COURSE #97533 — 2 CONTACT HOURS/CREDITS RELEASE: 10/01/20 REVIEW: 02/01/23 EXPIRATION: 09/30/23

Child Abuse Identification and Reporting: The New York Requirement

HOW TO RECEIVE CREDIT

- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Evaluation to NetCE by mail or fax, or complete online at www.NetCE.com. (If you are a physician, behavioral health professional, or Florida nurse, please return the included Answer Sheet/Evaluation.) Your postmark or facsimile date will be used as your completion date.
- Receive your Certificate(s) of Completion by mail, fax, or email.

Faculty

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families. (A complete biography appears at the end of this course.)

Faculty Disclosure

Contributing faculty, Alice Yick Flanagan, PhD, MSW, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Division Planners/Director Disclosure

The division planners and director have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for all New York physicians, physician assistants, nurses, and other professionals required to complete child abuse education.

Accreditations & Approvals

In support of improving patient care, NetCE is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

As a Jointly Accredited Organization, NetCE is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. State and provincial regulatory boards have the final authority to determine whether an individual course may be accepted for continuing education credit. NetCE maintains responsibility for this course.

NetCE has been approved by NBCC as an Approved Continuing Education Provider, ACEP No. 6361. Programs that do not qualify for NBCC credit are clearly identified. NetCE is solely responsible for all aspects of the programs.

NetCE is recognized by the New York State Education Department's State Board for Social Work as an approved provider of continuing education for licensed social workers #SW-0033.

This course is considered self-study, as defined by the New York State Board for Social Work. Materials that are included in this course may include interventions and modalities that are beyond the authorized practice of licensed master social work and licensed clinical social work in New York. As a licensed professional, you are responsible for reviewing the scope of practice, including activities that are defined in law as beyond the boundaries of practice for an LMSW and LCSW. A licensee who practices beyond the authorized scope of practice could be charged with unprofessional conduct under the Education Law and Regents Rules.

A complete Works Cited list begins on page 18.

Mention of commercial products does not indicate endorsement.

NetCE is recognized by the New York State Education Department's State Board for Mental Health Practitioners as an approved provider of continuing education for licensed mental health counselors. #MHC-0021.

This course is considered self-study by the New York State Board of Mental Health Counseling.

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This course is considered self-study by the New York State Board of Marriage and Family Therapy.

Designations of Credit

NetCE designates this enduring material for a maximum of 2 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Successful completion of this CME activity, which includes participation in the evaluation component, enables the participant to earn up to 2 MOC points in the American Board of Internal Medicine's (ABIM) Maintenance of Certification (MOC) program. Participants will earn MOC points equivalent to the amount of CME credits claimed for the activity. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABIM MOC credit. Completion of this course constitutes permission to share the completion data with ACCME.

Successful completion of this CME activity, which includes participation in the evaluation component, enables the learner to earn credit toward the CME and Self-Assessment requirements of the American Board of Surgery's Continuous Certification program. It is the CME activity provider's responsibility to submit learner completion information to ACCME for the purpose of granting ABS credit.

Successful completion of this CME activity, which includes participation in the activity with individual assessments of the participant and feedback to the participant, enables the participant to earn 2 MOC points in the American Board of Pediatrics' (ABP) Maintenance of Certification (MOC) program. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABP MOC credit.

This activity has been designated for 2 Lifelong Learning (Part II) credits for the American Board of Pathology Continuing Certification Program.

Successful completion of this CME activity, which includes participation in the evaluation component, earns credit toward the Lifelong Learning requirement(s) for the American Board of Ophthalmology's Continuing Certification program. It is the CME activity provider's responsibility to submit learner completion information to ACCME for the purpose of granting credit.

Through an agreement between the Accreditation Council for Continuing Medical Education and the Royal College of Physicians and Surgeons of Canada, medical practitioners participating in the Royal College MOC Program may record completion of accredited activities registered under the ACCME's "CME in Support of MOC" program in Section 3 of the Royal College's MOC Program.

NetCE designates this continuing education activity for 2 ANCC contact hours.

IPCE CREDIT™

This activity was planned by and for the healthcare team, and learners will receive 2 Interprofessional Continuing Education (IPCE) credits for learning and change.

NetCE designates this continuing education activity for 2.4 hours for Alabama nurses.

AACN Synergy CERP Category B.

Social Workers participating in this intermediate to advanced course will receive 2 Cultural Competency continuing education clock hours.

NetCE designates this continuing education activity for 1 NBCC clock hour.

Individual State Nursing Approvals

In addition to states that accept ANCC, NetCE is approved as a provider of continuing education in nursing by: Alabama, Provider #ABNP0353 (valid through 07/29/2025); Arkansas, Provider #50-2405; California, BRN Provider #CEP9784; California, LVN Provider #V10662; California, PT Provider #V10842; District of Columbia, Provider #50-2405; Florida, Provider #50-2405; Georgia, Provider #50-2405; Kentucky, Provider #7-0054 (valid through 12/31/2023); South Carolina, Provider #50-2405; West Virginia, RN and APRN Provider #50-2405.

Individual State Behavioral Health Approvals

In addition to states that accept ASWB, NetCE is approved as a provider of continuing education by the following state boards: Alabama State Board of Social Work Examiners, Provider #0515; Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health, Provider #50-2405; Illinois Division of Professional Regulation for Social Workers, License #159.001094; Illinois Division of Professional Regulation for Licensed Professional and Clinical Counselors, License #197.000185; Illinois Division of Professional Regulation for Marriage and Family Therapists, License #168.000190.

Special Approvals

This course is approved by the New York State Education Department to fulfill the requirement for 2 hours of training in the Identification and Reporting of Child Abuse and Maltreatment. Provider #80673.

This activity is designed to comply with the requirements of California Assembly Bill 1195, Cultural and Linguistic Competency.

