NYS Child Abuse: Identification and Reporting, 8th Edition

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 meets the New York State child abuse recognition and reporting requirements.

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

This program has been awarded 3.0 CHs through the New York State Nurses Association Accredited Provider Unit.

The New York State Nurses Association is accredited by the International Accreditors for Continuing Education and Training (IACET) and offers IACET CEUs for its learning events that comply with the ANSI/IACET Continuing Education and Training Standard. IACET is recognized internationally as a standard development organization and accrediting body that promotes quality of continuing education and training.

The New York State Nurses Association is authorized by IACET to offer 0.3 CEUs for this program.

This course is intended for RNs and other healthcare and licensed professionals regardless of whether a registrant is completing their initial registration application or renewing their registration. The New York State Education Department is now mandating all nurses and other licensed healthcare practitioners who have previously completed the one-time New York State Mandated Identification and Reporting of Child Abuse and Maltreatment Course to complete a newly updated training program by April 1, 2025. This program has been updated and satisfies the NYS requirement for all practitioners to meet the amended law. **In order to receive contact hours/CEUs, participants must read the course materials, pass an examination with at least 80%, and complete an evaluation.** Contact hours/CEUs will be awarded for this course until September 28, 2026.

All American Nurses Credentialing Center's *(*ANCC) accredited organizations' continuing nursing education credits 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).

NYSNA wishes to disclose that no commercial support or sponsorship has been received.

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.

Upon successful completion of this course, results are uploaded electronically to the NYSED, Licensing Division **every day at 4 p.m**. **Please understand the NYSED requires a minimum of 3 business days to update your state record.**

ATTENTION: New York State Education Department (NYSED) Mandate: The NYSED is now mandating all Nurses and other Licensed Healthcare Practitioners who have previously completed the one-time NYS Mandated Identification and Reporting of Child Abuse and Maltreatment course to NOW COMPLETE a NEWLY UPDATED TRAINING PROGRAM by **April, 1, 2025**

A new certificate of completion will be issued as proof participants have completed the updated three-hour program, along with the usual and customary NYSNA certificate of completion with the ANCC and IACET logos.

Even if NYSNA has previously submitted information directly to the Department of your successful completion of the child abuse program, NYSNA is still required to issue this new certificate to those practitioners who successfully complete the newly revised program. It is the responsibility of each practitioner to submit the completed new certificate to the State Education Department. NYSNA will NOT submit this completed new certificate to the NYSED as required by law.

Directions for completing the new NYSED certificate:

1. Complete the Child Abuse program and exam.
2. Download your NYSNA certificate of completion with the ANCC and IACET logo and keep this copy for your personal records.
3. Download the new NYSED certificate of completion.

   DO NOT FILL IN SECTION 1 (YOUR SOCIAL SECURITY NUMBER) OR SECTION 6 (MOTORIST ID). NYSNA does not keep copies of learner's social security and motorist ID numbers in its database.

4. **Make sure the information in Section 1, Numbers 2, 3, 4, 5, and 7 are correct. Make any necessary corrections.**
5. **Sign the new NYSED certificate of completion in Section 1, Line 8.**
6. Return the signed copy of the NYSED certificate of completion to NYSNA at: courses@nysna.org (with lines 2, 3, 4, 5, and 7 completed).
7. After returning your signed certificate to courses@nysna.org, fill in your social security number and motorist ID. Keep a copy of the fully completed certificate for your personal records.
8. Submit the completed NYSED certificate of completion in accordance with the directions noted on the new certificate of completion (also below).
   - If this certification of completion is being submitted in support of an application for New York State Licensure or Permit, Return Directly to: New York State Education Department, Office of the Professions, Division of Professional Licensing Services, [Be sure to give name of profession], 89 Washington Avenue, Albany, NY 12234-1000.
   - If this certification of completion is being submitted in support of an application for reregistration of a New York State license: Make sure to include this completed form with your reregistration application.
   - If this certification of completion is being submitted in support of an application for New York State Teacher Certification, Return directly to: New York State Education Department, Office of Teaching, 89 Washington Avenue, Albany, NY 12234-1000.

If you have any questions regarding the NYS mandated educational requirements, contact their office directly at: **NYSED, Office of the Professions, (518) 474 -3817** to contact your specific professional unit and attain fax and/or e-mail information.

About the Authors

This course was designed by a team of experts in the Nursing Education and Practice Department of the New York State Nurses Association (NYSNA). 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.

This course was updated in 2011 by **Victoria Greenwood, MS, RN**. Ms. Greenwood is employed as an educator at St. Peters Hospital, in Albany, New York. Additionally, Lynn McNall, MS, RN, then Associate Director in the Nursing, Education and Practice Program at NYSNA, reviewed and updated the course in March of 2012.

In September 2015, this course was reviewed and updated by **Lucille Contreras Sollazzo, MSN, RN-BC, NPD**. Ms. Contreras Sollazzo is employed as the Associate Director in the Nursing Education and Practice Department at NYSNA, in New York, NY. **Carol Lynn Esposito, Ed.D., JD, MS, RN-BC, NPD**, reviewed and updated this course in April 2018, in August, 2021, and in September 2023. Dr. Esposito is the Director of the Nursing Education and Practice Department at NYSNA.

NYSNA wishes to disclose that no commercial support or sponsorship was received. NYSNA program planners, presenters, and content experts declare that they have no financial relationship with an ineligible company.

The authors wish to declare they have no vested interest.

Learning Outcome:

At the conclusion of this program participants will be able to identify signs of maltreatment and neglect, adverse childhood experiences and trauma, implicit bias, and identification of child abuse virtually along with actions a mandated reporter might take to protect a child.

Objectives

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

- Differentiate what constitutes "abuse," "maltreatment," and "neglect" including in the virtual setting 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.
- Recognize the impact of trauma and Adverse Childhood Experiences (ACEs) on children, families, and practitioners.
- Recognize what equipment and chemicals may be signs of a clandestine methamphetamine lab.
- Define “drug-endangered child” and outline how to report child endangerment.
- Identify physical and behavioral indicators commonly associated with physical abuse, maltreatment, and/or 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.
- Recognize the mitigating effects of the five protective factors on trauma.
- Describe situations in which mandated reporters must report suspected cases of child abuse, maltreatment and/or neglect.
- Describe what constitutes "reasonable cause to suspect" that a child has been abused or maltreated.
- Recognize the impact of bias on decision-making.
- Outline the proper procedure for effectively making a report of suspected child abuse, maltreatment, and/or neglect.
- 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.

Course Introduction

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Child abuse and neglect, trauma, and adverse childhood experiences (ACEs) 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. Child abuse identification and reporting are not limited to one setting.

Chapter 544 of the laws of New York State (1988), as amended, established a requirement for certain professions (see Table 1) to provide documentation of having completed a minimum of **two hours** of coursework or training regarding the identification and reporting of child abuse and maltreatment (New York State Education Department, Office of the Professions [NYSED, OP], 2009). 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 (NYSED). The New York State Nurses Association (NYSNA) has been approved as a provider and this course meets the training requirements.

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, to recognize signs of an unlawful (clandestine) methamphetamine laboratory (New York State Office of Alcoholism and Substance Abuse Services, n.d.).

In 2019, the New York State Office of Children and Family Services (NYSOCFS) 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 Statewide 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, trauma, and ACEs and to engage in appropriate interventions.

Who Is Mandated to Report

Social Service Law

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

Table 1. Mandated Reporters		
Physician	Registered Physician Assistant	Surgeon
Medical Examiner	Coroner	Dentist
Dental Hygienist	Osteopath	Optometrist
Chiropractor	Podiatrist	Resident
Intern	Psychologist	Registered Nurse
Social Worker	Emergency Medical Technician	Licensed Creative Arts Therapist
Licensed Marriage and Family Therapist	Licensed Mental Health Counselor	Licensed Psychoanalyst
Licensed Behavior Analyst	Certified Behavior Analyst Assistants	Christian Science practitioner
Hospital personnel engaged in the admission, examination, care, or treatment of persons		
School official, including (but not limited to): • Teacher • Guidance Counselor • Psychologist • Social Worker • Nurse • Administrator or other school personnel required to hold a teaching or administrative license or certificate		
Director of a • Children's overnight camp • Summer day camp • Traveling summer day camp		
Social Services Worker	Day Care Center Worker	School Age Child Care Worker
Provider of family or group family day care	Employer or volunteer in a residential care facility for children	Any other child care or foster care worker
Mental Health Professional	Substance Abuse Counselor	Alcoholism Counselor

All persons credentialed by the NYS Office of Alcoholism and Substance Abuse Services	Peace Officer	Police Officer
District Attorney or Assistant District Attorney	Investigator employed in the office of a district attorney	Any other law enforcement official

The entire current list can be found in Article 6, Title 6, Section 413 of the New York Social Services Law, which can be accessed online through the New York State Legislature's Web site: http://public.leginfo.state.ny.us/menuf.cgi. Click on Laws of New York to access Social Services Law.

New York State Office of Children and Family Services (NYSOCFS) ((08-OCFS-INF-01 Mandated Reporters, Chapter 193 of the Laws of 2007, https://ocfs.ny.gov/main/policies/external/OCFS_2008/INFs/08-OCFS-INF-01%20Mandated%20Reporters,%20Chapter%20193%20of%20the%20Laws%20of%202007%20(replaces%2007-OCFS-INF-07).pdf (replaces 07-OCFS-INF-07) (ny.gov)) states:

- October 1, 2007, Chapter 193 of the Laws of 2007 were amended for those mandated reporters who work for a school, child care provider, foster care facility, residential care facility, hospital, medical institution or mental health facility, and who have direct knowledge of any allegation(s) of suspected child abuse or maltreatment.
- These persons must personally make a report to the Statewide Central Register of Child Abuse and Maltreatment (SCR) and then immediately notify the person in charge of the institution or his/her designated agent that a report has been made.
- The person in charge, or the designated agent of such person, is then responsible for all subsequent internal administration necessitated by the report. This may include providing follow-up information (ex. relevant information contained in the child's educational record) to Child Protective Services (CPS).
- CPS needs strong partnerships within the community to help prevent child abuse and maltreatment.

Note: Notification to the person in charge or designated agent of the medical or other public or private institution, school, facility or agency does not absolve the original mandated reporter of his or her responsibility to personally make a report to the SCR. ***A mandated reporter who has direct knowledge of possible child abuse or maltreatment,*** *and not the person in charge of the institution, school, facility, or agency, who does not have direct knowledge of the alleged abuse or maltreatment,* ***must make the initial report to SCR.***

- All initial or subsequent reports made to the SCR shall include the name, title and contact information for every staff person of an institution that is believed to have direct knowledge of the allegations contained in the report. Nothing in Chapter 193, however, is intended to *require* that more than one report from any such institution, school or agency be made to the SCR.
- No medical or other public or private institution, school, facility, or agency shall take retaliatory personnel action against an employee who made a report to the SCR. Furthermore, no school or school official, child care provider, residential care facility provider, hospital or medical institution provider, or mental health facility provider shall impose any conditions - including prior approval or prior notification - upon a member of their staff mandated to report suspected child abuse or maltreatment.
- 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 422 of this article, the finding of an investigation made pursuant to this title or Section 45.07 of the mental hygiene law.

(NYSOCFS, 2011)

Anytime mandated reporters suspect child abuse or maltreatment—and fail to report it—they can be found guilty of a Class A misdemeanor. This misdemeanor can result in a penalty of up to a year in jail, a fine of up to $1,000, or both. In addition, a mandated reporter who fails to make a required report to the SCR can be sued in civil court for monetary damages for any harm caused by the failure to report, including wrongful death (NYSOCFS, 2017, 2016).

Agency Responsibilities

Any person, institution, school, facility, agency, organization partnership or corporation which employs persons mandated to report suspected incidents of child abuse or maltreatment shall provide all such current and new employees with written information explaining the reporting requirements. 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 (NYSOCFS, 2011).

The person in charge or designated agent, when advised by a mandated reporter that the report was made to the SCR by another mandated reporter, shall confirm with the mandated reporter who made the call that a report was made and accepted by the SCR. The organization should establish a policy as to how this confirmation will be accomplished. When a report is accepted, the SCR will advise the mandated reporter who made the report of the SCR number assigned to the report. Included in the policy should be the process in which the mandated reporter notifies the agency of the SCR number assigned to the report and a way in which other mandated reporters in that organization who would have contact with the child, that a report was made, as every mandated reporter is not required to file a separate report if they know that a report of alleged abuse has been made.

Shared Mission

- The Offices of Children and Family Services (OCFS), the SCR, local CPS agencies and mandated reporters have a shared mission to promote the well-being of New York's children, families and communities.
- Mandated reporters are legally obligated to call the SCR only in certain circumstances, which will be described throughout this program.
- In certain circumstances, families in crisis may not meet the legal criteria required to call the SCR and may be better served by being connected to a variety of community services in their area. Those circumstances will be described throughout this program.
- Resources for practitioners and families include:

    - The OCFS H.E.A.R.S. – Help, Empower, Advocate, Reassure and Support - family line assists families by providing resources and referrals to a variety of services such as food, clothing, housing, childcare, parenting education and more. Representatives are available to help Monday through Friday 8:30am-4:30pm. If you know a family that could use support, please ask them to call the OCFS HEARS family line at 888-554-3277.
    - OCFS lists on its website resources on adverse childhood experiences, including information on how to access a wide variety of services: https://ocfs.ny.gov/programs/cwcs/aces.php.
    - NY Project Hope provides emotional support for New York State residents. This includes an Emotional Support Helpline (1-844-863-9314), Online Wellness Groups, and a website filled with supportive resources (NYProjectHope.org).
    - The New York State Office for the Prevention of Domestic Violence has a website that provides a number of resources for people who may be

experiencing, or are survivors of, domestic violence: https://opdv.ny.gov/survivors-victims.

- Prevent Child Abuse New York also has a prevention and parent helpline available for parents and caregivers that is confidential and multi-lingual and can refer or connect caregivers to community-based services. This helpline is available Monday through Friday from 9am-4pm at 1-800-CHILDREN.
- Parents and caregivers may also call 2-1-1, operated by the United Way, for health and human services information, referrals, assessments, and crisis support to help them find the assistance they need to address the everyday challenges of living, as well as those that develop during times of disaster or other community emergencies. 2-1-1 is multi-lingual and available 24 hours a day 7 days a week.
- For more information on what services are available for children and parents in your community, visit http://nysmandatedreporter.org.

Historical Factors Related to Child Abuse and Maltreatment

Each year in the United States, Child Protective Services (CPS) agencies investigate reports of suspected child maltreatment, In the Federal Fiscal Year 2019, 10.3% of cases involve concerns of physical abuse.

For Federal Fiscal Year 2019, CPS agencies received more than 4.4 million referrals involving more than 7.9 million children. 68.6% of those referrals came from professionals required to report with the highest percentages of reports coming from education personnel (21.0%), legal and law enforcement personnel (19.1%), and medical personnel (11.0%). 15.5% of reported cases are victims of two or more maltreatment types.

After investigation, in Federal Fiscal Year 2019, more than 656,000 children are substantiated as victims of abuse and neglect, and over 1840 child deaths are attributed to child abuse or neglect annually (USOHHS, ACF, ACYF, CB, 2019).

In 2019, there were 67,269 victims of child abuse in New York State, of which 39,379 were first-time victims. A majority of the victims were 1 year of age or less and both boys and girls equally were victims of abuse and maltreatment. Perpetrators of abuse and maltreatment by race where Caucasians, followed by Hispanics, African Americans, Multiple Races, Asians, Native Americans/Alaskans, and Pacific Islanders. In 2019, there were 95,673 victims of maltreatment in New York State, of which 95.5% of the cases were neglect (USDHHS, ACF, ACYF, CB, 2019).

A National Incidence Study (U.S. Department of Health & Human Services [USDHHS], 09; Flaherty, et al., 2006; NYSOCFS, 2011) found that professionals too often failed to report suspected cases of child abuse and maltreatment due to:

- Misunderstandings or confusion about the required reporting laws and procedures.
- A lack of awareness or knowledge about the clues or warning signs that signal that abuse is occurring.
- Perceived lack of benefit to the child if the abuse is reported; often influenced by personal, professional beliefs, values, and experiences.

Child abuse and maltreatment can occur in any family regardless of its education, ethnicity, or socio-economic status (NYSOCFS, 2011).

The role of the mandated reporter, while acting in their professional capacity (while “on duty” or “on the clock”, is to report suspected incidents of child abuse or maltreatment and/or neglect. Professional capacity specifically refers to anytime a person is acting within the scope of their practice and while in an employment setting or is carrying out functions that are part of their professional duties and responsibilities (NYSOCFS, 2011).

Childhood is a relatively new concept. Until approximately the 18th century, children were seen as small adults and as property of their parents or caregivers and did not have rights. Unfortunately, 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.

- In 1873, a nine year old orphan, living in New York City was physically abused almost daily by her caretaker, who often used a raw-hide whip (New York Society for the Prevention of Cruelty to Children [NYSPCC], 2015).

    - A social worker learned of the child's horrible situation, and despite efforts to intervene on her behalf, found that the law, as well as charitable institutions, were unable to protect the girl.
    - The Society for the Prevention of Cruelty to Animals intervened to protect the child as an abused member of the animal kingdom.
    - In April 1874, the abused child was brought into a New York courtroom to tell her story to a judge, which was the beginning of the children's rights movement.
- The Society for Prevention of Cruelty to Children (NYSPCC) was founded in New York City in 1875 due to this 1873 case.
- In 1969, a female child died prompting the creation of New York State's comprehensive Child Protection Laws (University of Maryland School of Public Policy, Welfare Reform Academy, n.d.).
- In 1987, the beating death of a six-year-old 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 (Florida International University College of Education, 2010).
    - There had been indications that the child was being abused, but this was not reported.
    - Her death led to the NYS requirement that all professionals in order to be licensed or certified must:
        1. Complete an educational program on the identification and reporting of child abuse and maltreatment.
        2. Be mandated to report child abuse and maltreatment.

Legal Definitions

The following are the definitions provided in New York State Laws (New York Family Court Act §1012 Definitions, 2021):

Child – means any person or persons under the age of 18 alleged to have been abused or neglected.

