Child Abuse Assessment & Reporting 7 Hours/Units

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1. Definitions, Statistics, and Warning Signs

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

Federal Law Definitions of Child Abuse and Neglect

Federal legislation provides guidance to States by identifying a minimum set of acts or behaviors that define child abuse and neglect. The Federal Child Abuse Prevention and Treatment Act (CAPTA) (42 U.S.C.A. § 5106g), as amended by the CAPTA Reauthorization Act of 2010, defines child abuse and neglect as, at minimum:

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

This definition of child abuse and neglect refers specifically to parents and other caregivers. A "child" under this definition generally means a person who is younger than age 18 or who is not an emancipated minor.

While CAPTA provides definitions for sexual abuse and the special cases of neglect related to withholding or failing to provide medically indicated treatment, it does not provide specific definitions for other types of maltreatment such as physical abuse, neglect, or emotional abuse. While Federal legislation sets minimum standards for States that accept CAPTA funding, each State provides its own definitions of maltreatment within civil and criminal statutes.

State law definitions of child abuse and neglect

While Federal legislation sets minimum standards for States that accept Federal funding, each State is responsible for defining child maltreatment in State law. Definitions of child abuse and neglect are typically located in two places within each State's statutory code:

- ✓ **Civil statutes** provide definitions of child maltreatment to guide individuals who are mandated to identify and report suspected child abuse and determine the grounds for intervention by State child protection agencies and civil courts. Locate definitions for your State by conducting a State Statues Search on the Information Gateway website.
- ✓ **Criminal statutes** define those forms of child maltreatment that can subject an offender to arrest and prosecution in criminal courts.

Many States recognize four major types of maltreatment in their definitions: neglect, physical abuse, sexual abuse, and emotional abuse or neglect.

Psychological and Emotional Abuse

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

Methods of Manipulative Control

➡ Positive Reinforcement

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

➡ Negative Reinforcement

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

➡ Intermittent or Partial Reinforcement

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

➡ Punishment

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

➡ Traumatic One-Trial Learning

A single extremely frightening experience can have long term effects on the victim, creating long term fear and anxiety. In abusive relationships fits of violent rage, sometimes including physical assault, can leave the victim too frightened and disorientated to leave the relationship or stand up for

themselves *(Bancroft, Lundy. Why does he do that? Inside the minds of angry and controlling men Berkley Publishing Group).*

Loss of Control

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

Physical Abuse

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

Forms of physical abuse include:

- Striking
- Punching
- Pushing, pulling
- Slapping
- Whipping
- Striking with an object
- Locking in or out of a room or place/false imprisonment
- Excessive pinching
- Kicking
- Having someone fall
- Kneeing
- Strangling
- Head butting
- Drowning

- Sleep deprivation
- Exposure to cold, freezing
- Exposure to heat or radiation, burning
- Exposure to electric shock
- Placing in "stress positions" (tied or otherwise forced)
- Cutting or otherwise exposing somebody to something sharp
- Exposure to a dangerous animal
- Throwing or shooting a projectile
- Exposure to a toxic substance
- Infecting with a disease
- Withholding food or medication
- Assault
- Bodily harm
- Humiliation
- Torture

Neglect

The National Child Abuse and Neglect Data System (NCANDS) defines neglect as, “A type of maltreatment that refers to the failure by the caregiver to provide needed, age-appropriate care although financially able to do so or offered financial or other means to do so”. Health care professionals, school officials, and relatives are the most frequent to report neglect.

Types of neglect include:
- Physical neglect
- Educational neglect
- Emotional/Psychological neglect
- Medical neglect

Sexual Abuse

Child sexual abuse is any interaction between a child and an adult (or another child) in which the child is used for the sexual stimulation of the perpetrator or an observer. Sexual abuse can include both touching and non-touching behaviors. Touching behaviors may involve touching of the vagina,

penis, breasts or buttocks, oral-genital contact, or sexual intercourse. Non-touching behaviors can include voyeurism (trying to look at a child's naked body), exhibitionism, or exposing the child to pornography. Abusers often do not use physical force, but may use play, deception, threats, or other forms of coercion to engage children and maintain their silence. Abusers frequently employ persuasive and manipulative tactics to keep the child engaged. These tactics—referred to as "grooming"—may include buying gifts or arranging special activities, which can further confuse the victim

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

Approximately 15% to 25% of women and 5% to 15% of men were sexually abused when they were children. Most sexual abuse offenders are acquainted with their victims; approximately 30% are relatives of the child, most often fathers, uncles or cousins; around 60% are other acquaintances such as friends of the family, babysitters, or neighbors; strangers are the offenders in approximately 10% of child sexual abuse cases. Most child sexual abuse is committed by men; women commit approximately 14% of offenses reported against boys and 6% of offenses reported against girls. Most offenders who abuse pre-pubescent children are pedophiles, however a small percentage do not meet the diagnostic criteria for pedophilia

Under the law, "child sexual abuse" is an umbrella term describing criminal and civil offenses in which an adult engages in sexual activity with a minor or exploits a minor for the purpose of sexual gratification. *The American Psychiatric Association* states that "children cannot consent to sexual activity with adults", and condemns any such action by an adult: "An adult who engages in sexual activity with a child is performing a criminal and immoral act which never can be considered normal or socially acceptable behavior." Incest between a child or adolescent and a related adult has been identified as the most widespread form of child sexual abuse with a huge capacity for damage to a child. One researcher stated that more than 70% of abusers are immediate family members or someone very close to the family. Another researcher stated that about 30% of all perpetrators of sexual abuse are related to their victim, 60% of the perpetrators are family acquaintances, like a neighbor, babysitter or friend and 10% of the perpetrators in child sexual abuse cases are strangers. A Child sexual abuse offense where the perpetrator is related to the child, either by blood or marriage, is a form of incest described as interfamilial child sexual abuse. The most-often reported

form of incest is father-daughter and stepfather-daughter incest, with most of the remaining reports consisting of mother/stepmother-daughter/son incest. Father-son incest is reported less often, however it is not known if the prevalence is less, because it is under-reported by a greater margin. Prevalence of parental child sexual abuse is difficult to assess due to secrecy and privacy; some estimates show 20 million Americans have been victimized by parental incest as children

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

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

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

Child sexual abuse occurs frequently in Western society. The rate of prevalence can be difficult to determine. In the UK it is estimated at about 8% for boys and 12% for girls. The estimates for the United States vary widely. A literature review of 23 studies found rates of 3% to 37% for males and 8% to 71% for females, which produced an average of 17% for boys and 28% for girls, while a statistical analysis based on 16 cross-sectional studies

estimated the rate to be 7.2% for males and 14.5% for females. The US *Department of Health and Human Services* reported 83,600 substantiated reports of sexually abused children in 2005.Including incidents which were not reported would make the total number even larger. Surveys have shown that one fifth to one third of all women reported some sort of childhood sexual experience with a male adult. One study found that professionals failed to report approximately 40% of the child sexual abuse cases they encountered. A study by Lawson & Chaffin indicated that many children who were sexually abused were "identified solely by a physical complaint that was later diagnosed as a venereal disease...Only 43% of the children who were diagnosed with venereal disease made a verbal disclosure of sexual abuse during the initial interview." It has been found in the epidemiological literature on CSA that there is no identifiable demographic or family characteristic of a child that can be used to bar the prospect that a child has been sexually abused.

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

Human Trafficking

The growing awareness of human trafficking in the United States and abroad requires government and human services agencies to reevaluate old policies and develop new ones for identifying and serving victims. Due to their potentially unstable living situations, physical distance from friends and family, traumatic experiences, and emotional vulnerability, children involved with child welfare are at risk for being targeted by traffickers who are actively seeking children to exploit. Recent Federal legislation established new requirements for child welfare agencies related to identifying and serving minor victims of human trafficking.

There are many forms of human trafficking related to minors. Although several definitions are included in this section, please visit the following link for more in depth statues https://www.childwelfare.gov/pubPDFs/definitions_trafficking.pdf

Both U.S. citizens and foreign national children can be victims of human trafficking within the United States. Federal law generally categorizes severe forms of trafficking in persons into either labor trafficking or sex trafficking.

- **Labor trafficking**. Per the Trafficking Victims Protection Act of 2000 (TVPA), which is part of the Victims of Trafficking and Violence Protection Act of 2000 (P.L. 106-386), labor trafficking is the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services through the use of force, fraud, or coercion in order to subject that person to involuntary servitude, peonage, debt bondage, or slavery. The definition of labor trafficking in the TVPA does not distinguish between children and adults, which means that children also must encounter force, fraud, or coercion to be victims of labor trafficking. Examples of labor trafficking include agricultural or domestic service workers and travelling sales crews that force children to sell legal items (e.g., magazines) or illegal items (e.g., drugs).

- **Sex trafficking**. The TVPA, as amended, defines sex trafficking as "the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purpose of commercial sex." While adults must be compelled to perform commercial sex by force, fraud, or coercion in order for it to be considered a severe form of trafficking in persons, this is not the case for children. By law, children under the age of

18 who are induced to engage in a commercial sex act are considered victims of sex trafficking. In addition to a minor engaging in a sex act in exchange for money, examples of sex trafficking include a minor engaging in "survival" sex (i.e., the victim engages in sex in order to obtain basic needs such as food, shelter, or clothing, which are considered something of value) and participating in certain types of pornography. Professionals in child welfare and related fields typically use the words "victims" or "survivors" to refer to individuals who have experienced or were experiencing human trafficking. The use of the term "victim" often has legal implications for foreign nationals in terms of their eligibility for services, legal standing, and rights, whereas the term "survivor" is frequently used to connote the strength and resilience of individuals who were exploited through human trafficking. Although the terms are sometimes used interchangeably in the field, this section uses the term "victim" while still acknowledging the strength and resiliency of those who have been trafficked.

There are several common misperceptions about trafficking (Center for the Human Rights for Children & International Organization for Adolescents):

➡ **Myth**: Trafficking always involves transporting the victim across State, country, or other borders.
✓ **Reality**: This is not included in the Federal definition of trafficking. An individual can be recruited and exploited for labor or commercial sex without having crossed any borders.
➡ **Myth**: All human trafficking victims in the United States are from other countries.
✓ **Reality**: Trafficking victims may be U.S. citizens or foreign nationals.
➡ **Myth**: Individuals must be physically restrained or locked up to be a victim.
✓ **Reality**: While some victims may be physically held by their trafficker, psychological means of control (e.g., trauma bonds, threats, coercion) are far more common.

For more information about how States classify human trafficking, view Information Gateway's Definitions of Human Trafficking at https://

www.childwelfare.gov/topics/systemwide/laws-policies/statutes/definitions-trafficking

Scope of Human Trafficking

The exact number of child victims of human trafficking in the United States is unknown, and trying to determine the number is difficult. The number of exploited children or children at risk for exploitation varies widely from source to source, often due to differences in definitions and methodologies. Challenges to data collection include victims of trafficking not self-identifying due to factors such as complex trauma, trauma bonds, and normalization of victimization. Additionally, victims may fear talking to authorities, distrust service providers, or may have been coached by their traffickers on what to say while talking to others. These factors, among others, often make it difficult for those screening for trafficking victims or collecting data to recognize victims. Nonetheless, there are various studies and organizations that provide a glimpse at how many children may be victims of human trafficking. One in six of the more than 18,500 children reported to the National Center for Missing and Exploited Children (2017a) as missing were the victims of child sex trafficking. It is important to remember that existing national data are not reliable indicators of the prevalence of human trafficking. The true prevalence of sex and labor trafficking is unknown, and most service providers believe that these statistics underestimate the scope of the problem.

Background

Although human trafficking is by no means a new issue, in recent years public agencies have strengthened their focus on its identification and prevention as well as treatment for its victims. The following provides information about the definitions of human trafficking, the scope of the problem, and the connection with child welfare.

Additional Definitions and Statistics

All 50 states, the District of Columbia, and the U.S. Territories have child abuse and neglect reporting laws that mandate certain professionals and institutions refer suspected maltreatment to a child protective services (CPS) agency.

Each state has its own definitions of child abuse and neglect that are based on standards set by federal law. Federal legislation provides a foundation for

states by identifying a set of acts or behaviors that define child abuse and neglect. The Child Abuse Prevention and Treatment Act (CAPTA), (P.L. 100–294), as amended by the CAPTA Reauthorization Act of 2010 (P.L. 111–320), retained the existing definition of child abuse and neglect as, at a minimum: Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act, which presents an imminent risk of serious harm.

The Justice for Victims of Trafficking Act added the requirement to include sex trafficking victims in the definition of child abuse and neglect. The following pages provide a summary of key information from this report. The information is provided in a question and answer format as the Children's Bureau is anticipating the most common questions for each chapter of the report. Please refer to the individual chapters for detailed information about each topic and the relevant data.

The most recent data available includes statistics through 2019. For 2019, CPS agencies received a national estimate of 4.4 million (4,378,000) total referrals. The 4.4 million total referrals alleging maltreatment includes approximately 7.9 million (7,880,400) children. The national rate of screened-in referrals (reports) is 32.2 per 1,000 children in the national population. Among the 45 states that report both screened-in and screened-out referrals, 54.5 percent of referrals are screened in and 45.5 percent are screened out.

Who Reported Child Maltreatment?

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. See Appendix D, State Commentary, for additional information provided by the states as to what is included in "other." (See chapter 2.)

Who Were the Child Victims?

For FFY 2019, there are nationally 656,000 (rounded) victims of child abuse and neglect. The victim rate is 8.9 victims per 1,000 children in the population. (See chapter 3.) Victim demographics include:

- ➡ Children in their first year of life have the highest rate of victimization at 25.7 per 1,000 children of the same age in the national population.
- ➡ The victimization rate for girls is 9.4 per 1,000 girls in the population, which is higher than boys at 8.4 per 1,000 boys in the population.
- ➡ American-Indian or Alaska Native children have the highest rate of victimization at 14.8 per 1,000 children in the population of the same race or ethnicity; and
- ➡ African- American children have the second highest rate at 13.7 per 1,000 children of the same race or ethnicity.

How Many Children Died from Abuse or Neglect?

Child fatalities are the most tragic consequence of maltreatment. For FFY 2019, a national estimate of 1,840 children died from abuse and neglect at a rate of 2.50 per 100,000 children in the population. The child fatality demographics show:

- ➡ The youngest children are the most vulnerable to maltreatment, with 45.4 percentof child fatalities younger than 1 year old and who died at a rate of 22.94 per100,000 children in the population of the same age.
- ➡ Boys have a higher child fatality rate at 2.98 per 100,000 boys in the populationwhen compared with girls at 2.20 per 100,000 girls in the population.
- ➡ The rate of African-American child fatalities (5.06 per 100,000 African-Americanchildren) is 2.3 times greater than the rate of White children (2.18 per 100,000White children) and 2.7 times greater than the rate of Hispanic children (1.89 per100,000 Hispanic children).

Who Abused and Neglected Children?

A perpetrator is the person who is responsible for the abuse or neglect of a child. Fifty-two states reported 525,319 perpetrators. (See chapter 5.) The analyses of case-level data show:

- ➡ 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.

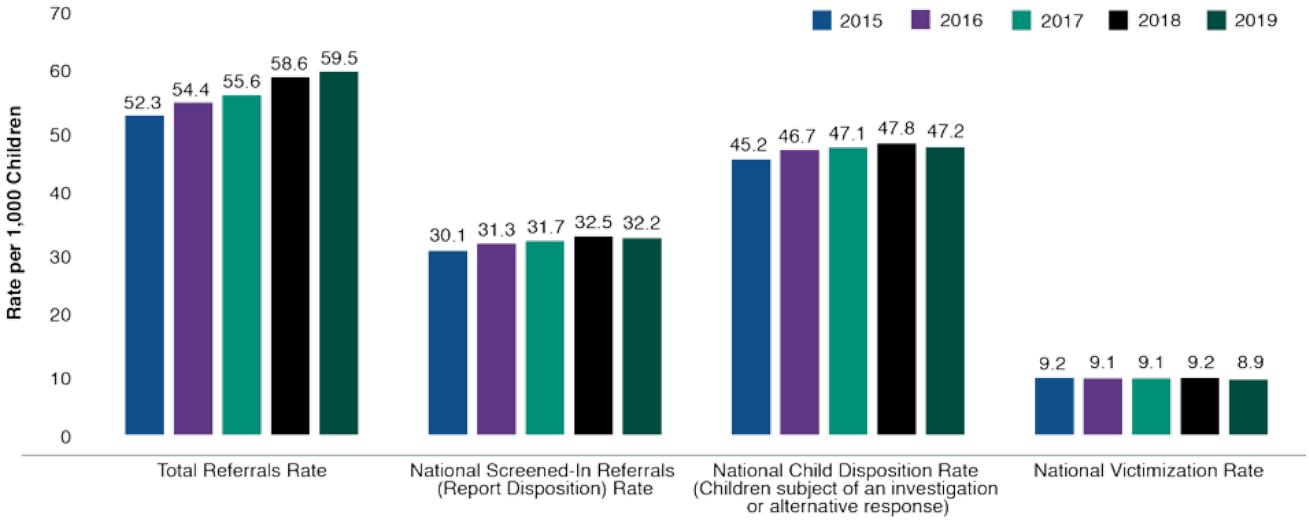
Who Received Services?
CPS agencies provide services to children and their families, both in their homes and in foster care. Reasons for providing services may include (1) preventing future instances of child maltreatment and (2) remedying conditions that brought the children and their family to the attention of the agency. During 2019:
✳ Forty-seven states reported approximately 1.9 million children received prevention services.
✳ Approximately 1.3 million children received post-response services from a CPS agency.
✳ Two-thirds (60.8%) of victims and one third (27.7%) of non-victims received post-response services.

How Many Victims of Sex Trafficking are There?
The Justice for Victims of Trafficking Act of 2015 includes an amendment to CAPTA to collect and report the number of children determined to be victims of sex trafficking. This is the second year for which states are reporting the new maltreatment type of sex trafficking. For FFY 2019, 29 states report 877 unique victims of sex trafficking.

How Many Infants with Prenatal Substance Exposure are There?
The Comprehensive Addiction and Recovery Act (CARA) of 2016 includes an amendment to CAPTA to collect and report the number of infants with prenatal substance exposure (IPSE), IPSE with a plan of safe care, and IPSE with a referral to appropriate services. FFY 2019 data show 38,625 children in 47 states were referred to CPS agencies as IPSE. Of those:
✦ Fewer than 1.0 percent (0.7%) had the alcohol abuse child risk factor.
✦ Nearly 71.0 percent (70.9%) had the drug abuse child risk factor.
✦ More than 11.0 percent (11.4%) had both the alcohol and drug abuse child factors.
✦ More than 83.0 percent (83.1%) were screened in for an investigation response or alternative response.

A summary of national rates per 1,000 children is provided below (S–1).

Exhibit S–1 Summary Child Maltreatment Rates per 1,000 Children, 2015–2019



New Reporting to NCANDS

FFY 2019 is the second year states are reporting data from two enacted laws that amended CAPTA and require states to report certain data elements to the extent practicable:

- The Justice for Victims of Trafficking Act of 2015 (P.L. 114–22)—the number of children determined to be victims of sex trafficking.
- The Comprehensive Addiction and Recovery Act of 2016 (P.L. 114–198)—the number of infants identified by healthcare providers as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder; the number of infants with prenatal substance exposure with safe care plans and the number of infants with prenatal substance exposure for whom appropriate service referrals were made, including services for the affected parent or caregiver.

Screening

A referral may be either screened in or screened out. Referrals that meet CPS agency criteria are screened in (and called reports) and receive an investigation or alternative response from the agency. Referrals that do not meet agency criteria are screened out or diverted from CPS to other

community agencies. Reasons for screening out a referral vary by state policy, but may include one or more of the following:

- ❖ Does not concern child abuse and neglect.
- ❖ Does not contain enough information for a CPS response to occur.
- ❖ Response by another agency is deemed more appropriate.
- ❖ Children in the referral are the responsibility of another agency or jurisdiction (e.g., military installation or tribe).
- ❖ Children in the referral are older than 18 years.

During FFY 2019, CPS agencies across the nation screened in 2.4 million (2,368,325) referrals in all 52 reporting states. This is a 5.8 percent increase from the 2.2 million (2,237,754) screened-in referrals during 2015. (See exhibit 2–A and related notes.)

Exhibit 2–A Screened-in Referral Rates, 2015–2019

Year	Reporting States	Child Population of Reporting States	Screened-in Referrals (Reports)	Rate per 1,000 Children	Child Population of 52 States	National Estimate/ Actual Screened-in Referrals
2015	52	74,350,047	2,237,754	30.1	74,350,047	2,237,754
2016	51	73,649,413	2,303,225	31.3	74,342,970	2,327,000
2017	52	74,236,882	2,356,356	31.7	74,236,882	2,356,356
2018	52	73,911,017	2,402,907	32.5	73,911,017	2,402,907
2019	52	73,611,881	2,368,325	32.2	73,611,881	2,368,325

Victims of sex trafficking may be reported up to anyone who has not reached the age of 24 years. See chapter 7 for more information about victims of sex trafficking.

Screened-in referrals are called reports and may include more than one child. Investigations are conducted on some reports in all states. This type of response includes assessing the allegation of maltreatment according to state law and policy. The primary purpose of the investigation is twofold: (1) to determine whether the child was maltreated or is at-risk of maltreatment and (2) to determine if services are needed and which services to provide.

In some states, reports (screened-in referrals) may receive an alternative response. This response is usually reserved for instances where the child is at a low or moderate risk of maltreatment. While states vary in how they implement their alternative response programs, the primary purpose is to focus on the service needs of the family. Twenty-two states report data on children in alternative response programs. See chapter 3 for more information about alternative response. In NCANDS, both investigations and alternative responses receive a CPS finding known as a disposition.

For 2019, a national estimate of 2.0 million (2,010,000) referrals were screened out. This is a 21.7 percent increase from the 1.7 million (1,651,000) screened-out referrals for 2015. (See exhibit 2–B and related notes.)

Exhibit 2–B Screened-out Referral Rates, 2015–2019

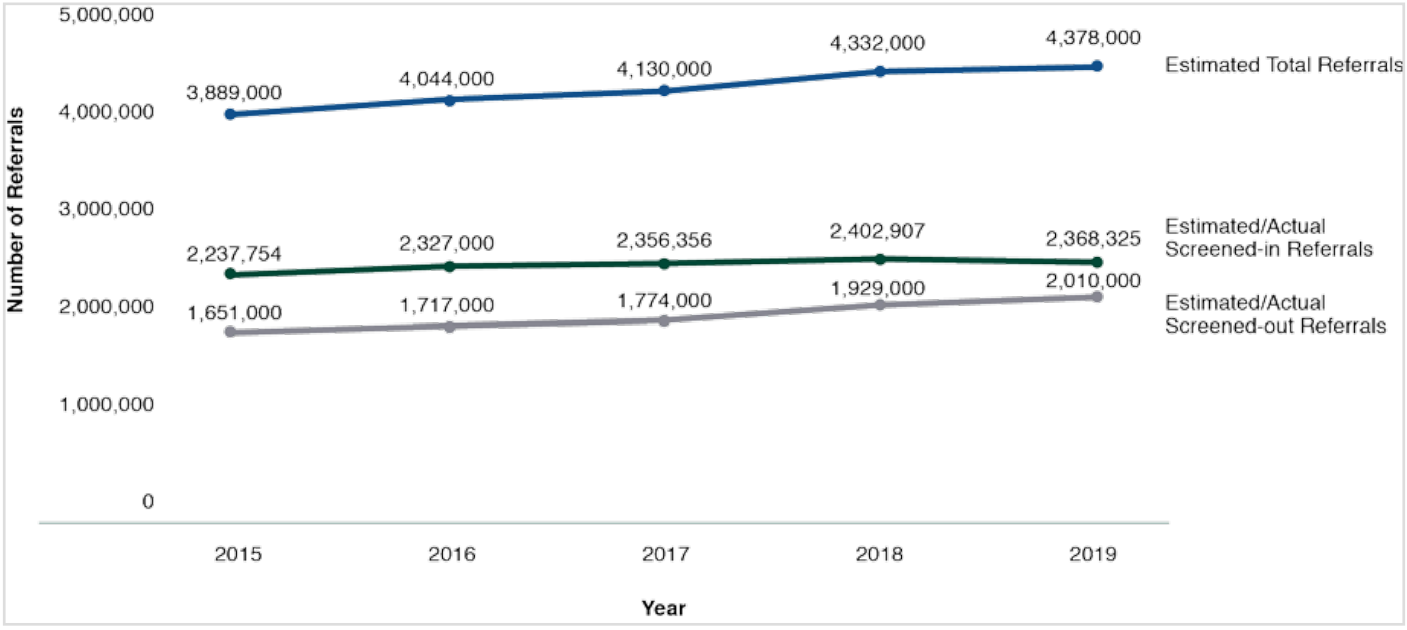
Year	Reporting States	Reporting States	Screened-out Referrals	Children	of 52 States	Referrals
2015	44	59,031,209	1,310,716	22.2	74,350,047	1,651,000
2016	45	59,453,054	1,374,053	23.1	74,342,970	1,717,000
2017	45	59,471,036	1,421,252	23.9	74,236,882	1,774,000
2018	46	59,903,593	1,563,226	26.1	73,911,017	1,929,000
2019	45	59,483,042	1,625,691	27.3	73,611,881	2,010,000

For 2019, CPS agencies received a national estimate of 4.4 million (4,378,000) total referrals. This is a 12.6 percent increase from the 3.9 million (3,889,000) total referrals received for 2015. The 4.4 million total referrals alleging maltreatment includes approximately 7.9 million (7,880,400) children.4,5 (See exhibit 2–C and related notes).

Exhibit 2–C Total Referral Rates, 2015–2019

	National Estimate/ Actual Screened-in Referrals	National Estimate of Screened-out Referrals	National Estimate of Total Referrals	Child Population of all 52 States	Total Referrals Rate per 1,000 Children
2015	2,237,754	1,651,000	3,889,000	74,350,047	52.3
2016	2,327,000	1,717,000	4,044,000	74,342,970	54.4
2017	2,356,356	1,774,000	4,130,000	74,236,882	55.6
2018	2,402,907	1,929,000	4,332,000	73,911,017	58.6
2019	2,368,325	2,010,000	4,378,000	73,611,881	59.5

Exhibit 2–D Number of Referrals, 2015–2019 *The number of total referrals received by CPS increased for the past 5 years.*



Several states with the largest increases for all referrals provided the following explanations: increased public awareness of child abuse and

neglect due to media coverage of child deaths, a centralized and publicly promoted child abuse and neglect hotline, improvements to exist-ing child abuse and neglect definitions, and improvements in the ability to collect and report maltreatment allegations.

States also provided explanations for a decrease in the number of screened-in reports as due to a reduction in backlog of referrals, a change in procedures for combining multiple reports, and a policy change to stop automatically screening in any referral for children younger than 3 years. Readers are encouraged to view state comments in Appendix D, State Commentary for additional information about screening policies and state comments about increases and decreases.

Report Sources

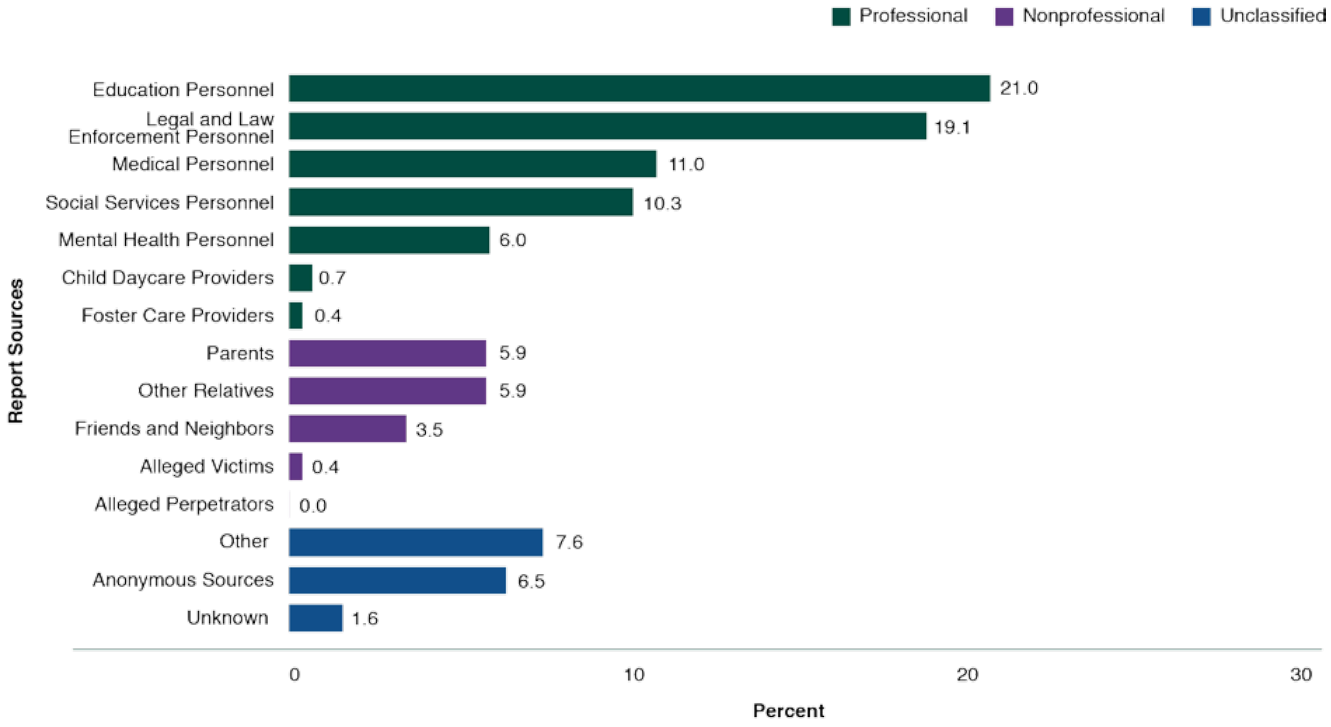
The report source is the role of the person who notified a CPS agency of the alleged child abuse or neglect in a referral. Only those sources in reports (screened-in referrals) that receive an investigation or alternative response are submitted to NCANDS. To facilitate comparisons, report sources are grouped into three categories: professional, nonprofessional, and unclassified.

Professional report sources are persons who encounter the child as part of their occupation, such as child daycare providers, educators, legal and law enforcement personnel, and medical personnel. State laws require most professionals to notify CPS agencies of suspected maltreatment (these are known as mandated reporters). Nonprofessional report sources are per-sons who do not have a relationship with the child based on their occupation, such as friends, relatives, and neighbors. State laws vary as to the requirements of nonprofessionals to report suspected abuse and neglect. Unclassified includes anonymous, "other," and unknown report sources. States use the code of "other" for any report source that does not have an NCANDS designated code. According to comments provided by the states, the "other" report source category might include such sources as religious leader, Temporary Assistance for Needy Families staff, landlord, tribal official or member, camp counselor, and private agency staff. Readers are encouraged to review Appendix D, State Commentary for additional information as to what is in the category of "other" report source.