About the Sponsor

The purpose of NetCE is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

Our contributing faculty members have taken care to ensure that the information and recommendations are accurate and compatible with the standards generally accepted at the time of publication. The publisher disclaims any liability, loss or damage incurred as a consequence, directly or indirectly, of the use and application of any of the contents. Participants are cautioned about the potential risk of using limited knowledge when integrating new techniques into practice.

Disclosure Statement

It is the policy of NetCE not to accept commercial support. Furthermore, commercial interests are prohibited from distributing or providing access to this activity to learners.

Course Objective

The purpose of this course is to enable healthcare professionals in all practice settings to define child abuse and identify the children who are affected by violence. This course describes how a victim can be accurately diagnosed and identifies the community resources available in the state of New York for child abuse victims.

Learning Objectives

Upon completion of this course, you should be able to:

1. Summarize the historical context of child abuse.
2. Define child abuse and neglect and identify the different forms of child abuse and neglect.
3. Discuss the scope of child abuse and neglect in New York State and in the United States.
4. Describe warning signs and consequences of child abuse and neglect.
5. Review the mandatory reporting process and mandated reporters in New York State, including possible barriers to reporting suspected cases of child abuse.

EVIDENCE-BASED PRACTICE RECOMMENDATION

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

HISTORICAL CONTEXT

There is an established system in the United States to respond to reports of child abuse and neglect; however, this has not always been the case. This is not because child abuse, neglect, and maltreatment are new social phenomena. Rather, the terms "child abuse," "child neglect," and "child maltreatment" are relatively new, despite the fact that this social problem has existed for thousands of years [1]. Cruelty to children by adults has been documented throughout history and across cultures. In China, infant girls were often neglected during times of famine or sold during times of extreme poverty. There is also historical evidence that cultures have taken steps to stop child abuse and cruelty. For example, 6,000 years ago in Mesopotamia, orphans had their own patron goddesses for help and protection [2].

In many cases, the physical abuse of children has been linked to physical punishment. Throughout history, physical child abuse was justified because it was believed that severe physical punishment was necessary either to discipline, rid the child of evil, or educate [2; 13].

It was not until 1861 that there was a public outcry in the United States against extreme corporal punishment. This reform was instigated by Samuel Halliday, who reported the occurrence of many child beatings by parents in New York City [2].

Sexual abuse of children, particularly incest (defined as sex between family members), is very much a taboo. The first concerted efforts to protect children from sexual abuse occurred in England during the 16th century. During this period, boys were protected from forced sodomy and girls younger than 10 years of age from forcible rape [2]. However, in the 1920s, sexual abuse of children was described solely as an assault committed by "strangers," and the victim of such abuse was perceived as a "temptress" rather than as an innocent child [2].

The first public case of child abuse in the United States that garnered widespread interest took place in 1866 in New York City. Mary Ellen Wilson was an illegitimate child, 10 years of age, who lived with her foster parents [3]. Neighbors were concerned that she was being mistreated; however, her foster parents refused to change their behaviors and said that they could treat the child as they wished [2]. Because there were no agencies established to protect children specifically, Henry Berge, founder of the Society for the Prevention of Cruelty to Animals, intervened on Mary's behalf [3]. He argued that she was a member of the animal kingdom and deserved protection. The case received much publicity, and as a result, in 1874 the New York Society for the Prevention of Cruelty to Children was formed [3]. Because of this case, every state now has a child protective services (CPS) system in place.

As a result of Berge's advocacy for children's safety, other nongovernmental agencies were formed throughout the United States, and the establishment of the juvenile court was a direct result of the Prevention of Cruelty to Children [13]. In 1912, the U.S. Children's Bureau was established to monitor and report on children's social and physical welfare [45]. The Bureau was the first formal federal government vehicle to address the welfare of children [45]. During this time, many states and counties had also established child welfare boards or departments. By 1919, all but three states had juvenile courts. However, many of these nongovernmental agencies could not sustain themselves during the Depression [13].

The topic of child abuse and neglect received renewed interest in the 1960s, when a famous study titled "The Battered-Child Syndrome" was published by Henry Kempe [1; 4]. In the study, researchers argued that the battered-child syndrome consisted of traumatic injuries to the head and long bones, most commonly to children younger than 3 years of age, by parents [1; 4]. The study was viewed as the seminal work on child abuse, alerting both the general public and the academic community to the problems of child abuse [1; 2]. This seminal study was the impetus to the adoption of a formal reporting system, and by 1967, all 50 states required physicians to report child abuse [14; 22]. In the early 1970s, Senator Walter Mondale noted that there was no official agency that spent its energies on preventing and treating child maltreatment [13]. Congress passed the Child Abuse Prevention and Treatment Act (CAPTA) of 1974, which targeted federal funds to improve states' interventions for the identification, reporting and training for child abuse [13; 22].

Today, child abuse and neglect are considered significant social problems with deleterious consequences. As noted, a system has been implemented in all 50 states to ensure the safety of children, with laws defining what constitutes abuse and neglect and who is mandated to report. In 2006, recognizing the role of physicians in the detection of child abuse, child abuse pediatrics became a board-certified subspecialty [46]. In 2010, additional prevention and treatment programs were funded through CAPTA, and in 2012, the Administration on Children, Youth, and Families began to focus on protective factors to child abuse and neglect [22].

DEFINITIONS OF CHILD ABUSE AND NEGLECT

The federal definition of child abuse is evident in CAPTA, published as a product of federal legislation. CAPTA defines a child to be any individual younger than 18 years of age, except in cases of sexual abuse. In cases of sexual abuse, the age specified by the child protection laws varies depending on the state in which the child resides [5]. CAPTA 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, or an act or failure to act which presents an imminent risk of serious harm" [6]. The state of New York defines child abuse and neglect as follows [7]:

> The term abuse encompasses the most serious harms committed against children. An "abused child" is a child whose parent or other person legally responsible for his/her care inflicts upon the child serious physical injury, creates a substantial risk of serious physical injury, or commits a sex offense against the child. Not only can a person be abusive to a child if they perpetrate any of these actions against a child in their case, they can be guilty of abusing a child if they allow someone else to do these things to that child.

