degree immersion burns.
- A school counselor calls the SCR and states that Teddy has missed 34 out of a possible 95 days of school. Teddy has submitted an excuse for 10 of his absences. The school has attempted to contact the parents. The parents have not responded to the contacts.
- A neighbor calls the SCR and states that Kim and Meghan Rourke, a three-year-old and four-year-old, sit on the windowsill every day during warm weather. The Rourkes live in a fourth floor apartment without any screens or bars.
- A mother calls the SCR and reports that she is afraid her husband is going to harm her six-month-old baby. He has on more than one occasion violently shaken the baby when the baby didn't stop crying.
- A grandmother calls the SCR and states that her daughter-in-law treats her 8-year-old grandson, Mark, terribly. She verbally abuses Mark by calling him filthy names and makes him cry.
- A neighbor calls the SCR and states that three young children, who live two trailers down, roam the trailer park all night long vandalizing neighbor's property.
- A 16-year-old boy, Roger, is repeatedly drinking (two - three times a week) to the point of intoxication. He drinks in front of his mother. The aunt is concerned and calls the SCR.

*Source: New York State Department of Social Services

Reasonable Cause

A person can have "reasonable cause" to suspect that a child is abused or maltreated if, considering what physical evidence she/he observes or is told about, and from her/his own training and experience it is **POSSIBLE** that the injury or condition was caused by neglect or by nonaccidental means. The reporter need not be absolutely certain that the injury or condition was caused by neglect or by nonaccidental means; the reporter should only **BE ABLE TO ENTERTAIN THE POSSIBILITY THAT IT COULD HAVE BEEN NEGLECT OR NONACCIDENTAL** in order to possess the necessary "reasonable cause."

Suspicion

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Certainty is not required; it is enough for the mandated reporter to distrust or doubt what she or he personally observes or is told. In child abuse cases, many factors can and should be considered in the formation of that doubt or distrust. Physical and behavioral indicators may also be helpful in forming a reasonable basis of suspicion. Although these indicators are not diagnostic criteria of child abuse, neglect, or maltreatment, they illustrate important patterns that may be recorded in the written report when relevant.

TEST YOURSELF QUESTION #6

Is it true that in order to possess the necessary "reasonable cause" to file a report of child abuse, the reporter must be certain that the injury was caused by neglect or non-accidental means?

a. Yes; otherwise, the reporter is making a libelous claim.
b. Yes; otherwise, the reporter may have his/her license temporarily suspended.
c. No; any suspicion, even without reasonable cause, must be reported.
d. No; if there is a professional judgment, a report should be filed

Please turn to page 50 for answer.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Reporting Procedures

When to Report

- Immediately, by telephone, at any time of day, seven days a week
- A written report must be filed within 48 hours of the verbal report

How to Report

- Mandated reporters who learn of abuse, maltreatment, or neglect in the course of their employment should make verbal telephone reports. The statewide toll-free telephone number for reporting is 1-800-635-1522.
- Other reports of suspected abuse by anyone other than a mandated reporter (neighbor, relative, friend, etc.) are made verbally by calling the New York State Central Register of Child Abuse and Maltreatment (SCR) toll-free at 1-800-342-3720. One county runs a child abuse hotline and may be used instead of the SCR:
    - Monroe County (585) 461-5690
- A written report, signed by the reporter, must be filed with the local child protective services (CPS) within 48 hours of the verbal report. You may request the address of the investigative district from the child protective specialist at the time you make the oral report to the State Central Register of Child Abuse and Maltreatment.
- Reporters may wish to maintain careful notes for their own personal records, noting such things as dates, times, places, names of individuals involved in any reporting incident, etc.

For purposes of reporting suspected cases of child abuse and maltreatment to the State Central Register and Child Protective Services, it is important to understand the definition "subject of the report" as defined by Section 412.4 of the Social Services Law.

"Subject of the Report" means any:

- Parent
- Guardian
- Custodian
- Other person 18 years of age or older:

    - ☐ Who is legally responsible (as defined in Section 1012(g)) of the Family Court Act for a child reported to the Central Register of Child Abuse and Maltreatment)
    - ☐ And who is allegedly responsible for causing, or allowing infliction of, injury, abuse, or maltreatment to such child.

"Subject of the Report" also means an:

- Operator of, or
- Employee or volunteer in a home operated or supervised by:

    - ☐ An authorized agency
    - ☐ The Division for Youth
    - ☐ Or an office of the Department of Mental Hygiene

OR

- A family day-care home, day-care center, group family day-care home, or a services program who is allegedly responsible for causing, or allowing the infliction of, injury, abuse, or maltreatment to a child who is reported to the Central Register.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

- Of course, abuse and maltreatment may be caused by individuals other than a parent or person legally responsible for the child's care, such as neighbors or strangers. Such individuals might not fit the legal definition of "subject of the report."
- When the alleged perpetrator of child abuse or maltreatment cannot be the "subject of a report" (as defined in section 412.4 of the Social Services Law), enforcement authorities should be contacted directly. If a call is received by the State Central Register, and the person allegedly responsible for the abuse and maltreatment cannot be the subject of the report, and SCR believes that the alleged acts or circumstances described by the caller may constitute a criminal and immediate threat to the child's health or safety, the SCR is required by law to transmit the information contained in the call to the appropriate law enforcement agency, district attorney, or other public official empowered to provide necessary aid or assistance (Social Services Law, Sec. 422.2(c)).

Reporting of Child Abuse in an Educational Setting

Written Statement of Parental Rights

Amendment to Section 100.2 of the Regulations of the Commissioner of Education Pursuant to NYS Education Law Sections 101, 207, 305, 1128, 1132, and 3028-b and sections 12 and 13 of Chapter 180 of the Laws of 2000 added a requirement that a written statement be provided to the parent of a child who is the subject of an allegation of child abuse in an educational setting. This sets forth rights, responsibilities, and procedures for parents, employees, school administrators, and superintendents. The amendment requires reporting and notification if a written report, that alleges that a child has been abused in an educational setting, is made. This is apart from the rules and regulations concerning the recognition and reporting of child abuse.

What to Include in the Report

Telephone Report:

- The names and addresses of the child, parents, and/or other persons responsible for the child's care.
- The child's name, age, gender, race.
- The nature and extent of the child's injuries, abuse, or maltreatment, including any evidence of prior injuries, abuse or maltreatment to the child or siblings.
- The name of the person or persons responsible for causing the injury, abuse, or maltreatment.
- Family composition.
- The source of the report.
- The person making the report and where she/he can be reached.
- The actions taken by the reporting source, including the taking of photographs or X-rays, custody of the child, and medical examiner or coroner notification.
- Any additional information that may be helpful.

Note: the lack of complete information does not prohibit a person from reporting. When the alleged perpetrator cannot be identified the appropriate law enforcement agency/DA will be notified by State Central Registration (SCR) to assist with the case.

Written Report - LDSS-2221-A (Report of Suspected Child Abuse or Maltreatment)

- Must be filed within 48 hours of verbal report.
- Document on the official form, obtainable from local CPS or from their Web site, http://www.ocfs.state.ny.us/main/forms/cps/
- Identical information as in telephone report (see above).
- Information should be written as clearly and objectively as possible.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Note: Written reports are admissible as evidence in any judicial proceedings; accurate completion is vital.

What to Expect When you Call the SCR Hotline:

Sections 422.2(a) and 422.11 of the Social Services Law establish the procedures to be followed by the Office of Children and Family Services after the phone call is received.

There may be times when you have very little information on which to base your suspicion of abuse or maltreatment, but this should not prevent you from calling the SCR. A CPS specialist will help to determine if the information you are providing can be registered as a report.

The mandated reporter form can be used to help you organize the identifying or demographic information you have at your disposal.

Be sure to ask the CPS special for the "Call I.D." assigned to the report you have made.

If the SCR staff do not register the child abuse or maltreatment report, the reason for the decision should be clearly explained to you. You may also request to speak to a supervisor who can help make determinations in difficult or unusual cases.

