Child Abuse Assessment and Reporting

COURSE OBJECTIVES

At the end of this course the particpant will be able to:

1. Identify potential signs of child abuse; physical abuse, sexual abuse, emotional abuse and child neglect
2. Describe impacts of childhood trauma on well-being
3. State definitions and strategies for assessing neglect
4. Explain strategies for addressing neglect including prevention
5. Define different types of child neglect
6. Cite ways to analyze assessments to develop effective case plans
7. Describe long-term consequences of child abuse and neglect
8. State penalties for failure to report and false reporting of child abuse
9. Cite resources on building resiliency
10. Define child sexual abuse
11. State consequences of child sexual abuse
12. Define abusive head trauma in children
13. Define forensic interviewing and describe best practices
14. Explain effects of maltreatment on brain development

Introduction

By the time we read about it in the newspaper or hear it on television, it is too late. A child has already been horrifically abused and/or neglected and perhaps has died. Perhaps more than one child was involved. The public asks, "Why wasn't anything done?" "Why didn't anyone know?" The answer to these questions is often just as troubling as the abuse itself; the abuse was not recognized, or if it was, those who knew about the abuse did not wish to become involved. Taking action would mean talking to child protection workers, police officers, medical personnel, and perhaps even testifying in court proceedings. "I'm too busy to become involved." "This is a family matter and none of my business." "I didn't know, I didn't realize what was happening." "I got hit when I was a kid and it didn't scar me for life. Kids aren't tough enough these days." "Parents should be able to discipline their kids as they see fit." "Words never hurt anyone." "It's not my child. I shouldn't try to intervene." "The parents told me that the child lies all the time."

While we absolve ourselves from responsibility, child abuse and neglect continues to be a "silent epidemic" in the United States. According to the Child Welfare Information Gateway, millions of children are abused and neglected each year, and the majority of these cases are not reported.

The first step in helping abused or neglected children is learning to recognize the signs and symptoms of abuse and neglect. It should be noted that simply because one sign of abuse or neglect is present does not mean that the child is truly the subject of maltreatment. This type of situation may be easily solved by parenting education. However, when signs of maltreatment occur repeatedly despite referrals to parenting education, mental health, medical and school professionals should consider the possibility of chronic abuse and/or neglect.

This course will review the signs of physical abuse, sexual abuse, emotional abuse, and neglect. Next, the course will focus on the short and long-term damage to the child caused by abuse and/or neglect. At times, vignettes will be used to illustrate a particular point; these vignettes are based upon actual mental health cases where the patient is an abuse survivor or perpetrator. All identifying information has been altered to protect the patients' confidentiality, but the facts of the case are genuine. The next part of the course covers mandatory reporting laws and the procedure for reporting suspected child maltreatment. Finally, the course includes information on special topics such as Munchausen's Syndrome by Proxy, infants born drug-addicted, the shaken baby syndrome, child exploitation and school bullying.

Chapter 1 - What Is Child Abuse and Neglect? Recognizing the Signs and Symptoms

Chapter 1 is sourced from the Child Welfare Information Gateway. (2019). *What is child abuse and neglect? Recognizing the signs and symptoms*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

The first step in helping children who have been abused or neglected is learning to recognize the signs of maltreatment. The presence of a single sign does not necessarily mean that child maltreatment is occurring in a family, but a closer look at the situation may be warranted when these signs appear repeatedly or in combination. This [chapter] is intended to help you better understand the Federal definition of child abuse and neglect; learn about the different types of abuse and neglect, including human trafficking; and recognize their signs and symptoms. It also includes additional resources with information on how to effectively identify and report maltreatment and refer children who have been maltreated.

A. How Is Child Abuse and Neglect Defined in Federal Law?

Federal legislation lays the groundwork for State laws on child maltreatment by identifying a minimum set of actions or behaviors that define child abuse and neglect. The Federal Child Abuse

Prevention and Treatment Act (CAPTA), as amended and reauthorized by the CAPTA Reauthorization Act of 2010, defines child abuse and neglect as, at a minimum, "any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation (including sexual abuse as determined under section 111), or an act or failure to act which presents an imminent risk of serious harm" (42 U.S.C. 5101 note, § 3).

Additionally, it stipulates that "a child shall be considered a victim of 'child abuse and neglect' and of 'sexual abuse' if the child is identified, by a State or local agency employee of the State or locality involved, as being a victim of sex trafficking[1] (as defined in paragraph (10) of section 7102 of title 22) or a victim of severe forms of trafficking in persons described in paragraph (9)(A) of that section" (42 U.S.C. § 5106g(b)(2)).

Most Federal and State child protection laws primarily refer to cases of harm to a child caused by parents or other caregivers; they generally do not include harm caused by other people, such as acquaintances or strangers. Some State laws also include a child's witnessing of domestic violence as a form of abuse or neglect.

For State-specific laws pertaining to child abuse and neglect, see Child Welfare Information Gateway's State Statutes Search page at https://www.childwelfare.gov/ systemwide/laws_policies/state/.

To view civil definitions that determine the grounds for intervention by State child protective agencies, visit Information Gateway's *Definitions of Child Abuse and Neglect* at https://www.childwelfare.gov/topics/ systemwide/laws-policies/statutes/define/.

B. What Are the Major Types of Child Abuse and Neglect?

Within the minimum standards set by CAPTA, each State is responsible for providing its own definitions of child abuse and neglect. Most States recognize four major types of maltreatment: physical abuse, neglect, sexual abuse, and emotional abuse. Additionally, many States identify abandonment, parental substance use, and human trafficking as abuse or neglect. While some of these types of maltreatment may be found separately, they can occur in combination. This section provides brief definitions for each of these types.

Physical abuse is a nonaccidental physical injury to a child caused by a parent, caregiver, or other person responsible for a child and can include punching, beating, kicking, biting, shaking, throwing, stabbing, choking, hitting (with a hand, stick, strap, or other object), burning, or otherwise causing physical harm.[2]

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[1] According to the Victims of Trafficking and Violence Protection Act of 2000, sex trafficking is categorized as a "severe form of trafficking in persons" and is defined as a "situation in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age." As of May 2017, States are required to have provisions and procedures in place as part of their CAPTA State Plans that require "identification and assessment of all reports involving children known or suspected to be victims of sex trafficking and…training child protective services workers about identifying, assessing, and providing comprehensive services for children who are sex trafficking victims, including efforts to coordinate with State law enforcement, juvenile justice, and social service agencies such as runaway and homeless youth shelters…"

[2] Nonaccidental injury that is inflicted by someone other than a parent, guardian, relative, or other caregiver (i.e., a stranger) is considered a criminal act that is not addressed by child protective services. Physical discipline, such as spanking or paddling, is not considered abuse as long as it is reasonable and causes no bodily injury to the child. Injuries from physical abuse could range from minor bruises to severe fractures or death.

Neglect is the failure of a parent or other caregiver to provide for a child's basic needs. Neglect generally includes the following categories:

- Physical (e.g., failure to provide necessary food or shelter, lack of appropriate supervision)
- Medical (e.g., failure to provide necessary medical or mental health treatment, withholding medically indicated treatment from children with life-threatening conditions)[3]
- Educational (e.g., failure to educate a child or attend to special education needs)
- Emotional (e.g., inattention to a child's emotional needs, failure to provide psychological care, permitting a child to use alcohol or other drugs)

Sometimes cultural values, the standards of care in the community, and poverty may contribute to what is perceived as maltreatment, indicating the family may need information or assistance. It is important to note that living in poverty is not considered child abuse or neglect. However, a family's failure to use available information and resources to care for their child may put the child's health or safety at risk, and child welfare intervention could be required. In addition, many States provide an exception to the definition of neglect for parents who choose not to seek medical care for their children due to religious beliefs.[4]

Sexual abuse includes activities by a parent or other caregiver such as fondling a child's genitals, penetration, incest, rape, sodomy, indecent exposure, and exploitation through prostitution or the production of pornographic materials. Sexual abuse is defined by CAPTA 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 caretaker or interfamilial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children"(42 U.S.C. § 5106g(a)(4)).

Emotional abuse (or psychological abuse) is a pattern of behavior that impairs a child's emotional development or sense of self-worth. This may include constant criticism, threats, or rejection as well as withholding love, support, or guidance. Emotional abuse is often difficult to

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[3] Although it can apply to children of any age, withholding of medically indicated treatment is a form of medical neglect that is defined by CAPTA as "the failure to respond to…life-threatening conditions by providing treatment (including appropriate nutrition, hydration, and medication) which, in the treating physician's or physicians' reasonable medical judgment, will be most likely to be effective in ameliorating or correcting all such conditions…" CAPTA does note a few exceptions, including infants who are "chronically and irreversibly comatose," situations when providing treatment would not save the infant's life but merely prolong dying, or when "the provision of such treatment would be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane."

[4] The CAPTA amendments of 1996 (42 U.S.C. § 5106i) added new provisions specifying that nothing in the act be construed as establishing a Federal requirement that a parent or legal guardian provide any medical service or treatment that is against the religious beliefs of the parent or legal guardian.

prove, and, therefore, child protective services may not be able to intervene without evidence of harm or mental injury to the child (Prevent Child Abuse America, 2016).

Abandonment is considered in many States as a form of neglect. In general, a child is considered to be abandoned when the parent's identity or whereabouts are unknown, the child has been left alone in circumstances where the child suffers serious harm, the child has been deserted with no regard for his or her health or safety, or the parent has failed to maintain contact with the child or provide reasonable support for a specified period of time. Some States have enacted laws—often called safe haven laws—that provide safe places for parents to relinquish newborn infants. Information Gateway produced a publication as part of its State Statutes series that summarizes such laws. *Infant Safe Haven Laws* is available at https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/safehaven/.

Parental substance use is included in the definition of child abuse or neglect in many States. Related circumstances that are considered abuse or neglect in some States include the following:

- Exposing a child to harm prenatally due to the mother's use of legal or illegal drugs or other substances
- Manufacturing methamphetamine in the presence of a child
- Selling, distributing, or giving illegal drugs or alcohol to a child
- Using a controlled substance that impairs the caregiver's ability to adequately care for the child

For more information about this issue, see Information Gateway's *Parental Drug Use as Child Abuse* at https:// www.childwelfare.gov/topics/systemwide/laws-policies/ statutes/drugexposed/.

Human trafficking is considered a form of modern slavery and includes both sex trafficking and labor trafficking. Sex trafficking is recruiting, harboring, transporting, providing, or obtaining someone for a commercial sex act, such as prostitution, pornography, or stripping. Labor trafficking is forced labor, including drug dealing, begging, or working long hours for little pay (Child Welfare Information Gateway, 2018). Although human trafficking includes victims of any sex, age, race/ ethnicity, or socioeconomic status, children involved in child welfare, including children who are in out-of-home care, are especially vulnerable (Child Welfare Information Gateway, 2018).

For more information, see Information Gateway's webpage on human trafficking at https://www.childwelfare.gov/topics/systemwide/trafficking/ and the State statutes on the definitions of human trafficking at https://www.childwelfare.gov/topics/systemwide/ laws-policies/statutes/definitions-trafficking/.

C. Recognizing Signs of Abuse and Neglect and When to Report

It is important to recognize high-risk situations and the signs and symptoms of maltreatment. If you suspect a child is being harmed, reporting your suspicions may protect him or her and help the family receive assistance. Any concerned person can report suspicions of child abuse or neglect. Reporting your concerns is not making an accusation; rather, it is a request for an investigation and assessment to determine if help is needed.

Some people (typically certain types of professionals, such as teachers or physicians) are required by State laws to report child maltreatment under specific circumstances. Some States require all adults to report suspicions of child abuse or neglect. Individuals required to report maltreatment are called mandatory reporters. Information Gateway's *Mandatory Reporters of Child Abuse and Neglect* discusses the laws that designate groups of professionals or individuals as mandatory reporters. It is available at https://www.childwelfare.gov/topics/systemwide/laws-policies/state/

For information about where and how to file a report, contact your local child protective services agency or police department. Childhelp's National Child Abuse Hotline (800.4.A.CHILD) and its website (https://www.childhelp.org/hotline/) offer crisis intervention, information, resources, and referrals to support services and provide assistance in more than 170 languages.

For information on what happens when suspected abuse or neglect is reported, read Information Gateway's *How the Child Welfare System Works* at https://www.childwelfare.gov/pubs/factsheets/ cpswork/.

A child may directly disclose to you that he or she has experienced abuse or neglect. Childhelp's *Handling Child Abuse Disclosures* defines direct and indirect disclosure and provides tips for supporting the child. [Chapter 2]

While it's important to know the signs of physical, mental, and emotional abuse and neglect, which are provided later in this [chapter], the following signs of general maltreatment also can help determine whether a child needs help:

Child

- Shows sudden changes in behavior or school performance
- Has not received help for physical or medical problems brought to the parents' attention
- Has learning problems (or difficulty concentrating) that cannot be attributed to specific physical or psychological causes
- Is always watchful, as though preparing for something bad to happen
- Lacks adult supervision
- Is overly compliant, passive, or withdrawn
- Comes to school or other activities early, stays late, and does not want to go home
- Is reluctant to be around a particular person
- Discloses maltreatment

Parent

- Denies the existence of—or blames the child for— the child's problems in school or at home
- Asks teachers or other caregivers to use harsh physical discipline if the child misbehaves
- Sees the child as entirely bad, worthless, or burdensome

- Demands a level of physical or academic performance the child cannot achieve
- Looks primarily to the child for care, attention, and satisfaction of the parent's emotional needs
- Shows little concern for the child

Parent and child

- Touch or look at each other rarely
- Consider their relationship entirely negative
- State consistently they do not like each other

The preceding list is not a comprehensive list of the signs of maltreatment. It is important to pay attention to other behaviors that may seem unusual or concerning. Additionally, the presence of these signs does not necessarily mean that a child is being maltreated; there may be other causes. They are, however, indicators that others should be concerned about the child's welfare, particularly when multiple signs are present or they occur repeatedly.

For information about risk factors for maltreatment as well as the perpetrators, see the webpage Risk Factors That Contribute to Child Abuse and Neglect, which is available at https://www.childwelfare.gov/topics/can/factors/, and the webpage Perpetrators of Child Abuse & Neglect, which is available at https://www.childwelfare.gov/topics/ can/perpetrators/.

a. Signs of Physical Abuse

A child who exhibits the following signs may be a victim of physical abuse:

- Has unexplained injuries, such as burns, bites, bruises, broken bones, or black eyes
- Has fading bruises or other noticeable marks after an absence from school
- Seems scared, anxious, depressed, withdrawn, or aggressive
- Seems frightened of his or her parents and protests or cries when it is time to go home
- Shrinks at the approach of adults
- Shows changes in eating and sleeping habits
- Reports injury by a parent or another adult caregiver
- Abuses animals or pets

Consider the possibility of physical abuse when a parent or other adult caregiver exhibits the following (Prevent Child Abuse America, 2018):

- Offers conflicting, unconvincing, or no explanation for the child's injury or provides an explanation that is not consistent with the injury
- Shows little concern for the child
- Sees the child as entirely bad, burdensome, or worthless
- Uses harsh physical discipline with the child
- Has a history of abusing animals or pets

b. Signs of Neglect

A child who exhibits the following signs may be a victim of neglect (Tracy, 2018a):

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

Consider the possibility of neglect when a parent or other caregiver exhibits the following (Tracy, 2018b):

- Appears to be indifferent to the child
- Seems apathetic or depressed
- Behaves irrationally or in a bizarre manner
- Abuses alcohol or other drugs

c. Signs of Sexual Abuse

A child who exhibits the following signs may be a victim of sexual abuse (American Academy of Child and Adolescent Psychology, 2014; Rape, Abuse and Incest National Network [RAINN], 2018a):

- Has difficulty walking or sitting
- Experiences bleeding, bruising, or swelling in their private parts
- Suddenly refuses to go to school
- Reports nightmares or bedwetting
- Experiences a sudden change in appetite
- Demonstrates bizarre, sophisticated, or unusual sexual knowledge or behavior
- Becomes pregnant or contracts a sexually transmitted disease, particularly if under age 14
- Runs away
- Reports sexual abuse by a parent or another adult caregiver
- Attaches very quickly to strangers or new adults in their environment

Consider the possibility of sexual abuse when a parent or other caregiver exhibits the following (RAINN, 2018b):

- Tries to be the child's friend rather than assume an adult role
- Makes up excuses to be alone with the child
- Talks with the child about the adult's personal problems or

relationships

d. Signs of Emotional Maltreatment

A child who exhibits the following signs may be a victim of emotional maltreatment (Prevent Child Abuse America, 2016):

- Shows extremes in behavior, such as being overly compliant or demanding, extremely passive, or aggressive
- Is either inappropriately adult (e.g., parenting other children) or inappropriately infantile (e.g., frequently rocking or head-banging)
- Is delayed in physical or emotional development
- Shows signs of depression or suicidal thoughts
- Reports an inability to develop emotional bonds with others

Consider the possibility of emotional maltreatment when the parent or other adult caregiver exhibits the following (Prevent Child Abuse America, 2016):

- Constantly blames, belittles, or berates the child
- Describes the child negatively
- Overtly rejects the child

D. The Impact of Childhood Trauma on Well-Being

Child abuse and neglect can have lifelong implications for victims, including on their well-being. While the physical wounds may heal, there are many long-term consequences of experiencing the trauma of abuse or neglect. A child or youth's ability to cope and thrive after trauma is called "resilience." With help, many of these children can work through and overcome their past experiences.

Children who are maltreated may be at risk of experiencing cognitive delays and emotional difficulties, among other issues, which can affect many aspects of their lives, including their academic outcomes and social skills development (Bick & Nelson, 2016). Experiencing childhood maltreatment also is a risk factor for depression, anxiety, and other psychiatric disorders (Fuller-Thomson, Baird, Dhrodia, & Brennenstuhl, 2016). For more information on the lasting effects of child abuse and neglect, read *Long-Term Consequences of Child Abuse and Neglect* at https://www.childwelfare.gov/pubs/factsheets/ long_term_consequences.

E. Resources

The National Child Traumatic Stress Network's factsheet *What Is Child Traumatic Stress?* (https://www. nctsn.org/resources/what-child-traumatic-stress) defines child traumatic stress and provides an overview of trauma, trauma signs and symptoms, and how trauma can impact children. Find more resources that strive to raise the standard of care and improve access to services for traumatized children, their families, and communities on the National Child Traumatic Stress Network at http:// www.nctsn.org/.

The Centers for Disease Control and Prevention (CDC) web section, Child Abuse and Neglect: Consequences, provides information on the prevalence, effects, and physical and mental consequences of child abuse and neglect as well as additional resources and a comprehensive

reference list. You can visit it at https:// www.cdc.gov/violenceprevention/childabuseandneglect/consequences.html.

Stop It Now! is a website that provides parents and other adults with resources to help prevent child sexual abuse. The site offers direct help to those with questions or concerns about child abuse, prevention advocacy, prevention education, and technical assistance and training. The website is available at http://www.stopitnow.org/.

The American Academy of Pediatrics' The Resilience Project gives pediatricians and other health-care providers the resources they need to more effectively identify, treat, and refer children and youth who have been maltreated as well as promotes the importance of resilience in how a child deals with traumatic stress. The webpage is available at https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/Pages/Resilience-Project.aspx.

Information Gateway has produced webpages and publications about child abuse and neglect:

The Child Abuse and Neglect webpage (https://www. childwelfare.gov/topics/can/) provides information on identifying abuse, statistics, risk and protective factors, and more.

The Reporting Child Abuse and Neglect webpage (https://www.childwelfare.gov/topics/responding/ reporting/) provides information about mandatory reporting and how to report suspected maltreatment.

Information Gateway also has several publications that cover understanding and preventing maltreatment:

Child Maltreatment: Past, Present, and Future: https://www.childwelfare.gov/pubs/issue-briefs/cm-prevention/

Preventing Child Abuse and Neglect: https://www.childwelfare.gov/pubs/factsheets/preventingcan/

Understanding the Effects of Maltreatment on Brain Development https://www.childwelfare.gov/pubs/issue-briefs/ brain-development/

The CDC produced *Understanding Child Maltreatment* (https://www.cdc.gov/violenceprevention/pdf/ understanding-cm-factsheet.pdf), which defines the many types of maltreatment and the CDC's approach to prevention.

Prevent Child Abuse America is a national organization dedicated to providing information on child maltreatment and its prevention. You can visit its website at http:// preventchildabuse.org/.

A list of organizations focused on child maltreatment prevention is available on Information Gateway's National Child Abuse Prevention Partner Organizations page at https://www.childwelfare.gov/ organizations/

F. References

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Citation:

Child Welfare Information Gateway. (2019). *What is child abuse and neglect? Recognizing the signs and symptoms*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Chapter 2 - Acts of Omission: An Overview of Child Neglect

Chapter 2 is sourced from the Child Welfare Information Gateway. (2018). *Acts of omission: An overview of child neglect.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

This [chapter] for child welfare professionals addresses the scope of the problem of child neglect as well as its consequences, reviews definitions and strategies for assessing neglect, presents lessons learned about prevention and intervention, and suggests sources of training and informational support. Strategies for addressing neglect, beginning with prevention, are included.

Neglect accounts for over three-quarters of confirmed cases of child maltreatment in the United States—far more than physical or sexual abuse (U.S. Department of Health and Human Services [HHS], Administration for Children and Families [ACF], Children's Bureau [CB], 2017c). It continues, however, to receive less attention from practitioners, researchers, and the media. Some reasons may be that neglect is not well understood and is difficult to identify, prevent, and treat effectively.

Scope of the Problem

According to the latest Children's Bureau *Child Maltreatment* report, more than 514,000 children were neglected in 2015, accounting for 75.3 percent of all unique victims of child maltreatment (HHS, ACF, CB, 2017c). In addition, neglect was either the sole cause or one of the contributors to nearly 73 percent of the 1,670 deaths related to child maltreatment in 2015.

These statistics include only children who came to the attention of State child protective services (CPS) agencies. The National Incidence Study (NIS) of Child Abuse and Neglect, which generates broader estimates by gathering data from sources beyond CPS agencies, generally shows higher numbers of maltreatment than those shown in the *Child Maltreatment* reports. The most recent version, NIS-4, uses data from 2005 to 2006 to show that more than 2.2 million children were neglected, accounting for about 77 percent of all children harmed or endangered by maltreatment (Sedlak et al., 2010). Although the rates of all types of maltreatment have declined in recent years, rates of neglect have decreased much less than the other types (Child Trends, 2016). The persistently high rates of neglect and its serious consequences point to the need for more effective prevention and for early intervention in cases of neglect.

Defining Child Neglect

Both Federal and State laws provide basic definitions of 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 the following, 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
- An act or failure to act which presents an imminent risk of serious harm

The Justice for Victims of Trafficking Act of 2015 (P.L. 114-22) expanded the Federal definition of "child abuse and neglect" and "sexual abuse" to include a child who is identified as a victim of sex trafficking or severe forms of trafficking in persons (HHS, ACF, CB, 2017b).

Neglect is commonly defined in State law as the failure of a parent or other person with responsibility for the child to provide needed food, clothing, shelter, medical care, or supervision to the degree that the child's health, safety, and well-being are threatened with harm (Child Welfare Information Gateway, 2016b). Some States specifically mention types of neglect in their statutes, such as educational neglect, medical neglect, and abandonment; in addition, some States include exceptions for determining neglect, such as religious exemptions for medical neglect and financial considerations for physical neglect.

State Statutes and Publications

To see how your State addresses neglect definitions in law, see Information Gateway's State Statute publication *Definitions of Child Abuse and Neglect,* available at https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/ define/.

Most States publish policy or procedure manuals to help professionals apply legal definitions of child abuse and neglect in practice. Use Information Gateway's State Guides and Manuals Search to find your State's resources online, available at https://www.childwelfare.gov/topics/systemwide/sgm/.

Child neglect is generally thought of as the inability of a parent or caregiver to meet a child's basic needs, potentially placing the child at risk of serious harm. For definitions, many State laws focus on omission in care by parents or caregivers, but holding parents or caregivers accountable for harm that results from failing to care for their children is challenging for child welfare workers who may feel uncomfortable labeling failure to provide necessary care as "neglect." Definitions and accountability are complicated by multiple and interacting factors, such as the following (Dubowitz, 2013):

- Whether care is adequate to meet a child's needs
- If harm is actual or potential
- Variety in the types of neglect
- Whether the neglect was intentional

These factors create difficulties in developing standard definitions of neglect, and the varied definitions contribute to a lack of consistency in research on neglect and responses to that research.

Types of Neglect

Although State laws vary regarding the types of neglect included in definitions, summarized below are the most commonly recognized categories of neglect:

- **Physical neglect:** Abandoning the child or refusing to accept custody; not providing for basic needs like nutrition, hygiene, or appropriate clothing
- **Medical neglect:** Delaying or denying recommended health care for the child
- **Inadequate supervision:** Leaving the child unsupervised (depending on length of time and child's age/maturity), not protecting the child from safety hazards, not providing adequate caregivers, or engaging in harmful behavior
- **Emotional neglect:** Isolating the child, not providing affection or emotional support, or exposing the child to domestic violence or substance use
- **Educational neglect:** Failing to enroll the child in school or homeschool, ignoring special education needs, or permitting chronic absenteeism from school

. . . .

For more information on types of neglect, visit Information Gateway's webpage on the Identification of Neglect at https://www.childwelfare.gov/topics/can/ identifying/neglect.

Reasons for Neglect

To fully understand the reasons for neglect, it is important to move beyond considerations of child neglect only as a function of parent or caregiver characteristics (National Alliance of Children's Trust & Prevention Funds [Alliance], 2014). Considerations should include the following four levels of the socioecological model (Alliance, 2013):

1. Child/Individual
2. Family/Parents
3. Community/Neighborhood
4. Society

To better understand the influences on individual families, it is important to explore the context for these different areas in the lives of families.

Examples of factors in each of the levels of the socioecological model that contribute to and protect against child neglect include the following:

- Child/Individual—Physical, emotional, intellectual, and other personal characteristics of the parent or child; current or past trauma; nurturing and attachment capacity of the parent and child; resilience
- Family/Parents—Healthy partner relationship; physical, emotional, and economic well-being; parent-child interactions
- Community/Neighborhood—Adequate resources to meet community needs (e.g., safe playgrounds, libraries, access to healthy foods); networks for support and assistance; neighborhood violence
- Society—Family policies that provide supports for families, lack of clarity on adequate parenting standards, concrete supports available to all families

Understanding reasons for neglect that extend beyond parents and caregivers may lead child welfare professionals to use strengths-based approaches and preventive strategies with parents who need support.

For more information on the Alliance, visit http://www. ctfalliance.org/

Consequences of Neglect

Although the initial impact may not be as obvious as physical or sexual abuse, the consequences of child neglect are just as serious. The effects of neglect are cumulative, and long-term research like that being performed by the Longitudinal Studies of Child Abuse and Neglect (http://www.unc.edu/depts/sph/longscan/), funded by the Children's Bureau, helps child welfare professionals better understand outcomes for children affected by neglect.

Neglect can have a negative effect on children in the following areas (Center on the Developing Child at Harvard University, 2012):

- Health and physical development—Malnourishment, impaired brain development, delays in growth or failure to thrive
- Intellectual and cognitive development—Poor academic performance, delayed or impaired language development

- Emotional and psychological development— Deficiencies in self-esteem, attachment, or trust
- Social and behavioral development—Interpersonal relationship problems, social withdrawal, poor impulse control

The impacts in these areas are interrelated; problems in one developmental area may influence growth in another area. In addition, research has established a clear link between child maltreatment, including neglect, with health and well-being issues (Metzler, Merrick, Klevens, Ports, & Ford, 2017).

The effects of neglect can vary, however, based on the following factors:

- The child's age
- The presence and strength of protective factors
- The frequency, duration, and severity of the neglect
- The relationship between the child and caregiver

Trauma and Neglect

While trauma—an emotional response to an intense event that threatens or causes harm—is often discussed in terms of witnessing or being harmed by an intensely threatening event, one or multiple experiences of neglect can also have a traumatic effect, especially in severe cases. Child neglect is one common type of childhood trauma that results in distress, posttraumatic stress disorder, and posttraumatic stress symptoms (De Bellis & Zisk, 2014). Children's experiences with neglect can negatively affect brain development by changing how they respond to intense events, thereby disrupting their ability to cope with adversity (Child Welfare Information Gateway, 2015; National Scientific Council on the Developing Child, 2012). A recent literature review addressing the traumatic nature of child neglect emphasizes the need for trauma-informed interventions and provides the following intervention guidelines when working with children who have been neglected and their families (Milot, St-Laurent, & Éthier, 2016):

1. Assess trauma experiences
2. Provide a safe environment
3. Build a feeling of emotional security
4. Improve parental sensitivity
5. Develop child emotional self-regulation
6. Offer parents emotional therapeutic support

More information on addressing trauma in children who have experienced neglect and their families is available in the National Child Traumatic Stress Network's Child Welfare Trauma Training Toolkit (http://www.nctsn.org/ products/child-welfare-trauma-training-toolkit-2008) and Information Gateway's bulletin for professionals, *Supporting Brain Development in Traumatized Children and Youth* (https://www.childwelfare.gov/pubs/ braindevtrauma).

Trauma Adapted Family Connections (TA-FC) is based on the principles of Family Connections (FC), an in-home, evidence-based neglect prevention intervention that began in 1996 as a demonstration project funded by the Children's Bureau. The intervention began at the University of Maryland School of Social Work (UM SSW) Ruth H. Young Center for Families and Children and aimed to prevent neglect in at-risk families. TA-FC is part of the Family Informed Trauma Treatment Center at UM SSW, as well as the National Child Traumatic Stress Network. It is a

manualized, trauma-focused practice designed to last up to 6 months and incorporates (1) trauma-focused family assessment and engagement, (2) education for families on trauma causes and symptoms, (3) safety capacity building within the community and immediate environment, (4) trauma-informed parenting practices, and (5) trauma-informed approaches to working with families. TA-FC is replicated across the social services. In child welfare, one program in Cleveland, OH, uses TA-FC to strengthen families reuniting after child removal due to homelessness, and one program in Washington, DC, assists grieving teens with difficulties at school and at home. TA-FC is also used in a county and a State site as an alternate response to unsubstantiated cases. Successes include, but are not limited to, reductions in posttraumatic stress symptoms and depression in both caregivers and children; reductions in caregiver anxiety; improvements in child behaviors; and improved outcomes in caregiver, child, and family well-being and safety (Collins et al., 2015).

Find more information about FC at http://www. family.umaryland.edu/fc-replication or contact Diane DePanfilis at 917.453.2296.

Fatal Neglect

A child's death is the most tragic consequence of neglect, and neglect caused or contributed to nearly three-quarters of all child maltreatment-related deaths in 2015 (HHS, ACF, CB, 2017c). A study of child fatalities in Oklahoma due solely to neglect found that fatalities due to lack of supervision and a dangerous environment were much more common than those caused by deprivation of needs or medical neglect (Welch & Bonner, 2013). Neglect fatalities can be difficult to identify due to lack of definitive medical evidence, limited resources for testing, varying levels of expertise and training for relevant personnel, and differing interpretations of child maltreatment definitions (U.S. Government Accountability Office, 2011).

For more information, visit the website of the National Center for Fatality Review and Prevention at https://www. ncfrp.org.

Risk Factors

While the presence of a risk factor does not mean that a child will be neglected, multiple risk factors are a cause for concern. Research indicates that many familial and societal factors, such as the following, place children at greater risk of being harmed or endangered by neglect:

- Poverty
- Single-parent status
- Dysfunctional family structure
- Lack of adequate support systems
- Lack of adequate family resources
- Mental health concerns
- Substance use disorders
- Domestic violence
- Parental childhood abuse (Hamilton & Bundy-Fazioli, 2013)

For more information on risk factors, see Information Gateway's Factors That Contribute to Child Abuse and Neglect webpage at https://www.childwelfare.gov/topics/ can/factors/contribute.

Protective Factors

Although several factors place children at greater risk of neglect, families with one or more of the following protective factors may be less likely to experience abuse or neglect (Center for the Study of Social Policy, 2016; Child Welfare Information Gateway, 2014b):

- Knowledge of parenting and child development
- Parental resilience
- Social connections of parents
- Concrete supports
- Social and emotional competence of children
- Nurturing and attachment

For more information on protective factors for child abuse and neglect, see the following resources:

- Information Gateway's Protective Factors to Promote Well-Being webpage at https://www.childwelfare.gov/ topics/preventing/promoting/protectfactors/
- Information Gateway's issue brief *Protective Factors Approaches in Child Welfare* at https://www. childwelfare.gov/pubs/issue-briefs/protective-factors/
- The Centers for Disease Control and Prevention's webpage Child Abuse and Neglect: Risk and Protective Factors at https://www.cdc.gov/ violenceprevention/childabuseandneglect/ riskprotectivefactors.html

Children's Bureau Grant Projects

In 2014, the Children's Bureau awarded five 3-year projects in its Grants in Child Maltreatment Research Using Innovative Approaches cluster. The purpose of the funding was to encourage and support child maltreatment research that used innovative research designs to address knowledge gaps in the field. Four of the five projects supported efforts to determine the efficacy or effectiveness of interventions that focus on child neglect. The grantees and their projects included the following:

1. An Ecological Systems Approach to the Investigation of Child Neglect: Early Head Start/Child Welfare Study III (Grantee: Children's Hospital Corporation)
2. Housing Services in Child Welfare: Economic Evaluation of Systems Coordination (Grantee: Washington University in St. Louis)
3. Addressing the Needs of Families Referred for Neglect and Substance Abuse: The FAIR Efficacy Trial (Grantee: OSLC Developments, Inc.)
4. Intervening in Child Neglect: A Microsimulation Evaluation Model of Usual Care (Grantee: Washington University in St. Louis)
5. MPSY Rhode Island Child and Family Well- Being: Wraparound Services for CPS-Identified Families (Grantee: Yale University)

For more on the FAIR Efficacy Trial, see page 11 of this bulletin or visit http://www.oslcdevelopments. org/fair/; to learn more about Early Head Start/ Child Welfare Study III, see page 17 of this bulletin.

For brief descriptions of each of the projects funded, visit the Children's Bureau's Discretionary Grant Library at https://library.childwelfare.gov/ cbgrants/ws/library/docs/cb_grants/GrantHome.

Special Considerations

Neglect rarely occurs in isolation; commonly related issues include poverty, substance use, and domestic violence. There are special considerations for addressing these issues with children who are at-risk or neglected and their families.

Poverty

Poverty is frequently linked to child neglect, but child welfare professionals should understand that most poor families do not neglect their children. NIS-4 data indicate that children from low socioeconomic status households (annual incomes below $15,000, family member participation in a poverty program, and/or parent education less than high school) were about seven times more likely to be neglected than children in higher socioeconomic households (Sedlak et al., 2010). While poverty is clearly linked with maltreatment, the relationship is not simple. Poverty increases the risk of neglect by interacting with and worsening related risks like family stress, access to necessary resources (e.g., healthy food and medical care), and the inability to provide appropriate care for children (Eckenrode, Smith, McCarthy, & Dineen, 2014). Because chronic neglect is commonly associated with co-occurring issues like cognitive development, mental health, or substance use disorder concerns (Child Welfare Information Gateway, 2013c), families living with neglect in poverty are likely to struggle with an array of risk factors. Lack of housing and transportation, in addition to lack of access to substance use disorder treatment, are common themes in child neglect cases.

Caseworkers must differentiate between neglectful situations and poverty; in many States, definitions of neglect include considerations for a family's financial means. For example, if a family living in poverty was not providing adequate food for their children, it would be considered neglect only if the parents were aware of but chose not to use food assistance programs. Taking poverty into consideration can prevent unnecessary removals and place the focus on providing concrete services for families to protect and provide for their children.

Substance Use

Parental substance use. According to Adoption and Foster Care Analysis and Reporting System data for fiscal year 2016, parental substance use is frequently reported as a reason for removal (34 percent) (HHS, 2017a), particularly in combination with neglect (Correia, 2013). Family life for children with one or both parents who misuse drugs or alcohol often can be chaotic and unpredictable. Children's basic needs—including nutrition, supervision, and nurturing—may go unmet, which can result in neglect (Child Welfare Information Gateway, 2014a). These parents may also have difficulty conforming to expected parenting roles (Parolin & Simonelli, 2016) and providing healthy parent-child attachment (Lander, Howsare, & Byrne, 2013). While treating the parent's substance use is a priority, treatment must be combined with services to address the child's needs and improve overall family functioning.

To learn how to help parents dealing with substance use, child welfare workers may refer to *Supporting Recovery in Parents With Co-Occurring Disorders in Child Welfare*, a three-part video series created by the Center for Advanced Studies in Child Welfare in partnership with the Minnesota Center for Chemical and Mental Health (https://www.cascw.org/portfolio-items/supporting-recovery-in-parents-with-co-occurring-disorders-in-child-welfare-training-videos).

More information is available in Information Gateway's bulletin *Parental Substance Use and the Child Welfare System* at https://www.childwelfare.gov/pubs/factsheets/ parentalsubabuse.

Substance-exposed newborns. The rates of opioid misuse and dependence is increasing in many communities, including among pregnant and parenting women (HHS, ACF, CB, 2016). Child welfare systems report increased caseloads, primarily among infants and young children entering the foster care system, and hospitals report increased rates of infants experiencing neonatal abstinence syndrome associated with opioid use during pregnancy. The Comprehensive Addiction and Recovery Act of 2016 (CARA) requires State CPS agencies to develop and monitor safe-care plans for infants affected by prenatal substance exposure (HHS, ACF, CB, 2016), which may require CPS intervention to place these infants in out-of-home care. The ACF memorandum on the CARA amendments provides guidance to States on implementing CARA in relation to infants affected by substance use (https://www.acf.hhs.gov/sites/default/files/ cb/pi1702.pdf).

For additional information on substance-exposed newborns, watch "A Framework for Intervention for Infants with Prenatal Exposure and Their Families," a web presentation by the Children's Bureau's Office on Child Abuse and Neglect and the Substance Abuse and Mental Health Services Administration (SAMHSA), in partnership with the National Center on Substance Abuse and Child Welfare (NCSACW), at https://youtu.be/nEaTjxydGp4.

For other resources, visit the NCSACW website, which is cosponsored by the Children's Bureau and SAMHSA at https://www.ncsacw.samhsa.gov, and browse the website of the Child Welfare League of America at https://www. cwla.org/details-on-cara-act-drug-legislation.

CHILDREN'S BUREAU GRANT PROJECT

Families Actively Improving Relationships.(FAIR) is a behavioral intervention that addresses substance use and psychosocial needs of parents involved in the child welfare system due to neglect. The FAIR program (also discussed on p. 9 of this bulletin) targets parents and families, many of whom are homeless or living in isolated, rural communities struggling particularly with methamphetamine and/or opiate use. Currently, FAIR is being provided throughout Lane County, OR. Core components span four integrated treatment targets, including parenting, substance use, mental health, and ancillary needs. Specific strategies include a family-based program with a parent-focused approach; 3-week, high-intensity, daily treatments followed by approximately 8 months of weekly sessions; strong relationships with family-focused corporations that donate toys and household items for incentives, budgeting, and shopping practice; and service coordination.