FORMS OF CHILD ABUSE AND NEGLECT

There are several acts that may be considered abusive, and knowledge of what constitutes abuse is vital for healthcare providers and other mandated reporters. In this section, specific behaviors that fall under the category of abuse and neglect will be reviewed.

Physical Abuse

Physical abuse injuries can range from minor bruises and lacerations to severe neurologic trauma and death. Physical abuse is one of the most easily identifiable forms of abuse and the type most commonly seen by healthcare professionals. Physical injuries that may be indicative of abuse include bruises/welts, burns, fractures, abdominal injuries, lacerations/abrasions, and central nervous system trauma [8; 61].

Bruises and welts are of concern, particularly those that appear on:

- The face, lips, mouth, ears, eyes, neck, or head
- The trunk, back, buttocks, thighs, or extremities
- Multiple body surfaces

Patterns such as the shape of the article (e.g., a cord, belt buckle, teeth, hand) used to inflict the bruise or welt should be noted. Cigar or cigarette burns are common, and they will often appear on the child's soles, palms, back, or buttocks. Patterned burns that resemble shapes of appliances, such as irons, burners, or grills, are of particular concern.

Fractures that result from abuse might be found on the child's skull, ribs, nose, or any facial structure. These may be multiple or spiral fractures at various stages of healing. When examining patients, note bruises on the abdominal wall, any intestinal perforation, ruptured liver or spleen, and blood vessel, kidney, bladder, or pancreatic injury, especially if accounts for the cause do not make sense. Look for signs of abrasions on the child's wrists, ankles, neck, or torso. Lacerations might also appear on the child's lips, ears, eyes, mouth, or genitalia. If violent shaking or trauma occurred, the child might experience a subdural hematoma [8; 61].

Sentinel injuries are those minor injuries (e.g., bruises, intraoral injuries, fractures) that are recognized by providers or parents prior to the formal recognition of child abuse [47; 48]. It is crucial to monitor for these sentinel injuries.

Sexual Abuse

Sexual abuse is defined by CAPTA as [6]:

> 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 caretaker or interfamilial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children.

Child sexual abuse can be committed by a stranger or an individual known to the child. Sexual abuse may be manifested in many different ways, including [9; 10]:

- Verbal: Obscene phone calls or talking about sexual acts for the purpose of sexually arousing the adult perpetrator
- Voyeurism: Watching a child get dressed or encouraging the child to masturbate while the perpetrator watches
- Commercial sexual exploitation and child sex trafficking: Involving the child in sexual acts for monetary profit
- Child pornography: Taking photos of a child in sexually explicit poses or acts
- Exhibitionism: Exposing his/her genitals to the child or forcing the child to observe the adult or other children in sexual acts
- Molestation: Touching, fondling, or kissing the child in a provocative manner; for example, fondling the child's genital area or long, lingering kisses
- Sexual penetration: The penetration of part of the perpetrator's body (e.g., finger, penis, tongue) into the child's body (e.g., mouth, vagina, anus)
- Rape: Usually involves sexual intercourse without the victim's consent and usually involves violence or the threat of violence

This definition is wide in scope and includes behaviors beyond touching, contact, or physical force. Instead, it encompasses sexual intent against an individual's will. It also takes into consideration consent, as there may be some who cannot consent due to age, disability, fear of harm, and/or state of consciousness or intoxication [62].

Physical Neglect

Undoubtedly, the definition of neglect is an area of controversy. Some argue that neglect is a form of abuse, because neglect involves a caregiver having lower priority and value of the welfare of the child [49]. Some differentiate between the two terms by the fact that emotional abuse involves a commission of an act, while emotional neglect involves an omission [50].

Due to the ambiguity of definitions of child abuse and neglect, CAPTA provides minimum standards that each state must incorporate in its definition. Examples of child neglect may include [6; 11; 12]:

- Failure to provide adequate food, clothing, shelter, hygiene, supervision, education, and protection
- Refusal and/or delay in medical attention and care (e.g., failure to provide needed medical attention as recommended by a healthcare professional or failure to seek timely and appropriate medical care for a health problem)
- Abandonment, characterized by desertion of a child without arranging adequate care and supervision. Children who are not claimed within two days or who are left alone with no supervision and without any information about their parents'/caretakers' whereabouts are examples of abandonment.
- Expulsion or blatant refusals of custody on the part of parent/caretaker, such as ordering a child to leave the home without adequate arrangement of care by others
- Inadequate supervision (i.e., child is left unsupervised or inadequately supervised for extended periods of time)

In New York state, neglect also involves parents/caregivers who fail to exercise a minimum of care of minor who "misuses drugs and alcohol to the extent he/she loses self-control of his/her actions" [63].

Emotional Abuse/Neglect

The following behaviors constitute emotional abuse and neglect [6; 11; 12]:

- Verbal abuse: Belittling or making pejorative statements in front of the child, which results in a loss or negative impact on the child's self-esteem or self-worth
- Inadequate nurturance/affection: Inattention to the child's needs for affection and emotional support
- Witnessing domestic violence: Chronic spousal abuse in homes where the child witnesses the violence
- Substance and/or alcohol abuse: The parent/caretaker is aware of the child's substance misuse problem but chooses not to intervene or allows the behavior to continue
- Refusal or delay of psychologic care: Failure or delay in obtaining services for the child's emotional, mental, or behavioral impairments
- Permitted chronic truancy: The child averages at least five days per month of school absence and the parent/guardian does not intervene
- Failure to enroll: Failure to enroll or register a child of mandatory school age or causing the child to remain at home for nonlegitimate reasons
- Failure to access special education services: Refusal or failure to obtain recommended services or treatment for remedial or special education for a child's diagnosed learning disorder

In New York, emotional abuse entails the above behaviors or behaviors that impair emotional health or mental or emotional condition [63].