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. "Of course, anyone may report any suspected abuse or maltreatment at any time and is encouraged to do so" (NYSOCFS, 2011).

Abuse - Abuse encompasses the most serious harms committed against children.

- An "abused child" is defined as one who is under 18 years of age whose parent or other person legally responsible for the child's care:

  A. Inflicts or allows to be inflicted on a child physical injury by other than accidental means.

  AND

  B. Such action causes or creates a substantial risk of 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.

  OR

  C. Creates or allows to be created a substantial risk of physical injury to such a child by other than accidental means

  AND

  D. Such action 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.

  OR

  E. Commits or allows to be committed a sex offense as described in §130 of the NYS Penal Law.
     1. Sexual misconduct
     2. Rape
     3. Criminal sexual act
     4. Forcible touching
     5. Persistent sexual abuse
     6. Sexual abuse
     7. Aggravated sexual abuse
     8. Course of sexual conduct against a child
     9. Female genital mutilation
     10. Facilitating a sex offense with a controlled substance
     11. Sexually motivated felony

12. Predatory sexual assault

OR

F. Allows, permits or encourages the child to engage in any act described in §230.25, §230.30, or §230.32 230.34-a of the NYS Penal Law (e.g., promoting prostitution and/or sex trafficking).

OR

G. Commits any acts described in §255.25, §255.26 and §255.27 of the NYS Penal Law (e.g., incest).

OR

H. Allows the child to engage in acts or conduct described in Article 263 of the Penal Law:
    1. Use of a child in a sexual performance.
    2. Promoting an obscene sexual performance by a child.
    3. Possessing an obscene sexual performance by a child.
    4. Promoting a sexual performance by a child.
    5. Possessing a sexual performance by a child.
    6. Facilitating a sexual performance by a controlled substance
    7. Facilitating a sexual performance by alcohol

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

A. A child residing in a group residential care facility under the jurisdiction of the New York State Office of Children and Family Services (NYSOCFS), Division for Youth (DFY), Office of Mental Health (OMH), Office for People With Developmental Disabilities (OPWDD), or the State Education Department (NYSED).

OR

B. A child with a handicapping condition who is no more than 21 years of age 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, or the parent's or legal guardian's failed to exercise a minimum degree of care.

- A maltreated child includes a child:

A. Less than 18 years of age, defined as a neglected child by the New York Family Court Act §1012 (2012).

AND

B. Who has had serious physical injury inflicted upon him/her by means other than accidental.

OR

C. Eighteen years of age or older, who is neglected and resides in one of the special residential care institutions previously listed.

Maltreatment occurs when a parent or other person legally responsible for the care of a child harms a child, or places a child in imminent danger of harm by failing to exercise the minimum degree of care in providing the child with any of the following: food, clothing, shelter, education or medical care when financially able to do so.

Maltreatment can also result from abandonment of a child by demonstrating an intent to forego his or her parental rights and obligations by failing to visit the child or communicate with the child, although able to do so, or from not providing adequate supervision for the child.

OR

A child may be maltreated if a parent engages in excessive use of corporal punishment or drugs or alcohol such that it interferes with their ability to adequately supervise the child (New York State Office of Children and Family Services (NYSOCFS) (July 7, 2021),Child Protective Services, https://ocfs.ny.gov/programs/cps/definition.php).

Neglect – A neglected child (a child less than 18 years of age), is defined as a child whose physical, mental, or emotional condition has been impaired or is in imminent danger of becoming impaired as a result of the failure of his/her parents or other person legally responsible for his/her care to exercise a minimum degree of care (New York Family Court Act §1012, 2012):

- 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.

OR

- In providing the child with proper supervision or guardianship, by unreasonably inflicting or allowing to be inflicted harm, or a substantial risk thereof, including the infliction of excessive corporal punishment.

OR

- By misusing a drug, drugs, or alcohol to the extent that he or she loses self-control of his/her actions.

OR

- By any other acts of similarly serious nature requiring the aid of the court.

OR

- Whom his/her parents or other person legally responsible for the child's care has abandoned.

AND

- 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 §1012 (2012) 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 including incorrigibility, ungovernability or habitual truancy.

- Emotional neglect is also defined as the failure of a parent or caregiver to supply the child with the love and support necessary for healthy development. This may include failure to provide warmth, attention, supervision, affection, praise, or encouragement to a child. Emotional neglect is not the same as emotional abuse; typically, emotional abuse is considered purposeful or intentional, while emotional neglect may not be.

OR

- 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 for People with Developmental Disabilities [OPWDD], or the State Education Department [NYSED]) 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.

OR

- 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.

OR

- Failing to adhere to standards for the supervision of children by inflicting or allowing to be inflicted physical harm or risk of harm.

OR

- Failing to conform to applicable state regulations for appropriate custodial conduct.

Person Legally Responsible – A legal caregiver or person legally responsible (PLR), in accordance with §1012(g) of the NYS Family Court Act (2012), is a:

- Parent
- Guardian
- Foster parent
- Custodian
    - The term "custodian" may include any person continually or at regular intervals found in the same household as the child when the conduct of such person causes or contributes to the abuse or maltreatment of the child.
- Day care provider
- Residential care provider
- Any other person responsible for the child's care at the relevant time

<u>Legislative Updates</u>

The Abandoned Infant Protection Act

New York's Abandoned Infant Protection Act (AIPA) was created in Chapter 156 of the Laws of 2000 and amended in the Laws of New York, 2010, Chapter 447. The purpose of AIPA is to prevent people from abandoning their babies in unsafe or dangerous places. Under this provision a parent, guardian, or other legally responsible person who is unable to care for their newborn infant (no more than 30 days old) may anonymously leave their infant at a safe place. Such individuals are not required to provide their names and will not be prosecuted for the Class E felony of Abandonment of a Child or the Class A misdemeanor of Endangering the Welfare of a Child if the following conditions are met:

- The person who abandoned the child intended that the child be safe from physical injury and be cared for in an appropriate manner;
- The child is left with an appropriate person, or in a suitable location and the person who leaves the child promptly notifies an appropriate person of the child's location; and
- The child is not more than 30 days old; and
- The person must intend to wholly abandon the infant by relinquishing responsibility for and rights to the care and custody of the infant (NYSOCFS, 2016a, 2015, n.d.-c).

The Abandoned Infant Protection Act does NOT affect your responsibilities as a mandated reporter, nor does it amend the law regarding mandated reporters, and it does NOT in any way change or lessen your obligations and responsibilities as a mandated reporter. Mandated reporters who learn of an abandoned infant, even if they do not know the name of the person leaving the child, must make a report to the SCR (NYSOCFS, 2016a, 2015).

False Reporting Statutes

Social Service Law

SOS § 422.14 The office shall refer suspected cases of falsely reporting child abuse and maltreatment in violation of subdivision four of section 240.50 of the penal law to the appropriate law enforcement agency or district attorney.*

* [The relevant portions of the penal law were amended and the sections renumbered. The penal law reference to intentional false reports is now at §240.50(4) of the penal law. The Social Service Law has not yet been changed to reflect that.]

Penal Law

PEN § 240.50 Falsely reporting an incident in the third degree. A person is guilty of falsely reporting an incident in the third degree when, knowing the information reported, conveyed or circulated to be false or baseless, he or she:

…

4. Reports, by word or action, an alleged occurrence or condition of child abuse or maltreatment or abuse or neglect of a vulnerable person which did not in fact occur or exist to:

   (a) the statewide central register of child abuse and maltreatment, as defined in title six of article six of the social services law or the vulnerable persons' central register as defined in article eleven of such law, or

   (b) any person required to report cases of suspected child abuse or maltreatment pursuant to subdivision one of section four hundred thirteen of the social services law or to report cases of suspected abuse or neglect of a vulnerable person pursuant to section four hundred ninety-one of such law, knowing that the person is required to report such cases, and with the intent that such an alleged occurrence be reported to the statewide central register or vulnerable persons' central register.

Falsely reporting an incident in the third degree is a class A misdemeanor.

Adoption and Safe Family Act

The Adoption and Safe Family Act (ASFA) was enacted by the federal government in 1997 because of the growing national concerns that there are too many children who linger for too long in foster care. ASFA sets standards for the operation of state foster care programs by requiring child welfare agencies to pay increased attention to children's health and safety, and their need for permanent families. One of the major changes created by ASFA is the requirement for a new type of hearing which is called a Permanency Hearing. At the Permanency Hearing the court determines the appropriateness of the agency's plan to create permanency for the child.

On August 23, 2005, Governor Pataki signed the New Permanency Bill which was effective December 21, 2005. It consolidates permanency hearing provisions regarding abused, neglected, voluntarily placed and freed children into a new Article 10A of the Family Court Act.

ASFA requires more frequent judicial reviews, criminal records screening, extensive judicial monitoring and documentation of children's progress toward achieving a permanent home, expands and expedites filings of proceedings to terminate parental rights and it imposes monetary sanctions when a state does not comply with these federal standards.

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 79 for answer.

Key Assessment Factors

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

□ Parent/caregiver history □ Parent/child history □ Environmental factors

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 one of safety.

Parent/Caregiver History

Items in the personal history of the parent/caregiver that should be seen as "red flags" include (Prevent Child Abuse New York, 2009; Hornor, 2005; NYSOCFS, 2011):

- 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 (Prevent Child Abuse New York, 2009; Jenny, 2007; NYSOCFS, 2011):

- 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.
    - Parent is cold and rejecting.
    - Parent seems unconcerned about child.
- Delay or failure in seeking health care for child's injury, illness, routine checkups, immunizations, etc.
- Parent views child as bad, evil, different, etc.

Environmental Factors

Environmental factors that should be seen as “red flags” include (Prevent Child Abuse NY, 2009; Dubowitz & Bennett, 2007; Hornor, 2005; NYSOCFS, 2011):

- 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
- disorganized, upsetting home life
- poverty and unemployment
- violence in communities

Injury Locations

When evaluating a situation to determine if there is reasonable cause to suspect child abuse or maltreatment/neglect based on injuries to the child, keep in mind the following points:

- Know the likely areas for normal versus suspicious injuries.
- Consider the size and shape of the injury.
- Consider the child’s developmental stage and related likely injuries.

If an explanation seems plausible, consider the child’s age and the location of the injury.

Accidental childhood injuries usually involve bony areas such as shins, elbows, and knees. Toddlers learning to walk will fall and skin or bruise these areas, just as slightly older children may do the same thing while learning to ride a bicycle. Suspicious injuries usually occur in areas that are not susceptible to accidental injuries, given the age of the child, and may include the back, buttocks, and backs of thighs or calves (NYSOCFS, 2017, 2011).

Finally, if an injury was serious but appropriate treatment was delayed or omitted, especially in a case where the mechanism of injury does not match the injuries as seen, there may be reasonable cause to suspect child abuse or maltreatment/neglect.

Behaviors of Parent/Caregivers of Abused Children

Behaviors of parent(s)/caregiver(s) of abused children that should be seen as “red flags” include (Dubowitz & Bennett, 2007; Hornor, 2005; NYSOCFS, 2011) the behaviors listed in Table 2. Both the abusing and non-abusing parent are ultimately responsible.

Table 2. Behaviors of Parent(s)/Caregiver(s) of Abused Children	
• Offers contradictory histories or gives different explanations for the same injury.	• Exhibits loss of control and/or disciplines the child too harshly.*.
• Presents a history of family discord.	• Attempts to conceal child's injury
• Has unrealistic expectations of the child.	• Over- or under-reacts to child's condition.
• Hospital "shops," delays in getting care.	• Refuses to give consent for diagnostic workup.
• Complains about issues unrelated to child's condition.	• Misuses alcohol or other drugs.
• Is very protective or jealous of the child.	• Seems unconcerned about child. o Reluctant to give information. o Blame the child's injury on siblings or others. o Takes an unusual amount of time to obtain medical care for the child.
• Cannot be located.	
• Provides explanation that is inadequate or inappropriate for child's injury.	

* New York State allows reasonable physical correction of a child but excessive corporal punishment is an indicator of neglect (see table above). Defining excessive corporal punishment is always a case-by-case consideration and you do not have to be able to define it in order to make a report to the SCR (NYSOCFS, 2011). [See Family Court Act §1012 (c)(i) and Penal Law §35:10(1).]

When evaluating a situation involving potential excessive corporal punishment it may help to ask yourself the following questions:

- Does the child have the capacity to understand the corrective quality of the discipline? Consider age, maturity, and the child's physical and mental condition.
- Is a less severe means of punishment available and likely to be effective?
- Is the punishment unnecessarily degrading?
- Was the punishment inflicted for gratification of parental rage?
- Was the punishment brutal?
- Did the punishment last for such a time that it surpassed a child's power of endurance?

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 minimally involved.
B. Parent who stutters.
C. Single parent family.
D. Parent was abused as a child.

Please turn to page 79 for answer.

Understanding Trauma and Adverse Childhood Experiences (ACEs)

Trauma

The American Psychological Association defines trauma as an emotional response to a terrible event like an accident, rape, or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships, and even physical symptoms like headaches or nausea (See: https://www.apa.org/topics/trauma). While these feelings are normal, some people have difficulty moving on with their lives.

The Substance Abuse and Mental Health Services Administration (SAMHSA) describes individual trauma as an event or circumstance resulting in:

- physical harm
- emotional harm
- and/or life-threatening harm

The event or circumstance has lasting adverse effects on the individual's:

- mental health
- physical health
- emotional health
- social well-being
- and/or spiritual well-being (https://www.samhsa.gov/trauma-violence).

Trauma is an intense event that threatens a person's life or safety in a way that is too much for the mind to handle and leaves the person powerless. Trauma can bring about physical reactions such as rapid heart rate, tense muscles, or shallow breathing. Common traumatic events could be going through or seeing:

- Family violence
- Sexual abuse
- Emotional abuse
- Violence in the community

For many parents, having a child removed from the home and dealing with the child welfare system are traumatic events.

Trauma impacts much of the work mandated reporters do. Practitioners must understand that trauma may impact the child or family that you are interfacing with. Additionally, your own past experiences and trauma may impact your decision-making and you should carefully assess each situation.

Trauma-informed Practice

Trauma-informed practice is a model for engaging with individuals and families that recognizes the impact and influence that trauma may have on the individuals and families you serve. Some key points to remember about trauma-informed practice include:

a. ACEs and trauma alone may not rise to the level of child abuse or maltreatment, it is the impact on the child that should be assessed.
b. Goals of a trauma-informed practice are (1) to avoid the inadvertent re-traumatization of individuals through your own interactions with them and to understand that trauma may have an impact on a person's behavior; and (2) reduce the effects of ACEs while supporting children and families while concomitantly increasing protective factors. See Table 3 and https://www.cdc.gov/violenceprevention/pdf/ACEs-Prevention-Resource_508.pdf.

c. Trauma-informed practice will assist you in identifying when your own past experiences or trauma may impact the way you evaluate an incident you encounter in your professional role.

d. SAMHSA provides a helpful framework for understanding and implementing a trauma-informed approach. It includes six elements. Key elements of trauma-informed practice include (https://www.cdc.gov/orr/infographics/6_principles_trauma_info.htm):

   - Safety. All people, children and adults, need to feel physically and psychologically safe with clinicians, with the organization, and in the physical setting.
   - Trustworthiness and transparency. Clients and families need to trust the organization and staff, and all the operations and decisions need to be open and transparent.
   - Peer support. “Peers” in this context are people who have lived experiences of trauma, or family members of children who have experienced traumatic events and are caregivers. They are sometimes called “trauma survivors.” Involving these people in the recovery process is important for establishing safety and hope.
   - Collaboration and mutuality. Because trauma often involves power differentials, it’s important to level out power differences between staff and clients and between organizational staff members. Sharing power is a key element to a trauma-informed approach.
   - Empowerment, voice, and choice. This principle involves centering the individual’s strengths and experiences and fostering a culture that believes in the ability of people to be resilient in the face of trauma, to heal, and to promote recovery. As SAMHSA puts it, “The organization understands that the experience of trauma may be a unifying aspect in the lives of those who run the organization, who provide the services and/or who come to the organization for assistance and support.”
   - Cultural, historical, and gender issues. Trauma-informed organizations work intentionally to erase biases and stereotypes based on race, gender identity, ethnicity, sexual orientation, age, religion, and geography. They honor the traditional cultures of clients and communities and recognize the presence of community and historical trauma.

e. The importance of protective factors cannot be understated. Protective factors helps us take a strength-based approach to helping families and also helps us view families more empathetically and optimistically. Through the lens of protective factors, we can view families on the basis of their strengths as opposed to their weaknesses or challenges alone.

f. Protective factors occur on both the individual/family level and the community level. They include:

   - Individual and Family Protective Factors
     - Families who create safe, stable, and nurturing relationships, meaning, children have a consistent family life where they are safe, taken care of, and supported
     - Children who have positive friendships and peer networks
     - Children who do well in school
     - Children who have caring adults outside the family who serve as mentors/role models

- Families where caregivers can meet basic needs of food, shelter, and health services for children
- Families where caregivers have college degrees or higher
- Families where caregivers have steady employment
- Families with strong social support networks and positive relationships with the people around them
- Families where caregivers engage in parental monitoring, supervision, and consistent enforcement of rules
- Families where caregivers/adults work through conflicts peacefully
- Families where caregivers help children work through problems
- Families that engage in fun, positive activities together
- Families that encourage the importance of school for children

- Community Protective Factors
  - Communities where families have access to economic and financial help
  - Communities where families have access to medical care and mental health services
  - Communities with access to safe, stable housing
  - Communities where families have access to nurturing and safe childcare
  - Communities where families have access to high-quality preschool
  - Communities where families have access to safe, engaging after school programs and activities
  - Communities where adults have work opportunities with family-friendly policies
  - Communities with strong partnerships between the community and business, health care, government, and other sectors
  - Communities where residents feel connected to each other and are involved in the community
  - Communities where violence is not tolerated or accepted

Table 3 Preventing ACEs

Strategy	Approach
Strengthen economic supports to families	• Strengthening household financial security • Family-friendly work policies
Promote social norms that protect against violence and adversity	• Public education campaigns • Legislative approaches to reduce corporal punishment • Bystander approaches • Men and boys as allies in prevention
Ensure a strong start for children	• Early childhood home visitation • High-quality child care • Preschool enrichment with family engagement
Teach skills	• Social-emotional learning • Safe dating and healthy relationship skill programs • Parenting skills and family relationship approaches
Connect youth to caring adults and activities	• Mentoring programs • After-school programs

Intervene to lessen immediate and long-term harms	• Enhanced primary care • Victim-centered services • Treatment to lessen the harms of ACEs • Treatment to prevent problem behavior and future involvement in violence • Family-centered treatment for substance use disorders

ACEs

Adverse childhood experiences (or ACEs) are negative experiences that occur during childhood. Child maltreatment and abuse are adverse childhood experiences.