The FAIR team includes counselors, skills coaches, a resource builder, and a clinical supervisor who travel regularly to clients' homes or other convenient locations, combining help with daily activities while providing support for trauma, depression, parental stress, poverty, and other determinants of substance use. An efficacy study of the model, funded by the Children's Bureau, uses a dynamic wait-list design to evaluate how parents who receive FAIR improve on measures including substance use, parenting skills, emotional regulation, child supervision, and appropriate discipline. Support from the Children's Bureau grant enabled the team to examine the impact of the FAIR model on neglectful parenting, mental health, child welfare system outcomes, and other needs, including housing, employment, and support with court and school attendance. As of the date of this publication, results from the study indicate that 62 percent of children remain either at home or return home within 8 months of the start of the program. Of the 23 percent of parents engaging in opiate use at the beginning of the study, none were using opiates at 16 months. Outcomes from this study replicate findings from a randomized clinical pilot trial of mothers who were randomly assigned to FAIR or to usual services. For more information about the model, visit the FAIR website at http://www.oslcdevelopments.org/fair

Domestic Violence

Most States do not include exposure to domestic violence in their legal definitions of child abuse or neglect (Child Welfare Information Gateway, 2013b). Children may witness domestic violence in their homes or be neglected by parents who are unresponsive to their children due to their own fears (Child Welfare Information Gateway, 2016a). However, nonviolent parents who are victims of domestic violence are sometimes charged with "failure to protect" for not preventing the child from witnessing domestic violence (California Partnership to End Domestic Violence, 2015). In collaboration with domestic violence professionals, child welfare caseworkers should consider the victim's access to resources or services outside the home, as well as the victim's reasonable efforts to ensure the child has basic necessities and lives in the least detrimental environment possible.

A strong relationship with the victim parent is a protective factor that can increase a child's resilience, and keeping the victim safe is a critical step toward protecting the child (Listenbee et. al, 2012; Russell, 2015). To address domestic violence cases involving children, workers should keep the victim parent and child together whenever possible; enhance the safety, stability, and well-being of all victims; and hold perpetrators of violence accountable through mechanisms such as batterer intervention programs. For more information, see the following resources:

- Information Gateway's *Domestic Violence and the Child Welfare System* at https://www.childwelfare.gov/ pubs/factsheets/domestic-violence
- Information Gateway's *What Is Child Welfare? A Guide for Domestic Violence Services Advocates* at https:// www.childwelfare.gov/pubs/cw-domestic-violence
- The Greenbook Initiative at http://www.thegreenbook. info
- The National Council of Juvenile and Family Court Judges: Family Violence and Domestic Relations at http://www.ncjfcj.org/our-work/domestic-violence
- The National Center on Domestic Violence, Trauma & Mental Health's *Tips for Supporting Children and Youth Exposed to Domestic Violence: What You Might See and What You Can Do* at http:// www.nationalcenterdvtraumamh.org/wp-content/ uploads/2012/05/Tipsheet_Children-Exposed_ NCDVTMH_May2012.pdf

Assessment

Identifying child neglect may seem more difficult than identifying other forms of maltreatment because neglect usually involves the absence of a certain behavior, rather than the presence. A thorough strengths-based assessment of the child's safety, risk, and protective factors, in collaboration with the parent, can help determine what kinds of services and supports the family may need and want. As in any assessment, it is important to talk with the parents to identify community and societal factors that may be presenting challenges that seem insurmountable to them. Often, the parent is seeking help to make changes and meet family needs and is not finding the assistance they need. Identifying these concerns is part of any comprehensive assessment.

Consider the possibility of neglect when the child:

- Is frequently absent from school
- Begs or steals food or money
- Lacks needed medical or dental care, immunizations, or glasses
- Is consistently dirty and has severe body odor

- Lacks sufficient clothing for the weather
- Uses alcohol or other drugs
- States that there is no one at home to provide care

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

- Indicates that lack of necessary supports is impacting the ability to meet the child's needs
- Feels overwhelmed addressing a range of challenges
- Appears to be indifferent to the child
- Seems apathetic or depressed
- Behaves irrationally or in a bizarre manner

The initial assessment should determine if neglect occurred and examine the child's safety and risk. Two of the most crucial factors that child welfare workers should consider are: (1) whether the child has any unmet cognitive, physical, or emotional needs; and (2) whether the child receives adequate supervision (DePanfilis, 2006). For assessment tools to gauge children's safety and risk, see *Child Neglect: A Guide for Prevention, Assessment, and Intervention* at https://www.childwelfare.gov/ pubPDFs/neglect.pdf.

Because neglect is so difficult to define and to recognize in a clinical setting, the need to train social work graduate students and caseworkers is critical, as missing opportunities to address child neglect can prolong serious maltreatment (Hamilton & Bundy-Fazioli, 2013; Tufford, Bogo, & Asakura, 2015). The following suggestions address the differing values of workers and parents and the role of personal and cultural frames of reference that caseworkers should consider when assessing parents for neglect:

- Balance the challenges facing the client with the ethical and legal responsibilities as mandated reporters.
- Demonstrate empathy while screening for potential maltreatment (demonstrate compassion for the person and accountability for the behavior).
- Take time to understand clients' behaviors, thoughts, and feelings, particularly with clients from different ethnic and cultural backgrounds (Tufford et al., 2015).
- Assess the co-occurring problems within the family.
- Engage the family and other service providers in collaborative relationships to alleviate neglect within the family.
- Rely on knowledge and competence of the six core values of the National Association of Social Workers Code of Ethics: service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence (DeLong Hamilton & Bundy-Fazioli, 2013; National Association of Social Workers, 2008).

Interviewing. One of the main activities of child neglect investigations involves interviewing children, parents, and others who may have knowledge to assist in the assessment. Caseworkers should understand that children who have been neglected may be traumatized by their experiences. They should also be careful to not retraumatize them and avoid asking leading or

suggestive questions. Consider these guidelines when interviewing children who may have been neglected (Faller, 2013):

- Set ground rules and expectations about the interview and inform the child of your role.
- Build rapport with the child by engaging her or him in brief conversations about interests and activities.
- Ask more open-ended questions before asking closed-ended questions; closed-ended questions that provide more information should be followed by more open-ended questions.
- Recap what the child has shared during the interview in the child's own words and ask if there is anything else he or she would like to share or ask before ending the interview.

In situations of child neglect, caseworkers will likely need to explore several domains, such as substance use or domestic violence, related to the child's experiences. The types of questions asked will vary depending on the child and her or his capacity to provide a narrative about the neglect and the type(s) of neglect experienced. Following are example questions to consider when determining whether children have experienced neglect (Faller, 2013):

- Who are the people important to you?
- Who takes care of you?
- Who helps you get dressed?
- Who cooks for you?
- Who takes care of you when you're sick?
- Where do you sleep?
- Who cleans at your house?
- Who does the laundry?
- Does anyone at your house drink alcohol, such as beer, wine, or hard liquor?
- Are there any drugs at your house?

For more information about interviewing children who have been neglected, refer to Faller's "Gathering Information from Children about Child Neglect" at http://ow.ly/dKoc30dY9cK, or Information Gateway's factsheet *Forensic Interviewing: A Primer for Child Welfare Professionals* at https://www.childwelfare.gov/pubs/ factsheets/forensicinterviewing.

Safety**.** Determining the child's safety is as critical in the decision-making process in cases of possible neglect as it is in cases of physical or sexual abuse. The determination should consider threats of danger in the family, the child's vulnerability, and the family's protective capacity, including any risks, needs, and complicating factors. Caseworkers may want to consider using an assessment that includes four areas of inquiry for parents, children, and other stakeholders (Turnell & Murphy, 2014):

1. What are family and stakeholders worried about? (Past harm, future danger and factors that could jeopardize safety)
2. What is working well? (Current safety)

3. What needs to happen? (Future safety)
4. Where is the family on a safety scale of 0 to 10? (Family and caseworker judgment)

The results of the assessment will inform whether the family requires additional assessment and intervention. A low-risk family may be referred for differential response (see box below), while the most severe cases may require placement in out-of-home care, preferably with relatives, to ensure the child's immediate safety while the family is assessed and a safety and service plan is developed.

For assessment tools and resources, see Information Gateway's webpage Screening & Assessment in Child Protection at https://www.childwelfare.gov/topics/ responding/iia.

The Children's Bureau's Capacity Building Center for States is developing a suite of products focused on quality contacts among caseworkers and children, youth, and families. Building quality contacts can improve assessment of children's risk of harm. For more information on the evolving suite, which will promote collective impact through a variety of publications and learning tools with definitions, program guidance, and supervisory and practice tips, visit https://capacity.childwelfare.gov/states/focus-areas/ foster-care-permanency/quality-matters.

Differential Response

Using family-centered and partnership-based approaches, differential response lets child welfare agencies focus on the family and the child's environment to meet the needs of families (Casey Family Programs, 2012). To address this need, several States use differential response, also referred to as "dual-track," "multiple-track," or "alternative-response" systems in which families with low risk are redirected to voluntary, often community-based, services to receive the supports they need. This approach allows CPS to respond in multiple ways to allegations of neglect or abuse. For low- or moderate-risk situations with no immediate safety concerns, CPS conducts a family assessment to determine the family's needs and strengths.

For more information see the following resources:

- Information Gateway's *Differential Response to Reports of Child Abuse and Neglect* at https:// www.childwelfare.gov/pubs/issue_briefs/ differential_response
- Children's Bureau's National Quality Improvement Center on Differential Response in Child Protective Services (no longer updated but housed on the Kempe Center website) at http://www.differentialresponseqic.org
- Child welfare jurisdictions interested in implementing differential response should access *The Differential Response (DR) Implementation Resource Kit: A Resource for Jurisdictions Considering or Planning for DR* at http://www.ucdenver.edu/academics/ colleges/medicalschool/departments/ pediatrics/subs/can/DR/Documents/ Differential%20Response%20%28DR%29%20 Implementation%20Resource%20Kit--May%20 2014%5B1%5D.pdf

Prevention and Intervention

The services and supports that children who are at risk for neglect or who have been neglected and their families vary greatly depending on the type of neglect they experienced; the severity of their situation; and underlying risks, strengths, and many other factors. Analyzing the information

gathered during the assessment is essential to developing an effective case plan in collaboration with the family, its support network, and related service providers.

Begin early. Research on the developing brain stresses the need for babies and young children to participate responsively in reciprocal ("serve and return") and dynamic interactions with people who care for them (Center on the Developing Child at Harvard University, 2012). Without sufficient attention and security, the circuitry of the developing brain, as well as other developing organs and metabolic systems, can be disrupted. Although it can be difficult to prevent neglect and identify it in its early stages, caseworkers can have a greater impact on families the earlier they intervene. At this stage, practitioners should assess the parent's readiness to enhance their parenting abilities and help the family focus on meeting the child's developmental needs. Caseworkers should assume that parents want to improve the quality of their children's care but need support to identify and build on their strengths and to potentially address any underlying trauma from previous life experiences.

For more on early intervention with families, read Information Gateway's *Addressing the Needs of Young Children in Child Welfare: Part C—Early Intervention Services* at https://www.childwelfare.gov/pubs/partc.

Provide concrete services first. Most parents cannot focus on interventions like parenting classes when they are still addressing crises in their families. In the early stages of working with a family, caseworkers should ensure that basic needs are met before expecting parents to fulfill other aspects of their case plan. Some concrete supports to address include the following:

- Housing and utilities
- Food and clothing
- Safety for domestic violence victims and their pets
- Transportation
- Childcare
- Health care and public benefits
- Attention to past trauma affecting the parent's life

Engage partners. Because child neglect is often associated with other needs, such as mental health services, having partners in place is often important. Child welfare professionals should develop relationships with community partners who can provide necessary services for children experiencing neglect.

Focus on strengths. Child welfare workers and other related professionals can form better relationships with families by encouraging them to focus on positive parenting strategies and supports they already have in place. The six protective factors described earlier can serve as a framework for assessing families' strengths and helping them identify ways to build on those strengths to protect their children from harm. The National Child Abuse Prevention Month website provides the most recent Prevention Resource Guide for child abuse prevention. It offers numerous tools and strategies for talking with families about their strengths and incorporating them into service systems (https://www.childwelfare.gov/topics/preventing/preventionmonth).

Encourage incremental change. Most changes don't happen overnight. In families that are stressed by the demands of caring for their child, parents may feel overwhelmed if child welfare workers expect them to accomplish too many goals too quickly (Corwin et al., 2014). In collaboration with the family, caseworkers can establish a contract with parents to affirm their

commitment to make required changes to keep their children safe and able to develop normally (Farmer & Lutman, 2014).

It is important to start with the most basic needs (e.g., food, housing, safety), then address critical underlying issues (e.g., substance use, mental health). Once those supports are in place, there will be fewer obstacles to achieving higher family functioning. Many programs that work with families affected by neglect require intensive, long-term services to help them achieve changes over time.

Provide Intensive Family Preservation Services. Short-term crisis support to high-risk families can prevent unnecessary child placement in out-of-home care. Children and families experiencing severe neglect may benefit from these kinds of services to address urgent issues, like housing or financial assistance, followed by ongoing family preservation and support to target underlying risk factors.

The National Family Preservation Network offers a continuous quality improvement intensive family preservation tool for use with Intensive Family Preservation Services (http://www.nfpn.org/assessment-tools/cqi-ifps-instrument).

Engage the family's social support network. Because caseworker time with the family is limited, a strong social support network for the family can reinforce lessons learned and address needs as they arise. Caseworkers should seek out relatives, friends, community members, and other service providers who will help the family practice and build new skills over time. Positive relationships with other caring adults can help support the child's healthy development and serve as a source of respite for parents if they face future crises.

Help the family find a local parent support group through Circle of Parents® (http://www.circleofparents.org) or Parents Anonymous® (http://www.parentsanonymous. org), or connect them to a respite program using the ARCH National Respite Network and Resource Center's locator service (http://archrespite.org/respitelocator).

Cultural competence and neglect. As with all child protection practice, cultural issues must be taken into consideration when assessing and intervening with families at risk of neglect. For example, parents from a culture in which shared caregiving is the norm may see no problem with allowing young children to care for their siblings, perhaps in a way that does not conform to cultural norms in the United States (Sawrikar, 2016).

When working with diverse families, child welfare workers should focus on ensuring that children's needs are met and that they are not harmed or endangered. Consult with knowledgeable staff or community members on how best to intervene in a way that is consistent with families' cultural practices. Visit the Cultural Competence section of the Information Gateway website for more information at https://www.childwelfare.gov/topics/systemwide/ cultural.

Other information on cultural competence includes the *Standards and Indicators for Cultural Competence in Social Work Practice* by the National Association of Social Workers at https://www.socialworkers.org/LinkClick. aspx?fileticket=7dVckZAYUmk%3D&portalid=0.

The National Family Preservation Network offers an evidence-based cultural competence training at http:// www.nfpn.org/assessment-tools/cultural-competence.

Promising Practices for Neglect

The following interventions for neglect were retrieved from the California Evidence-Based Clearinghouse for Child Welfare and are available at http://www.cebc4cw. org/topic/interventions-for-neglect. Both received a scientific rating of 2, which indicates they are supported by research evidence.

Childhaven Childhood Trauma Treatment. Provides therapeutic childcare to children ages 1 month through 5 years who are at risk for or have experienced abuse and neglect and their families. Services are provided daily (5.5 hours a day for 5 days a week) in a licensed childcare setting. Programs are individualized to the child and family need. (http://www.childhaven. org)

Homebuilders® Designed to prevent unnecessary placement of children outside the home. The program delivers family preservation services that are home and community based. The services aim to enlist parents as partners in assessment, treatment planning, and goal setting. (http://www.institutefamily.org)

Combined Parent-Child Cognitive Behavioral. Therapy.(CPC-CBT): A short-term evidence-based therapy program for children ages 3–17 and their parents (or caregivers) to improve the parent-child relationship and reduce children's issues resulting from maltreatment. (http://www.caresinstitute.org/services _parent-child.php)

Nurturing Parenting Program for Parents and Their School Age Children 5 to 11 Years: A 15-session, family-centered evidence-based program where one of the goals for parents is to gain parental empathy toward meeting the needs of their children. (http:// nurturingparenting.com/ecommerce/category/1:3:2)

Maternal, Infant, and Early Childhood Home Visiting (MIECHV): A Federal program that provides pregnant women and families, particularly those at risk for child maltreatment, with in-home services that teach caregivers basic parenting skills, support healthy child development, and show promise in reducing child abuse and neglect. (https:// mchb.hrsa.gov/maternal-child-health-initiatives/ home-visiting-overview)

Training

Effective training is important for caseworkers addressing the often complex issues faced by children at risk of being neglected and their families. Because neglect is still misunderstood by many professionals serving children and families, many trainings address neglect under the umbrella of child maltreatment. Ongoing training can help caseworkers remain aware of the latest research and refresh their skills over time.

Child welfare practitioners can learn more about training in child neglect by visiting the websites of the National Child Abuse and Neglect Technical Assistance and Strategic Dissemination Center at http://www. cantasd.org and the National Child Welfare Workforce Institute at http://ncwwi.org/index.php/teams-services/ university-partnerships.

The National Family Preservation Network (http://www.nfpn.org/SearchResults/tabid/83/Default. aspx?Search=training) provides training guides and tools for a variety of training needs, including the following:

Trauma Training (http://www.nfpn.org/articles/ trauma-training)

Assessment Training (http://www.nfpn.org/products/ training-packages)

The New York Society for the Prevention of Cruelty to Children provides the correspondence course and onsite lecture Identifying and Reporting Child Abuse and Neglect Training (http://www.nyspcc.org/training-institute/ identifying-reporting-child-abuse-neglect-training).

Conclusion

Child neglect is the most prevalent type of child maltreatment but has historically received the least attention from researchers and others. Child neglect continues to be a complex problem that is difficult to define, prevent, identify, and treat.

Assessing neglect involves a thorough examination of the child's safety and risk as well as the larger family and community context. To understand neglect, caseworkers should know how to address related problems such as poverty, substance use, and domestic violence. Interventions for children and families affected by neglect require customized and coordinated services. Defining, preventing, identifying, and treating child neglect is a significant challenge but one that researchers, professionals, communities, and families must face together if they are to protect children from its harmful consequences.

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Chapter 3 - Chronic Child Neglect

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Chronic child neglect occurs when a caregiver repeatedly fails to meet a child's basic physical, developmental, and/or emotional needs over time, establishing a pattern of harmful conditions that can have long-term negative consequences for health and well-being. This differs from a report of child neglect, which refers to a single incident of failing to meet a child's basic physical, psychological, or safety needs. While Federal statistics indicate that approximately threequarters of all child maltreatment victims in the United States during fiscal year 2017 were victims of neglect (U.S. Department of Health and Human Services, 2019), chronic child neglect is more difficult to quantify. Child welfare systems often lack the assessment tools, time, and resources to analyze child protective service reports and records for patterns that may constitute chronic child neglect.

This [chapter] outlines how child welfare professionals can identify and understand chronic neglect and looks at the important role of casework and community partnerships in strengthening families and their ability to provide safe care for children. It explores prevention and early intervention efforts to prevent and moderate the harmful effects of chronic neglect; outlines information on training and evidence-informed interventions; and provides State and local examples of ongoing work to address chronic neglect through casework practice, community collaboration, and efforts to build family well-being and resilience.

A. What Is Chronic Neglect?

Chronic child neglect refers to cases in which families are reported to child protective services (CPS) for multiple incidents of neglect in multiple domains rather than single instances of a specific type of neglect. It may accompany other forms of maltreatment and often coexists with enduring poverty, co-occurring mental health issues, substance use disorders, and domestic violence. Child welfare systems may consider neglect to be chronic based on its duration, frequency (e.g., the number of CPS reports or substantiated reports), a family's ongoing need for services, or referrals for multiple types of maltreatment.

There are several widely accepted indicators of chronic child neglect:

- One or more needs basic to a child's healthy development are not met.
- The neglect happens on a recurring or enduring basis.

- The neglect is perpetrated by a parent or a caregiver.

When these three identifiers result in cumulative harm or serious risk of harm to the child's safety, health, or well-being, a child can be said to be chronically neglected. Using this framework, chronic child neglect can be defined as a parent or caregiver's ongoing, serious pattern of deprivation of a child's basic physical, developmental, and/or emotional needs for healthy growth and development (Kaplan, Schene, DePanfilis, & Gilmore, 2009).

States hold varying definitions of child neglect. Only two States, Oklahoma and Washington, refer specifically to chronic child neglect while others allude to it in their definitions (e.g., Kentucky, Pennsylvania, and North Carolina).

For more information, see Child Welfare Information Gateway's State Statute publication Definitions of Child Abuse and Neglect (https://www.childwelfare.gov/topics/ systemwide/laws-policies/statutes/define/).

Child Welfare Information Gateway's Acts of Omission: An Overview of Child Neglect (https://www.childwelfare. gov/pubs/focus/acts/) addresses incident-based neglect, whereas this bulletin considers the accumulated record of neglect over time. For information on intergenerational neglect, see Intergenerational Patterns of Child Maltreatment: What the Evidence Shows (https://www. childwelfare.gov/pubs/issue-briefs/intergenerational/).

Risk Factors

Similar to incidents surrounding many types of child neglect—physical, educational, emotional, medical, etc.— chronic child neglect occurs within a social context that may include risk factors related to the family, community, and society. Prevention and remediation of chronic neglect requires reducing the associated risk factors and strengthening the protective factors that promote child safety and well-being.

While assessing for chronic neglect requires the consideration of a family's full pattern and comprehensive history of child neglect, rather than determining whether a specific alleged incident did or did not occur, most child protection statutes, policies, and protocols assess for specific incidents (American Humane Association, 2010). Several risk factors that may be predictive of chronic neglect include the following (Logan-Greene & Semanchin Jones, 2018):

- Families with children under age 1 and/or larger families
- Families with multiple allegations at the time of report
- Substantiated allegations in the first report to CPS
- Families with a child/children who was/were in the care or custody of others in the past
- A parent or caregiver with a history of domestic violence, substance use, mental health issues, social isolation, and/or cognitive impairment

A study of the case records of 38 families with five or more screened-in reports of neglect in a large Northeastern jurisdiction demonstrated multiple stressors associated with chronic child neglect: financial stressors in 92 percent of the families, substance use in 85 percent, domestic violence in 79 percent, and parental mental health issues in 76 percent (Semanchin Jones & Logan-Greene, 2016). The study also showed that most families (89 percent) included a child experiencing significant emotional or behavioral issues. A majority were single-parent families. The most frequent allegations in initial reports were, in descending order, inadequate guardianship; lack of supervision; parental substance use; minor physical abuse (bruises, scrapes, welts, etc.); and inadequate food, clothing, or shelter.

Vulnerable families may not understand that their children may be at risk. Because chronic neglect is often a recurring problem for such families, child welfare agencies are at risk of underserving them (Inkelas & Halfon, 1997) or having low expectations that parents can change (Daro, 1988). Caseworkers who embrace a strengths-based approach and who maintain optimism and a forward-thinking attitude are more likely to inspire change in the families they serve.

Protective factors in families and communities can help mitigate the risk factors associated with chronic neglect. This includes building a family's resilience, social connections, knowledge of parenting skills and child development, concrete supports, and the social-emotional competence of children. For more information, see Child Welfare Information Gateway's Prevention Resource Guide (https://www.childwelfare.gov/topics/ preventing/preventionmonth/resources/resourceguide/) and Protective Factors Approaches in Child Welfare (https://www.childwelfare.gov/pubs/issue-briefs/ protective-factors/).

Impacts of Chronic Neglect

Children who have experienced chronic neglect may suffer serious cognitive and social deficits because of the potential lack of responsive parent-to-child interaction that is essential for healthy child development (LoganGreene & Semanchin Jones, 2018; O'Hara, et al., 2015; Painter & Scannapieco, 2013). Chronic child neglect can also result in abnormal physical development, a compromised immune system, and long-term chronic physical disease. The impacts of chronic neglect on children can be cumulative and like those from trauma exposure (e.g., difficulties with emotion regulation). Children who have experienced chronic neglect may develop insecure or disorganized attachment issues, social withdrawal, learning deficits, poor school performance, internalization of negative behaviors, and changes in the brain due to toxic stress. Chronic neglect also has been linked to aggression and delinquency in adolescence, particularly in boys (Logan-Greene & Semanchin Jones, 2015). The societal impact of chronic neglect may include school absenteeism and dropouts, substance use, crime, and high costs to child welfare systems, juvenile courts, and schools (Capacity Building Center [CBC] for States, 2018).

For more information on the impact of neglect on child development, see The Science of Neglect: The Persistent Absence of Responsive Care Disrupts the Developing Brain from the Center on the Developing Child at Harvard University (https://developingchild.harvard.edu/ resources/the-science-of-neglect-the-persistent-absenceof-responsive-care-disrupts-the-developing-brain/).

B. Implications for Child Welfare

It is essential for child welfare leaders to take a comprehensive and holistic approach to responding to families experiencing chronic neglect7 in the communities they serve. This section explores some of the strategies to address the complex nature of chronic child neglect.

The Children's Bureau's CBC for States developed a professional development tool that provides detailed guidance on how to affect systems change to benefit children and families experiencing chronic neglect. The Building Capacity to Address Chronic Neglect From a Systems Perspective learning experience includes a simulated task force of child welfare administrators and frontline caseworkers who address chronic neglectrelated concerns flagged in the most recent Federal Child and Family Services Reviews. Learning modules include the following:

- Understanding chronic neglect
- Locating and using data sources to evaluate the need for change
- Strategies for evaluating and implementing adaptive and technical challenges to change

- Leveraging community relationships and services

Users can create a free online account to access learning modules that explore the processes and partnerships needed to respond to chronic neglect (https://learn. childwelfare.gov/). Topics include strategies for building support for change, understanding the role of agency culture in responding to chronic neglect, and the importance of collaboration.

Integrating Approaches Along the Child Welfare Continuum

Community-based child abuse prevention and differential response are two approaches that can be used to address chronic neglect. Community-based prevention and early intervention services (e.g., family support, home visiting, etc.) can help keep families from becoming chronically involved with child welfare. The FRIENDS National Center for Community-Based Child Abuse Prevention (FRIENDS) has a toolkit on preventing child neglect (https:// friendsnrc.org/neglect-toolkit) and offers the Protective Factors Survey (PFS) (https://www.friendsnrc.org/ protective-factors-survey)—as well as the second edition (PFS-2) of the survey—for use with parents and caregivers participating in family support and child maltreatment prevention services. The PFS and PFS-2 identify multiple protective factors that can help prevent child abuse and neglect. Both surveys can help agencies and programs assess changes in family protective factors—a major focus of prevention work.

In differential response, public child welfare systems assign screened-in CPS reports either to an investigative track or to an assessment track. For families served through the assessment track, caseworkers conduct a comprehensive assessment with an emphasis on child safety concerns and service needs, all while suspending the need to substantiate the child maltreatment allegation. For families who are chronically coming to the attention of child welfare, it is believed that the assessment track provides greater access to services designed to prevent the recurrence of child maltreatment. By encouraging a broader and more thorough assessment of a family's potential safety and risk issues, differential response has the potential to flag safety concerns for caseworkers and to be useful in cases of chronic neglect (Johnson, 2009). Differential response emphasizes meeting a family's broader needs through direct and community-based services and has been shown to reduce the need for traditional public child welfare services while enhancing family engagement, access to and participation in services, and satisfaction with the caseworker (Loman & Siegel, 2015; Ruppel, Huang, & Haulenbeek, 2011). The importance of providing families with early intervention services before a pattern of chronic neglect develops cannot be overemphasized.

For more information on differential response, see Differential Response to Reports of Child Abuse and Neglect at https://www.childwelfare.gov/pubs/ issue-briefs/differential-response/.

C. Casework Practice to Address Chronic Neglect

Persistent and pervasive chronic child neglect in a community can overwhelm local child protective systems and drain resources required to investigate or assess CPS reports (Loman, 2006). Because chronic child neglect is often entrenched in the family dynamic, confronting it requires a positive attitude, resolve, resources, skill, and patience. This section looks at steps caseworkers can take to work with families impacted by chronic neglect.

a. Casework Skills

It is imperative for caseworkers to demonstrate the following skills and strategies when working with families dealing with chronic neglect (Kaplan, Schene, DePanfilis, & Gilmore, 2009):

- Ability to engage families and their support systems holistically

- Well-honed risk assessment and decision-making skills, including a recognition of patterns of neglect
- An understanding of the role of hope and how to inspire it in struggling families
- Ability to help families sustain positive changes before closing a case

b. Intake

Caseworkers can look for common indicators of chronicity when screening reports of neglect, such as the number of reports during a specific timeframe and the range of allegations of neglect across multiple domains (e.g., hygiene, supervision, etc.). Caseworkers should consider a family's entire history and take note when numerous risk factors exist in the midst of few, if any, protective factors. Tapping into partnerships with other social service providers, educators, and local law enforcement may help to fill in details about a family's history. This initial discernment can inform next steps, as caseworkers consider the impact of the cumulative risk of harm from chronic neglect.

c. Successful Engagement

Engaging with a family can increase a caseworker's ability to gauge the level of neglect, determine the family's specific needs, and influence factors affecting safety. The quality of this relationship can be a powerful factor in change. Caseworkers can do the following to engage the family:

- Listen to and address issues that concern the family while identifying and attending to their immediate needs
- Identify family strengths and networks of support within the community to address the identified concerns
- Focus initially on "baby steps" (small actions that lead to immediate improvements in the parent's life and the child's life) and avoid overwhelming the family with too many services at once
- Focus on improving the capacity of family members to meet their basic needs and improve child and family safety and well-being
- Recognize and praise parents' strengths, especially examples of sensitivity to and concern for children in the family
- Return to the home regularly to develop a relationship with the caregiver and to evaluate the family's progress over time

Casework interventions should seek to empower caregivers by providing them with choices whenever possible and engaging them in the decision-making process. A search should be conducted for extended family members who might be helpful to children and parents for respite care or, if needed, for out-of-home care (Wilson, 2016). Family members and extended kin can also provide valuable moral support, emergency assistance, and help to develop parental resilience (i.e., the ability to rebound from adversity).

For more information, see Family Engagement: Partnering With Families to Improve Child Welfare Outcomes at https://www.childwelfare.gov/pubs/f-fam-engagement/.

d. Assessment

Comprehensive and individualized assessments can help to identify family members' unique strengths and needs as well as the associated safety threats and risk factors for chronic neglect (Johnson, 2009). Instead of focusing on incident-based neglect, assessments should identify referral patterns, parental strengths and challenges, and possible sources of ongoing support. To

make such a determination, the initial assessment should consider two points: (1) family history and cumulative developmental and physical harm resulting from neglect and other types of maltreatment and (2) services that have been utilized in past interventions. The assessment should carefully evaluate whether children's basic needs are met and whether there is evidence of recurring omissions in care that periodically create safety threats (DePanfilis, 2006). It is important to understand the parents' perspective on what their challenges are as well as what they believe would increase their capacity to meet their children's needs.

A study of families experiencing chronic neglect in the Northeast found that commonly used risk assessment tools may not be good at predicting chronic neglect, perhaps because they look at a point in time rather than the accumulation of harm that comes from chronic neglect (LoganGreene & Semanchin Jones, 2018). In addition to conducting a comprehensive assessment of family strengths and needs, the authors identify the following as key to responding to chronic neglect (Semanchin Jones & Logan-Greene, 2016):

- More consistent use of standardized risk and safety assessment protocols
- Better recognition of past patterns of neglect
- Effective supervision for coaching, support, and accountability for frontline staff
- Manageable caseloads
- Use of specialized chronic neglect teams

e. Case Planning and Intervention

Partnering with families to help them identify their strengths and needs allows them to feel greater ownership of their case plan and more invested in the outcomes. The following are elements to consider when intervening on behalf of families dealing with chronic neglect (Corwin, Maher, Rothe, Skrypek, & Kaplan, 2014):

- Meeting the concrete needs of the family first
- Building trust with the family members by keeping promises and promoting regular contact and accessibility
- Developing the family's skills through small and measurable steps with clearly defined goals
- Strengthening the family's support network
- Working with the family beyond 12 months

Using casework teams and promoting self-care to avoid caseworker burnout and secondary trauma (see Information Gateway's webpage at https://www.childwelfare.gov/topics/management/workforce/ retention/turnover/burnout/)

f. Case Closure

Families need a plan should they find themselves slipping back into the circumstances that brought them to the attention of child welfare agencies or if new issues arise. At the very least, such a transition plan will provide family members with the means to access ongoing family and community supports as well as any needed services. Caseworkers should ensure there is an appropriate handoff to community service providers in the event families require ongoing assistance and provide the families with information on how to seek services after their case is closed.

D. Multisystem Collaboration and Partnerships

Community and multisystem partnerships can help to create a holistic response to chronic neglect and a multidisciplinary approach to engaging and supporting more families. Potential community partners may include private child welfare agencies, courts, substance use and mental health treatment providers, housing systems, early childhood centers, schools, and faith communities. Data from child welfare agencies, school counselors, community centers, and families receiving Temporary Assistance for Needy Families, housing, food bank, or Medicaid help may help identify populations needing help (CBC for States, 2018). Collaboration should be tailored to the characteristics and strengths of the community (FRIENDS & National Alliance of Children's Trust and Prevention Funds, 2018).

FRIENDS developed a collaboration toolkit to promote effective community collaboration efforts. The toolkit includes information on collaborating with the substance use, mental health, and domestic violence systems (https://friendsnrc.org/neglect-toolkit).

Visit Child Welfare Information Gateway's webpage on Cross-System Collaboration in Prevention Services (https://www.childwelfare.gov/topics/preventing/ developing/collaboration/cross-system-collaborationin-prevention-services/) and the FRIENDS webpage on Promising/Emerging Multi-System Efforts (https:// friendsnrc.org/neglect-toolkit/policies-public-systems/ promising-emerging-multi-system-efforts) for additional examples of multisystem collaboration.

E. Evidence-Informed Interventions

Several evidence-based interventions and promising programs may prevent and mitigate conditions related to chronic child neglect. Because of the socioecological context in which chronic child neglect occurs, interventions require actions that go beyond standard service provision (Corwin, et al., 2014). This section looks at a sampling of interventions that may be relevant to chronic neglect cases.

The California Evidence-Based Clearinghouse for Child Welfare (CEBC) features a registry of evidence-based and nonevidence-based child welfare-related practices and interventions. Of the more than 300 programs it lists for children and families, only 5 programs specifically address neglect (CEBC, 2018). For more information, see the CEBC website at http://www.cebc4cw.org/registry/.

While the five CEBC programs do not address chronic child neglect specifically, interventions and programs that may be useful for families experiencing chronic neglect include the following:

Child First (http://www.childfirst.org/) is an intensive therapeutic home visiting model for primary caregivers and their children from birth through age 5 who are at high risk for developmental, emotional, or behavioral problems or maltreatment. Child First (Family Interagency, Resource, Support, and Training) connects families with community-based services to reduce family stress levels and provides in-home clinical services to help build parent-child attachment, heal trauma in both the caregiver and child, and prevent additional toxic stress.

Child FIRST is rated as a "near top-tier" program by the evidence-based policy team at Social Programs That Work (formerly the Coalition for Evidence-Based Policy). Families participating in a Child FIRST trial were found to be 39 percent less likely to be involved with CPS and had a 98 percent increase in access to community services and supports (Robert Wood Johnson Foundation, 2015).

Childhaven Childhood Trauma Treatment (http:// www.childhaven.org) is an evidence-based therapeutic child care program with a CEBC rating of 2—or one that is supported by research, according to CEBC's Scientific Rating Scale—for infants and children aged 1 month through 5 years and their families. Intensive early intervention and specialized treatment services are

provided in a licensed child care setting to heal the effects of early toxic stress, prepare the child for learning, and improve parenting skills to strengthen family relationships and build family resilience.

Family Connections (http://www.family.umaryland. edu/fc-replication) is a comprehensive family-centered home and community-based program for families with children ages 0 to 17 designed to help caregivers meet the basic needs of their children and reduce the risk of neglect. Family Connections seeks to increase family protective factors and decrease the risk factors associated with child maltreatment. CEBC rates the program a 3, or one backed by promising research evidence. Family Connections is governed by several service principles that may be particularly useful in practice with families experiencing chronic neglect. This includes community outreach, individualized family assessments, tailored interventions, and outcome-driven service plans. ƒ Homebuilders (http://www.institutefamily.org/) is an evidence-based program for parents and caregivers of children ages 0 to 17 with a CEBC rating of 2 that offers intensive family preservation services to help keep families together. The program is designed to engage families by serving them in their home environment and may be useful in neglect cases by helping primary caregivers improve their supervision of children and access to community-based supports.

SafeCare (http://www.safecare.org) is an evidence-based home visiting program for parents and caregivers of children ages 0 to 5. With over 60 studies conducted to validate the program, SafeCare has a CEBC rating of 2. The program focuses on three risk factors that are key for chronic neglect cases: the parent-child relationship, child health, and home safety. The Washington State Institute for Public Policy (WSIPP) rated SafeCare as having the highest financial return on every dollar invested—$22.41—in a cost-benefit analysis of various child welfare programs (WSIPP, 2018).

F. State and Local Examples

Several initiatives are underway aimed at reducing risk factors for chronic neglect and addressing its harmful effects on children and families.

Colorado

The Colorado Community Response (CCR) voluntary program provides families who have been reported to CPS—but whose cases were screened out—with comprehensive services, including access to vital support services, case management, and resource referrals to increase their ability to meet their children's needs. An evaluation of CCR found that families participating in the program enhanced protective factors, built social capital, increased stability, improved family functioning and self-reliance, and received concrete supports (Colorado Department of Human Services, Office of Early Childhood, 2018). Additionally, families who completed CCR had lower rates of repeated child welfare involvement than those who did not complete the program.

Connecticut

Connecticut's Office of Early Childhood (OEC) developed several innovative programs with potential to help families that may be dealing with chronic neglect (A. McKenna, personal communication, August 28, 2018). OEC launched a results-oriented initiative that incentivizes home visit providers to achieve important goals for children and families, such as a reduction in child maltreatment and increased parental employment (https://www.ct.gov/oec/lib/oec/ct_oec_miechv_rate_ card_fact_sheet.pdf). The OEC pilot program uses an outcomes rate card to reward providers with a bonus payment for every family that achieves the following:

- A healthy birth that avoids a risky and costly preterm delivery

- Avoidance of emergency room visits or substantiated claims of child maltreatment that result in high costs and future treatment needs
- Attainment of measurable stability goals by at-risk families, including secured child care, health care, and housing
- Caregiver employment or completion of a job-training program or educational attainment that will help advance family economic stability

The pilot is built on a public-private partnership between OEC and the Hartford Foundation for Public Giving, which is contributing outcomes payments for providers in the Hartford area.

