

CHILD ABUSE AND NEGLECT

An Introductory Manual for Professionals and Paraprofessionals

WORKING DRAFT JUNE 2005

STATE OF COLORADO

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Dedicated to protecting and improving the health and environment of the people of Colorado

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Colorado Department
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Dear Colleagues:

We are pleased to provide you with a copy of the newly revised manual, *Child Abuse and Neglect: An Introductory Manual for Professionals and Paraprofessionals*. Over the years, this manual has served as a guide for many professionals and paraprofessionals in the public health, child care and other arenas, to assist them in developing their own agency policies and approaches in recognizing and dealing with issues of child abuse and neglect in their respective settings. We hope that this updated manual will be of assistance to you as you continue your work with children and families.

We welcome your comments about this document and any suggestions for supplementary sections that would be helpful to you. Please direct your feedback to info@cdphe.state.co.us and include *Child Abuse and Neglect Manual* in the subject line.

The Child Abuse and Neglect Manual is available in PDF format at <http://www.cdphe.state.co.us/ps/cctfhom.asp>.

Sincerely,

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Introduction to Child Abuse and Neglect

It has been said that children are our greatest natural resource and this could be no closer to the truth. As such, the children of Colorado deserve care and protection to keep them from harm. This care currently includes thousands of professionals representing diverse disciplines such as medicine, law, social work, public health and education. Such diverse representation dedicated to this concern is indicative of the complexity of the problem of child maltreatment.

Since the publication of *The Battered Child* in 1960, child abuse and neglect have been “on the radar” of these professionals who have endeavored tirelessly to research the causes of maltreatment and to initiate methods and systems by which children can be protected.

The Purpose of the Child Abuse and Neglect Manual

The purpose of this manual is to educate professionals and the general public about the width and breadth of the issue of child abuse and neglect. This manual contains information concerning the prevention of child abuse and neglect, the definitions of child abuse and neglect, legal matters concerning abuse and neglect, as well as the reporting of child abuse and neglect.

The Scope of Child Abuse and Neglect

Child maltreatment, as generally defined, includes both abuse and neglect of children. Of these two general types, neglect represents approximately 60 percent of all child maltreatment, physical abuse represents 20 percent, sexual abuse represents 10 percent, and 7 percent were emotionally maltreated. Additionally, almost 20 percent of substantiations were associated with “other” types of maltreatment.

Nationally, more than 3 million reports of child maltreatment were made to local child protection agencies in 2002. Of these, almost 900,000 were substantiated as abuse or neglect. Nationwide, approximately 1,400 children died of maltreatment. In nearly 90 percent of the cases, these victims of maltreatment were abused and/or neglected by biological parents or another family figure.

In Colorado during 2004, there were 45,796 reports of child maltreatment made to county departments of Social Services or Human Services. Of these, 10,542 were found to be substantiated, making the rate of child abuse and neglect in Colorado to be approximately 9.1 individual children per 1,000. This represents a 23 percent increase from 2003, when the rate of substantiations per 1,000 children was 7.4. The pattern of perpetrator relationship to the child in Colorado follows the national paradigm: 78.5 percent of perpetrators were biological parents or another family figure.

Understanding Child Abuse and Neglect

There are multiple causes of child abuse and neglect. No true consensus exists about specific causes, but most people agree that child abuse occurs as a result of multiple stressors that interact and reinforce each other.

Certain factors may often be present in families in which abuse occurs, but their presence will not always result in abuse and neglect. Professionals must recognize multiple causes of the problem and must individualize their assessment and treatment of children and families.

One must consider factors associated with child abuse and categorize them according to factors related to parents, children, families and the environment.

Parent Factors

The most consistent finding is that abusive parents often report having been physically, sexually or emotionally abused or neglected themselves as children.¹ It would be incorrect to conclude, however, that all abused children grow up to be abusive parents. Some individuals who were not abused as children will become abusive, while some individuals who were abused will not.

No consistent set of personality traits has been identified in abusive parents. However, some characteristics are commonly identified in some parents: low self-esteem, low intelligence, impulsivity, isolation (from extended family and community), loneliness, fear of rejection, depression, low frustration tolerance, immaturity, and criminal behavior among others. Substance abuse is also a significant defining characteristic.

A variety of problems resulting from a lack of skills and knowledge also have been suggested as characteristic of abusive parents. These would include lack of parenting skills, overuse of physical punishment, problems with coping and self-control, marital difficulties and lack of interpersonal skills.² Lack of knowledge about child development is also a contributing factor.

Situational stressors, such as unplanned pregnancy or parental illness, also may increase the likelihood of abuse. Single parents may be at higher risk due to higher stressors and, in many instances, lower income. Although single parents do not necessarily have lower income than some two-parent households in which only one parent works outside of the home.

Child Factors

A child's behavior may increase the likelihood of abuse, especially if the parent is unable to empathize with the child. In general, children who are "different" from their peers, such as children with disabilities, are at greater risk for abuse and neglect. Children who are socially isolated also seem to be at higher risk.

Family Factors

Life stressors, such as marital conflict, difficult extended family relationships, drug and alcohol abuse, mental illness, domestic violence, financial stress and isolation may increase the likelihood that abuse will occur. In high-risk families, communication between parent and child tends to be poor, and abusive parents often use ineffective and inconsistent discipline. The importance of attachment and bonding between child and caretaker cannot be ignored.³

Environmental/Community Factors

It is important to note that factors such as poverty are associated with child abuse, a relationship indicated by an increase in rates during times of recession and parental job loss. Environmental factors are only one facet of child abuse.