FFY 2019 data show professionals submit 68.6 percent of reports. The highest percentages of reports are from education personnel (21.0%), legal

and law enforcement personnel (19.1%), and medical personnel (11.0%). Nonprofessionals submit 15.7 percent of reports with the largest category of nonprofessional reporters being parents (5.9%), other relatives (5.9%), and friends and neighbors (3.5%). Unclassified sources submit the remaining 15.7 percent. (See exhibit 2–E and related notes.)

Exhibit 2–E Report Sources, 2019 ***Professionals submitted the majority of screened-in referrals (reports) that received an investigation or alternative response***



The number of victims decreased nationally by 4.0 percent from 2015 to 2019. At the state level, the percent change of victims of abuse and neglect range from a 62.5 percent decrease to 100.0 percent increase from FFY 2015 to 2019. Changes to legislation, child welfare policy, and practice that may contribute to an increase or decrease in the number of victims are provided by states in Appendix D, State Commentary. For example, across the 5 years: one state changed its level of evidence, several states resolved investigation or assessment backlogs, and several states adopted new intake or screening processes. Other factors include the increase in reports due to

public awareness after media coverage of child deaths and severe storms that changed or reduced the population.

Exhibit 3–E Child Victimization Rates, 2015–2019

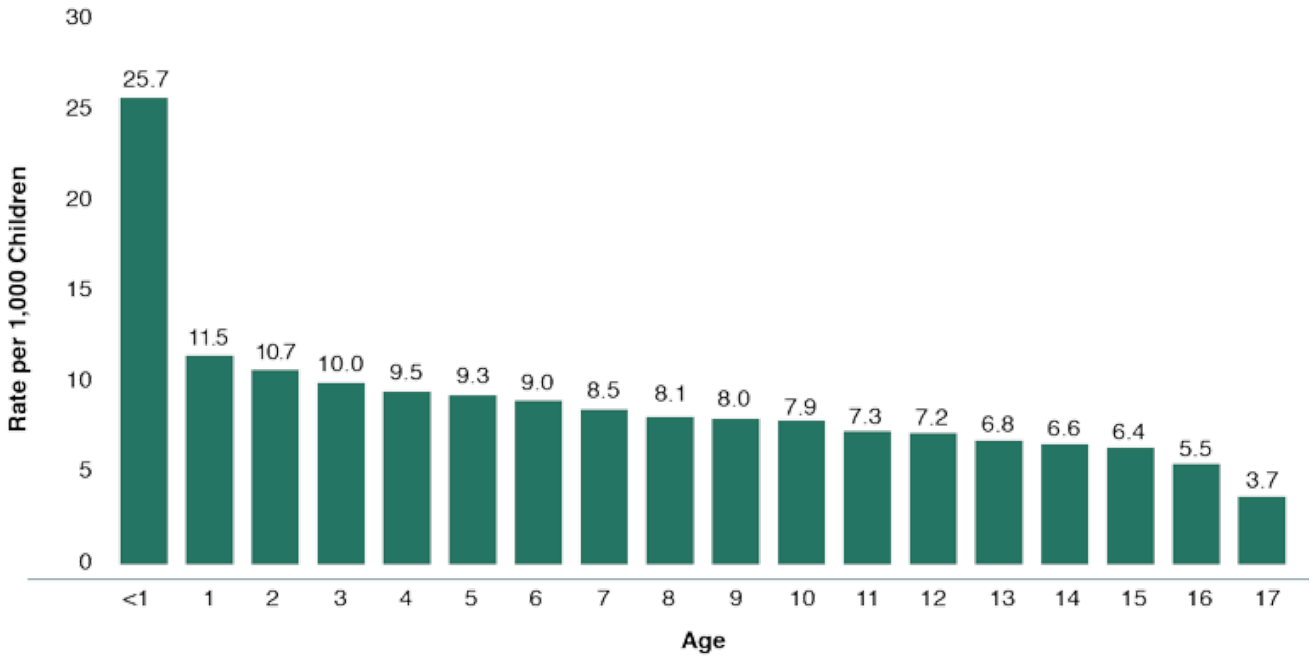
Year	Reporting States	Child Population of Reporting States	Victims from Reporting States	National Victimization Rate per 1,000 Children	Child Population of all 52 States	National Estimate/ Rounded Number of Victims
2015	52	74,350,047	683,221	9.2	74,350,047	683,000
2016	51	73,649,413	671,176	9.1	74,342,970	677,000
2017	52	74,236,882	673,630	9.1	74,236,882	674,000
2018	52	73,911,017	677,464	9.2	73,911,017	677,000
2019	52	73,611,881	656,243	8.9	73,611,881	656,000

Child Victim Demographics (unique count of child victims)
The youngest children are the most vulnerable to maltreatment. Nationally, more than one-quarter (28.1%) of victims are in the age range of birth through 2 years old. Victims younger than 1 year are 14.9 percent of all victims. The victimization rate is highest for children younger than 1 year old at 25.7 per 1,000 children in the population of the same age. This is more than double the rate of victims who are 1 year old (11.5 per 1,000 children). Victims who are 2 or 3 years old have victimization rates of 10.7 and 10.0 victims per 1,000 children of those respective ages in the population. Readers may notice some states have lower rates across age groups than other states. The states with lower rates may assign low-risk cases to alternative response or have other state policies or programs in place for maltreatment allegations. In general, the rate of victimization decreases with the child's age. (See exhibit 3–F.)

The percentages of child victims are similar for both boys (48.3%) and girls (51.4%). The sex is unknown for 0.3 percent of victims. The FFY 2019 victimization rate for girls is 9.4 per 1,000 girls in the population, which is higher than boys at 8.4 per 1,000 boys in the population. (See table 3–7 and related notes.) Most victims are one of three races or ethnicities—White (43.5%), Hispanic (23.5%), or African-American (20.9%). The racial distributions for all children in the population are 50.2 percent White, 25.6 percent Hispanic, and 13.7 percent African-American. (See table C–3 and related notes.) For FFY 2019, American-Indian or Alaska Native children

have the highest rate of victimization at 14.8 per 1,000 children in the population of the same race or ethnicity and African-American children have the second highest rate at 13.8 per 1,000 children in the population of the same race or ethnicity.

Exhibit 3–F Victims by Age, 2019 ***The youngest children are the most vulnerable to maltreatment***



Risk Factors

Risk factors are characteristics of a child or caregiver that may increase the likelihood of child maltreatment. NCANDS collects data for 9 child risk factors and 12 caregiver risk factors. Risk factors can be difficult to accurately assess and measure, and therefore may go undetected among many children and caregivers. Some states may not have the resources to gather information from other sources or agencies or have the ability to collect or store certain information in their child welfare system. In addition, some risk factors must be clinically diagnosed, which may not occur during the investigation or alternative response. If the case is closed prior to the diagnosis, the CPS agency may not be notified, and the information will not be reported to NCANDS.

Child Fatalities

The effects of child abuse and neglect are serious, and a child fatality is the most tragic consequence. NCANDS collects case-level data in the Child File on child deaths from maltreatment. Additional counts of child fatalities, for which case-level data are not known, are reported in the Agency File. Some child maltreatment deaths may not come to the attention of CPS agencies. Reasons for this include if there were no surviving siblings in the family, or if the child had not (prior to his or her death) received child welfare services.

The child fatality count in this section reflects the FFY in which the deaths are determined as due to maltreatment. The year in which a determination is made may be different from the year in which the child died. CPS agencies may need more time to determine a child died due to maltreatment. The time needed to conclude if a child was a victim of maltreatment often does not coincide with the timeframe for concluding that the death was a result of maltreatment due to multiple agency involvement and multiple levels of review for child deaths. The "maltreatment death date" field differentiates the year in which the death was reported to NCANDS in the Child File from the year in which the child died. For FFY 2019 data, 87.9 percent of child fatality reviews reach a determination about whether the death is due to maltreatment in 2 years or less.7 *7 Out of 1,515 fatalities reported in the Child File, 1,331 have a maltreatment death date in FFY 2018 or FFY 2019.*

Number of Child Fatalities

For FFY 2019, a national estimate of 1,840 children died from abuse and neglect at a rate of 2.50 per 100,000 children in the population. The 2019 national estimate is a 10.8 percent increase from the 2015 national estimate of 1,660.8 *8 Not all states report fatality data. The percent change is calculated using the national estimates for FFY 2015 and FFY 2019.*

Exhibit 4–A 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

Maltreatment Types

The Child Maltreatment report includes only those maltreatment types that have a disposition of substantiated or indicated by the CPS response. It is important to note that while these maltreatment types likely contributed to the cause of death, NCANDS does not have a field for collecting the official cause of death. Of the children who died, 72.9 percent suffered neglect and 44.4 percent suffered physical abuse either exclusively or in combination with another maltreatment type. The majority of the child fatalities reported with the "other" maltreatment type is due to one state that reports death as "other" in combination with additional maltreatments. The NCANDS Technical Team is working with this state to improve reporting. (See exhibit 4–E.)

Risk Factors

Risk factors are characteristics of a child or caregiver that may increase the likelihood of child maltreatment. Risk factors can be difficult to accurately

assess and measure, and therefore may go undetected among many children and caregivers. Some states are able to report data on caregiver risk factors for children who died as a result of maltreatment. Caregivers with these risk factors may or may not be the perpetrator responsible for the child's death. Please see the Risk Factors section in chapter 3 or Appendix B, Glossary, for more information and the NCANDS' definitions of these risk factors.

Exhibit 4–E Maltreatment Types of Child Fatalities, 2019

Maltreatment Type	Child Fatalities	Maltreatment Types	Maltreatment Types Percent
Medical Neglect	-	118	7.8
Neglect	-	1,105	72.9
Other	-	120	7.9
Physical Abuse	-	673	44.4
Psychological Abuse	-	14	0.9
Sexual Abuse	-	14	0.9
Sex Trafficking	-	-	-
Unknown	-	-	-
National	**1,515**	**2,044**	**-**

Based on data from 45 states. Data are from the Child File. A child may have suffered from more than one type of maltreatment and therefore, the total number of reported maltreatments exceeds the number of fatalities, and the total percentage of reported maltreatments exceeds 100.0 percent. The percentages are calculated against the number of child fatalities in the reporting states. Dashes are inserted into cells without any data included in this analysis.

Sex Trafficking

Child Maltreatment 2019 is the second report to include a special focus chapter. The purpose of this chapter is to highlight analyses of specific subsets of children. These analyses may otherwise have been spread throughout the report in different chapters, which can make it more difficult for readers to see the whole analytical picture. Some analyses are expected to change with each edition of Child Maltreatment. Similar to last year, the analyses included in this chapter for FFY 2019 focus on the data elements for sex trafficking and infants with prenatal substance exposure.

States are instructed to include sex trafficking cases by caregivers and non-caregivers in their NCANDS submissions. The Children's Bureau Information Memoranda ACYF-CB-IM-15-05 dated July 16, 2015, informed states that these data will be reported, to the extent practicable, to NCANDS.12 States began reporting these data with their FFY 2018 data submissions.

NCANDS added sex trafficking as a new maltreatment type, defined as: Sex trafficking: A type of maltreatment that refers to the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act. States have the option to report to NCANDS any sex trafficking victim who is younger than 24 years.

While states report all allegations regardless of the determination as to whether the maltreatment occurred, this report only presents maltreatment types that were substantiated or indicated. As this is the second year of reporting the sex trafficking maltreatment type, most reporting states provided a full year of data, however some states that began reporting this year may have submitted only a partial-year for these elements and will submit a full year with its FFY 2020 submission. A number of states are making internal changes to systems to report data already captured or are working to capture it. Two states are developing new child welfare systems and will add the maltreatment type to the new system.

Number and Demographics of Victims of Sex Trafficking (unique count of victims)

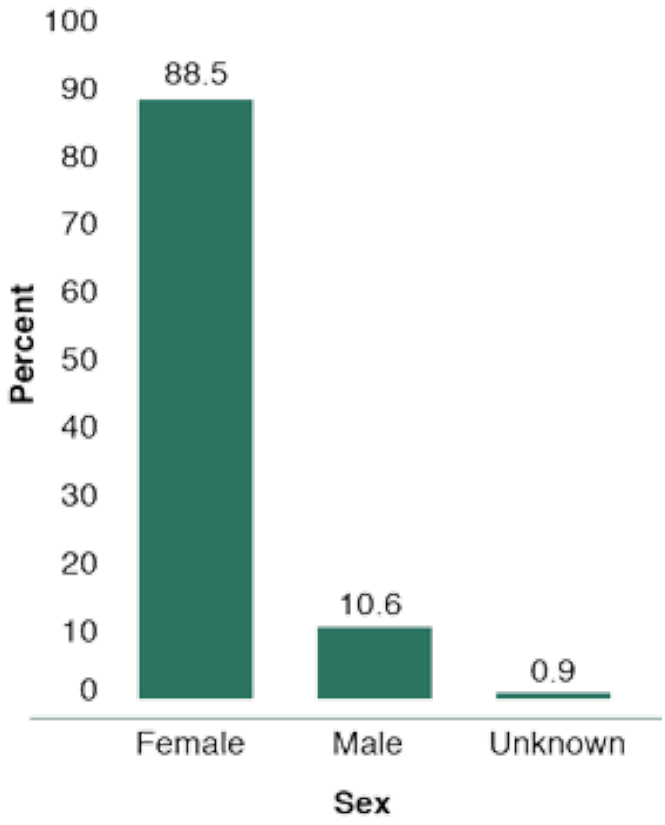
For FFY 2019, 29 states report 877 unique victims of sex trafficking. Analyzing victims of sex trafficking by demographics shows different patterns of abuse than for victims of all maltreatment types analyzed

together. The percentages of victims are evenly split by sex. However, for victims of the sex trafficking maltreatment type, the majority (88.5%) are female and 10.6 percent are male.

Different patterns also are seen by age. For victims of all maltreatment types, the youngest children are the most vulnerable to maltreatment as 28.1 percent are younger than 3 years and the percentages decrease for older victims. For victims of sex trafficking, less than 1.0 percent are younger than 3 years and the percentages increase for older victims. More than three-quarters of victims of sex trafficking are in the age range of 14–17.

Maltreatment Types (unique count of victims of sex trafficking, duplicate count of maltreatments)
Federal guidance is to report sex trafficking separately and not only in combination with sexual abuse. For both sexes, approximately one-half of the victims of sex trafficking (49.7% for female and 50.5% for male) are reported to NCANDS as victims of sex trafficking only and did not suffer any other maltreatment types. For those victims who did suffer from two or more maltreatment types, the highest percentages for females are sexual abuse with 30.7 percent and neglect with 22.7 percent. For males the categories are reversed, with 30.1 percent for neglect and 28.0 percent for sexual abuse.

Exhibit 7–A Victims of Sex Trafficking by Sex, 2019 ***Most sex trafficking victims are female***



Perpetrator Relationship (unique count of victims of sex trafficking, duplicate count of maltreatments)

Some of the categories on this table changed for *Child Maltreatment 2019*. The purpose of the changes is to be more descriptive of what the categories include and to reduce the number of relationships counted as unknown. Please see the table notes at the end of this chapter for Child Maltreatment 2019 specifics about the changes. More than one-half (51.3%) of victims of sex trafficking have an unknown or missing relationship to their perpetrators and more than 40.0 percent (41.4%) have no parental involvement in their maltreatment. The largest non-parent category is "other(s)" (31.1%). In NCANDS the term "other(s)" means not otherwise classified. One of the challenges for states with collecting these data is that the sex trafficker may not be the victim's caregiver. As the focus of CPS agencies is on caregivers, some states may not be able to collect non-caregiver sex trafficker perpetrator data due to agency scope and jurisdiction restrictions. The NCANDS category of "other(s)" perpetrator relationship includes any relationship that does not map to one of the NCANDS relationship categories. According to states' commentary, this category includes non-related adult, non-related child, foster sibling, babysitter, household staff, clergy, and school personnel.

Victims of sex trafficking have different relationship patterns to their perpetrators than victims of all maltreatment types analyzed together. As shown in table 3–12, 91.4 percent of victims are maltreated by one or more parents. However, for sex trafficking victims, only 13.6 percent are maltreated by a parent. (See exhibit 7–B)

Exhibit 7–B Victims of Sex Trafficking by Relationship Category to Their Perpetrators, 2019 ***More than one-half of sex trafficking victims have an unknown or missing relationship with their perpetrators***

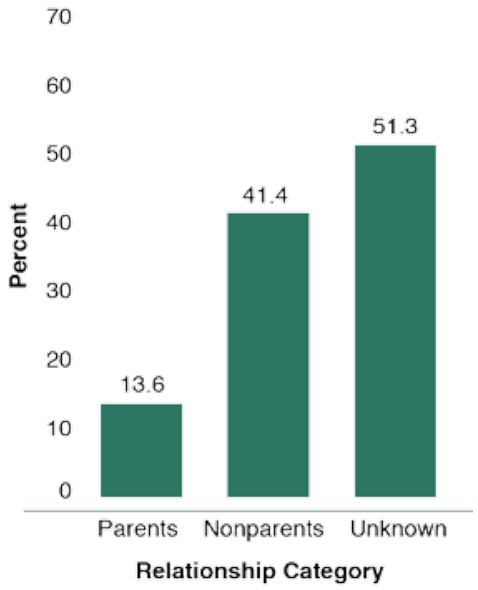


Table 7–4 Victims of Sex Trafficking by Relationship to Their Perpetrators, 2019

PERPETRATOR	Sex Trafficking Victims	Relationships	Relationships Percent
PARENT	-	-	-
Father	-	49	5.6
Father and Nonparent(s)	-	4	0.5
Mother	-	42	4.8
Mother and Nonparent(s)	-	10	1.1
Two Parents of known sex	-	5	0.6
Three Parents of known sex	-	-	-
Two Parents of known sex and Nonparent	-	-	-
One or more Parents of Unknown Sex	-	9	1.0
Total Parents	-	**119**	**13.6**
NONPARENT	-	-	-
Child Daycare Provider(s)	-	-	-

Foster Parent(s)	-	-	-
Friend(s) and Neighbor(s)	-	26	3.0
Group Home and Residential Facility Staff	-	2	0.2
Legal Guardian(s)	-	-	-
Other Professional(s)	-	6	0.7
Relative(s)	-	29	3.3
Unmarried Partner(s) of Parent	-	9	1.0
Other(s)	-	271	31.1
More Than One Nonparental Perpetrator	-	18	2.1
Total Nonparents	-	**361**	**41.4**
UNkNOWN	**-**	**447**	**51.3**
National	**872**	**927**	**106.3**

2. Child Abuse Screening and Assessment

Recognizing Signs of Abuse and Neglect

In addition to working to prevent a child from experiencing abuse or neglect, it is important to recognize high-risk situations and the signs and symptoms of maltreatment.

The following signs may signal the presence of child abuse or neglect. The Child:

- Shows sudden changes in behavior or school performance • Has not received help for physical or medical problems brought to the parents' attention
- Has learning problems (or difficulty concentrating) that cannot be attributed to specific physical or psychological causes
- Is always watchful, 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
- Is reluctant to be around a particular person
- Discloses maltreatment

The Parent:

- Denies the existence of—or blames the child for—the child's problems in school or at home
- Asks teachers or other caregivers to use harsh physical discipline if the child misbehaves
- Sees the child as entirely bad, worthless, or burdensome
- Demands a level of physical or academic performance the child cannot achieve
- Looks primarily to the child for care, attention, and satisfaction of the parent's emotional needs
- Shows little concern for the child

The Parent and Child:

- Rarely touch or look at each other
- Consider their relationship entirely negative
- State that they do not like each other

The above list may not be *all* the signs of abuse or neglect. It is important to pay attention to other behaviors that may seem unusual or concerning. In addition to these signs and symptoms, Child Welfare Information Gateway provides information on the risk factors and perpetrators of child abuse and neglect fatalities: https://www. childwelfare.gov/can/risk_perpetrators.cfm

Signs of Physical Abuse

Consider the possibility of physical abuse when the child:

★ Has unexplained burns, bites, bruises, broken bones, or black eyes
★ Has fading bruises or other marks noticeable after an absence from school
★ Seems frightened of the parents and protests or cries when it is time to go home
★ Shrinks at the approach of adults
★ Reports injury by a parent or another adult caregiver
★ Abuses animals or pets

Consider the possibility of physical abuse when the parent or other adult caregiver:

★ Offers conflicting, unconvincing, or no explanation for the child's injury, or provides an explanation that is not consistent with the injury
★ Describes the child as "evil" or in some other very negative way
★ Uses harsh physical discipline with the child
★ Has a history of abuse as a child
★ Has a history of abusing animals or pets

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

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

As a clinician concerned about a child whom you suspect is being abused, the best way to begin is by talking to the child.

✓ Start with open-ended questions. Don't assume that the child is being abused. There may be many explanations for why a child is behaving in a particular way or for how a child was injured. Some children have conditions, such as osteogenesis or blood clotting disorders that make them more vulnerable to bruising and/or broken bones.

✓ If the child has a visible injury, ask how the child was injured. Ask open-ended follow-up questions to look for inconsistencies if the explanation for the injury seems implausible or doesn't match the injuries.

There are many reasons why children don't tell about physical abuse, including:Fear that their parents will be mad at them or will hurt them worse for telling

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

Signs of Neglect

Consider the possibility of neglect when the child:

❖ Is frequently absent from school
❖ Begs or steals food or money
❖ Lacks needed medical or dental care, immunizations, or glasses
❖ Is consistently dirty and has severe body odor
❖ Lacks sufficient clothing for the weather
❖ Abuses alcohol or other drugs
❖ States that there is no one at home to provide care

Consider the possibility of neglect when the parent or other adult caregiver:

❖ Appears to be indifferent to the child
❖ Seems apathetic or depressed
❖ Behaves irrationally or in a bizarre manner
❖ Is abusing alcohol or other drugs

Signs of Sexual Abuse

Consider the possibility of sexual abuse when the child:

- ✦ Has difficulty walking or sitting
- ✦ Suddenly refuses to change for gym or to participate in physical activities
- ✦ Reports nightmares or bedwetting
- ✦ Experiences a sudden change in appetite
- ✦ Demonstrates bizarre, sophisticated, or unusual sexual knowledge or behavior
- ✦ Becomes pregnant or contracts a venereal disease, particularly if under age 14
- ✦ Runs away
- ✦ Reports sexual abuse by a parent or another adult caregiver
- ✦ Attaches very quickly to strangers or new adults in their environment

Consider the possibility of sexual abuse when the parent or other adult caregiver:

- ❖ Is unduly protective of the child or severely limits the child's contact with other children, especially of the opposite sex
- ❖ Is secretive and isolated
- ❖ Is jealous or controlling with family members

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

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

Although many children who have experienced sexual abuse show behavioral and emotional changes, many others do not. It is therefore critical to focus not only on detection, but on prevention and communication—by teaching children about body safety and healthy body boundaries, and by encouraging open communication about sexual matters.

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

Signs of Emotional Maltreatment

Consider the possibility of emotional maltreatment when the child:

- Shows extremes in behavior, such as overly compliant or demanding behavior, extreme passivity, or aggression
- Is either inappropriately adult (parenting other children, for example) or inappropriately infantile (frequently rocking or head-banging, for example)
- Is delayed in physical or emotional development
- Has attempted suicide
- Reports a lack of attachment to the parent

Consider the possibility of emotional maltreatment when the parent or other adult caregiver:

- Constantly blames, belittles, or berates the child
- Is unconcerned about the child and refuses to consider offers of help for the child's problems
- Overtly rejects the child

Human Trafficking and Child Welfare

Understanding Victim Needs Children who have been victims of trafficking have many needs similar to those of children who enter the child welfare system through other circumstances. For instance, children who have been trafficked need health care, mental health services, a safe place to live, help with education, and facilitated reconnections with family members. These are discussed below, along with some of the aspects that distinguish trafficking victims' needs from those of other children receiving child welfare services.

Physical Health

Children who have been trafficked often have experienced physical abuse, neglect (including medical and dental neglect), emotional abuse, and sexual abuse. Associated with this abuse, they may suffer from broken bones and other untreated internal and external injuries; sexually transmitted diseases, including HIV; and malnutrition. Their overall health may show the consequences of long periods of poor or no medical or dental care. Clinicians and child welfare professionals can help by ensuring that victims have access to medical screenings and treatment to address both immediate and long-term concerns. Connecting with a competent health-care provider who has experience with victims of trafficking may also provide reassurance to victims who may be reluctant to seek care.

*Behavioral Healt*h

Children who have been trafficked often have an array of complex behavioral health needs. Victims may have experienced regular beatings, sexual assault, and other acts of violence. Most children who have been trafficked have a need for long-term, intensive behavioral health services that can help them move forward into a new, healthier life. Studies have identified a number of mental health symptoms associated with trafficking, including post-traumatic stress disorder, panic attacks, obsessive-compulsive disorder, generalized anxiety disorder, major depressive disorder, dissociative disorders, and substance use. Screening by qualified behavioral health providers who have experience with youth who have been trafficked can be the first step to getting help. Screening can help determine the type of therapy that might be most useful. Clinicians and child welfare workers can help facilitate access to appropriate treatment providers.

Trafficking Prevention

The prevention of human trafficking requires a comprehensive, multidisciplinary approach that is coordinated at the local, State, national, and international levels. The child welfare field should be a key partner in any efforts, and it is especially suited to take the lead in efforts to curtail the victimization of children in or formerly in foster care, particularly those who run away from foster care. As mentioned earlier, a large percentage of children who are trafficking victims had been involved with child welfare. Child welfare agencies can help children in foster care and congregate care recognize situations and factors that increase their risk of being trafficked and also help them understand that they are safe in their placements, especially if they are victims who have escaped their traffickers. Traffickers may attempt to recruit children in foster care or group care settings (*HHS, ACF, Family and Youth Services Bureau*), and children who have been trafficked may attempt to maintain connections with the traffickers due to a trauma bond, which is sometimes referred to as Stockholm syndrome (*West & Loeffler*). For more information about youth who run away from foster care, refer to the Children's Bureau's Child Welfare Capacity Building Center for States' At Risk for Sex Trafficking: Youth Who Run Away From Foster Care at http://go.usa.gov/x9Zrx. UNICEF offers a guide for developing effective prevention efforts. Although the guide is intended for European professionals, it is applicable to U.S. efforts as well. For more information, see Reference Guide on Protecting the Rights of Child Victims of Trafficking in Europe at https://www.unicef.org/ceecis/UNICEF_Child_Trafficking34-43.pdf.

As mentioned earlier, clinicians can be an invaluable resource in helping respond to the human trafficking of children. Children involved with child welfare are at risk for being targeted by traffickers because of their potentially unstable living situations, physical distance from friends and family, traumatic experiences, and emotional vulnerability. Therefore, it is imperative that clinicians involved with child welfare be at the forefront of efforts to identify, respond to, and prevent human trafficking. This section explores how clinicians can identify and support children who have been victimized as well as children that are at greater risk for future victimization. It provides background information about the issue, strategies clinicians can use to identify and support victims and potential victims, and tools and resources that can assist clinicians.

Screening and Assessment Tools

In order for victims of human trafficking to receive the services and supports they need, child welfare and related professionals must be able to identify them. Receiving training about human trafficking is an important step toward improved identification, but professionals also need to have access to tools for screening and assessing victims and potential victims. Agencies may want to consider formally incorporating the use of these tools into their policies and practices. This could be done by using or adapting existing tools specifically designed to identify victims of human trafficking and their needs, creating new screening and assessment tools for trafficking, or by integrating trafficking indicators into tools intended to address broad child welfare-related issues. The Loyola University Center for the Human Rights of Children and the International Organization for Adolescents developed a series of tools and checklists to help child welfare professionals identify potential child victims of both sex and labor trafficking. To view these resources, including the

Since it can be difficult to document if a child is a victim of sex trafficking unless there is prior law enforcement involvement or self-identification, the Maryland Department of Human Resources (DHR) wanted to improve its identification process. DHR uses the Child and Adolescent Needs and Strengths (CANS) tool to assess children involved with its child welfare system. A supplemental CANS tool exists for assessing whether children are at risk for commercial sexual exploitation, but DHR did not want to add another assessment to the many others that caseworkers already conduct. Through a Children's Bureau grant, the University of Maryland, Baltimore (UMB) has helped DHR screen for potential victims of sex trafficking by using data already gathered in the CANS. UMB identified which items on the CANS showed increased risk for sex trafficking and developed an algorithm that is used to generate a monthly report of children at risk of sex trafficking. The caseworker then receives a notification so that she can conduct additional screening and help the child obtain services. The validity of the system was tested by using data regarding youth in the child welfare system who were already known to have been trafficked. For more information about CANS, which is a free, public domain tool, visit the Praed Foundation at http://praedfoundation.org/tools/

Rapid Screening Tool and the Comprehensive Screening and Safety Tool for Child Trafficking, refer to Building Child Welfare Response to Child Trafficking at http://www.luc.edu/media/lucedu/chrc/pdfs/BCWRHandbook2011.pdf. To view additional screening and assessment tools for sex trafficking, refer to the Children's Bureau's Child Welfare Capacity Building Collaborative's Identifying Minors and Young People Exploited Through Sex Trafficking: A Resource for Child Welfare Agencies at http://go.usa.gov/x92Md.

Identifying Human Trafficking

Child and youth victims of human trafficking often may be difficult to identify or locate. It is vitally important for clinicians, child welfare professionals, runaway and homeless youth service providers, domestic violence service providers, law enforcement, educators, and the community at large to become familiar with the warning signs that a young person is at risk or is a victim of human trafficking.

Possible Red Flags

While not an exhaustive list, these are some key red flags that could alert you to a potential trafficking situation that should be reported (U.S. Department of State, Office to Monitor and Combat Trafficking in Persons):

- ❖ Living with employer
- ❖ Poor living conditions
- ❖ Multiple people in cramped space
- ❖ Inability to speak to individual alone
- ❖ Answers appear to be scripted and rehearsed
- ❖ Employer is holding identity documents
- ❖ Signs of physical abuse
- ❖ Submissive or fearful
- ❖ Unpaid or paid very little
- ❖ Under 18 and in prostitution

Risk Factors

Victims of human trafficking are as diverse a group as any other child welfare population. They may be of any race or ethnicity, be U.S. citizens or foreign nationals, or identify with any sexual orientation or gender. Additionally, human trafficking can occur in any type of geography (e.g., rural, urban). Although there is not a comprehensive set of characteristics that define who will be a victim of human trafficking, there are factors that increase a child's risk *(HHS, ACF, Family and Youth Services Bureau*

[FYSB]; Child Welfare Capacity Building Collaborative, Greenbaum & Crawford-Jakubiak): History of maltreatment at home, especially sexual abuse Involvement with the child welfare or juvenile justice systems History of running away Homelessness Financial problems Inadequate family or other relationships Self or familial substance use or mental health problems Identification as lesbian, gay, bisexual, or transgender Unmet intangible needs (e.g., love, belonging, affection, protection) Low self-esteem Lack of identity The preceding risk factors are not exhaustive, and a child's experience with one or more of these factors is not a definite indication that they have been or will be trafficked. Additionally, the absence of these risk factors is not an indication that a child has not been trafficked or is not at risk of being trafficked. If your agency does not require screening for trafficking in all cases, you can use these risk factors as an informal way of assessing risk and determining if additional screening or assessment is necessary.

