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Contact Hours: **2.5**

Identifying and Reporting Child Abuse, Neglect, and Trafficking

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LEARNING OUTCOME AND OBJECTIVES: Upon completion of this course, you will have gained the knowledge to identify and report child abuse, child neglect, and trafficking. Specific learning objectives to address potential knowledge gaps include:

- Define terminology related to child abuse.
- Explain the risk and protective factors contributing to child abuse and neglect.
- Recognize physical and behavioral indicators of abuse, neglect, and trafficking.
- Summarize strategies for responding to victims' disclosures.
- Describe situations in which mandated reporters must report suspected cases of child maltreatment.
- Discuss the consequences for failing to report suspected child abuse.

WHAT IS CHILD ABUSE?

The government has a responsibility to protect children when parents or other persons legally responsible for a child's care fail to provide proper care and to intervene in cases of child maltreatment. State statutes are divided into criminal and civil categories within each state's statutory codes. Civil statutes provide guidance for mandated reporters and intervention by child protection agencies. Criminal statutes define which acts are criminal and can lead to arrest and prosecution of an offender.

Child abuse and neglect are significant public health problems which can lead to long-term adverse consequences for a child's health and well-being. Therefore, healthcare professionals

have both a legal and professional responsibility to recognize and report suspected child abuse and maltreatment.

Definitions

The Centers for Disease Control and Prevention (CDC) has developed uniform definitions pertaining to child abuse. However, since different states and government entities vary in their legal definitions of these terms, it is also important for healthcare professionals to know the definitions for child abuse and other related terms in the state(s) in which they live and/or practice.

Generally speaking, child abuse and neglect can be defined as any act or series of acts of commission or omission by a parent, caregiver, or another person in a custodial role (e.g., clergy, coach, teacher) that results in harm, potential for harm, or threat of harm to a child under the age of 18. In more than a dozen states, human trafficking of minors is included in the definition of abuse (CDC, 2021a; CWIG, 2019a). (See also "Types of Abuse" below for more details.)

FEDERAL GUIDANCE TO STATES

Federal legislation offers 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"

A *child* is defined as "a person who is younger than 18 years of age or who is not an emancipated minor."

This legislation sets minimum standards for states that accept CAPTA funding, but each state provides its own definitions of maltreatment within civil and criminal statutes (CWIG, 2019a).

ABUSED CHILD IN RESIDENTIAL CARE

Residential care and group homes, both public and private, provide a structured environment for children who have specific needs. These children may have behavioral health issues or disabilities. In the context of child maltreatment laws, the age limit may be extended up to 21 years old in some states if the child has a disabling condition and resides in a residential care setting.

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Types of Abuse

Four commonly recognized categories of abuse and neglect are physical abuse, sexual abuse, emotional abuse, and neglect.

PHYSICAL ABUSE

Physical abuse of a child includes any **nonaccidental physical injury** of a child that is inflicted by a parent or caretaker. Acts include but are not limited to biting, kicking, hitting, or burning a child under the age of 18. The legal definition of physical abuse also includes actions that pose a substantial risk of physical injury to the child even if no injury is sustained (CDC, 2021a).

SEXUAL ABUSE

Child sexual abuse generally includes **any sexual activity** by an adult with a minor, since a minor cannot by law consent to any form of sexual activity. Behaviors may include touching, fondling, penetration, or exposing a child to sexual activities. Federally, sexual abuse of a child is defined as the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct: or the rape, and in cases of a caretaker or interfamilial relationships, statutory rape, molestation, prostitution of children, or incest with children (CAPTA, 2010; CDC, 2021a).

In 33 states, sexual exploitation of minors is included in the definition of sexual abuse. This form of exploitation includes sex trafficking of children or engaging children in the production of pornography (CWIG, 2019a).

Child sexual abuse does not need to include physical contact between a perpetrator and a child. Some forms of child sexual abuse include:

- Exhibitionism (exposing oneself to a minor)
- Fondling
- Intercourse
- Masturbation in the presence of a minor or forcing a minor to masturbate
- Obscene phone calls, text messages, emails, or digital interaction
- Producing, owning, or sharing pornographic images or movies of children
- Sex of any kind with a minor, including vaginal, oral, or anal sex
- Sex trafficking (see below)
- Any other sexual conduct that is harmful to a child’s mental, emotional, or physical welfare
  (RAINN, 2021)

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EMOTIONAL ABUSE

Emotional abuse involves actions that **harm the self-esteem or emotional health** of a child. Behaviors may involve shaming, rejecting, name-calling, and suppressing love or affection. Emotional abuse may lead to impaired psychological growth and development and involves words, actions, and indifference. This form of abuse may be hard to recognize because there are no visible injuries. Children who are sexually or physically abused may also be emotionally abused.

Emotional abuse may include:

- Verbal abuse
- Constant criticism
- Shaming
- Name-calling
- Excessive demands on a child's performance (e.g., expectations of high grades in school or becoming "champion" school athletes)
- Not allowing a child to attend school
- Threats
- Rejecting
- Withholding affection
- Isolation
- Negligence

(Kids Matter, 2021; CDC, 2021a)

IMPACTS OF EXPOSURE TO VIOLENCE

The developing brain of a child is highly sensitive, and the chronic state of fear and stress experienced by children exposed to violence prevents the brain from developing normally. Instead, the brain is influenced adversely by abnormal patterns of neurological activities and brain chemicals. A violent environment will have the greatest adverse effects on the brains of the youngest children (Gaskill & Perry, 2012).

Children can also be harmed by exposure to the abuse of others. Children who witness violence in the home experience changes in the anatomic and physiological make up of their central nervous system. The CDC classifies children's exposure to violence as an adverse childhood experience that contributes to many risk factors, including premature death (Edwards, 2019).

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HUMAN TRAFFICKING

There are different types of human trafficking, also known as *trafficking in persons*.

The crime of **sex trafficking** of children (also referred to as *commercial sexual exploitation of children [CSEC])* is a type of child abuse increasingly encountered in the healthcare setting. It is defined in the Trafficking Victims Protection Act (18 USC §1591) as "to recruit, entice, harbor, transport, provide, obtain, or maintain by any means a person, or to benefit financially from such action, knowing or in reckless disregard that the person has not attained the age of 18 years and will be caused to engage in a commercial sex act."

The term *child prostitution* is misleading when used in the context of commercial sexual exploitation of children (CSEC). The children who are involved in commercial sex are victims. Traffickers may beat, rape, torture, and use drugs, alcohol, and emotional tactics to gain control over their child victims (US DOJ, 2020; Hornor & Sherfield, 2018).

According to U.S. federal law (22 USC § 7102), **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 for the purposes of subjection to involuntary servitude, peonage, debt bondage, or slavery. As with sex trafficking, force, fraud, or coercion do not need to exist if the labor trafficking victim is under the age of 18.

Child labor trafficking may include agricultural, domestic service, or factory work where workers provide involuntary labor. Labor trafficking can also occur in beauty services, restaurants, small businesses, or informal settings. Some common situations include peddling and traveling sales crews where young people are moved from town to town selling cheap products such as jewelry or magazines for little or no pay. Other situations include drug dealing in which children are forced to sell drugs. Sometimes labor trafficking may occur when a child is staying with a custodial family member or nonfamily member and is forced to work.

Children are controlled through fear and abuse by their traffickers. It is possible that a child is a victim of labor and sex trafficking simultaneously (NCSSLE, 2021).

Types of Neglect

Neglect is defined as the failure of a parent or other person with responsibility for the child to provide a child with basic physical and emotional needs such as food, clothing, shelter, education, and healthcare to the degree that the child's health, safety, and well-being are threatened with harm (CWIG, 2019a; CDC, 2021a).