A child's exposure to traumatic events can cause a lifelong impact. Research shows that four or more adverse childhood experiences (ACEs) can lead to a higher risk of developing health and behavioral challenges when the child becomes an adult. These include mental illness, emotional disorders, chronic disease, and high-risk behaviors. ACEs can also negatively impact education, job opportunities, and earning potential.

About 61-67% of U.S. adults reported they had experienced at least one type of ACE before age 18, and nearly one (1) in six (6) (17.3%) reported they had experienced four (4) or more types of ACEs (https://www.cdc.gov/violenceprevention/aces/fastfact.html#:~:text=ACEs%20are%20linked%20to%20chronic,How%20big%20is%20the%20problem%3F). Children who have experienced numerous adverse experiences have higher rates of negative health outcomes including depression, obesity, substance use, anxiety, heart disease and early death.

Research shows that ACEs are very common in **all** socioeconomic groups and all parties to the ACE experience (i.e.: the child, persons legally responsible for the child, and mandated reporters). However, some people are at greater risk of experiencing one or more ACEs than others. While all children are at risk of ACEs, numerous studies have shown inequities in such experiences linked to the historical, social, and economic environments in which some families live. ACEs were highest among females, non-Hispanic American Indian or Alaska Native adults, and adults who are unemployed or unable to work. (https://www.cdc.gov/violenceprevention/aces/fastfact.html#:~:text=ACEs%20are%20linked%20to%20chronic,How%20big%20is%20the%20problem%3F).

Other factors can intensify the effects of ACEs including poverty, racism, generational trauma and frequent unintended or indirect discrimination. ACEs don't have a single cause, and they can take several different forms. Many other factors contribute to ACEs, including personal traits and experiences, parents, the family environment, and the community itself. To prevent ACEs and protect children from neglect, abuse, and violence, it's essential to address each of these factors.

ACEs-related health consequences cost an estimated economic burden of $748 billion annually in Bermuda, Canada, and the United States.
https://www.cdc.gov/violenceprevention/aces/fastfact.html#:~:text=ACEs%20are%20linked%20to%20chronic,How%20big%20is%20the%20problem%3F.

For more information on ACEs, please visit https://ocfs.ny.gov/programs/cwcs/aces.php.

Toxic Stress

The brain is an ever-changing structure. Its development can thrive or deteriorate depending on the environment a child lives in. Chronically unstable environments can lead to lifelong effects from early childhood adversity and toxic stress.

Toxic stress occurs when a person experiences severe, prolonged adversity without adequate support. Toxic stress means that the stress response stays continuously activated in the body. Toxic stress impacts children developmentally/behaviorally.

Toxic stress from ACEs can not only negatively affect children's brain development, it also negatively affects children's immune systems, and stress-response systems. These changes can affect children's attention, decision-making, and learning.

Children growing up with toxic stress may have difficulty forming healthy and stable relationships. They may also have unstable work histories as adults and struggle with finances, jobs, and depression throughout life. These effects can also be passed on to their own children. Some children may face further exposure to toxic stress from historical and ongoing traumas due to systemic racism or the impacts of poverty resulting from limited educational and economic opportunities.

Additional resources include:

- OCFS Adverse Childhood Experiences (ACEs): https://ocfs.ny.gov/programs/cwcs/aces.php
- National Child Traumatic Stress Network: www.nctsn.org
- National Center for PTSD: www.ptsd.va.gov
- Parents Anonymous: www.parentsanonymous.org
- Center for the Study of Social Policy: www.cssp.org
- Prevent Child Abuse NY: www.preventchildabuseny.org
- New York State Trauma-informed Network: https://www.traumainformedny.org/Home
- Adverse Childhood Experiences Prevention Handbook: https://www.cdc.gov/violenceprevention/pdf/ACEs-Prevention-Resource_508.pdf.

TEST YOURSELF QUESTION #3:

Adverse childhood experiences can have a lasting impact on?

A. Children
B. Persons legally responsible (PLR)
C. Mandated reporters
D. All of the above

Please turn to page 79 for answer.

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*.** 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:

- Malnourishment and suffering are the effects of physical and/or sexual abuse.
- Low level exposures via inhalation, absorption, or ingestion of toxic chemicals, drugs, or contaminated foods that may result in nausea, dizziness, lack of coordination, chest pain, eye and tissue irritation, and chemical burns.
- High level exposure to toxic chemicals can produce shortness of breath, coughing, and death.
- Burns to their lungs or skin from chemicals, fire and explosions; some may die in explosions and fires.
- Chronic exposure of the chemical used in meth manufacture may cause cancer, and can damage the brain, liver, kidney, spleen, and immunologic system.
- Abuse and neglect; many have behavior problems as a result of 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 (National Center on Substance Abuse and Child Welfare, 2021; Swetlow, 2003).

<u>Methamphetamine</u>

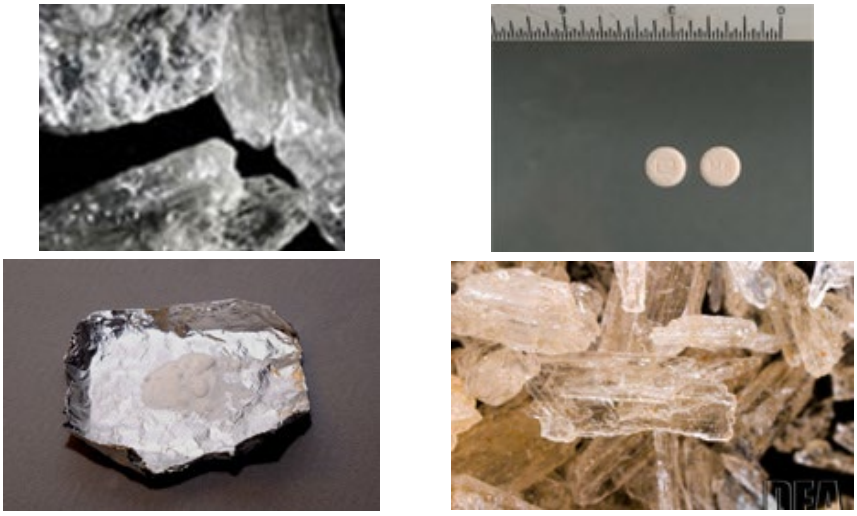
What is Methamphetamine?

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” (National Institute on Drug Abuse, 2013).

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 (National Institute on Drug Abuse, 2013).

Figure 1. Forms of Methamphetamine



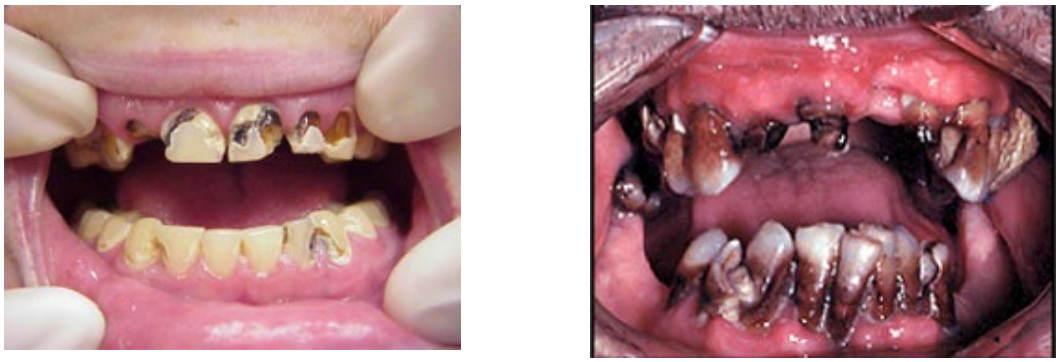
Note: Images of various forms of methamphetamine. Adapted from the United States Department of Justice (USDOJ-DEA) with permission.

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, weight loss, irritability, anxiety, nervousness, and convulsions. They may also exhibit aggressive and psychotic behavior, 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 (National Institute on Drug Abuse, 2013).

Figure 2. Methamphetamine Mouth



Note: Image of *“Meth Mouth*“, showing a long term effect of methamphetamine use. Adapted from *USDOJ-DEA* with permission.

Figure 3. Face of Meth user 11 months after beginning meth use.

Note: Adapted from *USDOJ-DEA* with permission.

What is a Clandestine Laboratory?

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 (NYSOCFS, 2008).

Clandestine labs can be found in:

- 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. Producers who operate laboratories in or near residences often produce methamphetamine using common household items including kitchen utensils, dishes, appliances, sheets, and other linens. These items may become contaminated and then fall into the hands of unsuspecting children. Children may ingest toxic chemicals by eating or drinking contaminated foods or beverages or by placing contaminated objects into their mouths.

Ingesting toxic chemicals or methamphetamine may result in potentially fatal poisoning, internal chemical burns, damage to organ function and development, and harm and inhibition to neurological and immunologic development and functioning, respiratory problems, and are known to cause cancer. Many clandestine meth lab operators are untrained in the use of dangerous chemicals. 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 domestic violence, child abuse, automobile accidents, and the spread of infectious diseases such as Hepatitis C and HIV (U.S. Department of Justice, n.d.).

Potential Health Effects

Table 4 lists common ingredients of methamphetamine and the symptoms and health effects potentially experienced from exposure to these ingredients.

Table 4. Ingredients Used to Produce Methamphetamine and Potential Health Effects of Exposure to Them		
Types	**Common Chemicals**	**Symptoms/Health Effects**
Solvents	• Acetone • Ether/starting fluid • Freon • Hexane • Methanol • Toluene • White gas • Xylene • Benzene • Chloroform	• 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) • Hydrogen peroxide • Hydriodic acid • Acetic acid	• 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 • Aluminum foil • Lead acetate • Magnesium	• 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 (odd hours) of the day or night.
- Occupants appear unemployed, yet seem to have plenty of money and pay bills with cash.
- Occupants display paranoid or odd behavior, are typically unfriendly, secretive about activity and may have extensive security systems or signs saying “private property” or “beware of dog”.
- Windows blackened or curtains always drawn.

- Chemical odors coming from the house, garbage or detached buildings.
- Garbage contains numerous bottles, containers, materials such as those listed in the section below, and may be placed in front of neighbor's collection area.
- Coffee filters, bed sheets or other material stained from filtering red phosphorus or other chemicals.

Table **5** lists common household cleaning chemicals/products, and over-the-counter (OTC) medications, frequently used in production of methamphetamine.

Table 5. Common Chemicals Used (in Large Quantities) in Meth Production

Chemical Name:	Commonly Found In:
Acetone	Nail polish remover
Alcohol	Isopropyl or rubbing alcohol
Ammonium sulphate fertilizer	Used to make anhydrous ammonia
Anhydrous ammonia	Farm fertilizer
Calcium bentonite or silica gel	Kitty litter
Carbon dioxide	Dry ice
Drierite	Used to remove water
Ether	Engine starter
Iodine	Teat dip or flakes/crystals
Liquid propane	Propane
Lithium	Batteries
Methanol/alcohol	Gasoline additives
Methylsulfonylmethane (MSM)	Dietary supplements
Muriatic acid	Household cleaning products
Pseudoephedrine/ephedrine	Cold tablets (Sudafed®)
Red phosphorus	Matches/road flares
Salt	Table/rock
Sodium or potassium metal	Kerosene
Sodium hydroxide	Lye
Sulfuric acid	Drain cleaner
Toluene	Brake cleaner
Trichloroethane	Gun scrubber

Table 6 lists some common household equipment used in meth production. Although these are common items, they are uncommon in the large quantities needed to produce meth.

Table 6. Common Equipment Used in Meth Production	
Pyrex or Corning dishes	Rubber tubing/gloves
Jugs/bottles	Pails/buckets
Paper towels	Gas cans
Coffee filters	Tape/clamps
Thermometers	Strainers
Cheesecloth	Aluminum foil
Funnels	Propane cylinders
Blenders	Hotplates
Scales	Mop pails
Measuring cups	Towels/bed sheets
Laboratory beakers/glassware	Plastic storage containers/ice chests

Children Affected by Meth Labs

A significant number of children are injured or killed by methamphetamine labs yearly. These children are exposed to the immediate and ongoing dangers of meth labs that include:

- Increased risk of child abuse and neglect
- Physical harms
- Social issues

Parents who use, manufacture, and/or traffic methamphetamine in the presence of children put their children at a higher risk of child abuse and neglect. More generally, of children in out-of-home care, 61% of infants and 41% of older children had a report of active alcohol and/or drug abuse by the primary caregiver, the secondary caregiver, or both. In some parts of the country, methamphetamine is the primary substance of abuse (National Center on Substance Abuse and Child Welfare, 2021).

What is Happening to Monitor and Decrease the Meth Labs in the US?

- October 2003, the Office of National Drug Control Policy announced a National Drug Endangered Children (DEC) 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.
- February 27, 2007, the Drug Endangered Children Act of 2007 (HR 1199) was introduced in the House of Representatives. The act passed in January 2008 and the DEC grant programs were extended 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.

Senator Thomas F. O'Mara of the NYS Senate, introduced a bill to reduce the number of clandestine methamphetamine laboratories, which would implement a series of increasingly severe felony offenses to strengthen the criminal penalties for methamphetamine manufacturing and the possession of meth manufacturing material. As of July 2021, the bill has not passed in the Assembly or Senate. (Please refer to: https://www.nysenate.gov/newsroom/in-the-news/thomas-f-omara/senate-approves-omara-legislation-target-meth-crimes-calls and https://www.nysenate.gov/legislation/bills/2021/S5440). According to the US Department of Justice, methamphetamine is one of the nation's greatest drug threats.

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
- 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.

TEST YOURSELF QUESTION #4:

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 79 for answer.

Assessing Physical Symptoms of Child Abuse

Abuse

Under New York State law, a child is abused when:

- A parent or person legally responsible for a child inflicts (or allows someone else to inflict) a non-accidental serious injury which causes:
  - a substantial risk of death
  - serious or protracted disfigurement
  - protracted loss or impairment of the function of any bodily organ, OR
- A parent or person legally responsible for a child creates (or allows to be created) a substantial risk of non-accidental physical injury which would be likely to:
  - cause death
  - serious or protracted disfigurement
  - protracted loss or impairment of the function of any bodily organ, OR
- A parent or person legally responsible commits (or allows someone else to commit) a sex crime against a child.

Special attention should be paid to injuries that are frequent, unexplained, or are inconsistent with the parent(s)/caregiver's explanation and/or the developmental stage of the child.

The US Department of Justice's booklet, *"Recognizing When a Child's Injury or Illness is Caused by Abuse"* (2002), states:

Repetitive Accidents:

Multiple bruises, wounds, abrasions, or other skin lesions in varying states of healing may indicate repetitive physical assault which may indicate that abuse is occurring.

Cutaneous (skin) Injuries:

The most common manifestations of non-accidentally inflicted injuries are skin injuries. Several Characteristics help to distinguish non-accidental from accidental ones, including their location and pattern, the presence of multiples lesions of different phases, and the failure of new lesions to appear after hospitalizations.

Bruises:

Bruises are due to the leakage of blood into the skin tissue that is produced by tissue damage from a direct blow or a crushing injury. Bruising is the earliest and most visible sign of child abuse. Bruises seen in infants, especially on the face and buttocks, are more suspicious and should be considered non-accidental until proven otherwise. Injuries to children's upper arms, the trunk, the front of their thighs, the sides of their faces, their ears and neck, genitalia, stomach, and buttocks are also more likely to be associated with non-accidental injuries. Injuries to their shins, hips, lower arms, nose, chin or elbows are more likely to signify accidental injury.

Age of Bruise:

When listening to the care-takers explanation of the time of injury, also determine the age of the bruise to see if it is consistent with explanation.

Color of Bruise	Age of Bruise
Red (swollen, tender)	0 – 2 days

Blue, Purple	2 – 5 days
Green	5 – 7 days
Yellow	7 – 10 days
Brown	10 – 14 days
No further evidence of bruising	2 – 4 weeks

Bruise Configurations:

- One of the easiest ways to identify the weapon used to inflict bruises is to ask the caretaker:
  - How were you punished as a child?
- The pattern of skin lesion may suggest the type of instrument used, therefore observe the configuration of the bruise.
- Fixed object bruising:
  - By a fixed object that can only strike one of the body's planes at a time.
  - Such as coat hangers, handles, paddles.
- Wraparound object bruising:
  - Bruising by an object that follows the contours of the body and strikes more than one of the body's planes.
  - Such as belts, closed- end cords, open-end cords.
- Hands:
  - Can make either kind of bruise, depending on the size of the offender's hands and the size of the child.
- Bite Marks:
  - May help with determining the biter's approximate age based on the size of the marks

Physical and behavioral signs that could indicate abuse include (O'Hara, 2001):

Ocular injuries occur in 40% of abused children and of that only 5% actually present with these injuries, including:		
• Periorbital contusions	• Hyphemas (hemorrhages in the anterior chamber of the eye)	• Injuries caused by fists, fingers, and belts

Bruises, welts, and bite marks (Hornor, 2005; NYSOCFS, n.d.; NYSOCFS, 2011):	
• On face, lips, mouth, neck, wrists, and ankles.	• Regularly appear after absence, weekend, or vacation.
• On torso, back, buttocks, and thighs. (See Figure 4.)	• In various stages of healing.
• Clustered, forming regular patterns reflecting shape of article used to inflict, i.e., electric cord, belt buckle, etc.	• Evidence of a human bite. (A human bite compresses the flesh, animal bite tears flesh and has narrower teeth imprint.)
• On several different surface areas.	• Grab marks on arms or shoulders. (See Figure 6.)
• On both eyes or cheeks, which is always of suspicious origin because only one side of the face is usually injured as the result of an accident. (See Figure 5.)	

NOTE: Photos displayed as Figures 4 – 14 were reprinted with permission from Corporate Graphics Resource.