Enacted in 2015, the Justice for Victims of Trafficking Act includes an amendment to CAPTA, and several states now track data related to the numbers of victims of sex trafficking. In 2020, 35 states reported 953 victims of sex trafficking [15].

The Comprehensive Addiction and Recovery Act (CARA) of 2016 included an amendment to CAPTA to collect and report the number of infants with prenatal substance exposure. In 2020, 47 states reported this data and referred prenatal substance exposure cases to Child Protective Service agencies. There have been a total of 27,709 reports since passage of this Act [15].

EPIDEMIOLOGY OF CHILD ABUSE AND NEGLECT

NATIONAL PREVALENCE

In 2020, there were 3.9 million referrals to CPS agencies in the United States [15]. Almost 2.2 million were assessed to be appropriate for a response, and 27.6% of reports were made by health and mental or behavioral health professionals [15]. Girls tend to be victims at a slightly higher rate (8.9 per 1,000 girls) compared with boys (7.9 per 1,000 boys) [15]. More than a half (52%) of perpetrators are women, and the majority (83.2%) are between the ages of 18 and 44 years [15].

As of 2020, there were at least 3.1 million children referred to CPS agencies and who received an investigation and some form of response, and 8.4 of every 1,000 children in the United States were victims of abuse and/or neglect [15]. This is the unique rate, meaning each child is counted only once regardless the number of times a report may have been filed for abuse/neglect. The fatality rate for 2020 was 2.38 deaths per 100,000 children [15].

CHILD ABUSE VICTIMIZATION ACCORDING TO RACE/ETHNICITY, 2020	
Race/Ethnicity	**Child Abuse Rate Per 1,000 Children**
Native American/Alaska Native	15.5
African American	13.2
Multi-race	10.3
Pacific Islander	9.0
White	7.4
Hispanic	7.8
Asian American	1.6
Source: [15]	*Table 1*

Research has shown that racial and ethnic minority children (particularly African American, Native American/Alaska Native, and multi-racial children) tend to have higher rates of reported child maltreatment compared to their white counterparts (***Table 1***) [15]. However, the lowest reported rate is among Asian American children [15].

NEW YORK STATE PREVALENCE

In 2020, the rate of child abuse and neglect in New York State was 14.8 per 1,000 children [15]. This translates to approximately 59,126 cases of child abuse and neglect in New York in 2020, a decrease of 9.2% compared with 2016 [15]. In terms of fatalities, 105 children in New York died in 2020 as a result of child abuse and neglect—a rate of 2.63 per 100,000 children [15]. This is greater than the national rate of 2.38 per 100,000 per children [15].

RECOGNIZING WARNING SIGNS

It is crucial that practitioners become familiar with the indications of child abuse and neglect. These factors do not necessarily conclusively indicate the presence of abuse or neglect; rather, they are clues that require further interpretation and clinical investigation. Some parental risk indicators include [8; 10; 12; 15; 16; 64]:

- Recounting of events that do not conform either with the physical findings or the child's physical and/or developmental capabilities
- Inappropriate delay in bringing the child to a health facility
- Unwillingness to provide information or the information provided is vague
- History of family violence in the home
- Parental misuse of substances and/or alcohol
- Minimal knowledge or concern about the child's development and care
- Environmental stressors, such as poverty, single parenthood, unemployment, or chronic illness in the family
- Unwanted pregnancy
- Early adolescent parent
- Expression that the parent(s) wanted a baby in order to feel loved
- Unrealistic expectations of the child
- Use of excessive physical punishment
- Healthcare service "shopping"
- History of parent "losing control" or "hitting too hard"
- Asks teacher to employ harsh disciplining for misbehaviors

Child risk indicators include [8; 10; 12; 16; 48; 64]:

- Multiple school absences
- Learning or developmental disabilities or special needs
- History of multiple, unexplained illnesses, hospitalizations, or accidents
- Poor general appearance (e.g., fearful, poor hygiene, malnourished appearance, inappropriate clothing for weather conditions)
- Begs for money or food
- Stress-related symptoms, such as headaches or stomachaches
- Frozen watchfulness

- Mental illness or symptoms, such as psychosis, depression, anxiety, eating disorders, or panic attacks
- Regression to wetting and soiling
- Sexually explicit play
- Excessive or out-of-the-ordinary clinging behavior
- Difficulties with concentration
- Disruptions in sleep patterns and/or nightmares
- Symptoms of wasting (i.e., unintended and significant weight loss), protruding ribs or bones, abdominal distension, edema, and sparse hair indicating nutritional neglect
- Abuses/mistreats pets

Some of the types of behaviors and symptoms discussed in the definitions of physical, sexual, and emotional abuse/neglect are also warning signs. For example, any of the injuries that may result from physical abuse, such as a child presenting with bruises in the shape of electric cords or belt buckles, should be considered risk factors for abuse.

CONSEQUENCES OF CHILD ABUSE

The consequences of child abuse and neglect vary from child to child; these differences continue as victims grow older. Several factors will mediate the outcomes. These factors include [17]:

- Severity, intensity, frequency, duration, and nature of the abuse and/or neglect
- Age or developmental stage of the child when the abuse occurred
- Relationship between the victim and the perpetrator
- Support from family members and friends
- Level of acknowledgment of the abuse by the perpetrator
- Quality of family functioning

In examining some of the effects of physical abuse, it is helpful to frame the consequences along a lifespan perspective [18]. During infancy, physical abuse can cause neurologic impairments. Most cases of infant head trauma are the result of child abuse [19]. Neurologic damage may also affect future cognitive, behavioral, and developmental outcomes. Some studies have noted that, in early childhood, physically abused children show less secure attachments to their caretakers compared to their nonabused counterparts [20].