PHYSICAL NEGLECT

Physical neglect is the failure to provide a child with adequate food, shelter, clothing, education, hygiene, medical care, and/or supervision needed for normal growth and development. Leaving a young child or children without supervision by a responsible person is a type of neglect (Childhelp.org, 2021a). Infants and toddlers should never be left alone, even briefly. While older

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preteens may be responsible and independent enough to be left alone, some older teenagers are too irresponsible or have special needs that limit their ability to be safe if left alone.

EMOTIONAL NEGLECT

Emotional neglect includes parent or other caretaker behaviors that cause or have the potential to cause serious cognitive, affective, or other behavioral health problems. The resulting emotional impairment must be clearly attributable to the unwillingness or inability of the parent or other person legally responsible for the child to exercise a minimum degree of care toward the child.

MEDICAL NEGLECT

Medical neglect is the failure to provide a child with necessary medical or mental health treatment. Some states make provisions for parents who choose not to seek certain forms of medical care for a child due to religious beliefs.

EDUCATIONAL NEGLECT

Educational neglect is the failure to educate a child (e.g., failure to enroll a child in school or preventing a child from attending school) or attend to special education needs (e.g., failure to obtain remedial education services). About half the states, the District of Columbia, American Samoa, Puerto Rico, and the Virgin Islands include failure to educate a child as required by law in their definition of neglect (CWIG, 2019a).

ABANDONMENT

Abandonment is a form of neglect in many states. A child is generally considered to be abandoned when a parent's whereabouts are unknown, the child has been left alone and suffers serious adverse consequences, or the parent fails to maintain contact with or provide reasonable support for a specified period of time.

SAFE HAVEN LAWS

"Safe haven" laws designate specific locations as safe places for parents to relinquish their unharmed newborns. The focus of safe haven laws is to protect newborns from endangerment by providing parents with an option to criminal abandonment and to protect law-abiding parents from criminal liability. Provisions of safe haven laws vary from state to state.

- These laws are usually limited to infants, and the age of the children who may be left at a safe haven varies among states. For example, in some states and Puerto Rico, only infants who are 72 hours old or younger may be relinquished to a designated safe haven, while other states allow infants up to one month of age.
- In most states, either parent may surrender a baby to a safe haven, but in a few states only the mother may relinquish her infant.

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- Each state specifies which locations may function as safe havens. Hospitals, emergency medical services providers, healthcare facilities, and fire stations are common locations.

To date, all 50 states, the District of Columbia, and Puerto Rico have enacted safe haven legislation. Healthcare professionals must be aware of the laws governing safe haven acts in the states in which they practice and live (CWIG, 2017a).

COMPARING ABUSE AND NEGLECT	
Abuse	**Neglect**
Parent or other persons legally responsible: • Inflict or allow to be inflicted serious injury or substantial risk of physical injury • Inflict or allow to be inflicted emotional harm • Commit or allow to be committed a sex offense, including sex trafficking or other forms of commercial sex	Parent or other persons legally responsible impair a child's physical, mental, or emotional condition by: • Failing to provide basic needs of food, clothing, shelter, education, or medical care, or education when financially able • Failing to provide adequate supervision • Engaging in excessive use of drugs or alcohol that interferes in the ability to provide adequate supervision

CHILD ABUSE VICTIM DEMOGRAPHICS

Nationally in 2019:

- 28.1% of victims were younger than three years.
- The victimization rate was highest for children younger than 1 year.
- The percentages of child victims were similar for both boys and girls.
- The majority of victims were of three races/ethnicities: White (43.5%), Hispanic (23.5%), and African American (20.9%).
- Native American or Alaska Native children had the highest rate at 14.8 per 1,000 children, and African American children had the second highest rate at 13.8 per 1,000 children.
- About 75% of victims were neglected, 17.5% were physically abused, and 9.3% were sexually abused. There were an additional 439 reports of sex trafficking. (USDHHS, 2021)

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RISK AND PROTECTIVE FACTORS

Health professionals must remain alert for risk factors that may increase the likelihood of child abuse and maltreatment. Risk factors may be either characteristics of a caregiver or of a child and may go undetected.

Caregiver Risk Factors

When health professionals observe indicators of possible abuse, they should consider whether the presence of risk factors in a caregiver may signal a need to examine the situation more carefully.

The National Child Abuse and Neglect Data System (NCANDS) cites the following caregiver risk factors:

- Alcohol abuse that is chronic
- Domestic violence in which the caregiver is the perpetrator or the victim
- Drug abuse that is chronic
- Financial problems that do not allow the family to meet basic needs
- Inadequate housing or homelessness
- Public assistance participation
- Any caregiver disability
  (USDHHS, 2021)

Child Risk Factors

The following **characteristics of children** were determined to be risk factors:

- Children younger than 4 years of age
- Special needs that may increase caregiver burden
- Physical disability
- Intellectual disability
- Mental health issues
- Chronic physical illnesses
  (CDC, 2021d)

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Additional risk factors include:

- Social isolation
- Family disorganization, dissolution, and violence, including intimate partner violence
- Parenting stress, poor parent-child relationships, and negative interactions
- Community violence
- Concentrated neighborhood disadvantage (e.g., high poverty and residential instability, high unemployment rates, and high density of alcohol sales outlets)
- Poor social connections
(CDC, 2021d)

Another risk factor is race. There is a problem of racial disproportionality and disparity in the child welfare system. Families of color are likely to receive disparate treatment within the system. Higher rates of poverty are strongly related to minority status, but racial bias and discrimination must also be considered. Structural racism, such as the exclusion of African Americans as home buyers, can be linked to child abuse since African American families have been unable to build wealth without owning homes, and are thus often compelled to live in neighborhoods associated with poverty, which is a known risk factor for abuse and neglect (CWIG, 2021).

Risk factors for **human trafficking** among youth populations include those youth:

- In the foster care system
- Who identify as LGBTQI
- Who are homeless or runaway
- With disabilities
- With mental health or substance abuse disorders
- With a history of sexual abuse
- With a history of being involved in the welfare system
- With family dysfunction
- Who are foreign nationals
- Who are living on their own
(AFRJ, 2018)

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PARENTAL SUBSTANCE ABUSE AND CHILD ABUSE

Parental substance abuse greatly increases the incidence of child abuse and neglect. A review of research on parental substance abuse and its impact on children showed that:

- 1 in 5 children in the United States live in homes with parental substance abuse.
- Parents who are chemically dependent are unable to effectively parent their children.
- The health and development of children is negatively impacted by parental substance abuse.
- Children who grow up in homes with prevalent substance abuse are more likely to misuse drugs and alcohol since such norms are established at a young age.
(Thatcher, 2020)

ACE STUDY

Many children suffer multiple types of abuse, which increases their risk of serious health consequences as adults. The Adverse Childhood Experience (ACE) study, published in 2009, investigated the association between childhood maltreatment and later-life health and well-being.

The findings suggest that certain negative experiences in childhood are major risk factors for illness, poor quality of life, and death later in life. The more adverse childhood experiences that were experienced by an individual, the greater the risk of developing:

- Substance abuse
- Chronic health problems
- Mental illness
(CDC, 2021b)

Protective Factors Against Adverse Childhood Experiences

Individual, family, and community protective factors safeguard children from experiencing adverse effects such as abuse and neglect. There is scientific evidence to indicate that a supportive family environment and social networks have a protective effect against adverse childhood experiences.

Individual and family protective factors include:

- Nurturing relationships in the family
- Stable family relationships where children are safe, cared for, and supported
- Children having positive peer relationships

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- Children being successful in school and education being valued by the family
- Children having relationships with caring adults outside the family
- Families able to provide shelter, food, clothing, and healthcare for children
- Caregivers having college degrees or higher education
- Caregivers being consistently employed
- Families having a good social support network
- Caregivers monitoring children and enforcing rules
- Adults resolving conflict in a nonviolent manner
- Families participating in fun activities together

Community protective factors include:

- Access to financial assistance in the community
- Access to medical and mental health services
- Access to housing that is safe and stable
- Access to good-quality childcare
- Access to good-quality preschool
- Access to good-quality afterschool programming
- Access to work opportunities with policies that are supportive to families
- Strong partnerships in the community between businesses, healthcare, government, and other institutions
- Residents feeling connected and involved with one another
- Violence not being tolerated
(CDC, 2021c)

RECOGNIZING PHYSICAL ABUSE

Physical Indicators of Physical Abuse

BRUISING

Some bruises indicate likely child abuse. It is important to know both normal and suspicious bruising patterns when assessing children's injuries. Normal bruising usually occurs in the front of the body over bony areas such as the forehead, knees, shins, and elbows.