How Victims Are Recruited and Controlled by Perpetrators

There is no single pathway for how children become victims of human trafficking. Victims of human trafficking may be coerced by peers, recruited by traffickers directly in-person or online, abducted, or sold or forced by family members *(Ijadi-Maghsoodi, Cook, Barnert, Gaboian, & Bath*). Some may be groomed by perpetrators, whereby the perpetrator seeks vulnerable children and coerces them using a variety of methods, such as gifts and compliments, normalizing the exploitation, providing drugs or alcohol, or establishing intimate "relationships" with them. Caseworkers should remember, however, that no child chooses to be exploited *(HHS, ACF, FYSB*). It is a situation into which they have been forced, coerced, or tricked. Children may be kept in exploitative situations through the use of physical force or violence (e.g., beatings, rape, imprisonment), psychological coercion and intimidation (e.g., fear of violence toward themselves or loved ones), or dependence on the trafficker for housing, money, food, and other basic needs, as well as substances to which the child may be addicted (at times due to the trafficker forcing the child to take them). Additionally, some children may develop an emotional connection with their traffickers, which is often referred to as trauma bonding or Stockholm syndrome (*Hardy, Compton, & McPhatter*). This trauma bond may cause the victim to support or protect the trafficker, which may make it difficult for child welfare personnel, law enforcement, or other service providers to assist the victim in escaping or receiving services or to prosecute the perpetrator. In some cases, victims who have been removed from their exploitive situations make

attempts to re-establish emotional or physical contact with the perpetrator, going so far as running away from their care settings to be with them (*West & Loeffler*). When child welfare caseworkers are aware of these types of bonds and work with foster families and other care and service providers to address them, they will be better able to ensure children remain safe in their placements.

Working With Victims

Victims of human trafficking have already experienced a wide range of trauma and may be hesitant to speak with authorities, provide detailed information about their situations, or even self-identify as victims. To properly determine whether a child is a victim of human trafficking and which services they may need, clinicians and caseworkers need to be able to build rapport and implement comprehensive screening tools.

Building Rapport

Many of the same techniques and approaches to working with children involved with child welfare are applicable to working with children who are victims of human trafficking, such as active listening, being empathetic, using interpreters when necessary, being nonjudgmental, maintaining open body language, and mirroring the terms used by the child. There are some strategies to building trust and rapport, however, that may be particular to working with children who are victims of trafficking or that should be emphasized when working with them:

- ✓ Ensure the child feels safe and has his or her basic needs met
- ✓ Be prepared to build a relationship with the child over multiple meetings before he or she is ready to divulge details of the exploitation
- ✓ Recognize that many victims do not view themselves as victims
- ✓ Let the child know if you have experience with similar cases, as appropriate
- ✓ Be sensitive to any fears the child may have about retribution by the trafficker toward the child or the child's family
- ✓ Ensure the child understands he or she is viewed as the victim and is not responsible for the exploitation or not leaving the situation
- ✓ Be aware that children who are victims of trafficking often are provided with a false story to tell authorities and are conditioned not to trust them
- ✓ Do not speak negatively about the exploiter, with whom the child may still have a complex relationship.

Clinicians and caseworkers can apply these techniques throughout their time with children who are victims of human trafficking— or who are potential victims—including during intake, screening, investigation, and service provision. Additionally, partnering with other organizations and individuals that may already have developed a trusting relationship with the victims, such as drop-in centers, sexual violence advocates, and survivor led organizations may be advantageous. This may help victims, who may be distrustful of authority figures, develop a rapport with clinicians and/or caseworkers. A potential barrier to building rapport is that some victims of human trafficking actively try to avoid contact with the behavioral health and child welfare system. Some victims of human trafficking have had previous negative experiences with behavioral health and child welfare and do not want to be involved again. Even victims who have no previous child welfare and/or behavioral health involvement may view it as a system that will not improve their situations. Some victims may have been instructed by their traffickers to avoid the child welfare system or coached on what to say if they encounter representatives of the system. They may withhold information from child welfare caseworkers or other service providers in order to evade a child maltreatment report or to thwart a child welfare investigation. Similarly, child victims may avoid contact with shelters or other social services so they do not have to provide information that may attract the attention of the child welfare system. This potential avoidance highlights the importance of providers building trust with victims and assuring them that they can provide help and support.

Resources to Assist With Identifying Victims and Building Relationships
The following resources each offer screening tools applicable to child victims of human trafficking as well as tips for building rapport and interviewing victims:

- ✓ **Comprehensive Human Trafficking Assessment** (National Human Trafficking Resource Center):https://humantraffickinghotline.org/sites/default/files/Comprehensive%20Trafficking%20Assessment.pdf
- ✓ **Rapid Screening Tool for Child Trafficking and Comprehensive Screening and Safety Tool for Child Trafficking** (Center for the Human Rights for Children and the International Organization for Adolescents [IOFA]): http://www.luc.edu/media/lucedu/chrc/pdfs/BCWRHandbook2011.pdf#page=50
- ✓ **Screening for Human Trafficking: Guidelines for Administering the Trafficking Victim Identification Tool** (TVIT) (Vera Institute of Justice): https://www.ncjrs.gov/pdffiles1/nij/grants/246713.pdf

✓ **Intervene: Identifying and Responding to America's Prostituted Youth** (Shared Hope International) https://www.thresholdglobalworks.com/pdfs/sex-trafficking-guide.pdf

A more comprehensive list of screening tools is available in the Child Welfare Capacity Building Collaborative publication titled Identifying Minors and Young People Exploited Through Sex Trafficking: A Resource for Child Welfare Agencies at http://go.usa.gov/x92Md.

Identifying Victims

Many screening tools exist to help professionals determine whether a child is the victim of human trafficking. Screening tools may be standalone and specific to human trafficking (sex, labor, or both), or they may be universal or broader tools that have questions related to trafficking. In a recent study by Casey Family Programs, only 44 percent of respondents indicated their agencies had a policy to address child victims of sex trafficking. It is also important to know the potential indicators of sex or labor trafficking so that you can be aware of the possibility of a child being a victim even when you are not administering a formal screening. The following are additional examples of indicators of possible sex and/or labor trafficking:

- ➡ Is not allowed to speak while alone or seeks another's approval before answering Appears to have been coached about how to speak with law enforcement or other authorities
- ➡ Does not possess identification or lies about identity Describes inconsistent life events Cannot provide evidence of a legal guardian
- ➡ Is not enrolled in school
- ➡ Works long hours
- ➡ Uses terms related to sex work (e.g., "daddy," "the life")
- ➡ Possesses hotel keys, large amounts of money, or multiple cell phones
- ➡ Describes multiple unexplained trips to other cities or states
- ➡ Lives with employer or other "employees"
- ➡ Is paid little or nothing for work or services provided
- ➡ Mentions that "pay" goes toward a debt to "employer," fees for travel, or housing provided by employer.

For a more complete set of indicators, refer to Building Child Welfare Response to Child Trafficking, which was developed by the Center for the Human Rights for Children at Loyola University Chicago and IOFA. The publication is available at http://www.luc.edu/media/lucedu/chrc/pdfs/BCWRHandbook2011.pdf#page=40. For a glossary of sex trafficking-related

terms that caseworkers may hear when talking with clients, visit the Shared Hope International website at http://sharedhope.org/the-problem/trafficking-terms/. Children Running Away From Foster Care Children who have runaway, as well as those who are homeless, face an increased risk of becoming victims of trafficking (*Countryman-Roswurm*).

Additional Human Trafficking Resources

Human Trafficking (Child Welfare Information Gateway) https://www.childwelfare.gov/topics/systemwide/trafficking/

Federal Government Efforts to Combat Human Trafficking (OTIP) https://www.acf.hhs.gov/otip/resource/federalgovernment-efforts-to-combat-human-trafficking Polaris https://polarisproject.org/

National Center for Missing and Exploited Children http://www.missingkids.com

Human Trafficking Awareness Month (National Child Traumatic Stress Network) http://www.nctsn.org/resources/public-awareness/human-trafficking

Commercial Sexual Exploitation of Children and Adolescents: Services for Victims (California EvidenceBased Clearinghouse for Child Welfare) http://www.cebc4cw.org/topic/commercial-sexualexploitation-of-children-and-adolescents-services-forvictims/

Child Abuse and the Investigative Process

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

When mental health professionals begin working with child abuse victims, they may have some preconceived and often inaccurate notions about children's reactions to traumatic stress. They may expect children to act depressed, traumatized, and/or frightened, and to be hoping to be saved from the abuser and the trauma-related environment. Yet sometimes children apparently long to be with their abuser, appear to be extremely attached to

the offender, or exhibit little or no emotion as they disclose abuse. Without an accurate understanding of how children recall traumatic events, mental health professionals may misinterpret children's behavior and statements, thus putting them at continued risk for traumatization.

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

How Trauma Affects Children's Ability to Recount Events

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

unable to disclose details of the abuse, or incorporate fantastic elements into their disclosure statements (*Everson; Dalenberg, et al*).

Memory Loss

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

Memory is sustained in the brain by a process of rethinking or rehearsing of events, often within the context of a relationship. Many child abuse victims do not have adults nearby with whom they can safely discuss what has happened to them. Without adults they can trust to help them process and understand traumatic events, children are less able to create a coherent account of the event within their sustained memory. On the other hand, victims of non-abusive trauma, such as those exposed to natural disasters or accidents, are more likely to discuss a traumatic event with a supportive adult. Such discussion can facilitate processing of the trauma and aid in

creating a coherent account of the event (*Epstein & Bottom*s). However, disclosing abuse to an adult does not always help the child remember. Even adults with good intentions (but without trauma-specific training) may tell a child: "Forget about it" and/or "Don't tell anyone else." The child's ability to remember traumatic abuse can also be affected if the offender warned the child not to tell or told the victim to forget what happened (*Epstein & Bottoms*).

Incomplete Disclosure of Details of Abuse

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

Fantastic statements

At the opposite extreme from nondisclosure are unbelievable or "fantastic statements." These may sometimes crop up during interviews with children about their abuse. Although there are certainly cases where false allegations are made and children do not tell the truth, a child's inability to recount the event or the making of fantastic statements could also be attributed to the trauma he/she has experienced. It has been shown that children aged 4-9 whose abuse was severe and violent are more likely to incorporate bizarre and impossible details into their abuse accounts (*Davis & Bottoms*) than are children whose abuse was less traumatic. Some children may incorporate

details of what they wished could have happened, such as, “Then I jumped out the window and ran away.”

Other Dynamics Affecting Disclosure of Abuse

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

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

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

At times during the investigative interview, children may present with a flat affect or appear to be very matter-of-fact. When the child reveals little or no emotion, it can be difficult for those who interact with the child to believe that the incident occurred. If children have had to tell their story multiple times, they may become desensitized to the feelings when asked yet again to describe their abusive experience. If a child dissociated during the abusive events, the report of the experience may be delivered with the affect of an observer rather than with that of a traumatized person. In the case of

observed flat affect, investigators should seriously consider the possibility that the child is suffering from depression. This is more likely if children have been abused by someone they know or have experienced chronic traumatic stress. Lanktree et al., studied a sample of child and adolescent psychiatric outpatients with sexual abuse histories, and found that they were four times more likely to be suffering from major depression than were patients with no molestation history.

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

Crisis Intervention During the Investigative Process

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

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

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

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

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

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

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

Conducting interviews in a neutral, fact-finding manner in a child-friendly setting can help redefine these relationships. When approached from a supportive rather than an adversarial position, the investigation can enable the mental health professionals to join with the non-offending caregiver in a partnership for the protection of the child.

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

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

The assessment process also includes eliciting information regarding how the family functions: its rules, methods of discipline, and interpersonal boundaries. It will be helpful for the interviewer to ascertain from the

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

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

All of these approaches are designed to identify barriers to the caregiver's ability and willingness to be a protective resource for the child, and to develop interventions designed to reduce or remove those barriers (*Ralston & Sosnowski*). Barriers associated with the parent/caregiver's own abilities to be protective (such as limited cognitive abilities, mental health issues, medical conditions, abuse history, or substance abuse) must be identified; and interventions to address and overcome these barriers provided. External barriers to provision of protection may include lack of financial resources, lack of a support system, lack of transportation, and a history of domestic violence. Finally, any child characteristics that may be barriers to the caregiver's ability or willingness to be a protective resource must be identified. Some of these barriers might include the caregiver's inability to manage the behavioral consequences of the child's abuse, the child's mental health or medical problems, and sexual reactivity of the child. Although symptom reduction is the target of treatment, it is common for children to

experience elevations in certain symptoms as they work through other issues related to the trauma. For instance, as a sexually abused child works through a narrative and processes feelings related to the trauma, he/she might demonstrate more sexual reactivity, a common outcome of sexual abuse. Provision of interventions to address this behavior are essential, which, if left untreated, may result in a child's sexually acting out with others.

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

3. Child Abuse in the Age of Covid-19

While the world has experienced many crises, COVID-19 presents unprecedented challenges. António Guterres, Secretary General of the UN, suggests that the coronavirus pandemic is quickly turning into a "broader child rights crisis". Media coverage indicates an increase of domestic violence and violence against children. It is abundantly clear that risk factors for violence, abuse, and neglect are on the rise for children under containment. At the same time, some COVID-19 prevention measures have abruptly cut children off from positive and supportive relationships they rely on when in distress, including at school, in the extended family, and in the community. Children's rights to safety and protection as outlined in the Convention on the Rights of the Child and the Minimum Standards for Child Protection in Humanitarian Action are threatened.

Child Abuse Considerations During COVID-19

As the COVID-19 pandemic continues, Americans are required to stay home to protect themselves and their communities. However, the home may not be safe for many families who experience domestic violence, which may include both intimate partners and children. COVID-19 has caused major economic devastation, disconnected many from community resources and support systems, and created widespread uncertainty and panic. Such

conditions may stimulate violence in families where it didn't exist before and worsen situations in homes where mistreatment and violence has been a problem. Violence in the home has an overall cost to society, leading to potentially adverse physical and mental health outcomes, including a higher risk of chronic disease, substance use, depression, post-traumatic stress disorder, and risky sexual behaviors. Further, victims of domestic violence including intimate partner abuse and child abuse are at great risk for injuries including death. *(APA (2020) "How COVID-19 may increase domestic violence and child abuse"*).

Children are specifically vulnerable to abuse during COVID-19. Research shows that increased stress levels among parents is often a major predictor of physical abuse and neglect of children. Stressed parents may be more likely to respond to their children's anxious behaviors or demands in aggressive or abusive ways. The support systems that many at-risk parents rely on, such as extended family, child care and schools, religious groups and other community organizations, are no longer available in many areas due to the stay-at-home orders. Child protection agencies are experiencing strained resources with fewer workers available, making them unable to conduct home visits in areas with stay-at-home orders. Since children are not going to school, teachers and school counselors are unable to witness the signs of abuse and report to the proper authorities. Also, many at-risk families may not have access to the technology children needed to stay connected with friends and extended family.

We must take action to alert victims of abuse that there is help available. We must work with law enforcement and other state and local personnel to understand that stay-at-home orders need to be relaxed when the home is unsafe. Schools should continue to offer virtual counseling or telephone check-ins whenever possible. The hotel and hospitality industry have played a large role in many jurisdictions helping to house the homeless or healthcare practitioners; businesses and localities must also remember the vulnerable population affected by domestic violence who can also benefit from these services. During this time, we must also ensure that healthcare practitioners are screening patients for intimate partner violence and child abuse.

Violence, abuse, and neglect of children in the context of COVID-19
All children - that is, people who are under 18 years of age - can be vulnerable to violence, abuse, and neglect. Such violations can take place in

a home environment under the care of parents and other family members. All children, particularly girls are at high risk of sexual violence. Children are also at risk outside of the home. This is especially true for children who are deprived of their liberties or who are living on the street, in institutions, associated with armed forces or groups, engaged in child labour or living in situations of conflict and fragility as well as refugee, internally displaced, migrant and stateless children.

Home should be a child's first line of defense and protection. Stressors related to COVID-19 are threatening that defense. Households worldwide are struggling to cope with new restrictions on travel and work, concerns over health, food security, financial instability at personal and global levels, and conflicting information on a range of issues.

Furthermore, millions of children are living in places that have instituted some form of confinement, including lockdowns and stay-at-home orders. These measures have disrupted the formal and informal protective systems that generally identify and respond to children's risks. Schools and communities are over-taxed and/or unable to support children and families' well-being. In a confined space, caregivers must now manage their children's schooling as well as their own work and caregiving responsibilities. Unpredictable and sudden events such as family deaths can shift care duties. Children, especially adolescents, may face mounting pressure to help provide for their families.

Common risk factors for violence, abuse and neglect associated with COVID-19 include:

- ➡ Increased poverty and food insecurity due to the loss of jobs and incomes;
- ➡ The inability of children to access education either in person or online;
- ➡ An increase in children's digital activity and a decrease in caregiver monitoring, which exposes them to greater digital risks;
- ➡ An absence of nutritious meals previously provided by schools and care programs;
- ➡ The disruption of peer and social support networks for children/ caregivers;
- ➡ The disruption of community and social support services for children/ caregivers;
- ➡ A breakdown in routines for children/caregivers;

- ➡ Increased alcohol and/or substance use by adolescents/caregivers; and
- ➡ *Ad hoc* child care arrangements.

Any and all of these factors can increase the risk of harm to children who are already trapped in abusive and neglectful situations. But they can also increase the potential for over-stressed caregivers to become violent or abusive. These new stresses are occurring at a time when children are less visible to individuals and professionals who are normally engaged in their protection, and child and family welfare services are over-stretched and disrupted.

Contextual Considerations

To be effective, policy and practice recommendations must be appropriate to the national and/or local context and be guided by the principles of 'the best interests of the child' and 'do no harm.' Suggested actions found in this technical note will need to be contextualized. Where possible, adaptations should be made in consultation with children, families, and communities with careful consideration of the following factors:

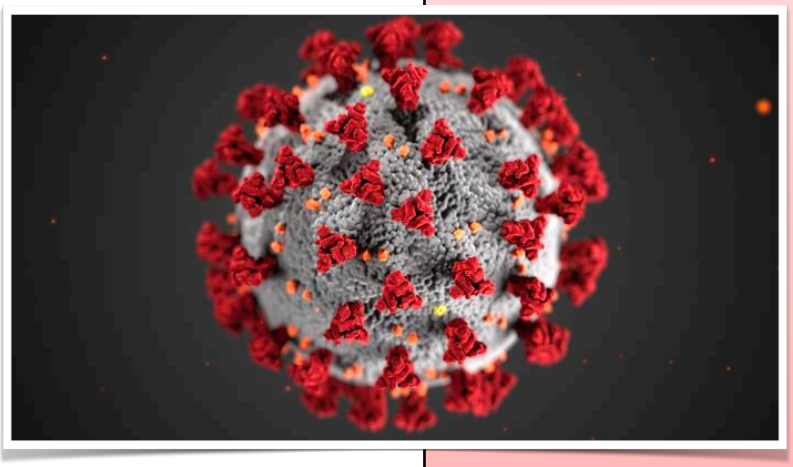
- ❖ ***Phase of the outbreak response in your context:*** The incidence of violence, abuse, and neglect aswell as the ability to prevent and respond to them are influenced by the measures used to controlthe spread of COVID-19. The pandemic response is a dynamic process which can includepreparedness, response, and recovery. The novel nature of COVID-19, and our continuouslyevolving understanding of it, demands that child protection actors rapidly adapt and changereadiness and response planning that is focused on essential child and family welfare services.Protection activities will vary across the following *non-linear* phases:o*Preparedness:* Mitigation measures are expected but not yet in place.
- ❖ ***Response (mitigation)*****:** Strict control measures are in place (e.g. lockdowns, socialdistancing, restriction on movement, etc.).
- ❖ ***Recovery*****:** Strict mitigation measures are lifted at once or in phases.
- ❖ ***Pre-existing conditions*****:** Any strategies to respond to violence in the home must be informed by pre-existing risks and vulnerabilities related to the prevalence, incidence, risk factors, and drivers of violence in the home and community;
- ❖ ***Existing*** policies, procedures, and institutional arrangements for child protection service delivery; existence and degree of humanitarian crises; and availability of financial and social resources.

- ***Connectivity and other appropriate communication mechanisms***: Digital access can facilitate virtual educational, financial, and social support. It can support the continued provision of social services and statutory functions of the government, such as case conferences or children' shearings. It is important to advocate for digital access, in terms of equipment and internet access.It is also important to advocate for non-digital solutions (e.g. educational radio programs, text message services, and loudspeaker systems) to accommodate those without digital access.
- ***Using data to drive action:*** Rapid situation analysis and drawing on pre-existing or new data, coupled with ongoing surveillance and monitoring, can ensure that response measures are relevant and indicate the effectiveness of interventions. Data should be disaggregated by age, gender, disability and other locally-relevant factors (e.g. socio-economic status, race) to better understand the unique needs of children. Where possible, multi-sectoral assessments and children and family's participation should be considered. The analysis of administrative data from helplines, notifications, case management, and other service provision is vital to informing responses.

Trends in U.S. Emergency Department Visits Related to Suspected or Confirmed Child Abuse and Neglect Among Children and Adolescents Aged <18 Years Before and During the COVID-19 Pandemic

Using National Syndromic Surveillance Program (NSSP) data from January 6, 2019–September 6, 2020, CDC tabulated weekly numbers of emergency department (ED) visits related to child abuse and neglect and calculated the proportions of such visits per 100,000 ED visits, as well as the percentage of suspected or confirmed ED visits related to child abuse and neglect ending in hospitalization, overall and stratified by age group (0–4, 5–11, and 12–17 years). The total number of ED visits related to child abuse and neglect began decreasing below the corresponding 2019 period during week 11 (March 15–March 22, 2020) for all age groups examined, coinciding with the declaration of a national emergency on March 13 (2); simultaneously, the proportion of these visits per 100,000 ED visits began increasing above the 2019 baseline for all age groups. Despite decreases in the weekly number of ED visits related to child abuse and neglect, the weekly number of these visits resulting in hospitalization remained stable in 2020; however, the yearly percentage of ED visits related to child abuse and neglect resulting in hospitalization increased significantly among all age groups. Although the increased proportion of ED visits related to child abuse and neglect might be

associated with a decrease in the overall number of ED visits, these findings also suggest that health care–seeking patterns have shifted during the pandemic. Hospitalizations for child abuse and neglect did not decrease in2020, suggesting that injury severity did not decrease during the pandemic, despite decreased ED visits.



Summary

What is already known about this topic?

Public health emergencies increase risk for child abuse and neglect because of increased stressors and loss of financial and social supports.

What is added by this report?

During the COVID-19 pandemic, the total number of emergency department visits related to child abuse and neglect decreased, but the percentage of such visits resulting in hospitalization increased, compared with 2019.

What are the implications for public health practice?

The pandemic has affected health care–seeking patterns for child abuse and neglect, raising concerns that victims might not have received care and that severity of injuries remained stable or worsened. Implementation of strategies to prevent child abuse and neglect is important, particularly during public health emergencies.

FIGURE 1. Number (A) and proportion (B) of emergency department (ED) visits related to suspected and confirmed child abuse and neglect among children and adolescents aged <18 years, by week — National Syndromic Surveillance Program, United States, 2019–2020

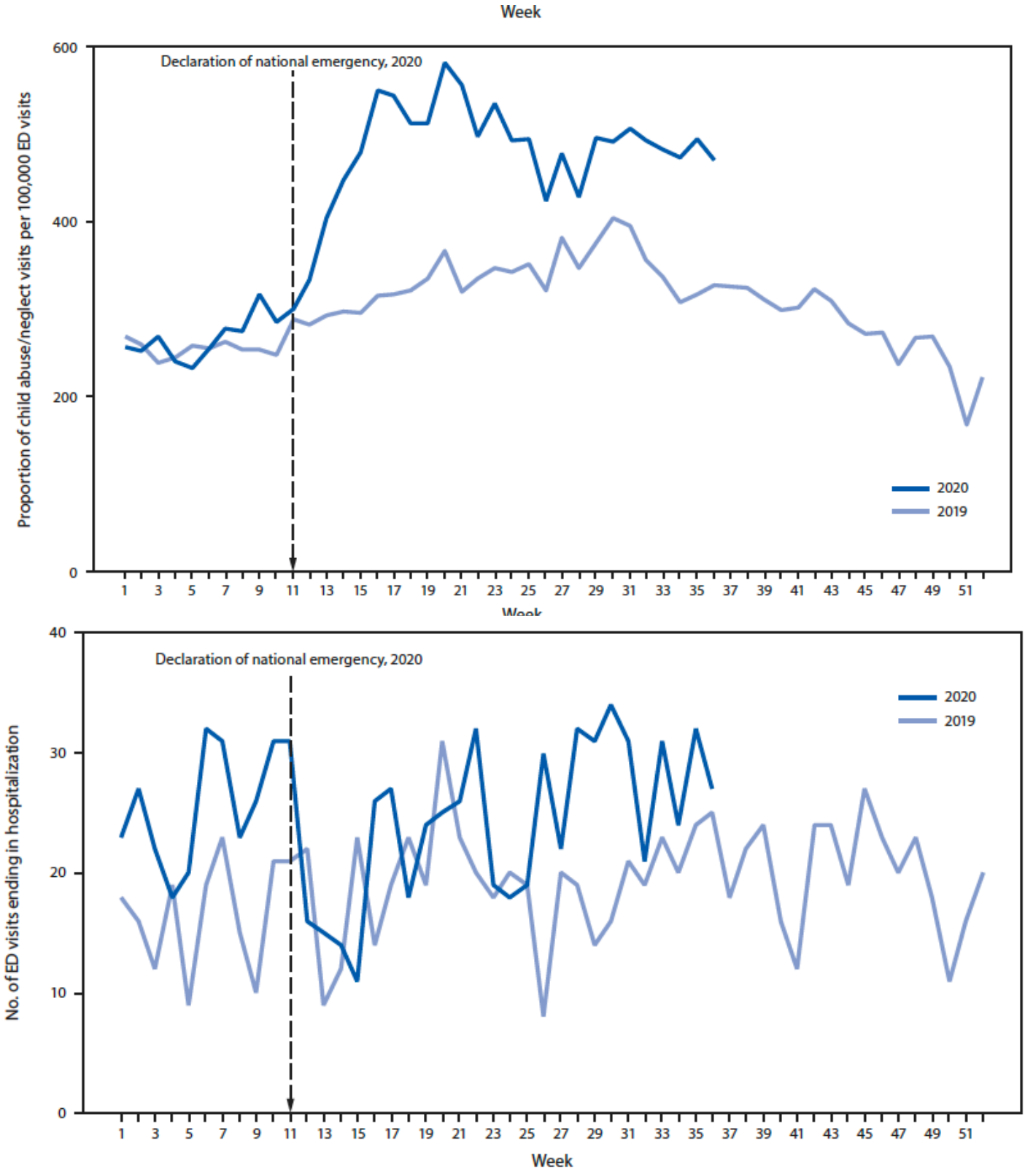
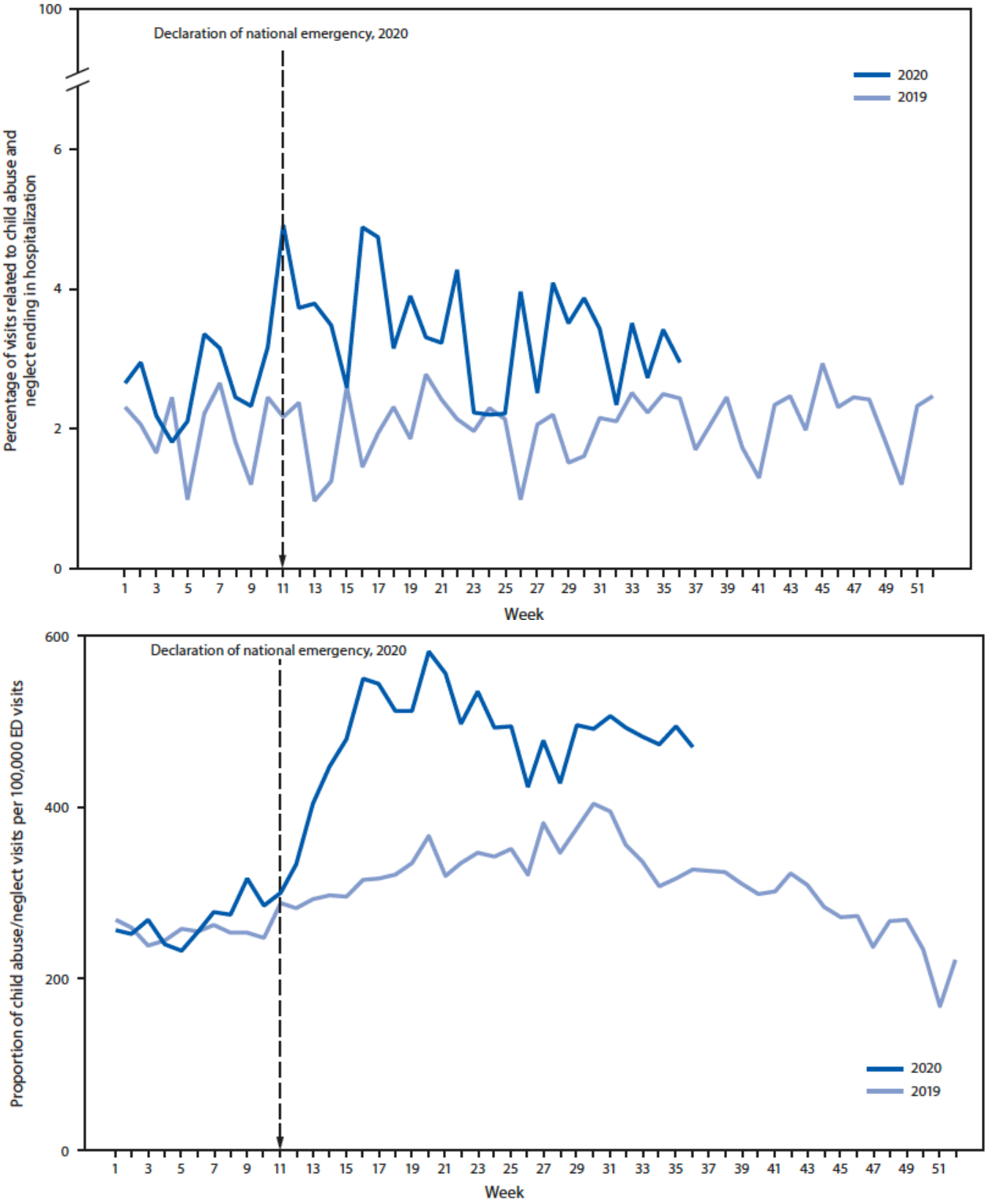


FIGURE 2. Number (A) and percentage (B) of emergency department (ED) visits related to suspected and confirmed child abuse and neglect ending in hospitalization among children and adolescents aged <18 years, by week — National Syndromic Surveillance Program, United States, 2019–2020



Prevention

Influence social norms and related behaviors to better safeguard children at home

- ✓ Identify positive and negative coping mechanisms or behaviors that are strengthened and exacerbated by the pandemic (e.g. alcohol use).
- ✓ Develop culturally and age-appropriate messaging to reinforce positive behaviors and discourage negative ones.
- ✓ Disseminate messages through context-appropriate low- and high-tech media, including online, text messaging, local radio stations, loudspeakers, and other solutions.
- ✓ Work with community and religious leaders to raise awareness and influence positive behavior.
- ✓ Include information on the protection of children from violence, abuse, and neglect during COVID-19 in general public health messaging, educational platforms, and within existing programs.