When any allegations contained in the phone call could reasonably constitute a report of child abuse or maltreatment, including reports involving children who reside in residential facilities or programs, such allegations must be immediately transmitted by the Office of Children and Family Services to the appropriate agency or local child protective service for investigation. If the department records indicate a previous report concerning a "subject of the report," other persons named in the report, or other pertinent information, the appropriate agency or local child protective service must be immediately notified of this fact.

Inquiring About the Report

- Section 422.4 of the Social Services Law provides that a mandated reporter can receive, upon request, the findings of an investigation made pursuant to his/her report. This request can be made to the SCR at the time of making the report or to the appropriate local CPS at any time thereafter. However, no information can be released unless the reporter's identity is confirmed.
- If the request for information is made prior to the completion of an investigation of a report, the released information shall be limited to whether the report is "indicated" (e.g., substantiated), "unfounded," or "under investigation," whichever the case may be.
- If the request for information is made after the completion of an investigation of a report, the released information shall be limited to whether a report is "indicated" or, if the report has been legally sealed.

Unfounded Reports

- Chapter 12 of the Laws of 1996 amended section 422.5 of the Social Services Law (SSL) to legally seal, rather than expunge, unfounded reports of child abuse or maltreatment.
- Section 422.5 of the SSL was amended by Chapter 136 of the laws of 1999 to establish when a legally sealed unfounded report could be unsealed and to whom it could be made available.
- Legally sealed unfounded reports may be unsealed when:
    - There is another report involving a child named in the prior unfounded report.
    - Subsequent report involves subject of the unfounded report.
    - Fatality review teams need to prepare a fatality report.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Note: A subject of a legally sealed unfounded report may now obtain access to the report at any time when previously access had to be requested within 90 days of notification that the report had been unfounded.

TEST YOURSELF QUESTION #7:

Under New York State law, unfounded reports of child abuse are expunged and may never be unsealed.

a. True
b. False

Please turn to page 50 for answer.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Other Mandated or Authorized Actions

Photographs

Any mandated reporter may take, or cause to be taken, at public expense, photographs of the area of trauma visible on a child. A reporter may ask the local CPS to take photographs when appropriate, suggested guidelines for photography of trauma are:

- **Objective:** Document the basis for your opinion
- **Film:**
    - A new roll of film should be entirely dedicated to the case at hand.
    - Use the entire roll.
    - Color prints or slides are acceptable using 100 ASA or finer grain film.
    - All negatives and prints/slides must be accounted for; they are evidence.
- **Identification:** Record of name, date, time, and speed should be kept. A rule of measure and color scale should be used.
- **Photos:**
    - Overview: should include frontal, rear, right and left sides of entire child.
    - Midrange: should include areas of trauma with surrounding anatomic landmarks.
    - Close-up: should include life size photos of the area.
- **Other Considerations:**
    - Save ruler used, it can be used as a color scale if a standard color scale is not available.
    - The area(s) in question should be photographed in pristine state and again after cleaning and drying.
    - **ANY** photograph is better than none.

X-rays

- If medically indicated, cause X-rays to be taken.
- Photos or X-rays must accompany the LDSS-2221-A, or be sent as soon as possible after its submission. They should be appropriately identified with the child's name, date, and name of person taking the photos or X-rays.

TEST YOURSELF QUESTION #8:

In terms of taking photographs of a child's visible trauma, a mandated reporter should

a. take photographs only if the hospital/police photographer is not available.
b. take photographs only if a 35 mm camera is available.
c. use a whole role of film when taking the photographs.
d. submit the highest quality photographs with the report.

Please turn to page 50 for answer.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Protective Custody

A child may be taken into protective custody (e.g., without court order or parental consent) if:

- The child is in such circumstance or condition that continuing to stay in his/her residence or in the care and custody of the parent or person legally responsible for the child's care presents an imminent danger to the child's life or health.
- There is not enough time to apply for an order of temporary removal from the Family Court. Protective custody should not be confused with status of a child admitted voluntarily to the hospital by the parents.

Persons legally authorized to place a child into protective custody:

- A peace officer (acting pursuant to his/her duties)
- A police officer
- A law enforcement official
- An agent of a duly incorporated society for the prevention of cruelty to children
- A designated employee of a city or county Office of Children and Family Services
- A person in charge of a hospital or similar institution

Actions required of authorized persons:

- She/he must bring the child immediately to a place designated by the rules of the Family Court for this purpose, unless the person is a physician treating the child and child is or will be presently admitted to a hospital.
- She/he must make every reasonable effort to inform the parent or other person legally responsible for the child's care of the facility to which the child has been brought.
- She/he must provide the parent or the person legally responsible with written notice, coincident with removal [Family Court Act 1024(b)(iii)].
- She/he must inform the court and make a report of suspected child abuse or maltreatment pursuant to Title 6 of the Social Services Law, as soon as possible [FCA, Sec. 1024(b)].
- She/he must immediately notify the appropriate local child protective service, which shall commence a child protective proceeding in the Family Court at the next regular weekday session of the appropriate Family Court or recommend that the child be returned to his/her parents or guardian. In neglect cases, pursuant to Section 1026 of the Family Court Act, the authorized person or entity (usually CPS) may return a child prior to a child protective proceeding if it concludes there is no imminent risk to the child's health.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

When a Report is Made

Investigation

- Goal: Determine whether credible evidence exists.
- Local Department of Social Services is immediately notified for investigation and follow-up when a report is registered at the SCR.
- CPS contacts the source, the children, the parents/caregivers, school programs, physicians, health professionals, relatives, neighbors.
- CPS contacts the mandated reporter.
- CPS evaluates the child and other children in the home.
- For court proceedings the mandated reporter's testimony and records may be requested.

Determination (Within 60 Days)

- A determination of risk to the children in the home is made.
- Indicated: there is reason to suspect that abuse occurred.
- Unfounded: determination that the evidence does not support claim.
- Mandated reporters may be informed of the outcome of the report if they wish.

Assessment/Service Planning

- An appropriate realistic service plan for the child and/or family must be developed to guard and ensure the child's well-being and development and to preserve and stabilize the family life.
- Services may be provided by CPS and other Agencies and referrals to other agencies may be indicated.
- If there is immediate threat to the child’s life or health, CPS may remove the child from the home.

Law Enforcement Referrals

When SCR staff receive information that leads them to believe there is an immediate threat to a child or that a crime has been committed against a child, but the SCR is unable to register a report (because it doesn't involve a parent or other person legally responsible for the child), the SCR staff will make a Law Enforcement Referral (LER). The relevant information will be recorded and transmitted to the New York State Police Information Network or to the New York City Special Victims Liaison Unit for action. Local CPS will not be involved.

TEST YOURSELF QUESTION #9:

After a report is filed, which of these actions does Child Protective Services usually take?

a. The child is immediately taken from the home.
b. The child's siblings are evaluated.
c. A surveillance team is placed outside the child's home.
d. The suspected child abuser is fingerprinted.

Please turn to page 50 for answer.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Legal Protection for Mandated Reporters

Immunity

To encourage prompt and complete reporting of suspected child abuse and maltreatment, the Social Services Law, Section 419, affords the reporter certain legal protections from liability. Any persons, officials, institutions who in good faith make a report, take photographs, and/or take protective custody, have immunity from all liability, civil or criminal, that might be a result of such actions. All persons, officials, or institutions who are required to report suspected child abuse or maltreatment are assumed to have done so in good faith as long as they were acting in the discharge of their official duties and within the scope of their employment and so long as these actions did not result from willful misconduct or gross negligence.

Confidentiality

Social Services Law provides confidentially for mandated reporters and all sources of child abuse and maltreatment reports. The Commissioner of Social Services, the local CPS, and local Office of Children and Family Services is not permitted to release to the subject of a report data which identify the person who made the report unless such person has given written permission for the central processing center to do so. The person who made the report may also grant the local CPS permission to release her/his identity to the subject of the report. If a reporter needs reassurance, she or he should feel free to stress the need for confidentiality if the situation warrants. Information regarding the source of the report may be shared with court officials, police, and district attorneys under certain circumstances.

Consequences in New York State for Failing to Report

Legal Repercussions

Any person, official, or institution required by the law to report a case of suspected child abuse or maltreatment that willfully fails to do so:

- May be guilty of a Class A misdemeanor and subject to criminal penalties
- May be civilly liable for monetary damages for any harm caused by such failure

Societal Repercussions

To protect children, suspicions of child abuse must be reported. Child Protective Services cannot act until child abuse is identified and reported, services cannot be offered to the family nor can the child be protected from suffering.