Figure 4

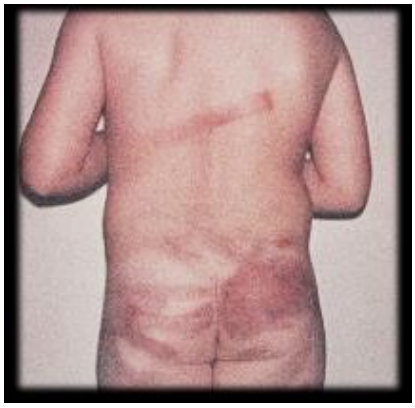


Figure 5

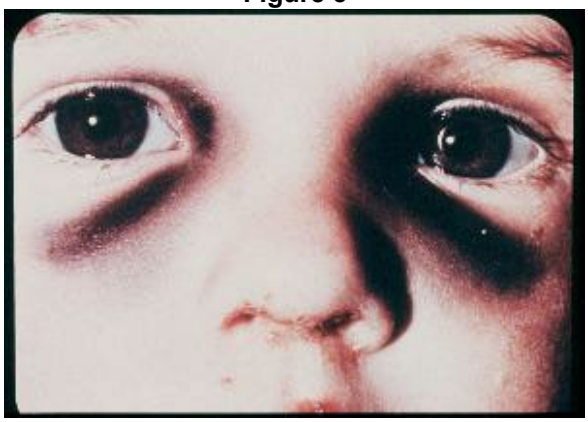
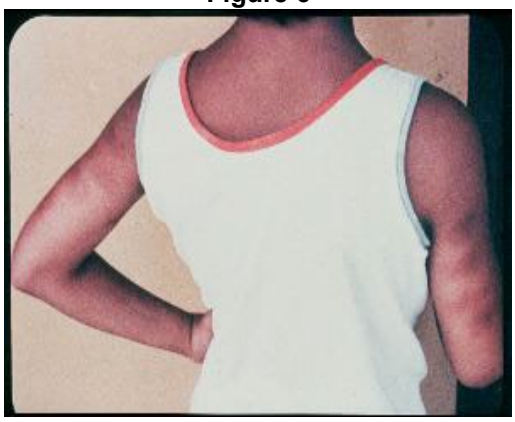


Figure 6



Lacerations or abrasions (Hornor, 2005; NYSOCFS, n.d.; NYSOCFS, 2011):		
• To mouth, lips, gums, eyes	• To external genitalia	• On backs or arms, legs or torso

Burns:	
• Immersion burns by scalding water (sock-like, glove-like, doughnut-shaped on buttocks or genitalia - "dunking syndrome"). (See Figure 7.)	• Steam iron injury. (See Figure 8.)
	• Rope burns on arms, legs, neck, or torso. (See Figure 9.)
• Patterned burn, for example electric burner, iron, etc.	• Cigar burns, cigarette burns, especially on soles, palms, back, or buttocks

Figure 7

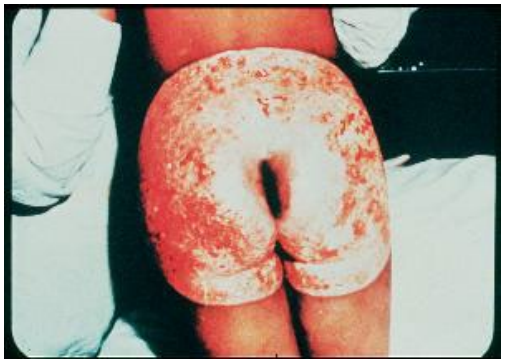


Figure 8

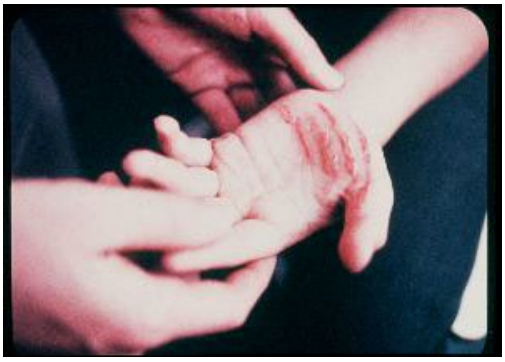
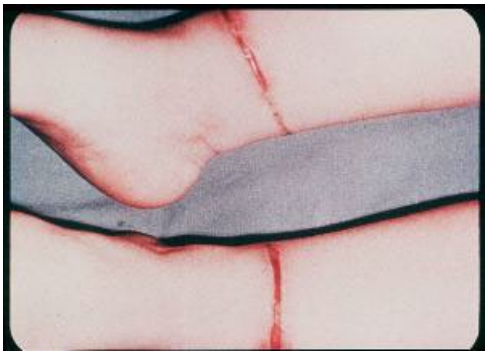


Figure 9



Indications that burns *may not have been accidental*:

- The burns are attributed to siblings.
- An unrelated adult brings the child for medical care.
- Accounts of injury differ.
- Treatment is delayed for more than 24 hours.
- There is evidence of prior “accidents”.
- The lesions are incompatible with the history.
- The burns are more likely found on the buttocks, in the anogenital region and on the ankles, wrists, palms, and soles.
- The burns have sharply defined edges.
- The burns are full thickness.
- The burns are symmetrical.
- The burns are infected or neglected.
- The burns are older than reported history indicates.
- The burns conform to the shape of the implement used.
- The degree of the burns is uniform and they cover a large area.

Indications that burns are *more likely to be accidental*:

- The history is compatible with the observed injury.
- The burns are usually found on the front of the body.
    - They occur in locations reflecting the child’s motor activity, level of development, and the exposure of the child’s body to the burning agent.
- The burns are asymmetrical.
- Apparently only one traumatic event has occurred, because the skin injuries are all of the same age.
- The burns are of partial thickness (only part of the skin has been damaged).
- The burns are of multiple depths interspersed with unburned areas and are usually less severe (such as splash burns).

Fractures (Dwek, 2011; Hornor, 2005; NYSOCFS, n.d.; NYSOCFS, 2011):		
• To skull, nose, facial structure.	• Swollen or tender limbs.	• In various stages of healing.
• Skeletal trauma accompanied by other injuries, such as dislocations. (See Figure 10.)	• Fracture "accidentally" discovered in the course of an exam.	• Multiple or spiral fractures. (See Figure 11.)

Certain fractures have high specificity for or strong association with child abuse, particularly infants, whereas others may have less specificity. Approximately 80% of all fractures caused by child abuse occur in children younger than 18 months, and approximately one quarter of fractures in children younger than 1 year are caused by child abuse. Rib fractures, scapular fractures, spinous process fractures and sternal fractures in infants and toddlers have high specificity to child abuse. Physical abuse is more likely to be the cause of femoral and humeral fractures in children who are not yet walking and the percentage of fractures caused by abuse declines sharply after the child begins to walk (Flaherty, Perez-Rossello, Levine, & Hennrikus, 2014).

Figure 10. Epiphyseal Separation

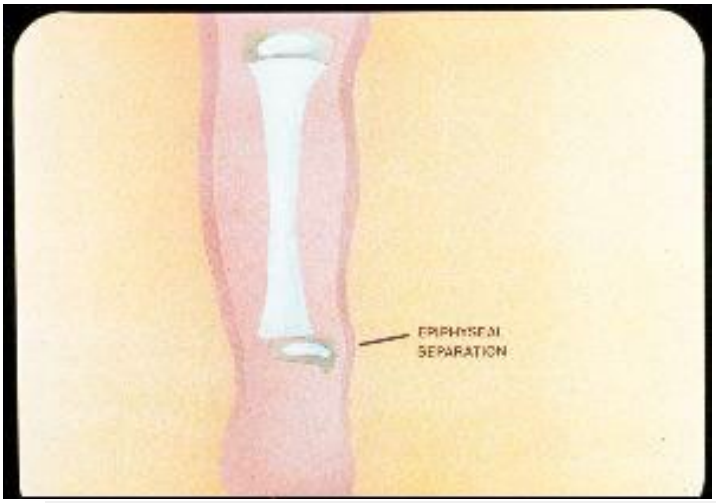
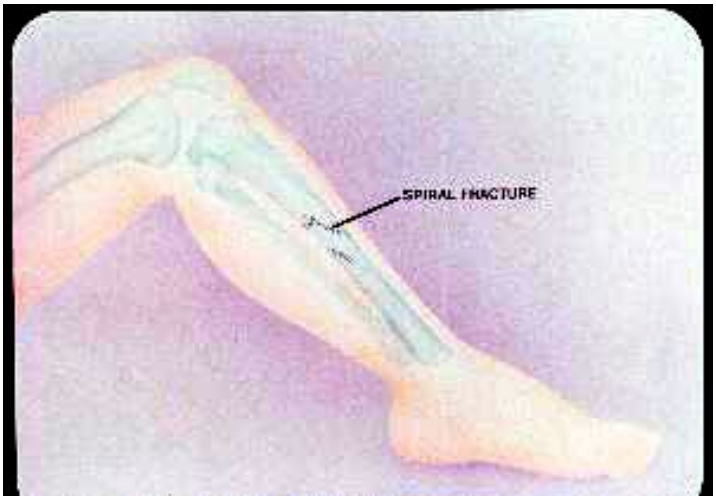


Figure 11. Spiral Fracture



Head Injuries (Dwek, 2011; Magana & Kaufhold, 2015; Hornor, 2005; NYSOCFS, n.d.):		
• Eye injury (detail below).	• Tooth or frenulum injury.	• Jaw and nasal fracture.
• Subdural hematoma (a hemorrhage beneath the outer covering of the brain, due to severe hitting or shaking). (See Figure 12.)		
• Shaken baby syndrome/whiplash shaken infant syndrome. (See Figure 13.)		
• Absence of hair and/or hemorrhaging beneath the scalp due to vigorous hair pulling.		
• Retinal hemorrhage or detachment, due to shaking.		

Figure 12. Subdural Hematoma

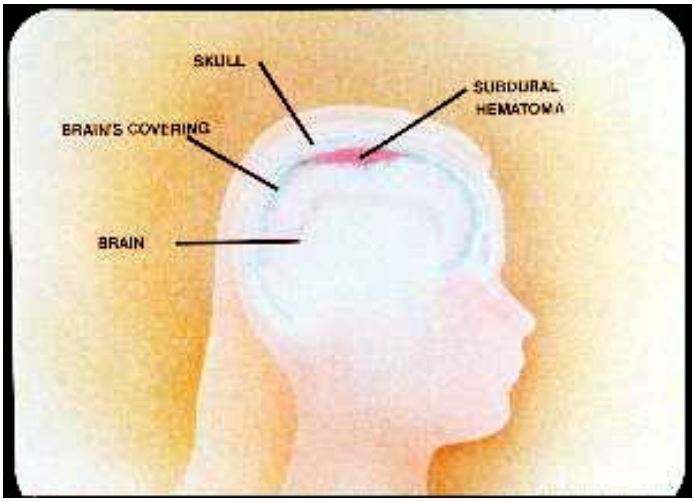


Figure 13. Depiction of a Shaken Child

Symptoms suggestive of parentally-induced or fabricated illnesses (Criddle, 2010; Sugandhan, et al., 2010):	
• Sometimes known as Munchausen Syndrome by Proxy (MSP).	• Example: repeatedly causing a child to ingest quantities of laxatives sufficient to cause diarrhea, dehydration, and hospitalization.

Eye Injuries (US Department of Justice, 2002):

- External eye injuries are so common that they are seldom clear-cut evidence of abuse.
- Two black eyes seldom occur together accidentally.
- The “raccoon eyes” associated with more swelling and skin injury are associated more often with non-accidental trauma.
- Child complaining of pain in the eye and having visual problems can be associated with hyphema which is traumatic entry of blood into the front chamber of the eye (such as from a belt buckle).
- Retinal hemorrhages are the hallmark of shaken baby syndrome and are only rarely associated with some other mechanism of injury.
- Nonaccidental trauma must always be considered in a child under three years of age who has retinal hemorrhages or any traumatic disruption of the structures of the globe of the eye or the skin around the eye.

Shaken Baby Syndrome (SBS) (USDOH, CDC, 2010):

- Babies less than one year of age (with the highest risk period at 2 - 4 months) are at greatest risk for SBS because they cry longer and more frequently, and are easier to shake than older and larger children.
- SBS injuries have been reported in children up to age five.
- SBS is the result of violent shaking that leads to a brain injury, which is much like an adult may sustain in repeated car crashes. It is child abuse, not play. This is why claims by perpetrators that the highly traumatic internal injuries that characterize SBS resulted from merely “playing with the baby” are false. While jogging an infant on your knee or tossing him or her in the air can be very risky, the injuries that result from SBS are not caused by these types of activities.
- The most common trigger for shaking a baby is inconsolable or excessive crying—a normal phase in infant development.

- Parents and their partners account for the majority of perpetrators. Biological fathers, stepfathers, and mothers' boyfriends are responsible for the majority of cases, followed by mothers.
- In most SBS cases there is evidence of some form of prior physical abuse, including prior shaking.

Babies with SBS, may **exhibit** the following:

Severe: Unresponsiveness, loss of consciousness, breathing problems, no pulse.

Less severe: Change in sleeping pattern or inability to be awakened, vomiting, convulsions or seizures, irritability, uncontrollable crying, inability to be consoled, inability to nurse or eat.

TEST YOURSELF QUESTION #5:

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 79 for answer.

Assessing Child's Behavioral Indicators

Children who have been abused may demonstrate some of the following behaviors (Magana & Kaufhold, 2015; Jenny, 2007; Hornor, 2005; NYSOCFS, n.d.; NYSOCFS, 2011; Child Welfare Information Gateway, 2013):

- Wary of contact with adults.
- Apprehensive when other children cry.
- Exhibits behavioral extremes:
    - Aggressiveness
    - Destructiveness
    - Withdrawal
    - Emotionless behavior
    - Extreme mood changes
    - Attempts suicide
    - Isolation from peers
- 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."
- Habit disorders:
    - Self-injurious behaviors
    - Psychological reactions (obsessions, phobias, compulsions, hypochondria)
- Wears long sleeves or other concealing clothing to hide physical indicators of abuse.
    - Often inappropriate for season
- Manifests low self-esteem
- Seeks affection from any adult
- The child shows sudden changes in behavior or school performance.
- Has not received help for physical, dental or medical problems brought to the parents' attention.
- Has learning problems (or difficulty concentrating) that cannot be attributed to specific physical or psychological causes.
- Is always watchful, as though preparing for something bad to happen.
- Lacks adult supervision
- Is overly compliant, passive or withdrawn
- Comes to school or other activities early, stays late, and does not want to go home.
- Consistent fatigue or falling asleep in class
- Infrequent school attendance
- Is reluctant to be around a particular person.
- Discloses maltreatment
- Begging for or stealing food

Maltreatment and Neglect

Maltreatment

Under New York State law, a child is maltreated when:

- A parent or other person legally responsible for the child fails to provide the ***minimum degree of care*** **and** that failure results in impairment or imminent danger of impairment to the child's physical, mental or emotional condition, OR
- A parent or other person legally responsible for the child causes a non-accidental, serious physical injury to the child. It is important to note with this subsection of the definition, actual impairment or harm is not required.

Poverty in and of itself is not maltreatment.

Minimum Degree of Care

Parents and Persons with Legal Responsibilities for the child (PLRs) in New York State must provide their children with the minimum degree of care. Minimum degree of care includes, but are not limited to, the following elements:

- Adequate food
- Adequate clothing
- Adequate shelter
- Adequate medical care
    - Basic dental care
    - Mental health services
    - Treatment for drug or alcohol misuse.
- **NOTE**: The minimum degree of care regarding adequate food, clothing, shelter and medical care must be considered in regard to whether the parent or PLR was financially able to do so or was offered other financial or reasonable means to do so.
- Adequate education
    - Parents must ensure the children in their care are actively enrolled in school.
    - Actively enrolled in school does not mean a child has to be earning high grades, participating in activities or have impeccable attendance.
    - The minimum degree of care regarding adequate education is measured by looking at the conduct of the parent after considering any efforts previously made by the school and/or CPS.

- Adequate supervision
- There is no provision in New York State law or regulation that dictates how old a child must be to be left alone without adult supervision.
    - Determining whether a child can be safely left alone must be made on a case-by-case basis.
    - A child left alone in a residence or in the community must be able to demonstrate that they have the knowledge and skills necessary to properly respond to a potential emergency and to care for themselves.
    - Just because an individual child may be left safely alone does not mean that child has the necessary skills to supervise other children without an adult present.
- Refraining from **excessive** corporal punishment
    - New York State law permits parents to use corporal (physical) punishment to discipline their children, but it cannot be excessive.
    - Excessive corporal punishment includes when:
        - The child lacks the capacity to understand the corrective quality of the discipline.
        - A less severe method is available and likely to be effective.

- The punishment is inflicted due to the parent's rage.
- The child receives injuries or bruises as a result.
- The length of punishment surpasses the child's endurance.

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 (Magana & Kaufhold, 2015; Jenny, 2007; Hornor, 2005; NYSOCFS, n.d.).

Table 7. Physical Indicators

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

Table 8. Behavioral Indicators

• Begging or stealing food	• Failure to thrive
• Extended stays at school (early arrival or late departure)	• Overly adaptive behavior (inappropriately adult or infantile)
• Attendance at school infrequent	• Conduct disorders (antisocial, destructive)
• Constant fatigue/listlessness/falling asleep in class	• Habit disorders (sucking, biting, rocking, head banging)
• Alcohol or drug use/abuse	• Delinquency (i.e., thefts)
• Runaway behavior	• Neurotic traits (sleep disorders, inhibited play)
• Psychoneurotic reactions (hysteria, phobias, hypochondria, compulsion)	• Behavioral extremes (compliant, passive, aggressive, demanding)
• Suicide attempts or gestures, self-mutilation	• Lags in mental, physical, and/or emotional development

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.

Molested children:

- By vast majority, are molested by family members or friends.
- Experience the fear of betraying a loved one and possibly losing affections forever if they disclose the abuse.
- Fear the overwhelming shame and guilt that disclosure may cause.
- Fear that family members and other significant people in their lives will blame them for the abuse.
- Fear the common threats of being hurt or even killed if they disclose the abuse.
- May retract the disclosure as the family system may begin to place pressure.
- Often decide to live in quiet and devastating isolation with their "secret" rather than risk the realization of their fears.