By middle to late childhood, the consequences are more notable. Studies have shown significant intellectual and linguistic deficits in physically abused children [18]. Other environmental conditions, such as poverty, may also compound this effect. In addition, a number of affective and behavioral problems have been reported among child abuse victims, including anxiety, depression, low self-esteem, excessive aggressive behaviors, conduct disorders, delinquency, hyperactivity, and social detachment [8; 10; 12; 18].

Surprisingly, there has been little research on the effects of childhood physical abuse on adolescents [18]. However, differences have been noted in parents who abuse their children during adolescence rather than preadolescence. It appears that lower socioeconomic status plays a lesser role in adolescent abuse as compared to abuse during preadolescence [21]. In addition, parents who abuse their children during adolescence are less likely to have been abused as children themselves compared to those parents who abused their children during preadolescence [21]. It is believed that the psychosocial effects of physical abuse manifest similarly in late childhood and adolescence.

Research findings regarding the effects of childhood physical abuse on adult survivors have been less consistent. Some adult survivors function well socially and in terms of mental and physical health, while others exhibit depression, anxiety, post-traumatic stress, substance abuse, criminal behavior, violent behavior, and poor interpersonal relationships [17; 18]. A 2012 meta-analysis found that victims of child abuse were more likely to experience depression than

non-abused counterparts, with the rates varying according to the type of abuse sustained (1.5-fold increase for physical child abuse, 2.11-fold increase for neglect, and 3-fold increase for emotional abuse) [24]. Similar results were found in a longitudinal study that compared a child welfare cohort to a group with no child welfare involvement. The child welfare group was twice as likely to experience moderate-to-severe depression and generalized anxiety compared with the control group [25].

Although not all adult survivors of sexual abuse experience long-term psychologic consequences, it is estimated that 20% to 50% of all adult survivors have identifiable adverse mental health outcomes [23]. In the Wisconsin Longitudinal Study, men who disclosed a history of childhood sexual abuse were more likely to have or develop depression, somatic symptoms, and increased levels of hostility [51]. Other possible psychologic outcomes include [10; 52]:

- Affective symptoms: Numbing, post-traumatic stress disorder, anxiety, depression, obsessions and compulsions, somatization
- Various health problems, including general pain and gastrointestinal symptoms
- Interpersonal problems: Difficulties trusting others, social isolation, feelings of inadequacy, sexual difficulties (e.g., difficulties experiencing arousal and orgasm), avoidance of sex
- Distorted self-perceptions: Poor self-esteem, self-loathing, self-criticism, guilt, shame
- Behavioral problems: Risk of suicide, substance abuse, self-mutilation, violence
- Increased risk-taking behaviors: Abuse of substances, cigarette smoking, sexual risk-taking

Adult male survivors of child sexual abuse are three times as likely to perpetrate domestic violence as non-victims. In addition, female survivors of child sexual abuse are more vulnerable to bulimia, being a victim of domestic violence, and being dependent on alcohol [28].

In more recent years, research has focused on the impact of adverse childhood experiences (ACEs) in general. ACEs are defined as potentially traumatic experiences that affect an individual during childhood (before 18 years of age) and increase the risk for future health and mental health problems (including increased engagement in risky behaviors) as adults [76]. Abuse and neglect during childhood are clear ACEs, but other examples include witnessing family or community violence; experiencing a family member attempting or completing suicide; parental divorce; parental or guardian substance abuse; and parental incarceration [76]. Adults who experienced ACEs are at increased risk for chronic illness, impaired health, violence, arrest, and substance use disorder [77; 78].

The economic costs of non-fatal child maltreatment equate to $210,012 per child victim, excluding the costs associated with adverse physical and mental health consequences and those incurred by the criminal justice and special education systems [53]. A 2017 study found a cost of more than $400,000 per child abuse victim over the course of his or her lifetime [65].

REPORTING SUSPECTED CHILD ABUSE

MANDATED REPORTERS

In the state of New York, certain professionals are legally required or mandated to report any suspected cases of child abuse, maltreatment, and/or neglect that they encounter in their professional roles to the New York Statewide Central Register (SCR) of Child Abuse and Maltreatment. Reasonable cause for suspicion is based upon behaviors that have been observed or reported that cause the professional to believe that a specific circumstance might involve child abuse or neglect [26]. Child abuse laws in New York, and in all states, do not require reporters to have absolute proof of abuse [27]. Reporting suspected cases should be done in good faith, and mandatory reporting laws give the reporter immunity from criminal and civil liability regardless of the

substantiation of abuse [16]. Good faith is defined as "the reporter, to the best of his or her knowledge, has reason to believe that the child in question is being subjected to abuse or neglect" [14]. However, if mandated reporters fail to report an incident of suspected child abuse or maltreatment, they may be charged with a Class A misdemeanor, subject to criminal penalties, and can be sued for monetary damages for any harm in a civil court [26]. It is vital to remember that mandated reporters are not required to provide absolute evidence; this is the responsibility of CPS [29].