OEC's Mind Over Mood (MoM) maternal mental health initiative helps young mothers with postpartum depression and the related mood disorders that can contribute to maternal neglect. The MoM initiative gives expectant and new mothers access to insurance-covered clinical services through a central phone line and in-home services. MoM has processed over 250 referrals for clinical services that help to create maternal, infant, and family well-being in multiple areas, including the following (A. McKenna, personal communication, August 28, 2018):

- Decreased anxiety and depression symptoms
- Increased bonding with baby and enjoyment of caregiving
- Increased parental sensitivity
- Increased ability for self-care
- Improved self-esteem
- Increased motivation and planning for the future
- Enhanced ability to meet daily demands

District of Columbia

The District of Columbia Child and Family Services Agency (CFSA) has instituted an "In-Home Levels-of Care" system to help caseworkers address safety and risk factors that may perpetuate chronic neglect. The CFSA levels-of-care system ensures that families with multiple and complex needs receive more intensive engagement and attention. Each level of care defines a graduated set of family needs, interventions, contact requirements, and case-length standards (R. Matthews and L. Walker, personal communication, August 8, 2018):

Intensive-level cases are those where a substantial risk to the safety and well-being of children has been flagged through the CPS investigation or a family is already being served through an in-home case. The majority of intensive-level cases have an active safety plan. Cases may be assigned to the intensive level when a court petition has been filed to spur compliance with a case plan (referred to as community papering and is particularly relevant to cases of educational or nonemergency medical neglect, substance use, or mental health problems). Other examples that might fall under the intensive-level category include cases where children are perceived to be vulnerable due to special needs or age, or where there is a perceived risk of exposure to domestic violence.

Intensive cases remain open for 8 to 10 months, and a CFSA social worker will meet face to face with the family once a week at a minimum. Families with an active safety plan may require more contact. The social worker ensures a team meeting is held within 60 days of the completion of the initial case plan, and additional meetings are held as needed.

Intermediate-level cases are those with multiple risk factors (e.g., homelessness, limited life skills and support networks, difficulty meeting children's needs) that are deemed to require considerable

attention and oversight to ensure children's needs are being met but where there is no imminent risk or danger. In these cases, which remain open for 6 months, a social worker visits twice a month at a minimum to ensure the family is moving toward case plan goals.

Graduation-level cases are those where the family has demonstrated that there is no imminent risk or danger and child welfare involvement is no longer necessary. Cases remain open for 30 to 60 days at the graduation level, with the social worker making at least one visit to the home to discuss case plan goals and progress, barriers, and safety. At the close of the case, a celebration is held to reward progress and to develop a sustainability plan for the family. The family is provided with a list of contacts that they can go to for help and a signed certificate that shows they have completed services. CFSA social workers make a referral to the family's neighborhood collaborative to ensure the family has a smooth transition into a continuum of care. Typically, a CFSA social worker contacts the collaborative for an internal meeting to update them on the case, followed by a joint home visit with the family. CFSA has moved away from the use of the term "voluntary" services to encourage families to see child welfare as a continuum. If a family declines services, family members are assured that they are always welcome to seek help from the collaborative at any time.

CFSA's restructured in-home case management system seeks to ensure that social workers are better at assessing a family's underlying needs, increasing teaming efforts with families and providers, and developing case plans to help families change their behaviors and increase protective factors to improve child safety. In circumstances where, for example, children are consistently missing school or when parents are not attending parenting classes, CFSA may seek court approval for community papering to spur a change in the family's behaviors. This has helped with parental participation and accountability and has increased court involvement in cases that might not normally receive court oversight. When a family successfully addresses its safety issues, CFSA may close the case. If unsuccessful, CFSA may move children to out-of-home care. When a case extends beyond the accepted period for the assigned

level of care, CFSA reviews it to determine whether a different level of care should be assigned or whether a new direction is needed (e.g., community papering or out-of-home care) (R. Matthews and L. Walker, personal communication, August 8, 2018).

Wisconsin

Wisconsin's Community Response Program (CRP) was created as a prevention program model for families who are screened out of CPS or whose cases are unsubstantiated but who demonstrate characteristics associated with chronic neglect and are deemed at high risk for a future CPS referral. CRP provides its families with case management, home visits, collaborative goal setting, a comprehensive assessment, and access to financial supports for up to 20 weeks. One of its primary goals is to reduce the economic stressors that can be associated with child maltreatment. CRP staff meet with families to identify immediate needs and to connect them with both formal and informal resources to meet those needs. CRP seeks to strengthen the families it serves, prevent maltreatment, and reduce repeated referrals to CPS.

For more information, see https://preventionboard.wi.gov/Pages/OurWork/CommunityResponse.aspx.

Oregon

In Oregon, community-based crisis relief nurseries provide infants and young children at risk of early maltreatment with early learning and skills to help build resilience. The relief nurseries offer early intervention programs to help overcome potential developmental delays and early trauma;

strengthen parenting and primary caregiver skills; and preserve families through home visits, support services, mental health counseling, parenting classes, early childhood education, and more.

Learn more on the Oregon Association of Relief Nurseries website (https://www.oregonreliefnurseries.org/).

G. Competencies and Training

Specialized training is key to providing professionals with a clear understanding of the complexities of chronic neglect.

Trainings should include the following:

- How to engage with families, identify their informal supports, and relate to them as experts on their own strengths and needs
- How to listen effectively to support a family and tailor services to their specific needs
- How to perform comprehensive assessments that consider the family's past patterns of neglect and identify risk factors such as substance use, cognitive impairment, or domestic violence
- How to work with the Strengthening Families Protective Factors framework to promote family well-being and prevent recurrences of neglect
- Research on adverse childhood experiences (ACEs) to help adult family members understand their own trauma and how to minimize adversities for their children
- Research on early childhood science and brain development

As mentioned on previously, *Building Capacity to Address Chronic Neglect From a Systems Perspective* simulates a child welfare task force to explain chronic child neglect and how to address it. The comprehensive learning modules are available on the CBC for States website at https://learn.childwelfare.gov/

H. Importance of Hope

When families and caregivers have hope, they are more likely to work toward case goals and achieve safety, well-being, and permanency. It is essential for caseworkers to motivate families through an optimistic and strengths-based approach so that they engage in services and work toward positive goals. Child welfare professionals can support families by helping cultivate positive relationships, experiences, and environments that work to buffer ACEs and promote healthy childhood development (Sege & Browne, 2017). For State and local examples of how a public health approach to child welfare, reliance on community data, and the science of ACEs and brain development are working to improve child and family safety and well-being, see the following reports:

- Balancing Adverse Childhood Experiences With HOPE (Health Outcomes of Positive Experiences): New Insights Into the Role of Positive Experience on Child and Family Development (https://hria.org/resources/ hopereport/)
- The Evolution of Hope: How Communities Across America Are Building Better Futures for Their Children and Families (https://www.casey.org/hope2017/)
- Moving Hope Forward: How Safety, Knowledge, and the Power of Community Can Transform Lives (https:// www.casey.org/hope2018/)

I Conclusion

Chronic neglect is the product of significant and multiple stressors on individuals and families with the potential to span generations, particularly absent effective interventions that consider these complex factors. Partnerships that share common goals and make good use of

community resources are essential in efforts to remediate and prevent chronic neglect. More research, prevention, and early interventions—combined with concrete supports and hope-based initiatives—are needed to address chronic neglect and its far-reaching effects on children and families.

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Chapter 4 – Parental Drug Use as Child Abuse

Chapter 4 is sourced from the Child Welfare Information Gateway. This publication is available online at https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/drugexposed/.

Abuse of drugs or alcohol by parents and other caregivers can have negative effects on the health, safety, and well-being of children. Approximately 47 States, the District of Columbia, Guam, and the U.S Virgin Islands have laws within their child protection statutes that address the issue of substance abuse by parents.[5] Two areas of concern are the harm caused by prenatal drug exposure and the harm caused to children of any age by exposure to illegal drug activity in their homes or environment.

Prenatal Drug Exposure

The Child Abuse Prevention and Treatment Act (CAPTA) requires States to have policies and procedures in place to notify child protective services (CPS) agencies of substance-exposed newborns (SENs) and to establish a plan of safe care for newborns identified as being affected by illegal substance abuse or having withdrawal symptoms resulting from prenatal drug exposure.[6] Several States currently address this requirement in their statutes. Approximately 19 States and the District of Columbia have specific reporting procedures for infants who show evidence at birth of having been exposed to drugs, alcohol, or other controlled substances; 14 States and the District of Columbia include this type of exposure in their definitions of child abuse or neglect.[7]

Some States specify in their statutes the response the CPS agency must make to reports of SENs. Maine requires the State agency to develop a plan of safe care for the infant. California, Maryland, Minnesota, Missouri, Nevada, Pennsylvania, and the District of Columbia require the agency to complete an assessment of needs for the infant and for the infant's family and to make a referral to appropriate services. Illinois and Minnesota require mandated reporters to report when they suspect that pregnant women are substance abusers so that the women can be referred for treatment.

Children Exposed to Illegal Drug Activity

There is increasing concern about the negative effects on children when parents or other members of their households abuse alcohol or drugs or engage in other illegal drug-related activity, such as the manufacture of methamphetamines in home-based laboratories. Many States have responded to this problem by expanding the civil definition of child abuse or neglect to

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[5] The word "approximately" is used to stress the fact that States frequently amend their laws. This information is current through April 2015. The statutes in American Samoa, Connecticut, New Jersey, Northern Mariana Islands, Puerto Rico, and Vermont do not currently address the issue of children exposed to illegal drug activity.

[6] 42 U.S.C. § 5106a(b), as amended by the CAPTA Reauthorization Act of 2010 (P.L. 111-320). For more information on these issues, as well as training resources and technical assistance, visit the website of the National Center on Substance Abuse and Child Welfare at https://www.ncsacw.samhsa.gov/ default.aspx.

[7] Alaska, Arizona, Arkansas, California, Illinois, Iowa, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nevada, Oklahoma, Pennsylvania, Utah, and Virginia have enacted specific reporting procedures for drug-exposed infants. Arizona, Arkansas, Colorado, Florida, Illinois, Indiana, Louisiana, Minnesota, North Dakota, South Carolina, South Dakota, Texas, Virginia, and Wisconsin include exposure of infants to drugs in their definitions of child abuse or neglect.

include this concern. Specific circumstances that are considered child abuse or neglect in some States include:

- Manufacturing a controlled substance in the presence of a child or on premises occupied by a child[8]
- Exposing a child to, or allowing a child to be present where, chemicals or equipment for the manufacture of controlled substances are used or stored[9]
- Selling, distributing, or giving drugs or alcohol to a child[10]
- Using a controlled substance that impairs the caregiver's ability to adequately care for the child[11].
- Exposing a child to the criminal sale or distribution of drugs[12]

Approximately 34 States and the U.S. Virgin Islands address in their criminal statutes the issue of exposing children to illegal drug activity.[13] For example, in 20 States the manufacture or possession of methamphetamine in the presence of a child is a felony,[14] while in 10 States, the manufacture or possession of any controlled substance in the presence of a child is considered a felony.[15] Nine States have enacted enhanced penalties for any conviction for the manufacture of methamphetamine when a child was on the premises where the crime occurred.[16]

Exposing children to the manufacture, possession, or distribution of illegal drugs is considered child endangerment in 11 States.[17] The exposure of a child to drugs or drug paraphernalia is a crime in eight States and the Virgin Islands.[18] In North Carolina and Wyoming, selling or giving an illegal drug to a child by any person is a felony. This publication is a product of the State Statutes Series prepared by Child Welfare Information Gateway. While every attempt has been made to be as complete as possible, additional information on these topics may be in other sections of a State's code as well as agency regulations, case law, and informal practices and procedures. Parental Drug Use as Child Abuse Suggested Citation: Child Welfare Information Gateway. (2016). Parental drug use as child abuse. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

This Chapter is from the Child Welfare Information Gateway. This publication is available online at

https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/drugexposed/.

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[8] In 11 States (Alabama, Colorado, Indiana, Iowa, Montana, Oklahoma, Oregon, Pennsylvania, South Dakota, Tennessee, and Wisconsin) and the District of Columbia.

[9] In 8 States: Alabama, Arizona, Arkansas, Iowa, New Mexico, North Dakota, Oklahoma, and Oregon.

[10] In 7 States (Arkansas, Florida, Hawaii, Illinois, Iowa, Minnesota, and Texas) and Guam.

[11] In 11 States: California, Delaware, Florida, Iowa, Kentucky, Minnesota, New York, Oklahoma, Rhode Island, Texas, and West Virginia

[12] Montana, South Dakota, and the District of Columbia.

[13] Alabama, Alaska, Arizona, Arkansas, California, Colorado, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, Utah, Virginia, Washington, West Virginia, and Wyoming currently address the issue in their criminal statutes.

[14] Arkansas, California, Colorado, Georgia, Illinois, Iowa, Kansas, Kentucky, Louisiana, Missouri, Montana, Nebraska, New Hampshire, Ohio, Pennsylvania, South Carolina, Virginia, Washington, West Virginia, and Wyoming.

[15] Alabama, Colorado, Hawaii, Idaho, Indiana, Kentucky, Louisiana, New Mexico, Ohio, and Oregon.

[16] Arkansas, California, Hawaii, Mississippi, Montana, North Carolina, Ohio, Virginia, and Washington.

[17] Alaska, Arizona, Delaware, Illinois, Iowa, Kansas, Kentucky, Minnesota, Missouri, Montana, and Washington.

[18] Montana, Nebraska, New Hampshire, North Dakota, South Carolina, Utah, Washington, and Wyoming.

Chapter 5 – Long-Term Consequences of Child Abuse and Neglect

Chapter 5 is sourced from Child Welfare Information Gateway. (2019). *Long-term consequences of child abuse and neglect*.

Aside from the immediate physical injuries children can experience through maltreatment, a child's reactions to abuse or neglect can have lifelong and even intergenerational impacts. Childhood maltreatment can be linked to later physical, psychological, and behavioral consequences as well as costs to society as a whole. These consequences may be independent of each other, but they also may be interrelated. For example, abuse or neglect may stunt physical development of the child's brain and lead to psychological problems, such as low self- esteem, which could later lead to high-risk behaviors, such as substance use. The outcomes for each child may vary widely and are affected by a combination of factors, including the child's age and developmental status when the maltreatment occurred; the type, frequency, duration, and severity of the maltreatment; and the relationship between the child and the perpetrator. Additionally, children who experience maltreatment often are affected by other adverse experiences (e.g., parental substance use, domestic violence, poverty), which can make it difficult to separate the unique effects of maltreatment (Rosen, Handley, Cicchetti, & Rogosch, 2018).

This [chapter] explains the long-term physical psychological, behavioral, and societal consequences of child abuse and neglect and provide an overview of adverse childhood experiences (ACEs). It also discusses the importance of prevention and intervention efforts and promoting protective relationships and environments.

A. Physical Health Consequences

Some long-term physical effects of abuse or neglect may occur immediately (e.g., brain damage caused by head trauma), but others can take months or years to emerge or be detectable. There is a straightforward link between physical abuse and physical health, but it is also important to recognize that maltreatment of any type can cause long-term physical consequences.

Childhood maltreatment has been linked to higher risk for a wide range of long-term and/or future health problems, including—but not limited to—the following (Widom, Czaja, Bentley, & Johnson, 2012; Monnat & Chandler, 2015; Afifi et al., 2016):

☐Diabetes
☐Lung disease
☐Malnutrition
☐Vision problems
☐Functional limitations (i.e., being limited in activities)
☐Heart attack
☐Arthritis
☐Back problems

☐High blood pressure
☐Brain damage
☐Migraine headaches
☐Chronic bronchitis/emphysema/chronic obstructive pulmonary disease
☐Cancer
☐Stroke
☐Bowel disease
☐Chronic fatigue syndrome

Child abuse and neglect also has been associated with certain regions of the brain failing to form, function, or grow properly. For example, a history of maltreatment may be correlated with reduced volume in overall brain size and may affect the size and/or functioning of the following brain regions (Bick & Nelson, 2016):

☐The amygdala, which is key to processing emotions
☐The hippocampus, which is central to learning and memory
☐The orbitofrontal cortex, which is responsible for reinforcement-based decision-making and emotion regulation
☐The cerebellum, which helps coordinate motor behavior and executive functioning
☐The corpus callosum, which is responsible for left brain/right brain communication and other processes (e.g., arousal, emotion, higher cognitive abilities)

Fortunately, however, there is promising evidence that children's brains may be able to recover with the help of appropriate interventions (Bick & Nelson, 2016). For additional information about these impacts, refer to Information Gateway's Understanding the Effects of Maltreatment on Brain Development (https://www.childwelfare.gov/pubs/issue-briefs/brain-development/).

Additionally, the type of maltreatment a child experiences can increase the risk for specific physical health conditions. For example, one study found that children who experienced neglect were at increased risk for diabetes, poorer lung functioning, and vision and oral health problems. Children who had been physically abused were at higher risk for diabetes and malnutrition. Children who were victims of sexual abuse were more likely to contract hepatitis C and HIV (Widom et al., 2012).

a. Epigenetics

Epigenetics refers to changes in how an individual's genes are expressed and used, which may be temporary or permanent (National Scientific Council on the Developing Child, 2010). These changes can even be passed on to the person's children. An epigenetic change can be caused by life experiences, such as child maltreatment or substance exposure. For example, one study found that children who had been maltreated exhibited changes in genes associated with various physical and psychological disorders, such as cancer, cardiovascular disease, immune disorders, schizophrenia, bipolar disorder, and depression (Cicchetti et al., 2016).

B. Psychological Consequences

Child abuse and neglect can cause a variety of psychological problems. Maltreatment can cause victims to feel isolation, fear, and distrust, which can translate into lifelong psychological consequences that can manifest as educational difficulties, low self-esteem, depression, and trouble forming and maintaining relationships. Researchers have identified links between child abuse and neglect and the following psychological outcomes.

Diminished executive functioning and cognitive skills. Disrupted brain development as a result of maltreatment can cause impairments to the brain's executive functions: working memory, self-control, and cognitive flexibility (i.e., the ability to look at things and situations from different perspectives) (Kavanaugh, Dupont-Frechette, Jerskey, & Holler, 2016). Children who were maltreated also are at risk for other cognitive problems, including difficulties learning and paying attention (Bick & Nelson, 2016).

Poor mental and emotional health. Experiencing childhood maltreatment is a risk factor for depression, anxiety, and other psychiatric disorders throughout adulthood. Studies have found that adults with a history of ACEs had a higher prevalence of suicide attempts then those who did not (Choi, DiNitto, Marti, & Segal, 2017; Fuller-Thomson, Baird, Dhrodia, & Brennenstuhl, 2016). (For additional information about ACEs, see the Federal Research on Adverse Childhood Experiences section later in this [chapter.] Further, adults with major depression who experienced abuse as children had poorer response outcomes to antidepressant treatment, especially if the maltreatment occurred when they were aged 7 or younger (Williams, Debattista, Duchemin, Schatzberg, & Nemeroff, 2016).

Attachment and social difficulties. Infants in foster care who have experienced maltreatment followed by disruptions in early caregiving can develop attachment disorders. Attachment disorders can negatively affect a child's ability to form positive peer, social, and romantic relationships later in life (Doyle & Cicchetti, 2017).
Additionally, children who experience abuse or neglect are more likely to develop antisocial traits as they grow up, which can lead to criminal behavior in adulthood (U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, 2017).

Posttraumatic stress. Children who experienced abuse or neglect can develop posttraumatic stress disorder (PTSD), which is characterized by symptoms such as persistent re-experiencing of the traumatic events related to the abuse; avoiding people, places, and events that are associated with their maltreatment; feeling fear, horror, anger, guilt, or shame; startling easily; and exhibiting hypervigilance, irritability, or
other changes in mood (Sege et al., 2017). PTSD in children can
lead to depression, suicidal behavior, substance use, and oppositional or defiant behaviors well into adulthood, which can affect their ability to succeed in school, and create and nurture important relationships.

C. Behavioral Consequences

Victims of child abuse and neglect often exhibit behavioral difficulties even after the maltreatment ends. The following are examples of how maltreatment can affect individuals' behaviors as adolescents and adults.

Unhealthy sexual practices. Studies suggest that abused or neglected children are more likely to engage in sexual risk-taking as they reach adolescence, including a higher number of sexual partners, earlier initiation of sexual behavior, and transactional sex (i.e., sex exchanged for money, gifts, or other material support) (Thompson et al., 2017), which increases their chances of contracting a sexually transmitted disease.

Juvenile delinquency leading to adult criminality. Several studies have documented the correlation between child maltreatment and future juvenile delinquency and criminal activities (Herrenkohl, Jung, Lee, & Kim, 2017).
According to research funded by the National Institute of Justice within the U.S. Department of Justice, Office of Justice Programs, children who experience maltreatment in the form of physical and emotional abuse are more likely to develop antisocial behaviors and form relationships with other antisocial people (U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, 2017).
Furthermore, there is a difference between girls and boys in the way child maltreatment influences delinquent behavior. In the study, girls tended to express internalizing behaviors (e.g., depression, social withdrawal, anxiety), while boys tended to express externalizing behaviors (e.g., bullying, aggression, hostility) leading up to adult criminal behavior (Herrenkohl et al., 2017).

Alcohol and other drug use. Adults who had been maltreated as children are at a significantly higher risk of substance use disorders than adults who have not been maltreated (LeTendre & Reed, 2017; (Choi, DiNitto, Marti, & Choi, 2017).

Future perpetration of maltreatment.
Although most children who have experienced abuse and neglect do not go on to abuse or neglect their own children, research suggests they are more likely to do so compared to children who were not maltreated (Yang, Font, Ketchum, & Kim, 2018). This cycle of maltreatment can be a result of children learning early on that physical abuse or neglect is an appropriate way to parent (Child Welfare Information Gateway, 2018). To learn more, read Information Gateway's *Intergenerational Patterns of Child Maltreatment: What the Evidence Shows*, available at https://www.childwelfare. gov/pubs/issue-briefs/intergenerational/.

D. Societal Consequences

Although the physical, psychological, and behavioral consequences of child abuse and neglect weigh heavily on the shoulders of the children who experience it, the impact of maltreatment does not end there. Society pays a price for child abuse and neglect in both direct costs (e.g., hospitalizations, foster care payments) and indirect costs (e.g., long-term care, lost productivity at school, juvenile and criminal justice systems costs).

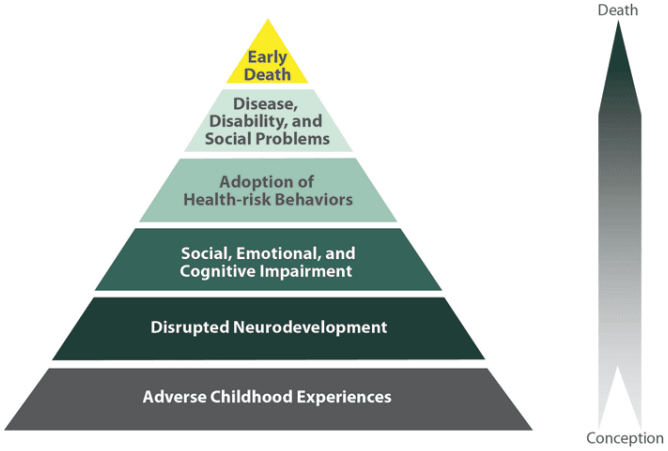
A study by researchers from the Centers for Disease Control and Prevention (CDC) developed estimates using 2015 data for the cost of child maltreatment in the United States. For nonfatal incidents of child maltreatment, the researchers estimated a lifetime cost of $831,000 per child, and for fatal incidents of child maltreatment, it estimated a lifetime cost of $16.6 million per child (Peterson, Florence, & Klevens, 2018). It appraised the annual cost of nonfatal child maltreatment in the United States to be $428 billion (based on the number of substantiated cases of nonfatal maltreatment) or $2 trillion (based on the number of investigated instances of nonfatal maltreatment). The costs in this study include both tangible costs (e.g., child welfare, health care, juvenile justice) and
intangible costs (e.g., pain, suffering, grief).

For more information on the economic and societal costs of child abuse and neglect, see the following Information Gateway webpages: Cost-of-Injury Analysis (https://www.childwelfare.gov/topics/preventing/developing/economic/cost-injury/) and Social and Economic Consequences of Child Abuse and Neglect (https://www.childwelfare.gov/topics/can/impact/consequences/).

E. Federal Research on Adverse Childhood Experiences

ACEs refers to a group of traumatic experiences in childhood, including maltreatment, that can cause toxic stress and affect an individual's physical, psychological, and behavioral well-being.[19] (See figure 1 for a representation of how ACEs affect an individual throughout his or her life.) Between 1995 and 1997, the CDC, in collaboration with Kaiser Permanente's Health Appraisal Clinic, conducted the landmark ACEs study, which examined the correlation between childhood trauma and adult health and well-being outcomes.

Research that explores ACEs and how to respond to them is still ongoing. Findings from a subsequent study showed that nearly half of children in the United States experienced at least one ACE and that about 1 in 10 had experienced three or more ACEs (Sacks & Murphey, 2018). For more information about the study, visit https://www.cdc.gov/violenceprevention/acestudy/.



Mechanism by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

[19] The following are the 10 ACEs generally studied: physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, intimate partner violence within the household, substance misuse within the household, mental illness within the household, parental separation or divorce, and incarcerated household member.

Figure 1. ACEs Pyramid

Two additional Federal research initiatives regarding ACES are the National Survey of Child and Adolescent Well-Being (NSCAW) and the Behavioral Risk Factor Surveillance System (BRFSS):

☐NSCAW is a project of the Administration on Children, Youth and Families within HHS/ACF. It seeks to describe the child welfare system and the experiences of children and families who come into contact with it. Survey data are collected firsthand from children, parents, other caregivers, caseworkers, and teachers as well as administrative records. As a longitudinal study, NSCAW follows the life course of these children to gather data about service receipt, child well-being, and other outcomes. This information will provide a clearer understanding of the life outcomes of children and families involved with child welfare. For more information, visit https://www.acf.hhs.gov/opre/research/project/national-survey-of-child-and-adolescent-well-being-nscaw.

☐BRFSS is an annual national telephone survey that collects State data on U.S. residents ages 18 years or older regarding their health-related risk behaviors, chronic health conditions, and use of preventative services. BRFSS consists of a core module as well as optional modules that States can incorporate. In addition, many States develop their own questions to meet their needs. The HHS CDC developed an optional ACEs module that was available from 2009 to 2011. Since 2011, many States have continued to add the ACEs module to their surveys as State-added questions. For more information, visit the CDC website at https://www.cdc.gov/brfss/index.html.

Promising evidence-based strategies have emerged to help combat the effects of ACEs on future outcomes and well-being. These include enlisting communities to promote stable, safe, and nurturing environments for children; using data to inform programs and services for preventing child maltreatment; and implementing community efforts that support parenting programs and positive parenting behaviors (HHS, CDC, National Center for Injury Prevention and Control, Division of Violence Prevention, 2014).

For more information on ACEs, including related research, refer to the following:
☐ACEs Connection [website]: https://www.acesconnection.com/
☐*ACEs Resource Packet: Adverse Childhood Experiences (ACEs) Basics*: http://childhealthdata.org/docs/default-source/cahmi/aces-resource-packet_all-pages_12_0616112336f3c0266255aab2ff00001023b1.pdf?sfvrsn=2
☐Adverse Childhood Experiences [webpage] https://www.cdc.gov/violenceprevention/acestudy/index.html
☐Childhood Trauma and Positive Health [webpage] http://www.cahmi.org/projects/adverse-childhood-experiences-aces/
☐*A National and Across-State Profile on Adverse Childhood Experiences Among U.S. Children and Possibilities to Heal and Thrive* http://www.cahmi.org/wp-content/uploads/2018/05/aces_brief_final.pdf

☐***The Prevalence of Adverse Childhood Experiences, Nationally, by State, and by Race or Ethnicity***
https://www.childtrends.org/publications/prevalence-adverse-childhood-experiences-nationally-state-race-ethnicity

F. Preventing and Reducing the Long-Term Consequences of Maltreatment

By reducing the incidence of child abuse and neglect through primary prevention approaches and providing comprehensive, trauma-informed care when it does occur, communities can limit its long-term consequences. In trauma-informed care, service professionals acknowledge a child's history of trauma and how that trauma can have an impact on the symptoms—or consequences—being experienced by the child.

For more information on trauma-informed practice, visit Information Gateway at https://www.childwelfare.gov/topics/responding/trauma/.

Communities can ensure that public and private agencies have the tools—such as assessments, evidence-informed interventions, and properly trained staff—to provide children and their families with timely, appropriate care to prevent child maltreatment and alleviate its effects.

Communities can also promote a variety of protective factors for children. Protective factors are conditions or attributes of individuals, families, communities, or society that promote well-being and reduce the risk for negative outcomes, including the long-term consequences discussed in this [chapter] (Child Welfare Information Gateway, 2015). They can "buffer" the effects of maltreatment. (See figure 2 for an illustration of the relationship between risk and protective factors.) Research shows the following are protective factors for victims of child maltreatment (Child Welfare Information Gateway, 2015):

☐**Individual level**
- ○ Sense of purpose
- ○ Agency (self-efficacy)
- ○ Self-regulation skills
- ○ Relational skills
- ○ Problem-solving skills
- ○ Involvement in positive activities

☐**Relationship level**
- ○ Parenting competencies
- ○ Positive peers
- ○ Parent or caregiver well-being

☐**Community level**
- ○ Positive school environment
- ○ Stable living situation
- ○ Positive community environment

For more information, visit Information Gateway's Preventing Child Abuse & Neglect (https://www.childwelfare.gov/topics/preventing/) and Responding to Child Abuse & Neglect (https://www.childwelfare.gov/topics/responding/) web sections.

Figure 2. Risk and protective Factors

G. Conclusion

Child abuse and neglect can have devastating and long-lasting effects on a child and can result in detrimental societal impacts, including high costs for services and increased involvement in the juvenile and criminal justice systems. However, communities can act to stem the effects of maltreatment and even prevent it.

Evidence-based services and supports can promote protective factors that mitigate the effects of maltreatment as well as provide families and communities with the tools to stop maltreatment before it occurs. Child welfare agencies can work with families and communities to spearhead initiatives that build upon strengths and address needs.

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Chapter 6 - Penalties for Failure to Report and False Reporting of Child Abuse and Neglect

Chapter 6 is sourced from the Child Welfare Information Gateway. (2019). *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.

To find statute information for a particular State, copy and paste this link:

https://www.childwelfare.gov/topics/systtemwide/laws-policies/state/

Many cases of child abuse and neglect are not reported, even when mandated by law. Therefore, nearly every State and U.S. territory imposes penalties, often in the form of a fine or imprisonment, on mandatory reporters who fail to report suspected child abuse or neglect as required by law.[1] In addition, to prevent malicious or intentional reporting of cases that are not founded, many States and the U.S. Virgin Islands impose penalties against any person who files a report known to be false.

A. Penalties for Failure to Report

Approximately 49 States, the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands impose penalties on mandatory reporters who knowingly or willfully fail to make a report when they suspect that a child is being abused or neglected.[20] In Florida, a mandatory reporter who fails to report as required by law can be charged with a felony. Failure to report is classified as a misdemeanor or a similar charge in 40 States and American Samoa, Guam, and the Virgin Islands.[21] Misdemeanors are upgraded to felonies for failure to report more serious situations in Arizona (for a serious offense such as child prostitution or incest) and Minnesota (for when a child has died because of the lack of medical care). In Connecticut, Illinois, Kentucky, and Guam, second or subsequent violations are classified as felonies.

Twenty States and the District of Columbia, Guam, the Northern Mariana Islands, and the Virgin Islands specify in the reporting laws the penalties for a failure to report.[22] Upon conviction, a mandated reporter who fails to report can face jail terms ranging from 30 days to 5 years, fines ranging from $300 to $10,000, or both jail terms and fines. In seven States, harsher penalties may be imposed under certain circumstances.[23] In seven States and American Samoa, in addition to any criminal penalties, the reporter may be civilly liable for any damages caused by the failure to report.[24]

Florida imposes a fine of up to $1 million on any institution of higher learning, including any State university and nonpublic college, who fails to report or prevents any person from reporting an instance of abuse committed on the property of the institution or at an event sponsored by the institution. In Maryland, an agency participating in a child abuse or neglect investigation that has reason to suspect that a health-care practitioner, police officer, or educator has failed to report as required must file a complaint with that professional's respective licensing authority. In Missouri, a film or photographic film processor, computer technician, or internet provider who fails to report child pornography commits a misdemeanor.

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[20] The word "approximately" is used to stress the fact that the States frequently amend their laws. This information is current through February 2019. Wyoming currently does not have a statute that imposes penalties on mandatory reporters for failure to report.

[21] Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey (charged as a disorderly person), New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, and West Virginia.

[22] Alabama, California, Connecticut, Delaware, Florida, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, New Mexico, Rhode Island, South Carolina, Tennessee, Vermont, Virginia, Washington, West Virginia, and Wisconsin.

[23] In California and Massachusetts, harsher penalties are imposed when the failure to report results in the child's death or serious bodily injury. Louisiana imposes harsher penalties when the reporter fails to report sexual abuse or serious bodily injury. Delaware and Virginia impose harsher penalties upon second or subsequent convictions for failure to report. Vermont imposes its fine for failure to report when the reporter willfully fails to report with the intent to conceal the abuse. West Virginia imposes harsher penalties for failure to report the sexual assault of a child.

[24] Arkansas, Colorado, Iowa, Michigan, Montana, New York, and Rhode Island.

a. Obstructing Reports of Abuse or Neglect

Approximately 10 States impose penalties against any employer who discharges, suspends, disciplines, or engages in any action to prevent or prohibit an employee or volunteer from making a report of suspected child maltreatment as required by the reporting laws.[25] In six States, an action to prevent a report is classified as a misdemeanor.[26] In Connecticut, an employer who interferes with making a report will be charged with a felony and may be subject to a civil penalty of up to $2,500. Three States specify the penalties for that action,[27] and in four States the employer is civilly liable for damages for any harm caused to the mandatory reporter.[28]

In Pennsylvania, a person commits a felony if he or she uses force, violence, or threat; offers a bribe to prevent a report; or has a prior conviction for the same or a similar offense. In Puerto Rico, any person who deliberately prevents another person from making a report commits a misdemeanor.[29] In the Northern Mariana Islands, any person who is convicted of interfering with the good-faith efforts of any person making or attempting to make a report shall be subject to imprisonment for up to 1 year, or a fine of $1,000, or both.

B. Penalties for False Reporting

Approximately 29 States and Puerto Rico carry penalties in their civil child protection laws for any person who willfully or intentionally makes a false report of child abuse or neglect.[30] In New York, Ohio, Pennsylvania, and the Virgin Islands, making false reports of child maltreatment is made illegal in criminal sections of State code.

Nineteen States and the Virgin Islands classify false reporting as a misdemeanor or similar charge.[31] In Florida, Illinois, Tennessee, and Texas, false reporting is a felony; while in Arkansas, Indiana, Missouri, and Virginia, second or subsequent offenses are upgraded to felonies. In Michigan, false reporting can be either a misdemeanor

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[25] Alabama, Arkansas, Connecticut, Maryland, Minnesota, North Dakota, Oklahoma, Pennsylvania, Vermont, and Wyoming.

[26] Alabama, Arkansas, Maryland, North Dakota, Pennsylvania, and Wyoming.

[27] Maryland ($10,000, 5 years in jail, or both), Minnesota ($10,000), and Wyoming ($750, 6 months in jail, or both).

[28] Minnesota, North Dakota, Oklahoma, and Vermont.

[29] Upon conviction, the person is subject to a fine of up to $5,000 or imprisonment of up to 90 days.

[30] Arizona, Arkansas, California, Colorado, Connecticut, Florida, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, North Dakota, Oklahoma, Rhode Island, South Carolina, Tennessee, Texas, Virginia, Washington, and Wyoming.

[31] Arizona, Arkansas, Colorado, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Missouri, New York, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, Virginia, Washington, and Wyoming. In Iowa, a person who makes more than three reports regarding the same child victim or the same alleged abuser that are determined to be false or without merit may be subject to criminal charges.

or a felony, depending on the seriousness of the alleged abuse in the report. No criminal penalties are imposed in California, Maine, Minnesota, Montana, and Nebraska; however, the immunity from civil or criminal action that is provided to reporters of abuse or neglect is not extended to those who make a false report. In South Carolina, in addition to any criminal penalties, the Department of Social Services may bring civil action against the person to recover the costs of investigation and any proceedings related to the investigation.

Eleven States, Puerto Rico, and the Virgin Islands specify the penalties for making a false report.[32] Upon conviction, the reporter can face jail terms ranging from 90 days to 5 years or fines ranging from $500 to $5,000. Florida imposes the most severe penalties: In addition to a court sentence of 5 years and $5,000, the Department of Children and Family Services may fine the reporter up to $10,000. In six States, the reporter may be civilly liable for any damages caused by the report.[33]

C. Citation

The previous chapter was from the Child Welfare Information Gateway. (2019). *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.

D. Summaries of State Law

Alabama

Current Through February 2019

Failure to Report

Citation: Ala. Code §§ 26-14-3(g); 26-14-13

Commencing on August 1, 2013, a public or private employer who discharges, suspends, disciplines, or penalizes an employee solely for reporting suspected child abuse or neglect pursuant to this section shall be guilty of a class C misdemeanor.

Any person who knowingly fails to make the report required by the reporting laws shall be guilty of a misdemeanor and shall be punished by a sentence of not more than 6 months imprisonment or a fine of not more than $500.

False Reporting

This issue is not addressed in the statutes reviewed.

Alaska

[32] Connecticut, Florida, Louisiana, Massachusetts, Michigan, Oklahoma, Rhode Island, South Carolina, Texas, Washington, and Wyoming.

[33] California, Colorado, Idaho, Indiana, Minnesota, and North Dakota.

Current Through February 2019

Failure to Report
Citation: Alaska Stat. § 47.17.068

A person who fails to comply with the laws requiring reports of child abuse or neglect or child pornography and who knew or should have known that the circumstances gave rise to the need for a report is guilty of a class A misdemeanor.

False Reporting

This issue is not addressed in the statutes reviewed.

American Samoa

Current Through February 2019

Failure to Report
Citation: Ann. Code § 45.2002(d)

Any person who willfully violates the provisions of § 45.2002(a) (requiring certain persons to report) commits a class A misdemeanor and is liable for damages proximately caused.

False Reporting

This issue is not addressed in the statutes reviewed.

Arizona

Current Through February 2019

Failure to Report
Citation: Rev. Stat. § 13-3620(O), (P)

A person who violates this section requiring the reporting of child abuse or neglect is guilty of a class 1 misdemeanor, except if the failure to report involves a reportable offense, in which case the person is guilty of a class 6 felony.

A 'reportable offense' means any of the following:

- Any offense listed in chapters 14 and 35.1 of this title or § 13-3506.01
- Surreptitious photographing, videotaping, filming, or digitally recording or viewing a minor pursuant to § 13-3019
- Child prostitution pursuant to § 13-3212
- Incest pursuant to § 13-3608
- Unlawful mutilation pursuant to § 13-1214

False Reporting
Citation: Rev. Stat. § 13-3620.01

A person acting with malice who knowingly and intentionally makes a false report of child abuse or neglect, or a person acting with malice who coerces another person to make a false report of child abuse or neglect, is guilty of a class 1 misdemeanor.

A person who knowingly and intentionally makes a false report that another person made a false report is guilty of a class 1 misdemeanor.