Professional Repercussions

In New York State it is considered professional misconduct for a professional not to report child abuse that occurs within the professional’s work role. The New York State Education Department can charge professionals with unprofessional conduct leading to an investigation and potential censure, fine or license revocation.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

TEST YOURSELF QUESTION #10:

In New York State, if a nurse does not report a suspected case of child abuse, it is considered

a. a felony.
b. assault and battery.
c. an intentional tort.
d. professional misconduct.

Please turn to page 50 for answer.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Frequently Asked Questions

How many children are reported and investigated for abuse or neglect?

For calendar year 2004, an estimated 1,800,000 referrals alleging child abuse or neglect were accepted by State and local child protective services (CPS) agencies for investigation or assessment. The referrals included more than 3 million children, and of those, approximately 872,000 children were determined to be victims of child abuse or neglect by the CPS agencies (ACF-HHS, 2004).

CPS agencies respond to the needs of children who are alleged to have been maltreated and ensure that they remain safe. The rate of children who received a disposition by CPS agencies was 47.8 per 1,000 children in the national population. This yields an estimate of 3,503,000 children who received investigations or assessments during 2004 (ACF-HHS, 2004).

An estimated 872,000 children were found to be victims, which was approximately 48% percent of all children who received an investigation or assessment. The national rate of victimization was 11.9 per 1,000 children (ACF-HHS, 2004).

The rate of all children who received an investigation or assessment increased from 36.1 per 1,000 children in 1990 to 47.8 per 1,000 children in 2004, which is a 32.4 percent increase (AFC-HHS, 2004).

Approximately 30 percent of the reports included at least one child who was found to be a victim of abuse or neglect. Sixty-one percent of the reports were found to be unsubstantiated (including intentionally false); the remaining reports were closed for additional reasons (ACF-HHS, 2004).

In 2003, the NYS Central Register of Child Abuse and Maltreatment (the Child Abuse Reporting Hotline) received 147,339 reports of suspected child abuse or neglect, 32.6 reports for every 1,000 children in the State. Out of those reports 30% or 44,495 were confirmed as cases of child abuse and neglect. Compared to the prior year, the number of reports increased by 4% (PCA-NY, 2006).

How many children are victims of maltreatment?

An estimated 872,000 children were determined to be victims of child abuse or neglect in 2004. The rate of victimization per 1,000 children in the national population has dropped from 13.4 children in 1990 to 11.2 children in 2004 (ACF-HHS, 2004).

Is the number of abused or neglected children increasing?

Although the rate of child abuse and neglect appears to have dropped from 1990 to 2004 (from 13.4 per 1,000 children in 1990 to 11.9 per 1,000 children in 2004--a 11.2 percent decrease), the rate of child abuse and neglect fatalities reported by National Child Abuse and Neglect Data System (NCANDS) has increased. Over the last several years there has been a slight increase in fatalities from 1.84 per 100,000 children in 2000 to 1.96 in 2001 and 2.03 in 2004. However, experts do not agree whether this represents an actual increase in child abuse and neglect fatalities, or whether it may be attributed to improvements in reporting procedures. For example, statistics on approximately 20 percent of fatalities were from health departments and fatality review boards for 2004, compared to 11.4 percent for 2001, an indication of greater coordination of data collection among agencies (HHS, 2004).

What are the most common types of maltreatment?

Neglect is the most common form of child maltreatment. During 2004, 62.4 percent of victims experienced neglect (including medical neglect); 17.5 percent were physically abused; 9.7 percent were sexually abused; and 7.0 percent were emotionally or psychologically maltreated. In addition, 14.5 percent of victims experienced such "other" types of maltreatment as "abandonment," "threats of harm to the child,"

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

and "congenital drug addiction." States may code any maltreatment type that does not fall into one of the main categories— physical abuse, neglect, medical neglect, sexual abuse, and psychological or emotional maltreatment— as "other." The maltreatment type percentages total more than 100 percent because many children were victims of more than one type of maltreatment and were coded multiple times (ACF-HHS, 2004).

Who are the child victims?

For 2004, 48.3 percent of child victims were boys, and 51.7 percent of the victims were girls. The youngest children had the highest rate of victimization. The rate of child victimization for the age group of birth to 3 years was 16.1 per 1,000 children of the same age group. The victimization rate of children in the age group of 4-7 years was 13.4 per 1,000 children in the same age group (ACF-HHS, 2004).

Overall, the rate of victimization was inversely related to the age of the child. The youngest children accounted for the largest percentage of victims. Children younger than 1-year-old accounted for 10.3 percent of victims (ACF-HHS, 2004).

American Indian or Alaska Native children, Pacific Islander children and African-American children had the highest rates of victimization at 15.5, 19.9 and 17.6 per 1,000 children of the same race or ethnicity, respectively. White children and Hispanic children had rates of approximately 10.7 and 10.4 per 1,000 children of the same race or ethnicity, respectively. Asian children had the lowest rate of 2.9 per 1,000 children of the same race or ethnicity (ACF-HHS, 2004).

One-half of all victims were White (53.8%); one-quarter (25.2%) were African-American; and 17% were Hispanic (ACF-HHS, 2004).

How many children die from abuse or neglect?

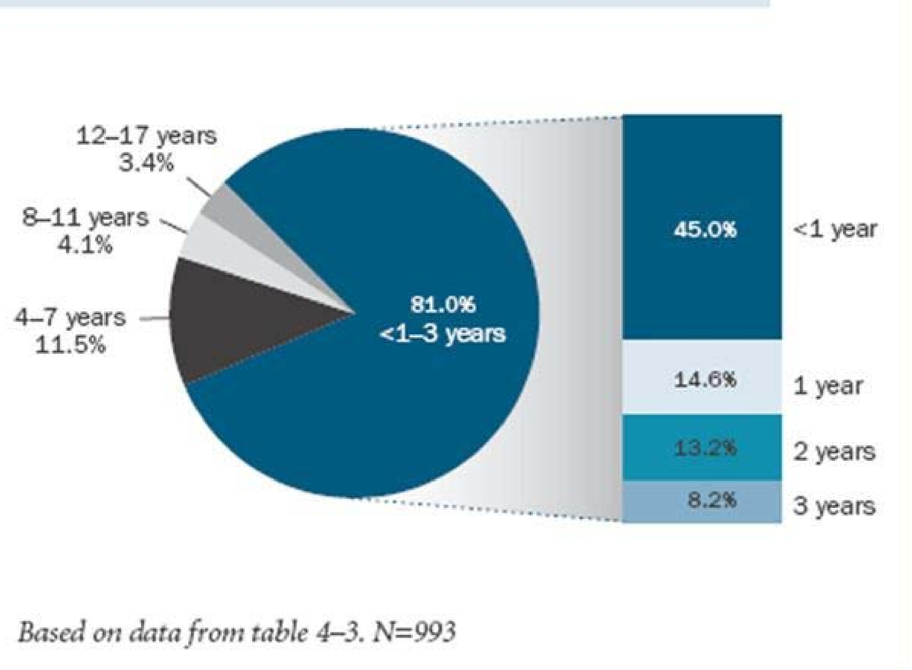
Child fatalities are the most tragic consequence of maltreatment. The National Child Abuse and Neglect Data System (NCANDS) reported an **estimated 1,490 child fatalities in 2004**. This translates to a rate of 2.03 children per 100,000 children in the general population. NCANDS defines "child fatality" as the death of a child caused by an injury resulting from abuse or neglect, or where abuse or neglect were contributing factors (HHS, 2004).