The following individuals are classified as mandated reporters in the state of New York [26]:

- Physicians (including osteopaths)
- Registered physician's assistants
- Surgeons
- Medical examiners
- Coroners
- Dentists
- Dental hygienists
- Optometrists
- Chiropractors
- Podiatrists
- Medical residents
- Interns
- Psychologists
- Registered nurses
- Social workers
- Emergency medical technicians
- Licensed creative arts therapists
- Licensed marriage and family therapists
- Licensed mental health counselors
- Licensed psychoanalysts
- Hospital personnel engaged in the admission, examination, care, or treatment of persons
- Christian Science practitioners
- School officials
- Social services workers
- Day care center workers
- Providers of family or group family day care
- Any employees or volunteers in a residential care facility for children
- Any other childcare or foster care workers
- Mental health professionals
- Substance abuse counselors
- Alcoholism counselors
- Peace officers
- Police officers
- District attorneys or assistant district attorneys
- Investigators employed in the Office of the District Attorney
- Any other law enforcement officials

THE PROCESS OF REPORTING TO THE NEW YORK STATEWIDE CENTRAL REGISTER (SCR) OF CHILD ABUSE AND MALTREATMENT

When mandated reporters suspect a case of child abuse or maltreatment, they must report to the SCR at 1-800-635-1522. The general public can report suspected abuse by calling 1-800-342-3720 [38].

The SCR is open 24 hours per day, 7 days per week [26]. The mandated reporter is not obligated to contact the parents or the legal guardians of the child either before or after the call to SCR [26]. Good practice dictates that the reporter either seek consent or notify the parent(s) that essential information is being (and is required to be) shared, unless doing so would put the child's health or safety at risk. However, even if the parent does not consent, the mandated reporter is still obligated to contact the SCR [26]. (Additional child abuse hotline information may be found in the ***Resources*** section of this course.)

The worker who answers the phone will attempt to accumulate as much information from you as possible. According to the New York State Office of Children and Family Services, they will ask you the following types of questions [26; 38]:

- What is the nature and extent of the child's injuries, or the risk of harm to the child?
- Have there been any prior suspicious injuries to this child or his/her siblings?
- What is the child's name, home address, age?
- What is the name and address of the parent or other person legally responsible who caused the injury, or created the risk of harm to the child?
- What are the names and addresses of the child's siblings and parents if different from the information provided above?
- Do you have any information regarding treatment of the child, or the child's current whereabouts?

Within 48 hours of reporting the suspected abuse to SCR, the reporter must also complete and sign a written report (LDSS-2221A) and submit the report to the local department of social services (LDSS) that has been assigned to the investigation [26]. The forms may be accessed on the New York State of Children and Family Services website at https://ocfs.ny.gov/search/docs.php.

The CPS unit of the LDSS is required to begin an investigation of the reported abuse within 24 hours [26]. A CPS specialist will ask questions about the suspected abuse and the child. For example, the specialist will ask for the child's name, age, and home address, the name of the suspected person who inflicted the abuse, his or her address, and the nature of the abuse. The specialist should also evaluate the safety of the child named in the report as well as that of any other children in the home. If the child's safety is at risk, the specialist may take the child and other children in the home into protective custody to prevent further abuse or maltreatment.

CPS has 60 days after receiving the report to determine whether it is "indicated" or "unfounded." CPS is obligated to inform the child's parents or other subject of the report of their rights, according to the New York State Social Services Law, and must inform the SCR of the determination of the investigation [26].

BARRIERS TO REPORTING

Studies have shown that many professionals who are mandated to report child abuse and neglect are concerned and/or anxious about reporting. Identified barriers to reporting include [29; 30; 31; 40; 54; 55]:

- Professionals may not feel skilled in their knowledge base about child abuse and neglect. In addition, they lack the confidence to identify sexual and emotional abuse.
- Professionals may be frustrated with how little they can do about poverty, unemployment, drug use, and the intergenerational nature of abuse.
- Although professionals understand their legal obligation, they may still feel that they are violating patient confidentiality.
- Many professionals are skeptical about the effectiveness of reporting child abuse cases given the bureaucracy of CPS and the large caseloads.
- Practitioners may be concerned that they do not have adequate or sufficient evidence of child abuse.
- Practitioners may have a belief that government entities do not have the right to get involved in matters within the family arena.
- There may be some confusion and emotional distress in the reporting process.
- Practitioners may fear that reporting will negatively impact the therapeutic relationship.

- Loyalty to the family
- Fear of driving the family away from seeking health, social, and mental health services
- Some professionals have concerns that there might be negative repercussions against the child by the perpetrator.
- Some simply underestimate the seriousness and risk of the situation and may make excuses for the parents.

The failure to identify and report child abuse may result in continued abuse of the child and potentially severe consequences. Improved and ongoing education about child abuse and maltreatment has been shown to improve identification and reporting rates among physicians and other professionals. The education should include [32]:

- Management and outcomes
- The role of the CPS investigator
- The role of the physician/other reporting professional
- The benefits of CPS involvement
- The benefits of mandated education on identification/reporting
- The benefits of professional debriefing for the reporter
- The benefits of collaboration (e.g., with local emergency departments, pediatric specialists)

Other suggestions for improving reporting include [32]:

- Improving the relationship between CPS and medical providers
- Allowing certain registered professionals with demonstrated expertise in identifying/treating child abuse "flexible reporting options" (e.g., defer reporting when no immediate threat exists or make the report confidentially and defer an investigation until deemed necessary)
- Improving interaction with the legal system

ASSESSMENT GUIDELINES FOR PROFESSIONALS

Assessment for child abuse and neglect involves the systematic collection of data. Information should be obtained regarding the primary reason for the visit, family health history, the child's health history, history of illnesses, the parents' attitudes toward discipline, and the child's pattern of nutrition, sleep, and diet [16]. If abuse is a concern after the preliminary evaluation, consultation with a child abuse specialist, pediatric specialist, or pediatrician experienced in this area, if available, may be helpful in determining the best way to proceed with assessment [16].

EVIDENCE-BASED PRACTICE RECOMMENDATION

The U.S. Preventive Services Task Force concludes that the current evidence is insufficient to assess the balance of benefits and harms of primary care interventions to prevent child maltreatment in children who do not have signs or symptoms of maltreatment. However, children with signs or symptoms suggestive of maltreatment should be assessed or reported according to the applicable state laws.

(https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/child-maltreatment-primary-care-interventions. Last accessed February 1, 2023.)