Maltreating families are often isolated from neighbors and the broader community. As a result, maltreating families tend to participate less in community organizations and make less use of available economic, health and social resources.⁴

Dr. Deborah Daro, a child abuse treatment and prevention researcher, reports: "Children continue to die at a rate of three each day as a result of child abuse and neglect. Perhaps most tragically, the youngest children are most at risk. We are very concerned that young children, who are least able to protect themselves, continue to be fatal victims at the hands of parents and caretakers."⁵

1 J. Garbarino, "What Have We Learned About Child Maltreatment?" U.S. Department of Health and Human Services, National center on Child abuse and Neglect, ed., *Perspectives on Child Maltreatment in the Mid 80's*, 84-30338, Washington, DC: Government Printing Office, 1984.

2 Goldstein, Keller, and Erne, *Changing the Abusive Parent*, Champaign, IL: Research Press, 1985, p 7

3 IBID

4 Goldstein, Keller, and Erne, *Changing the Abusive Parent*, p 19.

5 Dr. Deborah Daro, Director, National Center on Child Abuse Prevention Research, National Committee to Prevent Child Abuse, Chicago.

Prevention of Child Abuse and Neglect

What is Prevention?

Since the publication of *The Battered Child* in 1960, the prevention of child abuse and neglect has been an issue confronting professionals in many disciplines. The medical field, educational professionals, social workers, law enforcement and concerned adults in other fields have endeavored to make children safer and to confront child abuse and neglect before it starts.

Child abuse prevention covers a broad spectrum of services, such as public awareness, parent education, and home visitation, for audiences ranging from the general public to people who have abused or neglected a child. Community groups, social service agencies, schools and other concerned citizens may provide these services. Typically, prevention activities attempt to:

- Deter predictable problems and situations;
- Protect existing states of health; and
- Promote desired life objectives (Bloom, 1996).

Prevention efforts should occur before a problem develops so that the problem itself or some manifestation of the problem can be stopped or lessened (Willis, Holden and Rosenberg, 1992).

Specific risk factors found to be associated with child maltreatment include parental substance abuse, childhood disability and domestic violence. To prevent child abuse and neglect, programs may focus on one or several risk factors. For example:

- Substance abuse treatment programs for women with children;
- Respite care programs for families with children having disabilities; and
- Parent education programs and support groups for families affected by domestic violence

In addition, many prevention programs are focusing efforts on strengthening child and family protective factors, such as the knowledge and skills children need to protect themselves from sexual abuse, the promotion of positive interactions between children and parents, and the knowledge and skills parents need to raise healthy, happy children.

References

Bloom, M. (1996). Primary prevention practices. Thousand Oaks, CA: Sage.

Willis, D.J., Holden, E.W., & Rosenberg, M. (Eds.), Prevention of child maltreatment: Developmental and ecological perspectives (pp. 1-16). New York: John Wiley & Sons.

Types of Prevention

There are three distinct types of prevention of child abuse and neglect. Primary prevention seeks to prevent the abuse or neglect of children before it begins and is usually aimed at the population at large. Secondary prevention strategies address particular risks among particular populations to prevent child abuse or neglect before it starts. Lastly, tertiary prevention strategies seek to prevent the reoccurrence of child abuse and neglect.

Primary or Universal Prevention

The first level of prevention, primary prevention, focuses on strategies that are generally aimed at the public at large. Primary prevention strategies often seek to strengthen family functioning. The philosophy of primary prevention is that keeping children safe from abuse and neglect is the responsibility of the entire community. The long-term goal of such strategies is to educate the entire community to create social change that is intolerant of child maltreatment.

Possible goals of a communitywide comprehensive (primary) prevention strategy:

- Increase parents' knowledge and understanding of how children develop and what they can expect at each stage of development
- Enhance bonding and communication between parents and their children
- Increase parents' skills in coping with the stresses of caring for children with special needs
- Increase parents' knowledge about managing homes and families
- Reduce the burden of child care
- Increase access to social and health-care services for all community members

To achieve these goals, communitywide comprehensive prevention strategies could include:

- Programs that support new and expecting parents by helping them prepare for the challenges of child care
- Programs that educate parents about child care and child development
- Child care opportunities for working parents and for parents who need respite from the stresses of their responsibilities
- Programs that teach children how to protect themselves from abuse
- Life skills training that helps children and young adults learn the interpersonal communication skills they need to thrive as kids and later as adults and parents
- Self-help groups, peer-support systems, and other neighborhood support programs to reduce the isolation experienced by many parents

- 24-hour crisis care programs that provide immediate assistance to parents in a time of crisis by offering a telephone helpline, crisis caretakers, crisis nurseries, and crisis counseling

Secondary or Selected Prevention

The next level, secondary prevention, intervenes with strategies that are focused on those who are at-risk for abuse or neglect of their children. These strategies are often not defined by the program modality but rather by the population that they are trying to reach. From more than 40 years of research about child abuse and neglect, factors that place a child at risk for abuse or neglect have been well-documented. These include high-stress familial situations, lack of familial or community support and young maternal age.

Also, factors related to the child may place him or her at greater risk of abuse or neglect. Disability and a temperament that differs from the parents are two of these factors.

Possible goals of a risk-based (secondary) prevention strategy:

- Increase parents' knowledge and understanding of how their own upbringing influences their parenting skills and strategies
- Enhance bonding and communication between at-risk parents and their children
- Increase the connection between at-risk parents and resources or services in the community
- Increase parents' skills in coping with the stresses of caring for children with special needs
- Increase access to the social and health-care services for all community members.

To achieve these goals, risk-based (secondary) prevention strategies could include:

- Parenting education programs that are available to parents who are known to their local departments of social or human services as being at risk for child maltreatment
- Programs that educate parents about interacting with community resources
- Referrals for parents to address their depression or substance-abuse issues
- Crisis care nurseries or respite care
- Connection for parents with other parents in their community through support groups and other peer-support systems, such as mentoring or tandem families
- Programs that educate parents about child care and child development
- Parent education classes aimed at teen mothers and fathers

Tertiary or Indicated Prevention

Tertiary prevention is focused on treatment for families who have already encountered child abuse or neglect and serve to prevent the reoccurrence of such maltreatment.