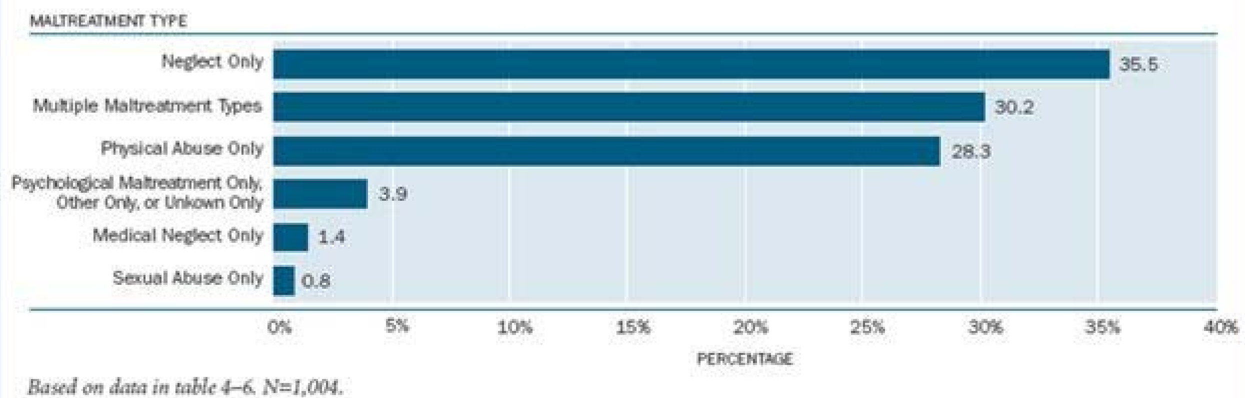
Research indicates very young children (ages 4 and younger) are the most frequent victims of child fatalities. NCANDS data for 2004 demonstrated children younger than 4 years accounted for 81 percent of fatalities. This population of children is the most vulnerable for many reasons, including their dependency, small size, and inability to defend themselves (HHS, 2004).

Children age 4 to 7 years old were fatal victims of abuse or neglect in 11.5 percent of cases; 4.1 percent were 8 to 11 years old; and 3.4 percent were 12 to 17 years old (HHS, 2004).

Infant boys (younger than 1 year old) had the highest rate of fatalities, nearly 18 deaths per 100,000 boys of the same age in the national population. Infant girls (younger than 1 year old) had a rate of 17 deaths per 100,000 (HHS, 2002).

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.





Source: US Department of Health and Human Services (2006)

Many researchers and practitioners believe child fatalities due to abuse and neglect are underreported. States' definitions of key terms such as "child homicide," "abuse," and "neglect" vary (therefore, so do the numbers and types of child fatalities they report). In addition, some deaths officially labeled as accidents, child homicides, and/or Sudden Infant Death Syndrome (SIDS) might be attributed to child abuse or neglect if more comprehensive investigations were conducted or if there was more consensus in the coding of abuse on death certificates (HHS, 2004).

In New York State in 2003, 62 children were confirmed to have died of as a result of child abuse and neglect, a rate of 1.37 per 100,000 children (PCA-NY, 2006).

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Who abuses and neglects children?

For 2004, 57.8 percent of the perpetrators were women and 42.2 percent were men. Female perpetrators were typically younger than male perpetrators. The median age of perpetrators was 31 years for women and 34 years for men. More than 40 percent (44.4%) of women who were perpetrators were younger than 30 years of age compared to one-third of the men (34.1%) who were younger than 30 years (ACF-HHS, 2004).

By far, the largest percentage of perpetrators (78.5%) were parents, including birth parents, adoptive parents, and stepparents. Other relatives accounted for an additional 6.5 percent. Unmarried partners of parents accounted for 4.1 percent of perpetrators (ACF-HHS, 2004).

More than one-half (57.9%) of all perpetrators were found to have neglected children. Slightly more than 10 percent (10.3%) of perpetrators physically abused children, and 6.9 percent sexually abused children (ACF-HHS, 2004).

There were variations in these overall patterns when the relationship of perpetrator to the child victim was considered. Less than 3 percent (2.6%) of parents committed sexual abuse while 62.9 percent committed neglect. Of the perpetrators who were friends or neighbors, nearly 73.8 percent committed sexual abuse (ACF-HHS, 2004).

In cases of fatal abuse, one fact of great concern is that the perpetrators are, by definition, individuals responsible for the care and supervision of their victims. In 2004, one or both parents were involved in 78.5 percent of child abuse or neglect fatalities. Of the other 21 percent of fatalities, 10.6 percent were the result of maltreatment by nonparent caretakers, 3.3 percent caused by male partners of a parent and 5 percent were unknown or missing. These percentages are consistent with findings from previous years (HHS, 2004).

There is no single profile of a perpetrator of fatal child abuse, although certain characteristics reappear in many studies. Frequently the perpetrator is a young adult in his or her mid-20s without a high school diploma, living at or below the poverty level, depressed, and who may have difficulty coping with stressful situations. In many instances, the perpetrator has experienced violence first-hand. Most fatalities from *physical abuse* are caused by fathers and other male caretakers. Mothers are most often held responsible for deaths resulting from *child neglect* (HHS, 2004).

Who reports child maltreatment?

In 2002, an estimated total of 3 million referrals concerning the welfare of approximately 5.5 million children were made to CPS agencies throughout the United States. Of these, approximately two-thirds (an estimated 3.6 million) were accepted for investigation or assessment; one-third were not accepted (HHS, 2004).

Professionals submitted more than one-half (55.8%) of the reports. "Professional" indicates that the report source came into contact with the alleged victim as part of the reporter's occupation. State laws require most professionals to notify CPS agencies of suspected maltreatment. The categories of professionals include educators, legal and law enforcement personnel, social services personnel, medical personnel, mental health personnel, child daycare providers, and foster care providers. The three most common sources of reports in 2004 were from professionals—educational personnel (16.5%), legal or law enforcement personnel (15.6%), and social services personnel (10.5%). Approximately 2/3 of substantiated or indicated reports were made from professional sources. Nonprofessional sources accounted for the largest percent of unfounded reports. (ACF-HHS, 2004).

Nonprofessional report sources submitted the remaining 44.2 percent of reports. These included parents, other relatives, friends and neighbors, alleged victims, alleged perpetrators, anonymous callers, and

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

"other" sources. Anonymous (9.4%), "other" sources (8.4%) and other relatives (7.9%) accounted for the largest groups of nonprofessional reporters (ACF-HHS, 2004).

What happens after I make a report?

The Child Protective Service (CPS) unit of the local department of social services is required to begin an investigation of each report within 24 hours. The investigation should include an evaluation of the safety of the child named in the report, and any other children in the home, and a determination of the risk to the children if they continue to remain in the home.

CPS may take a child into protective custody if it is necessary for the protection from further abuse or maltreatment. Based upon an assessment of the circumstances, CPS may offer the family appropriate services. CPS has no legal authority to compel the family to accept such services. However, the CPS caseworker has the obligation and authority to petition the Family Court to mandate services when they are necessary for the care and protection of a child.

CPS has 60 days after receiving the report to determine whether the report is "indicated" or "unfounded." The law requires CPS to provide written notice to the parents or other subjects of the report concerning the rights accorded to them by the New York State Social Services Law. The CPS investigator will document activities and decisions in the State Central Register file.

Are victims of child abuse more likely to engage in criminality later in life?

According to the National Institute of Justice (NIJ), maltreatment in childhood increases the likelihood of arrest as a juvenile by 53 percent, as an adult by 50 percent, and for a violent crime by 38 percent. Being abused or neglected in childhood increases the likelihood for arrest for females by 77 percent. A related NIJ report indicated that children who were sexually abused were 28 times more likely than a control group of non-abused children to be arrested for prostitution as an adult (NIJ, 2004).

Is there any evidence linking alcohol or other drug use to child maltreatment?

A study by the National Center on Addiction and Substance Abuse found that children of substance abusing parents were almost 3 times likelier to be abused and more than 4 times likelier to be neglected than children of parents who are not substance abusers. Other studies suggest that an estimated 50 percent to 80 percent of all child abuse cases substantiated by CPS involve some degree of substance abuse by the child's parents.

What is HIPAA and does it affect or limit my responsibility as a mandated reporter of suspected child abuse, neglect or maltreatment?

HIPAA stands for the Health Insurance Portability and Accountability Act of 1996. The privacy provisions contained in this regulation do not affect the responsibilities of mandated reporters, as they are defined in the New York State Social Services Law (NYSOCFS, 2003).