Strength of Recommendation: I (Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be measured.)

It is important for professionals to ask questions in a nonjudgmental manner [33]. An environment where support and concern facilitate an open, trusting relationship between the parent and the practitioner should be created. By providing such an environment, the parent has the opportunity to voice concerns and ask for help. Questions that convey concern and may provide valuable information to the professional include, "Who helps you care for your children?" or "How do you discipline your children?" It may be necessary to interview the child and parent separately; however, by spending some time with the child and parent together, practitioners can observe interactions and communication.

Accuracy in record taking is also important. Be sure to record the date and time of the visit, the sources of any information, and the date, time, and place of the alleged abuse or assault [16; 34]. When talking to the child, the practitioner should use developmentally appropriate language that will be easily understood. Leading questions should be avoided [34]. Be sensitive to the fact that children often wonder if the abuse actually happened, as the abuser may behave as if nothing occurred [56]. Asking the following questions may be helpful when interacting with children [34; 35]:

- "Do you know why you are here today?"
- "Can you tell me what happened?"
- "How did it begin?"
- "What happened next?"
- "Where did this happen?"
- "Have you been hurt lately?"

It is important to note the child's demeanor during questioning. Some children may be protective of their abuser, openly fearful of their abuser, or may fear retribution for "telling." Strong nonverbal cues of anxiety and reluctance to answer questions about potential abuse are important considerations when a safety plan for the child is necessary [16; 33].

Supporting and facilitating the victim's emotions are also important. This helps to promote rapport between the interviewer and the child. One way of promoting the rapport is by expressing interest or care by saying: "I want to know more about how you are feeling" [65]. Certain feelings or events may be legitimized by confirming to the child that he/she is safe talking about bad things. Finally, the interviewer can reinforce these sentiments by thanking the child for expressing certain emotions [65].

Because studies have demonstrated a correlation between child abuse and domestic violence, there is a need for dual screening for both types of family violence [16; 20]. An estimated 75% of victims of domestic violence live in a household with at least one child younger than 18 years of age, and between 3.3 million and 10 million children witness domestic violence annually [36; 37]. When a woman presents with a child whom the professional suspects to be at risk for child abuse, the professional should ask the woman if she has ever been hurt or injured by her spouse/intimate partner. Professionals should minimize the discomfort associated with the questioning by first discussing the prevalence of domestic violence in intimate relationships and by stating that such questioning is commonly done [39]. Because of the sensitive nature of child abuse, it can evoke extreme emotions on the part of the professional. However, it is important to manage emotions when talking to children [57].

In cases of child sexual abuse, the child should be interviewed alone. The professional should try to keep a neutral tone of voice and manner. Open-ended, nonleading questions should be used. For example, the practitioner may ask: "Has anyone ever touched you in a way that you did not like or that made you feel uncomfortable?" Because the interview may be admissible in court, careful documentation of the questions and responses is important; the exchange should be documented verbatim [16].

SCREENING FOR ABUSE IN CHILDREN WITH SPECIAL NEEDS OR DISABILITIES

The rates of child maltreatment for children with disabilities are reportedly 1.7 to 7 times higher compared with children without disabilities [42]. In one study, researchers found that among substantiated reports of maltreatment among children, 22% of victims had some form of disability, most commonly an emotional disability [58]. A systematic review found that there was a prevalence rate of 20.4% for physical abuse, 13.7% for sexual abuse, and 26.7% for both forms of abuse combined among children with intellectual disabilities [66]. Children with disabilities can be more vulnerable to maltreatment if the parents/caregivers view the disability and its associated behaviors as "difficult," if the parents have unrealistic expectations of the child's behavior or abilities, if the parents are facing additional caregiver stress, or if the parent perceives the child as unable to defend him/herself [43]. Furthermore, they may be less likely to disclose the abuse because they not only do not realize they have been harmed or they have impaired communication skills [59].

To effectively interview a child with a disability, the practitioner should first obtain some preliminary data, including [33]:

- The child's primary disability
- Accompanying disabilities, if any
- How the disability affects the child's current functioning
- Whether the child is highly distractible
- What the appropriate method of communication will be (e.g., sign language, language board, facilitative communication) if communication is an issue
- What, if any, behavioral challenges (e.g., compulsive, withdrawal) the child has

Overall, when conducting an interview of a child with a disability or special need, the practitioner should work with someone to validate impressions or feelings about the child, develop and use a multidisciplinary resource team, be aware of the child's vulnerabilities (e.g., behavioral challenges, accompanying disabilities), and remember that he/she may be the first person able to stop the child from being further victimized [41]. When questioning the child, it is important to ask open-ended questions, as this approach maximizes recall. Some assume that children with disabilities will not be able to handle open-ended questions, but this is not trictly true [67]. When working with those with intellectual disabilities, interviewers should try shorter open-ended questions before falling back to closed-ended questions [67]. Scaffolding questions, or breaking up the tasks and gradually building up the questions with specific instructions and comprehension checks along the way, can also be beneficial [68]. Comprehension check questions can be as simple as: "Can you repeat the question I just asked?" or "I just asked you <insert question>, what does that question mean to you?" [68].

SCREENING FOR ABUSE IN NON-ENGLISH-PROFICIENT FAMILIES

Communication with children and families regarding the signs and history of abuse is a necessary step in obtaining an accurate diagnosis. When interviewing children for whom English is not their first language, they may switch back to their first language during the interview, even if they express the wish to have the interview conducted in English [69].

There will also be many occasions when an interpreter is warranted. Without an interpreter, children may experience additional stress, struggling to find the right words in English, which can result in more feelings of fear, disempowerment, and voicelessness [44].

It may be tempting to locate a practitioner who has some language ability to speak to the child and/or family member; however, this should be avoided if at all possible [44]. When looking for an interpreter in the community, it is important to consider if the interpreter and the family are acquainted, as this can cause an uncomfortable situation [69]. The language for screening for child abuse requires precision as well as sensitivity, and professional interpreters are recommended.