Provide access to positive parenting resources

Provide parents and caregivers, including those who are the hardest to reach, with a variety of accessible resources that support positive parenting, non-violent discipline, and positive coping and stress management skills.

Strengthen the role of schools and education actors to support children in distress

- ✓ Help children to re-establish a sense of their education routines through remote schooling and by working with public and private entities to provide children with access to educators and virtual learning platforms (e.g. internet access, laptops/ tablets, etc.)
- ✓ Provide children with continued access to school-based counseling through telephone or online support where face-to-face contact is not possible, while enabling counsellors or the relevant school staff to continue to monitor the well-being of children in at-risk families.
- ✓ Encourage school counselors to work with at-risk children to develop personal safety plans.

Identification and Reporting

Strengthen and adapt child helplines

- ✓ Provide additional resources to adapt and strengthen child helplines to operate in the context of COVID-19, including enhanced capacity with child-friendly, COVID-19 counsellor training, and adapted and relevant referral strategies.

- ✓ Raise the awareness of a range of professionals on their roles in identifying and reporting signs of abuse or neglect
- ✓ Alert professionals who may have contact with children despite social distancing measures(e.g. pharmacists, medical personnel, school staff, police, first responders) on their roles in identifying and reporting signs of abuse and neglect.

Child and Family Welfare Services

Support families in distress

- ✓ Provide emergency cash assistance to vulnerable families to mitigate disruptions due to COVID-related livelihood shocks.
- ✓ Strengthen the capacities of the social service workforce to support children and families facing special challenges, such as a caregiver's mental illness, disability, drug dependency and/or domestic violence, which may have increased due to the pandemic.

Designate and support child protection as an essential service

- ✓ Support child protection authorities to meet their statutory duties throughout the COVID-19 response.
- ✓ Support para-social workers and other community-level child protection workers to deliver child protection services in fragile contexts and humanitarian crisis.
- ✓ Empower social service providers to effectively assess the risk of face-to-face versus telephone/online support (for both pre-existing and new cases) with due consideration for the safety of children at risk of violence, and to conduct home visits when necessary.
- ✓ In situations where social service workers have face-to-face interactions with sick individuals or their direct contacts, they should be provided with the appropriate Personal Protective Equipment as per WHO guidance or nationally mandated.

Ensure the continuity of child and family court services

- ✓ Ensure child and family courts function as an essential service while also adapting to public health measures.
- ✓ Continue to hold emergency hearings and execute court orders for the care and protection of children who are at an immediate risk of neglect or abuse.

Specialized services for children and families

- ✓ Adapt and continue the delivery of services that mitigate risk factors for violence, abuse, and neglect (e.g. caregivers' mental health, substance misuse, domestic violence, etc.).
- ✓ Adapt and continue key child protection interventions in pre-existing humanitarian settings that support children, families, and communities and promote family unity.
- ✓ Scale up the capacity of the family-based alternative care system to prevent unnecessary recourse to residential care during the pandemic.
- ✓ Provide children who are experiencing trauma with virtual specialized mental health and psychosocial support when public health measures preclude face-to-face contact.

Resources

Technical Notes and Annexes

Technical Note: Protection of Children During the COVID-19 Pandemic https://alliancecpha.org/en/COVD19

Technical Note: COVID-19 and Children Deprived of Their Liberty https://alliancecpha.org/en/child-protection-online-library/technical-note-covid-19-and-children-deprived-their-liberty Protection of Children During the COVID-19 Pandemic: Children and Alternative Care https://alliancecpha.org/en/child-protection-online-library/protection-children-during-covid-19-pandemic-children-

https://violenceagainstchildren.un.org/news/agenda-action-8-united-nations-entities-launch-roadmap-protect-children-violence-response-covid

Policy Notes

UN Policy Brief: The Impact of COVID-19 on Children https://unsdg.un.org/resources/policy-brief-impact-covid-19-children

COVID-19 Resource Hubs

The Alliance for Child Protection in Humanitarian Action - Child Protection and COVID-19 pandemic https://alliancecpha.org/en/series-of-child-protection-materials/protection-children-during-covid-19-pandemic

Global Partnership to End Violence Against Children COVID-19 Hub https://www.end-violence.org/protecting-children-during-covid-19-outbreak
Global Social Service Workforce Alliance resources page http://www.socialserviceworkforce.org/resources/database

International Society for the Prevention of Child Abuse and Neglect (ISPCAN) COVID-19 resources https://www.ispcan.org/covid19resourcepage/

Parenting in the time of COVID-19
https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public/healthy-parenting

Together for Girls COVID-19 Resource Page https://www.togetherforgirls.org/covid-19/

UNICEF pages on the coronavirus
https://www.unicef.org/coronavirus/covid-19

WHO Country & Technical Guidance - Coronavirus disease
https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance

4. Mandated Reporters and Child Abuse Reporting

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

State Reporting Laws

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

Most States define abuse as an act or failure to act that result in non-accidental physical injury or sexual abuse of a child. Neglect generally includes the denial of adequate food, shelter, supervision, clothing, or medical care when such resources or services are available. Each state

defines abuse and neglect differently, and the conditions considered to be neglect or abuse in one state may not be the same in others. Because state law often requires that treatment providers report suspected abuse and neglect, treatment staff should become familiar with their state's definitions of abuse and neglect. Staff can contact the State's CPS agency for information on current laws. (If the abuse occurred in another state, or if the perpetrator is currently living in another state, it is wise to check on the laws in the other state to ensure compliance. At times, there may be a need to report in both states.) Readers can also find state statutory child abuse and neglect definitions on the Internet at http://www.calib.com/nccanch/services/statutes.htm. Federal definitions of these terms appear in the Child Abuse Prevention and Treatment Act, 42 U.S.C. §5106(g). In some cases, the CPS agency can be consulted regarding whether or not a report must be made in a particular situation without divulging confidential (i.e., identifying) information. Consultation with the CPS agency must be done with great care, and this communication can be noted in the client's chart.

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

- The child has been seriously physically injured by a parent or other adult by other than accidental means.
- The child appears injured or ill to the point that a reasonable person would seek medical attention, but the parent has not sought medical attention, refuses to consider it, or fails to follow medical advice, putting the child at risk.
- An adult has sexually touched (or made the child sexually touch the adult), abused, or exploited the child.
- The child is not registered for or attending school, and the parent refuses to remedy the situation (home schooling must be adequately documented).

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

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

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

Mandated Reporters

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

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

Mandated reporters may not make an anonymous report. Mandated reporters, however, are not legally required to tell involved individuals that a report is about to be made. The law does not require mandated reporters to tell the parents that a report is being made. A client’s self-report does not negate the therapist's mandate to report. The role of a mandated reporter is to report and not investigate the allegation(s). Any attempts to investigate may have a negative clinical impact on the child and family. If a mandated reporter learns about suspected child abuse from a third party (hearsay), and

reasonable suspicion exists, the therapist must make a report if the information was revealed to the therapist within their professional capacit.

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

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

Typical Minimum Reporting Requirements

Typically, minimum requirements for what must be reported include:

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

Abuse or Neglect Suspected at an Institution or Facility

Mandated reporters are required to file a report whenever there is reasonable cause to suspect or believe any resident of a care facility has been abused or neglected by a staff member of a public or private institution or facility that provides care. Whenever the results of an investigation leads to the conclusion that there is reasonable cause to believe that that there has been abuse or neglect perpetrated by staff, then the institution, school or facility must provide records concerning the investigation to the appropriate

investigating agency and/or to the agency that licensed the facility. An institution may suspend employee(s) during an investigation, or, at the conclusion of an investigation, may impose penalties in addition to any separate penalties resulting from civil litigation or criminal prosecution. Employers may not discharge, discriminate or retaliate against an employee for making a good faith report or for testifying at an abuse or neglect proceeding.

Anonymity and Immunity

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

Conflicts

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

Informing Family Members and Guardians

Mandated reporters typically are not obligated to inform parents, siblings or offspring that a report has been made. In many circumstances, however, it may be necessary and/or beneficial to do so. When a report is made at a care giving facility, the person in charge of a hospital, school or other institution is generally required to notify family members, or other caregiver(s) responsible for the (possible) victim, that a report has been made. Healthcare professionals or members of the clergy, however, often must to talk with

family members or guardians to offer support and guidance, or to assess the cause of an injury. In cases of serious physical abuse or sexual abuse, it may be unwise to advise caregivers before a case is reported, as it may put a victim at greater risk and/or interfere with a criminal investigation.

Investigation of Reports

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

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

Professionals Responsible for Mandated Reporting

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

- Adult protective service employees
- Child advocates
- Child protective service employees
- Chiropractors
- Clergy
- Commercial Film and Photographic Print Processors
- Dentists and dental hygienists

- Emergency medical service providers
- Marital and family therapists
- Medical examiners
- Mental health professionals
- Nurses
- Ombudsmen
- Optometrists
- Parole officers
- Pharmacists
- Physical therapists
- Physician assistants
- Physicians
- Podiatrists
- Police officers
- Probation officers
- Psychologists
- Public health service providers responsible for the licensing or monitoring of child day care centers, long term care and nursing facilities, group day care homes, family day care homes, and youth camps
- Professional counselors
- Resident medical interns
- School teachers, coaches, guidance counselors, paraprofessionals, and principals
- Sexual assault and battered women's counselors
- Social workers
- Substance abuse rehabilitation counselors

Training is typically offered wherever mandated reporting laws are enforced, entailing matters such as recognition of abuse and neglect, what must be reported, how to report it, anonymity, immunity and penalties.

Summary of State Reporting Laws

The following includes a list of individual state and U.S territory reporting laws. This list and it's contents are routinely updated but please visit https://www.childwelfare.gov/pubPDFs/manda.pdf to verify updated reporting information (*Child Welfare Information Gateway. (2021). Mandatory reporters of child abuse and neglect. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.*)

Alabama

Professionals Required to Report:
Citation: Ala. Code § 26-14-3 Reports are required from all of the following: Hospitals, clinics, sanitariums, doctors, physicians, surgeons, medical examiners, coroners, dentists, osteopaths, optometrists, chiropractors, podiatrists, pharmacists, physical therapists, nurses, public and private K–12 employees, teachers, and school officials, peace officers and law enforcement officials, social workers, daycare workers or employees, mental health professionals, employees of public and private institutions of postsecondary and higher education, members of the clergy, any other person called upon to render aid or medical assistance to a child

Reporting by Other Persons Citation:
Ala. Code § 26-14-4 Any other person who has reasonable cause to suspect that a child is being abused or neglected may report.

Institutional Responsibility to Report Citation:
Ala. Code § 26-14-3 A public or private employer who discharges, suspends, disciplines, or penalizes an employee solely for reporting suspected child abuse or neglect pursuant to this section shall be guilty of a class C misdemeanor.

Standards for Making a Report Citation:
Ala. Code § 26-14-3 A report must be made when the child is known or suspected of being a victim of abuse or neglect. Privileged Communications Citation: Ala. Code §§ 26-14-3; 26-14-10 Only clergy-penitent and attorney-client privileges are permitted. Inclusion of Reporter's Name in Report The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity Citation: Ala. Code § 26-14-8 The department will not release the identity of the reporter except under court order when the court has determined that the reporter knowingly made a false report.

Alaska

Professionals Required to Report Citation:
Alaska Stat. §§ 47.17.020; 47.17.023 The following persons are required to report: Health practitioners or administrative officers of institutions, teachers and school administrators, including athletic coaches, of public and private schools, child care providers, paid employees of domestic violence and sexual assault programs, crisis intervention and prevention programs, or organizations that provide counseling or treatment to individuals seeking to control their use of drugs or alcohol, peace officers or officers of the Department of Corrections, persons who process or produce visual or printed matter, either privately or commercially, members of a child fatality review team or the multidisciplinary child protection team, volunteers who interact with children in a public or private school for more than 4 hours a week

Reporting by Other Persons Citation:
Alaska Stat. § 47.17.020 Mandated reporters may report cases that come to their attention in their nonoccupational capacities. Any other person who has reasonable cause to suspect that a child has been harmed may report.

Institutional Responsibility to Report Citation:
Alaska Stat. § 47.17.020(g) A person required to report child abuse or neglect who makes the report to the person's job supervisor or to another individual working for the entity that employs the person is not relieved of the obligation to make the report to the department as required by law.

Standards for Making a Report Citation:
Alaska Stat. §§ 47.17.020; 47.17.023 A report must be made when, in the performance of his or her occupational or appointed duties, a reporter has reasonable cause to suspect that a child has suffered harm as a result of abuse or neglect. A person providing—either privately or commercially—film, photo, visual, printed-matter processing, production, or finishing services; or computer installation, repair, or other services; or internet or cellular telephone services; who in the process of providing those services observes a film, photo, picture, computer file, image, or other matter and has

reasonable cause to suspect that the film, photo, picture, computer file, image, or other matter visually depicts a child engaged in conduct described in § 11.41.455(a) (sexual exploitation of a minor or child pornography) shall immediately report the observation to the nearest law enforcement agency.

Privileged Communications Citation: Alaska Stat. § 47.17.060 Neither the physician-patient nor the husband-wife privilege is recognized. Inclusion of Reporter's Name in Report The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity
This issue is not addressed in the statutes reviewed.

American Samoa

Professionals Required to Report Citation:
Ann. Code § 45.2002 The following persons are required to report: Physicians or surgeons, including physicians in training, osteopaths, optometrists, chiropractors, podiatrists, child health associates, medical examiners or coroners, dentists, nurses, or hospital personnel, Christian Science practitioners, school officials or employees, social workers or workers in family care homes or child care centers, mental health professionals

Reporting by Other Persons Citation:
Ann. Code § 45.2002 All other persons are urged and authorized to report. Institutional Responsibility to Report This issue is not addressed in the statutes reviewed.

Standards for Making a Report Citation:
Ann. Code § 45.2002 A report is required under the following circumstances: A reporter has reasonable cause to know or suspect that a child has been subjected to abuse or neglect, a reporter has observed the child being subjected to circumstances or conditions that would result in abuse or neglect.

Privileged Communications Citation:
Ann. Code § 45.2016 The physician-patient privilege and the husband-wife privilege are not recognized as grounds for excluding evidence.

Inclusion of Reporter's Name in Report Citation:
Ann. Code § 45.2010 The name, address, and occupation of the person making the report must be included in the report.

Disclosure of Reporter Identity Citation:
Ann. Code § 45.2027 The identity of the reporter is not released to the subject of the report if that release would be detrimental to the safety or interests of the reporter.

Arizona

Professionals Required to Report Citation:
Rev. Stat. § 13-3620 The following persons are required to report: Physicians, physician's assistants, optometrists, dentists, behavioral health professionals, nurses, psychologists, counselors, or social workers, peace officers, child welfare investigators, or child protective services workers, members of the clergy, priests, or Christian Science practitioners, parents, stepparents, or guardians, school personnel, domestic violence victim advocates, or sexual assault victim advocates, any other person who has responsibility for the care or treatment of minors

Reporting by Other Persons Citation:
Rev. Stat. § 13-3620 Any other person who reasonably believes that a minor is a victim of abuse or neglect may report.

Institutional Responsibility to Report
This issue is not addressed in the statutes reviewed.

Standards for Making a Report Citation:
Rev. Stat. § 13-3620 A report is required when a person reasonably believes that a minor is or has been the victim of physical injury, abuse, child abuse, a reportable offense, or neglect that appears to have been inflicted on the minor by other than accidental means or that is not explained by the available medical history as being accidental in nature. A 'reportable offense' means any of the following: Any offense listed in chapters 14 and 35.1 of this title or § 13-3506.01, surreptitious photographing, videotaping, filming, or digitally recording or viewing a minor pursuant to § 13-3019, child sex trafficking pursuant to § 13-3212, incest pursuant to § 13-3608, unlawful mutilation pursuant to § 13-1214

Privileged Communications Citation:
Rev. Stat. § 13-3620 Only the attorney-client and the clergy-penitent privileges are recognized.

Inclusion of Reporter's Name in Report Citation:
Rev. Stat. § 8-455 A report made to the child abuse hotline that is maintained by the Department of Child Safety must include the name and address or contact information for the person making the report.

Disclosure of Reporter Identity Citation:
Rev. Stat. § 8-807 Before it releases records pertaining to child maltreatment investigations, the department shall take whatever precautions it determines are reasonably necessary to protect the identity and safety of a person who reports child abuse or neglect.

Arkansas

Professionals Required to Report Citation:
Ann. Code § 12-18-402 The following individuals are mandated reporters: Child care, daycare, or foster care workers, coroners, dentists and dental hygienists, domestic abuse advocates and domestic violence shelter employees or volunteers, employees of the Department of Human Services, employees working under contract for the Division of Youth Services of the Department of Human Services, foster parents, judges, law enforcement officials, peace officers, and prosecuting attorneys, licensed nurses, physicians, mental health professionals or paraprofessionals, surgeons, resident interns, osteopaths, and medical personnel who may be engaged in the admission, examination, care, or treatment of persons, public or private school counselors; school officials, including, without limitation, institutions of higher education; and teachers, social workers and juvenile intake or probation officers, court-appointed special advocate program staff members or volunteers, attorneys ad litem, clergy members, which includes ministers, priests, rabbis, accredited Christian Science practitioners, or other similar functionaries of a religious organization, employees of a child advocacy center or a child safety center, sexual abuse advocates or volunteers who work with victims of sexual abuse, child abuse advocates or volunteers who work with child victims of abuse or maltreatment as employees of a community based victim service or a mental health agency, victim/witness coordinators, victim assistance professionals or volunteers, employees of the Crimes Against Children Division of the Department of Arkansas State

Police, employees or volunteers at reproductive health-care facilities, an individual not otherwise identified in this subsection who is engaged in performing his or her employment duties with a nonprofit charitable organization other than a nonprofit hospital

Reporting by Other Persons Citation:
Ann. Code § 12-18-401 Any person who has reasonable cause to suspect child maltreatment may report.

Institutional Responsibility to Report Citation:
Ann. Code §§ 12-18-402(c); 12-18-204 An employer or supervisor of an employee identified as a mandated reporter shall not prohibit an employee or a volunteer from directly reporting child maltreatment to the child abuse hotline. An employer or supervisor of an employee identified as a mandated reporter shall not require an employee or a volunteer to obtain permission or notify any person, including an employee or a supervisor, before reporting child maltreatment to the child abuse hotline. Nothing in the reporting laws shall prohibit any person or institution from requiring an employee or volunteer who is a mandatory reporter to inform a representative of that person or institution that the reporter has made a report to the child abuse hotline.

Standards for Making a Report Citation:
Ann. Code § 12-18-402 An individual listed as a mandatory reporter shall immediately notify the child abuse hotline in the following circumstances: He or she has reasonable cause to suspect that a child has been subjected to maltreatment, has died as a result of maltreatment, or died suddenly and unexpectedly. He or she observes a child being subjected to conditions or circumstances that would reasonably result in maltreatment.

Privileged Communications Citation:
Ann. Code §§ 12-18-402(c); 12-18-803 A privilege or contract shall not prevent a person from reporting child maltreatment when he or she is a mandated reporter and required to report under this section. No privilege, except that between a lawyer and a client and between a minister, including a Christian Science practitioner, and a person confessing to or being counseled by a minister, shall prevent anyone from testifying concerning child maltreatment. When a physician, psychologist, psychiatrist, counselor, or therapist conducts interviews with or provides therapy to a subject of a report of suspected child maltreatment for purposes related to child

maltreatment, the physician, psychologist, psychiatrist, licensed counselor, or therapist is deemed to be performing services on behalf of the child. An adult subject of a report of suspected child maltreatment cannot invoke privilege on the child's behalf.

Inclusion of Reporter's Name in Report Citation:
Ann. Code § 12-18-302 A mandated reporter may report child maltreatment or suspected child maltreatment by telephone call, facsimile transmission, or online reporting. Facsimile transmission and online reporting may be used in nonemergency situations by an identified mandated reporter who provides the following contact information: Name and phone number, in the case of online reporting, his or her email address. A mandated reporter who wishes to remain anonymous shall make a report through the toll-free child abuse hotline telephone system.

Disclosure of Reporter Identity Citation:
Ann. Code § 12-18-909 The identity of the reporter shall not be disclosed unless a court determines that the reporter knowingly made a false report.

California

Professionals Required to Report Citation:
Penal Code § 11165.7 Mandated reporters include the following: Teachers, teacher's aides, administrators, and employees of public or private schools, administrators or employees of day camps, youth centers, or youth recreation programs, administrators or employees of licensed community care or child daycare facilities, Head Start program teachers, public assistance workers, foster parents, group home personnel, and personnel of residential care facilities, social workers, probation officers, and parole officers, employees of school district police or security departments, district attorney investigators, inspectors, or local child support agency caseworkers, peace officers and firefighters, except for volunteer firefighters, physicians, surgeons, psychiatrists, psychologists, dentists, residents, interns, podiatrists, chiropractors, licensed nurses, dental hygienists, optometrists, marriage and family therapists, or social workers, state or county public health employees who treat minors for venereal diseases or other conditions, coroners and medical examiners, commercial film and photographic print or image processors, computer technicians, child visitation monitors, animal control or humane society officers, clergy members and custodians of records of clergy members, employees of police departments, county sheriff's

departments, county probation departments, or county welfare departments, employees or volunteers of a court-appointed special advocate program, alcohol and drug counselors, employees or administrators of public or private postsecondary institutions, athletic coaches, athletic administrators, or athletic directors employed by any public or private schools, athletic coaches, including, but not limited to, assistant coaches or graduate assistants involved in coaching at public or private postsecondary institutions

Reporting by Other Persons Citation:
Penal Code §§ 11165.7; 11166 Volunteers of public or private organizations whose duties require direct contact with and supervision of children are not mandated reporters but are encouraged to obtain training in the identification and reporting of child abuse and neglect and are further encouraged to report known or suspected instances of child abuse or neglect. Any other person who reasonably suspects that a child is a victim of abuse or neglect may report. For the purposes of this section, 'any other person' includes a mandated reporter who acts in his or her private capacity and not in his or her professional capacity or within the scope of his or her employment.

Institutional Responsibility to Report Citation:
Penal Code § 11166(h)-(i) When two or more persons who are required to report have joint knowledge of a known or suspected instance of child abuse or neglect, and when there is agreement among them, the telephone report may be made by a member of the team selected by mutual agreement, and a single report may be made and signed by the selected member of the reporting team. Any member who has knowledge that the member who was originally designated to report has failed to do so shall thereafter make the report. The reporting duties under this section are individual. No supervisor or administrator may impede or inhibit the reporting duties, and no person making a report shall be subject to any sanction for making the report. However, internal procedures to facilitate reporting and apprise supervisors and administrators of reports may be established, provided that they are not inconsistent with this article. An internal policy shall not direct an employee to allow his or her supervisor to file or process a mandated report under any circumstances. The internal procedures shall not require any employee required to make reports to disclose his or her identity to the employer. Reporting the information regarding a case of possible child abuse or neglect to an employer, supervisor, school principal, school counselor, coworker, or

other person shall not be a substitute for making a mandated report to an agency specified in § 11165.9.

Standards for Making a Report Citation:
Penal Code §§ 11166; 11165.7 A report is required when the following circumstances apply: A mandated reporter, in his or her professional capacity or within the scope of his or her employment, has knowledge of or observes a child whom the reporter knows or reasonably suspects is the victim of abuse or neglect. Commercial film and photographic print processors have knowledge of or observe any film, photograph, videotape, negative, or slide depicting a child under age 16 engaged in an act of sexual conduct. Commercial computer technicians have knowledge of or observe, within the scope of their professional capacity or employment, any representation of information, data, or an image, including, but not limited to, any computer hardware, software, file, floppy disk, data storage medium, CD-ROM, computer-generated equipment, or computer-generated image, that is retrievable in perceivable form and that is intentionally saved, transmitted, or organized on an electronic medium, depicting a child under age 16 engaged in an act of sexual conduct. For the purposes of this article, 'reasonable suspicion' means that it is objectively reasonable for a person to entertain a suspicion based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect child abuse or neglect. 'Reasonable suspicion' does not require certainty that child abuse or neglect has occurred nor does it require a specific medical indication of child abuse or neglect; any 'reasonable suspicion' is sufficient. For the purposes of this article, the pregnancy of a minor does not, in and of itself, constitute a basis for a reasonable suspicion of sexual abuse.

Privileged Communications Citation: Penal Code § 11166 The clergy-penitent privilege is permitted for penitential communications. This does not modify or limit a clergy member's duty to report known or suspected child abuse or neglect when the clergy member is acting in some other capacity that would otherwise make the clergy member a mandated reporter.

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

Disclosure of Reporter Identity Citation: Penal Code § 11167
The identity of the reporter shall be confidential and disclosed only as follows: Among agencies receiving or investigating mandated reports. To the prosecutor in a criminal prosecution or in an action initiated under § 602 of the Welfare and Institutions Code arising from alleged child abuse. To counsel appointed pursuant to § 317(c) of the Welfare and Institutions Code. To the county counsel or prosecutor in a proceeding under part 4 (commencing with section 7800) of division 12 of the Family Code or § 300 of the Welfare and Institutions Code. To a licensing agency when abuse or neglect in out-of-home care is reasonably suspected. When the reporter waives confidentiality. By court order.

Colorado

Professionals Required to Report Citation:
Rev. Stat. § 19-3-304 Persons required to report include the following: Physicians, surgeons, physicians in training, child health associates, medical examiners, coroners, dentists, osteopaths, optometrists, chiropractors, podiatrists, nurses, hospital personnel, dental hygienists, physical therapists, pharmacists, or registered dietitians, public or private school officials or employees, social workers, Christian Science practitioners, mental health professionals, psychologists, professional counselors, and marriage and family therapists, veterinarians, peace officers, firefighters, or victim's advocates, commercial film and photographic print processors, counselors, marriage and family therapists, or psychotherapists, clergy members, including priests; rabbis; duly ordained, commissioned, or licensed ministers of a church; members of religious orders; or recognized leaders of any religious bodies, workers in the State Department of Human Services, juvenile parole and probation officers, child and family investigators, officers and agents of the State Bureau of Animal Protection and animal control officers, the child protection ombudsman, educators providing services through a federal special supplemental nutrition program for women, infants, and children, as provided for in 42 U.S.C. § 1786, directors, coaches, assistant coaches, or athletic program personnel employed by private sports organizations or programs, persons registered as psychologist candidates, marriage and family therapist candidates, or licensed professional counselor candidates, emergency medical service providers,

officials or employees of county departments of health, human services, or social services, registered naturopathic doctors

Reporting by Other Persons Citation:
Rev. Stat. § 19-3-304 Any other person may report known or suspected child abuse or neglect.

Institutional Responsibility to Report
This issue is not addressed in the statutes reviewed.

Standards for Making a Report Citation:
Rev. Stat. § 19-3-304 A report is required when any of the following apply: A mandated reporter has reasonable cause to know or suspect child abuse or neglect, a reporter has observed a child being subjected to circumstances or conditions that would reasonably result in abuse or neglect, commercial film and photographic print processors have knowledge of or observe any film, photograph, videotape, negative, or slide depicting a child engaged in an act of sexual conduct.

Privileged Communications Citation:
Rev. Stat. §§ 19-3-304; 19-3-311 The clergy-penitent privilege is permitted. The physician-patient, psychologist-client, and husband-wife privileges are not allowed as grounds for failing to report.

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

Disclosure of Reporter Identity Citation:
Rev. Stat. § 19-1-307 The identity of the reporter shall be protected.

Connecticut

Professionals Required to Report Citation:
Gen. Stat. §§ 17a-101; 53a-65 The following persons are required to report: Physicians, surgeons, residents, interns, nurses, medical examiners, dentists, dental hygienists, optometrists, chiropractors, podiatrists, physician assistants, pharmacists, or physical therapists, psychologists or other mental health professionals, school employees, as defined by § 53a-65, social workers, police officers, juvenile or adult probation officers, or parole

officers, members of the clergy, alcohol and drug counselors, marital and family therapists, professional counselors, sexual assault counselors, or domestic violence counselors, licensed foster parents, licensed behavior analysts, emergency medical services providers, any person paid to care for a child in any public or private facility, child daycare center, group daycare home, or family daycare home that is licensed by the state, employees of the Department of Children and Families (DCF), the Department of Public Health, and the Office of Early Childhood who are responsible for the licensing of child daycare centers, group daycare homes, family daycare homes, or youth camps, the Child Advocate and any employee of the Office of Child Advocate, family relations counselor trainees or family services supervisors employed by the Judicial Department. The term 'school employee' includes teachers, substitute teachers, school administrators, school superintendents, guidance counselors, psychologists, social workers, nurses, physicians, school paraprofessionals, or coaches employed by a local or regional board of education or a private elementary, middle, or high school or any other person who, in the performance of his or her duties, has regular contact with students.

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

Institutional Responsibility to Report Citation:
Gen. Stat. §§ 17a-101b(d); 17a-101e(a) Whenever a mandated reporter has reasonable cause to suspect or believe that any child has been abused or neglected by a member of the staff of a public or private institution or facility that provides care for such child or a public or private school, the mandated reporter shall report as required by law. The DCF commissioner or the commissioner's designee shall notify the principal, headmaster, executive director, or other person in charge of the institution, facility, or school, or that person's designee, unless that person is the alleged perpetrator of the abuse or neglect of the child. In the case of a public school, the commissioner also shall notify the person's employing superintendent. The person in charge or the person's designee then shall immediately notify the child's parent or other person responsible for the child's care that a report has been made. No employer shall do any of the following: Discharge or in any manner discriminate or retaliate against any employee who in good faith makes a report of child abuse or neglect, testifies, or is about to testify in any

proceeding involving child abuse or neglect, hinder, prevent, or attempt to hinder or prevent any employee from making a report as required or testifying in any proceeding involving child abuse or neglect Standards for

Making a Report Citation:
Gen. Stat. § 17a-101a A report is required when, in the ordinary course of his or her employment or profession, a reporter has reasonable cause to suspect or believe the following of any child under age 18: Has been abused or neglected; Has had a non-accidental physical injury or an injury that is at variance with the history given of the injury; Is placed at imminent risk of serious harm Any school employee shall report when, in the ordinary course of his or her employment or profession, he or she has reasonable cause to suspect or believe that any person who is being educated by the technical high school system or a local or regional board of education, other than as part of an adult education program, is a victim of abuse and the perpetrator is a school employee. A mandated reporter's suspicion or belief may be based on factors, including, but not limited to, observations, allegations, facts, or statements by a child, victim, or a third party. Such suspicion or belief does not require certainty or probable cause.