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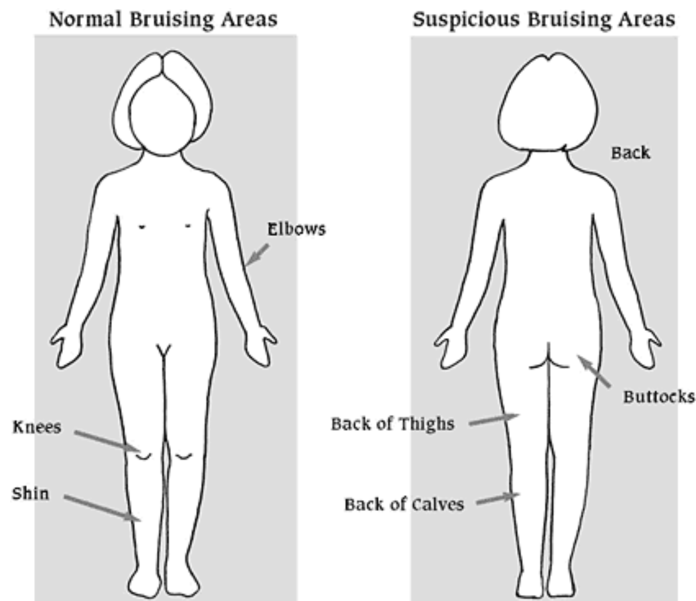
The “TEN-4 rule” (see below) is a mnemonic aid to remember when bruising requires immediate evaluation. Children who are under 4 years should not have any bruises in these areas, and infants under 4 months should have no bruises anywhere. The size of the bruise is not as important as the location.

TEN-4 RULE	
T	Torso
E	Ears
N	Neck
4	Under 4

Suspicious bruises include the following;

- Bruises on babies who are not yet mobile (“cruising”)
- Bruises on the ears, neck, eyes, cheeks, buttocks, or torso (torso includes chest, back, abdomen, genitalia)
- Bruises that are clustered or patterned (e.g., handprints) (Norton Children’s, 2020)



Normal and suspicious bruising areas.
(Source: Research Foundation of SUNY, 2011.)

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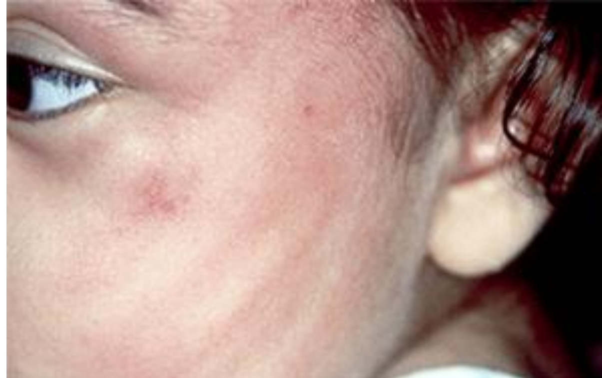
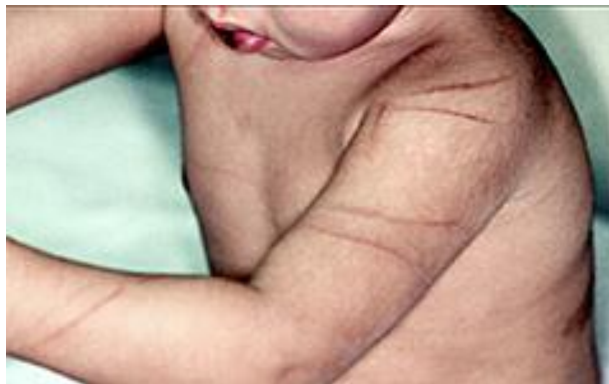


This pattern signals the blow of a hand to the face of a child.
(Source: Research Foundation of SUNY, 2011.)



Regular patterns reveal that a looped cord was used to inflict injury on this child.
(Source: Research Foundation of SUNY, 2011.)

LACERATIONS OR ABRASIONS

Typical indications of unexplained lacerations and abrasions that are suspicious include:

- On the face, lips, or mouth
- To external genitalia

BURNS

Unexplained burns include:

- Cigar or cigarette burns, especially on soles, palms, back, or buttocks
- Immersion burns by scalding water (sock-like, glove-like, doughnut-shaped on buttocks or genitalia; "dunking syndrome")
- Patterned like an electric burner, iron, curling iron, or other household appliance
- Rope burns on arms, legs, neck, or torso

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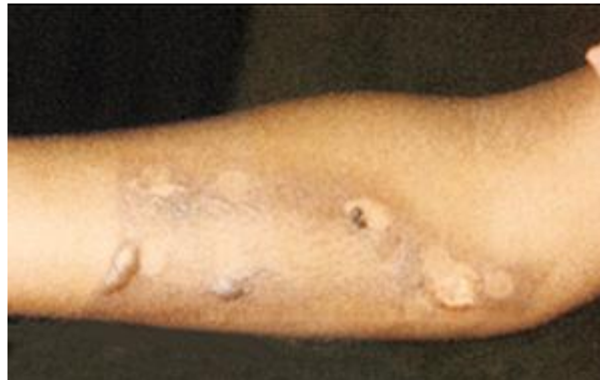

A steam iron was used to inflict injury on this child.
(Source: Research Foundation of SUNY, 2011.)

FRACTURES

Unexplained fractures may include:

- Fractures to the skull, nose, or facial structure
- Multiple or spiral fractures
- Fractures in various stages of healing
(SD DSS, 2020)

HEAD INJURIES

Typical indications of unexplained head injuries include:

- Absence of hair and/or hemorrhaging beneath the scalp due to vigorous hair pulling
- Subdural hematoma (a hemorrhage beneath the outer covering of the brain, due to severe hitting or shaking)
- Retinal hemorrhage or detachment, due to shaking
- Whiplash or pediatric abusive head trauma (see box below)
- Eye injury
- Jaw and nasal fractures
- Tooth or frenulum (of the tongue or lips) injury

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PEDIATRIC ABUSIVE HEAD TRAUMA

Pediatric abusive head trauma (AHT) is an inflicted head injury in children that can be caused by various mechanisms, including rotational and contact forces to the head as well as shaking. The prevalence is between 32 and 38 cases per 100,000 children who are under the age of 1 year. AHT is fatal in nearly 25% of cases.

Secondary brain injury may occur as a result of hypoxia, ischemia, or inflammation, and up to 70% of survivors have sequelae. Impairments that result from AHT may include encephalopathy, intellectual disability, cerebral palsy, cortical blindness, seizure disorders, behavior problems, and learning disabilities. Endocrine dysfunction is commonly seen in survivors of AHT and may be observed years after the event.

The clinical presentation of infants or children with AHT can vary. Findings may be subtle and include:

- Bruising (see “TEN-4 Rule” above)
- Oral injuries such as frenulum tears
- Retinal hemorrhages that are numerous, found in all layers of the retina, extend to the periphery of the retina, or retinoschisis (blood in the macula)
- Skull fractures
- Cerebral edema
- Subdural hemorrhages
- Spinal subdural hemorrhages

AHT should be considered when infants or young children present with:

- Fussiness or altered mental status
- Vomiting
- Apnea

Short falls (less than 5 feet) are often the explanation given to the provider for the injury, however serious injury or death is unlikely to result from a short fall. In addition to conducting a thorough examination with imaging when AHT is suspected, clinicians should report to Child Protective Services and educate parents about the dangers of AHT from shaking or striking a child or impacting the child’s head against a surface. It is also important to educate parents about alternatives to soothe a crying baby (Narang, 2020).