Arkansas

Current Through February 2019

Failure to Report

Citation: Ann. Code §§ 12-18-201; 12-18-202; 12-18-206; 12-18-204

A mandated reporter commits the offense of failure to notify by a mandated reporter in the first degree if he or she has reasonable cause to suspect that a child has been subjected to or has died as a result of child maltreatment or observes a child being subjected to conditions or circumstances that would reasonably result in child maltreatment, and he or she knowingly fails to notify the child abuse hotline of the child maltreatment or suspected child maltreatment.

Failure to notify by a mandated reporter in the first degree is a class A misdemeanor.

A mandated reporter commits the offense of failure to notify by a mandated reporter in the second degree if he or she has reasonable cause to suspect that a child has been subjected to or has died as a result of child maltreatment or observes a child being subjected to conditions or circumstances that would reasonably result in child maltreatment, and he or she recklessly fails to notify the child abuse hotline of the child maltreatment or suspected child maltreatment.

Failure to notify by a mandated reporter in the second degree is a class C misdemeanor.

A mandated reporter who purposely fails to report as required is civilly liable for damages proximately caused by that failure.

An employer or supervisor of an employee who is a mandated reporter commits the offense of unlawful restriction of child abuse reporting if he or she does the following:

- Prohibits a mandated reporter from making a report of child maltreatment or suspected child maltreatment
- Requires that a mandated reporter receive permission or notify a person before the mandated reporter makes a report
- Knowingly retaliates against a mandated reporter for reporting child maltreatment or suspected child maltreatment Unlawful restriction of child abuse reporting is a class A misdemeanor.

False Reporting

Citation: Ann. Code § 12-18-203

A person commits the offense of making a false report under this chapter if he or she purposely and knowingly makes a report containing a false allegation to the child abuse hotline.

A first offense of making a false report under this chapter is a class A misdemeanor. A subsequent offense of making a false report under this chapter is a class D felony.

California

Current Through February 2019

Failure to Report

Citation: Penal Code §§ 11166(c); 11166.01

Any mandated reporter who fails to report an incident of known or reasonably suspected child abuse or neglect is guilty of a misdemeanor punishable by up to 6 months in a county jail or by a fine of $1,000, or both. If a mandated reporter intentionally conceals his or her failure to report an incident known by the mandated reporter to be abuse or severe neglect, the failure to report is a continuing offense until an agency specified in § 11165.9 discovers the offense.

Any supervisor or administrator who violates § 11166(1) (that prohibits impeding others from making a report), shall be punished by not more than 6 months in a county jail or by a fine of not more than $1,000, or both.

Any mandated reporter who willfully fails to report abuse or neglect, or any person who impedes or inhibits a report of abuse or neglect, where that abuse or neglect results in death or great bodily injury, shall be punished by not more than 1 year in a county jail or by a fine of not more than $5,000, or both.

False Reporting

Citation: Penal Code § 11172(a)

Any person reporting a known or suspected instance of child abuse or neglect shall not incur civil or criminal liability as a result of any report, unless it can be proven that a false report was made and the person knew that the report was false or was made with reckless disregard of the truth or falsity of the report.

Any person who makes a report of child abuse or neglect known to be false or with reckless disregard of the truth or falsity of the report is liable for any damages caused.

Colorado

Current Through February 2019

Failure to Report

Citation: Rev. Stat. § 19-3-304(4)

Any mandatory reporter who willfully fails to report as required by § 19-3-304(1) commits a class 3 misdemeanor and shall be punished as provided by law and shall be liable for damages proximately caused

False Reporting

Citation: Rev. Stat. § 19-3-304(3.5), (4)

No person, including a mandatory reporter, shall knowingly make a false report of abuse or neglect to a county department or local law enforcement agency.

Any person who violates this provision commits a class 3 misdemeanor and shall be punished as provided by law and shall be liable for damages proximately caused.

Connecticut

Current Through February 2019

Failure to Report
Citation: Gen. Stat. §§ 17a-101a; 17a-101e(a)

Any mandated reporter who fails to report as required by law or fails to make such report within the time period prescribed by law shall be guilty of a class A misdemeanor. That person, however, shall be guilty of a class E felony if any of the following is true:

- The failure to report is a subsequent violation.
- The failure to report was willful, intentional, or due to gross negligence.
- The person had actual knowledge that a child was abused or neglected.

Any person who intentionally and unreasonably interferes with or prevents the making of a report pursuant to this section, or attempts or conspires to do so, shall be guilty of a class D felony. The provisions of this subdivision shall not apply to any child under age 18 or any person who is being educated by the Technical Education and Career System or a local or regional board of education, other than as part of an adult education program.

Any person found guilty under the provisions of this section shall be required to participate in an educational and training program.

The attorney general may bring an action in superior court against an employer who discharges or in any manner discriminates or retaliates against any in employee who in good faith makes a report of child abuse or neglect. The court may assess a civil penalty of no more than $2,500 and may order such other equitable relief as the court deems appropriate.

False Reporting
Citation: Gen. Stat. § 17a-101e(c)-(d)

Any person who is alleged to have knowingly made a false report of child abuse or neglect shall be referred to the office of the Chief State's Attorney for purposes of a criminal investigation.

Any person who knowingly makes a false report of child abuse or neglect shall be fined not more than $2,000 or imprisoned for not more than 1 year, or both.

Delaware

Current Through February 2019

Failure to Report
Citation: Ann. Code Tit. 16, § 914

Any person who violates § 903 of this title requiring certain persons to report suspected child abuse or neglect shall be liable for a civil penalty not to exceed $10,000 for the first violation and not to exceed $50,000 for any subsequent violation.

In any action brought under this section, if the court finds a violation, the court may award costs and attorneys' fees.

False Reporting

This issue is not addressed in the statutes reviewed.

District of Columbia

Current Through February 2019

Failure to Report

Citation: Ann. Code § 4-1321.07

Any person required to make a report under the reporting laws who willfully fails to make such a report shall be fined no more than the amount set forth in § 22-3571.01 ($1,000) or imprisoned for no more than 180 days, or both.

False Reporting

This issue is not addressed in the statutes reviewed.

Florida

Current Through February 2019

Failure to Report

Citation: Ann. Stat. § 39.205(1)-(4)

A person who is required to report known or suspected child abuse and who knowingly and willfully fails to do so, or who knowingly and willfully prevents another person from doing so, commits a felony of the third degree, which is punishable as provided in §§ 775.082, 775.083, or 775.084. Upon conviction, the person may be punished as follows:

- Imprisoned for a term not to exceed 5 years
- Fined $5,000

Unless the court finds that the person is a victim of domestic violence or that other mitigating circumstances exist, a person age 18 or older who lives in the same house or living unit as a child who is known or suspected to be a victim of child abuse and knowingly and willfully fails to report the child abuse commits a felony of the third degree.

Any Florida College System institution; State university; or nonpublic college, university, or school whose administrators knowingly and willfully, upon receiving information from faculty, staff, or other institution employees, fail to report known or suspected child abuse, abandonment, or neglect committed on the property of the university, college, or school or during an event or function sponsored by the university, college, or school, or who knowingly and willfully prevents another person from doing so, shall be subject to fines of $1 million for each such failure.

Any Florida College System institution; State university; or nonpublic college, university, or school whose law enforcement agency fails to report known or suspected child abuse, abandonment, or neglect committed on the property of the university, college, or school or during an event or function sponsored by the university, college, or school shall be subject to fines of $1 million for each such failure.

False Reporting

Citation: Ann. Stat. §§ 39.205(9); 39.206(1)

A person who knowingly and willfully makes a false report of child abuse, abandonment, or neglect, or who advises another to make a false report, is guilty of a felony of the third degree. Upon conviction, the person may be punished as follows:

- Imprisoned for a term not to exceed 5 years
- Fined $5,000

In addition to any other penalty authorized by this section or other law, the Department of Children and Family Services may impose a fine, not to exceed $10,000 for each violation, upon a person who knowingly and willfully makes a false report of abuse, abandonment, or neglect of a child or a person who counsels another to make a false report.

Georgia

Current Through February 2019

Failure to Report

Citation: Ann. Code § 19-7-5(h)

Any person or official required by law to report a suspected case of child abuse who knowingly and willfully fails to do so shall be guilty of a misdemeanor.

False Reporting

This issue is not addressed in the statutes reviewed.

Guam

Current Through February 2019

Failure to Report

Citation: Ann. Code Tit. 19, § 13207

Any person required to report who fails to report an instance of child abuse that he or she knows to exist or reasonably should know to exist is guilty of a misdemeanor that is punishable by imprisonment for a term not to exceed 6 months or a fine of no more than $1,000, or both.

A second or subsequent conviction shall be a felony in the third degree.

False Reporting

This issue is not addressed in the statutes reviewed.

Hawaii

Current Through February 2019

Failure to Report

Citation: Rev. Stat. § 350-1.2

Any mandatory reporter who knowingly prevents another person from reporting, or who knowingly fails to provide information as required by the reporting laws, shall be guilty of a petty misdemeanor.

False Reporting

This issue is not addressed in the statutes reviewed.

Idaho

Current Through February 2019

Failure to Report
Citation: Ann. Code § 16-1605(4)

Failure to report as required by the reporting laws shall be a misdemeanor.

False Reporting
Citation: Ann. Code § 16-1607

Any person who makes a report or allegation of child abuse, abandonment, or neglect knowing the report is false, or who reports or alleges the same in bad faith or with malice, shall be liable to the party or parties against whom the report was made for the amount of actual damages sustained or statutory damages of $2,500, whichever is greater, plus attorney's fees and costs of suit.

If the court finds that the defendant acted with malice or oppression, the court may award treble actual damages or treble statutory damages, whichever is greater.

Illinois

Current Through February 2019

Failure to Report
Citation: Comp. Stat. Ch. 325, §§ 5/4.02; 5/4

Any physician who willfully fails to report suspected child abuse or neglect shall be referred to the Illinois State Medical Disciplinary Board for action in accordance with the Medical Practice Act of 1987. Any dentist or dental hygienist who willfully fails to report suspected child abuse or neglect shall be referred to the Department of Professional Regulation for action in accordance with the Illinois Dental Practice Act.

Any mandatory reporter who willfully fails to report suspected child abuse or neglect shall be guilty of a Class A misdemeanor for a first violation and a class 4 felony for a second or subsequent violation.

Any person who knowingly and willfully violates any provision of this section is guilty of a class A misdemeanor for a first violation and a class 4 felony for a second or subsequent violation.

If the person acted as part of a plan or scheme with the object of preventing discovery of an abused or neglected child by lawful authorities for the purpose of protecting or insulating any person or entity from arrest or prosecution, the person is guilty of a class 4 felony

for a first offense and a class 3 felony for a second or subsequent offense (regardless of whether the second or subsequent offense involves any of the same facts or persons as the first or other prior offense).

False Reporting
Citation: Comp. Stat. Ch. 325, § 5/4

Any person who knowingly transmits a false report to the department commits the offense of disorderly conduct under Ch. 720, § 5/26.1(a)(7). A violation of this provision is a class 4 felony.

Indiana

Current Through February 2019

Failure to Report
Citation: Ann. Code § 31-33-22-1

A person who knowingly fails to make a report required by § 31-33-5-1 commits a class B misdemeanor.

A person who, in his or her capacity as a staff member of a medical or other institution, school, facility, or agency is required to make a report to the individual in charge of the institution, school, facility, or agency, or his or her designated agent, as required by § 31-33-5-2 or 31-33-5-2.5, and who knowingly fails to make a report commits a class B misdemeanor. This penalty is imposed in addition to the penalty imposed above.

False Reporting
Citation: Ann. Code § 31-33-22-3(a)-(b)

A person who intentionally communicates to a law enforcement agency or the Department of Child Services a knowingly false report of child abuse or neglect commits a class A misdemeanor. The offense is a level 6 felony if the person has a previous unrelated conviction for making a knowingly false report of child abuse or neglect.

A person who intentionally communicates to a law enforcement agency or the department a report of child abuse or neglect knowing the report to be false is liable to the person accused of child abuse or neglect for actual damages. The finder of fact may award punitive damages and attorney's fees in an amount determined by the finder of fact against the person.

Iowa

Current Through February 2019

Failure to Report
Citation: Ann. Stat. § 232.75(1)-(2)

Any person, official, agency, or institution required to report a suspected case of child abuse who knowingly and willfully fails to do so is guilty of a simple misdemeanor.

Any person, official, agency, or institution required by § 232.69 to report a suspected case of child abuse who knowingly fails to do so, or who knowingly interferes with the making of such a report in violation of § 232.70, is civilly liable for the damages proximately caused by such failure or interference.

False Reporting
Citation: Ann. Stat. §§ 232.75(3); 232.71B

A person who reports or causes to be reported to the Department of Human Services false information regarding an alleged act of child abuse, knowing that the information is false or that the act did not occur, commits a simple misdemeanor.

If the department receives more than three reports that identify the same child as a victim of child abuse or the same person as the alleged abuser of a child, or which were made by the same person, and the department determined the reports to be entirely false or without merit, the department shall provide information concerning the reports to the county attorney for consideration of criminal charges under § 232.75(3).

Kansas

Current Through February 2019

Failure to Report
Citation: Ann. Stat. § 38-2223(e)

Willful and knowing failure to make a report required by this section is a class B misdemeanor. It is not a defense that another mandatory reporter made a report.

Intentionally preventing or interfering with the making of a report required by this section is a class B misdemeanor.

False Reporting
Citation: Ann. Stat. § 38-2223(e)

Any person who willfully and knowingly makes a false report pursuant to this section or makes a report that such person knows lacks factual foundation is guilty of a class B misdemeanor.

Kentucky

Current Through August 2015

Failure to Report
Citation: Rev. Stat. § 620.030(6)

Any person who intentionally violates the provisions of this section shall be guilty of one of the following:

- A class B misdemeanor for the first offense
- A class A misdemeanor for the second offense

- A class D felony for each subsequent offense

False Reporting
Citation: Rev. Stat. § 620.050(1)

Any person who knowingly makes a false report and does so with malice shall be guilty of a class A misdemeanor.

Louisiana

Current Through February 2019

Failure to Report
Citation: Children's Code Art. 609; Rev. Stat. § 14:403

Violation of the duties imposed upon a mandatory reporter subjects the offender to criminal prosecution.

Any person who is required to report the abuse or neglect of a child and knowingly and willfully fails to do so shall be fined no more than $500 or imprisoned for no more than 6 months, or both.

Any person who is required to report the sexual abuse of a child or the abuse or neglect of a child that results in the serious bodily injury, neurological impairment, or death of the child and knowingly and willfully fails to report shall be fined no more than $3,000 or imprisoned with or without hard labor for no more than 3 years, or both. The term 'serious bodily injury' includes, but is not limited to, injury involving protracted and obvious disfigurement or protracted loss or impairment of the function of a bodily member, organ, or mental faculty; substantial risk of death; or injury resulting from starvation or malnutrition.

Notwithstanding the provisions above, any person who is age 18 or older who witnesses the sexual abuse of a child and knowingly and willfully fails to report the sexual abuse to law enforcement or to the Department of Children and Family Services, as required by law, shall be fined no more than $10,000 or imprisoned with or without hard labor for no more than 5 years, or both.

False Reporting
Citation: Children's Code Art. 609; Rev. Stat. § 14:403(A)(3)

The filing of a report that is known to be false may subject the offender to criminal prosecution.

Any person who reports a child as abused or neglected or sexually abused to the department or to any law enforcement agency knowing that such information is false shall be fined no more than $500 or imprisoned for no more than 6 months, or both.

Maine

Current Through February 2019

Failure to Report
Citation: Rev. Stat. Tit. 22, § 4009

A person who knowingly violates a provision of this chapter commits a civil violation for which a forfeiture of not more than $500 may be adjudged.

False Reporting

Citation: Rev. Stat. Tit. 22, § 4014(1)

Immunity from any criminal or civil liability for the act of reporting or participating in the investigation or proceeding is not extended in instances when a false report is made and the person knows the report is false. Nothing in this section may be construed to bar criminal or civil action regarding perjury.

Maryland

Current Through February 2019

Failure to Report

Citation: Fam. Law §§ 5-705.2; 5-705.4

An individual may not intentionally prevent or interfere with the making of a report of suspected abuse or neglect as required by law. A person who violates this section is guilty of a misdemeanor and, on conviction, is subject to imprisonment not exceeding 5 years or a fine not exceeding $10,000, or both.

If an agency participating in an investigation under § 5-706 has substantial grounds to believe that a person has knowingly failed to report suspected abuse or neglect as required by § 5-704, the agency shall do any of the following:

- File a complaint with the appropriate licensing board in accordance with the provisions of the Health Occupations Article if the person is a health practitioner
- File a complaint with the appropriate law enforcement agency if the person is a police officer
- File a complaint with the county board of education or the appropriate agency, institution, or licensed facility at which the person is employed if the person is an educator or a human service worker

False Reporting

This issue is not addressed in the statutes reviewed.

Massachusetts

Current Through February 2019

Failure to Report

Citation: Gen. Laws Ch. 119, § 51A

Any mandatory reporter who fails to report shall be punished by a fine of not more than $1,000.

Any mandated reporter who has knowledge of child abuse or neglect that resulted in serious bodily injury to or death of a child and willfully fails to report the abuse or neglect shall be punished by a fine of up to $5,000 or imprisonment for no more than 2 ½ years or by both, and, upon a guilty finding or a continuance without a finding, the court shall notify any appropriate professional licensing authority of the mandated reporter's violation of this paragraph.

False Reporting
Citation: Gen. Laws Ch. 119, § 51A

Whoever knowingly and willfully files a frivolous report of child abuse or neglect under this section shall be punished as follows:

- A fine of no more than $2,000 for the first offense
- Imprisonment for no more than 6 months and a fine of no more than $2,000 for the second offense
- Imprisonment for no more than 2 ½ years and a fine of no more than $2,000 for the third and subsequent offenses

Michigan

Current Through February 2019

Failure to Report
Citation: Comp. Laws § 722.633(1), (2)

A mandatory reporter who fails to report as required is civilly liable for the damages proximately caused by the failure.

A mandatory reporter who knowingly fails to report as required is guilty of a misdemeanor punishable by one or both of the following:

- Imprisonment for not more than 93 days
- A fine of not more than $500

False Reporting
Citation: Comp. Laws § 722.633(5)

Any person who intentionally makes a false report of child abuse or neglect knowing that the report is false is guilty of a crime as follows:

- If the child abuse or neglect would not constitute a crime but would constitute a misdemeanor if the report were true, the person is guilty of a misdemeanor punishable by imprisonment for not more than 93 days or a fine of not more than $100, or both.

- If the child abuse or neglect reported would constitute a felony if the report were true, the person is guilty of a felony punishable by the lesser of the following:

» The penalty for the child abuse or neglect falsely reported
» Imprisonment for not more than 4 years or a fine of not more than $2,000, or both

Minnesota

Current Through February 2019

Failure to Report
Citation: Ann. Stat. § 626.556, Subd. 4a; 6

An employer of any person required to make reports shall not retaliate against the person for reporting in good faith abuse or neglect pursuant to this section, or against a child with respect to whom a report is made, because of the report. The employer of any person required to report who retaliates against the person because of a report of abuse or neglect is liable to that person for actual damages and, in addition, a penalty up to $10,000. There shall be a rebuttable presumption that any adverse action within 90 days of a report is retaliatory.

A mandatory reporter who knows or has reason to believe that a child is neglected or physically or sexually abused or has been neglected or physically or sexually abused within the preceding 3 years, and fails to report the abuse, is guilty of a misdemeanor.

A mandatory reporter who knows or has reason to believe that two or more children not related to the perpetrator have been physically or sexually abused by the same perpetrator within the preceding 10 years and fails to report is guilty of a gross misdemeanor.

A parent, guardian, or caregiver who knows or reasonably should know that the child's health is in serious danger and who fails to report:

- Is guilty of a gross misdemeanor if the child suffers substantial or great bodily harm because of the lack of medical care
- Is guilty of a felony if the child dies because of the lack of medical care and may be subject to one or both of the following:

» Imprisonment for not more than 2 years
» A fine of not more than $4,000

The law providing that a parent, guardian, or caregiver may, in good faith, select and depend on spiritual means or prayer for treatment or care of a child does not exempt a parent, guardian, or caregiver from the duty to report under this provision.

False Reporting
Citation: Ann. Stat. § 626.556, Subd. 5

Any person who knowingly or recklessly makes a false report under the reporting laws shall be liable in a civil suit for any actual damages suffered by the person(s) so reported and for any punitive damages set by the court or jury, plus costs and reasonable attorney fees.

Mississippi

Current Through February 2019

Failure to Report
Citation: Ann. Code. § 43-21-353(7)

Anyone who willfully violates any provision of this section shall be, upon being found guilty, punished by a fine not to exceed $5,000 or by imprisonment in jail not to exceed 1 year, or both.

False Reporting

This issue is not addressed in the statutes reviewed.

Missouri

Current Through February 2019

Failure to Report
Citation: Ann. Stat. §§ 210.165(1); 573.215

Any person violating any provision of the reporting laws is guilty of a class A misdemeanor.

A person commits the offense of failure to report child pornography if he or she, being a film and photographic print processor, computer provider, installer or repair person, or any internet service provider who has knowledge of or observes, within the scope of the person's professional capacity or employment, any film, photograph, videotape, negative, slide, or computer-generated image or picture depicting a child under age 18 engaged in an act of sexual conduct fails to report such instance to any law enforcement agency immediately or as soon as practically possible.

The offense of failure to report child pornography is a class B misdemeanor.

Nothing in this section shall be construed to require a provider of electronic communication services or remote computing services to monitor any user, subscriber, or customer of the provider or the content of any communication of any user, subscriber, or customer of the provider.

False Reporting
Citation: Ann. Stat. § 210.165(2)-(3)

Any person who intentionally files a false report of child abuse or neglect shall be guilty of a class A misdemeanor.

Every person who has been previously convicted of making a false report to the Children's Division or its predecessor agency, the Division of Family Services, and who is subsequently convicted of making a false report is guilty of a class E felony and shall be punished as provided by law.

Montana

Current Through February 2019

Failure to Report
Citation: Ann. Code § 41-3-207

Any mandatory reporter who fails to report known or suspected child abuse or neglect or who prevents another person from reasonably doing so is civilly liable for the damages

proximately caused by such failure or prevention. Any mandatory reporter who purposely or knowingly fails to report when required or purposely or knowingly prevents another person from doing so is guilty of a misdemeanor.

False Reporting
Citation: Ann. Code § 41-3-203(1)

Anyone reporting any incident of child abuse or neglect as required by law is immune from any liability, civil or criminal, that might otherwise be incurred or imposed unless the person was grossly negligent, acted in bad faith or with malicious purpose, or provided information knowing the information to be false.

Nebraska

Current Through February 2019

Failure to Report
Citation: Rev. Stat. § 28-717

Any person who willfully fails to make any report of child abuse or neglect required by § 28-711 shall be guilty of a class III misdemeanor.

False Reporting
Citation: Rev. Stat. § 28-716

Any person participating in an investigation, making a report of child abuse or neglect, or participating in a judicial proceeding resulting from a report shall be immune from any liability, civil or criminal, that might otherwise be incurred or imposed, except for maliciously false statements.

Nevada

Current Through February 2019

Failure to Report
Citation: Rev. Stat. § 432B.240

Any person who knowingly and willfully violates the provisions of § 432B.220 is guilty of one of the following:

- For the first violation, a misdemeanor
- For each subsequent violation, a gross misdemeanor

False Reporting

This issue is not addressed in the statutes reviewed.

New Hampshire

Current Through February 2019

Failure to Report
Citation: Rev. Stat. § 169-C:39

Anyone who knowingly violates any provision of the reporting laws shall be guilty of a misdemeanor.

False Reporting

This issue is not addressed in the statutes reviewed.

New Jersey

Current Through February 2019

Failure to Report
Citation: Ann. Stat. § 9:6-8.14

Any person knowingly violating the reporting laws, including the failure to report an act of child abuse while having reasonable cause to believe that an act of child abuse has been committed, is a disorderly person.

False Reporting

This issue is not addressed in the statutes reviewed.

New Mexico

Current Through February 2019

Failure to Report
Citation: Ann. Stat. § 32A-4-3(F)

Any person who violates the provisions of this section pertaining to the duty to report is guilty of a misdemeanor and shall be sentenced pursuant to § 31-19-1.

Upon conviction, the person shall be imprisoned in the county jail for a definite term that is less than 1 year, be fined not more than
$1,000, or both, at the discretion of the judge.

False Reporting

This issue is not addressed in the statutes reviewed.

New York

Current Through February 2019

Failure to Report
Citation: Soc. Serv. Law § 420

Any mandatory reporter who willfully fails to report as required shall be guilty of a class A misdemeanor.

Any mandatory reporter who knowingly and willfully fails to report as required shall be civilly liable for the damages proximately caused by such failure.

False Reporting
Citation: Penal Law § 240.50(4)

A person is guilty of falsely reporting an incident in the third degree when, knowing the information reported, conveyed, or circulated to be false or baseless, he or she reports, by word or action, an alleged occurrence or condition of child abuse or maltreatment that did not in fact occur or exist to the following:

- The statewide central register of child abuse and maltreatment
- Any person required to report cases of suspected child abuse or maltreatment, knowing that the person is required to report such cases, and with the intent that such an alleged occurrence be reported to the statewide central register

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

North Carolina

Current Through February 2019

Failure to Report
Citation: Gen. Stat. § 7B-301

Any person or institution who knowingly or wantonly fails to report the case of a juvenile as required, or who knowingly or wantonly prevents another person from making a report as required, is guilty of a class 1 misdemeanor.

A director of social services who receives a report of sexual abuse of a juvenile in a child care facility and who knowingly fails to notify the State Bureau of Investigation of the report as required is guilty of a class 1 misdemeanor.

False Reporting

This issue is not addressed in the statutes reviewed.

North Dakota

Current Through February 2019

Failure to Report
Citation: Cent. Code §§ 50-25.1-13; 50-25.1-09.1

Any person required by this chapter to report or to supply information concerning a case of known or suspected child abuse, neglect, or death resulting from abuse or neglect who willfully fails to do so is guilty of a class B misdemeanor.

An employer who retaliates against an employee solely because the employee in good faith reported having reasonable cause to suspect that a child was abused or neglected, died as a result of abuse or neglect, or because the employee is a child with respect to whom a

report was made, is guilty of a class B misdemeanor. It is a defense to any charge brought under this section that the presumption of good faith, described in § 50-25.1-09, has been rebutted.

The employer of a person required or permitted to report pursuant to § 50-25.1-03 who retaliates against the person because of a report of abuse or neglect, or a report of a death resulting from child abuse or neglect, is liable to that person in a civil action for all damages, including exemplary damages, costs of the litigation, and reasonable attorney's fees.

False Reporting
Citation: Cent. Code § 50-25.1-13

Any person who willfully makes a false report or provides false information that causes a report to be made is guilty of a class B misdemeanor, unless the false report is made to a law enforcement official, in which case the person who causes the report to be made is guilty of a class A misdemeanor.

A person who willfully makes a false report or willfully provides false information that causes a report to be made also is liable in a civil action for all damages suffered by the person reported, including exemplary damages.

Northern Mariana Islands

Current Through February 2019

Failure to Report
Citation: Commonwealth Code Tit. 6, §§ 5315; 5316

Knowing or willful failure of any person to make a report pursuant to § 5313 shall, upon conviction, be punished by one or both of the following:

- Imprisonment for up to 1 year
- A fine of not more than $1,000

Knowing or willful interference by any person with the good-faith efforts of any person making or attempting to make a report under this chapter shall, upon conviction, be punished by imprisonment for up to 1 year or a fine of $1,000, or both.

False Reporting

This issue is not addressed in the statutes reviewed.

Ohio

Current Through February 2019

Failure to Report
Citation: Rev. Code § 2151.99

Any person who fails to report suspected child abuse or neglect, as required by § 2151.421, is guilty of a misdemeanor of the fourth degree.

Any person required to report by § 2151.421(A)(4) (requiring reports by clergy) who fails to report when knowing that a child has been abused or neglected and knowing that the person who committed the abuse or neglect was a cleric or another person other than a volunteer designated by a church, religious society, or faith to act as a leader, official, or delegate on behalf of the church, religious society, or faith is guilty of a misdemeanor of the first degree if the person who has failed to report and the person who committed the abuse or neglect belong to the same church, religious society, or faith.

The person who fails to report is guilty of a misdemeanor of the first degree if the child suffers or faces the threat of suffering the physical or mental wound, injury, disability, or condition that would be the basis of the required report when the child is under the direct care or supervision of another person over whom the offender has supervisory control.

False Reporting
Citation: Rev. Code § 2921.14

No person shall knowingly make or cause another person to make a false report alleging that any person has committed an act or omission that resulted in a child being abused or neglected.

Whoever violates this section is guilty of making or causing a false report of child abuse or child neglect, a misdemeanor of the first degree.

Oklahoma

Current Through February 2019

Failure to Report
Citation: Ann. Stat. Tit. 10A, § 1-2-101(B)(4); (C)

Any employer, supervisor, or administrator who discharges, discriminates, or retaliates against the employee or other person shall be liable for damages, costs, and attorney fees.

Any person who knowingly and willfully fails to promptly report suspected child abuse or neglect or who interferes with the prompt reporting of suspected child abuse or neglect may be reported to local law enforcement for criminal investigation and, upon conviction thereof, shall be guilty of a misdemeanor.

False Reporting
Citation: Ann. Stat. Tit. 10A, § 1-2-101(D)

Any person who knowingly and willfully makes a false report pursuant to the provisions of this section or a report that the person knows lacks factual foundation may be reported to local law enforcement for criminal investigation and, upon conviction thereof, shall be guilty of a misdemeanor.

If a court determines that an accusation of child abuse or neglect made during a child custody proceeding is false and the person making the accusation knew it to be false at the time the accusation was made, the court may impose a fine, not to exceed $5,000 and reasonable attorney fees incurred in recovering the sanctions, against the person making the accusation. The remedy provided by this paragraph is in addition to the first paragraph above or to any other remedy provided by law.

Oregon

Current Through February 2019

Failure to Report
Citation: Rev. Stat. § 419B.010(3)

A person who violates the reporting laws commits a class A violation. Prosecution under this law shall be commenced at any time within 18 months after the commission of the offense.

False Reporting
Citation: Rev. Stat. § 419B.016

A person commits the offense of making a false report of child abuse if, with the intent to influence a custody, parenting time, visitation, or child support decision, the person:

- Makes a false report of child abuse to the Department of Human Services or a law enforcement agency, knowing that the report is false
- Makes a false report of child abuse to a public or private official knowing that the report is false and with the intent that the public or private official make a report of child abuse to the department or a law enforcement agency

Making a false report of child abuse is a class A violation.

Pennsylvania

Current Through February 2019

Failure to Report
Citation: Cons. Stat. Tit. 23, § 6319; Tit. 18, § 4958

A mandatory reporter who willfully fails to report as required commits a misdemeanor of the third degree for the first violation and a misdemeanor of the second degree for a second or subsequent violation.

A person commits an offense if:

- The person acts to obstruct, impede, impair, prevent, or interfere with making a child abuse report, conducting of an investigation, or prosecuting a child abuse case.
- The person intimidates or attempts to intimidate any reporter, victim, or witness to engage in any of the following actions:

» Refrain from making a report of suspected child abuse
» Refrain from providing or withholding information, documentation, testimony, or evidence to any person regarding a child abuse investigation or proceeding
» Give false or misleading information, documentation, testimony, or evidence regarding a child abuse investigation or proceeding

» Elude, evade, or ignore any request or legal process summoning the reporter, victim, or witness to appear to testify or supply evidence regarding a child abuse investigation or proceeding

» Fail to appear at or participate in a child abuse proceeding or meeting involving a child abuse investigation to which the reporter, victim, or witness has been legally summoned

A person commits an offense if the person harms another person by any unlawful act or engages in a course of conduct that threatens another person in retaliation for anything that the other person has lawfully done in the capacity of a reporter, witness, or victim of child abuse.

A violation of this section is a felony of the second degree if the person:

- Uses force, violence, deception, or threat upon the reporter, witness, or victim
- Offers pecuniary or other benefit to the reporter, witness, or victim
- Has a prior conviction for a violation of this section or a similar law

An offense not otherwise addressed above is a misdemeanor of the second degree.

False Reporting
Citation: Cons. Stat. Tit. 18, § 4906.1

A person commits a misdemeanor of the second degree if the person intentionally or knowingly makes a false report of child abuse under chapter 23 (relating to child protective services) or intentionally or knowingly induces a child to make a false claim of child abuse.

Puerto Rico

Current Through February 2019

Failure to Report
Citation: Ann. Laws Tit. 8, § 450a

Any person, official, or public or private institution with the obligation of furnishing information pursuant to the provisions of either

§ 444 or 446 and who voluntarily and deliberately fails to comply with that obligation, who fails to perform any other act required by this chapter, or deliberately prevents another person acting reasonably from doing so shall commit a misdemeanor and if convicted shall be sanctioned by a fine up to $5000 or by imprisonment up to 90 days.

False Reporting
Citation: Ann. Laws Tit. 8, § 450a

Any person, official, or public or private institution with the obligation of furnishing information pursuant to the provisions of either

§ 444 or 446 who deliberately furnishes false information or advises another person to do so shall commit a misdemeanor and if convicted shall be sanctioned by a fine up to $5000 or by imprisonment up to 90 days. Any information furnished that is found to be false and whose natural or probable consequence is deemed to have interfered in the legitimate

exercise of custody, parental rights, and patria potestas shall be referred by the competent authority to the Department of Justice for evaluation and the subsequent corresponding prosecution.

Rhode Island

Current Through February 2019

Failure to Report
Citation: Gen. Laws § 40-11-6.1

Any mandatory reporter who knowingly fails to report as required or who knowingly prevents any person acting reasonably from doing so shall be guilty of a misdemeanor and, upon conviction, shall be subject to a fine of not more than $500 or imprisonment for not more than 1 year or both.

In addition, any mandatory reporter who knowingly fails to perform any act required by the reporting laws or who knowingly prevents another person from performing a required act shall be civilly liable for the damages proximately caused by that failure.

False Reporting
Citation: Gen. Laws § 40-11-3.2

Any person who knowingly and willingly makes or causes a false report of child abuse or neglect to be made to the Department of Children, Youth and Families shall be guilty of a misdemeanor and, upon conviction thereof, shall be fined not more than $1,000 or imprisoned for not more than 1 year or both.

South Carolina

Current Through February 2019

Failure to Report
Citation: Ann. Code § 63-7-410

Any mandatory reporter or any person required to perform any other function under the reporting laws who knowingly fails to do so, or a person who threatens or attempts to intimidate a witness, is guilty of a misdemeanor and, upon conviction, must be fined not more than $500 or be imprisoned for not more than 6 months, or both.

False Reporting
Citation: Ann. Code §§ 63-7-430; 63-7-440

If the family court determines that a person has made a report of suspected child abuse or neglect maliciously or in bad faith, or if a person has been found guilty of making a false report pursuant to § 63-7-440, the Department of Social Services may bring a civil action to recover the costs of the department's investigation and proceedings associated with the investigation, including attorney's fees. The department also is entitled to recover

costs and attorney's fees incurred in the civil action authorized by this section. The decision of whether to bring a civil action is in the sole discretion of the department.

If the family court determines that a person has made a false report of suspected child abuse or neglect maliciously or in bad faith or if a person has been found guilty of making a false report, a person who was subject of the false report has a civil cause of action against the person who made the false report and is entitled to recover from the person who made the false report such relief as may be appropriate, including actual damages, punitive damages, a reasonable attorney's fee, and other litigation costs reasonably incurred.

It is unlawful to knowingly make a false report of abuse or neglect. A person who violates this section is guilty of a misdemeanor and, upon conviction, must be fined not more than $5,000 or imprisoned for not more than 90 days, or both.

South Dakota

Current Through February 2019

Failure to Report
Citation: Ann. Stat. §§ 26-8A-3; 26-8A-4; 26-8A-6; 26-8A-7

Any mandatory reporter who knowingly and intentionally fails to make the required report is guilty of a class 1 misdemeanor. This provision includes the following:

- Reports that must be made to the coroner when the reporter suspects that a child has died as a result of abuse or neglect
- Reports that are required of hospital staff
- Reports that are required of staff of public or private schools

False Reporting

This issue is not addressed in the statutes reviewed.

Tennessee

Current Through February 2019

Failure to Report
Citation: Ann. Code § 37-1-412

Any person who knowingly fails to make a report required by § 37-1-403 commits a class A misdemeanor.

A person believed to have violated this section shall be brought before the court. If the defendant pleads not guilty, the juvenile court judge shall bind the defendant over to the grand jury. If the defendant pleads guilty, the juvenile court judge shall sentence the defendant under this section with a fine not to exceed $2,500.

False Reporting
Citation: Ann. Code § 37-1-413

Any person who either verbally or by written or printed communication knowingly and maliciously reports or causes, encourages, aids, counsels, or procures another to report a false accusation of child sexual abuse, or false accusation that a child has sustained any wound, injury, disability, or physical or mental condition caused by brutality, abuse, or neglect, commits a class E felony.

Texas

Current Through February 2019

Failure to Report
Citation: Fam. Code § 261.109

A person commits an offense if the person is required to make a report under § 261.101 and knowingly fails to make a report as required.

A person who is a professional as defined by § 261.101 commits an offense if the person is required to make a report and knowingly fails to make a report as provided in this chapter.

An offense by a person is a class A misdemeanor, except that the offense is a State jail felony if it is shown on the trial of the offense that the child was a person with an intellectual disability who resided in a State-supported living center, the medical assistance program for persons with intellectual disabilities component of the Rio Grande State Center, or a facility licensed under chapter 252, Health and Safety Code, and the actor knew that the child had suffered serious bodily injury as a result of the abuse or neglect.

An offense by a professional is a class A misdemeanor, except that the offense is a State jail felony if it is shown on the trial of the offense that the actor intended to conceal the abuse or neglect.

False Reporting
Citation: Fam. Code § 261.107

A person commits an offense if, with the intent to deceive, he or she knowingly makes a report of child abuse or neglect that is false. An offense under this subsection is either of the following:

- A State jail felony
- A felony of the third degree if the person has previously been convicted under this section A person who is convicted of an offense under this section shall be subject to the following:
- Be required to pay any reasonable attorney's fees incurred by the person who was falsely accused of abuse or neglect
- Be liable to the State for a civil penalty of $1,000

Utah

Current Through February 2019

Failure to Report

Citation: Ann. Code § 62A-4a-411

Any person, official, or institution required to report a case of suspected child abuse, child sexual abuse, neglect, fetal alcohol syndrome, or fetal drug dependency who willfully fails to do so is guilty of a class B misdemeanor.

Action for failure to report must be commenced within 4 years from the date of knowledge of the offense and the willful failure to report.

False Reporting

This issue is not addressed in the statutes reviewed.

Vermont

Current Through February 2019

Failure to Report
Citation: Ann. Stat. Tit. 33, § 4913(d)(2); (f)

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

A person who violates the law requiring mandated reporters to report suspected child abuse or neglect shall be fined no more than $500.

A person who violates the reporting laws with the intent to conceal abuse or neglect of a child shall be imprisoned no more than 6 months or fined for no more than $1,000, or both.

False Reporting

This issue is not addressed in the statutes reviewed.