Privileged Communications
This issue is not addressed in the statutes reviewed.

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

Disclosure of Reporter Identity Citation:
Gen. Stat. § 17a-28(f) The name of an individual reporting suspected child abuse or neglect or cooperating with an investigation of child abuse or neglect shall be kept confidential upon request or upon determination by the department that disclosure of such information may be detrimental to the safety or interests of the individual. The following are exceptions for which the name of the reporter may be disclosed: An employee of the department for reasons reasonably related to the business of the department, a law enforcement officer for purposes of investigating the following: » Abuse or neglect of a child or youth » An allegation that the individual falsely reported the suspected abuse or neglect of a child or youth, a state's attorney for purposes of investigating or prosecuting the following: » Abuse or

neglect of a child or youth » An allegation that the individual falsely reported the suspected abuse or neglect of a child or youth, an assistant attorney general or other legal counsel representing the department, a judge of the Superior Court and all necessary parties in a court proceeding pursuant to § 17a-112 or 46b-129, or a criminal prosecution involving child abuse or neglect, a state child care licensing agency, the executive director of any institution, school, or facility or superintendent of schools pursuant to § 17a-101i

Delaware

Professionals Required to Report Citation:
Ann. Code Tit. 16, § 903 Any person, agency, organization, or entity that knows or in good faith suspects child abuse or neglect shall make a report. For purposes of this section, 'person' shall include, but not be limited to, the following: Physicians, interns, residents, nurses, or medical examiners, other persons in the healing arts, including persons licensed to render services in medicine, osteopathy, or dentistry, school employees, social workers, or psychologists, hospitals or health-care institutions, the Medical Society of Delaware, law enforcement agencies

Reporting by Other Persons Citation:
Ann. Code Tit. 16, § 903 Any person who knows or in good faith suspects child abuse or neglect shall make a report. Institutional Responsibility to Report This issue is not addressed in the statutes reviewed. Standards for

Making a Report Citation:
Ann. Code Tit. 16, § 903 A report is required when the reporter knows or in good faith suspects child abuse or neglect.

Privileged Communications Citation:
Ann. Code Tit. 16, § 909 Only attorney-client and clergy-penitent privileges are recognized.

Inclusion of Reporter's Name in Report Citation:
Ann. Code Tit. 16, § 905 Although reports may be made anonymously, the Division of Family Services shall request the name and address of any person making a report.

Disclosure of Reporter Identity
This issue is not addressed in the statutes reviewed.

District of Columbia

Professionals Required to Report Citation:
Ann. Code § 4-1321.02 Persons required to report include the following: Child and Family Services Agency employees, agents, and contractors, physicians, psychologists, medical examiners, dentists, chiropractors, registered nurses, licensed practical nurses, or persons involved in the care and treatment of patients, law enforcement officers or humane officers of any agency charged with the enforcement of animal cruelty laws, school officials, teachers, or athletic coaches, Department of Parks and Recreation employees, public housing resident managers, social service workers, or daycare workers, human trafficking counselors, domestic violence counselors or mental health professionals

Reporting by Other Persons Citation:
Ann. Code § 4-1321.02 Any other person who knows or has reason to suspect that a child is being abused or neglected may report.

Institutional Responsibility to Report Citation:
Ann. Code § 4-1321.02 Whenever a person is required to report in his or her capacity as a member of the staff of a hospital, school, social agency, or similar institution, he or she shall immediately notify the person in charge of the institution, or his or her designated agent, who shall then be required to make the report. The fact that such a notification has been made does not relieve the person who was originally required to report from his or her duty to report.

Standards for Making a Report Citation:
Ann. Code § 4-1321.02 A report is required when any of the following apply: A mandated reporter knows or has reasonable cause to suspect that a child known to him or her in his or her professional or official capacity has been or is in immediate danger of being a mentally or physically abused or neglected child, a health professional, law enforcement officer, or humane officer, except an undercover officer whose identity or investigation might be jeopardized, has reasonable cause to believe that a child is abused as a result of inadequate care, control, or subsistence in the home environment due to exposure to drug-related activity, a mandated reporter knows or has

reasonable cause to suspect that a child known to him or her in his or her professional or official capacity has been, or is in immediate danger of being, the victim of sexual abuse or attempted sexual abuse; the child was assisted, supported, caused, encouraged, commanded, enabled, induced, facilitated, or permitted to become a prostitute; the child has an injury caused by a bullet; or the child has an injury caused by a knife or other sharp object that was caused by other than accidental means, a licensed health professional who in his or her own professional or official capacity knows that a child under 12 months of age is diagnosed as having a fetal alcohol spectrum disorder.

Privileged Communications Citation:
Ann. Code §§ 4-1321.02(b); 4-1321.05 A mandated reporter is not required to report when employed by a lawyer who is providing representation in a criminal, civil (including family law), or delinquency matter and the basis for the suspicion arises solely in the course of that representation. Neither the husband-wife nor the physician-patient privilege is permitted.

Inclusion of Reporter's Name in Report Citation: Ann. Code § 4-1321.03 Mandated reporters are required to provide their names, occupations, and contact information.

Disclosure of Reporter Identity Citation:
Ann. Code § 4-1302.03 The child protection register staff shall not release any information that identifies the source of a report or the witnesses to the incident referred to in a report to the alleged perpetrator of the abuse, the child's parent or guardian, or a child-placing agency investigating a foster or adoptive placement, unless said staff first obtains permission from the source of the report or from the witnesses named in the report.

Florida

Required to Report Citation:
Ann. Stat. § 39.201 The following persons are mandated reporters: • Physicians, osteopaths, medical examiners, chiropractors, nurses, or hospital personnel, other health or mental health professionals, practitioners who rely solely on spiritual means for healing, teachers or other school officials or personnel, social workers, daycare center workers, or other professional child care, foster care, residential, or institutional workers, law enforcement officers or judges

Reporting by Other Persons Citation:
Ann. Stat. § 39.201 Any person who knows or has reasonable cause to suspect that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for the child's welfare or that a child is in need of supervision and care and has no parent, legal custodian, or responsible adult relative immediately known and available to provide supervision and care shall report such knowledge or suspicion to the department. Any person who knows or who has reasonable cause to suspect that a child is abused by an adult other than a parent, legal custodian, caregiver, or other person responsible for the child's welfare shall report such knowledge or suspicion to the department. Any person who knows or has reasonable cause to suspect that a child is the victim of childhood sexual abuse or the victim of a known or suspected juvenile sexual offender shall report such knowledge or suspicion to the department. Institutional

Responsibility to Report Citation:
Ann. Stat. § 39.201 Nothing in this chapter or in the contracting with community-based care providers for foster care and related services as specified in § 409.1671 shall be construed to remove or reduce the duty and responsibility of any person, including any employee of the community-based care provider, to report a suspected or actual case of child abuse, abandonment, or neglect or the sexual abuse of a child to the central abuse hotline.

Standards for Making a Report Citation:
Ann. Stat. § 39.201 A report is required when either of the following apply: • A person knows or has reasonable cause to suspect that a child is abused, abandoned, or neglected. A person knows that a child is in need of supervision and care and has no parent, legal custodian, or responsible adult relative immediately known and available to provide supervision and care.

Privileged Communications Citation:
Ann. Stat. § 39.204 Only attorney-client and clergy-penitent privileges are permitted.

Inclusion of Reporter's Name in Report Citation:
Ann. Stat. § 39.201 Professionals who are mandated reporters are required to provide their names to hotline staff.

Disclosure of Reporter Identity Citation:
Ann. Stat. §§ 39.201; 39.202 The names of reporters shall be entered into the record of the report but shall be held confidential. The name of the reporter may not be released to any person other than employees of the Department of Children and Family Services responsible for child protective services, the central abuse hotline, law enforcement, the child protection team, or the appropriate State attorney, without the written consent of the person reporting. This does not prohibit the serving of a subpoena to a person reporting child abuse, abandonment, or neglect when deemed necessary by the court, the State attorney, or the department, provided the fact that such person made the report is not disclosed.

Georgia

Professionals Required to Report Citation:
Ann. Code §§ 19-7-5; 16-12-100 The following persons are required to report: Physicians, physician assistants, residents, interns, hospital and medical personnel, podiatrists, dentists, or nurses, teachers, school administrators, school counselors, visiting teachers, school social workers, or school psychologists, psychologists, counselors, social workers, or marriage and family therapists, child welfare agency personnel (as that agency is defined by § 49-5-12) or child-counseling personnel, child service organization personnel (includes any organization—whether public, private, for-profit, not-for-profit, or voluntary—that provides care, treatment, education, training, supervision, coaching, counseling, recreational programs, or shelter to children), law enforcement personnel, reproductive health-care facility or pregnancy resource center personnel and volunteers, persons who process or produce visual or printed matter. The term 'school' means any public or private prekindergarten, elementary school, secondary school, technical school, vocational school, college, university, or institution of postsecondary education.

Reporting by Other Persons Citation:
Ann. Code § 19-7-5 Any other person who has reasonable cause to believe that a child has been abused may report.

Institutional Responsibility to Report Citation:
Ann. Code § 19-7-5 If a person is required to report child abuse because that person attends to a child as part of the person's duties as an employee of or volunteer at a hospital, school, social agency, or similar facility, that person shall notify the person in charge of the facility, or the designated delegate thereof, and the person so notified shall report or cause a report to be made in accordance with this section. An employee or volunteer who makes a report to the person designated shall be deemed to have fully complied with this subsection. Under no circumstances shall any person in charge of such hospital, school, agency, or facility—or the designated delegate thereof—to whom such notification has been made exercise any control, restraint, or modification—or make other changes to—the information provided by the reporter, although each of the aforementioned persons may be consulted prior to the making of a report and may provide any additional, relevant, and necessary information when making the report.

Standards for Making a Report Citation:
Ann. Code §§ 19-7-5; 16-12-100 A report is required when either of the following apply: A reporter has reasonable cause to believe that child abuse has occurred, a person who processes or produces visual or printed matter has reasonable cause to believe that the visual or printed matter submitted for processing or producing depicts a minor engaged in sexually explicit conduct.

Privileged Communications Citation:
Ann. Code § 19-7-5(g) A mandated reporter must report regardless of whether the reasonable cause to believe that abuse has occurred or is occurring is based in whole or in part upon any communication to that person that is otherwise made privileged or confidential by law. However, a member of the clergy shall not be required to report child abuse reported solely within the context of confession or other similar communication required to be kept confidential under church doctrine or practice. When a clergy member receives information about child abuse from any other source, the clergy member shall comply with the reporting requirements of this section, even though the clergy member may have also received a report of child abuse from the confession of the perpetrator. Inclusion of Reporter's Name in Report The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity Citation:
Ann. Code § 49-5-41 Any release of records shall protect the identity of any person reporting child abuse.

Guam

Professionals Required to Report Citation:
Ann. Code Tit. 19, § 13201 Persons required to report suspected child abuse include, but are not limited to, the following: Physicians, medical examiners, dentists, osteopaths, optometrists, chiropractors, podiatrists, interns, nurses, hospital personnel, or Christian Science practitioners, clergy members, school administrators, teachers, nurses, or counselors, social services workers, daycare center workers, or any other child care or foster care workers, mental health professionals, peace officers, or law enforcement officials, commercial film and photographic print processors

Reporting by Other Persons Citation:
Ann. Code Tit. 19, § 13202 Any person may make a report if that person has reasonable cause to suspect that a child is an abused or neglected child.

Institutional Responsibility to Report
This issue is not addressed in the statutes reviewed.

Standards for Making a Report Citation:
Ann. Code Tit. 19, § 13201 A report is required when either of the following apply: A reporter, who in the course of his or her employment, occupation, or professional practice comes into contact with children, has reason to suspect on the basis of his or her medical, professional, or other training and experience that a child is an abused or neglected child, any commercial film and photographic print processor has knowledge of or observes any film, photograph, videotape, negative, or slide depicting a child under age 18 engaged in an act of sexual conduct.

Privileged Communications Citation:
Ann. Code Tit. 19, § 13201 No person may claim privileged communications as a basis for his or her refusal or failure to report suspected child abuse or neglect or to provide child protective services or the Guam Police Department with required information. Such privileges are

specifically abrogated with respect to reporting suspected child abuse or neglect or of providing information to the agency.

Inclusion of Reporter's Name in Report Citation:
Ann. Code Tit. 19, § 13203 Every report should include the name of the person making the report. Persons who are required by law to report shall be required to reveal their names.

Disclosure of Reporter Identity Citation:
Ann. Code Tit. 19, § 13203 The identity of the reporter shall be confidential and may be disclosed only as follows: Among child protective agencies, to counsel representing a child protective agency, to the attorney general's office in a criminal prosecution or family court action, to a licensing agency when abuse in licensed out-of-home care is reasonably suspected, when the reporter waives confidentiality, by court order

Hawaii

Professionals Required to Report Citation:
Rev. Stat. § 350-1.1 The following persons are required to report: Physicians, physicians in training, psychologists, dentists, nurses, osteopathic physicians and surgeons, optometrists, chiropractors, podiatrists, pharmacists, and other health-related professionals, medical examiners or coroners, employees or officers of any public or private school, child care employees or employees or officers of any licensed or registered child care facility, foster home, or similar institution, employees or officers of any public or private agency or institution, or other individuals, providing social, medical, hospital, or mental health services, including financial assistance, employees or officers of any law enforcement agency, including, but not limited to, the courts, police departments, departments of public safety, correctional institutions, and parole or probation offices, employees of any public or private agency providing recreational or sports activities Reporting by

Other Persons Citation:
Rev. Stat. § 350-1.3 Any other person who becomes aware of facts or circumstances that cause the person to believe that child abuse or neglect has occurred may report.

Institutional Responsibility to Report Citation:
Rev. Stat. § 350-1.1 Whenever a person designated as a mandatory reporter is a member of the staff of any public or private school, agency, or institution, that staff member shall immediately report the known or suspected child abuse or neglect directly to the department or to the police department and also shall immediately notify the person in charge or a designated delegate of the report made in accordance with this chapter.

Standards for Making a Report Citation:
Rev. Stat. § 350-1.1 A report is required when, in his or her professional or official capacity, a reporter has reason to believe that child abuse or neglect has occurred or that there exists a substantial risk that child abuse or neglect may occur in the reasonably foreseeable future.

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

*Inclusion of Reporter's Name in Repor*t
The reporter is not specifically required by statute to provide his or her name in the report.

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

Idaho

Professionals Required to Report Citation:
Ann. Code § 16-1605 The following persons are required to report: Physicians, residents on hospital staffs, interns, nurses, or coroners, teachers or daycare personnel, social workers or law enforcement personnel.

Reporting by Other Persons Citation:
Ann. Code § 16-1605 Any person who has reason to believe that a child has been abused, abandoned, or neglected is required to report.

Institutional Responsibility to Report Citation:
Ann. Code § 16-1605 When the attendance of a physician, resident, intern, nurse, daycare worker, or social worker is pursuant to the performance of services as a member of the staff of a hospital or similar institution, he or she shall notify the person in charge of the institution, or his or her designated delegate, who shall make the necessary reports.

Standards for Making a Report Citation:
Ann. Code § 16-1605 A report is required when either of the following apply: A person has reason to believe that a child has been abused, abandoned, or neglected, a person observes a child being subjected to conditions or circumstances that would reasonably result in abuse, abandonment, or neglect.

Privileged Communications Citation:
Ann. Code §§ 16-1605; 16-1606 Any privilege between a husband and wife and any professional and client, except for the clergy-penitent or attorney-client privilege, shall not be grounds for failure to report. Any privilege between husband and wife, or between any professional person—except the lawyer-client privilege and including, but not limited to, physicians, counselors, hospitals, clinics, daycare centers, and schools—and their clients shall not be grounds for excluding evidence at any proceeding regarding the abuse, abandonment, or neglect of the child or the cause thereof.

Inclusion of Reporter's Name in Report
The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity
This issue is not addressed in the statutes reviewed.

Illinois

Professionals Required to Report Citation:
Comp. Stat. Ch. 325, § 5/4; Ch. 720, § 5/11-20.2 The following persons are required to report: Physicians, residents, interns, hospital administrators and personnel, surgeons, dentists, dental hygienists, osteopaths, chiropractors, podiatric physicians, physician assistants, or substance abuse treatment personnel, funeral home directors or employees, coroners, or medical examiners, emergency medical technicians, acupuncturists, or crisis line or

hotline personnel, school personnel, including administrators and employees, educational advocates, or truant officers, personnel of institutions of higher education, members of a school board or the Chicago Board of Education, members of the governing body of a private school, social workers, social services administrators, or domestic violence program personnel, nurses, genetic counselors, respiratory care practitioners, advanced practice nurses, or home health aides, directors or staff assistants of nursery schools or child care centers, recreational or athletic program or facility personnel, early intervention providers, as defined in the Early Intervention Services System Act, law enforcement officers or probation officers, licensed professional counselors, psychologists, psychiatrists, or their assistants, field personnel of the Departments of Healthcare and Family Services, Juvenile Justice, Public Health, Human Services, Corrections, Human Rights, or Children and Family Services, supervisors and administrators of general assistance under the Illinois Public Aid Code, animal control officers or Department of Agriculture Bureau of Animal Health and Welfare field investigators, foster parents, homemakers, or child care workers, members of the clergy, commercial film and photographic print processors or computer technicians

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

Institutional Responsibility to Report Citation:
Comp. Stat. Ch. 325, § 5/4 Whenever such person is required to report in his or her capacity as a member of the staff of a medical or other public or private institution, school, facility, or agency, or as a member of the clergy, he or she shall make a report immediately to the Department of Children and Family Services and also may notify the person in charge of such institution, school, facility, or agency; or church, synagogue, temple, mosque, or other religious institution; or his or her designated agent that a report has been made. Under no circumstances shall any person in charge of such institution, school, facility, or agency; or church, synagogue, temple, mosque, or other religious institution; or his or her designated agent to whom such notification has been made exercise any control, restraint, modification, or other change in the report or the forwarding of the report to the department.

Standards for Making a Report Citation:
Comp. Stat. Ch. 325, § 5/4; Ch. 720, § 5/11-20.2 A report is required when any of the following apply: A reporter has reasonable cause to believe that a child known to him or her in his or her professional capacity may be abused or neglected, physician, physician's assistant, registered nurse, licensed practical nurse, medical technician, certified nursing assistant, social worker, or licensed professional counselor of any office, clinic, or any other physical location that provides abortions, abortion referrals, or contraceptives has reasonable cause to believe a child known to him or her in his or her professional or official capacity may be an abused child or a neglected child, commercial film and photographic print processors or computer technicians have knowledge of or observe any film, photograph, videotape, negative, slide, computer hard drive, or any other magnetic or optical media that depicts a child engaged in any actual or simulated sexual conduct.

Privileged Communications Citation:
Comp. Stat. Ch. 325, § 5/4; Ch. 735, § 5/8-803 The privileged quality of communication between any professional person required to report and his or her patient or client shall not apply to situations involving abused or neglected children and shall not constitute grounds for failure to report. A member of the clergy shall not be compelled to disclose a confession or admission made to him or her as part of the discipline of the religion. The reporting requirements shall not apply to the contents of a privileged communication between an attorney and his or her client or to confidential information within the meaning of rule 1.6 of the Illinois Rules of Professional Conduct relating to the legal representation of an individual client.

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

Reporter Identity Citation:
Comp. Stat. Ch. 325, § 5/11.1a Any disclosure of information shall not identify the person making the report.

Indiana

Professionals Required to Report Citation:

Ann. Code § 31-33-5-1 Any person who has reason to believe that a child is a victim of abuse or neglect must report.

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

Institutional Responsibility to Report Citation:
Ann. Code §§ 31-33-5-2; 31-33-5-2.5; 31-33-5-3; 31-33-5-5 Section 31-33-5-2 does not apply to an individual required to make a report under this article in the individual's capacity as a member of the staff of a licensed hospital. An individual required to make a report under this article in the individual's capacity as a member of the staff is subject to § 31-33-5-2.5. If an individual is required to make a report in the individual's capacity as a member of the staff of a medical or other public or private institution, school, facility, or agency, the individual shall immediately make a report to either the Department of Child Services or the local law enforcement agency. After making the report, the individual shall notify the individual in charge of the institution, school, facility, or agency that the report was made. Section 31-33-5-2.5 applies only to an individual required to make a report under this article in the individual's capacity as a member of the staff of a licensed hospital. If an individual is required to make a report under this article in the individual's capacity as a member of the staff of a licensed hospital, the individual shall immediately notify the individual in charge of the hospital. The individual in charge of the hospital who received the notification shall immediately report or cause a report to be made to the department or the local law enforcement agency. This chapter does not relieve an individual of the obligation to report on the individual's own behalf, unless a report has already been made to the best of the individual's belief. A medical institution or other public or private institution, public or nonpublic school, corporation, facility, or agency may not establish any policy that restricts or delays the duty of an employee or individual to report under this chapter.

Standards for Making a Report Citation:
Ann. Code § 31-33-5-1 In addition to any other duty to report arising under this article, an individual who has reason to believe that a child is a victim of child abuse or neglect shall make a report as required by this article.

Privileged Communications Citation:
Ann. Code § 31-32-11-1 Privileged communications between any of the following shall not be grounds for failing to report: A husband and wife, a health-care provider and the provider's patient • A licensed social worker, clinical social worker, marriage and family therapist, mental health counselor, addiction counselor, or clinical addiction counselor and a client of any of these professionals • A school counselor or psychologist and a student Inclusion of Reporter's Name in Report Citation: Ann. Code § 31-33-7-4 The written report must include the name and contact information for the person making the report.

Disclosure of Reporter Identity Citation:
Ann. Code § 31-33-18-2 The report shall be made available to the person about whom a report has been made, with protection for the identity of the following: Any person reporting known or suspected child abuse or neglect, any other person if the person or agency making the information available finds that disclosure of the information would be likely to endanger the life or safety of the person The report also may be made available to each parent, guardian, custodian, or other person responsible for the welfare of a child named in a report and an attorney of any of these individuals, with protection for the identity of reporters and other appropriate individuals.

Iowa

Professionals Required to Report Citation: Ann. Stat. §§ 232.69; 728.14 The following persons are required to report: Health practitioners, social workers or psychologists, school employees, certified para-educators, coaches, or instructors employed by community colleges, employees or operators of health-care facilities, child care centers, Head Start programs, family development and self-sufficiency grant programs, substance abuse programs or facilities, juvenile detention or juvenile shelter care facilities, foster care facilities, or mental health centers, employees of Department of Human Services institutions, peace officers, counselors, or mental health professionals, employees, operators, owners, or other persons who perform duties for certified children's residential facilities, commercial film and photographic print processors

Reporting by Other Persons Citation:
Ann. Stat. § 232.69 Any other person who believes that a child has been abused may report.

Institutional Responsibility to Report Citation:
Ann. Stat. §§ 232.70; 232.73A The employer or supervisor of a person who is a mandatory or permissive reporter shall not apply a policy, work rule, or other requirement that interferes with the person making a report of child abuse. An employer shall not take retaliatory action against an employee as a reprisal for the employee's participation in good faith in making a report, photograph, or x-ray; in the performance of a medically relevant test pursuant to this chapter; or in aiding and assisting in an assessment of a child abuse report. This section does not apply to a disclosure of information that is prohibited by statute. For purposes of this section, 'retaliatory action' includes, but is not limited to, an employer's action to discharge an employee or to take or fail to take action regarding an employee's appointment or proposed appointment to a position in employment, to take or fail to take action regarding an employee's promotion or proposed promotion to a position in employment, or to fail to provide an advantage in a position in employment. This section may be enforced through a civil action, as follows: A person who violates this section is liable to an aggrieved employee for affirmative relief, including reinstatement, with or without back pay, or any other equitable relief the court deems appropriate, including attorney fees and costs. When a person commits, is committing, or proposes to commit an act in violation of this section, an injunction may be granted through an action in district court to prohibit the person from continuing such acts. The action for injunctive relief may be brought by an aggrieved employee or the county attorney.

Standards for Making a Report Citation:
Ann. Stat. §§ 232.69; 728.14 A report is required when either of the following apply: A reporter, in the scope of his or her professional practice or employment responsibilities, reasonably believes that a child has been abused, a commercial film and photographic print processor has knowledge of or observes a visual depiction of a minor engaged in a prohibited sexual act or in the simulation of a prohibited sexual act.

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

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

Disclosure of Reporter Identity Citation:
Ann. Stat. § 232.71B A person named in a report shall be informed of the complaint or allegation made regarding the person. The person shall be informed in a manner that protects the confidentiality rights of the individual who reported the child abuse or provided information as part of the assessment process.

Kansas

Professionals Required to Report Citation:
Ann. Stat. § 38-2223 The following persons are required to report: Persons providing medical care or treatment, including persons licensed to practice the healing arts, dentistry, and optometry; persons engaged in postgraduate training programs approved by the State Board of Healing Arts; licensed professional or practical nurses; and chief administrative officers of medical care facilities, persons licensed by the state to provide mental health services, including psychologists, clinical psychotherapists, social workers, marriage and family therapists, behavioral analysts, professional counselors, and registered alcohol and drug abuse counselors, teachers, school administrators, or other employees of an educational institution that the child is attending, licensed child care providers or their employees at the place where the child care services are being provided to the child, firefighters, emergency medical services personnel, law enforcement officers, juvenile intake and assessment workers, court services officers, community corrections officers, case managers, and mediator, employees or volunteers for any organization, whether for profit or not-for-profit, that provides social services to pregnant teenagers, including, but not limited to, counseling, adoption services, and pregnancy education and maintenance

Reporting by Other Persons Citation:
Ann. Stat. § 38-2223 Any person who has reason to suspect that a child may be a child in need of care may report.

Institutional Responsibility to Report Citation:
Ann. Stat. § 38-2224 No employer shall terminate the employment of, prevent or impair the practice or occupation of, or impose any other sanction

on any employee because the employee made an oral or written report to or cooperated with an investigation by a law enforcement agency or the department relating to harm inflicted upon a child that the employee suspected was the result of the physical, mental, or emotional abuse or neglect or sexual abuse of the child. Violation of this section is a class B misdemeanor.

Standards for Making a Report Citation:
Ann. Stat. § 38-2223 A report is required when a reporter has reason to suspect that a child has been harmed as a result of physical, mental, or emotional abuse or neglect or sexual abuse.

Privileged Communications Citation:
Ann. Stat. § 38-2249 In all proceedings under this code, the rules of evidence of the code of civil procedure shall apply, except that no evidence relating to the condition of a child shall be excluded solely on the ground that the matter is or may be the subject of a physician-patient privilege, psychologist-client privilege, or social worker-client privilege.

Inclusion of Reporter's Name in Report
The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity Citation:
Ann. Stat. § 38-2212 Information from agency records that is authorized to be disclosed by this section shall not contain information that identifies a reporter of a child alleged or adjudicated to be a child in need of care.

Kentucky

Professionals Required to Report Citation:
Rev. Stat. § 620.030 All persons are required to report, including, but not limited to, the following: Physicians, osteopathic physicians, nurses, coroners, medical examiners, residents, interns, chiropractors, dentists, optometrists, emergency medical technicians, paramedics, or health professionals, teachers, school personnel, or child care personnel, social workers or mental health professionals peace officers

Reporting by Other Persons Citation:
Rev. Stat. § 620.030 Any person who knows or has reasonable cause to believe that a child is dependent, neglected, or abused shall immediately report. Any person who knows or has reasonable cause to believe that a child is a victim of human trafficking, as defined in § 529.010, immediately shall cause an oral or written report to be made to a local law enforcement agency or the State police, the cabinet or its designated representative, the Commonwealth's attorney, or the county attorney by telephone or otherwise. This subsection shall apply regardless of whether the person believed to have caused the human trafficking of the child is a parent, guardian, fictive kin, person in a position of authority, person in a position of special trust, or person exercising custodial control or supervision. Institutional

Responsibility to Report Citation:
Rev. Stat. § 620.030(1) Any supervisor who receives from an employee a report of suspected dependency, neglect, or abuse shall promptly make a report to the proper authorities for investigation. Nothing in this section shall relieve individuals of their obligations to report.

Standards for Making a Report Citation:
Rev. Stat. § 620.030 A report is required when a person knows or has reasonable cause to believe that a child is dependent, neglected, or abused.

Privileged Communications Citation:
Rev. Stat. § 620.030(4) Neither the husband-wife nor any professional-client/patient privilege, except the attorney-client and clergy-penitent privilege, shall be a ground for refusing to report. Inclusion of Reporter's Name in Report The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity Citation:
Rev. Stat. § 620.050(11) Identifying information concerning the individual initiating the report shall not be disclosed, except as follows: To law enforcement officials who have a legitimate interest in the case, to the agency designated by the cabinet to investigate or assess the report, to members of multidisciplinary teams, under a court order, after the court has conducted an in camera review of the record of the State related to the report and has found reasonable cause to believe that the reporter knowingly made a false report, to the external child fatality and near-fatality review panel

Louisiana

Professionals Required to Report Citation:
Children's Code Art. 603(17) Mandatory reporters include any of the following individuals: Health practitioners, including physicians, surgeons, physical therapists, dentists, residents, interns, hospital staff, podiatrists, chiropractors, nurses, nursing aides, dental hygienists, emergency medical technicians, paramedics, optometrists, medical examiners, or coroners, mental health/social service practitioners, including psychiatrists, psychologists, marriage or family counselors, social workers, members of the clergy, or aides, members of the clergy, including priests, rabbis, duly ordained clerical deacons or ministers, Christian Science practitioners, or other similarly situated functionaries of a religious organization, teaching or child care providers, including public or private teachers, teacher's aides, instructional aides, school principals, school staff members, bus drivers, coaches, professors, technical or vocational instructors, technical or vocational school staff members, college or university administrators, college or university staff members, social workers, probation officers, foster home parents, group home or other child care institutional staff members, personnel of residential home facilities, daycare providers, or any individual who provides such services to a child in a voluntary or professional capacity, police officers or law enforcement officials, commercial film and photographic print processors, mediators, parenting coordinators, court-appointed special advocates, organizational or youth activity providers, including administrators, employees, or volunteers of any day camp, summer camp, youth center, or youth recreation programs or any other organization that provides organized activities for children, school coaches, including, but not limited to, public technical or vocational school, community college, college, or university coaches and coaches of intramural or interscholastic athletics

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

Institutional Responsibility to Report
This issue is not addressed in the statutes reviewed.