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 (NYSOCFS, 2011).

Physical Indicators

Table 9. Physical indicators of sexual abuse. (Denton, Newton, & Vandeven, 2011; Swerdin, Berkowitz, & Craft, 2007; NYSOCFS, n.d.):	
• Difficulty in walking, sitting	• Genital pain, itching
• Torn, stained, bloody clothing or underwear	• Bruising, injury to the hard or soft palate (See Figure 14.)
• Painful urination or urinary tract infections	• Presence of foreign bodies in vagina or rectum
• Sexually transmitted diseases, especially in preteens, including venereal oral infections	• Bruises, bleeding, or any injury in genital, vaginal or anal areas (See Figure 14.)
• Pregnancy, especially in early adolescent years	• New sexual behavior or knowledge that is inconsistent with the child's development, age, circumstances or past behaviors

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.

Figure 14

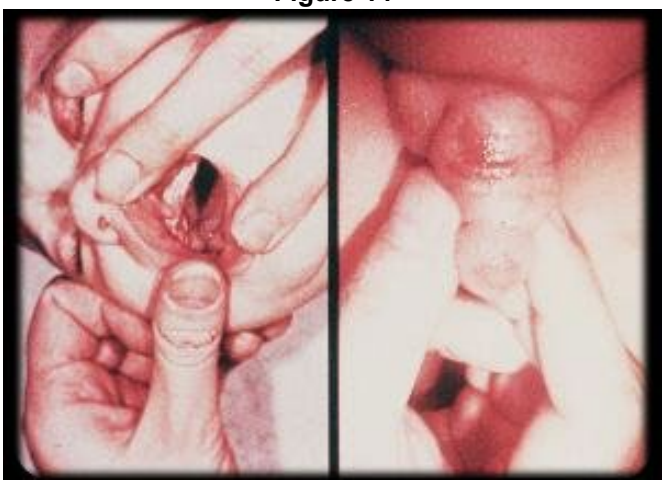


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Table 10. Behavioral indicators of sexual abuse.	
• Low self-esteem	• Sexual victimization of other children
• Refusal to participate in/or change for gym	• Delinquent, truancy, running away
• Infantile behavior	• Prostitution
• Poor peer relationships	• Extreme, exaggerated fear of closeness or physical contact
• Withdrawn/elaborate fantasy life	• Self-injurious activities/suicide attempts
• Aggressive, disruptive behavior	• Reports caretaker is sexual assailant
• Sexually suggestive, inappropriate, or promiscuous behavior or verbalization	• Expressing age-inappropriate knowledge of sexual relations

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 (such as testing for sexually transmitted diseases)
- Daycare and school reports

(NYSOCFS, 2011)

NYS Sex Offenses

Every year around 40,000 children are sexually abused in New York. Under previous law, after age 23, survivors no longer had the option to press charges against their abuser. On January 28, 2019, New York passed new legislation extending the statute of limitations for sexual abuse claims in the state. Before this legislation, victims had until they were 23 years-old to come forward and file their claim for abuse that took place when they were a child. Today, this deadline is extended. With the current one-year

window, you can file your claim until August 14, 2021 even if you are older than 23 to seek justice for abuse that happened when you were a minor.

The new statute of limitations allows victims of child sexual abuse until they are 55 to file their claims, but it does not apply retroactively. This means that if your abuse occurred before the Child Victims Act went into effect in 2019, you must file your claim before you turn 23 or else file the claim before August 14, 2021. If your abuse occurred after the law went into effect, you have until you turn 55 to file the claim.

Table 11: Offenses against children.

Penal Law Statue	Offense Class	Offense
120.70	E Felony	luring a child
130.20	A Misdemeanor	sexual misconduct
130.25	E Felony	rape in the third degree
130.30	D Felony	rape in the second degree
130.35	B Felony	rape in the first degree
130.40	E Felony	criminal sexual act in the third degree
130.40	E Felony	sodomy in the third degree
130.45	D Felony	criminal sexual act in the second degree
130.45	D Felony	sodomy in the second degree
130.50	B Felony	criminal sexual act in the first degree
130.50	B Felony	sodomy in the first degree
130.52	A Misdemeanor	forcible touching
130.53	E Felony	persistent sexual abuse
130.55	B Misdemeanor	sexual abuse in the third degree
130.60	A Misdemeanor	sexual abuse in the second degree
130.65	D Felony	sexual abuse in the first degree
130.65-a	E Felony	aggravated sexual abuse in the fourth degree
130.66	D Felony	aggravated sexual abuse in the third degree
130.67	C Felony	aggravated sexual abuse in the second degree
130.70	B Felony	aggravated sexual abuse in the first degree
130.75	B Felony	course of sexual conduct against a child in the first degree
130.80	D Felony	course of sexual conduct against a child in the second degree
130.85	E Felony	female genital mutilation
130.90	D Felony	facilitating a sex offense with a controlled substance
130.95	A-II Felony	predatory sexual assault
130.96	A-II Felony	predatory sexual assault against a child
135.05	A Misdemeanor	unlawful imprisonment in the second degree
135.10	E Felony	unlawful imprisonment in the first degree
135.20	B Felony	kidnapping in the second degree
135.25	A-I Felony	kidnapping in the first degree
230.04	A Misdemeanor	patronizing a prostitute in the third degree
230.05	E Felony	patronizing a prostitute in the second degree
230.06	D Felony	patronizing a prostitute in the first degree
230.11	E Felony	aggravated patronizing a minor for prostitution in the third degree
230.12	D Felony	aggravated patronizing a minor for prostitution in the second degree
230.13	B Felony	aggravated patronizing a minor for prostitution in the first degree
230.25	D Felony	promoting prostitution in the third degree
230.30(2)	C Felony	promoting prostitution in the second degree
230.32	B Felony	promoting prostitution in the first degree
230.33	B Felony	compelling prostitution
230.34	B Felony	sex trafficking
235.22	D Felony	disseminating indecent material to minors in the first degree
250.45 (2), (3) and (4)	E Felony	unlawful surveillance in the second degree

250.50	D Felony	unlawful surveillance in the first degree
255.25	E Felony	incest (committed prior to 11/1/06)
255.25	E Felony	incest in the third degree
255.26	D Felony	incest in the second degree
255.27	B Felony	incest in the first degree
263.05	C Felony	use of a child in a sexual performance
263.10	D Felony	promoting an obscene sexual performance by a child
263.11	E Felony	possessing an obscene sexual performance by a child
263.15	D Felony	promoting a sexual performance by a child
263.16	E Felony	possessing a sexual performance by a child
263.30	B Felony	facilitating a sexual performance by a child with a controlled substance or alcohol

Key Thoughts about Assessing Physical and Behavioral Indicators of Child Abuse and Maltreatment

Abuse or maltreatment should never be assumed. When assessing for physical and behavioral indicators of child abuse and maltreatment, do NOT view indicators in isolation. Each indicator must be considered in relation to the child's current age and circumstances and in the context of their physical condition or behavior.

- You may need to assess if there is an explanation for the presenting concern and whether the explanation is consistent with the observed physical and behavioral.
- Consider your prior experiences with this child and whether there is a difference in what you are currently observing.
- It is important to make an objective assessment that is free from any implicit or explicit bias.

Assessing Physical and Behavioral Indicators of Child Abuse and Maltreatment in the Virtual Setting

- Mandated reporters may have interactions with children that occur in a virtual environment. For example, children may attend school remotely, visit doctors using telemedicine and participate in therapy sessions on virtual platforms.
- It is important to remember that if you are interacting with children in your professional role – your responsibilities as a mandated reporter are the same in a virtual environment.
- When assessing safety virtually, where possible:
  - Be alert for indications that a child is trying to communicate something to you without someone else in the room noticing.
  - Note if a child's demeanor or behavior is different when someone else enters the room.
  - Listen for concerning statements a child makes to you, siblings, or their peers.
  - You may observe or hear an altercation between children or adults. If what you hear or observe does not rise to a level of making a report, it may still create an opportunity for a conversation about safety or managing stress.
  - Try to observe the child's body, even if you can only see the child's face, neck, shoulders, and chest, is there anything that seems suspicious? Does the child appear depressed or anxious?
- Also be sure to:
  - Use reliable technology with adequate lighting and sound.
  - Make sure the child is present for at least part of the visit.
  - Make sure to have everyone introduced that is in the room with the child or who enters the room after the visit starts.
  - Ask if there is enough privacy for the child and/or parent to discuss sensitive matters.
    - This may mean asking nonparticipating household members to move to a different room.
  - Confirm their physical location in the event you need to contact emergency services.
  - Watch carefully, verbalize what you think you are seeing and ask if the family agrees.

- Also be sure to:
    - Provide clear channels to reach out.
        - This can be done by email, phone, chat, text, or online tool.
    - Pay attention to non-verbal cues.
        - Note if a child's demeanor or behavior is different when someone else enters the room.
    - Be alert if a child turns off a webcam or is very hesitant to use one.
    - Look at the environment.
        - Are there noticeable unsafe conditions?
    - Is there appropriate supervision for the child?
    - Are young children watching even younger siblings?

<u>Educational Neglect</u>

- Poor school attendance, in and of itself, does not equate to a reasonable cause to suspect maltreatment.
- A report of suspected educational neglect should be called in to the SCR as a remedy for excessive absences only as a last resort.
    - School personnel should first try working with the student, family and community agencies to identify needs and resources available to meet those needs.
- All of the following elements must be present to warrant a call to the SCR for educational neglect:
    - Child must be of compulsory school age and currently living in NYS
    - Child must be excessively absent without a valid reason or excuse
    - The child's education must be impaired due to the excessive absenteeism (or the child has an IEP and has missed necessary services due to excessive absenteeism)
    - The Parent or PLR has been made aware of the excessive absenteeism and impairment by means beyond simply sending a note home or leaving a voicemail message
    - School officials have made efforts to engage the child & parent or PLR - No parent or PLR has taken any action to rectify the situation.

TEST YOURSELF QUESTION #6:

When determining if a child shows indicators of maltreatment or abuse it is important to remember:

A. indicators will always be of a physical nature and will be visible
B. not to view indicators in isolation
C. the explanation for the presenting concern is irrelevant
D. your prior experience with this child should not be factored in

Please turn to page 79 for answer.

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 New York State law requires that, when the cause of a child's injuries cannot be explained, the child and family are 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 information presented in the rest of this lesson 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 private, non-threatening atmosphere.
    - Remain calm, don’t overreact.
    - Provide frequent contact (note that cuddling/holding may not be appropriate).
    - Be honest, open, and up-front with the child.
    - Remain supportive.
    - Listen to the child.
    - Stress that it’s not the child’s fault.
- Integrate the child into a normal, daily routine as tolerated.
- Observe closely all interactions between the parent(s)/caregiver(s) and the child.
- Remove the parent(s)/caregiver(s) 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 parent(s)/caregiver(s) to verbalize; listen non-judgmentally.
- Avoid asking threatening questions about any specific incident of abuse.
- Don't interrogate or try to investigate, this is especially important in sexual abuse cases.
- Don't make judgments or promises.

(NYSOCFS, n.d.; NYSOCFS, 2011)

Parent/Caregiver

The parent/caregiver offender or nonoffender should be treated as well. If reunification is a therapeutic goal, certain preconditions must exist, including:

- Offender acknowledgment of abuse.
- Offender assumption of responsibility for the abuse.
- Offender awareness of offending pattern and commitment to change.
- Offender demonstration of willingness to participate in safety plan.
- Nonoffending caregiver acknowledgment of abuse.
- Nonoffending caregiver assumption of responsibility of safety for the child.
- Nonoffending caregiver demonstration of willingness to participate in safety plan.

(Lipovsky & Hanson, 2007)

Teaching and Discharge

- If the child is to be discharged in the custody of parent(s)/caregiver(s), 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(s)/caregiver(s) with child.
    - Number, time, and length of visits and the 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).
- Parent(s)/caregiver(s) level of comprehension of all instructions/teaching.

(NYSOCFS, 2011)

Mandated Reporters

Section 413 of Social Services Law (SSL) in New York State identifies professionals and officials who are required to report cases of suspected child abuse or maltreatment. Refer back to Table 1 for the full complement of licensed professionals who are required to report.

All Mandated Reporters are required by law to call the SCR when ***in the course of their professional role*****,** they develop a ***reasonable cause to suspect*** a child under the age of 18 is being maltreated or abused by a parent or person over the age of 18 who is legally responsible for the care of the child at the relevant time. Practitioners must be aware that **working or volunteering** in a role **that requires your specific licensure and/or certification** is considered the kind of activity that meets the provision of the law **"when in the course of your professional role".**

Reasonable Cause to Suspect

A *reasonable cause to suspect* occurs when what you have observed or been told, combined with your professional experience or training, leads you to reasonably believe that a child has been or is being maltreated or abused. A practitioner's reasonable suspicion does not require proof a child has been maltreated or abused. One indicator, or several indicators of abuse or maltreatment in combination may be sufficient to reasonably substantiate a reasonable suspicion. Remember, poverty, in and of itself, does not equate to maltreatment or abuse.

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 the child 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. (NYSOCFS, 2011)

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.

In the Case of Sexual Abuse:

There are specific guidelines that apply to cases of suspected sexual abuse.

Once a child reveals information that makes you suspect sexual abuse, avoid talking in detail with the child about the incident. Often CPS and law enforcement work together to interview a child at the same time. These professionals have been specifically trained in interviewing children.

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" or how the situation will work out.

Supporting the Child after the Report Has Been Made

If it is necessary for CPS 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.)

NYSOCFS, 2011

TEST YOURSELF QUESTION #7

As mandated reporters you must use critical thinking when deciding whether to call in a report. Critical thinking includes:

A. Gathering adequate information about the current situation
B. Analyzing that information to separate facts from assumptions
C. Determining whether you are legally required to call the SCR, and if not, determine what alternative options are available
D. All the above

Please turn to page 79 for answer.

Mitigating Effects of Protective Factors to Promote Well Being and Prevent Child Abuse and Neglect

Protective factors are conditions or attributes in individuals, families, and communities that promote the health and well-being of children and families. By using a protective factors approach, child welfare professionals and others can help parents find resources and supports that emphasize their strengths while also identifying areas where they need assistance, thereby reducing the chances of child abuse and neglect (See: https://www.childwelfare.gov/topics/preventing/promoting/protectfactors/).

There are a variety of protective factors approaches, with each highlighting a different set of factors. The following are the six factors included in the Children's Bureau's framework that community-based service providers can use to identify strengths within families and how those strengths can be further developed to prevent child abuse.

Protective Factor 1: Nurturing and attachment

A child's early experiences of being nurtured and developing a bond with a caring adult affects all aspects of behavior and development. When parents and children have strong, warm feelings for one another, children develop trust that their parents will provide what they need to thrive, including love, acceptance, positive guidance, and protection.

Research shows that babies who receive affection and nurturing from their parents have the best chance of healthy development. A child's relationship with a consistent, caring adult in the early years is associated later in life with better academic grades, healthier behaviors, more positive peer interactions, and an increased ability to cope with stress.

Protective Factor 2: Knowledge of parenting for child and youth development

There is extensive research linking healthy child development to effective parenting. Children thrive when parents provide not only affection but also respectful communication and listening, consistent rules and expectations, and safe opportunities that promote independence. Successful parenting fosters

psychological adjustment, helps children succeed in school, encourages curiosity about the world, and motivates children to achieve. The following resources offer information that helps families build their knowledge of child and youth development

Protective Factor 3: Parental Resilience

Parents who can cope with the stresses of everyday life, as well an occasional crisis, have resilience; they have the flexibility and inner strength necessary to bounce back when things are not going well. Multiple life stressors, such as a family history of abuse or neglect, health problems, marital conflict, or domestic or community violence—and financial stressors, such as unemployment, poverty, and homelessness—may reduce a parent's capacity to cope effectively with the typical day-to-day stresses of raising children. The following resources support parents and caregivers in building their resilience.

Protective Factor 4: Social connections

Parents and caregivers with a social network of emotionally supportive friends, family, and neighbors often find that it is easier to care for their children and themselves compared with those who do not have such a network. All caregivers need people they can call on once in a while when they need a sympathetic listener, advice, or concrete support. Research has shown that parents who are isolated and have few social connections are at higher risk for maltreating their children. The following resources provide an array of information that help families enhance their social connections.

Protective Factor 5: Concrete supports for parents

Many factors can affect a family's ability to care for its children. Partnering with parents to identify and access resources in the community may help prevent the stress that sometimes precipitates child maltreatment. Providing concrete supports may also help prevent the unintended neglect that sometimes occurs when parents are unable to provide for their children. The following resources outline resources that offer help to parents and caregivers.

Protective Factor 6: Social and emotional competence of children

Parents support healthy social and emotional development in children when they model how to express and communicate emotions effectively, self-regulate, and make friends. A child's social and emotional competence is crucial to sound relationships with family, adults, and peers. Conversely, delayed social-emotional development may obstruct healthy relationships. Early identification of such delays and early assistance for children and parents can provide support for family relationships and sustain positive and appropriate development.

TEST YOURSELF QUESTION #8

The following are protective factors that can mitigate child abuse and maltreatment except:

A. Parents having concrete supports in time of need.
B. Having a robust network of mandated reporters.
C. The child's social connections.
D. Parental resilience.

Please turn to page 79 for answer.

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 has been 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.

Crimes committed against children should be directly reported to law enforcement. If you are uncertain if an incident is criminal you can contact the SCR anyway. SCR staff are trained to make those distinctions or can make a Law Enforcement Referral (LER).

*Examples of Reportable Situations**

- A school principal calls the SCR and reports that a 10-year-old pupil 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.
- A mother brings her four-year-old daughter to the emergency room because of a vaginal discharge. The child is diagnosed with gonorrhea.
- A five-year-old boy is continually brought to the school nurse for an advanced case of head lice.
- A 12-year-old female, comes to school with two bruises. One is on the upper left arm and one is on the lower area of her neck. She states that her mother was upset yesterday and threw her against the refrigerator.
- A three-year-old is brought to the emergency room and is diagnosed to have second-degree immersion burns.
- A school counselor calls the SCR and states that a child has missed 34 out of a possible 95 days of school. The child 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 siblings, a three-year-old and four-year-old, sit on the windowsill every day during warm weather. The family lives 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 eight-year-old grandson terribly. She verbally abuses the child 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 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: NYOCFS, n.d.