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Behavioral Indicators of Physical Abuse

Careful assessment of a child's behavior may also indicate physical abuse, even in the absence of obvious physical injury. Behavioral indicators of physical abuse include the following:

- Withdrawal from friends or usual activities
- Changes in behavior (e.g., aggression, anger, hostility, or hyperactivity)
- Changes in school performance
- Depression, anxiety or unusual fears, or a sudden loss of self-confidence
- An apparent lack of supervision
- Frequent absences from school
- Reluctance to leave school activities, as if not wanting to go home
- Attempts at running away
- Rebellious or defiant behavior
- Self-harm or attempts at suicide

(Mayo Clinic, 2018)

FACTITIOUS DISORDER IMPOSED ON ANOTHER

Factitious disorder imposed on another (FDIA), formerly known as *Munchausen syndrome by proxy*, is a mental illness as well as a form of child abuse. In FDIA, an adult with the disorder falsifies an illness in the child under their care. Warning signs include:

- Unexplainable persistent problems
- Discrepancies of the history, findings, and clinical presentation
- A working diagnosis of a very rare condition, leading the clinician to believe that maltreatment is more likely
- Signs and symptoms only occur when the adult with the disorder is alone with the child
- The caregiver insists on hand-carrying medical records or states they are missing
- Other family members have had similar problems without explanation
- The caregiver routinely relates histories in a dramatic or exaggerated manner
- The caregiver is or has been a healthcare provider or has a history of a factitious disorder or extensive healthcare problems
- Members of the healthcare team are suspicious

(Feldman, 2020)

It is important to note that the perpetrator, not the child, receives the diagnosis of FDIA, and the child's safety is of utmost importance.

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RECOGNIZING PHYSICAL AND EMOTIONAL NEGLECT

Physical Neglect

Indicators of physical neglect include:

- Consistent hunger
- Poor hygiene (skin, teeth, ears, etc.)
- Inappropriate attire for the season
- Failure to thrive (physically or emotionally)
- Positive indication of toxic exposure, especially in newborns, such as drug withdrawal symptoms, tremors, etc.
- Delayed physical development
- Speech disorders
- Consistent lack of supervision, especially in dangerous activities or for long periods of time
- Unattended physical problems or medical or dental needs
- Chronic truancy
- Abandonment

(Clermont County CPS, 2021)

Emotional Neglect

A child may demonstrate **behavioral indicators** of neglect such as:

- Begging or stealing food
- Extended stays at school (early arrival or late departure)
- Constant fatigue, listlessness, or falling asleep in class
- Alcohol or other substance abuse
- Delinquency, such as shoplifting
- Reports there is no caretaker at home
- Runaway behavior
- Habit disorders (sucking, nail biting, rocking, etc.)
- Conduct disorders (antisocial or destructive behaviors)
- Neurotic traits (sleep disorders, inhibition of play)

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- Psychoneurotic reactions (hysteria, obsessive-compulsive behaviors, phobias, hypochondria)
- Extreme behavior (compliant or passive, aggressive or demanding)
- Overly adaptive behavior (inappropriately adult, inappropriately infantile)
- Delays in mental and/or emotional development
- Suicide attempt

(Clermont County CPS, 2021)

A **parent or guardian (other person legally responsible)** exhibiting the following behavioral indicators may be emotionally maltreating/neglecting a child:

- Calls the child names
- Insults the child
- Threatens violence
- Allows the child to observe abuse of others
- Does not offer love or support

(Carey, 2018)

CASE
Beginning at age 8, Riley, the youngest of four children, has spent every other week at his father's apartment without his siblings so that he and his father can have "one-on-one time." When Riley's parents divorced, and although the judge was aware that Riley's father was possibly abusive, it was the philosophy of the court that children suffer more damage when they have no contact at all with their parents. At age 9, Riley was developing obvious signs of anxiety, such as running away from Little League baseball games because he did not enjoy playing while people watched. His father ridiculed him and physically picked him up and put him back on the field in anger in the middle of the game. The coach tried to intervene, but the father prevailed, and Riley stood motionless in the field. By age 10, Riley was resisting visitation with his father, and a neighbor called 911 after observing Riley's father yelling at him and forcing him into the car, followed by Riley trying to jump out of the moving vehicle. Riley's teacher also reported to the authorities that he arrived late to school 10 days in a row following a visitation to his father and requested to go home to his mother on a daily basis because he had a "stomach ache." An investigation revealed that Riley was having severe separation anxiety from his mother and siblings and that the apartment where he stayed with his father was filled with storage items, leaving little room for the child. There was no bed at the residence for Riley, who slept on a mat on the floor, nor was there food in the refrigerator. Riley's father said that the child was "fat" and that he did not want to keep any food around for that reason.

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Riley was screened in to Child Protective Services (CPS) because he was diagnosed with a severe anxiety disorder by the school psychologist. A multidisciplinary team helped Riley and his family. Riley began seeing the school counselor, and at the recommendation of CPS, his visitation schedule was amended to exclude overnights with his father. In addition, his father was ordered by the court to attend parenting classes. Riley's symptoms improved within a few months after counseling, treatment with anti-anxiety medication, and the revised visitation schedule.

RECOGNIZING SEXUAL ABUSE

Child sexual abuse involves the coercion of a dependent, developmentally immature person to commit a sexual act with someone older. For example, an adult may sexually abuse a child or adolescent, or an older child or adolescent may abuse a younger child. A perpetrator does not have to be an adult in order to sexually abuse a child (RAINN, 2021).

The fact that sexual abuse may be carried out by a family member or friend further increases the child's reluctance to disclose the abuse, as does shame and guilt plus the fear of not being believed. The child may fear being hurt or even killed for telling the truth and may keep the abuse secret rather than risk the consequences of disclosure. Very young children may not have sufficient language skills or vocabulary to describe what happened (Clermont County CPS, 2021; RAINN, 2021).

Child sexual abuse is found in every race, culture, and class throughout society. Girls are sexually abused more often than boys; however, this may be due to boys'—and later, men's—tendency not to report their victimization.

Most perpetrators of child sexual abuse are people who are known to the victim. As many as 93% of children who are sexually abused under the age of 18 know the abuser. There is no particular profile of a child molester or of the typical victim. Even someone highly respected in the community—the parish priest, a teacher, or coach—may be guilty of child sexual abuse. Anyone, including parents, can be a perpetrator, and most are male.

Negative effects of sexual abuse vary from person to person and range from mild to severe in both the short and long term. Victims may exhibit anxiety, difficulty concentrating, and depression. They may develop eating disorders, self-injury behaviors, substance abuse, or suicide. The effects of childhood sexual abuse often persist into adulthood (Clermont County CPS, 2021; RAINN, 2021).

Physical Indicators of Sexual Abuse

Physical evidence of sexual abuse may not be present or may be overlooked. Victims of child sexual abuse are seldom injured due to the nature of the acts. Most perpetrators of child sexual abuse go to great lengths to "groom" the children by rewarding them with gifts and attention and try to avoid causing them pain in order to ensure that the relationship will continue.