Standards for Making a Report Citation:
Children's Code Art. 609; 610 A report is required when any of the following apply: A reporter has cause to believe that a child's physical or mental health or welfare is endangered as a result of abuse or neglect, a commercial film or photographic print processor has knowledge of or observes any film, photograph, videotape, negative, or slide depicting a child, whom he or she knows or should know is under age 17, that constitutes child pornography, a physician has cause to believe that a newborn was exposed in utero to an unlawfully used controlled dangerous substance, as determined by a toxicology test upon the newborn that may be administered without the consent of the newborn's parents or guardian. Positive test results shall not be admissible in a criminal prosecution, a physician observes symptoms of withdrawal in a newborn or other observable and harmful effects in his or her physical appearance or functioning that the physician has cause to believe are due to the chronic or severe use of alcohol by the mother during pregnancy.

Privileged Communications Citation:
Children's Code Art. 603(17); 609 A clergy member is not required to report a confidential communication from a person to a member of the clergy who, in the course of the discipline or practice of that church, denomination, or organization, is authorized or accustomed to hearing confidential communications and, under the discipline or tenets of the church, denomination, or organization, has a duty to keep such communications confidential. Notwithstanding any other provision of law to the contrary, when representing a child in a case arising out of this code, a mental health or social service practitioner shall not be considered a mandatory reporter under the following limited circumstances: When the practitioner is engaged by an attorney to assist in the rendition of professional legal services to that child, when the information that would serve as the basis for reporting arises in furtherance of facilitating the rendition of those professional legal services to that child, when the information that would serve as the basis for reporting is documented by the mental health/social service practitioner The documentation shall be retained by the mental health/social service practitioner until 1 year after the child has reached the age of majority. Notwithstanding any claim of privileged communication, any mandatory reporter who has cause to believe that a child's physical or mental health or welfare is endangered as a result of abuse or neglect, or that abuse or neglect was a contributing factor in a child's death, shall report.

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

Disclosure of Reporter Identity Citation:
Rev. Stat. § 46:56(F)(8)(b) The Department of Children and Family Services shall not disclose identifying information concerning an individual who initiated a report or complaint of alleged child abuse or neglect, except that the department shall disclose such information pursuant to a court order after the court has reviewed, in camera, the department's case record and finds reason to believe that the reporter knowingly made a false report.

Maine

Professionals Required to Report Citation:
Rev. Stat. Tit. 22, § 4011-A Mandatory reporters include the following: The following persons, when acting in a professional capacity: » Allopathic or osteopathic physicians, residents, interns, emergency medical services persons, medical examiners, physician's assistants, dentists, dental hygienists, dental assistants, chiropractors, podiatrists, or registered or licensed practical nurses » Teachers, guidance counselors, school officials, youth camp administrators or counselors, or social workers » Court-appointed special advocates or guardians ad litem » Homemakers, home health aides, medical or social service workers, psychologists, child care personnel, or mental health professionals » Law enforcement officials, State or municipal fire inspectors, or municipal code enforcement officials » Commercial film and photographic print processors » Clergy members » Chairs of professional licensing boards that have jurisdiction over mandated reporters » Humane agents employed by the Department of Agriculture, Conservation and Forestry » Sexual assault counselors or family or domestic violence victim advocates » School bus drivers or attendants, any person who has assumed full, intermittent, or occasional responsibility for the care or custody of the child, regardless of whether the person receives compensation, any person affiliated with a church or religious institution who serves in an administrative capacity or has otherwise assumed a position of trust or responsibility to the members of that church or religious institution, while acting in that capacity, regardless of whether the person receives compensation

Reporting by Other Persons Citation:
Rev. Stat. Tit. 22, § 4011-A Any person may make a report if that person knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected or that there has been a suspicious child death. An animal control officer may report to the State Department of Health and Human Services when that person knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected.

Institutional Responsibility to Report Citation:
Rev. Stat. Tit. 22, § 4011-A Whenever a person is required to report in a capacity as a member of the staff of a medical or public or private institution, agency, or facility, that person immediately shall notify either the person in charge of the institution, agency, or facility or a designated agent who then shall cause a report to be made. The staff also may make a report directly to the department. If a person required to report notifies either the person in charge of the institution, agency, or facility, or the designated agent, the notifying person shall acknowledge in writing that the institution, agency, or facility has provided confirmation to the notifying person that another individual from the institution, agency, or facility has made a report to the department. The confirmation must include, at a minimum, the name of the individual making the report to the department, the date and time of the report, and a summary of the information conveyed. If the notifying person does not receive the confirmation from the institution, agency, or facility within 24 hours of the notification, the notifying person immediately shall make a report directly to the department. An employer may not take any action to prevent or discourage an employee from making a report.

Standards for Making a Report Citation:
Rev. Stat. Tit. 22, §§ 4011-A; 4011-B A report is required when any of the following apply: The person knows or has reasonable cause to suspect that a child is or is likely to be abused or neglected or that a suspicious death has occurred, a child who is under 6 months of age or otherwise non-ambulatory exhibits evidence of the following: » Fracture of a bone » Substantial bruising or multiple bruises » Subdural hematoma » Burns » Poisoning » Injury resulting in substantial bleeding, soft tissue swelling, or impairment of an organ, a health-care provider involved in the delivery or care of an infant knows or has reasonable cause to suspect that the infant has been born affected by illegal substance use or is demonstrating withdrawal symptoms that have resulted from or have likely resulted from prenatal drug exposure that require medical monitoring or care beyond standard newborn care,

whether the prenatal exposure was to legal or illegal drugs, or has fetal alcohol spectrum disorders, a mandatory reporter shall report to the department if the person knows or has reasonable cause to suspect that a child is not living with the child's family. Although a report may be made at any time, a report must be made immediately if there is reason to suspect that a child has been living with someone other than the child's family for more than 6 months or if there is reason to suspect that a child has been living with someone other than the child's family for more than 12 months pursuant to a power of attorney or other nonjudicial authorization.

Privileged Communications Citation:
Rev. Stat. Tit. 22, §§ 4011-A; 4015 A member of the clergy may claim privilege when information is received during a confidential communication. The husband-wife and physician- and psychotherapist-patient privileges under the Maine Rules of Evidence and the confidential quality of communication under State and applicable Federal law are abrogated in relation to required reporting, cooperating with the department or a guardian ad litem in an investigation or other child protective activity, or giving evidence in a child protection proceeding.

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

Disclosure of Reporter Identity Citation:
Rev. Stat. Tit. 22, § 4008 The department will protect the identity of reporters and other persons as appropriate when disclosing information in the records to a child named in a report, the child's parent, custodian, or caregiver, or a party to a child protection proceeding.

Maryland

Professionals Required to Report Citation:
Fam. Law § 5-704 Persons required to report include the following: Health practitioners, educators or human service workers, police officers

Reporting by Other Persons Citation:
Fam. Law §§ 5-705; 5-704.1 Any other person who has reason to believe that a child has been subjected to abuse or neglect must report. An individual may notify the local department or the appropriate law enforcement agency

if the individual has reason to believe that a parent, guardian, or caregiver of a child allows the child to reside with or be in the regular presence of an individual, other than the child's parent or guardian, who is registered as a child sex offender and, based on additional information, poses a substantial risk of sexual abuse to the child.

Institutional Responsibility to Report Citation:
Fam. Law § 5-704 A mandated reporter who is acting as a staff member of a hospital, public health agency, child care institution, juvenile detention center, school, or similar institution immediately shall notify and give all information required by this section to the head of the institution or the designee of the head.

Standards for Making a Report Citation:
Fam. Law §§ 5-704; 5-705 A mandatory reporter is required to report when, acting in a professional capacity, the person has reason to believe that a child has been subjected to abuse or neglect. Other persons shall report when they have reason to believe that a child has been subjected to abuse or neglect.

Privileged Communications Citation: Fam. Law §§ 5-704; 5-705 Mandatory reporters are required to report regardless of any other provision of law, including any law on privileged communications. Only attorney-client and clergy-penitent privileges are permitted.

Inclusion of Reporter's Name in Report
The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity Citation:
Hum. Serv. Code § 1-202(c) Any disclosure of a report or record concerning child abuse or neglect must make provisions to protect the identity of the reporter or any other person whose life or safety is likely to be endangered by disclosing the information.

Massachusetts

Professionals Required to Report Citation:
Gen. Laws Ch. 119, § 21 Mandatory reporters include the following: Physicians, medical interns, hospital personnel, medical examiners, psychologists, emergency medical technicians, dentists, nurses,

chiropractors, podiatrists, optometrists, osteopaths, allied mental health and human services professionals, drug and alcoholism counselors, psychiatrists, or clinical social workers, public or private schoolteachers, educational administrators, guidance or family counselors, or child care workers, persons paid to care for or work with children in any public or private facility, home, or program that provides child care or residential services to children, persons who provide the services of child care resource and referral agencies, voucher management agencies, family child care systems, or child care food programs, licensors of the Department of Early Education and Care or school attendance officers, probation officers, clerk-magistrates of a district court, parole officers, social workers, foster parents, firefighters, police officers, or animal control officers, priests, rabbis, clergy members, ordained or licensed ministers, leaders of any church or religious body, or accredited Christian Science practitioners, persons performing official duties on behalf of a church or religious body that are recognized as the duties of a priest, rabbi, clergy, ordained or licensed minister, leader of any church or religious body, or accredited Christian Science practitioner, persons employed by a church or religious body to supervise, educate, coach, train, or counsel a child on a regular basis, persons in charge of a medical or other public or private institution, school, or facility or that person's designated agent, the child advocate

Reporting by Other Persons Citation:
Gen. Laws Ch. 119, § 51A Any other person who has reasonable cause to believe that a child is suffering from or has died as a result of abuse or neglect may file a report.

Institutional Responsibility to Report Citation:
Gen. Laws Ch. 119, § 51A(a), (h) If a mandated reporter is a member of the staff of a medical or other public or private institution, school, or facility, the mandated reporter may instead notify the person or designated agent in charge of such institution, school, or facility, who shall become responsible for notifying the department in the manner required by this section. No employer shall discharge, discriminate, or retaliate against a mandated reporter who, in good faith, files a report, testifies, or is about to testify in any proceeding involving child abuse or neglect. Any employer who discharges, discriminates, or retaliates against that mandated reporter shall be liable to the mandated reporter for treble damages, costs, and attorney's fees.

Standards for Making a Report Citation:
Gen. Laws Ch. 119, § 51A A mandated reporter must report when, in his or her professional capacity, he or she has reasonable cause to believe that a child is suffering physical or emotional injury resulting from any of the following: Abuse inflicted upon the child that causes harm or substantial risk of harm to the child's health or welfare, including sexual abuse, neglect, including malnutrition, physical dependence upon an addictive drug at birth, being a sexually exploited child, being a human trafficking victim, as defined by chapter 233, § 20M

Privileged Communications Citation:
Gen. Laws Ch. 119, § 51A Any privilege relating to confidential communications established by §§ 135 to 135B, inclusive, of chapter 112 (regarding social worker-client privilege) or by §§ 20A (clergy-penitent privilege) and 20B (psychotherapist-patient privilege) of chapter 233 shall not prohibit the filing of a report under this section or a care and protection petition under § 24, except that a priest, rabbi, clergy, member, ordained or licensed minister, leader of a church or religious body, or accredited Christian Science practitioner need not report information solely gained in a confession or similarly confidential communication in other religious faiths. Nothing in the general laws shall modify or limit the duty of a priest, rabbi, clergy member, ordained or licensed minister, leader of a church or religious body, or accredited Christian Science practitioner to report suspected child abuse or neglect under this section when the priest, rabbi, clergy member, ordained or licensed minister, leader of a church or religious body, or accredited Christian Science practitioner is acting in some other capacity that would otherwise make him or her a mandated reporter. Inclusion of

Reporter's Name in Report Citation:
Gen. Laws Ch. 119, § 51A A report shall include the name of the person making the report.

Disclosure of Reporter Identity
This issue is not addressed in the statutes reviewed.

Michigan

Professionals Required to Report Citation:
Comp. Laws § 722.623 Mandatory reporters include the following: Physicians, physician assistants, dentists, dental hygienists, medical

examiners, nurses, persons licensed to provide emergency medical care, or audiologists, school administrators, counselors, or teachers, regulated child care providers, psychologists, marriage and family therapists, licensed professional counselors, social workers, or social work technicians, persons employed in a professional capacity in any office of the friend of the court, law enforcement officers, members of the clergy, Department of Human Services employees, including eligibility specialists, family independence managers, family independence specialists, social services specialists, social work specialists, social work specialist managers, or welfare services specialists, any employee of an organization or entity that, as a result of federal funding statutes, regulations, or contracts, would be prohibited from reporting in the absence of a State mandate or court order

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

Responsibility to Report Citation:
Comp. Laws § 722.623 If the reporting person is a member of the staff of a hospital, agency, or school, the reporting person shall notify the person in charge of the hospital, agency, or school of his or her finding and that the report has been made and shall make a copy of the written report available to the person in charge. A notification to the person in charge of a hospital, agency, or school does not relieve the member of the staff of the hospital, agency, or school of the obligation of reporting to the department as required by this section. One report from a hospital, agency, or school is adequate to meet the reporting requirement. A member of the staff of a hospital, agency, or school shall not be dismissed or otherwise penalized for making a report required by this act or for cooperating in an investigation. Standards for

Making a Report Citation:
Comp. Laws § 722.623 A report is required when a reporter has reasonable cause to suspect child abuse or neglect.

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

Inclusion of Reporter's Name in Report
The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity Citation:
Comp. Laws §§ 722,625; 722.627 The identity of a reporting person is confidential and subject to disclosure only with the consent of that person or by judicial process. The identity of the reporter is protected in any release of information to the subject of the report.

Minnesota

Professionals Required to Report Citation:
Ann. Stat. § 626.556, Subd. 3 Mandatory reporters include the following: A professional or professional's delegate who is engaged in the practice of the healing arts, hospital administration, psychological or psychiatric treatment, child care, education, social services, correctional supervision, probation or correctional services, or law enforcement, a member of the clergy who received the information while engaged in ministerial duties

Reporting by Other Persons Citation:
Ann. Stat. § 626.556, Subd. 3 Any person may voluntarily report to the local welfare agency, agency responsible for assessing or investigating the report, police department, county sheriff, Tribal social services agency, or Tribal police department if the person knows, has reason to believe, or suspects a child is being or has been neglected or subjected to physical or sexual abuse.

Institutional Responsibility to Report Citation:
Ann. Stat. § 626.556, Subd. 3(c) A person mandated to report physical or sexual child abuse or neglect occurring within a licensed facility shall report the information to the agency responsible for licensing the facility or a non-licensed personal care provider organization. A health or corrections agency receiving a report may request the local child welfare agency to provide assistance. A board or other entity whose licensees perform work within a school facility, upon receiving a complaint of alleged maltreatment, shall provide information about the circumstances of the alleged maltreatment to the commissioner of education.

Standards for Making a Report Citation:
Ann. Stat. § 626.556, Subd. 3 A report is required when a reporter knows or has reason to believe that a child is being neglected or sexually or physically abused or has been neglected or physically or sexually abused within the preceding 3 years.

Privileged Communications Citation:
Ann. Stat. § 626.556, Subd. 3 & 8 A member of the clergy is not required by this subdivision to report information that is otherwise privileged under § 595.02, subdivision 1, paragraph (c). No evidence relating to the neglect or abuse of a child, or to any prior incidents of neglect or abuse involving any of the same persons accused of neglect or abuse, shall be excluded in any proceeding on the grounds of privilege set forth in § 595.02, subdivision 1, paragraph (a) (husband-wife), (d) (medical practitioner-patient), or (g) (mental health professional-client).

Inclusion of Reporter's Name in Report Citation:
Ann. Stat. § 626.556, Subd. 7 The written report from a mandatory reporter must include the name and address of the reporter. Disclosure of Reporter Identity Citation: Ann. Stat. § 626.556, Subd. 11 Any person conducting an investigation or assessment under this section who intentionally discloses the identity of a reporter prior to the completion of the investigation or assessment is guilty of a misdemeanor. After the assessment or investigation is completed, the name of the reporter shall be confidential. The subject of the report may compel disclosure of the name of the reporter only with the consent of the reporter or upon a written finding by the court that the report was false and that there is evidence that the report was made in bad faith.

Mississippi

Professionals Required to Report Citation:
Ann. Code § 43-21-353 The following professionals are required to report: Physicians, dentists, interns, residents, or nurses, public or private school employees or child care givers, psychologists, social workers, family protection workers, or family protection specialists, attorneys, ministers, or law enforcement officers

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

Responsibility to Report:
This issue is not addressed in the statutes reviewed. Standards for Making a

Report Citation:
Ann. Code § 43-21-353 A report is required when a person has reasonable cause to suspect that a child is abused or neglected.

Privileged Communications:
This issue is not addressed in the statutes reviewed.

Inclusion of Reporter's Name in Report Citation:
Ann. Code § 43-21-353 The report shall include the name and address of all witnesses, including the reporter if he or she is a material witness to the abuse.

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

Missouri

Professionals Required to Report Citation:
Rev. Stat. §§ 210.115; 352.400; 573.215 Professionals required to report include the following: Physicians, medical examiners, coroners, dentists, chiropractors, optometrists, podiatrists, residents, interns, nurses, hospital and clinic personnel, or other health practitioners, daycare center workers or other child care workers, teachers, principals, or other school officials, psychologists, mental health professionals, or social workers, ministers, including clergy-persons, priests, rabbis, Christian Science practitioners, or other persons serving in a similar capacity for any religious organization, juvenile officers, probation or parole officers, peace officers, law enforcement officials, or jail or detention center personnel, volunteers or personnel of community service programs that offer support services for families in crisis to assist in the delegation of any powers regarding the care and custody of a child by a properly executed power of attorney, other persons with responsibility for the care of children, film and photographic

print processors; computer providers, installers, or repair persons; or internet service providers

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

Institutional Responsibility to Report Citation:
Rev. Stat. § 210.115 If two or more members of a medical institution who are required to report jointly have knowledge of a known or suspected instance of child abuse or neglect, a single report may be made by a designated member of that medical team. Any member who has knowledge that the member designated to report has failed to do so shall thereafter immediately make the report. Nothing in this section, however, is meant to preclude any person from reporting abuse or neglect. The reporting requirements under this section are individual, and no supervisor or administrator may impede or inhibit any reporting under this section. No person making a report shall be subject to any sanction, including any adverse employment action, for making such report. Every employer shall ensure that any employee required to report has immediate and unrestricted access to the communications technology necessary to make an immediate report and is temporarily relieved of other work duties for such time as is required to make any report required by this section.

Standards for Making a Report Citation:
Rev. Stat. §§ 210.115; 573.215 A report is required under the following circumstances: A reporter has reasonable cause to suspect that a child has been subjected to abuse or neglect, a reporter observes a child being subjected to conditions or circumstances that would reasonably result in abuse or neglect, a film and photographic print processor has knowledge of or observes any film, photograph, videotape, negative, slide, or computer-generated image or picture depicting a child younger than age 18 engaged in an act of sexual conduct.

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

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

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

Montana

Professionals Required to Report Citation:
Ann. Code §§ 41-3-201; 15-6-201(2)(b) Professionals required to report include the following: Physicians, residents, interns, members of hospital staffs, nurses, osteopaths, chiropractors, podiatrists, medical examiners, coroners, dentists, optometrists, or any other health professionals, teachers, school officials, or school employees who work during regular school hours operators or employees of any registered or licensed daycare or substitute care facility, or operators or employees of child care facilities, mental health professionals or social workers, religious healers, foster care, residential, or institutional workers, members of the clergy, as defined in § 15-6-201(2)(b), guardians ad litem or court-appointed advocates authorized to investigate a report, peace officers or other law enforcement officials. The term 'clergy' includes any of the following: An ordained minister, priest, or rabbi, a commissioned or licensed minister of a church or church denomination that ordains ministers if the person has the authority to perform substantially all the religious duties of the church or denomination, a member of a religious order who has taken a vow of poverty, a Christian Science practitioner

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

Institutional Responsibility to Report
This issue is not addressed in the statutes reviewed.

Standards for Making a Report Citation:
Ann. Code § 41-3-201 A report is required when either of the following apply: A reporter knows or has reasonable cause to suspect, as a result of information received in his or her professional or official capacity, that a

child is abused or neglected, a health-care professional involved in the delivery or care of an infant knows that the infant is affected by a dangerous drug.

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

Inclusion of Reporter's Name in Report:
The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity Citation:
Ann. Code § 41-3-205 The identity of the reporter shall not be disclosed in any release of information to the subject of the report.

Nebraska

Professionals Required to Report Citation:
Rev. Stat. § 28-711 Professionals required to report include the following: Physicians, medical institutions, or nurses, school employees, social workers. The inspector general appointed under § 43-4317 The Office of Inspector General of Nebraska Child Welfare was created within the Office of Public Counsel for the purpose of conducting investigations, audits, inspections, and other reviews of the Nebraska child welfare system. The inspector general shall be appointed by the public counsel with approval from the chairperson of the Executive Board of the Legislative Council and the chairperson of the Health and Human Services Committee of the legislature.

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

Institutional Responsibility to Report:
This issue is not addressed in the statutes reviewed.

Standards for Making a Report Citation:
Rev. Stat. § 28-711 A report is required when either of the following apply: A reporter has reasonable cause to believe that a child has been subjected to abuse or neglect, a reporter observes a child being subjected to conditions or circumstances that reasonably would result in abuse or neglect.

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

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

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

Nevada

Professionals Required to Report Citation:
Rev. Stat. § 432B.220 Mandatory reporters include the following: Persons providing services licensed or certified in this State pursuant to, without limitation, hospitals, physicians and other medical personnel, psychologists, therapists, social workers, and counselors, as described in chapters 450B, 630, 630A, 631, 632, 633, 634, 634A, 635, 636, 637, 637B, 639, 640, 640A, 640B, 640C, 640D, 640E, 641, 641A, 641B, and 641C, any personnel of a licensed medical facility engaged in the admission, examination, care, or treatment of persons or an administrator, manager, or other person in charge of the medical facility upon notification of suspected abuse or neglect of a child by a member of the staff of the medical facility, coroners, members of the clergy, Christian Science practitioners, or religious healers, employees of public or private schools and any volunteers serving at such schools, persons who maintain or are employed by facilities that provide care for children, children's camps, or other public or private facilities, institutions, or agencies furnishing care to children, persons licensed to conduct foster homes, officers or employees of law enforcement agencies or adult or juvenile probation officers, except as otherwise provided below, attorneys, persons who maintain, are employed by, or serve as volunteers for agencies or services that advise persons regarding abuse or neglect of a child and refer

them to persons and agencies where their requests and needs can be met, persons who are employed by or serve as volunteers for a youth shelter, any adult person who is employed by an entity that provides organized activities for children, including, without limitation, any person who is employed by a school district or public school

Reporting by Other Persons Citation:
Rev. Stat. § 432B.220 Any other person may report.

Institutional Responsibility to Report:
This issue is not addressed in the statutes reviewed.

Standards for Making a Report Citation:
Rev. Stat. § 432B.220 A report is required when any of the following apply: A reporter, in his or her professional capacity, knows or has reason to believe that a child is abused or neglected, a reporter has reasonable cause to believe that a child has died as a result of abuse or neglect, a medical services provider who delivers or provides medical services to a newborn infant, in his or her professional or occupational capacity, knows or has reasonable cause to believe that the newborn infant has been affected by prenatal illegal substance abuse or has withdrawal symptoms resulting from prenatal drug exposure.

Privileged Communications Citation:
Rev. Stat. §§ 432B.220; 432B.225; 432B.250 The clergy-penitent privilege applies when the knowledge is gained during religious confession. Notwithstanding the provisions of § 432B.220, an attorney shall not make a report of the abuse or neglect of a child if the attorney acquired knowledge of the abuse or neglect from a client during a privileged communication if the client: Has been or may be accused of committing the abuse or neglect Is the victim of the abuse or neglect, is in foster care, and did not give consent to the attorney to report the abuse or neglect Nothing in this section shall be construed as relieving an attorney from either of the following: The duty to report the abuse or neglect of a child, except as otherwise provided above. Complying with any ethical duties of attorneys, including, without limitation, any duty to take reasonably necessary actions to protect his or her client if the client is not capable of making adequately considered decisions because of age, mental impairment, or any other reason Any other person who is required to report may not invoke privilege for failure to make a report.

Inclusion of Reporter's Name in Report
The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity
Citation: Rev. Stat. § 432B.290 Information maintained by a child welfare agency may be made available to the persons listed below, as long as the identity of the person making the report is kept confidential: The proposed guardian or proposed successor guardian of a child, a parent or legal guardian of the child and his or her attorney, a child age 14 or older over whom a guardianship is sought, upon written consent of the parent, any officer of this state or a city or county, or a legislator, to investigate the activities or programs of a child welfare agency. An agency investigating a report of the abuse or neglect of a child shall, upon request, provide to a person named in the report as allegedly causing the abuse or neglect of the child a written summary of the allegations made against the person who is named in the report as allegedly causing the abuse or neglect of the child. The summary must not identify the person responsible for reporting the alleged abuse or neglect or any collateral sources and reporting parties. Except as provided below, before releasing any information an agency shall take whatever precautions it determines are reasonably necessary to protect the identity and safety of any person who reports child abuse or neglect. A person who is the subject of an unsubstantiated report of child abuse or neglect who believes that the report was made in bad faith or with malicious intent may petition a district court to order the agency that provides child welfare services to release information maintained by the agency. If the court finds that there is a reasonable cause to believe that the report was made in bad faith or with malicious intent and that the disclosure of the identity of the person who made the report would not be likely to endanger the life or safety of the person who made the report, the court shall provide a copy of the information to the petitioner.

New Hampshire

Professionals Required to Report Citation:
Rev. Stat. § 169-C:29 The following professionals are required to report: Physicians, surgeons, county medical examiners, psychiatrists, residents, interns, dentists, osteopaths, optometrists, chiropractors, nurses, hospital personnel, or Christian Science practitioners, teachers, school officials,

nurses, or counselors, daycare workers or any other child or foster care workers, social workers, psychologists or therapists • Priests, ministers, or rabbis, law enforcement officials

Reporting by Other Persons Citation:
Rev. Stat. § 169-C:29 All other persons who have reason to suspect that a child has been abused or neglected must report.

Institutional Responsibility to Report:
This issue is not addressed in the statutes reviewed.

Standards for Making a Report Citation:
Rev. Stat. § 169-C:29 A report is required when a person has reason to suspect that a child has been abused or neglected.

Privileged Communications Citation:
Rev. Stat. § 169-C:32 Only the attorney-client privilege is permitted.

Inclusion of Reporter's Name in Report:
The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity Citation:
Rev. Stat. § 170-G:8-a The case records of the Department of Health and Human Services do not include the name of a person who makes a report of suspected abuse or neglect of a child or any information that would identify the reporter.

New Jersey

Professionals Required to Report
No professional groups are specified in statute; all persons are required to report.

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

Institutional Responsibility to Report:
This issue is not addressed in the statutes reviewed.

Standards for Making a Report Citation:
Ann. Stat. § 9:6-8.10 A report is required when a person has reasonable cause to believe that a child has been subjected to abuse or neglect.

Privileged Communications:
This issue is not addressed in the statutes reviewed.

Inclusion of Reporter's Name in Report:
The reporter is not specifically required by statute to provide his or her name in the report.

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

New Mexico

Professionals Required to Report Citation:
Ann. Stat. § 32A-4-3 Professionals required to report include the following: Licensed physicians, residents or interns, law enforcement officers or judges, registered nurses or visiting nurses, teachers or school officials, social workers acting in their official capacity, members of the clergy

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

Institutional Responsibility to Report:
This issue is not addressed in the statutes reviewed.

Standards for Making a Report Citation:
Ann. Stat. § 32A-4-3 A report is required when a person knows or has a reasonable suspicion that a child is abused or neglected.

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

Inclusion of Reporter's Name in Report Citation:
Ann. Stat. § 32A-4-5 The identity of the mandated reporter will be verified before any investigation is initiated.

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

New York

Professionals Required to Report Citation:
Soc. Serv. Law § 413 The following persons and officials are required to report: Physicians, physician assistants, surgeons, medical examiners, coroners, dentists, dental hygienists, osteopaths, optometrists, chiropractors, podiatrists, residents, interns, psychologists, registered nurses, social workers, or emergency medical technicians, licensed creative arts therapists, marriage and family therapists, mental health counselors, or psychoanalysts, hospital personnel or Christian Science practitioners, school officials, including, but not limited to, teachers, guidance counselors, school psychologists, school social workers, school nurses, or administrators, full- or part-time compensated school employees required to hold temporary coaching licenses or professional coaching certificates, social services workers, daycare center workers, providers of family or group family daycare, or any other child care or foster care worker, employees of publicly-funded emergency shelters for families with children, directors of children's overnight camps, summer day camps, or traveling summer day camps, employees or volunteers in residential care facilities for children that are licensed, certified, or operated by the Office of Children and Family Services, mental health professionals, substance abuse counselors, alcoholism counselors, or all persons credentialed by the Office of Alcoholism and Substance Abuse Services, employees of health home-care

agencies or home- and community-based services who are expected to have regular and substantial contact with children, peace officers, police officers, district attorneys or assistant district attorneys, investigators employed in the office of a district attorney, or other law enforcement officials

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

Institutional Responsibility to Report Citation:
Soc. Serv. Law § 413 Whenever a person is required to report in his or her capacity as a member of the staff of a medical or other public or private institution, school, facility, or agency, he or she shall make the report as required and immediately notify the person in charge of such institution, school, facility, or agency, or his or her designated agent. The person in charge, or the designated agent of such person, shall be responsible for all subsequent administration necessitated by the report. Any report shall include the name, title, and contact information for every staff person of the institution who is believed to have direct knowledge of the allegations in the report. Nothing in this section or title is intended to require more than one report from any such institution, school, or agency. A medical or other public or private institution, school, facility, or agency shall not take any retaliatory personnel action against an employee because such employee believes that he or she has reasonable cause to suspect that a child is an abused or maltreated child and that employee therefore makes a report in accordance with this title. 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 a member of their staff specifically required to report under this title.

Standards for Making a Report Citation:
Soc. Serv. Law § 413 A report is required when the reporter has reasonable cause to suspect that either of the following is true: A child coming before him or her in his or her professional or official capacity is an abused or maltreated child, the parent, guardian, custodian, or other person legally responsible for the child comes before the reporter and states from personal knowledge facts, conditions, or circumstances that, if correct, would render the child an abused or maltreated child.

Privileged Communications Citation:
Soc. Serv. Law § 415 Notwithstanding the privileges set forth in article 45 of the civil practice law and rules, and any other provision of law to the contrary, mandated reporters who make a report that initiates an investigation of an allegation of child abuse or maltreatment are required to comply with all requests for records made by a child protective services agency relating to the report.

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

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

North Carolina

Professionals Required to Report Citation:
Gen. Stat. § 7B-301 Any person or institution that has cause to suspect abuse or neglect shall report.

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

Institutional Responsibility to Report:
This issue is not addressed in the statutes reviewed.