In this multicultural landscape, interpreters are a valuable resource to help bridge the communication and cultural gap between patients and practitioners [33]. Interpreters are more than passive agents who translate and transmit information back and forth from party to party. When they are enlisted and treated as part of the interdisciplinary clinical team, they serve as cultural brokers, who ultimately enhance the clinical encounter. They should be familiar with both the nuances of the language and the cultural norms and value systems of the target community [44]. When providing care for children and parents for whom English is a second language, the consideration of the use of an interpreter and/or patient education materials in their native language may improve patient understanding and outcomes.

It is also vital to take into account interpreters' competence when working in the area of child abuse. Because of the sensitive nature of child abuse and the type of information being asked and recalled, interpreters should be well trained in communicating with victims and perpetrators [60].

INTERPROFESSIONAL COLLABORATIONS AND CHILD MALTREATMENT

Interprofessional collaboration, defined as a partnership or network of providers who work in a concerted and coordinated effort on a common goal for clients/patients and their families to improve health, mental health, social, and/or family outcomes, is a vital component in child abuse identification and intervention [70]. Positive outcomes with this approach have been demonstrated on individual and organizational levels, including increased patient/client safety and satisfaction and improved health outcomes and quality of life [71; 72; 73].

However, promoting interprofessional collaboration can be challenging, as it challenges the Western paradigm that focuses on individualism and working in a silo [74]. For example, physicians and other health professionals often do not ask their patients and family members about child abuse/neglect or about contact with the child welfare system. Even if this issue is not acute, knowledge of this background information can help to better understand the patient or family as a whole unit. Similarly, child welfare workers rarely engage with physicians, instead focusing primarily on their investigation [75].

Practitioners should work with each other to learn and understand each other's roles and traditions [79; 80]. In focus groups, physicians believed that child welfare workers were supposed to solve child abuse cases by providing social services and removing a child from the home, but did not appreciate the underlying complexities of child abuse and neglect. Child welfare workers overestimated physicians' understanding of the child welfare system [75].

Social workers are often an integral part of the interprofessional practice for child abuse and neglect, acting as a liaison between the families, healthcare workers, and outside entities [81]. When a family has to deal with an issue of suspected child abuse, social workers are able to intervene and offer tools to manage the crisis.

CONCLUSION

Child abuse and neglect are considered significant social problems with deleterious consequences. As noted, a system has been implemented in all 50 states to ensure the safety of children, with laws defining what constitutes abuse and neglect and who is mandated to report. Healthcare professionals, regardless of their discipline or field, are in a unique position to assist in the identification, education, and prevention of child abuse and neglect.

RESOURCES

American Academy of Pediatrics
345 Park Boulevard
Itasca, IL 60143
800-433-9016
https://www.aap.org

New York Statewide Central Register (SCR) of Child Abuse and Maltreatment
General Public
1-800-342-3720

Onondaga County
315-422-9701

Childhelp
6730 N. Scottsdale Road, Suite 150
Scottsdale, AZ 85253
1-800-4-A-CHILD
https://www.childhelp.org

Child Welfare Information Gateway
330 C Street SW
Washington, DC 20201
1-800-394-3366
https://www.childwelfare.gov

Child Welfare League of America
727 15th Street NW, 12th Floor
Washington, DC 20005
202-688-4200
https://www.cwla.org

National Council on Child Abuse and Family Violence
P.O. Box 5222
Arlington, VA 22205
202-441-1304
https://www.preventfamilyviolence.org

New York State Office of Children and Family Services Child Protective Services
Capital View Office Park
52 Washington Street
Rensselaer, New York 12144
518-473-7793
https://ocfs.ny.gov/programs/cps

Prevent Child Abuse New York
4 Global View
Troy, NY 12180
1-800-CHILDREN
https://www.preventchildabuseny.org

FACULTY BIOGRAPHY

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families. Previously acting as a faculty member at Capella University and Northcentral University, Dr. Yick Flanagan is currently a contributing faculty member at Walden University, School of Social Work, and a dissertation chair at Grand Canyon University, College of Doctoral Studies, working with Industrial Organizational Psychology doctoral students. She also serves as a consultant/subject matter expert for the New York City Board of Education and publishing companies for online curriculum development, developing practice MCAT questions in the area of psychology and sociology. Her research focus is on the area of culture and mental health in ethnic minority communities.

Implicit Bias in Health Care

The role of implicit biases on healthcare outcomes has become a concern, as there is some evidence that implicit biases contribute to health disparities, professionals' attitudes toward and interactions with patients, quality of care, diagnoses, and treatment decisions. This may produce differences in help-seeking, diagnoses, and ultimately treatments and interventions. Implicit biases may also unwittingly produce professional behaviors, attitudes, and interactions that reduce patients' trust and comfort with their provider, leading to earlier termination of visits and/or reduced adherence and follow-up. Disadvantaged groups are marginalized in the healthcare system and vulnerable on multiple levels; health professionals' implicit biases can further exacerbate these existing disadvantages.

Interventions or strategies designed to reduce implicit bias may be categorized as change-based or control-based. Change-based interventions focus on reducing or changing cognitive associations underlying implicit biases. These interventions might include challenging stereotypes. Conversely, control-based interventions involve reducing the effects of the implicit bias on the individual's behaviors. These strategies include increasing awareness of biased thoughts and responses. The two types of interventions are not mutually exclusive and may be used synergistically.

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Evidence-Based Practice Recommendations Citation

U.S. Preventive Services Task Force. Interventions to prevent child maltreatment: U.S. Preventive Services Task Force recommendation statement. *JAMA*. 2018;320(20):2122-2128. Available at https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/child-maltreatment-primary-care-interventions. Last accessed February 1, 2023.