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If physical indicators occur, they may include:

- Symptoms of sexually transmitted diseases, including oral infections, especially in preteens
- Difficulty in walking or sitting
- Torn, stained, or bloody underwear
- Pain, itching, bruising, or bleeding in the genital or anal area
- Bruises to the hard or soft palate
- Pregnancy, especially in early adolescence
- Painful discharge of urine and/or repeated urinary infections
- Foreign bodies in the vagina or rectum
- Painful bowel movements
  (Clermont County CPS, 2021; RAINN, 2021)

Behavioral Indicators of Sexual Abuse

Children's behavioral indicators of child sexual abuse include:

- Unwillingness to change clothes for or participate in physical education activities
- Withdrawal, fantasy, or regressive behavior, such as returning to bedwetting or thumb-sucking
- Inappropriate, bizarre, suggestive, or promiscuous sexual behavior
- Inappropriate sexual knowledge for age
- Verbal disclosure of sexual assault
- Involvement in commercial sexual exploitation
- Forcing sexual acts on other children
- Extreme fear of closeness or physical examination
- Suicide attempts or other self-injurious behaviors
- Layered or inappropriate clothing
- Hiding clothing
- Lack of interest or involvement in activities
  (Clermont County CPS, 2021; RAINN, 2021)

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RECOGNIZING TRAFFICKING

The media often portrays trafficking victims as women or girls who are in chains or have a sign written on their hands that says, “Help Me.” However, this is not what most trafficking victims look like. When victims of human trafficking present in healthcare settings, it is uncommon for them to self-disclose that they are victims. They have significant trust issues, and even when asked directly, they are not likely to disclose that they are victims. The exploiter may also accompany victims, and as with victims of other forms of child abuse, that presence will discourage victims from making any disclosures to a clinician.

A healthcare professional may encounter victims of sex trafficking in a clinic or emergency department setting who are requesting treatment or testing for pregnancy, abortion, sexually transmitted infections, and contraception. They may request a sexual assault forensic exam or treatment for substance abuse. Victims may suffer from broken bones or nonaccidental injury at the hands of exploiters or buyers.

Victims of labor trafficking may have physical injuries, pesticide poisoning, or salmonella from unclean water sources. If their illness or injury is severe, these patients may present in outpatient clinics or in the emergency department.

Behavioral health providers may encounter victims of trafficking who are depressed, cannot sleep, have anxiety, or are suicidal. Dentists may see these victims when dental problems become severe.

Being aware of warning signs and indicators of human trafficking can alert healthcare professionals to possible victims. They may note one or more of the following “red flags” in a child who is a victim of trafficking.

Physical Signs

- Signs or a history of deprivation of food, water, sleep, or medical care
- Physical injuries typical of abuse, such as bruises, burns, cuts, scars, prolonged lack of health or dental care, or other signs of physical abuse
- Brands, scars, clothing, jewelry, or tattoos indicating someone else’s “ownership”
- Presence of sexually transmitted infections
- Pregnancy
- Possession of cell phones, jewelry, large amounts of cash, or other expensive items that appear inconsistent with the patient’s stated situation
- Substance abuse or dependence signs and symptoms
- Clothing that is inappropriate for the weather or emblematic of commercial sex

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Psychological/Emotional Signs

- Fear, anxiety, depression, nervousness, hostility, flashbacks, avoidance of eye contact
- Restricted or controlled communication, or use of a third party to translate, with no indicator of inability to understand English
- Inconsistencies in the history of the illness or injury
- Denial of victimization
- Attempted suicide, submissiveness, fearfulness, self-harm, or other signs of psychological abuse
- Appearing to be controlled by a third party (e.g., looking for permission to speak, not being left alone)
- Isolation from family or former friends
- Fear of employer
- Described or implied threats to self or family/friends
- History of running away

Environmental/Situational Signs

- Working and living in the same place
- Lacking the freedom to leave their working or living conditions
- Being escorted or kept under surveillance when they are taken somewhere
- Not being in control of their own money
- Having no, or few, personal possessions
- Frequently lacking identifying documents, such as a driver’s license or passport
- Indicators of being a minor in a relationship with a significantly older adult
- Not knowing their own address
- Being in possession of hotel keys

SCREENING FOR COMMERCIAL SEXUAL EXPLOITATION OF CHILDREN

There are several validated screening tools for CSEC and a variety of known risk factors for victimization. Greenbaum and colleagues (2018) developed a short, six-question screening tool for CSEC that can be used effectively for youth in the healthcare setting. This short questionnaire also differentiates between victims of sex trafficking and youth who may have experienced sexual assault or abuse without sex trafficking. Each positive response is given a 1-point score. A cut-off score of 2 indicates a patient suspected for CSEC and indicates further questioning by someone trained in a trauma-informed approach.

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1. Is there a previous history of drug and/or alcohol use?
2. Has the youth ever run away from home?
3. Has the youth ever been involved with law enforcement?
4. Has the youth ever broken a bone, had a traumatic loss of consciousness, or sustained a significant wound?
5. Has the youth ever had a sexually transmitted infection?
6. Does the youth have a history of sexual activity with more than five partners?

CASE

Haley is 14 years old and has always wanted to be a dancer or a chef when she grows up. One day she met a young man at the mall who told her she was beautiful. They exchanged phone numbers and began talking on a regular basis. He gave her gifts, and Haley thought she was in love. Haley was being "groomed," one of the ways that exploiters gain trust and control over victims.

Haley's new "boyfriend" soon asked her to have sex with other men, something she said she did not want to do but did anyway because she wanted to please him. Haley also had a history of physical, emotional, and sexual abuse in the home, which made her particularly vulnerable to the methods of exploiters because the cycle of abuse was familiar to her. Because Haley had endured years of sexual abuse in her home, she already felt dirty and ashamed in relation to sex.

Haley's situation progressed to being sold to another exploiter, who beat her if she did not make any money and took all of her money when she was paid. She lived in a locked basement and slept on a mattress on the floor, with only a bucket to use as a toilet. Devoid of job skills, money, and fearing further abuse if she returned to her home, Haley felt trapped and that she had no way out.

Haley's exploiter took her for frequent STI testing at various free clinics to avoid suspicion. Chandra, a nurse practitioner who volunteered at several of the clinics, began to recognize Haley. At the insistence of her exploiter, Haley always registered as an 18-year-old whenever she requested services, but Chandra suspected that Haley was probably younger. Before asking Haley her true age, Chandra made an effort to gain Haley's trust, and Haley confided in her that she was only 14. This confirmed Chandra's suspicions that Haley was probably a minor victim of trafficking, and so she followed the state protocol to report suspected child abuse.

Haley was taken to an emergency receiving center, and because her parents had never filed a missing person report or made an attempt to find her, she was placed in protective custody. Later, Haley was placed in a residential recovery facility for trafficking survivors. Haley was given a safe place to live, extensive treatment for her trauma, and enrolled in high school.

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RECOGNIZING AND RESPONDING TO VICTIMS' DISCLOSURES

It is difficult for young children to describe abuse. They may only disclose part of what happened, or they may make an indirect disclosure such as, "My stepdad keeps me up at night." It is important not to rush the child and to listen to their concerns so that the child feels safe and supported. If a child discloses abuse, the following actions by the healthcare professional will help the child:

- Avoid denying what the child discloses.
- Provide safety and reassurance.
- Listen without making assumptions.
- Do not interrogate.
- Limit questioning to only four queries:
    1. What happened?
    2. When did it happen?
    3. Where did it happen?
    4. Who did it? (How do you know them?)
- Do not make promises.
- Document the child's statements using exact quotes.
- Remain nonjudgmental and supportive.
- Understand the dynamics of abuse and neglect.
- Report suspicions to the authorities.
  (Childhelp, 2021b)

Interviewing for Sexual Assault

If a child or adolescent discloses sexual abuse to a trusted adult, or there is cause for the adult to suspect sexual abuse, the adult should **not** question the child further. They should instead contact Child Protective Services or, if the child is in imminent danger, the police. These professionals have protocols in place to interview the child by a child interview specialist while police, prosecutors, and caseworkers observe.

Such **forensic interviewers** are trained to communicate in an age- and developmentally appropriate manner. Coordination of services with a child forensic interviewer is essential, with the expectation that one interview rather than several by different concerned parties reduces the chances of traumatizing the child further (US DOJ, 2015).