Information concerning the provisions of HIPAA may be found at www.hhs.gov/ocr/hipaa.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Answers to Test Yourself Questions

1. C (Answer can be found in Legal Definitions)
2. D (Answer can be found in Key Assessment Factors)
3. B (Answer can be found in Methamphetamine: How to Recognize Clandestine Labs)
4. D (Answer can be found in Assessing Physical Symptoms)
5. D (Answer can be found in Sexual Abuse)
6. D (Answer can be found in Reporting Child Abuse, Maltreatment, or Neglect)
7. B (Answer can be found in Reporting Procedures)
8. C (Answer can be found in Other Mandated or Authorized Actions)
9. B (Answer can be found in When a Report is Made)
10. D (Answer can be found in Legal Protection for Mandated Reporters)

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Resources

Hot Lines

New York State Child Abuse Hotline (mandated reporters)	1-800-635-1522
New York State Child Abuse Hotline (general public)	1-800-342-3720
New York State Domestic Violence Hotline	1-800-942-6906
Runaway Hotline	1-800-231-6946
National Runaway Switchboard	1-800-621-4000
National Child Abuse Hotline	1-800-792-5200

Compendium of Local, State and National Organizations and Agencies

Advocates for Children of New York State (CASANYS)
99 Pine Street, Suite C102
Albany, NY 12207
(518) 426-5354
Toll-free: (877) 80-VOICE
http://www.casanys.org

In 1991, The New York State CASA Association was founded under the Task Force on Permanency Planning to promote and support trained community volunteer advocacy programs. The role of these programs is to assist Family Courts in making crucial decisions affecting children who have been abused and neglected.

American Humane Association
Children's Division
63 Inverness Dr. East
Englewood, CO 80112-5117
(303) 792-9900
http://www.americanhumane.org/

This is a national center promoting responsive child protection services in every community through program planning, training, education, and consultation. It operates the National Resource Center on Child Abuse and Neglect. Please contact for free general information.

Children's Defense Fund (CDF)
25 E. St. NW
Washington, DC 20001
(202) 628-8787
www.childrensdefense.org

This national advocacy organization focuses on the education, care, welfare, and health of children, and on federal legislation affecting children and families. CDF offers numerous publications on important issues in child health and family welfare.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Children of the Night
14530 Sylvan St.
Van Nuys, CA 91411
(818) 908-4474
Hotline: (800) 551-1300
www.childrenofthenight.org

Provide protection and support for street children, usually runaways, ages 11 – 17 who are involved in pornography or prostitution. Provides shelter, a 24-hour hotline, and a street outreach program.

Child Welfare Information Gateway
Children's Bureau/ACYF
1250 Maryland Ave., SW, Eighth Floor
Washington, D.C. 20024
(703) 385-7565 or (800) 394-3366
www.childwelfare.gov

Child Welfare Information Gateway formerly **National Clearinghouse on Child Abuse and Neglect (NCCAN)** was established by the Child Abuse Prevention and Treatment Act in 1974. Its activities include conducting research, collecting and analyzing information, and providing assistance to states and communities for activities on the prevention of child abuse and neglect.

Child Welfare League of America (CWLA)
440 First St. NW
Third Floor
Washington, DC 20001
(202) 638-2952
www.cwla.org

This organization is comprised of public and private direct service agencies throughout the United States and Canada. CWLA offers a variety of publications and audiovisual materials for professionals.

Faith Trust Institute
2400 N. 45th St. #10
Seattle, WA 98103
(206) 634-1903
www.faithtrustinstitute.org

Faith Trust Institute formerly the **Center for Prevention of Sexual and Domestic Violence**, offers a wide range of services and resources, including training, consultation and educational materials, to provide communities and advocates with the tools and knowledge they need to address the religious and cultural issues related to abuse.

Family Support America
205 West Randolph St.
Suite 2222
Chicago, IL 60606
(312) 338-0900
www.familysupportamerica.org

This membership organization is comprised of social services, agencies concerned with family issues and preventive programs. FSA maintains a clearinghouse of information on family resource programs throughout the United States and Canada.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

National Association of Counsel of Children (NACC)
1825 Marion St., Suite 242
Denver, CO 80218
(800) 828-NACC
http://naccchildlaw.org

The center emphasizes the development of treatment programs for abused children, conducts training and consultation programs, and offers technical assistance. A catalog of materials and services is available upon request.

National Center for Missing and Exploited Children
699 Prince St.
Alexandria, VA 22314-3175
(703) 274-3900
Hotline: (800) 843-5678
www.missingkids.com

This nonprofit corporation operates a national resource and technical assistance center to deal with child abduction and exploitation.

National Coalition Against Domestic Violence (for members)
119 Constitution Ave. NE
Washington, DC 20002
(202) 544-7358
www.ncadv.org

The coalition is a national organization that works to end violence in the lives of battered women and their children. The coalition provides information, technical assistance, publications, newsletters, and resource materials. Call or write for membership information.

National Network for Youth
1319 F St. NW
Suite 401
Washington, DC 20004
(202) 783-7949
www.nn4youth.org

Works to ensure that young people can be safe and grow up to lead healthy and productive lives. Provides Community Youth Development (CYD) services to members and communities. CYD is an approach that models the best practice in youth work and focuses on lifelong learning in which youth develop skills and competencies.

New York State Council on Children and Families
5 Empire State Plaza
Suite 2810
Albany, NY 12223
(518) 474-6294
www.ccf.state.ny.us

The NYS Council on Children and Families is dedicated to reducing child abuse and neglect through development and support of programs and educational materials designed to help families cope successfully with the stresses of family life. Members include professionals, child advocates, local coalitions on child abuse and neglect, and commissioners and directors of relevant state agencies.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

New York State Federation on Child Abuse and Neglect
134 S Swan St.
Albany, NY 12210
(800) children
(800) 342-7472 (Parent information and help line)
www.preventchildabuseny.org

In its capacity as the New York State Chapter of the National Committee for Prevention of Child Abuse, the Federation supports the activities of regional task forces throughout the state that assist communities in their efforts to prevent child abuse and neglect.

New York State Office of Alcoholism and Substance Abuse Services
1450 Western Avenue
Albany, NY 12203-3526
(518) 485-1768 (General information)
http://www.oasas.state.ny.us/meth/

New York State Office of Children and Family Services
Capital View Office Park
52 Washington St.
Rensselaer, NY 12144
800-635-1522
Hotline: (518) 474-8740
www.ocfs.state.ny.us

New York State Office for the Prevention of Domestic Violence (OPDV)
Capital View Office Park
52 Washington St.
Rensselaer, NY 12144
(518) 486-6262
www.opdv.state.ny.us

Created in 1983 as the Governor's Commission on Domestic Violence, this agency studies all aspects of domestic violence and develops recommendations for ways the state can more effectively help victims and their families. The office has initiated a diverse range of projects and produces a number of publications to help victimized family members.

Office of the Professions, NYS Education Department
Child Abuse Identification and Reporting
www.op.nysed.gov/caproviders.htm

Approved providers of training.

Prevent Child Abuse America (PCAA)
200 South Michigan Ave. 17th Floor
Chicago, IL 60604
(312) 663-3520
www.preventchildabuse.org

This organization is committed to the reduction of child abuse and neglect through public awareness, education, research and advocacy. PCAA coordinates chapters at the state level and is a primary resource for local child abuse and neglect prevention efforts. A number of publications on the prevention of child abuse and neglect are produced by PCAA.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Prevent Child Abuse New York
134 S. Swan St.
Albany, NY 12210
24 hour Prevention and Parent Helpline: (800) 342-7472
www.preventchildabuseny.org

This is the New York State Chapter of Prevent Child Abuse America (discussed above). Programs include The Prevention Information Resource Center and Parent Helpline (24 hour hotline), Healthy Families New York, public awareness and education, advocacy, and annual Legislative and Prevention Conferences. The programs are an integrated whole, offering prevention services that begin with the needs of the child, the family, and the community they live in; expand to the human services and volunteer community that supports them; and reach out to the public officials and public policy makers who have ultimate responsibility to assure that every child has a protected childhood and people who can guide them to a successful future in safe communities.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

References

Alexander, R.C., Surrell, J.A., & Cohle, S.D. (1987). Microwave oven burns in children: An unusual manifestation of child abuse. *Pediatrics*, *79*, 255-260.