Possible goals of a reoccurrence (tertiary) prevention strategy:

- Decrease the likelihood of a reoccurrence of child abuse or neglect, perhaps by placing the child with other caretakers and/or incarceration of the perpetrator(s)
- Decrease the abuse of substances within the family milieu
- Increase the connection of families to other families through support groups and other peer-support systems, such as mentoring or tandem families
- Increase the connection between at-risk parents and resources or services in the community

To achieve these goals, reoccurrence (tertiary) prevention strategies could include:

- Rehabilitation of abusive parents by providing intensive treatment and/or therapy
- Intensive treatment and/or therapy for children who have been abused
- Referrals for parents to address their depression or substance-abuse issues
- Foster or familial care

Prevention – What Works?

While the study of the prevention of child abuse and neglect is fairly young, some effective strategies for reducing the risk to children are known. Some strategies have been proven through longitudinal research that has shown long-term effects on parents and children.

Research on the prevention of child maltreatment has been largely focused on home visitation, parent education and programs to prevent child sexual abuse (Caliber and Assoc., 2001).

Home Visitation Programs

Research suggests that intensive, professionally administered home visiting can be an effective approach. David Olds, at the University of Colorado Health Sciences Center, has conducted high quality, experimental research in the area of home visitation. Dr. Olds has found positive short-term and long-term outcomes through his research that spanned 20 years and several replications. Mothers who partook in the study were all young, first-time mothers. The research showed that an effective home-visitation

program decreased rates of child maltreatment, juvenile delinquency, maternal criminality, increased economic self-sufficiency and increased social-emotional development (Olds et al., 1997).

Parent Education

Little is actually known about the long-term effectiveness of parent education models but some studies have indicated some promising findings. In particular, the Nurturing Parenting Program, as composed by Dr. Stephen Bavolek, has shown promise in increasing parental skills in order to decrease child maltreatment.

This program focuses on four parenting constructs, including inappropriate parental expectations, lack of empathy toward the child, belief in corporal punishment, and parent-child role reversal. Statistically significant improvement from pre- to post-test of the Adult-Adolescent Parenting Inventory was found among at-risk rural families (Cowen, 2001).

Child Sexual Abuse Prevention

There is a correlative factor between individuals who participate in school-based sexual abuse prevention programs and a reduction in actual exposure to sexual abuse later in life (Caliber and Assoc., 2003). These individuals were more likely to express the methods by which they could protect themselves from sexual perpetration than those who did not participate in sexual abuse prevention programs.

Pay Now or Pay (More) Later

Prevent Child Abuse America, a national advocacy organization, has produced a report that estimated the annual costs of child abuse and neglect in the United States. That report includes estimates of the direct or immediate costs of abuse as well as the indirect or long-term costs, and it indicates that child abuse and neglect costs the nation \$258 million each day, or approximately \$94 billion each year (Prevent Child Abuse America, 2001).

The direct costs of abuse – which include costs associated with hospitalization, chronic health problems, mental health care, the child welfare system, law enforcement, and the judicial system – were estimated at approximately \$24 billion each year. Indirect costs of abuse, which include costs associated with special education, mental health and health care, juvenile delinquency, lost productivity, and adult criminality, were estimated at approximately \$70 billion each year. Prevent Child Abuse America cautions that its estimates likely understate the true annual cost since the analysis did not capture the full range of indirect costs, such as cash and food assistance to adults whose difficulties can be directly traced to past maltreatment. As perhaps the most comprehensive analysis to date in terms of the component costs of maltreatment that it includes, recent

estimates by Prevent Child Abuse America dwarf the results of all earlier analyses of the costs of violence in American families. The magnitude of these estimates is startling, and they may begin to exert influence on the manner in which the problem is approached and the direction of future public policy (Caliber and Assoc., 2003).

Studies conducted by the Michigan Children's Trust Fund and the Colorado Children's Trust Fund illustrate the potential value of child maltreatment programs that can reduce incidence. In 1992, the Michigan Children's Trust Fund estimated that the cost of responding to child maltreatment in Michigan was \$823 million annually, including the estimated costs associated with low-weight births, child fatalities and preventable infant mortality, medical treatment, child protective services, foster care, juvenile and adult criminality, and psychological problems. In contrast, the cost of providing prevention services to all first-time parents in Michigan was estimated at \$43 million annually.

The study concludes that while the incidence of abuse cannot be reduced to zero, investments in prevention can be cost-effective if they result in even modest reductions in abuse events (Caldwell, 1992).

A similar study commissioned by the Colorado Children's Trust Fund estimated that responding to child maltreatment costs Colorado \$402 million annually, whereas home visitation services for high-risk families would cost Colorado just \$24 million annually (Gould & O'Brien, 1995).

Child Abuse and Neglect Overview

Physical Abuse

Neglect

Emotional Abuse

Unlawful Sexual Behavior and Child Sexual Abuse

Physical Abuse

Legal Definitions of Physical Child Abuse

Aspects of child abuse and neglect are defined by Colorado Revised Statutes in the Colorado Children's Code (Title 19), the Colorado Human Services Code (Title 26), the Colorado Criminal Code (Title 18), and the Criminal Proceedings Code (Title 16). Please refer to Appendix One or view the statutes online at the Web links identified below.

Colorado Children's Code - Colorado Revised Statutes Title 19 Article 1 Part 103

Online: <http://198.187.128.12/colorado/lpext.dll?f=templates&fn=fs-main.htm&2.0>

Click on the "+" next to Colorado Statutes on the left side of the webpage.

Click on Title 19 for the Colorado Children's Code.