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Management

A **physically abused** child will need to be screened for emergent needs. Once stability has been established, the child will need a history and physical. Child Protective Services should be informed when there is a suspicion of abuse and the child may need to be seen in an in-patient facility so that lab work and imaging can be done.

A child who has been **sexually abused** also must be evaluated for physical, mental, and psychosocial needs. Baseline testing is needed for sexually transmitted infections (STIs) for children of all ages. Pregnancy and empiric treatment for STIs may also be given to adolescent victims. STI prophylaxis and emergency contraception may be offered if the patient presents within 72 hours. Medication may include a regimen of nonoccupational post-exposure prophylaxis (nPEP). Evaluation at the earliest opportunity can be helpful to examine for anogenital injury and collect forensic evidence (CDC, 2021e).

Photographing Evidence

Whenever there are allegations of suspected child abuse or neglect, any records of physical findings may be used as evidence at a trial. Therefore, photos, diagrams, and accurate reporting of medical examination findings are invaluable. Such documentation should use language that is not open to misinterpretation.

If photographs will be needed, it is a good idea to inform the child or adolescent and encourage them to participate in the process. Photographs are another form of medical documentation that can provide objective, visual documentation of abuse. There should be a protocol for releasing the photos after a formal request, and a chain of custody may be necessary as well.

CASE

A mother brought her 12-year-old daughter, Chantal, to the emergency department. She said that her daughter had been complaining about painful urination and wanted to check if she might have a bladder infection. The triage nurse, Janelle, asked the mother, who appeared to be in the last trimester of pregnancy, to fill out some paperwork while she took the girl to the bathroom for a urine specimen.

Janelle noticed that the daughter appeared fearful and sat in silence while her mother did all of the talking. When they were alone behind closed doors, Janelle asked Chantal if there was anything that she wanted to talk about privately. Chantal responded by shaking her head no, but Janelle sensed that the girl was holding something back.

Haley was able to produce a clear, pale yellow urine specimen and then followed the nurse to an exam room. Janelle asked her if she had any pain when she urinated, and Chantal said yes. The nurse asked her if she had begun menstruating, and the child said she had not.

Janelle brought the mother into the exam room to wait with her daughter. After obtaining a brief history from the mother, the physician ordered a urinalysis. The urinalysis was negative.

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The doctor did an external genital exam that revealed numerous vesicular lesions on her labia. The child denied any sexual activity. The doctor cultured the lesions for herpes and asked the mother to step into his office to discuss his findings.

Once Janelle and Chantal were alone again in the room, the child burst into tears and told the nurse that her mother's boyfriend had been rubbing his "private" on her and said that if she told anyone, her mother would go to jail. The nurse stopped questioning the child and reported her suspicion of child sexual abuse to the state child abuse hotline. The nurse knew that victims of child sexual abuse should only be minimally questioned until they can undergo a forensic interview.

On the following day, Chantal was interviewed by a child forensic interview specialist in a child-friendly advocacy center. She and her mother, who was also a victim of child sexual abuse, received counseling for over a year. Following an investigation by Child Protective Services, the mother's boyfriend was eventually tried and convicted of sexual abuse.

REPORTING CHILD ABUSE AND NEGLECT

The government has a responsibility to protect children when parents fail to provide proper care and to intervene in cases of child maltreatment. The federal Child Abuse Prevention and Treatment Act (CAPTA) requires each state to have a system in place that requires certain individuals to report suspected child abuse and neglect. All states list the mandated reporters, responsibilities of institutions, standards for making reports, and how confidentiality of the reporting party is maintained.

Who Must Report Abuse?

Anyone may report suspected child abuse at any time and is encouraged to do so. Such reports are typically confidential and may be made anonymously by members of the public.

Nearly all states designate certain professions whose members are **mandated by law** to report child maltreatment. Typically, these individuals have frequent contact with children. Such persons may include:

- Social workers
- Teachers and other school personnel
- Physicians, nurses, and other healthcare workers
- Mental health professionals
- Child care providers
- Medical examiners or coroners
- Law enforcement officers

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Some other professions include film or photograph processors, computer technicians, substance abuse counselors, probation or parole officers, and attorneys and clergy in certain circumstances. Domestic violence workers, animal control or humane officers, and court-appointed special advocates are also required to report in some states.

In more than one third of states, **any person** who suspects child abuse or neglect is required to report it. In most of those states, professionals who are mandated to report are also listed, but all persons who are aware of abuse are required to report.

It is important that all professionals be informed of the laws that pertain to the jurisdiction(s) of their own practice (CWIG, 2019b).

What Situations Require That a Report Be Made?

State statutes vary, but generally a mandatory reporter must make a report when they suspect or have reason to believe that a child is abused or neglected. In some states, the reporter must observe a child in a situation that is likely to result in harm to the child. The reporter does not have to provide proof of the suspected abuse or neglect (CWIG, 2019b).

(For state-by-state information on mandated reporting, see “Child Welfare Information Gateway” in the “Resources” section at the end of this course.)

REASONABLE CAUSE

There can be “reasonable cause” to suspect that a child is abused or maltreated if, considering the physical evidence observed or told about, and based on the reporter’s own training and experience, it is possible that the injury or condition was caused by neglect or by nonaccidental means.

Certainty is not required. The reporter need not be certain that the injury or condition was caused by neglect or by nonaccidental means. The reporter need only be able to entertain the possibility that it could have been neglect or nonaccidental in order to possess the necessary “reasonable cause.” It is enough for the mandated reporter to distrust or doubt what is personally observed or told about the injury or condition.

In child abuse cases, many factors can and should be considered in the formation of that doubt or distrust. Physical and behavioral indicators may also help form a reasonable basis of suspicion. Although these indicators are not diagnostic criteria of child abuse, neglect, or maltreatment, they illustrate important patterns that may be recorded in the written report when relevant.

CASE

Sharon, a sixth-grade math teacher, stops by her friend Anh’s house for coffee on the way to work. While she is there, Anh’s 5-year-old son, Tran, who has been diagnosed with autism, runs into the kitchen and for no apparent reason shoves his 2-year-old sister, who falls to the

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floor. The sister is not injured, but Anh rages at Tran, picks him up, and throws him across the kitchen, where he slides into a cabinet, hitting the back of his head.

Sharon takes off her coat and examines Tran, who is okay. While she knows that laws in her state do not require her to report a suspicion of child abuse since she is not currently acting in her professional capacity, Sharon also knows the importance of taking action for the safety of her friend's young son.

Sharon first sits down with Tran on her lap to talk to Anh. She empathizes with her friend and expresses her concern for the family. She acknowledges how frightening and stressful it must be for Anh to have a child with a serious condition and asks Anh if she could refer Tran to a program for autistic children that is provided by the school district. Anh tearfully agrees, and Sharon makes a few calls to the school district to gather information about the program.

Sharon makes a point to call Anh the next day and frequently thereafter. One month later, Anh tells Sharon that the school social worker has helped her find a program in which she has learned appropriate new ways of dealing with Tran's acting-out behaviors. Tran has also been enrolled in the school district's program for autistic children and is doing much better.

How Is a Report Made?

In most jurisdictions, a telephone report should be made immediately and then followed by a written report. States often provide standardized forms for this purpose.

Most healthcare facilities also have policies and procedures in place regarding the reporting of suspected child abuse. Healthcare professionals and other mandatory reporters must know what guidelines are in place at their place of employment as well as state mandates.

At the time of an oral telephone report, frequently to a state-subsidized 800 number, a Child Protective Services (CPS) specialist will typically request the following information:

- The condition of the child
- Names and addresses of the child and parents or other person responsible for care
- Location of the child at the time of the report
- Child's age, gender, and race
- Nature and extent of the child's injuries, abuse, or maltreatment, including any evidence of prior injuries, abuse, or maltreatment to the child or its siblings
- Name of the person or persons suspected to be responsible for causing the injury, abuse, or maltreatment ("subject of the report")
- Family composition
- Any special needs or medications

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- Whether an interpreter is needed
- Source of the report
- Person making the report and where reachable
- Actions taken by the reporting source, including taking of photographs or X-rays, removal or keeping of the child, or notifying the medical examiner or coroner
- Any additional information that may be helpful

A reporter is not required to know all of the above information in making a report; therefore, lack of complete information does not prohibit a person from reporting. However, information necessary to locate a child is crucial.