Reasonable Cause

A ‘reasonable cause’ to suspect means that based on what physical evidence a person has observed or has been told, combined with their training and experience, they feel that harm or imminent danger of harm to the child could be the result of an act or omission by the person legally responsible for the child.

The reporter need not be absolutely certain that the injury or condition was caused by neglect or by non-accidental means; the reporter should only **BE ABLE TO ENTERTAIN THE POSSIBILITY THAT IT COULD HAVE BEEN NEGLECT OR NON-ACCIDENTAL** in order to possess the necessary "reasonable cause" (NYSOCFS, 2011).

The law provides for, and in certain instances requires, the reporting of suspected cases of child abuse and maltreatment because the child protective system is based on investigation and intervention. The sooner a case is reported, the better the chances of protecting the child and rehabilitating the family (New York State Assembly, Committee on Children and Families, 2014).

Suspicion

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. Explanations that are inconsistent with observations and/or knowledge may be a basis for reasonable 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 (NYSOCFS, 2011).

Imminent Danger

Imminent danger means that the child is placed at immediate risk or substantial risk of harm. The standard to apply is reasonableness. Ask yourself: Is it reasonable to believe an intervening factor could occur? If the answer is yes, then there is no imminent danger. If the answer is no, then there is reasonableness to assume that harm could occur and there is imminent danger.

TEST YOURSELF QUESTION #9

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 79 for answer.

Understanding the Impact of and Reducing Implicit and Explicit Bias on Decision-Making

Implicit Bias in Decision-Making

- Understanding Bias
  - As humans we all have biases, whether implicit or explicit, that affect our beliefs, decisions and actions.
  - A bias is a personal and sometimes unreasoned judgment against a person, place or thing. Biases – including how a person looks, sounds, and even where they live – may influence our decision-making.
  - An ***implicit bias*** is a bias or prejudice that is present but not consciously held or recognized so we are often unaware of them.
  - An ***explicit bias*** is a personal and unreasoned judgement that we have about a person, place or thing on a conscious level.
  - Both implicit and explicit bias can show up as prejudice, discrimination and/or oppression on individual, group or systemic levels.
  - Individual biases are often deeply entrenched and are born out of a long history rife with unequal treatment of different social groups, discrimination and oppression, cultural conditioning, individual's upbringing and stereotypical portrayals of social groups.
  - The impact of decisions made that are rooted in biases often have significant impacts on individuals, social groups and communities.
  - One of the benefits of being aware of the potential impact of your own biases is that you can choose to take a proactive role in reducing how they impact your decision-making.

Understanding the Impact of Implicit Bias in Child Welfare

- National research shows, and OCFS data confirms, disparities exist throughout the child welfare system presently and historically.
  - OCFS' Disproportionate Minority Representation (DMR) data shows historical overrepresentation of children and families of color in the child welfare system.
    - Families of color have been more likely to be involved in a report to the SCR.
    - Children of color have been more likely to be placed in foster care and generally experience slower achievement of permanency goals.
  - Research shows that income status of families is a significant predictor of involvement with the child welfare system.
  - Poverty in and of itself does not equate to child abuse or maltreatment.
  - Research shows that families investigated by CPS have several poverty related risk factors such as unemployment, single parenthood, food insecurity, housing stability or lack of access to childcare.
  - Families living below the poverty line are three times more likely to be substantiated for child maltreatment.
  - This disparity has long lasting and devastating impacts on both families and communities.
- A mandated reporter's decision whether to call the SCR can change the course of the life of a child and the members of a family.
  - It is important to be aware of the propensity for implicit or explicit bias and to be intentional about making decisions based on the objective facts of a situation.
  - Part of this process is to increase our own awareness regarding our own beliefs including those that may be hidden or unconscious.

        - As a professional, you must ensure that your own implicit or explicit biases do not impact your decision to call the SCR.
        - Would your decision to call the SCR with a report of suspected child maltreatment or abuse change if the race, ethnicity, gender, gender identity, sexual orientation or expression, religion, immigration status, primary spoken language, culture, age, neighborhood where they reside, their disability, occupation or socioeconomic status of the individual or family were different?
        - You should only call the SCR as a mandated reporter when you have a legal obligation to do so.
    - You can support a family without having to a report a family.
        - It is important to keep in mind that we must approach our responsibility as mandated reporters with empathy, compassion, care and curiosity.
        - When assessing information received about a child and their family, instead of making assumptions or jumping to conclusions that a child is being maltreated or abused, we must ask ourselves the right analytical and evaluative questions.
        - Also consider if the needs of the family can be met through other means outside of the CPS system.
            - Can this family's needs be met by providing services or other resources outside of CPS involvement?

<u>Strategies to Reduce Implicit Bias</u>

- The first step in unraveling implicit bias is understanding our own lens that we see the world through.
- Bias can show up in a variety of ways. Bias might look like subconscious thoughts (implicit), conscious thoughts (explicit), stereotypes, or inaccurate judgments.
- Bias can be unlearned.
    - A proven strategy to reduce bias is to examine whether the facts of the situation would lead you to the same decision to call the SCR if the demographic information for the child or family were different.
    - Would you make the same decision to call if any of the following were different? The child or family's:
        - Race?
        - Ethnicity?
        - Gender?
        - Gender Identity?
        - Sexual Orientation or Expression?
        - Religion?
        - Immigration status?
        - Primary Spoken Language?
        - Culture?
        - Age?
        - Neighborhood where they reside?
        - Presence of a disability?
        - Occupation?
        - Socio-economic status of the family?
    - If you answered yes, bias may be impacting your decision to call the SCR.
- The best tool we have to reduce bias is critical thinking.
    - As mandated reporters, you must use critical thinking when deciding whether to call in a report to the SCR.
        - Identify what specifically concerns you about the current situation
        - Gather adequate information about the current situation

- Analyze that information to separate facts from assumptions
- Recognize the possibility of bias in your personal opinions
- Develop multiple hypotheses that could explain the situation
- Determine whether you are legally required to call the SCR and, if not, whether an alternative option is better, such as connecting the individual or family to appropriate services in their community

▪ Approach the situation with humility, recognize that we do not know everything about the situation and the family, and be open and willing to learn, and consider information that might be different from our first impressions and assumptions.

o Harvard University developed the Implicit Association Test (IAT) which measures attitudes and beliefs that you may be unwilling or unable to report.

▪ You can access a variety of IAT tests here: https://implicit.harvard.edu/implicit/takeatest.html

TEST YOURSELF QUESTION #10

Research on bias throughout the child welfare system shows:

A. An under representation of families of color
B. An over representation of families in poverty and families of color
C. A mandated reporter's decision to make a report is hardly ever influenced by bias
D. Bias does not have long lasting impacts on families and communities

Please turn to page 79 for answer.

Reporting Procedures and Preparing to Make the Call to SCR

When to Report

- **Immediately**, by telephone, at any time of day, seven days a week, when presented with a reasonable cause to suspect child abuse or maltreatment in a situation where a child, parent, or other person legally responsible for the child IS BEFORE the mandated reporter when the mandated reporter IS ACTING IN HIS OR HER OFFICIALOR PROFESSIONAL CAPACITY.
- The call should be made to the SCR mandated reporter line: **1-800-635-1522.**
- Always call 911 first if you are in an emergency situation.
- A written report must be filed within 48 hours of the verbal report, using form LDSS-2221A. A copy of this form can be obtained at ocfs.ny.gov.

Report Criteria

- The SCR is bound by legal criteria which dictates whether they can accept a report.
- For the SCR to accept a report, the following 3 criteria must be met:
    - The child must be born and must be under 18 years old,
    - The alleged perpetrator must be the child's parent or another person over age 18 who is a PLR for the child, and
    - The conduct described must meet the legal definition of maltreatment or abuse.
- The SCR is not legally required to accept the report just because you are calling as a mandated reporter.
- The SCR staff will conduct their own interview to determine if the information you provide during the call rises to the legal level of suspected child abuse or maltreatment.
    - If it does not rise to this level, based on the information you provide, the SCR cannot accept the report.
- If you call the SCR and provide all the information you have, you have fulfilled your legal obligation by making the call even if the SCR declines to accept the report.
- Once the SCR has accepted a report, the SCR forwards it to the local department of social services for investigation.

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**.
    - Calls to this hotline are given priority.
- The law does not require multiple reports on the same incident from the same organization.
- Reports of suspected abuse by anyone other than a mandated reporter (neighbor, relative, friend, etc.) or if you are not acting in your official capacity, the call should be made to the non-mandated reporter hotline.
    - Call the New York State Central Register of Child Abuse and Maltreatment (SCR) toll-free at **1-800-342-3720**.
- Two counties have their own localized hotlines that may be used instead of the SCR:
    1. Monroe County: **(585) 461-5690**
    2. Onondaga County: **(315) 422-9701**
- 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 SCR.
- 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.

Subject of the Report

For purposes of reporting suspected cases of child abuse and maltreatment to the SCR and CPS, 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, or 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 SCR.
    - 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, 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 day-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.

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 [SSL]), enforcement authorities should be contacted directly. If a call is received by the SCR 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.

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 effect on the child.

- Specific information which led to you having a reasonable suspicion of abuse or maltreatment.
- The names and addresses of the child, parent(s), and/or other persons responsible for the child's care. The role of the parent (or persons legally responsible).
  Please note, that it is crucial that you have an address or locating information for the child and/or relevant adults when you call the SCR. The SCR will not be able to accept the report if you do not have this information.
- Parents or other adults' dates of birth, when available.
- The child's full name, age, date of birth, gender, race, special needs, and medications.
- 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 or is the child at risk for harm, by who, and how. Ongoing pattern or single episode.
- The name of the person or persons responsible for causing the injury, abuse, or maltreatment.
- Family composition.
- The full name of the source of the report.
- The full name of the person making the report and where she/he can be reached.
- The name of your agency or organization.
- The name, title, and contact information (including telephone number and email address) of every staff person of an agency/institution believed to have direct knowledge of the allegations in the report.
- 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.
    - Any personal safety issues for the local CPS worker.
    - Any related issues for the local caseworker to know (weapons, dogs, etc.).
    - The mandated reporter's contact information.
    - Any identifying information so the CPS agency can locate the child.
    - Is there the need for an interpreter?
    - Does the child have any special needs? What are they?
    - Is the child on any medications?
    - Are there any related issues that could be helpful for the local caseworker to know?

Note: A reporter is not required to know all of the above information when making a report; therefore, the lack of complete information does not prohibit a person from reporting. However, information to locate a child is crucial. When the alleged perpetrator cannot be identified the appropriate law enforcement agency/DA will be notified by SCR to assist with the case (NYSOCFS, 2011).

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

- Must be filed within **48** hours of verbal report to the appropriate CPS office.
- Document on the official form, obtainable from the Office of Children and Family Services (OCFS) Web site: https://ocfs.ny.gov/forms/ldss/LDSS-2221/OCFS-LDSS-2221A.docx. Upon completion of the form, send the LDSS-2221A form to your Local Department of Social Services. There is a link included on the form to assist with finding that address.
- Identical information as in telephone report (see above).
- Information should be written as clearly and objectively as possible.
- *It may be helpful to fill out the form before placing the call to SCR. This enables you to organize whatever demographic and identifying data, as well as the allegations and concerns that are most helpful for the case.*

  REMEMBER: The safety of the child must come before the completion of the form.

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

A mandated reporter who initiates an investigation of an allegation of child abuse or maltreatment, *is required* to comply with all requests for records made by CPS relating to such report**.**

What to Expect When Calling the SCR Hotline:

Sections 422.2(a) and 422.11 of the SSL establish the procedures to be followed by OCFS 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 specialist for the "Call I.D." assigned to the report you have made as well as their full name.

If the SCR staff does 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 OCFS 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.

TEST YOURSELF QUESTION #611

When must a LDSS 2221A form be filed?

A. Depends on the severity of the injury.
B. Within five business days of making the oral report.
C. Within 48 hours of making an oral report.
D. The 2221A is no longer required.

Please turn to page 79 for answer.

Inquiring About the Report

- Section 422.4 of the SSL 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 SSL to legally seal, rather than immediately expunge unfounded reports of child abuse or maltreatment. Unfounded reports can be ultimately expunged after ten (10) years.
- 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.

Remember you only need reasonable cause to suspect the child is being abused.

- You do not have to prove it.
- A feeling of distrust or doubt is enough.
- Even if it is based on an actual observation or just a disclosure.

If you suspect imminent danger:

- Place distance between the child and harm.
- Harm could occur immediately or in the very near future.
- Try to determine how direct the threat is to the child.
- If you find a family in crisis and the children are **no**t in imminent danger of harm, it is best to assess the situation to see if the family could benefit from other community resources.

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.

Connecting Individuals and Families with Other Services

Family resource centers (FRCs) are welcoming, community-based hubs of support, services, and social connection that have demonstrated effectiveness in reducing the risk of a report of child maltreatment and entry into foster care. Depending on the jurisdiction, they also may be called family enrichment centers, family success centers, family support centers, or parent-child centers. Whatever the name, the centers emphasize community engagement, leadership, partnership, and the development of relationships between staff and families based on equality and respect. They can play an important role in supporting family well-being and in addressing challenges so families can thrive, particularly those issues that are poverty-driven and systemic in nature, and that can result in unnecessary contact with the child protection agency. The National Family Support Network has developed Standards of Quality for Family Strengthening and Support (https://8c49defa-92cd-4bf1-ac5b-91471683def4.filesusr.com/ugd/ec0538_8dd6d9ef51d54151b9df550c30cf4572.pdf) as a guide for a broad range of approaches for designing family resource centers in terms of delivery, structure, funding, and services, given the emphasis on customizing FRCs to the local community.

Family Assessment Programs (FAP) provides support to families that are struggling with everyday challenges. FAP works to strengthen families, reduce conflict, and connect the family to many services that provide ongoing support in the community. It helps families handle concerns such as a child running away, skipping school, or disruptive behavior, without having to go to court.

- Throughout the City of New York, resources are available to provide support services to overwhelmed parents. Parents can call 311 and ask for “parenting support.” Parents can also contact the NYC Administration for Child Services (ACS) Community Partnerships.

- For help finding preventive services, parents can call the ACS Parent Help Line (OPTA) at (212) 676-7667.
- Parents should be cautious when leaving children with caregivers.
- For teens acting out, parents should contact the ACS Family Assessment Project (FAP) in their borough for help.

TEST YOURSELF QUESTION #~~7~~12:

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 79 for answer.

Other Mandated or Authorized Actions

Photographs

According to NYS Child Protective Services Manual, Chapter IV, Section D.3g, p. 45, 2007:

Photographs can be an important source of evidence in a child abuse or neglect investigation.

- Provide information for child protective staff to consider, weigh, and evaluate in making a determination.
- Photographs graphically preserve visible evidence and accurately document the child's condition.
- Important not only for documenting the reasons for caseworker's decisions and actions, but can also be essential in presenting a case at a fair hearing or in family court.
- Photographs of children who may be victims of abuse or maltreatment should be taken or arranged for whenever there are visible physical injuries or trauma.

Mandated reporters, under certain circumstances, are required to take photographs.

Additionally, when a case is reported by a mandated reporter who is employed by an agency or institution which has the capacity to take high quality photos of injuries or trauma, CPS may choose to use the agency's photographs when CPS knows that they can have access to such photos as needed.

Certain guidelines should be followed to enhance the evidentiary value of the investigative photographs:

- All photos should be in color.
- Hard copies of photos should be obtained, especially when the photo is taken with a digital camera.
    - For 35 mm cameras, the negatives should be saved in the case file.
    - If the caseworker has the capacity to transfer images from the camera to a CD, that CD should be kept in the file as the digital original of the hard copy of the photos.
- Photos should accurately represent the scene or object and be free of distortion.
- Different views of the same scene should be taken.
- A full face photo should be taken for identification purposes, even if the trauma or injury does not appear in that area.
- A photo showing the relationship between the traumatized or injured area and the general area of the child's body should be taken. A close-up should be taken which shows the traumatized or injured area in more detail.
- The photo should be labeled with the date and time.
    - If the camera has this function, it should be used.
    - When a hard copy of the photo is obtained, the caseworker should label the back of the photo with a clear statement of the subject of the photo (e.g., Mr. Smith's living room at 123 Main St., Bob Smith's right arm, etc.).
- The photographer should be able to testify about the date and time each photo was taken and the camera location and direction.
    - It is not necessary for the photographer to appear in court for the photo to be entered into evidence.
    - If the camera does not have a date and time stamp, you can write the date and time on the actual photograph or write it on a sign to include when the photograph is taken.
    - The photo should be initialed by the person who took the photos and any witnesses to the taking of the photos.
- When taking the photos:
    - A neutral colored background and proper lighting is advisable.
    - Photo should not be 'artistic' or strive to appeal to emotions. It is evidence and should display the scene or subject as objectively as possible.
    - To the greatest extent possible, the photographer should photograph the child and/or injuries in a comforting non-threatening manner.

- Keep in mind the child's potential to be fearful or embarrassed, or have negative emotional responses to the situation and the photograph.
- Where photographs have been taken by a mandated reporter, CPS staff should try to obtain those photos in conjunction with the mandated reporter's written report (Form LDSS-2221-A) or as soon thereafter as possible.
  - CPS is authorized to reimburse mandated reporters for expenses incurred in their taking of photos.
- All photos taken by CPS staff or other photographers and provided to CPS are part of the case record and must be kept secure and confidential with the local case record.

X-rays

- X-rays should be taken if medically indicated.
- Photos or x-rays must accompany the LDSS-2221-A, or be sent as soon as possible after its submission.
- Photos or x-rays should be appropriately identified with:
  - Child's name
  - Date
  - Name of person taking the photos or x-rays

TEST YOURSELF QUESTION #13:

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. Include the date and time the photo was taken.
D. Submit the highest quality photographs with the report.

Please turn to page 79 for answer.

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 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
- A designated employee of a city or county OCFS
- A physician in their capacity as a member of staff 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 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 (FCA) 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 SSL, 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 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 FCA, 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 (NYSOCFS-CPS, 2007).