American Academy of Pediatric Dentistry. (1986). Child abuse and neglect (Special issue). *Pediatric Dentistry*, *8*, 65-121.

Anderson, C.L. (1987). Assessing parental potential for child abuse risk. *Pediatric Nursing*, *13*(5), 323-327.

American Board of Forensic Odontology. (1986). Guidelines for the analysis of the marks in forensic investigation. *JADA*, *12*(3), 383-386.

Augoustinos, M. (1987). Development effects of child abuse: Recent findings. *Child Abuse and Neglect*, *11*(1) 15-27.

Baer, J.W. (1987). Case report: Munchausen's/AIDS. *General Hospital Psychiatry*, *9*, 75-76.

Barton, S.J. (2000). Ask the expert: Family-centered care when abuse or neglect is suspected. *Journal of the Society of Pediatric Nurses, 5*(2)*,* 96-99.

Becker, H.A., Needleman, H.L., & Kotelchuck, M. (1978). Child abuse and dentistry: Orificial trauma and its recognition by dentists, *JADA*, *97*(1), 24-28.

Behanan, N., & Koblinsky, S. (1984, September). Child sexual abuse: The educator's role in prevention, detection and intervention. *Young Children*.

Benedict, M.I., & White, R.B. (1985). Selected perinatal factors and child abuse. *American Journal of Public Health*, *75*(7), 780-781.

Billmire, M.G., & Myers, P.A. (1985). Serious head injury in infants: Accident or abuse? *Pediatrics*, *75*, 340-342.

Brassard, M. (Ed.). (1986). *The Psychological maltreatment of children and youth*. Elmsford, NY: Pergaman Press.

Broadhurst, D. (1986). *Educators, schools, and child abuse*. Chicago: National Committee For Prevention of Child Abuse.

Burgess, A.W. (1990) Assessing child abuse: The TRIADS checklist. *Journal of Psychosocial Nursing and Mental Health Services*, *28*(4), 40-1.

Campbell, J., & Humphreys, J. (1984). *Nursing care of victims of family violence*. Reston, VA: Reston Publishing Co.

Campbell, J., & Humphreys, J. (1993). *Nursing care of survivors of family violence.* St. Louis, MO: Mosby-Year Book.

Chaney, S.E. (2000). Child abuse: clinical findings and management. *Journal of the American Academy of Nurse Practitioners, 12,* 467-471.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Cheung, K.K. (1999). Practice guidelines: Identifying and documenting findings of physical child abuse and neglect. *Journal of Pediatric Health Care, 13,* 142-143.

Child Neglect: When the family couldn't care less. (1988). *Nursing* 88, *18*(11), 68-72, 74.

Child Welfare Information Gateway. (1996). *Executive summary of the third national incidence study of child abuse and neglect*. Retrieved July 2007, from http://www.childwelfare.gov/pubs/statsinfo/nis3.cfm

Child Welfare League of America. (1989). *Highlights of questions from the working paper on chemical dependency.* Washington, DC: Author.

Christensen, M.L., Schommer, B.L., & Velasauez J. (1984). An interdisciplinary approach to child abuse. *American Journal of Maternal-Child Nursing*, *9*(2), 107-112.

Colao, F., & Hosansky, T. (1983). *Your child should know*. New York: Bobbs-Merrill Company.

Cowen, P.S. (1999). Child neglect: Injuries of omission. *Pediatric Nursing, 25,* 410-405, 409-418.

Crime and Violence Prevention Center, California Attorney General's Office. (1999). *Clandestine drug labs* [Brochure]. Sacramento, CA: Author.

Crume, T., DiGuiseppi, C., Byers, T., Sirotnak, A., & Garrett, C. (2002). Underascertainment of child maltreatment fatalities by death certificates, 1990-1998*. Pediatrics, 110,* 2.

Culp, R.E. (1987). Maltreated children's developmental scores: Treatment versus non-treatment. *Child Abuse and Neglect*, *11*(1) 29-34.

Drug Enforcement Agency. (2002) *Drug intelligence brief: The forms of methamphetamine*. Washington, DC: Author.

Dykes, L. (1986). The whiplash shaken infant syndrome: What has been learned? *Child Abuse and Neglect, 10*(2), 211.

Epstein, M.A., Markowitz, R.L., & Gallo D.M. (1987). Munchausen Syndrome by Proxy: Considerations in diagnosis and confirmation by video surveillance. *Pediatrics, 80*(2), 220-224.

Feldman, K.W. (1988). Child abuse by burning. In Helfer, R.E. & Kempe, R.S. (Eds.) *The battered child* (pp. 197-213) (4th ed.) Chicago: University of Chicago Press.

Field, M. (1984). Follow-up: Developmental status of infants hospitalized for non-organic failure-to-thrive. *Journal of Pediatric Psychology*, *9*(2), 241-257.

Fontana, V.J. (1976). *Somewhere a child is crying*. New York: New American Library.

Fontana, V.J., Donovan, D., & Wong, R.J. (1963, December 8). The maltreatment syndrome in children. *New England Journal of Medicine*, *269,* 1389-1394.

Fontana, V.J., & Besharov, D. (1977). *The maltreated child*. Springfield, IL: Charles C. Thomas.

Gammon, J.A. (1981). Ophthalmic manifestations of child abuse. In Ellerstein, N.S. (Ed.). *Child abuse and neglect: A medical reference* (pp. 121-139). New York: John Wiley and Sons.

Garbarino, J. (1987). *The psychologically battered child*. San Francisco: Jossey-Bass.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Heger, A., Emans, S.J., & Muram. D. (2000). *Evaluation of the sexually abused child: A medical textbook and photographic atlas.* Oxford, England: Oxford University Press.

Helfer, R.E. (1988). The litany of the smoldering neglect of children. In Helfer, R.E. & Kempe, R.S. (Eds.). *The battered child* (pp. 301-311) (4th ed.). Chicago: University of Chicago Press.

Herman-Giddens, M., Brown, G., Verbiest, S., Carlson, P., Hooten, E., Howell, E., & Butts, J. (1999). Underascertainment of child abuse mortality in the United States. JAMA: *Journal of the American Medical Association, 282(*5). 463-467.

Hobbs, C.J. (1986). When are burns accidental? *Archives of Diseases in Childhood*, *61*, 357-361.

Hornor, G. (2005). Physical abuse: Recognition and reporting. *Journal of Pediatric Health Care, 19*(1), 4-11.

Johnson, C.F., & Showers, J. (1985). Injury variables in child ause. *Child Abuse and Neglect*, 9, 207-211.

Jurgrau, A. (1990). How to spot child abuse. *RN*, *53*(10), 26-33.

Kelley, S.J. (1988). Physical abuse of children: Recognition and reporting. *Journal of Emergency Nursing*, *14*(2), 82-90.

Kempe, C.H. (1984). The battered child syndrome. *JAMA: Journal of the American Medical Association*, *251*, 3288.

Klein, D.M. (1981). Central nervous system Injuries. In Ellerstein, N.S. (Ed.). *Child abuse and neglect: A medical reference* (pp. 73-93). New York: John Wiley and Sons.

Lung, R.J., Miller, S.H., Davis, T.S., & Graham, W.P. (1997). Recognizing burn injuries as abuse. *American Family Physician*, *15*, 134-135.

MacDonald, G. (2001). *Effective interventions for child abuse and neglect: An evidence-based approach to planning and evaluating interventions.* New York: John Wiley and Sons.

Mayer, B.W. (2000). Differential diagnosis of abuse injuries in infants and young children. *Nurse Practitioner: American Journal of Primary Health Care, 25*(10)*,* 15-16.

McAllister, M. (2000). Domestic violence: a life-span approach to assessment and intervention. *Lippincott's Primary Care Practice, 4,* 174-192.

Merten, D.F., & Osborne, D.R.S. (1984). Craniocerebral trauma in the child abuse syndromes. *Pediatric Annals*, *12*, 882-885.

Meth 360. (2006). Retrieved March 4, 2007, from http://www.drugfree.org/Portal/DrugIssue/MethResources/default.html

Mittleman, R.E. (1987). What child abuse really looks like. *American Journal of Nursing*, *8*7, 1185A-6B, 1188D-F.