"[C]hild abuse or neglect ... means an act or omission in one of the following categories that threatens the health or welfare of a child: Any case in which a child exhibits evidence of skin bruising, bleeding, malnutrition, failure to thrive, burns, fracture of any bone, subdural hematoma, soft tissue swelling, or death and either: Such condition or death is not justifiably explained; the history given concerning such condition is at variance with the degree or type of such condition or death; or the circumstances indicate that such condition may not be the product of an accidental occurrence..."

Colorado Criminal Code - Colorado Revised Statutes Title 18 Article 6 Part 401

Online: <http://198.187.128.12/colorado/lpext.dll?f=templates&fn=fs-main.htm&2.0>

Click on the "+" next to Colorado Statutes on the left side of the webpage.

Click on Title 18 for the Colorado Criminal Code.

"A person commits child abuse if such person causes an injury to a child's life or health, or permits a child to be unreasonably placed in a situation that **poses a threat of injury to the child's life or health**, or engages in a continued pattern of conduct that results in malnourishment, lack of proper medical care, cruel punishment, mistreatment, or an accumulation of injuries that ultimately results in the death of a child or serious bodily injury to a child..."

Human Services Code – Colorado Revised Statutes Title 26 Article 3.1 Part 101

Online: <http://198.187.128.12/colorado/lpext.dll?f=templates&fn=fs-main.htm&2.0>

Click on the "+" next to Colorado Statutes on the left side of the webpage.

Click on Title 26 for the Human Services Code.

"Abuse which occurs: [w]here there is infliction of physical pain or injury, as demonstrated by, but not limited to, substantial or multiple skin bruising, bleeding, malnutrition, dehydration, burns, bone fractures, poisoning, subdural hematoma, soft

tissue swelling, or suffocation; where unreasonable confinement or restraint is imposed; or where there is subjection to nonconsensual sexual conduct or contact classified as a crime under the ‘Colorado Criminal Code...’”

Potential Signs, Behaviors or Characteristics of Physical Child Abuse

Physical Signs	Child’s Behavior	Parental Characteristics
<p>Frequent injuries always explained as “accidental”</p> <p>Injuries that are inappropriate for the child’s developmental age -child who is not yet walking who has a spiral fracture</p> <p>Unexplained bruises/welts - in clusters or unusual patterns - on several different body areas - in various stages of healing (different colors, old/new scars) - in the shape of instruments used to inflict wound (hand, fingers, belt, hanger) - bruising around the mouth in oral mucus cavity</p> <p>Unexplained burns - in shape of instrument (cigarette, rope, iron, or hot poker) - caused by immersion in hot water or other liquid</p> <p>Unexplained lacerations or abrasions</p>	<p>Reports - fear of parent(s) - injuries inflicted by parent - unbelievable reasons for injuries - complains of soreness or moves uncomfortably</p> <p>Extremes in behavior - very aggressive - very withdrawn - submissive, overly compliant, caters to adults - hyperactive - depressed/apathetic - uncomfortable with physical contact, shrinks from being physically touched - wears clothes inappropriate to weather in an effort to cover body - clingy or easily attached to new person/stranger</p> <p>Easily frightened/fearful - of parents, adults - of physical contact - of going home - when other children cry</p> <p>Destructive to self/others - poor social relations - craves attention - indiscriminate attachment to strangers - relates poorly to peers - manipulates adults to get attention</p>	<p>Conceals the child’s injury - gives explanation which doesn’t fit the injury - dresses child to cover injury - keeps child home from school</p> <p>Does not appear to be concerned about the child - cares more about what will happen to himself or herself than what happens to the child</p> <p>Describes the child as bad, different or evil</p> <p>Believes in severe discipline - or inappropriate discipline for child’s age or size</p> <p>Low self-esteem abuses alcohol/drugs</p> <p>Immature</p> <p>Maltreated as a child</p>

<ul style="list-style-type: none"> - to mouth, lips, gums or eyes - to external genitalia - on backs of arms, legs, torso, buttocks, trunk <p>Unexplained skeletal injuries</p> <ul style="list-style-type: none"> - fractures of any bone - multiple fractures - stiff, swollen or tender joints <p>Other Injuries-</p> <ul style="list-style-type: none"> - bald spots on the scalp that could be caused by hair pulling - missing or loosened teeth - human-size bite marks (especially if adult size and recurrent) <p>Unexplained abdominal injuries</p> <ul style="list-style-type: none"> - swelling of the abdomen - localized tenderness - constant vomiting <p>School absence correlates with appearance of injury</p> <p>Clothing inappropriate for the weather may be concealing injuries</p>	<p>Demonstrates poor self-concept</p> <p>Learning/school problems</p> <ul style="list-style-type: none"> - developmental lags - poor academic performance - short attention span - language delayed - arrives at school early or stays late, as if afraid to be at home <p>Chronic runaway, especially adolescents</p> <p>Attempted suicide</p> <p>Delinquency</p>	
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The chart was abstracted from *Preventing Child Abuse in the Harvest: A Handbook for Migrant Educators*, prepared and administered by the Eco-Behavioral System for the Complex Assessment of Preschool Environments (ESCAPE), a U.S. Department of Education Section 143 Project in Interstate Coordination.

Types of Physical Abuse

While many of the injuries mentioned below can occur unintentionally while a child is at play, physical abuse should be suspected if the explanations do not fit the injury or if a

pattern of frequency is apparent. The presence of many injuries in various stages of healing makes it obvious that the injuries did not all occur as a result of one “accident.” Note: Remember to consider ethnic/cultural traditions that may apply in abuse situations. Refer to the end of this section to identify cultural healing vs. marks of child abuse.