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, police, and any other service provider or agency who might have information about the child.
- 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.
- Once the local department of social services has the report, they must commence an investigation within 24 hours of receiving it.
- During the investigation, the assigned CPS caseworker must comply with numerous regulations and policies to ensure they conduct a thorough investigation and safety assessment.
    - CPS is required to contact the parent or PLR and child(ren) involved.
    - CPS will also contact the source of the report and may ask for clarification or additional information.
    - The CPS caseworker may also request copies of records or reports which you are required by law to provide.

Determination (Within 60 Days)

Within 60 days, the CPS agency must determine whether the allegations are substantiated (meaning there was a fair preponderance of evidence the allegations were true) or unsubstantiated (meaning there was not a fair preponderance of evidence the allegations were true).

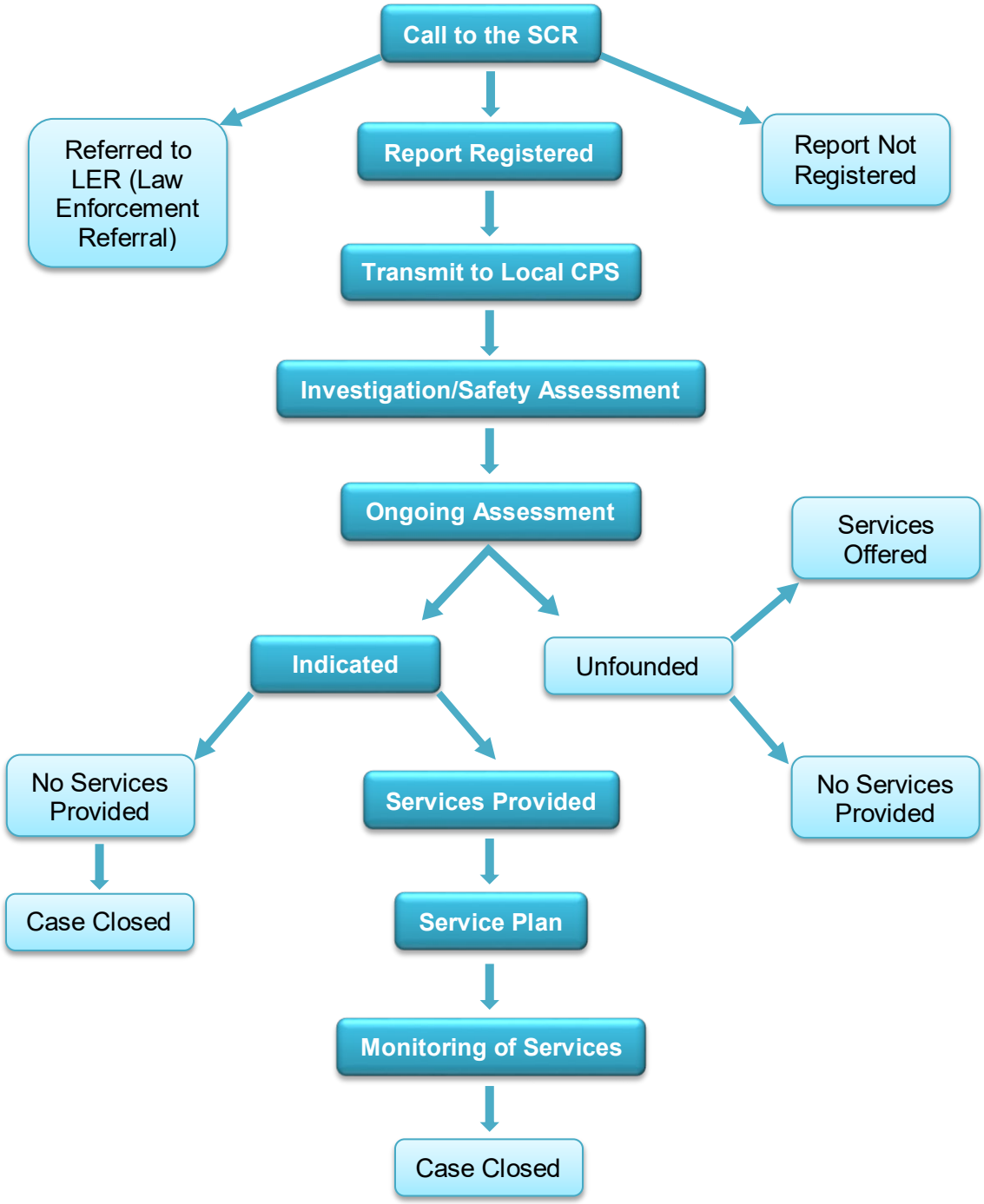
- A determination of risk to the children in the home is made.
    - Determination of reports is a difficult task.
    - No matter how thorough the investigation, sometimes there is no clear evidence of what happened.
- Indicated: there is reason to suspect that abuse occurred
    - The report will remain on file at the SCR.
- Unfounded: determination that the evidence does not support claim
    - The report is then sealed.
    - Sealed reports are expunged after a period of ten (10) years from the date of the report.
- 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.
- CPS caseworkers are also required to offer the parents or PLR and children services which may be helpful.
- The most common outcome of a CPS investigation is that the caseworker will work with the family to obtain necessary services or aid to alleviate problems and promote safety.
    - It is important to keep in mind that CPS intervention is not required for parents, children or families to obtain services.
    - You can support a family without having to report a family.

Local CPS Response

The chart below shows the systematic approach of a report called into the SCR. Once a report is made, the CPS specialist determines if it is registered or not registered. If it is not registered but there is a crime or imminent danger to a child they will make a Law Enforcement Referral (LER) (NYSOCFS, 2011).



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 (NYSOCFS, 2011).

TEST YOURSELF QUESTION #14:

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 79 for answer.

Legal Protection for Mandated Reporters

Immunity from Liability

To encourage prompt and complete reporting of suspected child abuse and maltreatment, SSL, Section 419, affords the reporter certain legal protections from liability.

- Any persons, officials, institutions who, in good faith and with a reasonable cause to suspect child abuse or maltreatment has occurred, 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 (NYSOCFS, 2011). Good faith reporting will continue to be presumed, even if CPS finds no evidence of abuse or maltreatment.

Source Confidentiality

SSL provides confidentiality for mandated reporters and all sources of child abuse and maltreatment reports. The Commissioner of Social Services, the local CPS, and local Children and Family Services (CFS) is not permitted to release to the subject of the report or any data that would identify the source of the report unless: (1) the source has given written permission for the central processing center to do so, or (2) in very limited circumstances described in the law, the identity of the source of the CPS report may be discoverable. For more information on when the identity of a source of a report to the SCR may be disclosed please visit: http://nysmandatedreporter.org. Information regarding the source of the report may be shared with court officials, police, and district attorneys, but only in certain circumstances (NYSOCFS, 2011).

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.

The legal obligation to report suspected child abuse and maltreatment under New York State law supersedes client-patient confidentiality provisions. The Health Insurance Portability and Accountability Act (commonly referred to as “HIPAA”) contains specific provisions allowing health care and other professionals to report information to the SCR, including personally protected health information that is otherwise confidential.

Retaliatory Personnel Action

No medical or other public or private institution, school, facility, or agency shall take any retaliatory personnel action against an employee who made a report to the SCR.

No school, school official, child care provider, foster care provider, residential care facility provider, hospital, medical institution provider, or mental health facility provider shall impose any conditions, including prior approval or prior notification, upon member of their staff mandated to report suspected child abuse or maltreatment.

Consequences in New York State for Failing to Report

Legal Repercussions

Any person, official, or institution required by law to report a reasonable suspicion of child abuse or maltreatment or a case of suspected child abuse or maltreatment while in their professional role that willfully fails to do so:

- May be guilty of a Class A misdemeanor and subject to criminal penalties of up to one (1) year in jail, a fine of $1,000.00 or both.
- May be civilly liable (sued) for monetary damages for any harm caused by the mandated reporter's failure to make a report to the SCR, including a wrongful death lawsuit.
- The mandated reporter may also be held civilly liable for any harm suffered by a child due to their failure to call the SCR.
- No employer or organization is permitted to require that you seek or obtain approval prior to calling the SCR.
- Your legal obligations as a mandated reporter are personal to you, and your organization may not impede you from calling the SCR.

Societal Repercussions

To protect children, suspicions of child abuse must be reported. CPS 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 (NYSOCFS, 2011).

TEST YOURSELF QUESTION #15:

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 79 for answer.

Frequently Asked Questions

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

For Federal Fiscal Year 2019, CPS agencies received more than 4.4 million referrals involving more than 7.9 million children. After investigation, in Federal Fiscal Year 2019, more than 656,000 children are substantiated as victims of abuse and neglect, and over 1840 child deaths are attributed to child abuse or neglect annually (USOHHS, ACF, ACYF, CB, 2019).

In 2019, there were 67,269 victims of child abuse in New York State, of which 39,379 were first-time victims. A majority of the victims were 1 year of age or less and both boys and girls equally were victims of abuse and maltreatment.

How many children are victims of maltreatment?

An estimated 656,000 children nationwide were determined to be victims of child abuse or neglect in 2019. This is an increase by 608,459 victims compared to 2017 when the estimate was approximately 47,541 victims. A majority of the victims were 1 year of age or less and both boys and girls equally were victims of abuse and maltreatment. Perpetrators of abuse and maltreatment by race where Caucasians, followed by Hispanics, African Americans, Multiple Races, Asians, Native Americans/Alaskans, and Pacific Islanders. In 2019, there were 95,673 victims of maltreatment in New York State, of which 95.5% of the cases were neglect (USDHHS, ACF, ACYF, CB, 2019).

Is the number of abused or neglected children increasing?

New federal child abuse and neglect data shows 2019 had the lowest number of victims who suffered maltreatment in five years.

Of the 3,476,000 million (rounded) children who were the subject of an investigation or alternative response in fiscal year 2019, 656,000 (rounded) children were determined to be victims of maltreatment, down from 677,000 (rounded) victims in 2018. Most victims, 84.5 percent, suffered from a single type of maltreatment and 15.5 percent suffered from two or more types of maltreatment. The most common single maltreatment type was neglect with 61.0 percent, followed by physical abuse with 10.3 percent. See https://www.acf.hhs.gov/media/press/2021/child-abuse-neglect-data-released.

What are the most common types of maltreatment?

Each state bases its own definitions of child abuse and neglect on standards set by federal law. Most states recognize four major types of maltreatment: neglect, physical abuse, psychological maltreatment, and sexual abuse. Additional types of maltreatment measured in the report include medical neglect and sex trafficking. Although any of the forms of child maltreatment occur separately, they can also occur in combination. The maltreatment type of sex trafficking was introduced in the fiscal year 2018 data cycle. For 2019, there were 877 victims of sex trafficking in the 29 states that were able to report this relatively new field. See https://www.acf.hhs.gov/media/press/2021/child-abuse-neglect-data-released.

States may consider any condition that does not fall into one of the main categories — e.g. physical abuse, neglect, or emotional maltreatment — as "other." These maltreatment type percentages total more than 100% because children who were victims of more than one type of maltreatment were counted for each incident (NEC, 2013).

The table below shows the types of child maltreatment cases in New York State in 2019 (USDHHS, ACF, ACYF, CB, 2019).

Table 12. Numbers and Percentages of Child Maltreatment Cases in New York, 2019

# Victims	Medical Neglect	Neglect	Other	Physical Abuse	Psychological Maltreatment	Sexual Abuse	Sex Trafficking	Unknown	Total Maltreatment Types
67,269	4,282	64,262	18,246	6,112	509	2,267	--	--	95,673
	6.4%	95.5%	27.1%	9.1%	0.8%	3.5%	--	--	142.2%

Who are the child victims?

The numbers of child victims of maltreatment in New York State from 2015 to 2019 were 66,676 (15.9 per 1,000 children), 65,123 (15.7 per 1,000 children), 71,226 (17.3 per 1,000 children), 68,785 (16.9 per 1,000 children), and 67,269 (16.7 per 1,000 children). 39,375 children in New York (9.8 per 1,000 children) were first time victims in New York state.

The table below shows the ages of child victims in New York State in 2019 (USDHHS, ACF, ACYF, CB, 2019).

Table 13. Numbers of Child Victims of Maltreatment in New York State, 2019.

Age < 1	1	2	3	4	5	6	7	8	9	10
6,444	4,001	3,837	3,741	3,659	3,924	4,126	3,971	3,836	3,696	3,712
Age 11	12	13	14	15	16	17		Total		
3,598	3,457	3,359	3.412	3,492	3,124	1,738		67,269		

Statistics on New York State child victims by sex in 2019 were as follows: 33,460 (16.2 per 1,000) boys, 33,754 (17.1 per 1,000) girls, for a total of 67,269 child victims. The table below shows the ethnicities of child victims in New York State in 2019 (USDHHS, ACF, ACYF, CB, 2019).

Table 14. Ethnicities of Child Victims of Maltreatment in New York, 2019

African American	American Indian or Alaska Native	Asian	Hispanic	Multiple Race	Pacific Islander	White	Unknown		Total Victims
19,139	234	1,720	19,488	3,050	29	22,352	1,257		67,269
31.7 per 1,000	19.7 per 1,000	5.3 per 1,000	19.4 per 1,000	20.2 per 1,000	14.7 per 1,000	11.6 per 1,000			

How many children die from abuse or neglect?

Child fatalities are the most tragic consequence of maltreatment. The number of child fatalities due to child abuse and neglect increased by 60 in fiscal year 2019. The number and rate of fatalities have fluctuated during the past five years. A national estimate of 1,840 children died from abuse and neglect in fiscal year 2019 compared to an estimated 1,780 children who died in fiscal year 2018. See https://www.acf.hhs.gov/media/press/2021/child-abuse-neglect-data-released.

FFY 2019 data showed that 70.3% of all child fatalities are younger than 3 years of age. Close to one-half (45.5%) of child fatalities were younger than age one, and died at a rate of 22.94 per 100,000 children in the population of the same age. This was 3.3 times the fatality rate for one year old children (6.87 per 100,000 children in the population of the same age). The child fatality rates mostly decrease with age. Boys have a higher child fatality rate than girls (USDHHS, ACF, ACYF, CB, 2019).

The table below shows the national child fatality rates per 100,000 children from 2015 to 2019 (USDHHS, ACF, ACYF, CB, 2019).

Table 15. National Child Fatality Rates Per 100,000 Children: 2015 - 2019

Year	Reporting States	Child Population of Reporting States	Child Fatalities from Reporting States	National Fatality Rate Per 100,000 Children	Child Population of all 52 States	National Estimate of Child Fatalities
2015	50	71,806,672	1,603	2.23	74,350,047	1,660
2016	50	73,394,916	1,708	2.33	74,342,970	1,730
2017	50	72,610,987	1,677	2.31	74,236,882	1,710
2018	51	72,546,232	1,751	2.41	73,911,017	1,780
2019	51	72,259,081	1,809	2.50	73,611,881	1,840

Who abuses and neglects children?

Child maltreatment occurs across socio-economic, religious, cultural, racial, and ethnic groups (NEC, 2013). There is no single profile related to a perpetrator of child abuse, although certain characteristics reappear in many studies.

A perpetrator is the person who is responsible for the abuse or neglect of a child. Fifty-two states reported 525,319 perpetrators. The analyses of case-level data for FFY 2019 showed (USDHHS, ACF, ACYF, CB, 2019):

- More than four-fifths (83.0%) of perpetrators are between the ages of 18 and 44 years old.
- More than one-half (53.0%) of perpetrators are female and 46.1 percent of perpetrators are male.
- The three largest percentages of perpetrators are White (48.9%), African-American (21.1%), and Hispanic (19.7%).
- The majority (77.5%) of perpetrators are a parent to their victim

Who reports child maltreatment?

Anyone can report suspected child abuse or neglect. Certain professionals are required by law to report suspected child abuse or maltreatment to the New York State Central Register (SCR) of Child Abuse and Maltreatment. The law also assigns civil and criminal liability to those professionals who do not comply with their mandated reporter responsibilities.

For 2019, professionals submitted 68.6 percent of reports alleging child abuse and neglect. The term professional means that the person has contact with the alleged child maltreatment victim as part of his or her job. This term includes teachers, police officers, lawyers, and social services staff. The highest percentages of reports are from education personnel (21.0%), legal and law enforcement personnel (19.1%), and medical personnel (11.0%).Nonprofessionals—including friends, neighbors, and relatives—submitted fewer than one-fifth of reports (15.7%). Unclassified sources submitted the remaining reports (15.7%). Unclassified includes anonymous, “other,” and unknown report sources. States use the code

"other" for any report source that does not have an NCANDS designated code (USDHHS, ACF, ACYF, CB, 2019).

What happens after I make a report?

The Child Protective Services (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 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 (NYSOCFS, 2011).

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 59%, as an adult by 28%, and for a violent crime by 30%. 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 (National Institute of Justice, 2011). In 2007, the NBER Digest notes that child maltreatment roughly doubles the probability that the individual will engage in many types of crime (Picker, 2007).

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

There is significant research that demonstrates this connection. Research has shown that among confirmed cases of child abuse and neglect, 40% involved the use of alcohol or other drugs. Substance abuse does not cause child abuse and neglect, but it is a distinct factor in its occurrence (NEC, 2013).

Forty-seven states reported that 38,625 infants with prenatal substance exposure were referred to child welfare agencies for fiscal year 2019. This is an increase from the 27,709 infants with prenatal substance exposure that were reported in 45 states during 2018

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, 2011).

Information concerning the public health provisions of HIPAA may be found at http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/publichealth/.

What about HIV records?

§2782(7) of the Public Health Law specifically provides that nothing in this law limits a person or agencies responsibility or authority to report.

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. D (Answer can be found in Adverse Childhood Experiences [ACEs])
4. B (Answer can be found in Methamphetamine and Children at Risk)
5. D (Answer can be found in Assessing Physical Symptoms.)
6. B (Answer can be found in Maltreatment and Neglect.)
7. D (Answer can be found in Recognizing and Responding to Disclosures)
8. B (Answer can be found in Protective Factors)
9. D (Answer can be found in Reporting Child Abuse, Maltreatment or Neglect.)
10. B (Answer can be found in Impact of Bias on Decision Making)
11. C (Answer can be found in Reporting Procedures)
12. B (Answer can be found in Reporting Procedures.)
13. C (Answer can be found in Other Mandated or Authorized Actions.)
14. B (Answer can be found in When a Report is Made.)
15. D (Answer can be found in Legal Protection for Mandated Reporters.)