Virgin Islands

Current Through February 2019

Failure to Report
Citation: Ann. Code Tit. 5, § 2539

Any person, official, or institution required by this subchapter to report a case of alleged child abuse, sexual abuse, or neglect or to perform any other act, who knowingly fails to do so, shall be guilty of a misdemeanor and shall be fined no more than $500 or imprisoned for no more than 1 year, or both.

False Reporting
Citation: Ann. Code Tit. 14, §§ 2146(c); 2144(a)

A person is guilty of falsely reporting an incident in the second degree when, knowing the information reported, conveyed, or circulated to be false or baseless, he or she reports, by word or action, to the Department of Human Services or Department of Health an alleged occurrence of child abuse or maltreatment that did not, in fact, occur or exist. A person who is found guilty of reporting an incident in the second degree shall be fined $5,000 and be imprisoned for no less than 5 years.

Virginia

Current Through February 2019

Failure to Report
Citation: Ann. Code § 63.2-1509(D)-(E)

Any person required to file a report pursuant to this section who fails to do so as soon as possible, but no longer than 24 hours after having reason to suspect a reportable offense of child abuse or neglect, shall be fined no more than $500 for the first failure and, for any subsequent failures, no less than $1,000. In cases evidencing acts of rape, sodomy, or object sexual penetration, as defined in § 18.2-61, et seq., a person who knowingly and intentionally fails to make the report required pursuant to this section shall be guilty of a class 1 misdemeanor.

No person shall be required to make a report pursuant to this section if the person has actual knowledge that the same matter has already been reported to the local department or the toll-free child abuse and neglect hotline of the Department of Social Services.

False Reporting
Citation: Ann. Code § 63.2-1513(A)

Any person age 14 or older who makes or causes to be made a report of child abuse or neglect that he or she knows to be false shall be guilty of a class 1 misdemeanor.

Any person age 14 or older who has been previously convicted under this subsection and who is subsequently convicted of making a false report of child abuse or neglect shall be guilty of a class 6 felony.

Washington

Current Through February 2019

Failure to Report
Citation: Rev. Code §§ 26.44.080; 9A.20.021

Every person who is required to make a report pursuant to the reporting laws and who knowingly fails to make such a report shall be guilty of a gross misdemeanor.

Every person convicted of a gross misdemeanor shall be punished by imprisonment in the county jail for up to 364 days or a fine of no more than $5,000, or both.

This section applies to only those crimes committed on or after July 1, 1984. The fines in this section apply to adult offenders only.

False Reporting
Citation: Rev. Code §§ 26.44.060(4); 9A.20.021

A person who intentionally and in bad faith knowingly makes a false report of alleged abuse or neglect shall be guilty of a misdemeanor.

Every person convicted of a misdemeanor shall be punished by imprisonment in the county jail for no more than 90 days or a fine of no more than $1,000, or both.

This section applies to only those crimes committed on or after July 1, 1984. The fines in this section apply to adult offenders only.

West Virginia

Current Through February 2019

Failure to Report
Citation: Ann. Code § 49-2-812

Any person, official, or institution required by this article to report a case involving a child known or suspected to be abused or neglected who knowingly fails to do so or knowingly prevents another person acting reasonably from doing so, is guilty of a misdemeanor and, upon conviction, shall be confined in jail not more than 90 days or fined not more than $5,000, or both fined and confined.

Any person, official, or institution required by this article to report a case involving a child known or suspected to be sexually assaulted or sexually abused, or a student known or suspected to have been a victim of any nonconsensual sexual contact, sexual intercourse, or sexual intrusion on school premises, who knowingly fails to do so or knowingly prevents another person acting reasonably from doing so is guilty of a misdemeanor and, upon conviction thereof, shall be confined in jail not more than 6 months or fined not more than $10,000, or both.

False Reporting

This issue is not addressed in the statutes reviewed.

Wisconsin

Current Through February 2019

Failure to Report
Citation: Ann. Stat. § 48.981(6)

Whoever intentionally violates the reporting laws by failure to report as required may be fined no more than $1,000 or imprisoned for no more than 6 months, or both.

False Reporting

This issue is not addressed in the statutes reviewed.

Wyoming

Current Through February 2019

Failure to Report
Citation: Ann. Stat. § 14-3-205

Any employer, public or private, who discharges, suspends, disciplines, or penalizes an employee solely for making a report of neglect or abuse is guilty of a misdemeanor punishable by imprisonment for no more than 6 months or a fine of no more than $750, or both.

False Reporting
Citation: Ann. Stat. § 14-3-205(d)

Any person who knowingly and intentionally makes a false report of child abuse or neglect, or who encourages or coerces another person to make a false report, is guilty of a misdemeanor that is punishable by imprisonment for no more than 6 months or a fine of no more than $750, or both.

Chapter 7 - Preventing Child Abuse and Neglect

Chapter 7 is sourced from the Child Welfare Information Gateway. (2018). Preventing child abuse and neglect. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

Despite the statistics, child abuse and neglect are preventable. State and local governments, community organizations, and private citizens *can* take action every day to protect children. You can help, too.

Research shows that parents and caregivers who have support—from family, friends, neighbors, and their communities—are more likely to provide safe and healthy homes for their children. When parents lack this support or feel isolated, they may be more likely to make poor decisions that can lead to neglect or abuse.
Increasingly, concerned citizens and organizations are realizing that the best way to prevent child maltreatment is to help parents develop the skills and identify the resources they need to understand and meet their children's emotional, physical, and developmental needs and protect their children from harm.

This [chapter] provides information on how communities, community leaders, and individual citizens can strengthen families, protect children, and prevent child abuse and neglect.

A. Protective Factors

Protective factors are assets in families and communities that increase the health and well-being of children and families. Protective factors help parents who might be at greater risk of abusing or neglecting their children to use resources, supports, or coping strategies that allow them to parent effectively, even under stress. Focusing on family strengths allows parents to build resilience, develop parental skills, and gain knowledge of resources that can decrease exposure to risks.

The following six protective factors can lower the risk of child abuse and neglect:

☐**Nurturing and attachment**. When parents and children feel compassion and warmth for each other, parents are better able to provide positive parenting, as well as support the healthy physical, social, and emotional development of their children. (https://www.childwelfare.gov/topics/preventing/promoting/protectfactors/nurture-attach/)

☐**Knowledge of parenting and of child and youth development**. Parents who understand developmental milestones and how children grow can provide an environment where children can live up to their potential. (https://www.childwelfare.gov/topics/preventing/promoting/protectfactors/knowledge/

☐**Parental resilience.** Parents who are emotionally resilient have a positive attitude, are creative problem solvers, effectively address challenges, and less often direct anger and frustration toward their children. (https://www.childwelfare.gov/topics/preventing/promoting/protectfactors/resilience/)

☐**Social connections.** Trusted and caring family friends provide emotional support to parents by offering them encouragement and assistance as they face the daily challenges of raising a family. (https://www.childwelfare.gov/topics/preventing/promoting/protectfactors/ social-connect/)

☐**Concrete supports for parents.** Parents who can provide basic resources, such as food, clothing, housing, transportation, and access to essential services like child care and physical and mental health care, are better able to ensure the health and well- being of their children. (https://www.childwelfare.gov/topics/preventing/promoting/protectfactors/concrete-supports/)

☐**Social and emotional competence of children**. Parents who instill in their children the ability to positively interact with others, control their behaviors, and communicate their feelings are more likely to raise children who have positive relationships with family, friends, and peers. Children without these skills may be at greater risk for abuse. (https://www.childwelfare.gov/topics/preventing/promoting/protectfactors/competence/)

The Prevention Resource Guide, produced as part of the Children's Bureau's National Child Abuse Prevention Month efforts, supports service providers in their work with parents, caregivers, and children to strengthen families and prevent child abuse and neglect. While this resource is aimed at child welfare professionals, service providers, and community partners, its helpful tip sheets for parents and caregivers address a number of parenting issues.

The guide and tip sheets are available on Child Welfare Information Gateway's website at https://www.childwelfare.gov/topics/preventing/preventionmonth/resources/resource-guide.

For more about protective factors, visit Information Gateway's Protective Factors Framework webpage at https://www.childwelfare.gov/topics/preventing/promoting/protectfactors/protective-factors.

B. Community-Based Primary Prevention Programs and Services

To effectively stop child abuse and neglect before it occurs, communities need to be engaged in efforts to address family needs, and families need to be able to access supports and resources where they live, work, and worship—leveraging relationships already in place. The following are examples of community-based primary prevention programs, including two Community-Based Child Abuse Prevention (CBCAP) programs funded by the Children's Bureau—Bring Up Nebraska and Hope Center for Children—that focus on strengthening families.

Bring Up Nebraska: Connects diverse individuals and organizations and State and local strategies to enhance collaboration to help communities coordinate resources to improve child and family well-being. (http://www.bringupnebraska.org/)

Hope Center for Children: Provides a holistic continuum of care to meet the immediate and long-term needs of children and families through individualized support and empowerment. (http://www.hopecfc.org/about.php)

Live Well San Diego: Brings together individuals, community organizations, and government to improve the health of families and cultivate opportunities for communities to grow. (http://www.livewellsd.org/)

Harlem Children's Zone: Provides families in the community with support and services in a safe place where they can learn, play, and become more stable. (https://hcz.org/)

Center for Family Life: Partners with community-based family organizations to provide access to resources and opportunities that strengthen families. (http://sco.org/programs/center-for-family-life/about/)

a. National Prevention Efforts

Through its CBCAP grants, the Children's Bureau funds 50 State lead agencies (SLAs); Washington, DC; Puerto Rico; and three set-aside Tribal and migrant organizations. The 50 SLAs; Washington, DC; and Puerto Rico use a majority of their grant funds to support community organizations in the provision of services to families and communities. You can learn more about CBCAP, including its funding and approach to prevention, at https://friendsnrc.org/prevention.

The FRIENDS National Center for CBCAP is a service of the Children's Bureau that provides training and technical assistance to SLAs and set-aside grantees. Prevention resources developed by FRIENDS are available through its website. FRIENDS also has an Online Learning Center that offers free trainings available to anyone, with courses ranging from CBCAP 101 to Protective Factors and Implementation Science. To take a course (free registration required), visit the FRIENDS Online Learning Center at https://friendsnrcelearning.remote-learner.net/.

State children's trust and prevention funds distribute more than $100 million in funding each year to support evidence-based and innovative statewide and community-based prevention strategies. You can find your local children's trust and prevention fund on the website of the National Alliance of Children's Trust and Prevention Funds (the Alliance) at https://ctfalliance.org/. The Alliance supports these State prevention strategies with training, technical assistance, and resources, most of which are available on the Alliance website.

Prevent Child Abuse America's 50 chapters nationwide sponsor a number of evidence-based, State-specific programs designed to prevent child maltreatment. Community members and individuals can make a difference
through mentoring, becoming an advocate, and other forms of outreach. Use Prevent Child Abuse America's map to find your State's chapter and website at http://preventchildabuse.org/get-involved.

Stop It Now! is a national organization focused on preventing sexual abuse that offers information, support, and resources for prevention. Some of its materials aimed at parents and community members include tip sheets on prevention and warning signs of abuse. The Help and Guidance section offers resources on how to speak up about your concerns and take the next steps. Learn more at http://www.stopitnow.org/help-guidance.

b. Parent Leadership and Engagement

Prevention is most effective when parents are engaged in all aspects of programs, services, implementation, and evaluation. If parents feel isolated, they may make poor decisions that can lead to abuse or neglect. When parents and caregivers are supported by families, friends, neighbors, and communities, they are less likely to experience stress from routine parenting duties and are able to focus more easily on providing safe and healthy homes for their children.

C. How You Can Help

Parenting is one of the toughest and most important jobs. Individuals and communities play a role in helping families to raise safe, healthy, and productive children and in promoting healthy relationships

a. Individual Actions

☐**Learn how to recognize signs of child abuse and neglect.** The first step in helping children who have been abused or neglected is learning to recognize the signs of child abuse and neglect. For more information, see
Information Gateway's factsheet, What Is Child Abuse and Neglect? Recognizing the Signs and Symptoms, at https://www.childwelfare.gov/pubs/ factsheets/whatiscan.

☐**Report your concerns**. If you suspect a child is being abused or neglected, reporting your concerns may protect that child and get help for a
family who needs it. For more information on reporting, visit https://www.childwelfare.gov/organizations/?CWIGFunctionsaction=rols:main.dspList&rolType=Custom&RS_ID=%205.

☐**Help a family under stress**. Offer to babysit, help with chores and errands, or suggest resources in the community. Consider some simple ways to help a neighbor at https://familyreviewguide.com/5-simple-
ways-to-help-your-neighbor. You may visit http://www.211.org or dial 2-1-1 to learn about community organizations and programs that support parents and families in your area.

☐**Be an active community member**. Lend a hand at local schools, community- or faith-based organizations, children's hospitals, social services agencies, or other places where families and children are supported. Learn how you (and your children) can get involved at https://kidshealth.org/en/parents/volunteer.html.

☐**Keep your neighborhood safe.** Start a Neighborhood Watch or plan a local "National Night Out" policing-awareness community event. You will get to know your neighbors while helping to keep your neighborhood and
children safe. Learn how to start a neighborhood watch at https://www.nnw.org/register-watch.

Circle of Parents® provides a friendly, supportive environment led by parents and other caregivers where anyone in a parenting role can openly discuss the successes and challenges of raising children. You can find more information about Circle of Parents® at http://circleofparents.org.

The FRIENDS National Center for CBCAP website offers education and support programs designed to give parents the tools they need to become more confident and build relationships with other parents. Resources are available at https://friendsnrc.org/parent-leadership.

b. Community Organization Actions

☐**Engage communities.** Promote community engagement to show support for families in your community. Access resources on engaging communities to support children and families by visiting Information Gateway's Engaging Communities to Support Families webpage at https://www.childwelfare.gov/topics/famcentered/communities.

☐**Spark conversations with potential community partners.** Watch “Building Community, Building Hope,” a film series produced by the National Child Abuse and Neglect Technical Assistance and Strategic Dissemination Center, a service of the Children’s Bureau, to learn how to form partnerships to ensure the safety and well-being of children and families.

Access the series, which comes with discussion toolkits and other resources, at https://cantasd.acf.hhs.gov/ bcbh.

c. Healthy Relationship Resources for Individuals and Communities

Safe, stable, and nurturing relationships are paramount to healthy child development and in preventing child maltreatment. Essentials for Childhood: Steps to Create Safe, Stable, and Nurturing Relationships, a guide from the National Center for Injury Prevention, Division of Violence Prevention, within the Centers for Disease Control and Prevention, aims to help concerned individuals and communities promote these healthy relationships. The guide is available at https://www.cdc.gov/violenceprevention/childmaltreatment/essentials.html.

Conclusion

True prevention of child abuse and neglect requires a full-scale, all-hands-on-deck commitment from every facet of the community. Individuals, neighborhood groups, and local organizations must work together to know the signs of abuse and neglect and raise awareness of protective factors that strengthen families and mitigate the effects of maltreatment. Everyone has a role to play, and every role is important.

Citation

The preceding chapter was taken from the Child Welfare Information Gateway. (2018). Preventing child abuse and neglect. Washington, DC: U.S. Department of Health and Human Services, Children’s Bureau.

Chapter 8 – Domestic Violence and the Child Welfare System

Chapter 8 is from the Child Welfare Information Gateway. Available online at https://www.childwelfare.gov/pubs/factsheets/domestic_violence/

Domestic violence is a devastating social problem that affects every segment of the population. It is critical for child welfare professionals and other providers who work with children who have experienced abuse to understand the relationship between domestic violence and child maltreatment, as many families experiencing domestic violence also come to the attention of the child welfare system.

Increasingly, child welfare professionals, domestic violence victim advocates, courts, and other community stakeholders are working together to address the impact of domestic violence on children. This [chapter] discusses the extent of the overlap between domestic violence and child welfare, some of the effects of domestic violence on child witnesses, and the trend toward a more collaborative, communitywide response to the issue. It also features promising practices from States and local communities.

A. Definitions

Domestic Violence:

The Women's Resource and Rape Assistance Program defines domestic violence (http://www.wraptn.org/domestic-violence.html) as:

"A pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner. Domestic violence can be physical, sexual, emotional, economic, or psychological actions or threats of actions that influence another person. This includes any behaviors that intimidate, manipulate, humiliate, isolate, frighten, terrorize, coerce, threaten, blame, hurt, injure, or wound someone. Domestic violence can happen to anyone regardless of race, age, sexual orientation, religion, or gender. Domestic violence affects people of all socioeconomic backgrounds and education levels. Domestic violence occurs in both opposite-sex and same-sex relationships and can happen to intimate partners who are married, living together, or dating.

Domestic violence not only affects those who are abused but also has a substantial effect on family members, friends, coworkers, other witnesses, and the community at large. Children who grow up witnessing domestic violence are among those seriously affected by this crime. Frequent exposure to violence in the home not only predisposes children to numerous social and physical problems, but also teaches them that violence is a normal way of life—therefore, increasing their risk of becoming society's next generation of victims and abusers."

Intimate Partner Violence:

The U.S. Centers for Disease Control and Prevention (CDC) defines intimate partner violence (IPV) (http://www.cdc.gov/violenceprevention/intimatepartnerviolence/definitions.html) as "physical, sexual, or psychological harm by a current or former partner or spouse. This type of violence can occur among heterosexual or same-sex couples and does not require sexual intimacy. IPV can vary in frequency and severity. It occurs on a continuum, ranging from one hit that may or may not impact the victim to chronic, severe battering."

Family Violence

The National Council of Juvenile and Family Court Judges' (NCJFCJ's) model code for family violence (http://www.ncjfcj.org/sites/default/files/modecode_fin_printable.pdf) defines family violence as "the occurrence of one or more of the following acts by a family or household member, but does not include acts of self-defense:

(a) Attempting to cause or causing physical harm to another family or household member;
(b) Placing a family or household member in fear of physical harm; or
(c) Causing a family or household member to engage involuntarily in sexual activity by force, threat of force, or duress.

'Family or household members' include:
(a) Adults or minors who are current or former spouses;
(b) Adults or minors who live together or who have lived together;
(c) Adults or minors who are dating or who have dated;
(d) Adults or minors who are engaged in or who have engaged in a sexual relationship;
(e) Adults or minors who are related by blood or adoption;
(f) Adults or minors who are related or formerly related by marriage;
(g) Persons who have a child in common; and
(h) Minor children of a person in a relationship that is described in paragraphs (a) through (g)."

B. Scope of the Problem

Estimates of the number of children who have been exposed to domestic violence each year vary. Research suggests that nearly 30 million children in the United States will be exposed to some type of family violence before the age of 17, and there is a 30 to 60 percent overlap of child maltreatment and domestic violence (Hamby, Finkelhor, Turner, & Ormrod, 2011; Taggart, 2011). The most comprehensive data collected on this issue were gathered by the National Survey of Children's Exposure to Violence (NATSCEV), sponsored by the Office of Juvenile Justice and Delinquency Prevention (OJJDP) and the CDC. Researchers surveyed 4,549 children and youth ages 17 and younger between January and May 2008. Findings show that more than 11 percent of children and youth were exposed to some form of family violence within the past year, and 26 percent were exposed to at least one form of family violence during their lifetimes. Extrapolating these findings to the general population yields an estimate of more than 8 million children and youth who were exposed to family violence in the past year and more than 18 million exposed to family violence during their lifetime (Hamby et al., 2011).

Large numbers of children come in contact with domestic violence service providers each year. Every year, the National Network to End Domestic Violence (NNEDV) conducts a 1-day, unduplicated count of adults and children seeking domestic violence services in the United States. On September 12, 2012, the NNEDV census found that "18,968 children and 16,355 adults found safety in emergency shelters and transitional housing, while 5,815 children and 23,186 adults received advocacy and support through nonresidential services" (National Network to End Domestic Violence, 2013).

Exposure to both domestic violence and child maltreatment can have immediate and, often, long-term impact on children and youth.

Impact of Domestic Violence on Children

Children who have been exposed to domestic violence are more likely than their peers to experience a wide range of difficulties, and the potential effects vary by age and developmental stage. The challenges faced by children and youth exposed to domestic violence generally fall into three
categories:

- **Behavioral, social, and emotional problems**. Children in families experiencing domestic violence are more likely than other children to exhibit signs of depression and anxiety; higher levels of anger and/or
disobedience; fear and withdrawal; poor peer, sibling, and social relationships; and low self-esteem (National Child Traumatic Stress Network, n.d.).

- **Cognitive and attitudinal problems**. Children exposed to domestic violence are more likely than their peers to experience difficulties in school and with concentration and task completion; score lower on assessments of verbal, motor, and cognitive skills; lack conflict resolution skills; and
possess limited problem- solving skills. Children exposed to domestic violence also are more likely to exhibit pro-violence attitudes (National Child Traumatic Stress Network, n.d.).

- **Long-term problems**. In addition to higher rates of delinquency and substance use, exposure to domestic violence is also one of several adverse childhood experiences (ACEs) that have been shown be risk factors for many of the most common causes of death in the United States, including alcohol abuse, drug abuse, smoking, obesity, and more. (For more information, visit the Adverse Childhood Experiences (ACE) Study website at http://www.acestudy.org.)

Additional factors that influence the impact of domestic violence on children include:

- **Nature of the violence.** Children who witness frequent and severe forms of violence or fail to observe their caretakers resolving conflict may undergo more distress than children who witness fewer incidences of physical violence and experience positive interactions between their caregivers.

- **Age of the child.** Younger children appear to exhibit higher levels of emotional and psychological distress than older children. Children ages 5 and younger may experience developmental regression—the loss of acquired skills—or disruptions in eating or sleeping habits. Adolescents may exhibit impulsive and/or reckless behavior, such as substance use or running away (National Child Traumatic Stress Network, n.d.). Age-related differences can result from older children's more fully developed cognitive abilities, which help them to better understand the violence and select various coping strategies to alleviate upsetting symptoms. Additionally,

because very young children are more likely to have closer physical proximity to and stronger emotional dependence on their mothers (often the victims of domestic violence), they may be more susceptible to and exhibit enhanced trauma symptoms (Levendosky, Bogat, & Martinez-Torteya,
2013).

☐**Elapsed time since exposure.** Children often have heightened levels of anxiety and fear immediately after a violent event. Fewer observable effects are seen in children as time passes after the violent event.
Domestic Violence and the Child Welfare System

☐**Gender.** In general, boys exhibit more externalized behaviors (e.g., aggression and acting out), while girls exhibit more internalized behaviors (e.g., withdrawal and depression) (Moylan et al., 2010).

☐**Presence of child physical or sexual abuse.** Children who witness domestic violence and are physically or sexually abused are at higher risk for emotional and psychological maladjustment than children who witness violence and are not abused (Moylanet al., 2010).

Despite these findings, not all children exposed to domestic violence will experience negative effects. Children's risk levels and reactions to domestic violence exist on a continuum; some children demonstrate enormous resiliency, while others show signs of significant maladaptive adjustment. Protective factors such as social competence, intelligence, high self-esteem, and a supportive relationship with an adult (especially a nonabusive parent) can help protect children from the adverse effects of exposure to domestic violence (Martinez-Torteya, Bogat, von Eye, & Levendosky, 2009).

It's important for domestic violence, child welfare, and other child-serving professionals to understand the impact of trauma on child development
and how to minimize its effects without causing additional trauma.

Child Welfare Information Gateway's issue brief Protective Factors Approaches in Child Welfare provides an overview of protective factors approaches to the prevention and treatment of child abuse and neglect
at https://www.childwelfare.gov/pubs/issue_briefs/protective_factors.
cfm.

Resources on Building Resiliency

Promising Futures Without Violence, a national technical assistance provider for the U.S. Family and Youth Services Bureau (FYSB), produced an infographic depicting the relationship among individual, family, and community protective factors—circumstances in families and communities that increase the health and well-being of children and families—that can
help children heal and build resiliency:
http://promising.futureswithoutviolence.org/files/2014/01/Promising-Futures-Infographic-FINAL.jpg.

The Safe Start Center offers a series of trauma-informed care tip sheets for a variety of audiences, including tips for professionals working in domestic violence shelters, tips for child welfare professionals, tips for staff working with and engaging fathers, and more: http://web.safestartcenter.org/resources/tip-sheets.php.

Responding to Domestic Violence

Often families impacted by domestic violence may be involved with child welfare and child-serving community agencies. It is important to work with State domestic violence coalitions and local domestic violence programs to ensure an understanding of the dynamics of domestic violence, how abusive parents affect children, and how to support the safety of both children and nonabusive parents.

Promising practices for building and sustaining community partnerships include:

☐Building and sustaining relationships and partnerships with employees of other agencies and systems that affect family safety

☐Establishing a shared vision for practice based on safety for all family members

☐Understanding various perspectives and work processes and acknowledging the experience and skills of staffs in other agencies

☐Developing joint protocols and policies to guide Practice

Investing in meaningful training and technical assistance partnerships is critical to supporting victims of domestic violence and their children. Domestic violence coalitions, local domestic violence shelter programs, Tribal domestic violence programs, and culturally specific community-based organizations are all an integral part of any coordinated health care and social service response to domestic violence.
Each State, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, and American Samoa have a Domestic Violence Coalition. These coalitions are connected to more than 2,000 local domestic violence programs receiving funding from FYSB's Family Violence Prevention and Services Program (FVPSA). The domestic violence coalition working with programs in your community can be found at http://www.vawnet.org/links/state-coalitions. php.

Additional information about FVPSA domestic violence coalitions can be found at http://www.acf.hhs.gov/programs/fysb/resource/dvcoalitions.

Addressing the issue of domestic violence requires a communitywide response. While there are some challenges to responding to this serious social problem, the emergence of trauma-informed care and differential response are fostering cross-system collaboration to protect children and strengthen families.

Challenges

Although adult and child victims often are found in the same families, child welfare and domestic violence programs have traditionally responded separately to victims. This focus on the safety and protection of only one victim can lead to unintended consequences. For example, removing children from their homes and placing them in out-of-home care can cause additional trauma.

Individual therapies focused on parents may not help rebuild family relationships or strengthen protective factors, to prevent future violence or abuse. In recent years, however, enhanced collaboration among child- and family-serving organizations and domestic violence programs has led to more comprehensive services to better meet the needs of both children and adults affected by domestic violence.

One example of enhanced collaboration efforts is the groundbreaking Greenbook Initiative, which was composed of six demonstration sites working on issues related to the intersection of domestic violence and child maltreatment. The projects implemented guidelines and policies outlined in the 1999 publication Domestic Violence and Child Maltreatment Cases: Guidelines for Policy and Practice (the Greenbook). The demonstration sties were funded from 2000 to 2007, and many service providers, agencies, and the courts continue to implement guidelines put forth by the Greenbook. For more information, visit http://thegreenbook.info.

A training module on the Greenbook Initiative is available on the website of the Center for Advanced Studies in Child Welfare: https://umconnect.umn.edu/p24584437/.

Still, challenges in responding to the issue of domestic violence and child maltreatment continue. Domestic violence is not always reported to authorities or identified by caseworkers. Of the data gathered through NATSCEV, authorities knew about approximately one- half (49 percent) of the incidents of children witnessing domestic violence (Finkelhor, Ormrod, Turner, & Hamby, 2012). While a majority of children with reports of abuse or neglect remain at home after an investigation, they may remain in a home where they experience domestic violence. The National Survey of Child and Adolescent Well-Being II found that one-quarter of the caregivers for children with reports of maltreatment—and who remained in the home following investigation—indicated having experienced domestic violence within the previous 12 months. Caseworkers for those families identified active domestic violence in 1 out of 10, highlighting the possibility that domestic violence is underidentified in some child welfare cases (Casanueva, Ringeisen, Smith, & Dolan, 2013).

A Trauma-Informed Approach

Trauma-informed practice—the services and programs specifically designed to address and respond to the impact of traumatic stress—help children and families build resiliency and prevent further trauma. The importance of this approach has become especially evident in child welfare, since the majority of children and families involved with child welfare have experienced some form of past trauma (Wilson, 2013). A trauma- informed approach means that all service providers share values and goals, focus on promoting healing and preventing further trauma, and work to identify and eliminate the abuse or violence that caused the trauma (VAWnet.org, 2013).

One helpful resource has been made available by the Children's Bureau's National Resource Center for Child Protective Services (NRC CPS), which sponsored a webinar series focused on domestic violence and child protection. Audio recordings, presentation slides, and handouts from the series, titled "Safety Organized, Trauma-Informed, Solution-Focused Approaches to Domestic Violence in Child Protection," are available on the NRC website at http://nrccps.org/special-initiatives/domestic-violence/ nrccps-webinar-domestic-violence-and-child-protective- services-summer-series/.

The National Center on Domestic Violence, Trauma and Mental Health (NCDVTMH) offers the Creating Trauma- Informed Services: Tipsheet Series, which includes Tips for Supporting Children and Youth Exposed to Domestic Violence: What You Might See and What You Can Do. This tip sheet for child advocates outlines ways to support children who have been exposed to violence at home and tips for supporting parents as they help their children heal from trauma. Divided by age group—infants, toddlers, preschoolers; school-age children; and adolescents—the tip sheet lists signs and symptoms of violence exposure and corresponding tips for offering support. Find it at http://www.nationalcenterdvtraumamh.org/wp-content/ uploads/2012/05/Tipsheet_Children-Exposed_NCDVTMH_May2012.pdf.

NCDVTMH also offers a trauma-informed approach framework for domestic violence victim advocacy. Find links to all three parts at http://www.nationalcenterdvtraumamh.org/2013/04/announcing-the-trauma-informed-domestic-violence-services-special-collection/.

Integrating Differential Response Into Domestic Violence Intervention

Some experts in the field assert that families and their children who show minimal evidence of harm resulting from exposure to domestic violence, and who have other protective factors present in their lives, may benefit more from voluntary services in the community. An emerging child welfare practice—differential response—reflects this approach. Differential response (DR), also called alternative response, multiple response, or dual track, allows for more than one method of initial response from child protective services (CPS) to reports of abuse or neglect. DR child welfare practices emphasize a broad assessment of a family's situation and a determination of whether the family can be helped while maintaining the children in the home using both child welfare services as well as services and supports outside of the child welfare system and dependency courts.

Initially, child welfare systems included only two DR tracks or responses. Over time, however, some States (e.g., Hawaii, Minnesota, and Tennessee) recognized the value of additional tracks, and Olmsted County, MN, includes a specialized noninvestigative pathway for families dealing with domestic violence.

Depending on legislation or agency policies, eligibility criteria for an alternative response vary by State or even by jurisdiction within a State. Once CPS receives a report of child maltreatment, determining whether a family is eligible for a noninvestigative response is generally based on immediate safety concerns and risk for the children, the type of maltreatment, previous reports, age of the child or children, and caregiver factors. Based on those factors, CPS decides whether to initiate a standard investigation or move forward with a noninvestigative assessment response.

For more information on alternative or differential response in child welfare, read Child Welfare Information Gateway's issue brief Differential Response to Reports of Child Abuse and Neglect at https://www.childwelfare.gov/pubs/issue_briefs/differential_response/.

Or, visit Information Gateway's web section Differential Response in Child Protective Services at https://www.childwelfare.gov/responding/alternative/.

Collaborative Approaches

Despite their differences, child welfare advocates and domestic violence service providers share significant goals that can help bridge the gap between them. These include:

☐Ending violence against adults and children

☐Ensuring children's safety

☐Protecting adult victims so their children are not harmed by violence

☐Promoting parents' strengths

☐Deferring CPS intervention—as long as child safety is preserved—and referring adult and child victims to community-based services

The National Resource Center for Permanency and Family Connections, formerly the National Resource Center for Family-Centered Practice and Permanency Planning (Toussaint, 2006), suggests the following policies to align efforts of child abuse and domestic violence practitioners:

☐Identify and assess domestic violence in all child welfare cases

☐Provide services to families where domestic violence has been identified (even if child abuse has not been substantiated), including helping abused women protect themselves and their children using noncoercive, supportive, and empowering interventions whenever possible

☐Hold perpetrators of domestic violence accountable for stopping the violent behavior in order to protect children

To help judges hold perpetrators accountable, the NCJFCJ developed the *Checklist to Promote Perpetrator Accountability in Dependency Cases Involving Domestic Violence*, available at http://www.ncjfcj.org/sites/default/files/checklist-to-promote-accountability_0.pdf.

In recent years, increased awareness of the co-occurrence of domestic violence and child abuse has compelled both child welfare systems and domestic violence programs to reevaluate their interventions with families experiencing both forms of violence. Many professionals now acknowledge that communities can serve families better by allocating resources to build partnerships among domestic violence service providers, child protective service providers, and an array of informal and formal systems within the community. National, State, and local initiatives are demonstrating that a collective ownership and intolerance for abuse against adults and children alike can form the foundation of a coordinated and comprehensive approach to ending child abuse and domestic violence. Additionally, the 2010 reauthorization of the Child Abuse Prevention and Treatment Act authorized grants to develop or expand effective collaborations between child protective service and domestic violence service entities.

Institutional and societal changes can begin to eliminate domestic violence only when service providers integrate their expertise, resources, and services into an expansive network. New practices are enhancing cross-system understanding and interactions between agencies and communities. New
protocols are institutionalizing change and ensuring that child welfare workers and domestic violence advocates benefit from the lessons learned by their predecessors and colleagues.

A collaborative approach to working with families that experience the co-occurrence of domestic violence and child maltreatment has a number of potential benefits: families receive more comprehensive and coordinated services, while avoiding redundant interviews and program requirements;
agencies can effectively identify and provide appropriate services; and caseworkers can minimize blaming of the adult victim, hold batterers accountable, and advocate on behalf of all family members (Banks, Dutch, & Wang, 2008). To improve collaboration within and among systems and to engage new community partners in keeping families safe, organizations must have certain strategies. While some of these are described in more detail later in this bulletin, examples of strategies to improve collaboration include:

☐Collaborative learning and practice as a prelude to new Policies

☐New strategies to address issues of race, culture, and gender

☐Greater participation by survivor mothers and children

☐Greater investment in community

☐Differential responses for families based on risk

☐Therapeutic and other services and supports for mothers and children

☐Greater accountability for men who batter and greater attention to the roles they continue to play as fathers and providers

☐Broad, meaningful engagement of men as allies in protecting children (Rosewater & Goodmark, 2007)

The National Online Resource Center on Violence Against Women offers a list of contact information for all domestic and sexual violence coalitions across the country at http://www.vawnet.org/links/state-coalitions.php.

FYSB's Family Violence Prevention and Services Program (FVPSA) funds a network of culturally specific resource centers that work to address the impact of domestic violence and provide culturally specific programming and culturally relevant responses for the African-American, Asian and Pacific Islander, and Hispanic and Latina communities. More information on FVPSA services and programs is available on its website at http://www.acf.hhs.gov/programs/fysb/programs/family-violence-prevention-services.

The Asian and Pacific Islander Institute on Domestic Violence produced a publication that aims to share the voices of immigrant, refugee, and indigenous women who are survivors of intimate partner violence and who have been involved with child protective services. By gathering and sharing the experiences of these women, the project hoped the information would help with the development of policies, practices, and interventions that more effectively address the issue of family violence. Battered Mothers Involved With Child Protective Services: Learning from Immigrant, Refugee and Indigenous Women's Experiences is available here: http://www.apiidv.org/files/Battered.Mothers.Involved.With.CPS-Report-APIIDV-2003(Rev.2010).pdf.

Responding Early: Teens and Dating Violence

Children and youth learn about healthy relationships by watching and modeling the relationships they witness. Children who are exposed to domestic violence may later repeat the abuse they see, thinking that it is a normal part of relationships. This can be especially concerning with young adults forging their first romantic relationships. Child welfare professionals, domestic violence victim advocates, and related professionals can work together to help youth understand that healthy relationships are nonviolent
relationships, and they can help young people who have experienced dating violence develop resilience and heal.

In addition to a web section on teen dating violence (http://www.cdc.gov/violenceprevention/intimatepartnerviolence/teen_dating_violence.html), the CDC offers a 1-hour training for youth-serving organizations to help young people understand the risk factors of dating violence. *Dating Matters: Understanding Teen Dating Violence Prevention* is available on the CDC website at http://vetoviolence.cdc.gov/datingmatters/.

Other resources with information and materials on teen dating
violence include the following:

☐Child Welfare Information Gateway's web section on teen dating violence prevention that offers links to prevention programs and other materials on the subject:
https://www.childwelfare.gov/systemwide/domviolence/prevention/teen_dating.cfm

☐The National Online Resource Center on Violence Against Women's resource collection on collaborative and multilevel approaches to the prevention of and response to teen dating violence: http://www.vawnet. org/special-collections/TDV.php

☐The National Center for Victims of Crime's bulletins for teens that define teen dating violence and the signs and symptoms of abuse, in addition toproviding information on getting help: http://www.victimsofcrime.org/help-for-crime-victims/get- help-bulletins-for-crime-victims/bulletins-for-teens/ dating-violence

☐Break the Cycle: Empowering Youth to End Domestic Violence, which provides comprehensive dating abuse prevention programs exclusively to young people, including tools for action, training, and a Dating Violence 101
section: http://www.breakthecycle.org/

Promising Practices

The following are examples of strategies used to support more effective collaboration between domestic violence services and child welfare systems.

In 2012, The National Resource Center on Domestic Violence,
along with the U.S. Department of Health and Human Services' Administration for Children and FYSB, published Enhanced Services to Children and Youth Exposed to Domestic Violence: Promising Practices and Lessons Learned. The guide outlines promising practices and lessons learned from nine demonstration projects funded between 2005 and 2008 through FVPSA: http://www.vawnet.org/Assoc_Files_VAWnet/ESCY-PPLLGuide. pdf.

For specific information about addressing the co-occurrence of domestic violence and child maltreatment in State Program Improvement Plans, see
also Child and Family Service Review Outcomes: Strategies to Improve Domestic Violence Responses in CFSR Program Improvement Plans, developed by the NCJFCJ in partnership with the Family Violence Prevention Fund and the National Resource Center for Child Protective Services: http://www.ncjfcj.org/sites/default/files/cfsr%20dv_web.pdf.

The Domestic Violence Evidence Project also offers evidenced-based practices for domestic violence: http://www.dvevidenceproject.org/.

Integrating Domestic Violence Assessment and Training Into Home Visiting Programs

Enhanced Nurse Family Partnership Study [Oregon].
This clinical intervention is an enhancement of the Nurse Family Partnership (NFP) that targets at-risk, first- time mothers-to-be, offering support from community nurses from the second trimester of pregnancy until the child reaches the age of 2. The Enhanced Nurse Family Partnership study incorporates intimate partner violence prevention (IPV) into NFP by utilizing nurses trained in IPV prevention. The Enhanced NFP program is centered on an empowerment model that provides its participants with strategies for meeting relationship goals and maintaining

safety. For more information on the Enhanced Nurse Family Partnership Study, contact Dr. Lynette Feder, Portland State University at lfeder@pdx.edu.

Colocating Domestic Violence Advocates in Child Welfare Offices for Case Consultation and Supportive Services

Center for Human Services Research [New York]. As of 2012, 37 percent of local districts in New York State have adopted a colocation model placing domestic violence advocates within child protective services offices to increase collaboration. In those districts, the colocated domestic violence advocates provide training and case consultation, attend joint home visits with child protective services workers, and participate in workgroups to define and clarify the roles. More information about New York's collaborative approach for serving families experiencing both intimate partner violence and child maltreatment is available at http://www.albany.edu/chsr/csp-dv.shtml.