Bruises: The location of a bruise often helps determine whether the bruise was accidental or the result of abuse. Bruises obtained during play are more likely to occur on bony prominences, such as knees, shins, forehead or elbows. Bruises that may be suspicious as signs of abuse are those occurring on the face, neck, cheeks, buttocks, backs of thighs or calves, abdomens, or chests. This may occur from belts or straps on a child’s legs, back or arms and from hands on the child’s face, which is often in the outline of fingers. Age of bruising can sometimes be determined by the color. The following is a chart that estimates the “color” of the bruise and the approximate age of the bruise. These timeframes are only estimates, as many factors can influence the color change of resolving bruises.

<u>COLOR</u>	<u>TIME</u>
Light bluish-red	After a few hours
Purple (dark)	1 day to 1 week
Green-yellow	End of 1 week
Brown	Later than 1 week
Disappearance	2-4 weeks

Fractures: Unintentional fractures are, and always will be, a normal part of childhood and can be a result of falling out of trees, bike crashes, and other play-related falls. Fractures in non-mobile infants and children, including physically disabled children who are not mobile, should be a concern. Cardiopulmonary resuscitation (CPR) does not typically cause fractured ribs in children. If an adult claims that a child’s ribs are fractured due to CPR, a health care provider should closely examine the case. While there are diseases that cause bone weakening and fractures in children, these diseases are extremely rare.

Internal injuries: Internal injuries are caused by blows that injure internal organs. Physical indicators include pain in the stomach, chest, or any internal area; external bruising of the chest or stomach; distended, tender or swollen abdomen; tense abdominal muscles; labored breathing; severe, pinching pain in the chest while breathing; nausea and/or vomiting. Usually diagnosed by a health care provider using CAT scans of the chest and abdomen.

Head and Brain Injuries: Head injuries can result from a traumatic birthing process. If the injury is not noticed within a few days of birth, child abuse should be suspected. Head and brain injuries can occur from falls and car crashes, as well as shaking and beating.

Subdural hematoma: When blood vessels break in the brain, blood collects under the dura, or tissue covering the brain, and this could result in swelling of, and pressure on, brain tissue. Hematomas are diagnosed by a health care provider using a CAT scan of the head.

Skull fracture: Skull fractures can be caused by a blow to the head or by a child bumping his/her head unintentionally, if the child is older and there is a clear and logical explanation of the incident. Bumps, lumps and/or tender areas on the skull may be an overt sign of a skull fracture.

Eye injuries: Eye injuries are usually caused by direct blows. Black eyes are evidence of an eye injury. It is important to remember that eye injuries can be intentional or unintentional, so the history provided for the black eye is significant. Retinal bleeding is caused by Shaken Baby Syndrome and cannot be seen without looking in the dilated eye with an eye scope. A health care provider should diagnose retinal bleeding.

Ear injuries: Usually caused by direct blows, pinching, or other hitting and usually identified by a health care provider.

Nasal, oral, dental or lip injuries: These injuries may occur when an object is forced into the nose or mouth. Blows directly to the face can also cause injuries. Cuts or swelling may indicate injuries to the nose and mouth.

Hair loss: Hair pulled from the scalp.

Poisoning: A parent may treat the child with roots or herbs for a common ailment. Some of these treatments may have side effects resulting in poisoning. Adult education could help to make parents aware of the possible effects of root and herb treatments. If a child ingests a poisonous substance accidentally, an investigation of neglect may be warranted.

Water Burns: Unintentional burns do happen, especially since tap water can be set at high temperatures. However, abusive burns are usually distinctively different from unintentional burns. Abusive burns have clear lines defining the skin and they are often deep. Unintentional burns, on the other hand, tend to be scattered and do not penetrate the skin as deeply.

Differentiating between Natural Marks and Marks of Physical Child Abuse

Mongolian Spots: Mongolian spots are most common among children of color. They are grayish blue, appear on the back and buttocks and are present at birth lasting for

two to three years. Mongolian spots appear in Afro-American (95.5%), Asian (81%), Hispanic (70.1%) and white, non-Hispanic, (9.6%) babies.

Salmon Patches: These are also called “angel’s kiss” or “stork bites” and appear on newborns. They are pink marks appearing on the nape of the neck, eyelids, above the nose and at mid-forehead.

Strawberry Marks: These marks are not usually present at birth but appear within the first few weeks of life.

Impetigo: This bacterial infection can cause circular, reddened or scale like lesions and can mimic cigarette burns.

Eczema: This dry, reddened skin condition can be seen on the legs, arms and face.

Reference

Smith, Jean C., et al. (1989) *Understanding the Medical Diagnosis of Child Maltreatment*. American Humane Association.

Neglect

Child neglect is the most common form of child maltreatment reported to public child protective services. The National Child Abuse and Neglect Data System (NCANDS) reports that more than 3.1 million children were reported for maltreatment in 2002, and 875,996 of those cases were substantiated or indicated abuse and neglect victims. The report estimated that 1,356 children died as a result of maltreatment and that 37 percent of those fatalities were attributed to neglect.¹

Legal Definition of Neglect

Aspects of child abuse and neglect are defined by Colorado Revised Statutes in the Colorado Children's Code (Title 19), the Colorado Human Services Code (Title 26), the Colorado Criminal Code (Title 18), and the Criminal Proceedings Code (Title 16). Please refer to Appendix One or view the statutes online at the Web link identified below.

Colorado Children's Code - Colorado Revised Statutes Title 19 Article 1 Part 103

Online: <http://198.187.128.12/colorado/lpext.dll?f=templates&fn=fs-main.htm&2.0>

Click on the "+" next to Colorado Statutes on the left side of the webpage.

Click on Title 19 for the Colorado Children's Code.

Child neglect is "[a]ny case in which a child is a child in need of services because the child's parents, legal guardian, or custodian fails to take the same actions to provide adequate food, clothing, shelter, medical care, or supervision that a prudent parent would take."