(See also "Childhelp National Child Abuse Hotline" in the "Resources" section at the end of this course.)

Mandatory Notification of Substance Exposed Infants

The CAPTA Reauthorization Act of 2003 contained legislation that called for mandated reporters to notify Child Protective Services when infants were identified as affected by substance abuse or withdrawal symptoms resulting from in-utero exposure to substances. The CAPTA Reauthorization Act of 2010 included additional legislation requiring that mandated reporters notify CPS for infants affected by fetal alcohol spectrum disorder (FASD). In 2016, further changes to CAPTA were made in response to the nation's opioid epidemic, for instance, no longer specifying "illegal" in regard to substance abuse.

CAPTA also requires a plan of safe care, immediate screening, risk and safety assessment, and timely investigation for substance- and alcohol-affected infants. Safe care plans must address the affected caregiver as well as the infant. CAPTA also requires that states report data on affected infants and create and provide oversight systems to assure that safe care plans are implemented (NCSACW, 2017).

HEALTHCARE PROVIDERS REQUIRED TO REPORT

The healthcare providers required to submit this notification vary by state but generally include licensed hospitals or healthcare facilities or persons who are licensed, certified, or otherwise regulated to provide healthcare services. These professions typically include physician, podiatrist, optometrist, psychologist, physical therapist, certified nurse practitioner, registered nurse, nurse midwife, physician's assistant, chiropractor, dentist, pharmacist, and those accredited or certified to provide behavioral health services.

PLAN OF SAFE CARE

After notification of a child born affected by substance use or withdrawal symptoms resulting from prenatal drug exposure or a fetal alcohol spectrum disorder, a multidisciplinary team meets prior to the child's discharge from the healthcare facility. The meeting informs an assessment of

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the needs of the child and the child's parent(s) and immediate caregiver(s) to determine the most appropriate lead agency for developing, implementing, and monitoring a plan of safe care. Depending on the needs of the child and parents/caregivers, ongoing involvement of a county agency may not be required.

The child's parents and immediate caregivers must also be engaged to identify the need for access to treatment for any substance use disorder or other physical or behavioral health condition that may impact the safety, early childhood development, and well-being of the child.

For the purpose of informing the plan of safe care, the multidisciplinary team may include public health agencies, maternal and child health agencies, home visitation programs, substance use disorder prevention and treatment providers, mental health providers, public and private children and youth agencies, early intervention and developmental services, courts, local education agencies, managed care organizations, private insurers, hospitals, and medical providers.

Consequences for Failing to Report

Nearly every state imposes a penalty of a fine or incarceration for mandated reporters who willfully do not report suspected child abuse or neglect. Such mandated reporters may be charged with a misdemeanor or felony for the failure to report. In several states, mandated reporters can also be held liable by civil statutes for damages that result from their failure to report (CWIG, 2019c).

Perhaps more importantly, failure to report can also lead to more serious consequences for the child and family. CPS cannot act until child abuse is identified and reported—that is, services cannot be offered to the family nor can the child be protected from further suffering.

Legal Protections for Reporters

CAPTA requires states to provide immunity from liability for individuals making good-faith reports of child abuse or neglect. States must comply with this mandate in order to be eligible for federal grants. In addition, the identity of the reporter is protected from disclosure to the alleged perpetrator (CWIG, 2019d).

Mandatory reporting laws may recognize the right to maintain confidential communications between professionals and their clients, patients, or congregants. In order to provide protection to maltreated children, the reporting laws in most states and territories restrict this privilege for mandated reporters.

Among the requirements for receiving federal funding under CAPTA is that states must also preserve the confidentiality of all child abuse and neglect reports and records. This mandate protects the privacy of the child and their parents or guardians, except in certain limited circumstances. All jurisdictions have provisions that protect abuse and neglect records from public view, and many jurisdictions include specific provisions for this purpose (CWIG, 2017b).

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REPORTING IMPLICATIONS OF HIPAABOX

Mandated reporters often express reluctance to report child abuse because they are concerned they may compromise patient privacy under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA provisions do not, in fact, inhibit the responsibilities of mandated reporters of child abuse and neglect. HIPAA 164.512, b (1) states that "a covered entity may use or disclose protected health information for the public health activities and purposes described in this paragraph to a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect." This means that mandated reporters may report suspected child abuse and neglect to a local agency that is authorized to receive the information. The agency may be a social services department or a police department, for example (USDHHS, 2020).

CONCLUSION

Child abuse and neglect negatively impact the health and well-being of society. Child victimization is not only a social problem but also a serious public health issue. Child abuse and neglect affect not only the victims while they are children but also shape the adults these children will become. Prevention of child abuse and neglect is a fundamental goal to create healthy children who will in turn become healthy adults.

Research on child abuse and neglect indicates that its incidence can be reduced and its harmful effects can be diminished through prevention and treatment. Individuals, communities, and society must provide safe environments for all children.

Mandated reporters are obligated to report suspected child abuse and neglect. Reporting suspected child abuse is their duty as professionals, but it is also an opportunity to help improve the health and well-being of children and take part in creating a healthier society.

RESOURCES

Abandoned Infant Protection Act Information Hotline
866-505-SAFE (7233)

American Professional Society on the Abuse of Children
https://apsac.org

Childhelp National Child Abuse Hotline
800-422-4453 (call or text)
https://childhelphotline.org/

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Child Welfare Information Gateway
http://www.childwelfare.gov

Council on Child Abuse and Neglect (American Academy of Pediatrics)
https://services.aap.org/en/community/aap-councils/child-abuse-and-neglect/

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

National Runaway Safeline
800-RUNAWAY (786-2929)
https://www.1800runaway.org/

State statutes database (CWIG)
https://www.childwelfare.gov/topics/systemwide/laws-policies/state/

REFERENCES

Alliance for Freedom, Restoration, and Justice. (AFRJ). (2018). Human trafficking 101: who are the victims? Retrieved from https://engagetogether.com/human-trafficking-101-victims/

CAPTA, 42 U.S.C.A. § 5106g(4). (2010). Child Abuse Prevention and Treatment Act. Retrieved from https://www.acf.hhs.gov/sites/default/files/documents/cb/capta.pdf

Carey E. (2018). Child emotional and psychological abuse. *Heathline*. Retrieved from https://www.healthline.com/health/child-neglect-and-psychological-abuse

Centers for Disease Control and Prevention (CDC). (2021a). Preventing child abuse and neglect. Retrieved from https://www.cdc.gov/violenceprevention/childabuseandneglect/fastfact.html

Centers for Disease Control and Prevention (CDC). (2021b). Preventing adverse childhood experiences. Retrieved from https://www.cdc.gov/violenceprevention/aces/fastfact.html

Centers for Disease Control and Prevention (CDC). (2021c). Adverse childhood experiences: risk and protective factors. Retrieved from https://www.cdc.gov/violenceprevention/aces/riskprotectivefactors.html#anchor_1609868131796

Centers for Disease Control and Prevention (CDC). (2021d). Child abuse and neglect: risk and protective factors. Retrieved from https://www.cdc.gov/violenceprevention/childabuseandneglect/riskprotectivefactors.html

Centers for Disease Control and Prevention (CDC). (2021e). Sexually transmitted infections treatment guidelines, 2021: sexual assault or abuse of children. Retrieved from https://www.cdc.gov/std/treatment-guidelines/sexual-assault-children.htm