Domestic Violence Liaison Pilot Project [New Jersey].
The Domestic Violence Liaison Pilot Project is a partnership between the Department of Children and Families and the New Jersey Coalition for Battered Women at the State level and the Division of Youth and Family Services (DYFS) offices and domestic violence programs at the county level. Domestic Violence Liaisons are domestic violence experts colocated at DYFS Offices (when available) to provide onsite case consultation to
DYFS and support and advocacy for domestic violence victims and their children. The purpose of this collaboration is to (1) increase safety and
improve outcomes for children and their nonoffending parents/caregivers in domestic violence situations and (2) strengthen DCF/DYFS capacity to provide effective assessments and intervention for families in domestic
violence situations. More information on this project is available at
http://www.law.capital.edu/uploadedFiles/Law_School/NCALP/NJ%20FINAL%20DV%20Case%20Practice%20Protocol%20Oct%20%202009.pdf.

Developing Cross-System Protocols and Partnerships to Ensure Coordinated Services and Responses to Families

West Virginia Collaborative: West Virginia has implemented new statutes, rules, case law, and departmental policies that eradicated the "failure to protect" doctrine and replaced it with innovative new ways to empower victims of domestic violence, hold batterers accountable, and increase safety for children. The change required a collaborative, strength-based, systemic change effort that now enables child protective service workers to partner with adult victims of domestic violence and empower them to protect their children by
(1) removing the term "failure to protect" from all agency policies, (2) permitting the adult victims to co-petition with the State, and (3) allowing the State to request a no-fault battered parent adjudication if co-petitioning is not the best option. For more information, go to the Collaborative Projects link and click on Child Victimization on the West Virginia Coalition Against Domestic Violence website: http://www.wvcadv.org/.

PALS Expansion Project [New Jersey]: The New Jersey Coalition for Battered Women leads an innovative partnership between child welfare, domestic violence shelters, and mental health professionals that established a model program for children who have been exposed to

domestic violence. The Peace: A Learned Solution (PALS) program provides children ages 3 through 12 with creative arts therapy to help them heal from exposure to domestic violence. The PALS Expansion project works with 11 counties to ensure that the therapeutic intervention provided
is evidence-based and provides intensive technical assistance and training to improve practice. For more information, visit http://promising.futureswithoutviolence.org/advancing-the-field/communities-in-action/new-jersey-coalition-for-battered-women/.

The San Diego Family Justice Center [San Diego, CA].
The Family Justice Center was launched by the City of San Diego to assist victims of family violence. It was the first comprehensive "one-stop shop" in the nation for victims of family violence and their children. More than 25 agencies under one roof provide coordinated legal, social, and health
services to women, men, children, and families in need. There, victims of family violence can talk to an advocate, get a restraining order, plan for their safety, talk to a police officer, meet with a prosecutor, receive medical assistance, receive information on shelter, and get help with transportation. For more information, visit http://www.sandiegofjc.org.

Cross Training Domestic Violence and Child Welfare Advocates

Families First [Michigan]. Families First is an intensive, short-term crisis intervention and family education services program—a core service of the Michigan Department of Human Services for the State's 83 counties. In 1993, Families First asked the Governor's Domestic Violence Prevention and Treatment Board (DVPTB) to provide domestic violence in-service training seminars for family preservation workers. Families First and DVPTB worked together to develop extensive cross training, and in 1995, Michigan became the first State to institutionalize mandatory domestic violence training for family preservation workers and supervisors. Ten federally recognized Indian reservations also make referrals to Families
First. For more information, visit http://www.michigan.gov/dhs/0,1607,7-124-5452_7124_7210-15373--,00.html.

Summary

The co-occurrence of domestic violence and child maltreatment is a serious and pervasive social problem. The adverse effects of domestic violence on children can include behavioral, social, emotional, and cognitive problems that may last into adulthood. A literature review reveals general agreement that the most effective approach to reducing domestic violence is based on comprehensive partnerships within and among child- and family-serving systems. Only by cooperating with one another can these systems ensure the safety and well- being of children and families.

Resources, Training, and Tools

Futures Without Violence (formerly, the Family Violence Prevention Fund) provides educational materials and participates in community-based programs and public policy work focused on ending domestic and sexual violence. The organization offers a number of resources for family- and
child-serving programs and professionals:

☐**Connect: Supporting Children Exposed to Domestic Violence** is a 3-hour training with related tools for use in child welfare settings with caregivers at all levels of experience in caring for children who have been exposed to domestic violence.
http://www.futureswithoutviolence.org/connect-supporting-children-exposed-to-domestic-violence//

☐**Healthy Moms, Happy Babies: A Train the Trainer Curriculum on Domestic Violence, Reproductive Coercion and Children Exposed** supports States and their home-visitation programs in developing core competency strategies, ensuring that all home visitation programs are equipped to help women and children living in homes with domestic violence.
http://www.futureswithoutviolence.org/userfiles/file/HealthCare/Healthy%20Moms%20Happy%20Babies%203-7-13.pdf

☐**Promising Futures: Best Practices for Serving Children, Youth, and Parents Experiencing Domestic Violence**
(http://www.PromisingFuturesWithoutViolence.org) is a website
developed by Futures Without Violence designed to help domestic violence advocates enhance their programming for children and their mothers. The
website includes:

○ A searchable database of evidence-based interventions and promising practices for serving children and youth strategies for strengthening program capacity to deliver developmentally appropriate, trauma-
informed, and effective programming

○ Strategies for collaborating with community partners

○ Information and resources on protective factors, resilience, and interventions that strengthen the mother-child bond

○ Guidance on program evaluation and adaptation

○ Resources and guidance on working with culturally diverse families

○ Training curricula, research articles, and other tools for advocates and parents/caregivers

For more information on the work of and resources of Futures Without Violence, visit http://www.futureswithoutviolence.org/.

The Chadwick Trauma-Informed Systems Project (CTISP) identifies effective treatments and develops specialized service delivery models to serve victims of child abuse and children exposed to domestic violence who are involved with child welfare.
http://www.chadwickcenter.org/CTISP/ctisp.htm

The National Center on Domestic Violence, Trauma & Mental Health offers training and technical assistance, publications, research, and other supports to domestic violence advocates and related professionals in the fields of mental health, substance use, and the courts. http://www.nationalcenterdvtraumamh.org/

The National Council of Juvenile and Family Court Judges provides resources, knowledge, and training to professionals involved with juvenile, family, and domestic violence cases to help improve the lives of families and children. NCJFCJ resources include the following:

☐*Reasonable Efforts Checklist for Dependency Cases Involving Domestic Violence* (RE Checklist): The RE Checklist describes the dynamics of domestic violence, how domestic violence affects parenting, and the
interrelationships between domestic violence and substance abuse and mental health, and it provides information on what constitutes reasonable efforts in a dependency case involving domestic violence.
http://www.ncjfcj.org/sites/default/files/reasonable%20efforts%20checklist_web2010.pdf

☐*Checklist to Promote Perpetrator Accountability in Dependency Cases Involving Domestic Violence* (Accountability Checklist): The Accountability Checklist provides information to help dependency courts intervene with perpetrators of domestic violence in ways that promote accountability and the safety of the children and victim parent. The Accountability Checklist provides a framework to hold perpetrators accountable, identify and provide appropriate services, and improve judicial decision-making. http://www.
ncjfcj.org/sites/default/files/checklist-to-promote-accountability_0.pdf

☐Resource Center on Domestic Violence: Child Protection and Custody provides technical assistance, training, and resource development. To request technical assistance, email fvdinfo@ncjfcj.org, or call 800-52-PEACE (800.527.3223).

For more information on the NCJFCJ, visit its website at
http://www.ncjfcj.org/.

The National Resource Center on Domestic Violence works to improve the community response to domestic violence and prevent its occurrence by providing technical assistance, training, and resource development through its key initiatives:

☐Building Comprehensive Solutions to Domestic Violence provides a victim-defined framework for creating solutions to domestic violence.
http://www.bcsdv.org/

☐AWnet, the National Online Resource Center on Violence Against Women, offers a resource library with thousands of materials on domestic violence, sexual violence, funding, research, and more. http://www.vawnet.org/

For more information, visit the NRCDV website:
http://www.nrcdv.org/

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Chapter 9 – Preventing Child Sexual Abuse

Chapter 9 is sourced from the CDC, National Center for Injury Prevention and Control, Division of Violence Prevention, last reviewed December 16, 2019.

What is child sexual abuse?

Child sexual abuse is a significant but preventable adverse childhood experience and public health problem. Child sexual abuse refers to the involvement of a child (person less than 18 years old) in sexual activity that violates the laws or social taboos of society and that he/she:

- does not fully comprehend
- does not consent to or is unable to give informed consent to, or
- is not developmentally prepared for and cannot give consent to

How big is the problem?

Child sexual abuse is a significant but preventable public health problem. Many children wait to report or never report child sexual abuse. Although estimates vary across studies, the data shows:

- About 1 in 4 girls and 1 in 13 boys experience child sexual abuse at some point in childhood.
- 90% of child sexual abuse is perpetrated by someone the child or child's family knows.
- The total lifetime economic burden of child sexual abuse in the United States in 2015 was estimated to be at least **$9.3 billion.** Although this is likely an underestimate of the true impact of the problem since child sexual abuse is underreported.

What are the consequences?

Approximately **3.7 million** children experience child sexual abuse each year in the United States. Experiencing child sexual abuse is an **adverse childhood experience (ACE)** that can affect how a person thinks, acts, and feels over a lifetime, resulting in short- and long-term physical and mental/emotional health consequences.
Examples of physical health consequences include:

- unwanted/unplanned pregnancies
- physical injuries
- chronic conditions later in life, such as heart disease, obesity, and cancer

Examples of mental health consequences include:

- depression
- posttraumatic stress disorder (PTSD)

Examples of behavioral consequences include:

- substance abuse
- risky sexual behaviors, such as unprotected sex, sex with multiple partners
- increased risk for suicide or suicide attempts

Another outcome commonly associated with child sexual abuse is an increased risk of re-victimization throughout a person's life. For example, recent studies have found:

- Females exposed to child sexual abuse are at a **2-13 times increased risk of sexual victimization in adulthood**
- Individuals who experienced child sexual abuse are at **twice the risk for non-sexual intimate partner violence**
- The odds of attempting suicide are **six times higher for men and nine times higher for women with a history of child sexual abuse** than those without a history of child sexual abuse

What are the current gaps in child sexual abuse prevention?

Adults must take the steps needed to prevent child sexual abuse. Adults are responsible for ensuring that all children have safe, stable, nurturing relationships and environments. Resources for child sexual abuse have mostly focused on treatment for victims and criminal justice-oriented approaches for perpetrators. While these efforts are important after child sexual abuse has

occurred, little investment has been made in primary prevention, or preventing child sexual abuse before it occurs. Limited effective evidence-based strategies for proactively protecting children from child sexual abuse are available. More resources are needed to develop, evaluate, and implement evidence-based primary prevention strategies to ensure that all children have safe, stable, nurturing relationships and environments.

What are the recommendations for future research?

CDC surveillance systems, violence prevention initiatives, and efforts to support partners in the field have increased our understanding of child sexual abuse, but critical gaps still need to be addressed. We can all lead efforts to prevent child sexual abuse and improve the health, well-being, and quality of life for children, families, and communities. CDC has identified gaps in research and practice that are important to address in our efforts to promote primary prevention of child sexual abuse.

Additional efforts in child sexual abuse prevention are needed to:

- Improve surveillance systems and data collection for monitoring child sexual abuse
- Increase our understanding of risk and protective factors for child sexual abuse perpetration and victimization
- Strengthen existing and develop new evidence-based policies, programs, and practices the primary prevention of child sexual abuse
- Increase dissemination and implementation of evidence-based strategies for child sexual abuse prevention

Youth- and family-serving organizations, public/governmental agencies, faith communities, and others must have the information necessary for effective primary prevention strategies. Child sexual abuse is preventable and CDC provides leadership, using a public health approach, to reduce children's exposure to sexual abuse and ensure safe, stable, nurturing relationships and environments for all children.

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Chapter 10 - Preventing Abusive Head Trauma in Children

Know the Facts about Abusive Head Trauma

- Abusive head trauma is a leading cause of physical child abuse deaths in children under 5 in the United States.
- Abusive head trauma accounts for approximately one third of all child maltreatment deaths.
- The most common trigger for abusive head trauma is inconsolable crying.
- Babies less than one year old are at greatest risk of injury from abusive head trauma.

What Is Abusive Head Trauma?

Abusive head trauma (AHT), which includes shaken baby syndrome, is a preventable and severe form of physical child abuse that results in an injury to the brain of a child. AHT is most common in children under age five, with children under one year of age at most risk. It is caused by violent shaking and/or with blunt impact. The resulting injury can cause bleeding around the brain or on the inside back layer of the eyes.

Nearly all victims of AHT suffer serious, long-term health consequences such as vision problems, developmental delays, physical disabilities, and hearing loss. At least one of every four babies who experience AHT dies from this form of child abuse.

AHT often happens when a parent or caregiver becomes angry or frustrated because of a child's crying. The caregiver then shakes the child and/or hits or slams the child's head into something in an effort to stop the crying.

Crying, including long bouts of inconsolable crying, is normal behavior in infants. Shaking, throwing, hitting, or hurting a baby is never the right response to crying.

How Can Abusive Head Trauma Be Prevented?

Anyone can play a role in preventing AHT by understanding the dangers of violently shaking or hitting a baby's head into something, knowing the risk factors and the triggers for abuse, and finding ways to support parents and caregivers.

Counsel for parents or caregivers

- Understand that infant crying is worse in the first few months of life, but it will get better as the child grows.
- Try calming a crying baby by rocking gently, offering a pacifier, singing or talking softly, taking a walk with a stroller, or going for a drive in the car.
- If the baby won't stop crying, check for signs of illness and call the doctor if you suspect the child is sick.
- If you are getting upset, focus on calming yourself down. Put the baby in a safe place and walk away to calm down, checking on the baby every 5 to 10 minutes.
- Call a friend, relative, neighbor, or parent helpline for support.
- Never leave your baby with a person who is easily irritated or has a temper or history of violence.

Counsel for friends, family members, or observers of a parent or caregiver

- Be aware of new parents in your family and community who may need help or support.
- Offer to give a parent or caregiver a break when needed.
- Let the parent know that dealing with a crying baby can be very frustrating, but infant crying is normal and it will get better.
- Encourage parents and caregivers to take a calming break if needed while the baby is safe in the crib.
- Be sensitive and supportive in situations when parents are dealing with a crying baby.
- Be supportive of work policies (e.g., paid family leave) that make it easier for working parents to stay with their infants during the period of increased infant crying (i.e., between 4-20 weeks of age).

See Child Abuse and Neglect Resources for more articles, publications, and prevention resources about preventing abusive head trauma.

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Chapter 11 - Forensic Interviewing: A Primer for Child Welfare Professionals

Forensic interviewing is a means of gathering information from a victim or witness for use in a legal setting, such as a court hearing. It is a key component of many child protective services investigations. The purpose of these interviews is to gather factual information in a legally defensible and developmentally appropriate manner about whether a child (or other person) has been abused (Newlin et al., 2015). Forensic interviews are conducted by trained professionals, including child welfare caseworkers, law enforcement, and specialized forensic interviewers at children's advocacy centers (CACs). These interviewers are frequently part of a multidisciplinary team investigating the case. This factsheet provides child welfare professionals with a brief overview of forensic interviewing so they can better understand how such interviews affect their practice with children and families.

Overview

In the 1980s, the manner in which children were interviewed during child abuse investigations came under increased scrutiny (Faller, 2015). This was largely due to high-profile cases involving sexual abuse at child care centers. Critics of the interviews asserted children were coerced or otherwise improperly interviewed. The assertion that many interviews about alleged incidences of child abuse were conducted improperly helped energize a review and reformation of the interviewing process (Faller, 2015). The forensic interviews conducted with alleged victims of child abuse are often essential to the investigation because, particularly in sexual abuse cases, the alleged victim and alleged perpetrator may be the only people who know what really happened (Mart, 2010). Research on interview techniques, child development, and other related topics shaped what is now referred to as forensic interviewing in child welfare cases.

Forensic interviews are used by trained professionals to gather information about incidents of alleged child abuse in a manner that will yield factual information from the child and stand up to scrutiny in court. For example, forensic interviewing techniques are designed to remove or minimize the potential for the interviewer to use suggestive or leading questions that may call the child's statements into question. Forensic interviews can also help shape the investigation by highlighting areas for further investigation or evidence collection. There are more than a dozen well-respected interview models (see the Forensic Interviewing Models section of this publication). Model use varies by jurisdiction, agency, and interviewer training. Who conducts the forensic interview also varies. Many jurisdictions use specialized forensic interviewers whose primary role is to conduct forensic interviews; other jurisdictions rely on law enforcement, child welfare, or other professionals who have been trained in forensic interviewing. Other professionals may observe the interview either from behind a one-way mirror, by using a real-time video link, or by accessing audio or video recordings. Only trained professionals should conduct forensic interviews (McCoy & Keen, 2014).

The interviews are often conducted at CACs, which began in the 1980s. CACs use a multidisciplinary approach to coordinate the response to child maltreatment, which can help reduce the number of interviews children experience and provides a central process to coordinate all necessary services and supports. (For more information about CACs, visit the National Children's Advocacy Center website at http://www.nationalcac.org/.) Interviews may also be

conducted in other locations in the community that are child friendly and otherwise appropriate for the interview (e.g., private, quiet).

The requirements or guidance about which cases should include a forensic interview may vary by jurisdiction. Child welfare professionals and others working on the case should consult their supervisors, other agency staff, or law enforcement about the circumstances under which a forensic interview should be conducted.

Forensic Interviewing Models

A variety of forensic interviewing models have been developed, and the one used in a child protective or criminal investigation may vary depending on jurisdiction, agency, or the training of the interviewer. The following are examples of forensic interviewing models; however, this is not an exhaustive list:

- American Professional Society on the Abuse of Children Practice Guidelines (http://www.apsac.org/ child-forensic-interview-clinics)
- CornerHouse Forensic Interview Protocol (https://www. cornerhousemn.org/training.html)
- National Children's Advocacy Center Forensic Interview Structure (http://www.nationalcac.org/ forensic-interviewing-of-children-training/)
- National Institute of Child Health and Human Development Forensic Interview Protocol
- ChildFirst Forensic Interviewing Protocol (http://www.gundersenhealth.org/ncptc/ childfirst-forensic-interviewing-protocol/)

Although the exact methods employed in each model differ to some extent, they all tend to have the following phases in common (Newlin et al., 2015):

- **Rapport-building phase:** The interviewer attempts to build a trusting relationship with the child and explains some of the details about the interview process (e.g., documentation, instructions). This phase also allows the interviewer to better understand the child's developmental level, linguistic capabilities, legal competency, and other characteristics and may provide the child with opportunities to practice providing narrative information.
- **Substantive phase:** The interviewer seeks information related to the alleged abuse. This may include obtaining a narrative description of the event, inquiring about additional details, and testing alternative or multiple hypotheses (e.g., other possible scenarios), if appropriate.
- **Closure phase:** The interviewer may address the child's socioemotional or other immediate needs, transition to a topic not related to the alleged incident, or answer any questions.

The following are some of the ways in which forensic interviewing models differ:

- **Interview structure:** Models may be scripted (i.e., interviewers are provided what to say verbatim), semi-structured (i.e., interviewers are given guidance but are able to make certain decisions about how to proceed), or flexible (i.e., the interviewer is given great leeway so he or she can better follow the lead of the child) (Faller, 2015).

- **Instructions:** The exact instructions, or ground rules, presented to the child differ from one model to the next. Common topics covered by the instructions include requesting that the child

only provide information about things that actually happened, giving the child permission to say "I don't know," advising the child to ask the interviewer to clarify a question if the child does not understand, and informing the child to alert the interviewer if the interviewer provides incorrect information. There is also some variation regarding when the interviewer provides the instruction. For example, most models provide the instructions during the rapport phase, but the CornerHouse method calls for the interviewer to provide some instruction at the beginning and then incorporate instructions throughout the interview, where appropriate (Anderson, 2013). The interviewer also may provide the child with opportunities to practice following the instructions (e.g., asking the child a question to which he or she would not know the answer in order to see if he or she will respond with "I don't know").

- **Truthfulness discussion:** During the rapport-building phase, some models request that the interviewer ask the child to promise to tell the truth and/or for the interviewer to address the difference between telling the truth and a lie. Analogue research shows that children tend to be more likely to tell the truth if they promised to do so prior to being interviewed about the event in question, but the evidence is not as strong about whether having a moral discussion about truth and lies increases truthfulness (Evans & Lee, 2010).1 State and local rules and practices may dictate if and how a truth/lie discussion should occur during a forensic interview (Newlin, 2015).

- **Appropriate questions:** The purpose of all forensic interviewing models is to discourage the use of leading questions or techniques, but they may vary to some degree about which are the most preferred types of questions. There is consensus that open-ended questions (i.e., a question that invites a detailed, multiword response, such as "Tell me what happened.") are better than closed-ended questions (i.e., those that can be answered with a one-word response or little detail, such as "Did the man come into your bedroom?"). Some models, though, favor open-ended probes, such as "Tell me what happened," rather than a question, such as "Do you remember what happened?" (Faller, 2007). There also may be variations in the order of preference given to other types of questions or probes along the continuum from open-ended to closed-ended, such as those that request more detail on a particular topic (Faller, 2015).

Use of Anatomical Dolls and Diagrams

The use of anatomical dolls and diagrams to help children describe or demonstrate their experiences is still up for debate in the field of forensic interviewing (Lyon, 2012). Open-ended questions and probes encourage free recall by the child (i.e., the child is not externally prompted to recall a particular memory) and are most accurate, but in children free recall is often limited (Faller, 2007). Anatomical dolls and drawings rely on recognition memory (i.e., the child chooses a response from a series of alternatives), which may be less accurate but more detailed. The cue of the anatomical doll or diagram could trigger the child's recognition of other body-related experiences. Proponents of anatomical dolls and diagrams rely on analogue research that indicates they can help a child disclose actual experiences with a very small increase in false positives. Opponents emphasize that free recall memory is more accurate and are concerned interviewers may use dolls or diagrams in leading or suggestive ways. Further, there is a modest body of research that indicates that children age 3 and younger cannot make the representational shift to understand that the doll is being used to represent themselves or the alleged offender (Faller, 2015). In addition, forensic interviewing models differ about if and when to introduce dolls

or diagrams in the interview. For example, some models introduce dolls or diagrams in the rapport-building part of the interview to clarify a child's terminology for body parts. Other models advise only using them after the child has disclosed abuse (McCoy & Keen, 2014). Finally, some models caution about their use altogether. The use of anatomical dolls and diagrams will vary based on the model used by the interviewer and local practice. When given flexibility about the use of dolls and diagrams, interviewers should review the relevant research and determine if their use is appropriate given the context of each case.

For additional information, refer to *Anatomical Dolls and Diagrams* by the Gundersen National Child Protection Training Center and the ChildFirst/Finding Words Forensic Interview Training Programs (http://www. gundersenhealth.org/app/files/public/3580/NCPTC-Anatomical-Dolls-and-Diagrams-position-paper.pdf) and *Position Paper on the Use of Human Figure Drawings in Forensic Interviews* by the National CAC (http://www. chicagocac.org/wp-content/uploads/2015/10/NCAC-Position-paper-use-of-human-figure-drawings.pdf).

Important Considerations

Each forensic interview will be a unique experience for both the interviewer and the child, as no two interviews are exactly alike. The following factors are critical to the understanding and practice of forensic interviewing:

Age and developmental level: A child's age and developmental levels should be factored into any forensic interview. These levels can affect a child's memory, comprehension, sense of time, linguistic capability, attention span, and other attributes relevant to recalling and recounting an experience (Newlin, 2015). Some jurisdictions have policies about the minimum age a child must be (often age 3 years) to participate in a forensic interview.

Effect of trauma on memory: Traumatic experiences may shape how children store and recall memories of the event. Although some children may remember the traumatic event with the same clarity as a nontraumatic event, others may not be able to provide the same level of detail or coherence (Fanetti, O'Donohue, Happel, & Daly, 2015).

Suggestibility: Analogue research indicates some children are more suggestible than others. Depending on a range of factors, such as cognitive ability, mental state, and culture, some children may be susceptible to having their memories altered based on how the interviewer phrases questions or otherwise presents information (Hritz, 2015). A false suggestion to a child could be made in many ways. For example, before the child has disclosed any abuse, the interviewer could explicitly say that something happened (e.g., "The man touched you inappropriately, didn't he?") or phrase a question in a way that implies an event occurred (e.g., "What did you smell when the man touched you?"). Interviewers also could increase a child's risk for suggestibility by repeating the same question, which may imply to the child that he or she provided incorrect information when responding to the original question (McCoy & Keen, 2014).

Multiple interviews: There is a growing body of research that indicates that some children need more than one interview (Newlin, 2015). If more than one interview is needed, the same interviewer should interview the child. Communities and agencies should define cases that warrant more than one interview because, although interviewing children over multiple sessions can help yield more new information, including disclosures of abuse, they also have the potential to allow for a child to make contradictory statements over the course of the various sessions,

which could complicate the investigation (Block, Foster, Pierce, Berkoff, & Runyan, 2014). Interviewers should ensure they adhere to good forensic interviewing practice to help limit any negative consequences of conducting multiple interviews, such as the child experiencing additional trauma when providing multiple accounts of the maltreatment (Faller, Cordisco-Steele, & Nelson-Gardell, 2010).

Bias: Interviewers should be aware that they view allegations through the lens of their professional and personal experiences and that this could affect the child and the investigation. Interviewers who believe they already know what happened to the children or that no maltreatment occurred may try to elicit that information to confirm the bias or ignore information that does not conform to their preconceived narratives (McCoy & Keen, 2014). One way to help avoid bias is to use the interview to address a variety of hypotheses rather than to confirm or negate a particular one. Working with a team of professionals could help mitigate the effects of any biases.

Training

Caseworkers, law enforcement, or other professionals require training in order to conduct effective forensic interviews. Training generally ranges from 4 days to 1 week and is sponsored by a variety of organizations, including state agencies, professional organizations, and agencies responsible for conducting interviews. Advanced training is also available on a variety of topics, such as interviewing young children, interviewing across cultures, interviewing developmentally challenged children, managing bias, delivering court testimony, and secondary trauma. Many forensic interviewers are trained in the use of more than one model (Stephens, Martinez, & Braun, 2012).

To help strengthen their skills and address difficulties they have encountered, many forensic interviewers participate in supervision or peer review. Supervision involves the interviewer meeting individually with a more experienced interviewer, who can review interview transcripts or video and provide feedback. This may assist in ensuring the newer interviewer is adhering to the model being implemented as well as general best practices. Peer review allows interviewers to discuss cases and current research and provide feedback and support to each other in a group setting. To achieve accreditation by the National Children's Alliance (NCA), CACs must ensure forensic interviewers participate in peer review. (For additional information on accreditation, see the NCA website at http://www.nationalchildrensalliance.org/ ncas-standards-accredited-members.)

Conclusion

Forensic interviewing is an extremely valuable tool for the investigation of child abuse allegations. When properly executed, it can assist in gathering factual information about the allegations using legally defensible techniques. A good forensic interview also can lead to the child and family receiving services and supports that best meet their needs. Given the intricate issues related to forensic interviews and the complexity of conducting such interviews, it is crucial that child welfare and other professionals be properly trained before attempting to conduct a forensic interview.

For a more detailed overview of forensic interviewing, refer to *Child Forensic Interviewing: Best Practices,* which was published by the Office of Juvenile Justice and Delinquency Prevention of the U.S. Department of Justice. It is available at https://www.ojjdp.gov/pubs/248749.pdf. For information about conducting a forensic interview with Spanish-speaking children, refer to the *Guide for Forensic Interviewing of Spanish- Speaking Children from the Center for Innovation and*

Resources at http://cacnc.org/wp-content/ uploads/2016/06/Guide-for-Forensic-Interviewing-of-Spanish-Speaking-Children-English.pdf.

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Chapter 12 - Child Forensic Interviewing: Best Practices

Highlights

This [chapter] consolidates the current knowledge of professionals from several major forensic interview training programs on best practices for interviewing children in cases of alleged abuse. The authors discuss the purpose of the child forensic interview, provide historical context, review overall considerations, and outline each stage of the interview in more detail.

Among the topics that the authors discuss are the following:

• No two children will relate their experiences in the same way or with the same level of detail and clarity. Individual characteristics, interviewer behavior, family relationships, community influences, and cultural and societal attitudes determine whether, when, and how they disclose abuse.

• The literature clearly explains the dangers of repeated questioning and duplicative interviews; however, some children require more time to become comfortable with the process and the interviewer.

• Encouraging children to give detailed responses early in the interview enhances their responses later.

• Forensic interviewers should use open-ended questions and should allow for silence or hesitation without moving to more focused prompts too quickly. Although such questions may encourage greater detail, they may also elicit potentially erroneous responses if the child feels compelled to reach beyond his or her stored memory.

During the last quarter of the 20th century, the United States began to fully recognize the incidence of child abuse and neglect affecting our country. Increased public awareness and empirical literature have improved efforts to intervene effectively on behalf of children. One of the most significant interventions has centered on how to elicit accurate information from children regarding abuse and neglect—a process commonly referred to as “forensic interviewing” (Saywitz, Lyon, and Goodman, 2011). Following two decades of research and practice, professionals have gained significant insight into how to maximize children’s potential to accurately convey information about their past experiences. Yet, as this effort continues and practice evolves, professionals face new challenges in standardizing forensic interviewing practice throughout the country.

A relative lack of both research and practice experience challenged pioneers in the field. As such, protocols and training efforts underwent significant revisions as more research was conducted and people began gaining practice-based experience, which informed further training. Additionally, given the dearth of resources at the time, geographically diverse training programs began to

develop naturally throughout the United States, emanating from frontline service providers who struggled to provide quality services themselves and who also wanted to help fellow professionals. Different case experiences, contextual perspectives, and community standards influenced these training efforts. In addition, these service providers were not directly communicating with one another about the content of their training or their theoretical approaches. This further supported the existence of various approaches and the lack of standardized training language regarding forensic interviewing.

It is now widely accepted that professionals should have formal initial and ongoing forensic interview training (National Children's Alliance [NCA], 2011). However, the field has yet to determine one standardized practice to follow throughout the country. Although national training programs are generally based on the same body of research, some differences exist. Focusing on the variations among them often obscures consistencies within the various forensic interview models. In some cases, the veracity of the child's statement or the performance of the forensic interviewer has been questioned solely on the basis of the model being used. However, forensic interviewers often receive training in multiple models and use a blended approach to best meet the needs of the child they are interviewing (Midwest Regional Children's Advocacy Center [MRCAC], 2014). Furthermore, the model being used and any subsequent adaptations to it are often rooted in jurisdictional expectations. State statutes and case law dictate aspects of interview practice, further demonstrating that no one method can always be the best choice for every forensic interview.

In 2010, representatives of several major forensic interview training programs—the American Professional Society on the Abuse of Children, the Corner House Interagency Child Abuse Evaluation and Training Center, the Gundersen National Child Protection Training Center, the National Children's Advocacy Center, and the National Institute of Child Health and Human Development— gathered to review their programs' differences and similarities. The resulting discussions led to this bulletin, which consolidates current knowledge on the generally accepted best practices of those conducting forensic interviews of children in cases of alleged abuse or exposure to violence.

This nation must remain committed to consistently putting the needs of children first. It is the authors' hope that this document will become an essential part of every forensic interview training program and will be widely used as an authoritative treatise on the implementation of best practices in forensic interviewing.

Purpose of the Child Forensic Interview

The forensic interview is one component of a comprehensive child abuse investigation, which includes, but is not limited to, the following disciplines: law enforcement and child protection investigators, prosecutors, child protection attorneys, victim advocates, and medical and mental health practitioners. Although not all of the concerned disciplines may directly participate in or observe the forensic interview, each party may benefit from the information obtained during the interview (Jones et al., 2005).

Most child abuse investigations begin with a forensic interview of the child, which then provides direction for other aspects of the investigation. Although forensic interviewers are trained to conduct quality interviews, it is important to note there is no "perfect" interview.

For the purposes of this bulletin, and in an effort to build consensus within the field, the authors offer the following definition of a child forensic interview:

> A forensic interview of a child is a developmentally sensitive and legally sound method of gathering factual information regarding allegations of abuse or exposure to violence. This interview is conducted by a competently trained, neutral professional utilizing research and practice-informed techniques as part of a larger investigative process.

Historical Context

In the 1980s, several high-profile cases involving allegations that daycare providers had sexually abused multiple children in their care became the subject of considerable analysis because of the interview techniques that were used (Ceci and Bruck, 1995). Law enforcement depended on mental health practitioners because of their ability to establish rapport with children. However, mental health practitioners often used therapeutic techniques that were later deemed inappropriate for forensic purposes, primarily because of concerns regarding suggestibility. The courts scrutinized the interview procedures used in these early cases and found that techniques that invited make-believe or pretending were inappropriate for criminal investigations.

As awareness of child abuse grew, professionals realized that it might take special skills to interview children. Sgroi (1978) was the first medical/mental health professional to address the issue of investigative interviewing in the literature. The American Professional Society on the Abuse of Children (APSAC) wrote the first practice guidelines—*Psychosocial Evaluation of Suspected Sexual Abuse in Young Children* (APSAC, 1990)—the title of which reflects the initial focus of these interviews: mental health. Today, the focus has shifted from the mental health or clinical perspective to a forensic perspective. Even the nomenclature changed to include terms such as "forensic interview" and "child forensic interview training."

In the late 1980s and early 1990s, substantial empirical literature discussed children's developmental capabilities and appropriate ways of engaging them in the interview process. The Cognitive Interview (Fisher and Geiselman, 1992) and Narrative Elaboration (Saywitz, Geiselman, and Bornstein, 1992) models included specific strategies that applied memory-based techniques to elicit detailed information from witnesses. Traces of both models remain in current approaches to evidence-based forensic interviewing (Saywitz and Camparo, 2009; Saywitz, Lyon, and Goodman, 2011).

Considerations Regarding the Child

Many influences have an impact on a child's experience of abuse and on his or her ability to encode and communicate information. These influences interact in a uniquely individual manner, such that no two children will ever engage or relate their experiences in the same way or with the same level of detail and clarity. This section describes the major influences on children's memory, language abilities, and motivation to converse.

Development

All of the forensic interviewing models agree that considering the age and development of the child is essential. Lamb and colleagues (2015) state that “age is the most important determinant of children’s memory capacity.” A child’s age and developmental abilities influence his or her perception of an experience and the amount of information that they can store in long-term memory (Pipe and Salmon, 2002). Infants and toddlers can recall experiences, as demonstrated through behavioral reactions to people, objects, and environments; however, these early memories are not associated with verbal descriptions. Even as they begin to develop their language capabilities, young children are less able to make sense of unfamiliar experiences, have a more limited vocabulary, and are less accustomed to engaging in conversations about past experiences than older children. As children age, their attention span improves and they are better prepared to comprehend, notice unique elements, and describe their experiences verbally. This, in turn, allows them to store more information and also allows them to discuss remembered events with others, which further serves to consolidate and strengthen memories. Children of all ages are more likely to recall salient and personally experienced details rather than peripheral details (Perona, Bottoms, and Sorenson, 2006).

Metacognition—the ability to recognize whether one understands a question and has stored and can retrieve relevant information—also improves as children mature. Very young children find it difficult to focus their attention and to search their memory effectively when interviewed. They may simply respond to recognized words or simple phrases without considering the entire question, and they are unable to monitor their comprehension or answers to questions (Lamb et al., 2015). As children grow older, both natural development and knowledge gained from school improve their skills.

Remembering an experience does not ensure that a child will be able to describe it for others. Forensic interviews are challenging for children, as they involve very different conversational patterns and an unfamiliar demand for detail (Lamb and Brown, 2006). Young children may use words before they completely understand their meaning and may continue to confuse even simple concepts and terms such as “tomorrow,” “a lot,” or “a long time.” As children mature, they acquire the ability to use words in a more culturally normative way, although terminology for sexual encounters, internal thoughts and feelings, and particularly forensic and legal matters may be beyond their grasp (Walker, 2013). Forensic interviewers and those who evaluate the statements that children make in a legal context would do well to appreciate the many extraordinary demands made on child witnesses.

Although concerns about younger children’s verbal and cognitive abilities are well recognized, the challenges of effectively interviewing adolescents are often overlooked. Because adolescents look much like adults, forensic interviewers and multidisciplinary team members may fail to appreciate that adolescents vary greatly in their verbal and cognitive abilities and thus fail to build rapport, provide interview instructions, or ensure the comprehension of questions (Walker, 2013). Ever conscious of wanting to appear competent, adolescents may be reluctant to ask for assistance. Forensic interviewers and investigators must guard against unreasonably high expectations for teenage witnesses and should not adopt a less supportive approach or use convoluted language, which will complicate matters.

Culture and Development

A child's family, social network, socioeconomic environment, and culture influence his or her development, linguistic style, perception of experiences, and ability to focus attention (Alaggia, 2010). Cultural differences may present communication challenges and can lead to misunderstandings within the forensic interview. Fontes (2008) highlights the importance of having clear-cut guidelines and strategies for taking culture into account when assessing whether child abuse or neglect has occurred. Forensic interviewers and investigators must consider the influence of culture on perception of experiences, memory formation, language, linguistic style, comfort with talking to strangers in a formal setting, and values about family loyalty and privacy when questioning children and evaluating their statements (Fontes, 2005, 2008; Perona, Bottoms, and Sorenson, 2006).

Disabilities

Children with disabilities are potentially at greater risk for abuse and neglect than children without disabilities (Hershkowitz, Lamb, and Horowitz, 2007; Kendall-Tackett et al., 2005). Forensic interviewers are unlikely to have specialized training or experience in the broad field of disabilities or regarding developmental or medical concerns; thus, collaboration is often necessary to successfully interview these children. Interviewers should use local resources—including disability specialists or other professionals who work with children and their primary caregivers—to gain insight into the functioning of specific children and any needs they may have for special accommodations (Davies and Faller, 2007). The interviewer may have to adapt each stage of the interview, balancing these adaptations with the demand for forensic integrity (Baladerian, 1997; Hershkowitz, Lamb, and Horowitz, 2007). More than one interview session may be necessary to gain the child's trust, adapt to the child's communication style and limitations, and allow adequate time to gather information (Faller, Cordisco Steele, and Nelson-Gardell, 2010).

Trauma

Children who have been victims of maltreatment or were witnesses to violent crime often react uniquely to their experiences. Forensic interviewers must be cognizant of factors that mitigate or enhance the impact, as trauma symptoms may interfere with a child's ability or willingness to report information about violent incidents (Ziegler, 2002). The memories of children who have suffered extreme forms of trauma may be impaired or distorted (Feiring and Tasca, 2005); these children may not recall their experiences in a linear fashion but, instead, as "flashbulb memories" or snapshots of their victimization (Berliner et al., 2003). In addition, their memories of traumatic experiences may be limited, with a particular emphasis on central rather than peripheral details (Fivush, Peterson, and Schwarzmueller, 2002). Interviewers and those involved in investigating child abuse may need to modify their expectations of what a traumatized child is able to report. They should not attempt to force a disclosure or continue an interview when a child becomes overly distressed, which may revictimize the child. Children who are severely traumatized may benefit from additional support and multiple, nonduplicative interview sessions (Faller, Cordisco Steele, and Nelson-Gardell, 2010; La Rooy et al., 2010).