¹ U.S. Department of Health and Human Services, Administration on Children, Youth and Families. *Child Maltreatment 2002* (Washington, D.C.: U.S. Government Printing Office, 2004).

Potential Signs, Behaviors or Characteristics of Child Neglect

Physical Signs	Child's Behavior	Parental Characteristics
<p>Poor growth pattern -emaciated, i.e. no fat pads on buttocks and cheeks -distended stomach</p> <p>Consistent hunger/malnutrition</p> <p>Poor hygiene - lice - body odor</p> <p>Lacks appropriate/necessary clothing</p> <p>Unattended physical problems or medical needs - lack of proper immunizations - gross dental problems - needs glasses/hearing aids -withholding medical treatment (However this could be a result of some parents' religious beliefs.)</p> <p>Consistent lack of supervision</p> <p>Constant fatigue/listlessness - falls asleep in school</p>	<p>Developmental lags - Physical, emotional and/or intellectual</p> <p>Fear of abandonment</p> <p>Chronic fatigue/listlessness</p> <p>Steals or hides food, begs food from classmates</p> <p>Reports that no one is at home</p> <p>Extremes in behavior - hyperactive - aggressive - withdrawn - assumes adult responsibilities - acts in a pseudo mature fashion - submissive/overly compliant</p> <p>Infantile behavior - depressed/apathetic</p> <p>Seeks attention/affection - hypochondria</p> <p>School - frequent school tardiness - frequent absence from school - school dropout, especially as adolescent</p> <p>Delinquency</p>	<p>Apathetic/passive</p> <p>Depressed</p> <p>Unconcerned with the child or does not seem to recognize child's needs - not bothered by the child's lack of basic necessities or behavior, due to parental negligence - no food in the house - does not seek child care - lack of appropriate clothing for weather</p> <p>Socially isolated</p> <p>Low self-esteem</p> <p>Abuses alcohol and/or drugs</p> <p>Impulsive behavior</p> <p>Mentally retarded</p> <p>Psychiatric illness</p> <p>Maltreated as a child</p> <p>Unsafe living conditions - home life chaotic - drugs/poisons in reach of children - garbage/excrement in living areas</p>

The chart was abstracted from *Preventing Child Abuse in the Harvest: A Handbook for Migrant Educators*, prepared and administered by the Eco-Behavioral System for the Complex

Types of Child Neglect

Failure to Thrive: This term describes infants and children who do not gain weight and grow. If it is the result of organic deficiencies that is a medical cause or disease, it is not classified as neglect. When failure to thrive is diagnosed, and there is no underlying disease or physical condition, this lack of growth is non-organic and psychosocial in nature. The failure to thrive may be due to neglect or significant problems in the parent-child relationship. Additional information on failure to thrive is provided in the Current Topics in Child Maltreatment section on page 32.

Medical Neglect: Medical neglect occurs when important medical care, necessary to the child's health and well-being, is either withheld from the child or not sought and obtained. Concern is warranted not only when a parent refuses medical care for a child in an emergency or for an acute illness, but also when a parent ignores medical recommendations for a child with a treatable chronic disease or disability, resulting in frequent hospitalizations or significant deterioration. Parents may refuse medical care for their children for different reasons – religious beliefs, fear or anxiety about a medical condition or treatment, or financial issues. If child protective services becomes involved, CPS may seek a court order for medical treatment to save the child's life or to prevent life-threatening injury, disability or disfigurement. Although medical neglect is highly correlated with poverty, there is a distinction between a caregiver's inability to provide the needed care, based on cultural norms or the lack of financial resources, and a caregiver's knowing reluctance or refusal to provide care. Children and their families may be in need of services even though the parent may not be intentionally neglectful. When poverty limits a parent's resources to adequately provide necessities for the child, services should be offered to help families provide for their children.

Safety Neglect: The child is at risk of harm and injury when a parent neglects important safety issues. For instance, a parent or caregiver may leave a child unattended in a car or fail to safely store weapons or toxic materials out of the reach of children. This is also identified as supervisory neglect.

Educational Neglect: This involves the failure of a parent or caregiver to enroll a child in school, support that child's attendance in school, or provide appropriate home schooling or needed special educational training, thus allowing the child or youth to engage in chronic truancy. Educational neglect can lead to the child failing to acquire basic life skills, dropping out of school, or continually displaying disruptive behavior.

Emotional Abuse

Legal Definition of Emotional Abuse

Aspects of child abuse and neglect are defined by Colorado Revised Statutes in the Colorado Children’s Code (Title 19), the Colorado Human Services Code (Title 26), the Colorado Criminal Code (Title 18), and the Criminal Proceedings Code (Title 16). Please refer to Appendix One or view the statutes online at the Web links identified below.

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Click on the “+” next to Colorado Statutes on the left side of the webpage.

Click on Title 19 for the Colorado Children’s Code.

"[E]motional abuse means an identifiable and substantial impairment of the child's intellectual or psychological functioning or development or a substantial risk of impairment of the child's intellectual or psychological functioning or development."