Monk, M. (1998). Interviewing suspected victims of child maltreatment in the emergency department. *Journal of Emergency Nursing, 24,* 31-34.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Mulryan, K., Cathers, P., & Fagin, A. (2000). Combating abuse, part II: Protecting the child. *Nursing2000, 30,* 39-45.

Murry, S.K., Baker, A.W., & Lewin, L. (2000). Screening families with young children for child maltreatment potential. *Pediatric Nursing, 26,* 47-54, 65.

New York State. (2004). *2003 New York State child protective services data. About child abuse*. Retrieved July 10, 2006, from http://preventchildabuseny.org/2004cpsdata.shtml

New York State Office of Children and Family Services. (n.d.). *Report of suspected child abuse or maltreatment.* Retrieved July 2007, from http://www.ocfs.state.ny.us/main/Forms/cps/

New York State Office of Children and Family Services. (2002). *Summary Guide for Mandated Reporters in NYS.* Retrieved January 2003, from http://ocfs.state.ny.us/main/publications/pub1159.pdf

New York State Office of Children and Family Services. (2003). *Frequently asked questions*. Retrieved August 2003, from http://ocfs.state.ny.us/main/faqs

New York State Office of Children and Family Services. (n.d.). *Child abuse prevention. Frequently asked questions*. Retrieved July 10, 2006, from http://www.ocfs.state.ny.us/main/prevention/faqs.asp

Office of National Drug Control Policy. (2007, March 2). *Drug Endangered Children (DEC)*. Retrieved March 5, 2007, from http://www.whitehousedrugpolicy.gov/enforce/dr_endangered_child.html

Polansky, N.A. (1988). The psychological ecology of the neglectful mother. *Child Abuse and Neglect*, *9*, 265-275.

Pollitt, E., Eichler, A.W., & Chan, C. (1975). Psychosocial development and behavior of mothers of failure-to-thrive children. *American Journal of Orthopsychiatry*, *45*, 525.

Prevent Child Abuse-New York (2003). *Statistics.* Retrieved July 2007, from http://www.preventchildabuseny.org/childabusestats.shtml

Price, J. (2000). Beyond the law: One nurse's reflections on conflicts and consequences in mandated reporting. *AWHONN-Lifelines, 4,* 41-43.

Reid, J., Macchetto, P., & Foster, S. (1999*). No safe haven: Children of substance-abusing parents*. New York, NY: National Center on Addiction and Substance Abuse, Columbia University.

Rew, L. (1990). Childhood sexual abuse: Toward self-care framework for nursing intervention and research. *Archives in Psychiatric Nursing*, *4*, 147-53.

Rhodes, A.M. (1987). Identifying and reporting child abuse. *MCN: American Journal of Maternal Child Nursing*, *12*, 399.

Ryan, J.M. (1989) Child abuse and the community health care nurse. *Home Healthcare Nurse*, *7*(2), 23-6.

Schanberger, J. (1981). Inflicted burns in children. *Topics in Emergency Medicine*, *2,* 85-92.

Scherb, B.J. (1988). Suspected abuse and neglect of children. *Journal of Emergency Nursing*, *14*(1), 44-7.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Schmidt, B.D. (1988). The child with non-accidental trauma. In Helfer, R.E. & Kempe, R.S. (Eds.). *The battered child* (4th ed., pp. 178-196). Chicago: University of Chicago Press.

Schornstein, S.L., & Schornstein S.L. (1997). *Domestic violence and health care: A primer for healthcare professionals.* Thousand Oaks, CA: Sage Publications.

Schwaab, N.C. (1989). Child abuse and neglect: Legal and clinical implication for school nursing practice. *School Nurse, 5*(4), 17-20, 25-8.

Senner, A. (1990). Munchausen Syndrome by Proxy*. Issues in Contemporary Pediatric Nursing*, *12*, 345-57.

Study of national incidence and prevalence of child abuse and neglect: Study findings. (1988). Washington, DC: National Center on Child Abuse and Neglect, U.S. Children's Bureau, Administration for Children, Youth and Families, USDHHS.

Tammelleo, A.D. (1988). If you suspect child abuse. *RN, 51*(7), 57-9.

Temporary Commission of Investigation of the State of New York. (1994*). Secrets that can kill: Child abuse investigations in New York State.* Retrieved June, 2004 at http://www.nysl.nysed.gov/edocs/investigation/secrets.htm

The identification and reporting of child abuse in New York State. (1991). Guilderland, NY: New York State Nurses Association.

Tower, C.C. (1984). *Child abuse and neglect: A teacher's handbook for detection, reporting, and classroom management*. Washington, DC: National Education Association.

U.S. Advisory Board on Child Abuse and Neglect. (1995). *A nation's shame: Fatal child abuse and neglect in the United States.* Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families.

U.S. Department of Health & Human Services. *Sexual abuse of children: Selected readings*. Washington, DC: Government Printing Office.

U.S. Department of Health & Human Services, Administration for Children & Families. (2004). *Summary: Child maltreatment, 2004*. Retrieved July 10, 2006, from http://www.acf.hhs.gov/programs/cb/pubs/cm04/summary.htm

U.S. Department of Health & Human Services, Administration for Children and Families (2002). *Child maltreatment 2002.* Retrieved July 2007, from http://www.acf.hhs.gov/programs/cb/pubs/cm02/

U.S. Department of Health & Human Services & National Center on Child Abuse and Neglect. (1999). *Child maltreatment 1997: Reports from the states to the national child abuse and neglect data system*. Washington, DC: Government Printing Office.

U.S. Department of Health & Human Services & National Center on Child Abuse and Neglect. (1991). *National Incidence and Prevalence of Child Abuse and Neglect: The 1988 Revised Report (NIS-2)*. Washington, DC: Governmental Printing Office, 1991.

U.S. Department of Health & Human Services & National Center on Child Abuse and Neglect. (n.d.). *Third National Incidence Study of Child Abuse and Neglect: Final report*. Washington, DC: Government Printing Office.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

U.S. Department of Health & Human Services & National Center on Child Abuse and Neglect. (n.d.). *A report on child maltreatment in alcohol-abusing families.* Washington, DC: Government Printing Office.

U.S. Department of Health & Human Services & National Clearinghouse on Child Abuse and Neglect Information (2004). *Child Abuse Fatalities: Statistics and Interventions*. Retrieved July 2007, from http://www.childwelfare.gov/pubs/factsheets/fatality.cfm

U.S. Department of Health & Human Services & National Clearinghouse on Child Abuse and Neglect Information (2002). *Child maltreatment 2002: Summary of key findings.* Retrieved June 2004, from http://nccanch.acf.hhs.gov/pubs/factsheets/canstats.cfm

U.S. Department of Justice. (2002). *Clandestine drug labs* (16th ed.) [Brochure]. Washington DC: Author.

Velasquez, J., Christensen, M.L., & Scholmmer, B.L. (1984). Intensive services help prevent child abuse. *Journal of Maternal-Child Nursing*, *2*(9), 113-117.

Volpe, R., Breton, M., & Mitton, J., (Eds.). (1980). *The maltreatment of the school-aged child*. Boston: Lexington Books.

Widom, C.S. (1992). *The cycle of violence.* Washington, DC: National Institute of Justice.

Widom, C.S., & Ames, M.A. (1994). Criminal consequences of child sexual victimization. *Child Abuse and Neglect*, *18*, 303-318.

Wolverton, L.M. (1987). *What's a teacher to do? Child abuse education for the classroom*. Ithaca, NY: Family Life Development Center, Cornell University.

Wohl, A., & Kaufman, B. (1985). *Silent screams and hidden cries*. New York: Brummer/Mazel.

Worlock, P. (1986). Patterns of fractures in accidental and non-accidental injury in children. *British Medical Journal*, 293:100-103.

Www.streetdrugs.org. (2006). *Methamphetamine labs* (Ver V). [Brochure]. Plymouth, MN: Author.