Disclosure

Understanding the disclosure process is critical for both the investigative process and child protection outcomes. Research to date on children's disclosure of sexual abuse— based mainly

on retrospective surveys of adults and reviews of past child abuse investigations—indicates that no single pattern of disclosure is predominant (Lyon and Ahern, 2010). Disclosure happens along a continuum ranging from denial to nondisclosure to reluctant disclosure to incomplete disclosure to a full accounting of an abusive incident (Olafson and Lederman, 2006). Some children also disclose less directly, over a period of time, through a variety of behaviors and actions, including discussions and indirect nonverbal cues (Alaggia, 2004).

The interaction of individual characteristics, interviewer behavior, family relationships, community influences, and cultural and societal attitudes determines whether, when, and how children disclose abuse (Alaggia, 2010; Bottoms, Quas, and Davis, 2007; Hershkowitz et al., 2006; Lyon and Ahern, 2010). Factors that help to explain a child's reluctance are age, relationship with the alleged offender, lack of parental support, gender, fear of consequences for disclosing, and fear of not being believed (Malloy, Brubacher, and Lamb, 2011; McElvaney, 2013). A review of contemporary literature reveals that when disclosure does occur, significant delays are common. In a recent analysis of child sexual abuse disclosure patterns, Alaggia (2010) found that as many as 60 to 80 percent of children and adolescents do not disclose until adulthood. If outside corroborative evidence exists (e.g., physical evidence, offender confessions, recordings, witness statements), there is still a high rate of nondisclosure (Lyon, 2007; Sjoberg and Lindblad, 2002). Furthermore, children who disclose often do not recount their experiences fully and may, over time, provide additional information (McElvaney, 2013).

Current literature on children's disclosure of sexual abuse has implications for practice. According to Malloy, Brubacher, and Lamb (2013), precipitating events or people frequently motivate children to disclose abuse. Some children require a triggering event, such as a school safety presentation, to allow them to discuss abuse without being the one to broach the subject (McElvaney, 2013). Other children may need to be questioned specifically about the possibility of abuse. Child abuse professionals should understand the many intersecting dynamics that help a child disclose maltreatment and should be open to the possibility that disclosure is not an all-or-nothing event.

Considerations Regarding the Interview

Almost universal agreement exists regarding the need to interview children about allegations of abuse. Once this is accepted, there are a number of important considerations, such as timing, documentation, setting, interviewer, questions to be asked, and whether to use interview aids/media.

Timing

Conduct the forensic interview as soon after the initial disclosure of abuse, or after witnessing violence, as the child's mental status will permit and as soon as a multidisciplinary team response can be coordinated (APSAC, 2012; Saywitz and Camparo, 2009). As time passes, the opportunity to collect potential corroborative evidence may diminish, children's fortitude to disclose may wane, and opportunities for contamination, whether intentional or accidental, increase (Johnson, 2009). However, children who are overly fatigued, hungry, frightened, suffering from shock, or still processing their traumatic experiences may not be effective reporters in a forensic interview (APSAC, 2012; Home Office, 2007; Myers, 2005).

Documentation

Electronic recordings are the most complete and accurate way to document forensic interviews (Cauchi and Powell, 2009; Lamb et al., 2000), capturing the exchange between the child and the interviewer and the exact wording of questions (Faller, 2007; Warren and Woodall, 1999). Video recordings, used in 90 percent of Children's Advocacy Centers (CACs) nationally (MRCAC, 2014), allow the trier of fact in legal proceedings to witness all forms of the child's communication. Recordings make the interview process transparent, documenting that the interviewer and the multidisciplinary team avoided inappropriate interactions with the child (Faller, 2007). Recorded forensic interviews also allow interviewers and others to review their work and facilitate skill development and integrity of practice (Lamb, Sternberg, Orbach, Esplin, and Mitchell, 2002; Price and Roberts, 2011; Stewart, Katz, and La Rooy, 2011).

Neutral and Objective Setting

The National Children's Alliance (NCA), as a part of its accreditation process, requires CACs to provide child-focused settings that are "comfortable, private, and both physically and psychologically safe for diverse populations of children and their non-offending family members" (NCA, 2011:36). However, there is a dearth of literature on what constitutes a child-friendly environment (NCA, 2013).

Interview rooms come in all shapes and sizes, are often painted in warm colors, may incorporate child-sized furniture, and should only use artwork of a non-fantasy nature. The room should be equipped for audio- and video-recording, and case investigators and other CAC staff should be able to observe the forensic interview (Myers, 2005; NCA, 2013; Pence and Wilson, 1994). Although it is generally recommended that there be minimal distractions in the interview room (APSAC, 2012; Saywitz, Camparo, and Romanoff, 2010), opinions differ about the allowance of simple media, such as paper and markers. More recently published literature suggests that younger children may benefit from having access to paper and markers during the forensic interview (Poole and Dickinson, 2014). Materials that encourage play or fantasy are uniformly discouraged, as is any interpretation by the interviewer of the child's use of media or other products.

Role of the Interviewer

Forensic interviewers should encourage the most accurate, complete, and candid information from a child and, to this end, the child should be the most communicative during the forensic interview (Teoh and Lamb, 2013). Interviewers must balance forensic concerns with decisions about how much information to introduce (APSAC, 2012; Orbach and Pipe, 2011). In addition, they should be attentive to the possibility that their preconceived ideas may bias the information gathered—particularly if the interview is conducted in an unduly leading or suggestive manner—and should avoid such practices (Ceci and Bruck, 1995; Faller, 2007).

Question Type

Maximizing the amount of information obtained through children's free recall memory is universally accepted among forensic interview models as a best practice. Forensic interviewers should use open-ended and cued questions skillfully and appropriately to support children's ability and willingness to describe remembered experiences in their own words (Lamb, Orbach, Hershkowitz, Esplin, and Horowitz, 2007; Myers, 2005; Saywitz and Camparo, 2009; Saywitz, Lyon, and Goodman, 2011). Ask more focused questions later in the interview, depending on the

developmental abilities of the child, the child's degree of candor or reluctance, the immediacy of child protection issues, and the existence of reliable information previously gathered (e.g., suspect confession, photographs) (Imhoff and Baker-Ward, 1999; Lamb et al., 2003; Perona, Bottoms, and Sorenson, 2006). This approach reduces the risk of the interviewer contaminating the child's account.

A common language for labeling the format of questions does not exist; however, similarities in currently used labels do exist (Anderson, 2013; APSAC, 2012; Lyon, 2010). Agreement also exists that questions should not be judged in isolation. The labels for memory prompts may be classified into two main categories—recall and recognition—and are based on the type of memory accessed.

Recall prompts are open-ended, inviting the child to tell everything he or she remembers in his or her own words; such prompts have been shown to increase accuracy (Lamb, Orbach, Hershkowitz, Horowitz, and Abbott, 2007; Lamb et al., 2008). Open-ended questions encourage children to elaborate and to include salient details without significant input from the interviewer, who should use them throughout the interview. Recall prompts may include directives or questions, such as "Tell me everything that happened," "And then what happened?" and "Tell me more about (specific person/action/place that the child previously mentioned)." Although the accounts retrieved through the use of recall prompts can be quite detailed and accurate, they may not be complete. Interviewers may ask specific, focused questions to obtain additional details about topics the child has already mentioned, using a "who, what, where, when, and how" format. Although these detailed questions focus the child on certain aspects of his or her report that are missing, the child may or may not recall such information. These questions may promote a narrative response or may elicit brief answers (Saywitz and Camparo, 2009; Hershkowitz et al., 2012). They do not introduce information or pose options to the child: "You said you were in the house. What room were you in?" followed by "Tell me about that."

Once open-ended questions are exhausted, it may be necessary to progressively focus the query. Children may omit details because they do not know the significance of the information sought or because they are reluctant to divulge certain information. In contrast to recall prompts, recognition prompts provide the child with context or offer interviewer-created options. Recognition prompts may elicit greater detail once the child has exhausted his or her capability for narrative or when a child cannot comprehend a more open-ended question. The risk of using recognition prompts is that they may elicit responses that are less accurate or potentially erroneous if the child feels compelled to reach beyond his or her stored memory. It is essential to use these questions judiciously, as overuse can significantly affect the integrity and fact-finding function of the interview (Faller, 2007; Lamb, Orbach, Hershkowitz, Horowitz, and Abbott, 2007; Myers, 2005; Perona, Bottoms, and Sorenson, 2006). Suggestive questions are those that "to one degree or another, [suggest] that the questioner is looking for a particular answer" (Myers, Saywitz, and Goodman, 1996) and should be avoided.

Interview Aids/Media

The goal of a forensic interview is to have the child verbally describe his or her experience. A question remains, however, as to whether limiting children to verbal responses allows all children to fully recount their experiences, or whether media (e.g., paper, markers, anatomically detailed drawings or dolls) may be used during the interview to aid in descriptions (Brown et al., 2007; Katz

and Hamama, 2013; Macleod, Gross, and Hayne, 2013; Patterson and Hayne, 2011; Poole and Dickinson, 2011; Russell, 2008). The use of media varies greatly by model and professional training. Decisions are most often made at the local level, and interviewer comfort and multidisciplinary team preferences may influence them. Ongoing research is necessary to shed further light on the influence of various types of media on children's verbal descriptions of remembered events.

The Forensic Interview

Forensic interview models guide the interviewer through the various stages of a legally sound interview; they vary from highly structured/scripted to semi-structured (interviewers cover predetermined topics) to flexible (interviewers have greater latitude). All models include the following phases:

- The initial **rapport-building phase** typically comprises introductions with an age- and context-appropriate explanation of documentation methods, a review of interview instructions, a discussion of the importance of telling the truth, and practice providing narratives and episodic memory training.

- The **substantive phase** most often includes a narrative description of events, detail-seeking strategies, clarification, and testing of alternative hypotheses, when appropriate.

- The **closure phase** gives more attention to the socioemotional needs of a child, transitioning to nonsubstantive topics, allowing for questions, and discussing safety or educational messages.

Divergent research, state statutes, community standards, and identified child/case populations contribute to the variations among models. Lack of adherence to a particular model does not, in and of itself, deem an interview forensically unsound. Increasingly, forensic interviewers receive training in multiple models and use a blend of models individualized to the needs of the child and the case (MRCAC, 2014).

Rapport-Building Phase

All interview models acknowledge that building rapport is important for both the child and the interviewer. During this phase, the child can begin to trust the interviewer and become oriented to the interview process. The interviewer can begin to understand the child's linguistic patterns, gauge the child's willingness to participate, and start to respond appropriately to the child's developmental, emotional, and cultural needs. A narrative approach to building rapport sets a pattern of interaction that should be maintained throughout the interview (Hershkowitz et al., 2015; Collins, Lincoln, and Frank, 2002; Hershkowitz, 2011).

Interview Instructions

Giving interview instructions during the rapport-building phase sets expectations that the child should provide accurate and complete information and also mitigates suggestibility. The child's age may influence the number of instructions and, perhaps, the type of instructions that may be most helpful. Interviewers may want to include some of the following instructions:

- "I was not there and don't know what happened. When I ask you questions, I don't know the answer to those questions."

- "It's okay to say 'I don't know' or 'I don't understand that question.'"

- "Only talk about things that really happened." (This emphasizes the importance of the conversation.)

For younger children, interviewers may want to have them "practice" following each guideline to demonstrate their understanding (APSAC, 2012; Saywitz and Camparo, 2009; Saywitz, Lyon, and Goodman, 2011). When children demonstrate these skills spontaneously, interviewers should reinforce them.

"Truth Versus Lies" Discussion

Recent research indicates that children may be less likely to make false statements if they have promised to tell the truth before the substantive phase of the interview (Lyon and Evans, 2014; Lyon and Dorado, 2008; Talwar et al., 2002). State statutes and community practices may vary about whether to include a "truth versus lies" discussion in forensic interviews. Some states require such a discussion or mandate that children take a developmentally appropriate oath before the substantive phase of the interview. In other states, interviewers have more autonomy regarding the techniques they use to encourage truth telling—to assess whether the child will be a competent witness in court and to increase the likelihood that the recorded interview will be admitted into evidence (Russell, 2006).

Narrative Practice/Episodic Memory Training

A substantial body of research indicates that encouraging children to give detailed responses early in the interview (i.e., during the rapport-building phase) enhances their informative responses to open-ended prompts in the substantive portion of the interview. When interviewers encourage these narrative descriptions early on, children typically will begin to provide more details without interviewers having to resort to more direct or leading prompts (Brubacher, Roberts, and Powell, 2011; Lamb et al., 2008; Poole and Lamb, 1998).

To help a child practice providing narratives, the interviewer may select a topic that was raised during a response to an earlier question, such as "Tell me some things about yourself," "What do you like to do for fun?" or "What did you do this morning?"; ask a question about a favorite activity; or ask for a description of the child's morning. The interviewer should then instruct the child to describe that topic from "beginning to end and not to leave anything out." The interviewer should continue to use cued, open-ended questions that incorporate the child's own words or phrases to prompt the child to greater elaboration. The interviewer may cue the child to tell more about an object, person, location, details of the activity, or a particular segment of time. This allows the child to provide a forensically detailed description of a nonabuse event and enables the interviewer to begin to understand the child's linguistic ability and style (APSAC, 2012; Saywitz and Camparo 2009; Saywitz, Lyon, and Goodman, 2011; Walker, 2013).

Substantive Phase

The interviewer should be as open-ended and nonsuggestive as possible when introducing the topic of suspected abuse, using a prompt such as “What are you here to talk to me about today?” If the child acknowledges the target topic, the interviewer should follow up with another open invitation, such as “Tell me everything and don’t leave anything out” (APSAC, 2012; Lamb et al., 2008; Orbach and Pipe, 2011; Saywitz and Camparo, 2009; Saywitz, Lyon, and Goodman, 2011) and proceed to the narrative and detail-gathering phase of the interview.

However, if a child is anxious or embarrassed, has been threatened or cautioned not to talk, or has not made a prior outcry of abuse, the interviewer may need a more focused approach (Pipe et al., 2007). There is a distinction between real and apparent reluctance. Real reluctance refers to children who are cautious and significantly unwilling to respond to questions, whereas apparent reluctance refers to children who are introspective before responding to questions. Interviewers should therefore allow for silence or hesitation without moving to more focused prompts too quickly. In many cases, gently reassuring the child that it is important for the interviewer to understand everything that happened can effectively combat a child’s reluctance.

Interviewers should plan for this transitional period deliberately, taking into account the child’s characteristics, information included in the initial report, and any case concerns (Smith and Milne, 2011). Variations exist among interviewing models as to the most effective and defensible way to help a reluctant child transition to the substantive portion of the interview. Broadly speaking, options range from (1) the use of escalating and focused prompts gleaned from information in the allegation report (APSAC, 2012; Lamb et al., 2008; Saywitz, Lyon, and Goodman, 2011) to (2) the use of an incremental approach exploring various topics, such as family members, caregiving routines, body safety, and so forth (APSAC, 2012; Faller, 2007) to (3) the use of human figure drawings along with a discussion of body safety and appropriate and inappropriate contact (Anderson et al., 2010).

Forensic interviewers who have been trained in multiple models may use a variety of options, depending on child and case characteristics. Use focused or direct prompts only if good reason exists to believe the child has been abused and the risk of continued abuse is greater than the risk of proceeding with an interview if no abuse has occurred (Lamb et al., 2008; Orbach and Pipe, 2011).

Narrative and Detail Gathering

All forensic interview models direct the interviewer to ask the child to provide a narrative account of his or her experience to gain a clear and accurate description of alleged events in the child’s own words. Do not interrupt this narrative, as it is the primary purpose of the forensic interview. Open-ended invitations (“Tell me more” or “What happened next?”) and cued narrative requests (“Tell me more about [fill in with child’s word]”) elicit longer, more detailed, and less self-contradictory information from children and adolescents (Lamb et al., 2008; Orbach and Pipe, 2011; Perona, Bottoms, and Sorenson, 2006). Because of their relatively underdeveloped memory retrieval processes, very young or less cognitively and linguistically skilled children may require greater scaffolding and more narrowly focused open-ended questions to elicit information regarding remembered events (Faller, 2007; Hershkowitz et al., 2012; Lamb et al., 2003; Orbach and Pipe, 2011). Cued and open-ended prompts, attentive listening, silence, and facilitators, such as reflection and paraphrasing, may help (Evans and Roberts, 2009). Additionally, “wh” questions

are the least leading way to ask about important but missing details and can either be open-ended ("What happened?") or more direct ("What was the man's name?") (Hershkowitz et al., 2006; Orbach and Pipe, 2011). Interviewers should delay the use of recognition prompts and questions that pose options for as long as possible (APSAC, 2012; Lamb et al., 2008; Saywitz and Camparo, 2009; Saywitz, Lyon, and Goodman, 2011).

Because many children experience multiple incidents of abuse, interviewers should ask them whether an event happened "one time or more than one time." If a child has been abused more than once, the interviewer should explore details regarding specific occurrences in a developmentally appropriate way (Walker, 2013), using the child's own wording to best cue the child to each incident (Brubacher, Roberts, and Powell, 2011; Brubacher et al., 2013; Brubacher and La Rooy, 2014; Schneider et al., 2011). Using prompts such as "first time," "last time," and other appropriate labels may lead to additional locations, acts, witnesses, or potential evidence.

No one recalls every detail about even well-remembered experiences. Questions related to core elements of the abuse can maximize the quantity and quality of information a child provides. Research suggests that children and adults may recall personally experienced events better than they recall peripheral details or events they witnessed (Perona, Bottoms, and Sorenson, 2006; Peterson, 2012).

Once the child's narrative account of an alleged incident(s) has been fully explored, the interviewer can then follow with focused questions, asking for sensory details, clarification, and other missing elements. If a child provides only brief responses, the interviewer should follow up by asking for additional information or explanation using focused questions that incorporate terms the child previously provided. Although particular elements may have forensic significance (e.g., temporal dating, number of events, sexual intent, penetration), the child may not have accurately perceived or stored the information in long-term memory (Friedman and Lyon, 2005; Hershkowitz et al., 2012; Orbach and Lamb, 2007; Lamb et al., 2015). Forensic interviewers should proceed with caution when encouraging children through the use of recognition prompts to provide such information.

Introducing externally derived information (e.g., information gathered outside the interview or that the child has not divulged) may be appropriate in some interviews. There is broad consensus, however, that interviewers should use such information with caution and only after attempting other questioning methods. It is important to understand the suggestibility of such information within the context of the overall interview, the other questions asked, the child's presentation and development, and the strength of any external evidence obtained. Before or during the interview, multidisciplinary teams should discuss how, if, and when to introduce externally derived information or evidence. The manner and extent to which this information is presented varies across jurisdictions and models.

Alternative Hypotheses

Contextually appropriate questions that explore other viable hypotheses for a child's behaviors or statements are essential to the overall integrity of the interview. Allow the child to explain apparently contradictory information, particularly as it concerns forensically relevant details (e.g., the suspect's identity or specific acts committed). Additionally, the interviewer may need to explore

the circumstances surrounding the targeted event to distinguish abuse from caregiving activities, particularly with a young child or one with limited abilities.

Questions about the child's source of information or prior conversations or instructions may be helpful if there are concerns about possible coaching or contamination. There is no one set of questions used routinely in every interview, as child characteristics, contextual settings, allegations, and case specifics vary greatly.

Consultation With the Multidisciplinary Team

Forensic interviews are best conducted within a multidisciplinary team context, as coordinating an investigation has been shown to increase the efficiency of the investigation while minimizing system-induced trauma in the child (Cronch, Viljoen, and Hansen, 2006; Jones et al., 2005). Before the interview, multidisciplinary team members should discuss possible barriers, case-specific concerns, and interviewing strategies, such as how best to introduce externally derived information, should that be necessary. Regardless of whether the forensic interview is conducted at a CAC or other child-friendly facility, the interviewer should communicate with the team members observing the interview to determine whether to raise additional questions or whether there are any ambiguities or apparent contradictions to resolve (Home Office, 2007; Jones et al., 2005). The interviewer often has to balance the team's request for further questions with the need to maintain legal defensibility and with the child's ability to provide the information requested.

Closure Phase

The closure phase helps provide a respectful end to a conversation that may have been emotionally challenging for the child. The interviewer may use various strategies during this phase (Anderson et al., 2010; APSAC, 2012; Home Office, 2007; Poole and Lamb, 1998):

- Ask the child if there is something else the interviewer needs to know.
- Ask the child if there is something he or she wants to tell or ask the interviewer.
- Thank the child for his or her effort rather than for specific content.

- Address the topic of safety plans and educational materials and provide a contact number for additional help.

Other Considerations

Multiple evidence-supported forensic interview models are used throughout the United States, and all of these require the interviewer to adapt the model to the needs of each child based on unique situational variables. Some of the more commonly faced situational variables are highlighted below.

Multiple, Nonduplicative Interviews

One comprehensive forensic interview is sufficient for many children, particularly if the child made a previous disclosure, possesses adequate language skills, and has the support of a family member or other close adult (APSAC, 2002; Faller, 2007; London et al., 2007; NCA, 2011; Olafson and Lederman, 2006). The literature clearly demonstrates the dangers of multiple interviewers repeatedly questioning a child or conducting duplicative interviews (Ceci and Bruck, 1995; Fivush, Peterson, and Schwarzmueller, 2002; Malloy and Quas, 2009; Poole and Lamb, 1998; Poole and Lindsay, 2002). However, some children require more time and familiarity to become comfortable and to develop trust in both the process and the interviewer. Recent research indicates that multiple interview sessions may allow reluctant, young, or traumatized children the opportunity to more clearly and completely share information (Leander, 2010; Pipe et al., 2007). Multiple, nonduplicative interviews are most effective when the interviewer uses best practices in forensic interviewing; adapts the interview structure to the developmental, cultural, and emotional needs of the child; and avoids suggestive and coercive approaches (Faller, Cordisco Steele, and Nelson-Gardell, 2010; La Rooy et al., 2010; La Rooy, Lamb, and Pipe, 2009).

Supervision and Peer Review

Although agreement exists that knowledge of forensic interviewing significantly increases through training, this newly acquired knowledge does not always translate into significant changes in interviewer practices (Lamb, Sternberg, Orbach, Hershkowitz, Horowitz, and Esplin, 2002; Lamb et al., 2008; Price and Roberts, 2011; Stewart, Katz, and La Rooy, 2011). Supervision, peer reviews, and other forms of feedback should help forensic interviewers integrate the skills they learned during initial training and also improve their practice over time.

Supervision facilitates one-on-one interaction between a more experienced forensic interviewer and a professional new to the job and may or may not include assessment of the interviewer's performance (Price and Roberts, 2011; Stewart, Katz, and La Rooy, 2011). Larger CACs may employ multiple forensic interviewers who can provide

individual support to newly trained interviewers. Often, CACs operating within a regional service area undertake similar efforts.

Peer review is a facilitated discussion with other interviewers or team members and is intended to both maintain and increase desirable practices in forensic interviewing (Stewart, Katz, and La Rooy, 2011). It is an opportunity for forensic interviewers to receive emotional and professional support and for other professionals to critique their work. The peer review should be a formalized process in a neutral environment with established group norms and a shared understanding of goals, processes, and purpose. Power dynamics, a lack of cohesion, and differing expectations can easily derail peer review efforts, leading to a failure to achieve real improvements in practice. Training in the use of tools for providing more effective feedback (e.g., guidelines for giving and receiving feedback), checklists to assist peer reviewers in defining practice aspects for review, and strong leadership can assist practitioners in establishing a meaningful and productive process.

Vicarious Trauma and Self-Care

Professionals exposed to the reports of abuse and victimization of children often suffer from vicarious traumatization, an affliction commonly called “the cost of caring” that has symptoms similar to those of posttraumatic stress disorder (Figley, 1995; Perron and Hiltz, 2006; Lipsky and Burk, 2009). Studies suggest that forensic interviewers, law enforcement officers, child protection workers, victim advocates, therapists, medical personnel, attorneys, and judges can all suffer from repeatedly hearing reports of child victimization (Conrad and Kellar-Guenther, 2006; Perron and Hiltz, 2006; Russell, 2010).

Vicarious trauma can be mitigated at multiple levels. Supervisors and organizations should be particularly attentive to the mental health of their staff and should be aware of factors that can exacerbate the development of vicarious trauma, including gender, past personal trauma, work dissatisfaction, large caseloads, long hours, and a lack of personal and professional support systems (Meyers and Cornille, 2002). Individuals should recognize the benefits of the work they undertake in their professional lives and celebrate their successes, knowing they have made a difference in a child’s life.

Summary

The CAC movement was born out of the concept that the traditional fragmented and duplicative child abuse investigative process was not in the best interests of children. The multidisciplinary team approach has proven to be more child-friendly and better able to meet the needs of children and their families (Bonarch, Mabry, and Potts-Henry, 2010; Miller and Rubin, 2009). This revolutionary approach should continue to guide the

nation's response to child abuse investigations. To increase the likelihood of successful outcomes for all children, it is imperative to continue ongoing discussions among professionals in both direct service delivery and program planning.

Although there have been significant efforts over the past several decades to improve the nation's response to child maltreatment, these efforts have often emanated from a single program or region without leading to a national debate on a particular topic, such as the development of forensic interviewing with children. This bulletin serves as the first collaborative effort, by professionals from many nationally recognized forensic interview training programs, to summarize the current knowledge and application of best practices in the field.

Interviewer Tips

Overall Considerations

- Conduct the interview as soon as possible after initial disclosure.
- Record the interview electronically.
- Hold the interview in a safe, child-friendly environment.
- Use open-ended questions throughout the interview, delaying the use of more focused questions for as long as possible.
- Consider the child's age, developmental ability, and culture.

Building Rapport With the Child

- Engage the child in brief conversation about his or her interests or activities.
- Provide an opportunity for the child to describe a recent nonabuse-related experience in detail.
- Describe the interview ground rules.
- Discuss the importance of telling the truth.

Conducting the Interview

- Transition to the topic of the suspected abuse carefully, taking into account the characteristics of the child and the case.
- Ask the child to describe his or her experience in detail, and do not interrupt the child during this initial narrative account.
- Once the initial account is fully explored, begin to ask more focused questions if needed to gather additional details, get clarification, or fill in missing information.
- Mirror the child's wording when asking follow-up questions.
- Exercise caution at this stage. Use focused queries judiciously and avoid suggestive questions that could compel the child to respond inaccurately.
- Explore other viable hypotheses for the child's behaviors or statements.

- Consult with those observing the interview to determine whether to raise additional questions or whether to resolve any ambiguities or contradictions.

Ending the Interview

- Ask the child if there is anything else he or she would like to share or to ask.
- Discuss safety plans and provide educational materials.
- Thank the child for participating.

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Chapter 13 - Understanding the Effects of Maltreatment on Brain Development

In recent years, there has been a surge of research into early brain development. Neuroimaging technologies, such as magnetic resonance imaging (MRI), provide increased insight about how the brain develops and how early experiences affect that development.

One area that has been receiving increasing research attention involves the effects of abuse and neglect on the developing brain, especially during infancy and early childhood. Much of this research is providing biological explanations for what practitioners have long been describing in psychological, emotional, and behavioral terms. There is now scientific evidence of altered brain functioning as a result of early abuse and neglect. This emerging body of knowledge has many implications for the prevention and treatment of child abuse and neglect.

This [chapter] provides basic information on typical brain development and the potential effects of abuse and neglect on that development. The information is designed to help professionals understand the emotional, mental, and behavioral impact of early abuse and neglect in children who come to the attention of the child welfare system.

How the Brain Develops

What we have learned about the process of brain development helps us understand more about the roles both genetics and the environment play in our development. It appears that genetics predispose us to develop in certain ways, but our experiences, including our interactions with other people, have a significant impact on how our predispositions are expressed. In fact, research now shows that many capacities thought to be fixed at birth are actually dependent on a sequence of experiences combined with heredity. Both factors are essential for optimum development of the human brain (Shonkoff & Phillips, 2000).

Early Brain Development

The raw material of the brain is the nerve cell, called the *neuron*. During fetal development, neurons are created and migrate to form the various parts of the brain. As neurons migrate, they also differentiate, or specialize, to govern specific functions in the body in response to chemical signals (Perry, 2002). This process of development occurs sequentially from the "bottom up," that is, from areas of the brain controlling the most primitive functions of the body (e.g., heart rate, breathing) to the most sophisticated functions (e.g., complex thought) (Perry, 2000a).

The first areas of the brain to fully develop are the brainstem and midbrain; they govern the bodily functions necessary for life, called the autonomic functions. At birth, these lower portions of the nervous system are very well developed, whereas the higher regions (the limbic system and cerebral cortex) are still rather primitive. Higher function brain regions involved in regulating emotions, language, and abstract thought grow rapidly in the first 3 years of life (ZERO TO THREE, 2012). (See Exhibit 1 for more information.)

The Growing Child's Brain

Brain development, or learning, is actually the process of creating, strengthening, and discarding connections among the neurons; these connections are called *synapses*. Synapses organize the brain by forming pathways that connect the parts of the brain governing everything we do—from breathing and sleeping to thinking and feeling. This is the essence of postnatal brain development, because at birth, very few synapses have been formed. The synapses present at birth are primarily those that govern our bodily functions such as heart rate, breathing, eating, and sleeping.

The development of synapses occurs at an astounding rate during a child's early years in response to that child's experiences. At its peak, the cerebral cortex of a healthy toddler may create 2 million synapses per second (ZERO TO THREE, 2012). By the time children are 2 years old, their brains have approximately 100 trillion synapses, many more than they will ever need. Based on the child's experiences, some synapses

are strengthened and remain intact, but many are gradually discarded. This process of synapse elimination—or pruning—is a normal part of development (Shonkoff & Phillips, 2000). By the time children reach adolescence, about half of their synapses have been discarded, leaving the number they will have for most of the rest of their lives.

Another important process that takes place in the developing brain is *myelination*. Myelin is the white fatty tissue that forms a sheath to insulate mature brain cells, thus ensuring clear transmission of neurotransmitters across synapses. Young children process information slowly because their brain cells lack the myelin necessary for fast, clear nerve impulse transmission (ZERO TO THREE, 2012). Like other neuronal growth processes, myelination begins in the primary motor and sensory areas (the brain stem and cortex) and gradually progresses to the higher-order regions that control thought, memories, and feelings. Also, like other neuronal growth processes, a child's experiences affect the rate and growth of myelination, which continues into young adulthood (Shonkoff & Phillips, 2000).

By 3 years of age, a baby's brain has reached almost 90 percent of its adult size. The growth in each region of the brain largely depends on receiving stimulation, which spurs activity in that region. This stimulation provides the foundation for learning.

Adolescent Brain Development

Studies using MRI techniques show that the brain continues to grow and develop into young adulthood (at least to the midtwenties). White matter, or brain tissue, volume has been shown to increase in adults as old as 32 (Lebel & Beaulieu, 2011). Right before puberty, adolescent brains experience a growth spurt that occurs mainly in the frontal lobe, which is the area that governs planning, impulse control, and reasoning. During the teenage years, the brain goes through a process of pruning synapses—somewhat like the infant and toddler brain— and also sees an increase in white matter and changes to neurotransmitter systems (Konrad, Firk, & Uhlhaas, 2013). As the teenager grows into young adulthood, the brain develops more myelin to insulate the nerve fibers and speed neural processing, and this myelination occurs last in the frontal lobe. MRI comparisons between the brains of teenagers and the brains of young adults have shown that most of the brain areas were the same—that is, the teenage brain had reached maturity in the areas that govern such abilities as speech and sensory capabilities.

The major difference was the immaturity of the teenage brain in the frontal lobe and in the myelination of that area (National Institute of Mental Health, 2001).

Normal puberty and adolescence lead to the maturation of a physical body, but the brain lags behind in development, especially in the areas that allow teenagers to reason

and think logically. Most teenagers act impulsively at times, using a lower area of their brains—their “gut reaction”—because their frontal lobes are not yet mature. Impulsive behavior, poor decisions, and increased risk-taking are all part of the normal teenage experience. Another change that happens during adolescence is the growth and transformation of the limbic system, which is responsible for our emotions. Teenagers may rely on their more primitive limbic system in interpreting emotions and reacting since they lack the more mature cortex that can override the limbic response (Chamberlain, 2009).

Plasticity—The Influence of Environment

Researchers use the term *plasticity* to describe the brain’s ability to change in response to repeated stimulation. The extent of a brain’s plasticity is dependent on the stage of development and the particular brain system or region affected (Perry, 2006). For instance, the lower parts of the brain, which control basic functions such as breathing and heart rate, are less flexible, or plastic, than the higher functioning cortex, which controls thoughts and feelings. While cortex plasticity decreases as a child gets older, some degree of plasticity remains. In fact, this brain plasticity is what allows us to keep learning into adulthood and throughout our lives.

The developing brain’s ongoing adaptations are the result of both genetics and experience. Our brains prepare us to expect certain experiences by forming the pathways needed to respond to those experiences. For example, our brains are “wired” to respond to the sound of speech; when babies hear people speaking, the neural systems in their brains responsible for speech and language receive the necessary stimulation to organize and function (Perry, 2006). The more babies are exposed to people speaking, the stronger their related synapses become. If the appropriate exposure does not happen, the pathways developed in anticipation may be discarded. This is sometimes referred to as the concept of “use it or lose it.” It is through these processes of creating, strengthening, and discarding synapses that our brains adapt to our unique environment.

The ability to adapt to our environment is a part of normal development. Children growing up in cold climates, on rural farms, or in large sibling groups learn how to function in those environments. Regardless of the general environment, though, all children need stimulation and nurturance for healthy development. If these are lacking (e.g., if a child’s caretakers are indifferent, hostile, depressed, or cognitively impaired), the child’s brain development may be impaired. Because the brain adapts to its environment, it will adapt to a negative environment just as readily as it will adapt to a positive one.

Sensitive Periods

Researchers believe that there are sensitive periods for development of certain capabilities. These refer to windows of time in the developmental process when certain parts of the brain may be most susceptible to particular experiences. Animal studies have shed light on sensitive periods, showing, for example, that animals that are artificially blinded during the sensitive period for developing vision may never develop the capability to see, even if the blinding mechanism is later removed.

It is more difficult to study human sensitive periods, but we know that, if certain synapses and neuronal pathways are not repeatedly activated, they may be discarded, and their capabilities may diminish. For example, infants have a genetic predisposition to form strong attachments to their primary caregivers, but they may not be able to achieve strong attachments, or trusting, durable bonds if they are in a severely neglectful situation with little one-on-one caregiver contact. Children from Romanian institutions who had been severely neglected had a much better attachment response if they were placed in foster care—and thus received more stable parenting—before they were 24 months old (Smyke, Zeanah, Fox, Nelson, & Guthrie, 2010). This indicates that there is a sensitive period for attachment, but it is likely that there is a general sensitive period rather than a true cut-off point for recovery (Zeanah, Gunnar, McCall, Kreppner, & Fox, 2011).

While sensitive periods exist for development and learning, we also know that the plasticity of the brain often allows children to recover from missing certain experiences. Both children and adults may be able to make up for missed experiences later in life, but it is likely to be more difficult. This is especially true if a young child was deprived of certain stimulation, which resulted in the pruning of synapses (neuronal connections) relevant to that stimulation and the loss of neuronal pathways. As children progress through each developmental stage, they will learn and master each step more easily if their brains have built an efficient network of pathways to support optimal functioning.

Memories

The organizing framework for children's development is based on the creation of memories. When repeated experiences strengthen a neuronal pathway, the pathway becomes encoded, and it eventually becomes a memory. Children learn to put one foot in front of the other to walk. They learn words to express themselves. And they learn that a smile usually brings a smile in return. At some point, they no longer have to think much about these processes—their brains manage these experiences with little effort because the memories that have been created allow for a smooth, efficient flow of information.

The creation of memories is part of our adaptation to our environment. Our brains attempt to understand the world around us and fashion our interactions with that world in a way that promotes our survival and, hopefully, our growth, but if the early environment is abusive or neglectful, our brains may create memories of these experiences that adversely color our view of the world throughout our life.

Babies are born with the capacity for *implicit memory*, which means that they can perceive their environment and recall it in certain unconscious ways (Applegate & Shapiro, 2005). For instance, they recognize their mother's voice from an unconscious memory. These early implicit memories may have a significant impact on a child's subsequent attachment relationships.

In contrast, *explicit memory*, which develops around age 2, refers to conscious memories and is tied to language development. Explicit memory allows children to talk about themselves in the past and future or in different places or circumstances through the process of conscious recollection (Applegate & Shapiro, 2005).

Sometimes, children who have been abused or suffered other trauma may not retain or be able to access explicit memories of their experiences; however, they may retain implicit memories of the physical or emotional sensations, and these implicit memories may produce flashbacks, nightmares, or other uncontrollable reactions (Applegate & Shapiro, 2005). This may be the case with very young children or infants who suffer abuse or neglect.

Responding to Stress

We all experience different types of stress throughout our lives. The type of stress and the timing of that stress determine whether and how there is an impact on the brain. The National Scientific Council on the Developing Child (2014) outlines three classifications of stress:

- **Positive stress** is moderate, brief, and generally a normal part of life (e.g., entering a new child care setting). Learning to adjust to this type of stress is an essential component of healthy development.
- **Tolerable stress** includes events that have the potential to alter the developing brain negatively, but which occur infrequently and give the brain time to recover (e.g., the death of a loved one).
- **Toxic stress** includes strong, frequent, and prolonged activation of the body's stress response system (e.g., chronic neglect).

Healthy responses to typical life stressors (i.e., positive and tolerable stress events) are very complex and may change depending on individual and environmental characteristics, such as genetics, the presence of a sensitive and responsive caregiver,

and past experiences. A healthy stress response involves a variety of hormone and neurochemical systems throughout the body, including the sympathetic-adrenomedullary (SAM) system, which produces adrenaline, and the hypothalamic-pituitary-adrenocortical (HPA) system, which produces cortisol (National Council on the Developing Child, 2014). Increases in adrenaline help the body engage energy stores and alter blood flow. Increases in cortisol also help the body engage energy stores and also can enhance certain types of memory and activate immune responses. In a healthy stress response, the hormonal levels will return to normal after the stressful experience has passed.

Effects of Maltreatment on Brain Development

Just as positive experiences can assist with healthy brain development, children's experiences with child maltreatment or other forms of toxic stress, such as domestic violence or disasters, can negatively affect brain development. This includes changes to the structure and chemical activity of the brain (e.g., decreased size or connectivity in some parts of the brain) and in the emotional and behavioral functioning of the child (e.g., over-sensitivity to stressful situations). For example, healthy brain development includes situations in which babies' babbles, gestures, or cries bring reliable, appropriate reactions from their caregivers. These caregiver-child interactions—sometimes referred to as "serve and return"—strengthen babies' neuronal pathways regarding social interactions and how to get their needs met, both physically and emotionally. If children live in a chaotic or threatening world, one in which their caregivers respond with abuse or chronically provide no response, their brains may become hyperalert for danger or not fully develop. These neuronal pathways that are developed and strengthened under negative conditions prepare children to cope in that negative environment, and their ability to respond to nurturing and kindness may be impaired (Shonkoff & Phillips, 2000).