Potential Signs, Behaviors or Characteristics of Emotional Child Abuse

Physical Signs	Child’s Behavior	Parental Characteristics
<p>Health problems</p> <ul style="list-style-type: none"> - obesity - skin disorders -- acne - speech disorders -- stuttering - delayed physical development - chronic medical problems - asthma - allergies - ulcers <p>Infantile behavior</p> <ul style="list-style-type: none"> - pants/bed wetting - thumb sucking - soiling or defecating – urine or fecal matter <p>Failure to thrive in infancy</p>	<p>Learning problems</p> <p>Developmental lags</p> <ul style="list-style-type: none"> - physical - emotional - intellectual <p>Extremes in behavior</p> <ul style="list-style-type: none"> - hostile/aggressive - withdrawn, passive, shy, apathetic - antisocial - hyperactive, poor locus of control - constant watchfulness <p>Emotional disturbances</p> <ul style="list-style-type: none"> - eating disorder - anxiety disorder <p>Destructive to self/others; compulsive behaviors</p>	<p>Unrealistic expectations of child</p> <p>Poor responses to child</p> <ul style="list-style-type: none"> - belittles - rejects - degrades - ignores the child <p>Expects child to care for parent</p> <p>Threatens the child</p> <ul style="list-style-type: none"> - with severe punishment/violence - with abandonment <p>Describes the child as</p> <ul style="list-style-type: none"> - bad - different - evil

<p>Poor Appearance - poor hygiene</p> <p>Substance abuse</p>	<ul style="list-style-type: none"> - sucking - rocking - head-banging - inhibition of play <p>Sleep disorders - nightmares</p> <p>Demonstrates poor self-concept/negative self-image - withdrawal/ shyness - depressed/apathetic - suicidal</p> <p>Inappropriate social responses and ineffective social skills</p> <p>Delinquent behavior (especially adolescents) - Alcohol/drug use -Engages in violent acts</p>	<p>Low self-esteem</p> <p>Depressed</p> <p>Lacking bonding and attachment</p>
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The chart was abstracted from *Preventing Child Abuse in the Harvest: A Handbook for Migrant Educators*, prepared and administered by the Eco-Behavioral System for the Complex Assessment of Preschool Environments (ESCAPE), a U.S. Department of Education Section 143 Project in Interstate Coordination.

Types of Emotional Abuse

Rejecting: Parent refuses to acknowledge the child's worth and the validity of the child's needs.

Terrorizing: Parent verbally assaults the child, instills fear through bullying and threatening. The world is defined as a hostile and frightening place.

Ignoring: The child is deprived of emotional stimulation and interaction.

Isolating: The child is separated and cut off from normal social relationships. The child is prevented from forming friendships and made to feel alone.

Corrupting: The child is taught, encouraged, or forced to develop inappropriate or illegal behaviors. It may involve self-destructive or antisocial acts of the parent or

caregiver, such as teaching the child how to steal or forcing a child into prostitution. Observation of domestic violence should be considered potentially emotionally abusive.

Verbally assaulting: This involves constantly belittling, shaming, ridiculing, or verbally threatening the child.

Unlawful Sexual Behavior and Sexual Abuse

Legal Definition of Unlawful Sexual Behavior and Sexual Abuse

Aspects of child abuse and neglect are defined by Colorado Revised Statutes in the Colorado Children’s Code (Title 19), the Colorado Human Services Code (Title 26), the Colorado Criminal Code (Title 18), and the Criminal Proceedings Code (Title 16). Please refer to Appendix One or view the statutes online at the Web links identified below.

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Click on the “+” next to Colorado Statutes on the left side of the webpage.

Click on Title 19 for the Colorado Children’s Code.

“[C]hild abuse or neglect ... is [a]ny case in which a child is subjected to unlawful sexual behavior as defined in section 16-22-102 (9), C.R.S.” (See Appendix One).

Potential Signs, Behavior or Characteristics of Child Sexual Abuse

Physical Signs	Child’s Behavior	Parental Characteristics
Difficulty walking or sitting Torn, stained or bloody underclothing Abnormalities in genital/anal areas - trauma to the genitals or rectum - genital pain or itching - bruises/bleeding in external genitalia - frequent urinary or yeast	Disclosure: CHILD STATES THAT SHE/HE HAS BEEN ABUSED. REMEMBER, OFTEN THERE ARE NO VISIBLE SIGNS OF SEXUAL ABUSE. Sudden decline in school performance - sudden school problems - truancy Poor peer relationships - lack of school involvement Unwillingness to change clothing in gym	Possessive and jealous of the victim - denies the child any normal social contact with others - accuses the child of sexual promiscuity and seductiveness - is abnormally attentive to the victim Low self-esteem Poor impulse control Was sexually abused as a child

<p>infections - poor sphincter control - vaginal or penile discharge</p> <p>Sexually transmitted disease</p> <p>Pregnancy</p> <p>Psychosomatic illness</p>	<p>- unwilling to participate in physical education class</p> <p>Sexual knowledge beyond age - displays bizarre, sophisticated sexual behavior - inappropriate sex play - premature understanding of sex - excessive seductiveness</p> <p>Poor self-concept - withdrawn, chronic depression - suicidal - apathy - fantasy or infantile behavior - overly concerned with siblings - poor self-esteem, self devaluation, lack of confidence - hysteria, lack of emotional control - massive weight change - self-destructive behavior</p> <p>Extremes in Behavior - sexually aggressive - withdrawn/fearful of males or females - threatened by physical contact or closeness - eating, sleeping or elimination disturbances - indirect messages expressing fear or dislike of particular individual - compulsive behaviors, e.g., taking an excessive number of baths - fear of going home; refusal to go home; chronically runs away</p> <p>Regression to earlier developmental stage - baby talk - bedwetting</p>	<p>Abuses alcohol/drugs</p> <p>Socially isolated</p> <p>Poor relationship with spouse</p> <p>Believes child enjoys sexual contact</p> <p>Believes sexual contact expresses familial love</p> <p>Role reversal of mother and daughter or father and son</p> <p>Father is overly protective of daughter</p> <p>Father thinks of himself as boyfriend</p> <p>Mother thinks of daughter as a rival</p> <p>NOTE: Perpetrator may be close member of the family.</p>
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	- wetting pants	
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The chart was abstracted from *Preventing Child Abuse in the Harvest: A Handbook for Migrant Educators*, prepared and administered by the Eco-Behavioral System for the Complex Assessment of Preschool Environments (ESCAPE), a U.S. Department of Education Section 143 Project in Interstate Coordination.