Childhelp. (2021a). What is child abuse? Retrieved from https://childhelphotline.org/wp-content/uploads/2021/03/Neglect-Abuse.pdf

Childhelp. (2021b). Handling child abuse disclosures. Retrieved from https://www.childhelp.org/wp-content/uploads/2014/10/Disclosure-PDF.pdf

Child Welfare Information Gateway (CWIG). (2021). *Child welfare practice to address racial disproportionality and disparity.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved from https://www.childwelfare.gov/pubs/issue-briefs/racial-disproportionality/

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Child Welfare Information Gateway. (2019a). *Definitions of child abuse and neglect.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved from https://www.childwelfare.gov/pubPDFs/define.pdf

Child Welfare Information Gateway. (2019b). *Mandatory reporters of child abuse and neglect.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved from https://www.childwelfare.gov/pubPDFs/manda.pdf

Child Welfare Information Gateway. (2019c). *Penalties for failure to report and false reporting of child abuse and neglect.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved from https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/report/

Child Welfare Information Gateway. (2019d). *Immunity for reporters of child abuse and neglect.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. Retrieved from https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/immunity/

Child Welfare Information Gateway (CWIG). (2017a). Infant safe haven laws. Retrieved from https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/safehaven/

Child Welfare Information Gateway (CWIG). (2017b). Disclosure of confidential child abuse and neglect records. Retrieved from https://www.childwelfare.gov/pubPDFs/confide.pdf

Clermont County Children's Protective Services (CPS). (2021). Detecting child abuse and neglect. Retrieved from https://cps.clermontcountyohio.gov/identifying-abuse/#5

Edwards B. (2019). Alarming effects of children's exposure to domestic violence. *Psychology Today.* Retrieved from https://www.psychologytoday.com/us/blog/progress-notes/201902/alarming-effects-childrens-exposure-domestic-violence

Feldman M, Sheridan M, & Xiong G. (2020). Factitious disorder imposed on another. *Medscape*. Retrieved from https://emedicine.medscape.com/article/295258-overview

Gaskill R & Perry B. (2012). Child sexual abuse, traumatic experiences, and their impact on the developing brain. In Paris Goodyear-Brown, Ed., *Handbook of child sexual abuse.* Hoboken, NJ: John Wiley & Sons. Retrieved from https://childtrauma.org/wp-content/uploads/2014/01/Gaskill_Perry_2012-.pdf

Greenbaum VJ, Dodd M, & McCracken C. (2018). A short screening tool to identify victims of child sex trafficking in the health care setting. *Pediatric Emergency Care, 34,* 33–7.

Hornor G & Sherfield, J. (2018). Commercial sexual exploitation of children: health care use and case characteristics. *Journal of Pediatric Health Care, 32,* 3. doi:10.1016/j.pedhc.2017.11.004

Kids Matter. (2021). What should I do if I suspect a child is being emotionally abused? Retrieved from https://kidsmatterinc.org/child-safety/types-of-child-abuse/emotional-abuse/

Mayo Clinic. (2018). Child abuse. Retrieved from https://www.mayoclinic.org/diseases-conditions/child-abuse/symptoms-causes/syc-20370864

Narang SK, Fingarson A, Lukefahr J, & Council on Child Abuse and Neglect. (2020). Abusive head trauma in infants and children. *Pediatrics, 145*(4), e20200203. Retrieved from https://pediatrics.aappublications.org/content/145/4/e20200203

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National Center on Safe Supportive Learning Environments (NCSSLE). (2021). Human trafficking in America's schools: child labor trafficking. Retrieved from https://safesupportivelearning.ed.gov/human-trafficking-americas-schools/child-labor-trafficking

National Center on Substance Abuse and Child Welfare (NCSACW). (2017). Child abuse and prevention treatment act (CAPTA) substance exposed infants statutory summary. Retrieved from https://ncsacw.samhsa.gov/files/CAPTA_SEI_Statutory_Summary.pdf

Norton Children's. (2020). How to tell if a bruise is from abuse. Retrieved from https://nortonchildrens.com/news/how-to-tell-if-a-bruise-is-from-abuse/

Rape, Abuse & Incest National Network (RAINN). (2021). Child sexual abuse. Retrieved from https://www.rainn.org/articles/child-sexual-abuse

Research Foundation of SUNY/Center for Development of Human Services. (2011). *Mandated reporter training: identifying and reporting child abuse and maltreatment/neglect.* Buffalo, NY: author. Retrieved from http://www.ocfs.state.ny.us/ohrd/materials/58451.pdf

South Dakota Department of Social Services (SD DSS). (2020). Signs of child abuse and neglect. Retrieved from https://dss.sd.gov/childprotection/signs.aspx

Thatcher T. (2020). Families in crisis: how parental substance abuse and mental health impacts kids. Retrieved from https://valleycares.com/blog/families-in-crisis-how-parental-substance-abuse-and-mental-health-impacts-kids/

U.S. Department of Health & Human Services (USDHHS), Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2021). *Child Maltreatment 2019.* Retrieved from https://www.acf.hhs.gov/cb/research-data-technology/ statistics-research/child-maltreatment

U.S. Department of Health and Human Services (USDHHS). (2020). Health information privacy: public health. Retrieved fromhttps://www.hhs.gov/hipaa/for-professionals/special-topics/public-health/index.html

U.S. Department of Justice (US DOJ). (2020). Child sex trafficking. Retrieved from https://www.justice.gov/criminal-ceos/child-sex-trafficking

U. S. Department of Justice (US DOJ). (2015). Child forensic interviewing: best practices. Retrieved from https://www.ojjdp.gov/pubs/248749.pdf

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TEST

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1. The Federal Child Abuse Prevention and Treatment Act defines a child as a person who is:

a. Younger than 18 years of age.
b. Still living with his or her parents.
c. An emancipated minor.
d. Still in school.

2. The definition of child neglect includes:

a. Engaging in sexual activity with a child or involving a child in commercial sexual activity.
b. Inflicting serious physical injury to a child.
c. Parental use of drugs or alcohol that interferes with the ability to adequately supervise the child.
d. Causing the death or disfigurement of a child by accidental means.

3. Which is **not** a known protective factor against adverse childhood experiences?

a. Work policies that are supportive to families
b. Schools with onsite police officers
c. Caregivers who enforce rules
d. Families participating in fun activities together

4. The mother of a baby boy reports that the baby suffered a short fall off a low bed onto a carpeted floor the previous evening and that he has become lethargic over the past eight hours. The clinician suspects possible abusive head trauma when observing which other sign?

a. Equal pupil sizes
b. Wheezing
c. Vomiting
d. Sunken fontanel

5. Which is **not** a question included in the Greenbaum screening tool for commercial sexual exploitation (sex trafficking) of children?

a. Has the youth ever run away from home?
b. Has the youth ever had a sexually transmitted infection?
c. Does the youth have a previous history of drug or alcohol use?
d. Has the youth voluntary chosen to engage in child prostitution?

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6. When child sexual abuse is suspected, the **best** way to question a child is to:

a. Establish trust by assuring the child you will not share his or her disclosure with others.

b. Extensively interview the child yourself to gather all the details that might be needed by the legal system.

c. Use only proper anatomic terms for genitalia instead of the child's own terms.

d. Avoid further detailed questioning after a child has disclosed abuse and report the abuse to authorities.

7. "Reasonable cause" to suspect child abuse or maltreatment requires:

a. Certainty that an injury was nonaccidental.

b. Doubting what is personally observed or stated about an injury.

c. Believing what a parent says happened to an injured child.

d. Believing it possible that an injury occurred because of abuse or neglect.

8. When a mandated reporter fails to report suspected child abuse or maltreatment, it is important to know that:

a. There are moral but no legal consequences for failing to report.

b. Child Protective Services will eventually find out about the abuse anyway.

c. Mandated reporters can be charged with a misdemeanor or felony.

d. Penalties for failing to report can include fines but not incarceration.

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