The specific effects of maltreatment may depend on such factors as the age of the child at the time of the maltreatment, whether the maltreatment was a one-time incident or chronic, the identity of the abuser (e.g., parent or other adult), whether the child had a dependable nurturing individual in his or her life, the type and severity of the maltreatment, the intervention, how long the maltreatment lasted, and other individual and environmental characteristics.

Effects of Maltreatment on Brain Structure and Activity

Toxic stress, including child maltreatment, can have a variety of negative effects on children's brains:

- **Hippocampus:** Adults who were maltreated may have reduced volume in the hippocampus, which is central to learning and memory (McCrory, De

Brito, & Viding, 2010; Wilson, Hansen, & Li, 2011). Toxic stress also can reduce the hippocampus's capacity to bring cortisol levels back to normal after a stressful event has occurred (Shonkoff, 2012).

- **Corpus callosum:** Maltreated children and adolescents tend to have decreased volume in the corpus callosum, which is the largest white matter structure in the brain and is responsible for inter-hemispheric communication and other processes (e.g., arousal, emotion, higher cognitive abilities) (McCrory, De Brito, & Viding, 2010; Wilson, Hansen, & Li, 2011).
- **Cerebellum:** Maltreated children and adolescents tend to have decreased volume in the cerebellum, which helps coordinate motor behavior and executive functioning (McCrory, De Brito, & Viding, 2010).
- **Prefrontal cortex:** Some studies on adolescents and adults who were severely neglected as children indicate they have a smaller prefrontal cortex, which is critical to behavior, cognition, and emotion regulation (National Scientific Council on the Developing Child, 2012), but other studies show no differences (McCrory, De Brito, & Viding, 2010). Physically abused children also may have reduced volume in the orbitofrontal cortex, a part of the prefrontal cortex that is central to emotion and social regulation (Hanson et al., 2010).
- **Amygdala:** Although most studies have found that amygdala volume is not affected by maltreatment, abuse and neglect can cause overactivity in that area of the brain, which helps determine whether a stimulus is threatening and trigger emotional responses (National Scientific Council on the Developing Child, 2010b; Shonkoff, 2012).
- **Cortisol levels:** Many maltreated children, both in institutional and family settings, and especially those who experienced severe neglect, tend to have lower than normal morning cortisol levels coupled with flatter release levels throughout the day (Bruce, Fisher, Pears, & Levine, 2009; National Scientific Council on the Developing Child, 2012). (Typically, children have a sharp increase in cortisol in the morning followed by a steady decrease throughout the day.) On the other hand, children in foster care who experienced severe emotional maltreatment had higher than normal morning cortisol levels. These results may be due to the body reacting differently to different stressors. Abnormal cortisol levels can have many negative effects. Lower cortisol levels can lead to decreased energy resources, which could affect learning and socialization; externalizing disorders; and increased vulnerability to autoimmune disorders (Bruce, Fisher, Pears, & Levine, 2009). Higher cortisol levels could harm cognitive processes, subdue immune and inflammatory reactions, or heighten the risk for affective disorders.

- **Other:** Children who experienced severe neglect early in life while in institutional settings often have decreased electrical activity in their brains, decreased brain metabolism, and poorer connections between areas of the brain that are key to integrating complex information (National Scientific Council on the Developing Child, 2012). These children also may continue to have abnormal patterns of adrenaline activity years after being adopted from institutional settings. Additionally, malnutrition, a form of neglect, can impair both brain development (e.g., slowing the growth of neurons, axons, and synapses) and function (e.g., neurotransmitter syntheses, the maintenance of brain tissue) (Prado & Dewey, 2012).

We also know that some cases of physical abuse can cause immediate direct structural damage to a child's brain. For example, according to the National Center on Shaken Baby Syndrome (n.d.), shaking a child can destroy brain tissue and tear blood vessels. In the short-term, this can lead to seizures, loss of consciousness, or even death. In the long-term, shaking can damage the fragile brain so that a child develops a range of sensory impairments, as well as cognitive, learning, and behavioral disabilities. Other types of head injuries caused by physical abuse can have similar effects.

Epigenetics

A burgeoning field of research related to brain development is epigenetics. Epigenetics refers to alterations to the genes that do not include structural changes to the DNA nucleotide sequence (Orr & Kaufman, 2014). An epigenetic modification occurs when chemical "signatures" attach themselves to genes, which, in turn, helps determine how the genes are expressed (i.e., whether they are turned on or off). These changes can affect the expression of genes in brain cells, may be permanent or temporary, and can be inherited by the person's offspring (National Scientific Council on the Developing Child, 2010a). The chemical experiences are initiated by life experiences, both positive and negative, as well as nutrition and exposure to toxins or drugs (National Scientific Council on the Developing Child, 2010a).

Although the field of epigenetics is still in its infancy, studies have indicated that child maltreatment can cause epigenetic modifications in victims. In one study of individuals with posttraumatic stress disorder (PTSD), those who had been maltreated as children exhibited more epigenetic changes in genes associated with central nervous system development and immune system regulation than nonmaltreated individuals with PTSD (Mehta et al., 2013). Furthermore, the findings indicated that the maltreated individuals had up to 12 times more epigenetic changes than nonmaltreated individuals, which may mean that maltreated individuals may experience PTSD uniquely and may require different types of treatment than other groups with PTSD. Another study found decreased hippocampal glucocorticoid receptor expression, which affects HPA activity,

in suicide victims with histories of child abuse compared to nonabused suicide victims (McGowan et al., 2009).

Effects of Maltreatment on Behavioral, Social, and Emotional Functioning

The changes in brain structure and chemical activity caused by child maltreatment can have a wide variety of effects on children's behavioral, social, and emotional functioning.

Persistent Fear Response. Chronic stress or repeated trauma can result in a number of biological reactions, including a persistent fear state (National Scientific Council on the Developing Child, 2010b). Chronic activation of the neuronal pathways involved in the fear response can create permanent memories that shape the hild's perception of and response to the environment. While this adaptation may be necessary for survival in a hostile world, it can become a way of life that is difficult to change, even if the environment improves. Children with a persistent fear response may lose their ability to differentiate between danger and safety, and they may identify a threat in a nonthreatening situation (National Scientific Council on the Developing Child, 2010b). For example, a child who has been maltreated may associate the fear caused by a specific person or place with similar people or places that pose no threat. This generalized fear response may be the foundation of future anxiety disorders, such as PTSD (National Scientific Council on the Developing Child, 2010b).

Hyperarousal. When children are exposed to chronic, traumatic stress, their brains sensitize the pathways for the fear response and create memories that automatically trigger that response without conscious thought. This is called *hyperarousal*. These children may be highly sensitive to nonverbal cues, such as eye contact or a touch on the arm, and they may be more likely to misinterpret them (National Scientific Council on the Developing Child, 2010b). Consumed with a need to monitor nonverbal cues for threats, their brains are less able to interpret and respond to verbal cues, even when they are in an environment typically considered nonthreatening, like a classroom. While these children are often labeled as learning disabled, the reality is that their brains have developed so that they are constantly on alert and are unable to achieve the relative calm necessary for learning (Child Trauma Academy, n.d.).

Increased Internalizing Symptoms. Child maltreatment can lead to structural and chemical changes in the areas of the brain involved in emotion and stress regulation (National Scientific Council on the Developing Child, 2010b). For example, maltreatment can affect connectivity between the amygdala and hippocampus, which can then initiate the development of anxiety and depression by late adolescence (Herringa et al., 2013).

Additionally, early emotional abuse or severe deprivation may permanently alter the brain's ability to use serotonin, a neurotransmitter that helps produce feelings of well-being and emotional stability (Healy, 2004).

Diminished Executive Functioning. Executive functioning generally includes three components: working memory (being able to keep and use information over a short period of time), inhibitory control (filtering thoughts and impulses), and cognitive or mental flexibility (adjusting to changed demands, priorities, or perspectives) (National Scientific Council on the Developing Child, 2011). The structural and neurochemical damage caused by maltreatment can create deficits in all areas of executive functioning, even at an early age (Hostinar, Stellern, Schaefer, Carlson, & Gunnar, 2012; National Scientific Council on the Developing Child, 2011). Executive functioning skills help people achieve academic and career success, bolster social interactions, and assist in everyday activities. The brain alterations caused by a toxic stress response can result in lower academic achievement, intellectual impairment, decreased IQ, and weakened ability to maintain attention (Wilson, 2011).

Delayed Developmental Milestones. Although neglect often is thought of as a failure to meet a child's physical needs for food, shelter, and safety, neglect also can be a failure to meet a child's cognitive, emotional, or social needs. For children to master developmental tasks in these areas, they need opportunities and encouragement from their caregivers. If this stimulation is lacking during children's early years, the weak neuronal pathways that developed in expectation of these experiences may wither and die, and the children may not achieve the usual developmental milestones. For example, babies need to experience face-to-face baby talk and hear countless repetitions of sounds in order to build the brain circuitry that will enable them to start making sounds and eventually say words. If babies' sounds are ignored repeatedly when they begin to babble at around 6 months, their language may be delayed. In fact, neglected children often do not show the rapid growth that normally occurs in language development at 18–24 months (Scannapieco, 2008). These types of delays may extend to all types of normal development for neglected children, including their cognitive-behavioral, socio-emotional, and physical development (Scannapieco, 2008).

Weakened Response to Positive Feedback. Children who have been maltreated may be less responsive to positive stimuli than nonmaltreated children. A study of young adults who had been maltreated found that they rated monetary rewards less positively than their peers and demonstrated a weaker response to reward cues in the basal ganglia areas of the brain responsible for reward processing (Dillon et al., 2009).

Complicated Social Interactions. Toxic stress can alter brain development in ways that make interaction with others more difficult. Children or youth with toxic stress may find it more challenging to navigate social situations and adapt to changing social contexts (Hanson et al., 2010). They may perceive threats in safe situations more frequently and react accordingly, and they may have more difficulty interacting with others (National Scientific Council on the Developing Child, 2010b). For example, a maltreated child may misinterpret a peer's neutral facial expression as anger, which may cause the maltreated child to become aggressive or overly defensive toward the peer.

Impact of Maltreatment on Adolescents The effects of maltreatment can continue to influence brain development and activity into adolescence and adulthood. These effects may be caused by the cumulative effects of abuse or neglect throughout their lives or by maltreatment newly experienced as an adolescent. Most teens act impulsively at times, but for teens who have been maltreated, this impulsive behavior may be even more apparent. Often, these youth have developed brains that focus on survival, at the expense of the more advanced thinking that happens in the brain's cortex (Chamberlain, 2009). An underdeveloped cortex can lead to increased impulsive behavior, as well as difficulties with tasks that require higher-level thinking and feeling. These teens may show delays in school and in social skills as well (Chamberlain, 2009). They may be more drawn to taking risks, and they may have more opportunities to experiment with drugs and crime if they live in environments that put them at increased risk for these behaviors. Maltreatment as a younger child can have longitudinal negative effects on brain development during adolescence. Adolescents with a history of childhood maltreatment can have decreased levels of growth in the hippocampus and amygdala compared to nonmaltreated adolescents (Whittle et al., 2013). Adolescents also may experience the effects highlighted in the previous section.

Implications for Practice and Policy

The knowledge we gained from research examining the effects of maltreatment on brain development can be helpful in many ways. With this information we are better able to understand what is happening within the brains of children who have been abused and neglected. In fact, much of this research is providing concrete/scientific evidence for what professionals and caregivers have long described in behavioral, emotional, and psychological terms. We also now know that children who were reared in severely stressful environments can see positive effects on brain development and functioning when their living environments improve. For example, children who lived in Romanian institutions and then moved into foster care settings had larger total volumes in cortical white matter and the posterior corpus callosum than children who remained in institutional care (though these volumes were smaller than never-institutionalized

children) (Sheridan, Fox, Zeanah, McLaughlin, & Nelson, 2012). We can use this information to improve our systems of care and to strengthen our prevention efforts.

The Role of the Child Welfare System

While the goal of the child welfare system is to protect children, many child welfare interventions—such as investigation, appearance in court, removal from home, placement in a foster home, etc.—may actually reinforce the child's view that the world is unknown, uncontrollable, and frightening. A number of trends in child welfare may help provide a more caring view of the world to an abused or neglected child. These trends include:

- Trauma-informed care
- Family-centered practice and case planning, including parent-child interaction therapy
- Individualized services for children and families
- The growth of child advocacy centers, where children can be interviewed and assessed and receive services in a child-friendly environment
- The use of differential response to ensure children's safety while providing nonadversarial support to families in low-risk cases
- The promotion of evidence-based practices

Federal Focus on Trauma- Informed Care More child welfare agencies are using a trauma-informed approach to serve children and families. They are considering the impact of traumatic events, such as maltreatment, domestic violence, being separated from loved ones, and the effects of poverty, on children and families and incorporating practices that acknowledge the effects of current and intergenerational trauma. During the past decade, the U.S. Department of Health and Human Services (HHS) has emphasized the use of trauma-informed care by agencies and professionals. It funded grants focusing on this approach, such as the Promoting Well-Being and Adoption After Trauma cluster (2013) and the Integrating Trauma-Informed and Trauma- Focused Practice in Child Protective Service (CPS) Delivery cluster (2011). (For more information about the latter cluster, view the related Children's Bureau Express article at https://cbexpress.acf.hhs.gov/index.cfm?event=website.viewArticles&issueid=132&articleid=3392.) HHS also has incorporated trauma-informed care into its guidance to States, including a letter to all the directors of State and Tribal child welfare agencies (see http://www.hhs.gov/secretary/ about/blogs/childhood-trauma-recover.html).

For more information about trauma-informed care, visit Child Welfare Information Gateway at https://www.childwelfare. gov/topics/responding/trauma.

Prevention. Child welfare systems that devote significant efforts to prevention may be the most successful in helping children and families and promoting healthy brain development. By the time a child who has been abused or neglected comes to the attention of professionals, some negative effects are likely. Prevention efforts should focus on supporting and strengthening children's families so that children have the best chance of remaining safely in their homes and communities while receiving proper nurturing and care. These efforts may target the general population ("primary" or "universal" prevention) by educating the public and changing policies to promote healthy brain development. Prevention efforts also may target children and families considered to be at-risk of developing problems ("secondary" or "selected" prevention).

Prevention efforts for at-risk families should focus on strengthening the family and building on the family's positive attributes. Recent prevention resource guides from the HHS Children's Bureau (2015) encourage professionals to promote six "protective factors" that can strengthen families, help prevent abuse and neglect, and promote healthy brain development:

- Nurturing and attachment
- Knowledge of parenting and of child and youth development
- Parental resilience
- Social connections
- Concrete supports for parents
- Social and emotional competence for children

Brain research underscores the importance of prevention efforts that target the youngest children. For example, early childhood home visiting programs for expectant and new mothers, who might be at-risk because of their age, income, or other circumstances, show promise for mitigating maternal stress, thus keeping adversity from becoming toxic stress (Garner, 2013). Parent education programs also serve as a prevention method that can promote protective factors and lead to positive outcomes for both parents and children. The Centers for Disease Control and Prevention (CDC) developed the Essentials for Childhood Framework to help communities prevent child maltreatment. This framework is based on establishing safe, stable, and nurturing relationships between children and caregivers. (See http://www.cdc.gov/ViolencePrevention/childmaltreatment/ essentials/index.html for more information.)

Early Intervention. Intensive, early interventions when the brain is most plastic are much more effective than reactive services as the child ages (Perry, 2009). In

recognition of this fact, Federal legislation requires States to develop referral procedures for children ages 0–36 months who are involved in a substantiated case of child abuse or neglect. Once a child is identified, States must provide intervention services through Early Intervention Plans funded under Part C of the Individuals with Disabilities Education Improvement Act. A number of States developed innovative programs to meet these requirements and to identify and help the youngest victims of abuse and neglect (Child Welfare Information Gateway, 2013). (For more information about early intervention, refer to *Addressing the Needs of Young Children in Child Welfare: Part C—Early Intervention Services* at https://www.childwelfare.gov/pubs/partc/.)

One theory about healing a damaged or altered brain is that the interventions must target those portions of the brain that have been altered (Perry, 2000b). Because brain functioning is altered by repeated experiences that strengthen and sensitize neuronal pathways, interventions should not be limited to weekly therapy appointments. Interventions should address the totality of the child's life, providing frequent, consistent replacement experiences so that the child's brain can begin to incorporate a new environment—one that is safe, predictable, and nurturing.

The following are examples of models and interventions available to child welfare and related professionals to assist children and youth who have been maltreated or otherwise exposed to toxic stress:

- **The neurosequential model of therapeutics (NMT)** is based on the fact that the higher brain functions (e.g., speech, relational interactions) depend on input from lower brain functions (e.g., stress responses) (Perry, 2009). Many clinical interventions, however, focus on the higher brain functions rather than the lower brain functions, which may be the source of the child's issues. NMT has three central elements: (1) a developmental history that helps delineate the timing, nature, and severity of developmental challenges; (2) a current assessment of functioning to help determine which neural systems and brain areas are affected and what the developmental level of the child is in various areas (e.g., speech, social skills); and (3) specific recommendations for the interventions to be used, with a focus on the sequence of the interventions (i.e., focusing on deficits in the lower brain first and progressing to the higher brain functions).

- **The Attachment and Biobehavioral Catch-up (ABC) for Infants and Young Children** intervention is designed for the parents of young children who have experienced early adversity (Dozier &

Fisher, 2014). ABC is implemented during 10 sessions in the parents' homes and includes both the parents and children. The sessions focus on providing clear feedback to parents about nurturance and following their child's lead, and include the review of video clips of interactions between the parents and child. A study of ABC found that children who received the intervention showed a steeper slope of cortisol production and higher wake-up cortisol values (i.e., healthier cortisol levels) than nonintervention children (Dozier & Fisher, 2014). These effects were still seen even at 3 years after the intervention.

- **Multidimensional Treatment Foster Care for Preschoolers (MTFC-P),** which typically lasts 9 to 12 months, helps parents learn and practice behavior management techniques (Dozier & Fisher, 2014). This helps children experience a more controlled and stable environment, which, in turn, helps enhance their regulatory capabilities. Foster parents are trained prior to placement, and program staff are available 24 hours a day to provide support. A support group is available, too. Children also participate in a weekly therapeutic playgroup to practice self-regulatory skills. If children will be returning to their birth families, MTFC-P staff provide training to the birth parents as well. Similar to the ABC intervention, children receiving MTFC-P had more stable cortisol levels than those who did not receive MTFC-P (Dozier & Fisher, 2014).

Children's recovery depends on a variety of factors, including the timing, severity, and duration of the maltreatment or other toxic stress, the intervention itself, and the individual child's response to the maltreatment (National Scientific Council on the Developing Child, 2012).

In some cases, doctors may prescribe psychotropic medications for certain mental health conditions, such as depression or anxiety. The Children's Bureau developed a guide, *Making Healthy Choices: A Guide on Psychotropic Medications for Youth in Foster Care*, to help adolescents better understand their options. The guide is available at https://www.childwelfare.gov/ pubs/makinghealthychoices.

For more information about psychotropic medications, visit Child Welfare Information Gateway at https://www.childwelfare.gov/topics/systemwide/mentalhealth/effectiveness/psychotropic.

The Role of Caregivers

Many children who suffered abuse and neglect are removed from their homes (for their safety) by the child welfare system. Extended family, foster parents, or group home staff may temporarily care for these children, and some will be adopted. In these cases, educating caregivers about the possible effects of maltreatment on brain development, and the resulting symptoms, may help them to better understand and support the children in their care. Child welfare workers may also want to explore any past abuse or trauma experienced by parents that may influence their parenting skills and behaviors.

It is important for caregivers to have realistic expectations for their children. Children who have been abused or neglected may not be functioning at their chronological age in terms of their physical, social, emotional, and cognitive skills. They may also be displaying unusual and/or difficult coping behaviors.

For example, abused or neglected children may:

- Be unable to control their emotions and have frequent outbursts
- Be quiet and submissive
- Have difficulties learning in school
- Have difficulties getting along with siblings or classmates
- Have unusual eating or sleeping behaviors
- Attempt to provoke fights or solicit sexual experiences
- Be socially or emotionally inappropriate for their age
- Be unresponsive to affection

Understanding some basic information about the neurobiology underlying many challenging behaviors may help caregivers shape their responses more effectively. They also need to know as much as possible about the particular circumstances and background of the individual children in their care.

In general, children who have been abused or neglected need nurturance, stability, predictability, understanding, and support (Committee on Early Childhood, Adoption and Dependent Care, 2000). They may need frequent, repeated experiences of these kinds to begin altering their view of the world from one that is uncaring or hostile to one that is caring and supportive. Until that view begins to take hold in a child's mind, the child may not be able to engage in a truly positive relationship, and the longer a child lives in an abusive or neglectful environment, the harder it will be to convince the child's brain that the world can change. Consistent nurturing from caregivers who receive training and support may offer the best hope for the children who need it most.

Summary

In 2012, approximately 686,000 children were determined to be victims of abuse and/or neglect (U.S. Department of Health and Human Services, 2013), but it is likely that many more children are actually suffering under adverse conditions. These children may have already suffered damage to their growing brains, and this damage may affect their ability to learn, form healthy relationships, and lead healthy, positive lives.

One lesson we have learned from the research on brain development is that environment has a powerful influence on development. Stable, nurturing caregivers and knowledgeable, supportive professionals can have a significant impact on these children's development. Focusing on preventing child abuse and neglect, helping to strengthen families through trauma-informed systems and practices, and ensuring that children receive needed services are some of the most important efforts we can undertake.

Glossary

Amygdala: A component of the limbic system that is involved in the expression and perception of emotion

Axon: The fiber-like extension of a neuron through which the cell carries information to target cells

Basal ganglia: Deeply placed masses of gray matter within each cerebral hemisphere that assist in voluntary motor functioning

Brainstem: The structure at the base of the brain through which the forebrain sends information to, and receives information from, the spinal cord and peripheral nerves

Cerebellum: A portion of the brain that helps regulate posture, balance, and coordination

Cerebral cortex: The intricately folded surface layer of gray matter of the brain that functions chiefly in coordination of sensory and motor information. It is divided into four lobes: frontal, parietal, temporal, and occipital

Corpus callosum: The largest white matter structure in the brain. It connects the left and right cerebral hemispheres and facilitates communication for emotion and higher cognitive abilities

Cortisol: A glucocorticoid produced by the adrenal cortex that mediates various metabolic processes, has anti-inflammatory and immunosuppressive properties, and whose levels in the blood may become elevated in response to physical or psychological stress

Epigenetics: The study of how environmental factors like diet, stress, and post-natal care can change gene expression (when genes turn on or off) without altering DNA sequence

Executive functioning: A group of skills that help people focus on multiple streams of information at the same time and revise plans as necessary

Frontal lobe: One of the four divisions of each cerebral hemisphere. The frontal lobe is important for controlling movement, thinking, and judgment

Gray matter: Neural tissue, especially of the brain and spinal cord, that contains cell bodies as well as some nerve fibers, has a brownish gray color, and forms most of the cortex and nuclei of the brain, the columns of the spinal cord, and the bodies of ganglia

Hippocampus: A component of the limbic system that is involved in learning and memory

Hypothalamic-pituitary-adrenocortical (HPA) system: A hormonal system that produces cortisol in the outer shell of the adrenal gland to help regulate the body's stress response system

Limbic system: A set of brain structures that regulates our feelings, emotions, and motivations and that is also important in learning and memory. Includes the thalamus, hypothalamus, amygdala, and hippocampus

Midbrain: The upper part of the brainstem, which controls some reflexes and eye movements

Neuron: A unique type of cell found in the brain and body that is specialized to process and transmit information

Neurotransmitter: A chemical produced by neurons to carry messages to other neurons

Plasticity: The capacity of the brain to change its structure and function within certain limits. Plasticity underlies brain functions, such as learning, and allows the brain to generate normal, healthy responses to long-lasting environmental changes

Prefrontal cortex: A highly developed area at the front of the brain that plays a role in executive functions such as judgment, decision-making, and problem-solving, as well as emotional control and memory

Receptor: A protein that recognizes specific chemicals (e.g., neurotransmitters, hormones) and transmits the message carried by the chemical into the cell on which the receptor resides

Sensitive period: Windows of time in the developmental process when certain parts of the brain may be most susceptible to particular experiences

Sympathetic-adrenomedullary (SAM) system: A hormonal system that produces adrenaline in the central part of the adrenal gland to help regulate the body's stress response system and triggers the "fight or flight" response

Synapse: The site where presynaptic and postsynaptic neurons communicate with each other

Temporal lobe: One of the four major subdivisions of each hemisphere of the cerebral cortex that assists in auditory perception, speech, and visual perceptions

White matter: Neural tissue, especially of the brain and spinal cord, that consists largely of myelinated nerve fibers bundled into tracts that help transmit signals between areas of the brain. It gets its name from the white color of the myelin

Additional Resources

California Evidence-Based Clearinghouse for Child Welfare (CEBC)—The CEBC identifies and disseminates information about evidence-based practices in child welfare, including trauma treatment for children and youth. http://www.cebc4cw.org/topic/trauma-treatment-for-children/

Center on the Developing Child—Founded and directed by Jack Shonkoff, M.D., the Center publishes and links to research on early brain development, learning, and behavior and how to apply that knowledge to policies and practices. www.developingchild.harvard.edu

Centers for Disease Control and Prevention (CDC)— The CDC website offers several publications that promote safe, stable, and nurturing relationships to prevent child maltreatment. CDC also sponsors the Adverse Childhood Experiences study. http://www.cdc.gov/ ViolencePrevention/childmaltreatment/essentials/index.html http://www.cdc.gov/violenceprevention/acestudy/

Child Trauma Academy—This website offers online courses, trainings, and other resources on early brain development and the impact of maltreatment. www.childtrauma.org/

From Neurons to Neighborhoods: The Science of Early Childhood Development—This book was written in 2000 by a committee of experts (Committee on Integrating the Science of Early Childhood Development, J. P. Shonkoff and D. A. Phillips, eds.). It highlights findings of neurobiology and explores how we can nurture and protect young children. http://www.nap. edu/catalog/9824/from-neurons-to-neighborhoods-the-science-of-early-childhood-development

The National Child Traumatic Stress Network— This federally funded initiative is a collaboration of academic and community-based service centers with a mission to improve access to care, treatment, and services for traumatized children and adolescents. The website includes an assortment of publications, toolkits, and trainings. http://www.nctsn.org/

ZERO TO THREE—This national nonprofit organization offers resources, training, and support for professionals and parents of young children. The online Baby Brain Map is a useful tool for showing how brain development parallels very young children's behavior/ http:// www.zerotothree.org/ www.zerotothree.org/site/ PageServer?pagename=ter_util_babybrainflash

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Chapter 14 - Child Abuse and Neglect Fatalities 2017: Statistics and Interventions

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Despite the efforts of the child protection system, child maltreatment fatalities remain a serious problem. Although the untimely deaths of children due to illness and accidents are closely monitored, deaths that result from physical abuse or severe neglect can be more difficult to track. This [chapter] describes data on child fatalities and how communities can respond to this critical issue and, ultimately, prevent these deaths.

How Many Children Die Each Year From Child Abuse and Neglect?

According to data from the National Child Abuse and Neglect Data System (NCANDS), 50 States reported a total of 1,688 fatalities. Based on these data, a nationally estimated 1,720 children died from abuse or neglect in FFY 2017, a slight decrease

from the FFY 2016 number of 1,750. However, it is 11 percent more than 2013. This translates to a rate of 2.32 children per 100,000 children in the general population and an average of nearly five children dying every day from abuse or neglect. NCANDS defines “child fatality” as the death of a child caused by an injury resulting from abuse or neglect or where abuse or neglect was a contributing factor.

The number and rate of fatalities reported by States have fluctuated during the past 5 years. The national estimate is influenced by which States report data as well as by the U.S. Census Bureau’s child population estimates. Some States that reported an increase in child fatalities from 2012 to 2013 attributed it to improvements in reporting after the passage of the Child and Family Services Improvement and Innovation Act (P.L. 112–34), which passed in 2010.

Most data on child fatalities come from State child welfare agencies. However, States may also draw on other data sources, including health departments, vital statistics departments, medical examiners’ offices, law enforcement, and fatality review teams. This coordination of data collection contributes to better estimates.

Many researchers and practitioners believe that child fatalities due to abuse and neglect are underreported (Schnitzer, Gulino, & Yuan, 2013). The following issues affect the accuracy and consistency of child fatality data:

- Variation among reporting requirements and definitions of child abuse and neglect and other terms
- Variation in death investigation systems and training
- Variation in State child fatality review and reporting processes
- The length of time (up to a year in some cases) it may take to establish abuse or neglect as the cause of death
- Inaccurate determination of the manner and cause of death, which results in the miscoding of death certificates and includes deaths labeled as accidents, sudden infant death syndrome, or undetermined that would have been attributed to abuse or neglect if more comprehensive investigations had been conducted
- Limited coding options for child deaths, especially those due

to neglect or negligence, when using the International Classification of Diseases to code death certificates

- The ease with which the circumstances surrounding many child maltreatment deaths can be concealed or rendered unclear
- Lack of coordination or cooperation among different agencies and jurisdictions

A report by the U.S. Government Accountability Office (2011) that assessed NCANDS data, surveys, and interviews with State child welfare administrators and practitioners and site visit reports from three States suggests that facilitating the sharing of information and increased cooperation among Federal, State, and local agencies would provide a more accurate count of maltreatment deaths. A study of child fatalities in three States found that combining at least two data sources resulted in the identification of more than 90 percent of child fatalities ascertained as being due to child maltreatment (Schnitzer, Covington, Wirtz, Verhoek-Oftedahl, & Palusci, 2008).

What Groups of Children Are Most Vulnerable?

Almost three-quarters (71.8 percent) of child fatalities in FFY 2017 involved children younger than 3 years, and children younger than 1 year accounted for 49.6 percent of all fatalities. See exhibit 1 for additional data about the age of fatality victims. Young children are the most vulnerable for many reasons, including their dependency, small size, and inability to defend themselves.

How Do These Deaths Occur?

Fatal child abuse may involve repeated abuse over a period of time, or it may involve a single, impulsive incident (e.g., drowning, suffocating, shaking a baby). In cases of fatal neglect, the child's death does not result from anything the caregiver does; rather, it results from a caregiver's failure to act. The neglect may be chronic (e.g., extended malnourishment) or acute (e.g., an infant who drowns after being left unsupervised in the bathtub).

In 2017, 75.4 percent of children who died from child maltreatment suffered neglect either alone or in combination with another maltreatment type, and 41.6 percent of children who died suffered physical abuse either alone or in combination with other maltreatment. Medical neglect either alone or in combination with another maltreatment type was reported in 7.4 percent of fatalities. See exhibit 2 for additional information about fatalities by maltreatment type.

Who Are the Perpetrators?

In 2017, parents—acting alone or with another parent or individual—were responsible for 80.1 percent of child abuse or neglect fatalities. More than one-quarter (30.5 percent) of fatalities were perpetrated by the mother acting alone, 15.5 percent were perpetrated by the father acting alone, and 20.2 percent were perpetrated by the mother and father acting together. Nonparents (including kin and child care providers, among others) were responsible for 15.2 percent of child fatalities, and child fatalities with unknown perpetrator relationship data accounted for 4.7 percent of the total.

How Do Communities Respond to Child Fatalities?

The response to child abuse and neglect fatalities is often hampered by inconsistencies and other issues, including the following:

- Underreporting of the number of children who die each year as a result of abuse or neglect
- Lack of consistent standards for child autopsies or death investigations
- Varying investigative roles of child protective services (CPS) agencies in different jurisdictions
- Uncoordinated, nonmultidisciplinary investigations
- Medical examiners or elected coroners who do not have specific child abuse and neglect training

To address some of these issues, multidisciplinary and multiagency child fatality review teams have emerged to provide a coordinated approach to understanding child deaths, including deaths caused by religion-based medical neglect. The development of these teams was further supported in an amendment to the 1992 reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA), which required States to include information on child death reviews (CDR) in their program plans. Many States received initial funding for these teams through Children's Justice Act grants awarded by the Administration on Children, Youth and Families of the U.S. Department of Health and Human Services (HHS).

Child fatality review teams, which exist at the State, local, or combination State/local levels in every State plus the District of Columbia, are composed of prosecutors, coroners or medical examiners, law enforcement personnel, CPS workers, public health-care providers, and others. Child fatality review teams respond to the issue of child deaths by improving interagency communication, identifying gaps in community child protection systems, and acquiring comprehensive data that can guide agency policy and practice as well as prevention efforts.

The teams review cases of child deaths and facilitate appropriate follow-up. Follow-up may include ensuring that services are provided for surviving family members, providing information to assist in the prosecution of perpetrators, and developing recommendations to improve child protection and community support systems.

Recent data show that 48 States have a case-reporting tool for CDR; however, there has been little consistency among the types of information compiled. This contributes to gaps in the understanding of infant and child mortality as a national problem. In response, the National Center for Fatality Review and Prevention, in cooperation with 30 State CDR leaders and advocates, developed a web-based CDR Case Reporting System for State and local teams to use to collect data and analyze and report on their findings. As of February 2019, 45 States were using the standardized system.3 As more States use the system and the number of reviews entered into it increase, a more representative and accurate view of how and why children die from abuse and neglect will emerge (Palusci & Covington, 2013). The ultimate goal is to use the data to advocate for actions to prevent child deaths and to keep children healthy, safe, and protected. (For more information about child fatality review efforts in specific States, visit the National Center for Fatality Review and Prevention at https:// www.ncfrp.org/)

Since its 1996 reauthorization, CAPTA has required States that receive CAPTA funding to set up citizen review panels. These panels of volunteers conduct reviews of CPS agencies in their States, including policies and procedures related to child fatalities and investigations. As of December 2018, 16 State CDR boards serve additional roles as the citizen review panels for child fatalities.4

How Can These Fatalities Be Prevented?

The following strategies and initiatives offer a variety of approaches to the prevention of child fatalities as well as child maltreatment in general.

Child fatality review teams. Well-designed child fatality review teams appear to offer hope for defining the underlying nature and scope of fatalities due to child abuse or neglect. The child fatality review process helps identify risk factors that may assist prevention professionals, such as those engaged in home visiting and parenting education, to prevent future deaths. The information and recommendations generated by the review teams may also help influence policymakers.

Data collection and analysis. Some States have begun to integrate CPS data with other data to help identify high-risk families and provide prevention services before maltreatment happens (Putnam-Hornstein, Wood, Fluke, Yoshioka- Maxwell, & Berger,

2013). Integrating data from birth certificates, emergency room visits, and other social services sectors with CPS data and then analyzing those data for trends in risk may also help child welfare professionals make better informed decisions about prevention (Putnam-Hornstein et al., 2013). Users of the CDR Case Reporting System can record their recommendations to prevent future deaths. Examples of recommendations entered into the system include improved multiagency coordination policies for death investigations; improvements in CPS intake, referral, and case-management procedures; intensive home visiting; worker training; and improved judicial practices (Palusci & Covington, 2013).

Public health approach. A number of experts have championed a public health approach to addressing child maltreatment fatalities, which focuses on improving the health and well-being of individuals and communities before child maltreatment happens (Richmond-Crum, Joyner, Fogerty, Ellis, & Saul, 2013). Specifically, a public health approach involves defining the problem, identifying risk and protective factors, understanding consequences, and developing prevention strategies (Covington, 2013). Additionally, a public health approach engages the entire community in preventing child maltreatment and ensuring that parents have the support and services they need before abuse or neglect occur.

Improved training. Researchers have noted the need for better training for child welfare workers in identifying potentially fatal situations. Current child welfare training curricula do not always address child maltreatment fatalities. A recent study of preservice child welfare training curricula in 20 States found that only 10 States even mentioned child maltreatment fatalities and that only 1 State included a full section on the topic (Douglas, Mohn, & Gushwa, 2014). Given the complex nature of child maltreatment, training should go beyond the use of tools and assessments to include good critical thinking and decision-making skills (Pecora, Chahine, & Graham, 2013).

Federal initiatives. The Federal Government has a long history of promoting prevention. The first National Child Abuse Prevention Week, declared by Congress in 1982, was replaced the following year with the first National Child Abuse Prevention Month. Other activities followed, including a 1991 initiative by Louis W. Sullivan, M.D., the Secretary of HHS, which was designed to raise awareness and promote coordination of prevention and treatment. In 2003, the Office on Child Abuse and Neglect, which is within the Children's Bureau of the HHS Administration for Children and Families, launched a child abuse prevention initiative that included an opportunity for individuals and organizations across the country to work together. This ongoing initiative also includes the publication of an annual resource guide, which is available at https://www.childwelfare.gov/topics/preventing/preventionmonth/resources/resource-

guide/. Increasingly, this effort focuses on promoting protective factors that enhance the capacity of parents, caregivers, and communities to protect, nurture, and promote the healthy development of children.

Summary

While the exact number of children affected is uncertain, child fatalities due to abuse or neglect remain a serious problem in the United States. Fatalities due to child maltreatment disproportionately affect young children and most often are caused by one or both of the child's parents. One of the most promising approaches to curtailing child fatalities is review teams, which can help communities accurately count, respond to, and prevent these as well as other preventable deaths.

Additional Resources

National Center for the Review and Prevention of Child Deaths https://www.ncfrp.org/ The National Center for Fatality Review and Prevention is a resource center for State and local CDR programs. The HHS Maternal and Child Health Bureau established the center in 2002 and has funded it ever since. The State map tool at https://www.ncfrp.org/cdr-programs/u-s-cdr-programs/ provides links to CDR reports for each State.

National Citizen Review Panels Virtual Community http://www.cantasd.org/crp.html This website is a virtual community containing information about each State's citizens review panel as well as tip sheets, newsletters, and other resources.

National Fetal-Infant Mortality Review Program http://www.nfimr.org This program is a collaborative effort between the American College of Obstetricians and Gynecologists and the Maternal and Child Health Bureau. The resource center provides technical assistance on many aspects of developing and carrying out fetal infant mortality review programs.

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Conclusion

Millions of American children each year are abused and/or neglected. Unless citizens speak up and report suspicions of child maltreatment, this number will not only be sustained, but will most likely increase. Adults are in a significant degree of power over children; it is the beaten child, the neglected child, the emotionally battered child, the child molestation victim and the unborn child who has no voice in the events of their early life. They are the child who has no choice about their life circumstances. When adults misuse their power and authority to harm children instead of gently, firmly raising

them into productive healthy adults, ***all citizens*** and most certainly mandatory reporters must act on the behalf of those who cannot protect themselves.

Therapy alone will not eradicate child abuse and neglect. Clinicians must develop, organize, and use all the resources available to help children. Parents and family members, school, law enforcement, and child welfare personnel are all striving to protect children from trauma generated by abuse and neglect. A comprehensive and cooperative effort that builds on the skills and services in the community will improve the condition of abused and neglected children.