Wyszynski, M.E. (1999). Shaken baby syndrome: Identification, intervention, and prevention. *Clinical Excellence for Nurse Practitioners, 3,* 262-267.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

Identification and Reporting of Child Abuse in NYS
Course Exam

After studying the downloaded course and completing the course exam, you need to enter your answers online. **Answers cannot be graded from this downloadable version of the course.** To enter your answers online, go to e-leaRN's Web site, www.elearnonline.net and click on the Login/My Account button. As a returning student, log in using the username and password you created, click on the "Go to Course" link and proceed to the course exam.

1. Which of these occurrences may be considered child abuse?

   a. Holding the penis of a four-year-old child when he urinates.
   b. Kissing a ten-year-old child near the mouth.
   c. Having sexual activity with a consenting 14-year-old boy.
   d. Hiring a 19-year-old female prostitute.

2. Children are ***most*** often physically abused by:

   a. Strangers.
   b. Older children.
   c. Their teachers.
   d. Their parents.

3. The chemicals involved in methamphetamine production are:

   a. Generally safe household items.
   b. Toxic and highly irritating to skin, eyes, and lungs.
   c. Are used under controlled conditions by trained laboratory technicians.
   d. None of the above.

4. Meth use contributes to domestic violence, child abuse, automobile accidents, and the spread of infectious diseases such as Hepatitis C and HIV.

   a. True
   b. False

5. Child abuse/neglect, burns to the skin, and respiratory ailments may signal a drug-endangered child.

   a. True
   b. False

6. If you suspect a clandestine meth lab, which of the following agencies may become involved?

   a. Local law enforcement
   b. HAZMAT
   c. Social Services
   d. All of the above

7. Physical signs that almost always indicate child abuse are:

   a. Bruises.
   b. Lacerations.
   c. Persistent diaper rash.
   d. Injuries to both eyes or both cheeks.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

8. A burn that should be considered a physical indicator of child abuse is one that:

   a. Occurs during the night.
   b. Has a patterned design.
   c. Affects one limb only.
   d. Is nearly healed on first presentation.

9. Special attention should be paid to a child's injuries when they are:

   a. Easily explained by parent/caretaker.
   b. Consistent with the explanations given.
   c. Inconsistent with the child's developmental stage.
   d. Explained with a great deal of emotion by parent/caretaker.

10. Which of these behavioral signs is ***most*** likely to indicate that a 6-year-old child has been physically abused?

   a. Is frightened when other children cry.
   b. Wears only long-sleeved shirts despite hot weather.
   c. Will drink only warmed liquids.
   d. Has erratic eating habits, often refusing to eat.

11. Which of the following is ***least*** likely to be an indicator of maltreatment and/or neglect in a 12 year old child?

   a. Chronic truancy.
   b. Use of profanity.
   c. Untreated physical problems.
   d. Delayed physical development.

12. Family histories can reveal clues that suggest further investigation is warranted if child abuse is suspected. Which of the following is such a clue?

   a. Grandparents were divorced.
   b. Single parent family.
   c. Parent who stutters.
   d. Parent was abused as a child.

13. Which of the following parent/child interactions warrants further assessment for a possible report of abuse?

   a. Parent verbalizes mental limits of a child who is developmentally disabled.
   b. Parent appears to be nurtured or cared for by child.
   c. Parent frequently attends school activities with child.
   d. Parent appears overly concerned with the child's shyness

14. A 2-year-old toddler is brought into your emergency room with pain and restricted movement in the upper right arm. His parents state he fell off his tricycle. An X-ray reveals a spiral fracture of the humorous. You would:

   a. Educate the parents about bike safety.
   b. Question the parents further about the accident.
   c. Report the suspicion of child abuse immediately.
   d. Advise the parents to seek counseling.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

15. Environmental factors that are associated with abusive behavior include:

    a. Frequent moves to new residences.
    b. Presence of extended family in or near the home.
    c. Television sets in each room of the residence.
    d. Sharing of bedrooms by children of the opposite sex.

16. Which of the following behaviors demonstrated by a 15-year-old boy is ***most*** likely a sign of maltreatment and neglect?

    a. He often wears no coat to school despite below zero weather.
    b. He earns a "C" average in school.
    c. He enjoys playing violent video games.
    d. He is compliant and passive.

17. Which of the following behaviors is the ***most*** likely sign of current or previous sexual abuse?

    a. A 14-year-old boy has poor peer relationships.
    b. A 15-year-old girl who wears revealing clothing.
    c. A 16-year-old girl is sexually active.
    d. A 12-year-old boy sexually assaulted a younger child.

18. Which of these actions by a mandated reporter is often crucial to protect a child from further abuse?

    a. Reporting the suspicion of abuse immediately.
    b. Collecting more evidence about the abuse.
    c. Having the child examined by a physician immediately.
    d. Contacting the parent to discuss the situation.

Use the following situations for questions 19- 21.

A. A 4-year-old girl with gonorrhea.
B. A 4-week-old infant who fractured his skull falling out of his crib.
C. A 3-year-old and her 3-month-old brother who stay alone while their mother works.
D. A 12-year-old with a fractured collarbone and leg that he says he injured on a friend's skateboard.

---

19. Which of the situations is ***most*** likely to indicate possible neglect?

    a. A
    b. B
    c. C
    d. D

20. Which of the situations is ***most*** likely to indicate possible physical abuse?

    a. A
    b. B
    c. C
    d. D

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

21. Which of the situations is ***most*** likely to indicate possible sexual abuse?

    a. A
    b. B
    c. C
    d. D

22. Is it true that in order to possess the necessary “reasonable cause” to file a report of child abuse, the reporter must be certain that the injury was caused by neglect or non-accidental means?

    a. Yes; otherwise, the reporter is making a libelous claim.
    b. Yes; otherwise, the reporter may have his/her license revoked.
    c. No; any suspicion whatsoever must be reported.
    d. No; if there is a professional judgment, a report should be filed.

23. In terms of taking photographs of a child’s visible trauma, a mandated reporter should:

    a. Take photographs only if the hospital/police photographer is not available.
    b. Take photographs only if a 35 mm camera is available.
    c. Use a whole roll of film when taking the photographs.
    d. Submit the highest quality photographs with the report.

24. Which of the following statements is true concerning a mandated report of child abuse?

    a. Reporters are presumed to have done so in good faith.
    b. Reporters are professionally liable within their scope of practice for their statements.
    c. The name of the reporter is released only to the subject of a report.
    d. The reporter must appear in court if charges against the parent are filed.

25. Under New York State law, is it possible for an individual over 18 years of age, who has a disability and resides in a New York state-approved residential care facility, to be classified as an abused child?

    a. No, since the person is over the age limit.
    b. No, since the person is considered a ward of the state.
    c. Yes, this person can be included in this classification.
    d. Yes, but only if mentally compromised.

26. After a report is filed, which of these actions does Child Protective Services usually take?

    a. The child is immediately taken from the home.
    b. The child’s siblings are evaluated.
    c. A surveillance team is placed outside the child’s home.
    d. The suspected child abuser is fingerprinted.

27. In the event the mandated reporter makes a verbal telephone report of child abuse, a written report must be filed within:

    a. 24 hours.
    b. 48 hours.
    c. 3 days.
    d. 7 days.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.

28. A 10-year old girl asks the school nurse, “What would happen if someone told you that her father touched her in a private place?” Based on this comment, which of these actions should the nurse take ***initially***?

    a. Encourage the child to tell the nurse what the child knows about the girl.
    b. Find out from the child’s teacher what has been going on in class.
    c. File a written report of suspected sexual abuse.
    d. Contact the child’s family.

29. A mandated reporter is treating a woman in the emergency department of a hospital. She tells the clinician that her husband “is not a good father.” He constantly hits her son, calls him “unmentionable” names, and often sends him to bed without dinner. The child has lost weight but says he loves his father. Is this situation considered reportable?

    a. No, this is hearsay and as a mandated reporter you cannot act on this information.
    b. No, this child needs a medical referral.
    c. Yes, this father’s behavior is considered abusive, and as a mandated reporter you must report what this patient is telling you.
    d. Yes, any poor parenting must be reported as child abuse.

30. In New York State, if a nurse does not report a suspected case of child abuse, it is considered:

    a. A felony.
    b. Assault and battery.
    c. An intentional tort.
    d. Professional misconduct.

© 2007 NYSNA, all rights reserved. Material may not be reproduced without written permission.