Standards for Making a Report Citation:
Gen. Stat. § 7B-301 A report is required when a reporter has cause to suspect that any juvenile is abused, neglected, or dependent or has died as the result of maltreatment.

Privileged Communications Citation:
Gen. Stat. § 7B-310 No privilege shall be grounds for failing to report, even if the knowledge or suspicion is acquired in an official professional capacity, except when the knowledge or suspicion is gained by an attorney from that

attorney's client during representation only in the abuse, neglect, or dependency case. No privilege, except the attorney-client privilege, shall be grounds for excluding evidence of abuse, neglect, or dependency.

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

Disclosure of Reporter Identity Citation:
Gen. Stat. § 7B-302 The Department of Social Services shall hold the identity of the reporter in strictest confidence, except that the department shall disclose confidential information regarding the identity of the reporter to any Federal, State, or local government entity or its agent with a court order. The department may only disclose confidential information regarding the identity of the reporter to a Federal, State, or local government entity or its agent without a court order when the entity demonstrates a need for the reporter's name to carry out the entity's mandated responsibilities.

North Dakota

Professionals Required to Report Citation:
Cent. Code §§ 50-25.1-03; 25-01-01 The following professionals are required to report: Dentists, dental hygienists, optometrists, medical examiners or coroners, or any other medical or mental health professionals Tier 1, tier 2, tier 3, or tier 4 mental health professionals, as defined under § 25-01-01, religious practitioners of the healing arts, schoolteachers, administrators, or school counselors, child care workers or foster parents, police or law enforcement officers, juvenile court personnel, probation officers, or division of juvenile services employees, licensed social workers, family services specialists, or child care licensors, members of the clergy Mental health professionals are classified as follows: Tier 1 mental health professionals include licensed psychiatrists, psychologists, physicians, or physician assistants, and advanced practice registered nurses. Tier 2 mental health professionals include licensed independent clinical social workers, professional clinical counselors, marriage and family therapists, addiction counselors, and registered nurses. Tier 3 mental health professionals include licensed associate professional counselors, master social workers, baccalaureate social workers, professional counselors, associate marriage and family therapists, occupational therapists, practical nurses, behavior analysts, vocational rehabilitation counselors, school psychologists, and

human relations counselors. Tier 4 mental health professionals include direct care associates or technicians.

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

Responsibility to Report Citation:
Cent. Code §§ 50-25.1-04; 50-25.1-09.1 Reports involving known or suspected institutional child abuse or neglect must be made and received in the same manner as all other reports made under this chapter. An employer is prohibited from retaliating against an employee solely because the employee in good faith reported having reasonable cause to suspect that a child was abused or neglected or died as a result of abuse or neglect or because the employee is a child with respect to whom a report was made. There is a rebuttable presumption that any adverse action within 90 days of a report is retaliatory. For purposes of this subsection, an 'adverse action' is action taken by an employer against the person making the report or the child with respect to whom a report was made, including any of the following: Discharge, suspension, termination, or transfer from any facility, institution, school, agency, or other place of employment, discharge from or termination of employment, demotion or reduction in remuneration for services, restriction or prohibition of access to any facility, institution, school, agency, or other place of employment or persons affiliated with it

Standards for Making a Report Citation:
Cent. Code § 50-25.1-03 A report is required when a reporter has knowledge of or reasonable cause to suspect that a child is abused or neglected, if the knowledge or suspicion is derived from information received by that person in that person's official or professional capacity. A person who has knowledge of or reasonable cause to suspect that a child is abused or neglected based on images of sexual conduct by a child discovered on a workplace computer shall report the circumstances to the department.

Privileged Communications Citation:
Cent. Code §§ 50-25.1-03; 50-25.1-10 A member of the clergy is not required to report such circumstances if the knowledge or suspicion is derived from information received in the capacity of spiritual adviser. Any privilege of communication between husband and wife or between any

professional person and the person's patient or client, except between attorney and client, cannot be used as grounds for failing to report.

Inclusion of Reporter's Name in Report:
The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity Citation:
Cent. Code § 50-25.1-11 All reports are confidential and must be made available to a parent, the child's guardian, and any person who is the subject of a report provided that the identity of persons reporting or supplying information is protected.

Ohio

Professionals Required to Report Citation:
Rev. Code § 2151.421 Mandatory reporters include the following: Attorneys, physicians, interns, residents, dentists, podiatrists, nurses, or other health-care professionals, licensed psychologists, school psychologists, or marriage and family therapists, speech pathologists or audiologists, coroners, administrators or employees of child daycare centers, certified child care agencies, or other public or private children services; residential camps; child day camps; or private, nonprofit therapeutic wilderness camps agencies, teachers, school employees, or school authorities, persons engaged in social work or the practice of professional counseling, peace officers or agents of county humane societies, persons, other than clerics, rendering spiritual treatment through prayer in accordance with the tenets of a well-recognized religion, professional employees of a county Department of Job and Family Services who works with children and families, superintendents or regional administrators employed by the Department of Youth Services, superintendents, board members, or employees of county boards of developmental disabilities; investigative agents contracted with by a county board of developmental disabilities; employees of the Department of Developmental Disabilities; employees of a facility or home that provides respite care; employees of a home health agency; or employees of an entity that provides homemaker services, persons performing the duties of an assessor or third party employed by a public children's services agency to assist in providing child- or family-related services, court-appointed special advocates or guardians ad litem

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

Institutional Responsibility to Report:
This issue is not addressed in the statutes reviewed.

Standards for Making a Report Citation:
ev. Code § 2151.421 A report is required when a mandated person is acting in an official or professional capacity and knows or suspects that a child under age 18 or a person under age 21 with a developmental disability or physical impairment has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child.

Privileged Communications Citation:
Rev. Code § 2151.421 An attorney, physician, or cleric is not required to make a report concerning any communication the attorney, physician, or cleric receives from a client, patient, or penitent in a professional relationship, if, in accordance with § 2317.02, the attorney, physician, or cleric could not testify with respect to that communication in a civil or criminal proceeding. If all the following apply, the client, patient, or penitent in the relationship is deemed to have waived any testimonial privilege with respect to any communication the attorney, physician, or cleric receives, and the attorney, physician, or cleric shall make a report with respect to that communication: The client, patient, or penitent, at the time of the communication, is either a child under age 18 or a mentally retarded, developmentally disabled, or physically impaired person under age 21. The attorney, physician, or cleric knows, or has reasonable cause to suspect based on facts that would cause a reasonable person in similar position to suspect, as a result of the communication or any observations made during that communication, that the client, patient, or penitent has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the person. The abuse or neglect does not arise out of the person's attempt to have an abortion without the notification of her parents, guardian, or custodian in accordance with § 2151.85.

Inclusion of Reporter's Name in Report Citation:
Rev. Code § 2151.421 The reporter is not required to provide his or her name in the report, but if he or she wants to receive information on the outcome of the investigation, he or she must provide his or her name, address, and telephone number to the person who receives the report.

Disclosure of Reporter Identity Citation:
Rev. Code § 2151.421 The information provided in a report made pursuant to this section and the name of the person who made the report shall not be released for use and shall not be used as evidence in any civil action or proceeding brought against the person who made the report.

Oklahoma

Professionals Required to Report Citation:
Ann. Stat. Tit. 10A, § 1-2-101; Tit. 21, § 1021.4 Mandatory reporters include the following: All persons. Commercial film and photographic print processors or computer technicians

Reporting by Other Persons Citation:
Ann. Stat. Tit. 10A, § 1-2-101 Every person who has reason to believe that a child is a victim of abuse or neglect must report.

Institutional Responsibility to Report Citation:
Ann. Stat. Tit. 10A, § 1-2-101 The reporting obligations under this section are individual, and no employer, supervisor, administrator, governing body, or entity shall interfere with the reporting obligations of any employee or other person or in any manner discriminate or retaliate against the employee or other person who in good faith reports suspected child abuse or neglect or who provides testimony in any proceeding involving child abuse or neglect. Any employer, supervisor, administrator, governing body, or entity that discharges, discriminates, or retaliates against the employee or other person shall be liable for damages, costs, and attorney fees. If a child who is the subject of the report or other child is harmed by the discharge, discrimination, or retaliation described in this paragraph, the party harmed may file an action to recover damages, costs, and attorney fees.

Standards for Making a Report Citation:
Ann. Stat. Tit. 10A, § 1-2-101; Tit. 21, § 1021.4 A report is required when any of the following apply: Any person has reason to believe that a child

under age 18 is a victim of abuse or neglect. A physician, surgeon, other health-care professional (including doctors of medicine, licensed osteopathic physicians, residents, and interns), or midwife is involved in the prenatal care of expectant mothers or the delivery or care of infants and an infant tests positive for alcohol or a controlled dangerous substance or is diagnosed with neonatal abstinence syndrome or fetal alcohol spectrum disorder. A commercial film and photographic print processor or computer technician has knowledge of or observes any film, photograph, videotape, negative, or slide depicting a child engaged in an act of sexual conduct.

Privileged Communications Citation:
Ann. Stat. Tit. 10A, § 1-2-101 No privilege shall relieve any person from the requirement to report.

Inclusion of Reporter's Name in Report:
This issue is not addressed in the statutes reviewed.

Disclosure of Reporter Identity Citation:
Ann. Stat. Tit. 10A, § 1-2-101 The Department of Human Services shall electronically record each referral received by the statewide centralized child abuse reporting hotline and establish a secure means of retaining the recordings for 12 months. The recordings shall be confidential and subject to disclosure only if a court orders the disclosure of the referral. The department shall redact any information identifying the reporting party unless otherwise ordered by the court.

Oregon

Professionals Required to Report Citation:
Rev. Stat. §§ 419B.005; 419B.010 The following public or private officials are mandated to report: Physicians, physician assistants, naturopathic physicians, interns, residents, optometrists, chiropractors, dentists, nurses, nurse practitioners, pharmacists, nurse's aides, home health aides, or employees of in-home health services, school employees, including employees of higher education institutions (such as community colleges and public and private universities), employees of the Department of Human Services, the Oregon Health Authority, the Early Learning Division, the Youth Development Council, the Office of Child Care, the Oregon Youth Authority, a local health department, a community mental health program, a community developmental disabilities program, a county juvenile

department, a licensed child-caring agency, or an alcohol and drug treatment program, peace officers, members of the clergy, psychologists, social workers, professional counselors, or marriage and family therapists, certified foster care or child care providers, attorneys or court-appointed special advocates, firefighters or emergency medical technicians, members of the legislative assembly, physical, speech, or occupational therapists, audiologists or speech-language pathologists, employees of the Teacher Standards and Practices Commission directly involved in investigations or discipline by the commission, operators of preschool or school-age recorded programs, employees or a private agency or organization facilitating the provision of respite services for parents pursuant to a properly executed power of attorney, employees of organizations providing child-related services or activities, including youth groups or centers, scout groups or camps, or summer or day camps, coaches, assistant coaches, or trainers of athletes, if compensated and if the athlete is a child, personal support and home care workers.

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

Institutional Responsibility to Report Citation:
Rev. Stat. § 419B.010 The duty to report under this section is personal to the public or private official alone, regardless of whether the official is employed by, a volunteer of, or a representative or agent for any type of entity or organization that employs persons or uses persons as volunteers who are public or private officials in its operations. The duty to report under this section exists regardless of whether the entity or organization that employs the public or private official or uses the official as a volunteer has its own procedures or policies for reporting abuse internally within the entity or organization.

Standards for Making a Report Citation:
Rev. Stat. § 419B.010 A report is required when any public or private official has reasonable cause to believe that any child with whom the official comes in contact has suffered abuse.

Privileged Communications Citation:
Rev. Stat. § 419B.010 A psychiatrist, psychologist, member of the clergy, or attorney shall not be required to report if such communication is privileged under law. An attorney is not required to make a report of information

communicated to the attorney in the course of representing a client if disclosure of the information would be detrimental to the client.

Inclusion of Reporter's Name in Report:
The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity Citation:
Rev. Stat. § 419B.015 The name, address, and other identifying information about the person who made the report may not be disclosed.

Pennsylvania

Professionals Required to Report Citation:
Cons. Stat. Tit. 23, § 6311 The following adults are required to report: Persons licensed or certified to practice in any health-related field, medical examiners, coroners, or funeral directors, employees of licensed health-care facilities who are engaged in the admission, examination, care, or treatment of individuals, school employees, employees of a child care service or public library, a clergyman, priest, rabbi, minister, Christian Science practitioner, religious healer, or spiritual leader of any regularly established church or other religious organization, any person, paid or unpaid, who, on the basis of the person's role in a program, activity, or service, is a person responsible for the child's welfare or has direct contact with children, employees of a social services agency, a peace officer or law enforcement official, an emergency medical services provider, an individual supervised or managed by a person listed above who has direct contact with children, an independent contractor, an attorney affiliated with an agency, institution, or other entity, including a school or established religious organization that is responsible for the care, supervision, guidance, or control of children, a foster parent, an adult family member who is a person responsible for the child's welfare and provides services to a child in a family living home, community home for individuals with an intellectual disability, or licensed host home for children, a school employee' is an individual who is employed by a school or who provides an activity or service sponsored by a school. The term does not apply to administrative personnel unless that person has direct contact with children. A school is a facility providing elementary, secondary, or postsecondary educational services, including public and nonpublic schools, vocational-technical schools, and institutions of higher education.

Reporting by Other Persons Citation:
Cons. Stat. Tit. 23, § 6312 Any person may make an oral or written report of suspected child abuse, which may be submitted electronically, if that person has reasonable cause to suspect that a child is a victim of child abuse.

Institutional Responsibility to Report Citation:
Cons. Stat. Tit. 23, § 6311 Whenever a person is required to report in the capacity as a member of the staff of a medical or other public or private institution, school, facility, or agency, that person shall report immediately in accordance with § 6313 and shall immediately thereafter notify the person in charge of the institution, school, facility, or agency, or the designated agent of the person in charge. Upon notification, the person in charge or the designated agent, if any, shall facilitate the cooperation of the institution, school, facility, or agency with the investigation of the report. Any intimidation, retaliation, or obstruction in the investigation of the report is subject to the provisions of title 18, § 4958 (relating to intimidation, retaliation, or obstruction in child abuse cases). This chapter does not require more than one report from any such institution, school, facility, or agency.

Standards for Making a Report Citation:
Cons. Stat. Tit. 23, § 6311 A mandated reporter shall make a report of suspected child abuse if he or she has reasonable cause to suspect that a child is a victim of child abuse under any of the following circumstances: • The mandated reporter comes into contact with the child in the course of employment, occupation, and practice of a profession or through a regularly scheduled program, activity, or service. • The mandated reporter is directly responsible for the care, supervision, guidance, or training of the child or is affiliated with an agency, institution, organization, school, regularly established church or religious organization, or other entity that is directly responsible for the care, supervision, guidance, or training of the child, a person makes a specific disclosure to the mandated reporter that an identifiable child is the victim of child abuse, an individual age 14 or older makes a specific disclosure to the mandated reporter that the individual has committed child abuse. Nothing in this section shall require a child to come before the mandated reporter in order for the mandated reporter to make a report of suspected child abuse. Nothing in this section shall require the mandated reporter to identify the person responsible for the child abuse to make a report of suspected child abuse.

Privileged Communications Citation:
Cons. Stat. Tit. 23, § 6311.1 The privileged communications between a mandated reporter and a patient or client of the mandated reporter shall not apply to a situation involving child abuse nor relieve the mandated reporter of the duty to make a report of suspected child abuse. The following protections shall apply: Confidential communications made to a member of the clergy are protected under title 42, § 5943 (relating to confidential communications to clergymen), confidential communications made to an attorney are protected so long as they are within the scope of title 42, § 5916 (relating to confidential communications to an attorney) and § 5928 (relating to confidential communications to an attorney), the attorney work product doctrine, or the rules of professional conduct for attorneys. Inclusion of

Reporter's Name in Report Citation:
Cons. Stat. Tit. 23, § 6313 A written report of suspected child abuse, which may be submitted electronically, shall include the name, telephone number, and email address of the person making the report.

Disclosure of Reporter Identity Citation:
Cons. Stat. Tit. 23, § 6340 Upon a written request, a subject of a report may receive a copy of all information, except for the identity of the person who made the report. Except for reports released to law enforcement officials and the district attorney's office, and in response to a law enforcement official investigating allegations of false reports under title 18, § 4906.1 (relating to false reports of child abuse), the release of data that would identify the person who made a report of suspected child abuse or who cooperated in a subsequent investigation is prohibited. Law enforcement officials shall treat all reporting sources as confidential informants.

Puerto Rico

Professionals Required to Report Citation:
Ann. Laws Tit. 8, § 446 The following individuals and entities are required to report: Professionals or public officials, public, private, or privatized entities, professionals in the fields of health, justice, education, social work, or public order, persons who administer or work in caregiving institutions or centers, rehabilitation institutions, centers for minors, or foster homes, processors of film or photographs

Reporting by Other Persons Citation:
Ann. Laws Tit. 8, § 446 Any person who has knowledge of or suspects that a minor is a victim of abuse or neglect must report.

Institutional Responsibility to Report:
This issue is not addressed in the statutes reviewed.

Standards for Making a Report Citation:
Ann. Laws Tit. 8, § 446 A report is required when either of the following apply: A person, in his or her professional capacity and in the performance of his or her functions, learns or comes to suspect that a minor is, has been, or is at risk of becoming a victim of abuse, a film processor has knowledge of or observes any motion picture, photograph, videotape, negative, or slide that depicts a minor involved in a sexual activity.

Privileged Communications:
This issue is not addressed in the statutes reviewed.

Inclusion of Reporter's Name in Report:
The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity Citation:
Ann. Laws Tit. 8, § 446 The identity of the person who made the report shall be kept in strict confidence.

Rhode Island

Professionals Required to Report Citation:
Gen. Laws § 40-11-6 Any physician, duly certified registered nurse practitioner, or other health-care provider is required to report.

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

Institutional Responsibility to Report:
This issue is not addressed in the statutes reviewed.

Standards for Making a Report Citation:
Gen. Laws §§ 40-11-3(a); 40-11-6 A report is required when the following apply: A person has reasonable cause to know or suspect that a child has been abused or neglected. The following apply to a physician, nurse practitioner, or other health-care provider: » He or she is involved in the delivery or care of infants born with, or identified as being affected by, substance abuse or withdrawal symptoms resulting from prenatal drug exposure or a fetal alcohol spectrum disorder. » He or she has cause to suspect that a child brought to them for treatment is an abused or neglected child. » He or she determines that a child younger than age 12 is suffering from any sexually transmitted disease.

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

Inclusion of Reporter's Name in Report:
The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity:
This issue is not addressed in the statutes reviewed.

South Carolina

Professionals Required to Report Citation:
Ann. Code § 63-7-310 The following professionals are required to report: Physicians, nurses, dentists, optometrists, medical examiners, or coroners, employees of county medical examiner's or coroner's offices, any other medical, emergency medical services, mental health, or allied health professionals, members of the clergy, including Christian Science practitioners or religious healers, clerical or nonclerical religious counselors who charge for services, school teachers, counselors, principals, assistant principals, or school attendance officers, social or public assistance workers, substance abuse treatment staff, or child care workers in a child care center or foster care facility, foster parents, police or law enforcement officers or juvenile justice workers, undertakers, funeral home directors, or employees of a funeral home, persons responsible for processing films or computer

technicians, judges, volunteer non-attorney guardians ad litem serving on behalf of the South Carolina Guardian Ad Litem Program or the Richland County Court-Appointed Special Advocates program.

Reporting by Other Persons Citation:
Ann. Code § 63-7-310 A person who has reason to believe that a child's physical or mental health or welfare has been or may be adversely affected by abuse and neglect may report, and is encouraged to report, in accordance with this section.

Institutional Responsibility to Report Citation:
Ann. Code §§ 63-7-310; 63-7-315 A person who reports child abuse or neglect to a supervisor or person in charge of an institution, school, facility, or agency is not relieved of his or her individual duty to report in accordance with this section. The duty to report is not superseded by an internal investigation within the institution, school, facility, or agency. An employer must not dismiss, demote, suspend, or otherwise discipline or discriminate against an employee who is required or permitted to report child abuse or neglect pursuant to § 63-7-310 based on the fact that the employee has made a report of child abuse or neglect. An employee who is adversely affected by conduct that is in violation of this section may bring a civil action for reinstatement and back pay. An action brought pursuant to this section may be commenced against an employer, including the State; a political subdivision of the State; and an office, department, independent agency, authority, institution, association, or other body in State government.

Standards for Making a Report Citation:
Ann. Code § 63-7-310 A report is required when a reporter, in his or her professional capacity, receives information that gives him or her reason to believe that a child has been or may be abused or neglected.

Privileged Communications Citation:
Ann. Code § 63-7-420 The privileged quality of communication between husband and wife and any professional person and his or her patient or client, except that between attorney and client or clergy member, including a Christian Science practitioner or religious healer, and penitent, does not constitute grounds for failure to report. However, a clergy member, including a Christian Science practitioner or religious healer, must report in accordance with this sub-article except when information is received from the alleged perpetrator of the abuse and neglect during a communication that

is protected by the clergy and penitent privilege as provided for in § 19-11-90.

Inclusion of Reporter's Name in Report:
The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity Citation:
Ann. Code § 63-7-330 The identity of the person making a report pursuant to this section must be kept confidential by the agency or department receiving the report and must not be disclosed, except as specifically provided for in statute.

South Dakota

Professionals Required to Report Citation:
Ann. Laws § 26-8A-3 Mandatory reporters include the following: Physicians, dentists, osteopaths, chiropractors, optometrists, emergency medical technicians, paramedics, religious healing practitioners, podiatrists, hospital interns or residents, nurses, or coroners, teachers, school counselors, or officials, licensed or registered child welfare providers, mental health professionals or counselors, psychologists, social workers, chemical dependency counselors, employees or volunteers of domestic abuse shelters, or religious healing practitioners, employees or volunteers of child advocacy organizations or child welfare service providers, parole or court services officers or law enforcement officers, any safety-sensitive position (as defined in § 23-3-64), including any law enforcement officer authorized to carry firearms and any custody staff employed by any agency responsible for the rehabilitation or treatment of any adjudicated adult or juvenile.

Reporting by Other Persons Citation:
Ann. Laws § 26-8A-3 Any person who knows or has reasonable cause to suspect that a child younger than age 18 has been abused or neglected may report.

Institutional Responsibility to Report Citation:
Ann. Laws §§ 26-8A-6; 26-8A-7 Any person who has contact with a child through the performance of services as a member of a staff of a hospital or similar institution shall immediately notify the person in charge of the

institution or his designee of suspected abuse or neglect. The person in charge shall report the information in accordance with the provisions of § 26-8A-8. Any person who has contact with a child through the performance of services in any public or private school—whether accredited or unaccredited, as a teacher, school nurse, school counselor, school official, or administrator—or any person providing services pursuant to § 13-27-3 shall notify the school principal or school superintendent or designee of suspected abuse or neglect. The school principal or superintendent shall report the information in accordance with the provisions of § 26-8A-8. Each school district shall have a written policy on reporting of child abuse and neglect.

Standards for Making a Report Citation:
Ann. Laws § 26-8A-3 A report is required when a reporter has reasonable cause to suspect that a child has been abused or neglected.

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

Inclusion of Reporter's Name in Report:
The reporter is not specifically required by statute to provide his or her name in the report.

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

Tennessee

Professionals Required to Report Citation:
Ann. Code §§ 37-1-403; 37-1-605 Persons required to report include the following: • Physicians, osteopaths, medical examiners, chiropractors, nurses, hospital personnel, or other health or mental health professionals, teachers, other school officials or personnel, or daycare center workers, other professional child care, foster care, residential, or institutional workers,

social workers, practitioners who rely solely on spiritual means for healing, judges or law enforcement officers, neighbors, relatives, or friends, authority figures at community facilities, including any facility used for recreation or social assemblies or for educational, religious, social, health, or welfare purposes, including, but not limited to, facilities operated by schools, the Boy or Girl Scouts, the YMCA or YWCA, the Boys and Girls Club, or church or religious organizations, other persons.

Reporting by Other Persons Citation:
Ann. Code §§ 37-1-403; 37-1-605 Any person who has knowledge that a child has been harmed by abuse or neglect must report.

Institutional Responsibility to Report Citation:
Ann. Code § 37-1-403 Nothing in this section shall be construed to prohibit any hospital, clinic, school, or other organization responsible for the care of children from developing a specific procedure for internally tracking, reporting, or otherwise monitoring a report made by a member of the organization's staff, including requiring a member of the organization's staff who makes a report to provide a copy of or notice concerning the report to the organization, so long as the procedure does not inhibit, interfere with, or otherwise affect the duty of a person to make a report as required by law. Nothing in this section shall prevent staff of a hospital or clinic from gathering sufficient information, as determined by the hospital or clinic, in order to make an appropriate medical diagnosis or to provide and document care that is medically indicated and is needed to determine whether to report an incident as defined in this part. Those activities shall not interfere with nor serve as a substitute for any investigation by law enforcement officials or the department. However, if any hospital, clinic, school, or other organization responsible for the care of children develops a procedure for internally tracking, reporting, or otherwise monitoring a report, the identity of the person who made a report of harm shall be kept confidential.

Standards for Making a Report Citation:
Ann. Code §§ 37-1-403; 37-1-605 A report is required when any of the following apply: A person has knowledge that a child has been harmed by abuse or neglect, a person is called upon to render aid to any child who is suffering from an injury that reasonably appears to have been caused by abuse, a person knows or has reasonable cause to suspect that a child has been sexually abused, a physician diagnoses or treats any sexually transmitted disease in a child age 13 or younger or diagnoses pregnancy in

an unemancipated minor. Any school official, personnel, employee, or member of the board of education who is aware of a report or investigation of employee misconduct on the part of any employee of the school system that in any way involves known or alleged child abuse, including, but not limited to, child physical or sexual abuse or neglect, shall immediately upon knowledge of such information notify the Department of Children's Services or law enforcement official of the abuse or alleged abuse.

Privileged Communications Citation:
Ann. Code § 37-1-411 The following privileges may not be claimed: Husband-wife, psychiatrist-patient or psychologist-patient.

Inclusion of Reporter's Name in Report:
The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity Citation:
Ann. Code § 37-1-409 Except as may be ordered by the juvenile court, the name of any person reporting child abuse or neglect shall not be released to any person, other than employees of the department or other child protection team members responsible for child protective services, the abuse registry, or the appropriate district attorney general upon subpoena of the Tennessee Bureau of Investigation, without the written consent of the person reporting. The reporter's identity shall be irrelevant to any civil proceeding and shall, therefore, not be subject to disclosure by order of any court. This shall not prohibit the issuance of a subpoena to a person reporting child abuse when deemed necessary by the district attorney general or the department to protect a child who is the subject of a report, provided that the fact that the person made the report is not disclosed.

Texas

Professionals Required to Report Citation:
Fam. Code § 261.101 For purposes of the reporting laws, persons required to report include professionals who are licensed or certified by the State or who are employees of facilities licensed, certified, or operated by the State and who, in the normal course of official duties or duties for which licensure or certification is required, have direct contact with children. Professionals include the following: Teachers or daycare employees, nurses, doctors, or employees of a clinic or health-care facility that provides reproductive

services, juvenile probation officers or juvenile detention or correctional officers

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

Institutional Responsibility to Report Citation:
Fam. Code §§ 261.101; 261.110 A professional may not delegate to or rely on another person to make the report. An employer may not suspend or terminate the employment of, or otherwise discriminate against, a person who is a professional and who in good faith does any of the following: Reports child abuse or neglect to the person's supervisor, an administrator of the facility where the person is employed, a State regulatory agency, or a law enforcement agency, initiates or cooperates with an investigation or proceeding by a governmental entity relating to an allegation of child abuse or neglect. A person whose employment is suspended or terminated or who is otherwise discriminated against in violation of this section may sue for injunctive relief, damages, or both. Standards for Making a Report Citation: Fam. Code § 261.101 A report is required when a person has cause to believe that a child has been adversely affected by abuse or neglect. In addition, a person or professional shall make a report if the person or professional has cause to believe that an adult was a victim of abuse or neglect as a child and the person or professional determines in good faith that disclosure of the information is necessary to protect the health and safety of another child, an elderly person, or person with a disability.

Privileged Communications Citation:
Fam. Code §§ 261.101; 261.202 The requirement to report applies without exception to an individual whose personal communications may otherwise be privileged, including an attorney, a member of the clergy, a medical practitioner, a social worker, a mental health professional, an employee or member of a board that licenses or certifies a professional, and an employee of a clinic or health-care facility that provides reproductive services. In a proceeding regarding the abuse or neglect of a child, evidence may not be excluded on the ground of privileged communication except in the case of communication between an attorney and client.

Inclusion of Reporter's Name in Report:
The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity Citation:
Fam. Code §§ 261.101; 261.201 Unless waived in writing by the person making the report, the identity of an individual making a report is confidential and may be disclosed only as follows: As provided by § 261.201 To a law enforcement officer for the purposes of conducting a criminal investigation of the report A report of alleged or suspected abuse or neglect and the identity of the person making the report are confidential. A court may order the disclosure of such confidential information if, after a hearing and an in camera review of the requested information, the court determines the disclosure is the following: Essential to the administration of justice, not likely to endanger the life or safety of a child who is the subject of the report, a person who made the report, or any other person who participates in an investigation of reported abuse or neglect or who provides care for the child The Texas Youth Commission shall release a report of alleged or suspected abuse if the report relates to abuse or neglect involving a child committed to the commission. The commission shall edit any report disclosed under this section to protect the identity of the following: A child who is the subject of the report, the person who made the report, any other person whose life or safety may be endangered by the disclosure

Utah

Professionals Required to Report Citation:
Ann. Code § 62A-4a-403 Any person, including any person licensed under the Medical Practice Act or the Nurse Practice Act, is required to report.
Reporting by Other Persons Citation:
Ann. Code § 62A-4a-403 Any person who has reason to believe that a child has been subjected to abuse or neglect must report.

Institutional Responsibility to Report:
This issue is not addressed in the statutes reviewed.

Standards for Making a Report Citation:
Ann. Code § 62A-4a-403 A report is required when a person has reason to believe that a child has been subjected to abuse or neglect or observes a

child being subjected to conditions or circumstances that would reasonably result in abuse or neglect.

Privileged Communications:
Ann. Code §§ 62A-4a-403; 62A-4a-412(5) The requirement to report does not apply to a member of the clergy, with regard to any confession made to the member of the clergy while functioning in the ministerial capacity of the member of the clergy and without the consent of the individual making the confession, if both of the following apply: The perpetrator made the confession directly to the member of the clergy, the member of the clergy is, under canon law or church doctrine or practice, bound to maintain the confidentiality of that confession. The physician-patient privilege is not a ground for excluding evidence regarding a child's injuries or the cause of those injuries in any proceeding resulting from a report made in good faith pursuant to this part.

Inclusion of Reporter's Name in Report:
The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity Citation:
Ann. Code § 62A-4a-412(3)(b) The name and contact information of the reporter shall be deleted prior to any release of records to the subject of the report.