Resources

Hotlines

New York State Child Abuse Hotline (mandated reporters/ reporting suspicions within professional capacity)	**1-800-635-1522**
New York State Child Abuse Hotline (general public/ reporting suspicions outside professional capacity)	**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**
Monroe County	**1-585-461-5690**
Onondaga County	**1-315-422-9701**

Compendium of Local, State and National Organizations and Agencies

American Humane Association
Children's Division
1400 16th Street NW, Suite 360
Washington, DC 20036
(800) 227 - 4645
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.

CASA (Court Appointed Special Advocates) Advocates for Children of New York State (CASANYS)
911 Central Avenue #117
Albany, NY 12206
(315) 246 – 3558
Mail@casanys.org
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.

Children's Defense Fund (CDF)
15 Maiden Lane, Suite 1200
New York, NY 10038
(212) 697-2323

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.

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

This organization provides protection and support for street children, usually runaways, ages 11 – 17 who are involved in pornography or prostitution. Children of the Night 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
(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)
1726 M St. NW, Suite 500
Washington, DC, 20036
(202) 688 - 4200
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
2900 Eastlake Ave E.
Suite 200
Seattle, WA 98102
(206) 634-1903
http://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
307 W 200 S
Suite 2004
Salt Lake City, UT 84101
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.

National Association of Counsel for Children (NACC)
13123 E. 16th Avenue, B390
Aurora, CO 80045
(888) 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) 224-2150
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)
2000 M Street NW, Suite 480
Washington, DC 20036
(202) 467-8714
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.

The National Network for Youth
741 8th Street, SE
Washington, DC 20003
(202) 783-7949
Hotline: (800) 786-2929
www.nn4youth.org

This organization works to ensure that young people can be safe and grow up to lead healthy and productive lives. It 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
52 Washington Street West Building
Suite 99
Rensselaer, NY 12144
(518) 473-3652
http://ccf.ny.gov/

The NYS Council on Children and Families orients its priorities toward the development of comprehensive and coordinated systems of care that respond to the wide needs of children and families in New York.

New York State Domestic Violence Hotline
(800) 942-6906 Multilingual
Deaf or hard of hearing: 711
NYC: (800) 621-4673
www.opdv.ny.gov

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 Mandated Reporter Training
www.nysmandatedreporter.org

This site is designed to be a resource for information about the role and responsibility of a mandated reporter of child abuse and maltreatment in New York State. Through this site, training for all mandated reporters in New York State is available at no cost to participants.

New York State Office of Alcoholism and Substance Abuse Services
1450 Western Avenue
Albany, NY 12203-3526
(518) 473-3460 (General information)
http://www.oasas.ny.gov

The mission of OASAS is to improve the lives of New Yorkers by leading a premier system of addiction services through prevention, treatment, recovery.

New York State Office of Children and Family Services (OCFS)
52 Washington St.
Rensselaer, NY 12144
Hotline: 800-342-3720
(518) 473-7793
www.ocfs.state.ny.us

OCFS provides a variety of resource information related to child abuse and maltreatment/neglect specific to New York State. *Summary Guide for Mandated Reporters in NYS* can be obtained from this Web site, and is available in English, Spanish, Chinese, Russian and Arabic.

New York State Office for the Prevention of Domestic Violence (OPDV)
Alfred E. Smith Building
80 South Swan Street, 11th Floor
Room Number 1157
Albany, NY 12210
(518) 457-5800
http://www.opdv.ny.gov/

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.

NYS Office of the Professions
State Education Building - 2nd Floor
Albany, NY 12234
(518) 474-3817
http://www.op.nysed.gov/training/caproviders.htm

The Office of the Professions provides a number of services to the public and the professions, including licensure and registration, professional discipline, and public and professional education and information. Their Web site identifies, by region, approved providers of training for Child Abuse Identification and Reporting.

Prevent Child Abuse America (PCAA)
228 South Wabash Avenue, 10th Floor
Chicago, IL 60604
(312) 663-3520
Info. & Referral: (800) 244-5373
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.

Prevent Child Abuse New York
33 Elk St, Suite 201
Albany, NY 12207
(518) 445-1273
24 hour Prevention and Parent Helpline: (800) 244-5373
www.preventchildabuseny.org

This is the New York State Chapter of Prevent Child Abuse America. Programs include:

- The Prevention Information Resource Center and Parent Helpline (24 hour hotline).
- Healthy Families New York.
- Public awareness and education.
- Advocacy.
- 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; expands to the human services and volunteer community that supports them; and reaches out to the public officials and public policy makers who have an ultimate responsibility to assure that every child has a protected childhood and people who can guide them to a successful future in safe communities. Both English and Spanish services are offered.

Social Services Laws of New York State regarding Child Abuse
http://public.leginfo.state.ny.us/menuf.cgi

Click on the Laws of New York link under the Search heading to access an alphabetical list of links to NYS consolidated laws.

References

Child Welfare Information Gateway. (2013). *What is Child Abuse and Neglect? Recognizing the Signs and Symptoms*. Fact sheet. Retrieved from https://www.childwelfare.gov/pubpdfs/whatiscan.pdf.

Child Welfare Information Gateway. (2015). *Child Abuse and Neglect Fatalities 2013: Statistics and Interventions*. Retrieved from https://www.childwelfare.gov/pubPDFs/fatality.pdf.

Corporate Graphics Resource. (n.d.). *Child abuse photos.* Corporate Graphics Resource, Albany, N.Y. 12203.

Criddle, L. (2010). Pediatric care. Monsters in the closet: Munchausen syndrome by proxy. *Critical Care Nurse, 30* (6), 46-56.

Denton, J., Newton, A.W., & Vandeven, A.M. (2011). Update on child maltreatment: Toward refining the evidence base. *Current Options in Pediatrics*, *23*, 240-248. doi:10.1097/MOP.0b013e3283446010

Dubowitz, H. & Bennett, S. (2007). Physical abuse and neglect of children. *Lancet*, *369* (9578), 1891-1899.

Dwek, J. R. (2011). The radiographic approach to child abuse. *Clinical Orthopaedics and Related Research, 469* (3), 776-789. doi:10.1007/s11999-010-1414-5

Flaherty, E.G., Sege, R., Price, L., Christoffel, K., Norton, D., & O'Connor, K. (2006). Pediatrician characteristics associated with child abuse identification and reporting: Results from a national survey of pediatricians. *Child Maltreatment*, *11* (4), 361-369.

Flaherty, E.G., Perez – Rossello, J.M., Levine, M.A., Hennrikus, W.L. (2014). Evaluating children with fractures for child physical abuse. *American Academy of Pediatrics, 133*(2), e477-e489.

Florida International University College of Education. (2010). Child abuse tutorial: *The Lisa Steinberg case*. Retrieved from http://childabuse.fiu.edu/statistics.php

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

Jenny, C. (2007). Recognizing and responding to medical neglect. *Pediatric, 120*(6)*, 1385*-1389.

Lipovsky, J.A., Hanson, R. F. (2007). Treatment of child victims of abuse and neglect. *Children's Law Center*. Retrieved from http://childlaw.sc.edu/frmPublications/TreatmentforChildVictimsofAbuseandNeglect.pdf.

Magana, J., & Kaufhold, M. (2015). Medscape Reference; Drugs & Diseases. *Child abuse*. Retrieved from http://emedicine.medscape.com/article/800657-overview

National Center on Substance Abuse and Child Welfare. (2021). Supporting children affected by Methamphetamine use. Retrieved from https://ncsacw.samhsa.gov/files/meth-tip-sheet-children.pdf.

National Institute of Justice. (2011). Impact of abuse on delinquency and arrest. Retrieved from http://www.nij.gov/topics/crime/child-abuse/pages/impact-on-arrest-victimization.aspx.

National Institute on Drug Abuse. (2013). Research report: Methamphetamine. Retrieved from http://www.drugabuse.gov/publications/research-reports/methamphetamine/what-methamphetamine.

New York Family Court Act §1012 Definitions. (2012). Retrieved from http://law.onecle.com/new-york/family-court/FCT01012_1012.html

New York Society for the Prevention of Cruelty to Children (NYSPCC). (2015). *History.* Retrieved from http://www.nyspcc.org/nyspcc/history/

New York State Assembly, Committee on Children and Families. (2014). *A Guide to New York's Child Protective Services System, 2014 Revised Edition*. Retrieved from http://assembly.state.ny.us/comm/Children/20140128/index.pdf.

New York State Education Department, Office of the Professions (NYSED, OP). (2009). *Mandated training related to child abuse*. Retrieved from http://www.op.nysed.gov/training/camemo.htm

New York State Office of Children and Family Services (NYSOCFS). (n.d.). *OCFS forms for Child Protective Services/State Central Register.* Retrieved from http://ocfs.ny.gov/main/documents/docs.asp?document_type=1&category_number=5.

New York State Office of Children and Family Services (NYSOCFS). (2008). How to recognize the signs of a clandestine methamphetamine laboratory. *OCFS Pub. 5076*. Retrieved from http://www.nationaldec.org/goopages/pages_downloadgallery/download.php?filename=20866.pdf&orig_name=1016.pdf.

New York State Office of Children and Family Services (NYSOCFS). (2011). Identifying and reporting child abuse and maltreatment/neglect. *Mandated reporter trainer's resource guide.* Buffalo, N.Y.

New York State Office of Children and Family Services (NYSOCFS). (2015). Summary guide for mandated reporters in New York State. *Pub. 1159*. Retrieved from http://ocfs.ny.gov/main/publications/Pub1159.pdf.

New York State Office of Children and Family Services (NYSOCFS). (2017). 2017 Monitoring and analysis profiles with selected trend data: 2013-2017. Retrieved from https://ocfs.ny.gov/main/reports/maps/counties/New%20York%20State.pdf.

New York State Office of Children and Family Services, Child Protective Services (NYSOCFS-CPS). (2007). IV. Local District Child Protective Services, D. Investigation/assessment, 3. Interviewing contacts, g. Photographs. In *Child Protective Services program manual*. Retrieved from http://www.ocfs.state.ny.us/main/cps/cps_manual.asp

O'Hara, M. (2001). What to do when you suspect child abuse. *American Orthoptic Journal*, *51*, 121-124.

Picker, L. (2007). *Does Child Abuse Cause Crime?* (Publication). Retrieved from https://www.nber.org/digest/jan07/jan07.pdf

Prevent Child Abuse New York. (2009). *2009 Child Abuse and Neglect Fact Sheet*. Retrieved from http://www.preventchildabuseny.org/resources/about-child-abuse/facts-and-statistics/.

Sugandhan, S., Gupta, S., Khandpur, S., Khanna, N., Mehta, M., & Inna, P. (2010). 'Munchausen syndrome by proxy' presenting as battered child syndrome: A report of two cases. International *Journal of Dermatology*, *49*(6), 679-683. doi:10.1111/j.1365-4632.2009.04188.x

Swerdin, A., Berkowitz, C., & Craft, N. (2007). Cutaneous signs of child abuse. *Journal of the American Academy of Dermatology, 57*(3), 371-392.

Swetlow, K. (2003). Children at clandestine methamphetamine labs: Helping meth's youngest victims. *OVC Bulletin.* Retrieved from http://www.ovc.gov/publications/bulletins/children/197590.pdf.

The National Exchange Club (NEC). (2013). *About Child Abuse – Frequently Asked Questions*. Retrieved from https://www.preventchildabuse.com/content/about-child-abuse.

University of Maryland School of Public Policy, Welfare Reform Academy. (n.d.) *The legal definition of "child abuse".* Retrieved from http://www.welfareacademy.org/pubs/childwelfare/provingchildabuse/2legaldefinition.pdf

U.S. Department of Health & Human Services, Administration for Children & Families, Administration on Children, Youth and Families, Children's Bureau (USDHHS, ACF, ACYF, CB). (2009). *Child maltreatment 2009.* Retrieved from http://www.acf.hhs.gov/programs/cb/pubs/cm09/cm09.pdf

U.S. Department of Health & Human Services, Administration for Children & Families, Administration on Children, Youth and Families, Children's Bureau (USDHHS, ACF, ACYF, CB). (2019). *Child maltreatment 2019* Retrieved from https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2019.pdf

U.S. Department of Health & Human Services, Centers for Disease Control (CDC). (2010). A journalist's guide to shaken baby syndrome: A preventable tragedy. *A part of CDC's "Heads Up" Series*. Retrieved from https://stacks.cdc.gov/view/cdc/5865.

U.S. Department of Justice. (n.d.) Meth awareness. Retrieved from http://www.justice.gov/archive/olp/methawareness/

U.S. Department of Justice. (2002). Recognizing when a child's injury or illness is caused by abuse. Retrieved from https://www.ncjrs.gov/pdffiles1/ojjdp/160938.pdf.

NYS Child Abuse: Identification and Reporting

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.

Note: Contact hours/CEUs will be awarded for this course until **September 28, 2026.**

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.

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 humerus. 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.

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.

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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

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. Include the date and time the photo was taken.
    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.

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

31. What should a mandated reporter do before reporting any allegations of abuse/neglect?

    a. Have clear and sufficient evidence of the abuse or neglect.
    b. Discuss the concerns with the parent or guardian of the child.
    c. Talk to the child about what to say to the child protective services worker.
    d. Have reasonable cause to suspect the child has been abused or neglected.

32. If you are a mandated reporter in a school and a child has been missing from school and the parents are not responding to the schools attempts to discuss the child's lack of attendance, what should you do?

    a. Make a report to the SCR for educational neglect.
    b. Assess if other efforts can be made by the school to engage the family.
    c. Discuss the matter with the child's friends.
    d. Call the police.

33. What should a mandated reporter do before reporting any allegations of abuse/neglect?

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    c. Talk to the child about what to say to the child protective services worker.
    d. Have reasonable cause to suspect the child has been abused or neglected.

34. When are mandated reporters required to call the State Central Register to report suspected child abuse or maltreatment?

    a. Immediately.
    b. Within a week.
    c. Within 48 hours.
    d. Depends on the severity of the suspected injury.

35. Some Mandated Reporters connect with children virtually. Choose the true statement below:

    a. Due to the virtual setting a mandated reporter cannot assess indicators of abuse/maltreatment.
    b. Pay attention to non-verbal cues from the child. Does the child's demeanor change when a particular adult enters the room?
    c. Mandated reporters can only report what they see or hear in person.
    d. Meeting virtually places children in more danger.

36. Which of the following describes a child who is abused by the parent(s)?

    a. Unintentially contributes to the abusing situation
    b. Belongs to a low socioeconomic population
    c. Is healthier than the nonabused siblings
    d. Abuses siblings in the same way as child is abused by the parent(s)

37. A common characteristic of those who sexually abuse children is which of the following?

    a. Pressure victim into secrecy
    b. Are usually unemployed and unmarried
    c. Are unknown to victims and victim's families
    d. Have many victims that are each abused only once

38. A 3-month-old infant dies shortly after arrival to the Emergency Department. The infant has subdural and retinal hemorrhages but no external signs of trauma. The nurse should expect:

    a. unintentional injury
    b. shaken-baby syndrome
    c. sudden infant death syndrome (SIDS)
    d. congenital neurologic problem

39. Probably the most important criterion on which to base the decision to report suspected child abuse is which of the following?

    a. Inappropriate parental concern for the degree of injury
    b. Absence of parents for questioning about child's injuries
    c. Inappropriate response of child
    d. Incompatibility between the history and injury observed

40. Which of the following statements is correct about young children who report sexual abuse by one of their parents?

    a. They may exhibit various behavioral manifestations
    b. In most cases, the child has fabricated the story
    c. Their stories are not believed unless other evidence is apparent
    d. They should be able to retell the story the same way to another person

41. When determining if a child shows indicators of maltreatment or abuse it is important to remember:

a. indicators will always be of a physical nature and will be visible
b. not to view indicators in isolation
c. the explanation for the presenting concern is irrelevant
d. your prior experience with this child should not be factored in

42. Which is not a form of maltreatment?

a. Excessive corporal punishment
b. Lack of Supervision
c. Poverty
d. Inadequate guardianship

43. Adverse childhood experiences can have a lasting impact on:

a. Children
b. Persons Legally Responsible (PLR) for children
c. Mandated Reporters
d. All of the above

44. The following are protective factors that can mitigate child abuse and maltreatment except:

a. Parents having concrete supports in time of need.
b. Having a robust network of mandated reporters.
c. The child's social connections.
d. Parental resilience.

45. Research on bias throughout the child welfare system shows:

a. An under representation of families of color
b. An over representation of families in poverty and families of color
c. A mandated reporter's decision to make a report is hardly ever influenced by bias
d. Bias does not have long lasting impacts on families and communities

46. As mandated reporters you must use critical thinking when deciding whether to call in a report. Critical thinking includes:

a. Gathering adequate information about the current situation
b. Analyzing that information to separate facts from assumptions
c. Determining whether you are legally required to call the SCR, and if not, determine what alternative options are available
d. All the above

47. If you are a mandated reporter in a school and a child has been missing from school and the parents are not responding to the schools attempts to discuss the child's lack of attendance, what should you do?

a. Make a report to the SCR for educational neglect.
b. Assess if other efforts can be made by the school to engage the family.
c. Discuss the matter with the child's friends.
d. Call the police.

48. When a mandated reporter finds a family in crisis and the children are not in imminent danger of harm, it is best to:

a. Call the State Central Register and make a report just in case.
b. Assess the situation to see if the family could benefit from other community resources.

c. Do nothing.
d. Call law enforcement

49. What should a mandated reporter do before reporting any allegations of abuse/neglect?

a. Have clear and sufficient evidence of the abuse or neglect.
b. Discuss the concerns with the parent or guardian of the child.
c. Talk to the child about what to say to the child protective services worker.
d. Have reasonable cause to suspect the child has been abused or neglected.

50. When must a LDSS 2221A form be filed?

a. Depends on the severity of the injury.
b. Within five business days of making the oral report.
c. Within 48 hours of making an oral report.
d. The 2221A is no longer required.