Vermont

Professionals Required to Report Citation:
Ann. Stat. Tit. 33, § 4913 Mandatory reporters include the following: Health-care providers, including physicians, surgeons, osteopaths, chiropractors, physician assistants, resident physicians, interns, hospital administrators, nurses, medical examiners, emergency medical personnel, dentists, psychologists, and pharmacists, individuals who are employed or contracted and paid by a school district or an approved or recognized independent school, including school superintendents, headmasters, teachers, student teachers, school librarians, school principals, and school guidance counselors, child care workers, mental health professionals and social workers, police officers and probation officers, employees, contractors, and grantees of the Agency of Human Services who have

contact with clients, camp owners, camp administrators, and camp counselors, members of the clergy.

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

Institutional Responsibility to Report Citation:
Ann. Stat. Tit. 33, § 4913 An employer or supervisor shall not discharge; demote; transfer; reduce pay, benefits, or work privileges; prepare a negative work performance evaluation; or take any other action detrimental to any employee because that employee filed a good-faith report in accordance with the provisions of this subchapter. Any person making a report under this subchapter shall have a civil cause of action for appropriate compensatory and punitive damages against any person who causes detrimental changes in the employment status of the reporting party by reason of his or her making a report.

Standards for Making a Report Citation:
Ann. Stat. Tit. 33, § 4913 A report is required when a mandated reporter reasonably suspects the abuse or neglect of a child.

Privileged Communications Citation: Ann. Stat. Tit. 33, § 4913 A person may not refuse to make a report required by this section on the grounds that making the report would violate a privilege or disclose a confidential communication, except that a member of the clergy is not required to report if the knowledge comes from a communication that is required to be kept confidential by religious doctrine.

Inclusion of Reporter's Name in Report Citation:
Ann. Stat. Tit. 33, § 4914 Reports shall contain the name and address or other contact information of the reporter.

Disclosure of Reporter Identity Citation:
Ann. Stat. Tit. 33, § 4913 The name of and any identifying information about either the person making the report or any person mentioned in the report shall be confidential unless any of the following apply: The person making the report specifically allows disclosure, a Human Services Board proceeding or judicial proceeding results from the report, a court, after a hearing, finds probable cause to believe that the report was not made in good

faith and orders the department to make the name of the reporter available, a review has been requested pursuant to § 4916a of this title, and the department has determined that identifying information can be provided without compromising the safety of the reporter or the persons mentioned in the report.

Virginia

Professionals Required to Report Citation:
Ann. Code § 63.2-1509 The following professionals are required to report: Persons licensed to practice medicine or any of the healing arts, hospital residents or interns and nurses, social workers, family-services specialists, or probation officers, teachers or other employees at public or private schools, kindergartens, or nursery schools, persons providing full-time or part-time child care for pay on a regular basis, mental health professionals, law enforcement officers, animal control officers, or mediators, professional staff employed by private or State-operated hospitals, institutions, or facilities to which children have been placed for care and treatment, persons age 18 or older associated with or employed by any public or private organization responsible for the care, custody, or control of children, court-appointed special advocates, persons age 18 or older who have received training approved by the Department of Social Services for the purposes of recognizing and reporting child abuse and neglect, persons employed by a local department who determine eligibility for public assistance, emergency medical services providers, unless such providers immediately report the matter directly to the attending physician at the hospital to which the child is transported, persons employed by public or private institutions of higher education, other than an attorney who is employed by a public or private institution of higher education as it relates to information gained in the course of providing legal representation to a client, athletic coaches, directors, or other persons age 18 or older employed by or volunteering with private sports organizations or teams, administrators or employees age 18 or older of public or private day camps, youth centers, and youth recreation programs, ministers, priests, rabbis, imams, or duly accredited practitioners of any religious organization or denomination usually referred to as a church

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

Institutional Responsibility to Report Citation:
Ann. Code § 63.2-1509 If the information is received by a teacher, staff member, resident, intern, or nurse in the course of professional services in a hospital, school, or similar institution, such person may, in place of making a report, immediately notify the person in charge of the institution or department, or his or her designee, who shall make the report forthwith. If the initial report of suspected abuse or neglect is made to the person in charge of the institution or department or his or her designee, such person shall notify the teacher, staff member, resident, intern, or nurse who made the initial report when the report of suspected child abuse or neglect is made to the local department or to the toll-free child abuse and neglect hotline, and of the name of the individual receiving the report, and shall forward any communication resulting from the report, including any information about any actions taken regarding the report.

Standards for Making a Report Citation:
Ann. Code § 63.2-1509 A report is required when, in his or her professional or official capacity, a reporter has reason to suspect that a child is abused or neglected. For purposes of this section, 'reason to suspect that a child is abused or neglected' shall include the following: A finding made by a health-care provider within 6 weeks of the birth of a child that the child was born affected by substance abuse or experiencing withdrawal symptoms resulting from in utero drug exposure, a diagnosis made by a health-care provider within 4 years following a child's birth that the child has an illness, disease, or condition that, to a reasonable degree of medical certainty, is attributable to maternal abuse of a controlled substance during pregnancy, a diagnosis made by a health-care provider within 4 years following a child's birth that the child has a fetal alcohol spectrum disorder attributable to in utero exposure to alcohol. When 'reason to suspect' is based upon this subsection, that fact shall be included in the report along with the facts relied upon by the person making the report.

Privileged Communications Citation:
Ann. Code §§ 63.2-1509; 63.2-1519 A minister, priest, rabbi, imam, or duly accredited practitioner of any religious organization or denomination must report, unless the information supporting the suspicion of child abuse or neglect is required by the doctrine of the religious organization or denomination to be kept in a confidential manner. The physician-patient or husband-wife privilege is not permitted.

Inclusion of Reporter's Name in Report:
The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity Citation:
Ann. Code § 63.2-1514 Any person who is the subject of an unfounded report who believes that the report was made in bad faith or with malicious intent may petition the court for the release of the records of the investigation or family assessment. If the court determines that there is a reasonable question of fact as to whether the report was made in bad faith or with malicious intent and that disclosure of the identity of the reporter would not be likely to endanger the life or safety of the reporter, it shall provide to the petitioner a copy of the records of the investigation or family assessment.

Washington

Professionals Required to Report Citation:
Rev. Code § 26.44.030 The following persons are required to report: Practitioners, county coroners, or medical examiners, law enforcement officers, professional school personnel, registered or licensed nurses, social service counselors, psychologists, or pharmacists, employees of the Department of Children, Youth, and Families, licensed or certified child care providers or their employees, employees of the Department of Social and Health Services, juvenile probation officers, placement and liaison specialists, responsible living skills program staff, or HOPE center staff, state family and children's ombudsman or any volunteer in the ombudsman's office, host home programs, persons who supervise employees or volunteers who train, educate, coach, or counsel children or have regular unsupervised access to children, department of Corrections personnel, any adult with whom a child resides, guardians ad litem and court-appointed special advocates. The reporting requirement also applies to administrative and academic or athletic department employees, including student employees, of public and private institutions of higher education.

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

Institutional Responsibility to Report:
This issue is not addressed in the statutes reviewed.

Standards for Making a Report Citation:
Rev. Code § 26.44.030 A report is required when any of the following apply: A reporter has reasonable cause to believe that a child has suffered abuse or neglect, any person, in his or her official supervisory capacity with a nonprofit or for-profit organization, has reasonable cause to believe that a child has suffered abuse or neglect caused by a person over whom he or she regularly exercises supervisory authority, Department of Corrections personnel observe offenders or the children with whom the offenders are in contact and, as a result of these observations, have reasonable cause to believe that a child has suffered abuse or neglect, any adult has reasonable cause to believe that a child who resides with him or her has suffered severe abuse.

Privileged Communications Citation:
Rev. Code §§ 26.44.030; 26.44.060 No one shall be required to report when he or she obtains the information solely as a result of a privileged communication as provided in § 5.6.060. Information considered privileged by statute and not directly related to reports required by this section must not be divulged without a valid written waiver of the privilege. Conduct conforming with reporting requirements shall not be deemed a violation of the confidential communication privilege of §§ 5.60.060 (3) and (4) (regarding clergy-penitent and physician-patient privilege), 18.53.200 (regarding optometrist-patient privilege), and 18.83.110 (regarding psychologist-client privilege).

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

Disclosure of Reporter Identity Citation:
Rev. Code § 26.44.030 The department shall provide assurances of appropriate confidentiality of the identification of persons reporting under this section.

West Virginia

Professionals Required to Report Citation:
Ann. Code § 49-2-803 The following professionals are required to report: Medical, dental, or mental health professionals, Christian Science

practitioners or religious healers, teachers or other school personnel, social service, child care, or foster care workers, emergency medical services personnel, peace officers, law enforcement officials, or humane officers, members of the clergy, circuit court judges, family court judges, employees of the Division of Juvenile Services, or magistrates, youth camp administrators, counselors, employees, coaches, or volunteers of entities that provide organized activities for children, commercial film or photographic print processors.

Reporting by Other Persons Citation:
Ann. Code § 49-2-803 Nothing in this article is intended to prevent individuals from reporting suspected abuse or neglect on their own behalf. In addition to those persons and officials specifically required to report situations involving suspected abuse or neglect of children, any other person may make a report if that person has reasonable cause to suspect that a child has been abused or neglected in a home or institution or observes the child being subjected to conditions or circumstances that would reasonably result in abuse or neglect.

Institutional Responsibility to Report Citation:
Ann. Code § 49-2-803 Any person required to report who is a member of the staff or volunteer of a public or private institution, school, entity that provides organized activities for children, facility, or agency also shall immediately notify the person in charge of the institution, school, entity that provides organized activities for children, facility, or agency, or a designated agent thereof, who may supplement the report or cause an additional report to be made. Notifying a person in charge, supervisor, or superior does not exempt a person from his or her mandate to report suspected abuse or neglect.

Standards for Making a Report Citation:
Ann. Code § 49-2-803 Any mandatory reporter who has reasonable cause to suspect that a child is neglected or abused or observes the child being subjected to conditions that are likely to result in abuse or neglect, including sexual abuse or sexual assault, shall report the circumstances to the Department of Health and Human Resources. In any case where the reporter believes that the child suffered serious physical abuse or sexual abuse or sexual assault, the reporter shall also immediately report, or cause a report to be made, to the State police and any law enforcement agency having jurisdiction to investigate the complaint.

Privileged Communications Citation:
Ann. Code § 49-2-811 The privileged quality of communications between husband and wife and between any professional person and his or her patient or client, except that between attorney and client, cannot be invoked in situations involving suspected or known child abuse or neglect.

Inclusion of Reporter's Name in Report:
The reporter is not specifically required by statute to provide his or her name in the report.

Disclosure of Reporter Identity Citation:
Ann. Code § 49-5-101 Information related to child abuse or neglect proceedings, except information relating to the identity of the person reporting or making a complaint of child abuse or neglect, shall be made available, upon request, to the agencies and entities listed in the statute.

Wisconsin

Professionals Required to Report Citation:
Ann. Stat. § 48.981 The following professionals are required to report: Physicians, coroners, medical examiners, nurses, dentists, chiropractors, optometrists, acupuncturists, other medical or mental health professionals, physical therapists, physical therapist assistants, dietitians, occupational therapists, speech/language pathologists, audiologists, emergency medical technicians, or emergency medical services practitioners, schoolteachers, administrators, or counselors, school employees not otherwise specified above, child care workers in child care centers, group homes, or residential care centers, or child care providers, alcohol or other drug abuse counselors, marriage and family therapists, professional counselors, or members of the treatment staff employed by or working under contract with a county department or a residential care center for children and youth, social workers, public assistance workers (including financial and employment planners), emergency medical responders, police or law enforcement officers, mediators, or court-appointed special advocates, members of the clergy or a religious order, including brothers, ministers, monks, nuns, priests, rabbis, or sisters.

Reporting by Other Persons Citation:
Ann. Stat. § 48.981 Any person not specified above, including an attorney, who has reason to suspect that a child has been abused or neglected or who has reason to believe that a child has been threatened with abuse or neglect and that abuse or neglect of the child will occur may report.

Institutional Responsibility to Report Citation:
Ann. Stat. § 48.981 No person making a report in good faith may be discharged from employment, disciplined, or otherwise discriminated against in regard to employment or threatened with any such treatment for so doing.

Standards for Making a Report Citation:
Ann. Stat. § 48.981 A mandatory reporter is required to report when he or she has reasonable cause to suspect that a child seen by him or her in the course of professional duties has been abused or neglected or when he or she has reason to believe that a child seen by him or her in the course of professional duties has been threatened with abuse or neglect and that abuse or neglect of the child will occur. A health-care provider shall report if he or she has reason to suspect any of the following regarding a child in the provider's care: That sexual intercourse or sexual contact occurred or is likely to occur with a caregiver, that the child suffered or suffers from a mental illness or mental deficiency that rendered or renders the child temporarily or permanently incapable of understanding or evaluating the consequences of his or her actions, that the child, because of his or her age or immaturity, was or is incapable of understanding the nature or consequences of sexual intercourse or sexual contact, that the child was unconscious at the time of the act or for any other reason was physically unable to communicate unwillingness to engage in sexual intercourse or sexual contact, that another participant in the sexual contact or sexual intercourse was or is exploiting the child, that the provider has any reasonable doubt as to the voluntariness of the child's participation in the sexual contact or sexual intercourse.

Privileged Communications Citation:
Ann. Stat. § 48.981 A member of the clergy is not required to report child abuse information that he or she receives solely through confidential communications made to him or her privately or in a confessional setting if he or she is authorized to hear or is accustomed to hearing such communications and, under the disciplines, tenets, or traditions of his or her

religion, has a duty or is expected to keep those communications secret. Those disciplines, tenets, or traditions need not be in writing. A person delegated care and custody of a child under § 48.979 is not required to report any suspected or threatened abuse or neglect of the child. Such a person who has reason to suspect that the child has been abused or neglected or who has reason to believe that the child has been threatened with abuse or neglect and that the abuse or neglect of the child will occur may report. Inclusion of

Reporter's Name in Report:
The reporter is not specifically required by statute to provide his or her name in the report.

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

Wyoming

Professionals Required to Report:
No professional groups are specified in statute; all persons are required to report.

Reporting by Other Persons Citation:
Ann. Stat. § 14-3-205 All persons must report.

Institutional Responsibility to Report Citation:
Ann. Stat. § 14-3-205(b) If a person reporting child abuse or neglect is a member of the staff of a medical or other public or private institution, school, facility, or agency, he or she shall notify the person in charge or his or her designated agent, who is thereupon also responsible to make the report or cause the report to be made, as soon as possible. Nothing in this subsection is intended to relieve individuals of their obligation to report on their own behalf, unless a report has already been made or will be made. Any employer, public or private, who discharges, suspends, disciplines, or penalizes an employee solely for making a report of neglect or abuse is guilty of a misdemeanor punishable by imprisonment for no more than 6 months or a fine of no more than $750, or both. Mandatory Reporters of Child Abuse and Neglect https://www.childwelfare.gov

Standards for Making a Report Citation:
Ann. Stat. §§ 14-3-205; 14-3-206 A report is required when any of the following apply: A person knows or has reasonable cause to believe or suspect that a child has been abused or neglected, a person observes any child being subjected to conditions or circumstances that would reasonably result in abuse or neglect. Effective July 1, 2019: Any physician, physician's assistant, or nurse practitioner who examines a child and finds reasonable cause to believe the child is a victim of child abuse or neglect and has reasonable cause to believe that other children residing in the same home also may be a victim of child abuse or neglect shall report to law enforcement the results of the examination and facts supporting reasonable cause with respect to the other child or children.

Privileged Communications Citation:
Ann. Stat. § 14-3-210 Evidence regarding a child in any judicial proceeding resulting from a report made pursuant to the reporting laws shall not be excluded on the ground it constitutes a privileged communication, as follows: Between husband and wife, claimed under any provision of law other than § 1-12-101(a)(i) (regarding attorney-client or physician-patient privilege) and § 1-12-101(a)(ii) (regarding privilege of a clergy member or priest as it relates to a confession made to him or her in his or her professional character if enjoined by the church to which he or she belongs), claimed pursuant to § 1-12-116 (regarding the confidential communication between a family violence and sexual assault advocate and victim)

Inclusion of Reporter's Name in Report Citation:
Ann. Stat. § 14-3-206 The report must include any available photographs, videos, and x-rays with the identification of the person who created the evidence and the date the evidence was created.

Disclosure of Reporter Identity:
This issue is not addressed in the statutes reviewed.

5. Intervention and Treatment

A variety of treatment is available to victims of child abuse. Some of the treatment modalities that have strong research support include Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) (Cohen et al.) to treat sexually abused children. Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a conjoint child and parent/caregiver psychotherapy model for

children who are experiencing significant emotional and behavioral difficulties related to traumatic life events. It is a components-based hybrid treatment model that incorporates trauma sensitive interventions with cognitive behavioral, family, and humanistic principles. Essential components include:

P - Psychoeducation

P - Parenting skills

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

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

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

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

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

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

E - Enhancing personal safety and future growth: Training and education

on personal safety skills and healthy sexuality/interpersonal relationships; encouraging the utilization of skills learned to manage future stressors and/or trauma reminders.

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

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

- Educate individuals and families about relevance of CBT model and physical abuse.
- Establish agreement with family to refrain from using physical force and to discuss any incidents involving the use of force within the family.
- Review the child's exposure to emotional abuse in the family and provide education about the parameters of abusive experiences (causes, characteristics, and consequences) to help child and caregiver to better understand the context in which they occurred.
- Identify and address cognitive contributors to abusive behavior in caregivers (e.g., misattributions/high expectations) and/or their consequences in children (e.g., views supportive of aggression, self-blame) that could maintain any physically abusive or aggressive behavior.
- Teach affect-management skills.
- Teach caregivers behavioral strategies to reinforce and punish children's behavior as alternatives to physical discipline.
- Teach prosocial communication and problem-solving skills to the family and help them establish these skills as everyday routines.

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

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

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

The goal of treatment is not only to treat current mental health issues, but to focus on prevention as well. Children often present for treatment in one of several circumstances, including criminal investigations, custody battles, problematic behaviors, and referrals from CPS.

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

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

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

teenage years, a bipolar-like switching between sexual compulsion and shut-down, and distorted thinking on the subject of sexual abuse (for instance, that it is common and happens to everyone). When first presenting for treatment, the patient can be fully aware of their abuse as an event, but their appraisal of it is often distorted, such as believing that the event was unremarkable (a form of isolation). Frequently, victims do not make the connection between their abuse and their present pathology *(Julia Whealin, Ph.D., "Child Sexual Abuse". National Center for Post Traumatic Stress Disorder, US Department of Veterans Affairs).*

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

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

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

Substance Abuse

Because many parents who abuse substances also neglect or abuse their children, it is common for clients in substance abuse treatment to have

contact with some part of the child protective services (CPS) system. While the organizational roles and titles will vary, a CPS agency is the part of a State's child welfare system responsible for investigating and processing child abuse and neglect cases. For convenience, the term "CPS agencies" is used in this chapter to refer to all aspects of social services related to child welfare.

Some substance-abusing parents will be drawn into the CPS system during treatment; others will be compelled into substance abuse treatment by a CPS agency. In either case, it is critical that treatment providers become familiar with the laws governing the child protective system, including:

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

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

Clinical Concerns

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

this purpose.) This practice is also endorsed by the American Psychological Association and the Code of Ethics for Social Workers.

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

If there is imminent risk to a child, the counselor may not have time to engage the parent in the process. For example, if a counselor learns that the client has scalded his child and tied him to the bed, it would be appropriate to contact a CPS agency immediately. Similarly, if there is a risk that the client will continue his behavior and seek to cover his tracks, the counselor would probably not involve him in the report or inform him until after it has been made.

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

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

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

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

Parental Substance Abuse as Child Abuse and Neglect
The differences in the ways States define child abuse and neglect are particularly striking in the area of parental substance abuse. In some States, parental substance abuse, by itself, may constitute child abuse or neglect. In others, something more must be shown. For example, in South Carolina, giving birth to a drug-exposed infant is a criminal offense; a conviction may send the mother to prison (*State v. Whitner, 328 S.C. 1, 492; S.E. 2d 777, cert. denied, 118 S. Ct.*). In other States, like New York, "[a] report which shows only a positive toxicology for a controlled substance [in the newborn] generally does not in and of itself prove that a child has been [neglected]" (*Nassau County Department of Social Services* v. *Denise J.*, 87 N.Y. 2d 73, 661 N.E. 2d 138, 637 NYS 2d 666).

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

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

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

CPS Agency Investigation and Potential Outcomes

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

- ➡ It may reach an agreement with the family (without filing any court action) regarding what changes are needed and what services will help the family achieve those changes. It will then develop a service plan outlining the remedial steps the family has agreed to take and establishing a timetable for the family to complete those steps.
- ➡ A CPS agency can bring a neglect or abuse petition against the parent or guardian in a family or trial-level court. After a trial or fact-finding hearing, the court may take one of the following actions:

- ✓ Dismiss the petition (setting the parent free from further obligation)
- ✓ Issue an order requiring the parent to comply with all or part of the CPS agency's service plan, an order the court may review periodically to assess the parent's compliance (If the parent fails to comply with the court's order, the court may, after a hearing, either give the parent another chance or, if the case has been pending for some time, the parent has made little progress, or her behavior is particularly egregious, remove the child and begin proceedings to terminate parental rights.)

➡ Issue an order for the child's removal

1. If the situation is life threatening, a CPS agency can remove the child (and any siblings) immediately and schedule a prompt court hearing at which the parent or guardian may contest the removal. If the court finds the removal unnecessary, the child may be returned, but the parent may still be required to comply with a service plan.
2. A CPS agency can refer the case to criminal justice officials.

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

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

Clinical Issues

The counselor's role can be critical for a client involved in a child abuse or neglect investigation or proceeding. Getting the client to sign a consent form allowing communication and joint service planning can be an important first step. The counselor can help a client understand what is happening, help her

stay focused on what needs to be accomplished, and provide support and encouragement. However, to offer the client sound assistance the counselor needs some basic information:

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

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

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

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

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

Clinicians and substance abuse counselors must keep in mind that they may communicate with or respond to requests for information only when the proposed communication conforms to one of the Federal regulations' narrow exceptions permitting a disclosure. If a counselor fails to abide by Federal confidentiality rules, an unpleasant and expensive lawsuit may be brought against the program and possibly the counselor. Moreover, if word spreads that the program fails to protect information about its clients, it may have a difficult time in retaining its clients' confidence and in attracting new clients

into its treatment services (as well as the possibility of professional sanctions and relicensing difficulties).

The following discussion about communicating with parts of the child welfare and legal systems relies heavily on four exceptions to the Federal regulations that permit disclosures:
✳Proper written consent from the client (§2.31)
✳Proper written criminal justice system consent from the client (§2.35)
✳Court orders (§§2.64-2.66)
✳Qualified service organization agreements (§§2.11, 2.129(c)4))

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

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

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

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

If the client has signed a proper consent form authorizing the counselor to communicate with the caseworker at the CPS agency, how much information should the counselor disclose and how active a role should he take? In some cases, disclosing information to the CPS agency or court will benefit the client. It may also help the client if the counselor participates in developing a service plan for the family. However, it is up to the client and the lawyer, not the counselor, to determine whether communication or cooperation with a CPS agency will benefit the client. Therefore, it is essential that the counselor communicate with the client's attorney *before* taking it upon himself to communicate with a CPS agency.

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

Responding to Lawyers' Inquiries

If a lawyer calls to find out about a client's treatment history or current treatment, unless the client has consented in writing to the counselor's communicating with the lawyer, the counselor must tell the lawyer, "I'm sorry. I can't respond to that question right now. Can I have your telephone number and call you back at another time?" This is because the Federal

confidentiality regulations prohibit any other response without the client's written consent. The regulations view any response indicating that the person in question is the counselor's client as a disclosure that the person is in fact in substance abuse treatment. This applies even if the lawyer already knows that the client is in treatment.

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

The clinician should then speak with the client to ask whether the client knows what information the caller is seeking and whether the client wants her to disclose that or any other information. She should leave the conversation with a clear understanding of the client's instructions--whether she should disclose the information and, if so, how much and what kind. It may be that the lawyer is representing the client and the client wants the counselor to share all the information she has. On the other hand, the lawyer may represent the CPS agency, the prosecuting attorney, or some other party with whom the client is not anxious to share information. There is nothing wrong with refusing to answer a lawyer's questions.

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

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

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

Communicating With the Court
Sometimes, the court hearing a client's case will ask a treatment program to write a report about his progress in treatment. Or a client's lawyer may ask an agency to submit a letter to the court to support a disposition she is advocating. In any letter it submits, the agency should limit itself to reporting factual information, such as client attendance and urine toxicology screen results; it should not speculate on the future of the client or the client's family. Nor should it offer an opinion as to where the child should be placed. Of course, any information the agency releases in the form of a letter-report must be limited to the kind and amount of information the client agreed to have released when he signed the consent form. Moreover, the agency should consult with the client's attorney to ensure the letter covers the areas of concern and will do no damage.

What should a counselor do if the client is continuing to abuse the child, the counselor knows this, and the counselor is asked to submit a report? First, if a counselor believes that her client is continuing to abuse a child and that the

child's life or health is in danger, the counselor can make another "initial" report to the CPS agency (even when no report has been requested).

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

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

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

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

Responding to Inquiries by Law Enforcement

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

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

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

Connecting Child Trafficking Victims With Services
After determining a child is a victim of human trafficking, it is imperative for clinicians and caseworkers to connect the child with services that can meet their complex needs. Providers should seek out services and supports within their agencies and in the community that can meet the short and long-term needs of this population. Two obstacles facing providers, however, are the scant evidence base about how to serve this population and the lack of effective and available services (*Institute of Medicine & National Research Council*). Frequently, when services are available in communities, they are not specialized for victims of human trafficking. The following information may help caseworkers when seeking out available resources or working with service providers to establish effective supports: Although trauma-informed services were not necessarily developed for trafficking victims and have not been evaluated thoroughly for this population, many professionals believe they are critical to successful interventions with trafficking victims (*Hardy, Compton, & McPhatter*). Providers should ensure that service providers use trauma-informed practices and are knowledgeable of issues related to

trafficking. Children and service providers may not agree about what are the child's most pressing needs. For example, a provider may view mental health services as the foremost need, but the child may prioritize "survival" needs, such as food, housing, and employment *(Lutnick*). Children are more likely to utilize services when they are provided in-house (i.e., where the child is placed) or are co-located with other services (*Gibbs et al*.). This is particularly important because children may leave a service program if the services they desire are not immediately available (*Lutnick*). Children who have been trafficked often desire independence or view any restrictions placed on them as reducing freedoms to which they may have become accustomed (*West & Loeffler*). They may view these restrictions, including those designed to keep them safe, as being punitive, which could increase noncompliance or decreased utilization. One strategy to ameliorate this belief is to empower victims to be partners in their case planning.

6. Legal and Ethical Considerations

Subpoenas and Court Orders

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

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

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

Traumatized children and their families are often involved with multiple service systems, including law enforcement, child welfare, the courts, schools, primary care, and mental health. When different systems have different and potentially competing priorities, there is a risk that children and

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

Role Clarity

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

Psychotherapy and Court Proceedings

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

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

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

Prosecuting attorneys may need to be given information on the functions of therapy to help dissuade them from dispensing inappropriate advice to families. As cases extend for months and years, the legal system bears witness to despair, victimization, and family dysfunction—none of which it can effectively address. Since implementation of The Adoption and Safe Families Act in 1997, courts face an increased responsibility to ensure safety, permanency, and well-being for children in the child welfare system. The courts are unlikely to meet this mandate unless they develop close collaboration with mental health and prevention systems and providers *(Lederman & Osofsky)*.

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

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

Client Confidentiality and Sharing of Information

Once an investigation is complete, law enforcement and CPS staff may have limited (or no) contact with the family. Mental health professionals, however, may work with the family for months after the investigation is complete, and typically will form strong, trusting relationships with families. The mental health professional is in a unique position to recognize the strengths of—and potential risks for—a family, and to learn what the family's greatest concerns are related to the investigation and its outcome.

Thus, the sharing of information between the mental health provider and the team can be beneficial both to the family and to the team's effort to conduct a thorough investigation and successfully resolve the case.

Confidentiality laws, including Health Insurance Portability and Protection Act (HIPPA) regulations, also extend to clients' mental health records. Mental health professionals are legally and ethically bound to adhere to these laws. Confidentiality should be discussed as treatment begins and proceeds. For example, if the mental health professional is a participant in a weekly case review in which the status and progress of cases are discussed, he or she should explain to the family the purpose of the case review meeting. Therapy records should include documentation signed by clients indicating that they understand the protection of their private health information.

7. Resources

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

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

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

- Prevent Child Abuse Texas - Works to prevent child abuse and neglect in all its forms throughout Texas. Advocacy opportunities, conference information, abuse facts and upcoming events.

Organizations and Agencies

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

The ChildTrauma Academy
5161 San Felipe, Suite 320
Houston, TX 77056
Phone: (713) 818-3967
www.childtrauma.org

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

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

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

National Association for Prevention of Child Abuse and Neglect
PO Box K241

Haymarket
NSW 1240
Phone: 02 9211 0224
www.napcan.org.au

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

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

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

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

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

enforcement, and social services personnel regarding child abuse and neglect on reservations, Tribal family resources.

Other Resources

The Information Gateway Reporting Child Abuse and Neglect webpage provides information about mandatory reporting and how to report suspected abuse: https://www.childwelfare.gov/responding/reporting.cfm

The National Child Abuse Prevention Month web section provides tip sheets for parents and caregivers, available in English and Spanish, that focus on concrete strategies for taking care of children and strengthening families: https://www.childwelfare.gov/preventing/preventionmonth/tipsheets.cfm

Information Gateway also has produced a number of publications about child abuse and neglect:

Child Maltreatment: Past, Present, and Future: https://www.childwelfare.gov/pubs/issue_briefs/cm_prevention.pdf

Long-Term Consequences of Child Abuse and Neglect: https://www.childwelfare.gov/pubs/factsheets/long_term_consequences.pdf

Preventing Child Abuse and Neglect: https://www.childwelfare.gov/pubs/factsheets/preventingcan.pdf

Understanding the Effects of Maltreatment on Brain Development: https://www.childwelfare.gov/pubs/issue_briefs/brain_development/brain_development.pdf

The Centers for Disease Control and Prevention (CDC) produced *Understanding Child Maltreatment*, which defines the many types of maltreatment and the CDC's approach to prevention, in addition to providing additional resources: http://www.cdc.gov/violenceprevention/pdf/cm_factsheet2012-a.pdf

Prevent Child Abuse America is a national organization dedicated to providing information on child maltreatment and its prevention: http://www.preventchildabuse.org/index.shtml

The National Child Traumatic Stress Network strives to raise the standard of care and improve access to services for traumatized children, their families, and communities: http://www.nctsn.org/

Child Welfare Information Gateway's web section on child abuse and neglect provides information on identifying abuse, statistics, risk and protective factors, and more:

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About the Course Presenter:

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