Common Indicators of Sexual Abuse by Age Group

Early Childhood Indicators	School-Age Indicators	Adolescent Indicators
<p>Physical Symptoms</p> <ul style="list-style-type: none"> - sexually transmitted disease - unexplained bruises of or bleeding or discharge from external parts of vagina or anus - complaints of irritation, pain or injury to the genital area - difficulty walking or sitting due to genital or anal pain - unexplained recurrent urinary tract infections - oral injuries 	<p>Physical Symptoms</p> <ul style="list-style-type: none"> - sexually transmitted disease - unexplained bruises of or bleeding or discharge from external parts of vagina or anus - complaints of irritation, pain or injury to the genital area - difficulty walking or sitting due to genital or anal pain - unexplained recurrent urinary tract infections 	<p>Physical Symptoms</p> <ul style="list-style-type: none"> - sexually transmitted disease - unexplained pregnancy or attempts to conceal a pregnancy - unexplained bruises of or bleeding or discharge from external parts of vagina or anus - complaints of irritation, pain or injury to the genital area - difficulty walking or sitting due to genital or anal pain
<p>Psychosomatic Symptoms or Complaints</p> <ul style="list-style-type: none"> - onset of daytime wetting or enuresis - encopresis (fecal soiling) - sleep or eating disturbances 	<p>Psychosomatic Symptoms or Complaints</p> <ul style="list-style-type: none"> - recurrent abdominal pain - headaches - sleep or eating disturbances - depression - encopresis (fecal soiling) - enuresis 	<p>Psychosomatic Symptoms or Complaints</p> <ul style="list-style-type: none"> - recurrent abdominal pain - headaches - sleep or eating disturbances - depression
<p>Behaviors</p> <ul style="list-style-type: none"> - excessive fears or phobias, e.g., fear of males, fear of bed time - age-inappropriate behavior, e.g., regressive - compulsive masturbation (interruption of play to masturbate, especially chronic or in public, female masturbation involving vaginal penetration) - inappropriate, unusual or aggressive sexual behavior with playmates or toys (pretending oral, vaginal, anal penetration with dolls, playmates, animals, e.g., humping) - excessive curiosity about 	<p>Behaviors</p> <ul style="list-style-type: none"> - school problems or significant change in school performance, e.g., attitudes, grades, frequent absences - expressed feelings of depression, shame, humiliation, guilt, betrayal, self-hate - social withdrawal - self-consciousness of body beyond that expected for such an age - acting out, runaway, aggressive, out-of-control behavior - lack of friendships with others their own age, poor social skills, inability to make friends 	<p>Behaviors</p> <ul style="list-style-type: none"> - promiscuity - alcohol or drug abuses - running away - school problems or significant change in school performance, e.g., attitudes, grades, frequent absences - expressed feeling of depression, shame, humiliation, guilt, betrayal, self-hate - social withdrawal - lack of friendships with others their own age, poor social skills, inability to make friends <p>Psychiatric Symptoms</p>

sexual matters or private parts (self or others) - detailed and age-inappropriate understanding of sexual behavior - aggressive, out-of-control behavior	Psychiatric Symptoms - self-mutilation - suicide attempts - bulimia - multiple personality	- self-mutilation - suicide attempts - bulimia - multiple personality
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CHILD SEXUAL ABUSE, Janet Murphy, RN-C, MSN, CPNP. Journal of School Nursing. October, 1993. Volume 9, Number 3. p. 33.

Types of Unlawful Sexual Behavior and Child Sexual Abuse

Touching sexual offenses include:

- Fondling, with or without clothing on;
- Making a child touch an adult's sexual organs or the touching of the clothing covering the intimate parts of either person, if that touching is for the purpose of sexual arousal, gratification or abuse; and
- Penetrating a child's vagina or anus, no matter how slight, with a penis or any object that doesn't have a valid medical purpose.

Intimate parts means the external genitalia or the perineum or the anus or the buttocks or the pubes or the breasts of any person.

Non-touching sexual offenses include:

- Engaging in indecent exposure or exhibitionism;
- Exposing children to pornographic material;
- Deliberately exposing a child to the act of sexual intercourse; and
- Masturbating in front of a child.

Sexual exploitation can include:

- engaging a child or soliciting a child for the purposes of prostitution and sexual exploitation;
- using a child to film, photograph, or model pornography, including digital imagery.

Age-Related Factors in Identifying Sexual Abuse

Sexual acts are considered abusive if:

- The child is 15 or 16 years old and the adult is at least 10 years older;
- The child is less than 15 years old and the actor is at least four years older; or
- The child is between 15 and 18 years old and the actor is in a position of trust to the child.

For sexual exploitation, the child is less than 18 years of age.

Process for Reporting Child Abuse and Neglect

Process for Reporting: Questions and Answers

Who should report child abuse and neglect?

While any person who knows of or suspects child abuse or neglect can make a report, the following individuals are mandated by Colorado statute to report child abuse and neglect:

- Physician or surgeon, including a physician in training;
- Child health associate;
- Medical examiner or coroner;
- Dentist;
- Osteopath;
- Optometrist;
- Chiropractor;
- Chiropodist or Podiatrist;
- Registered nurse or licensed practical nurse;
- Hospital personnel engaged in the admission, care or treatment of patients;
- Christian science practitioner;
- Public or private school official or employee;
- Social worker or worker in a family care home or child care center;
- Mental health professional;
- Dental hygienist;
- Psychologist;
- Physical therapist;
- Veterinarian;
- Peace officer;
- Pharmacist;
- Commercial film and photographic print processor as provided in subsection (2.5) of this section;
- Firefighter;
- Victim's advocate;
- Licensed professional counselor;
- Licensed marriage and family therapists;
- Unlicensed psychotherapists;
- Clergy member;
- Registered dietician; and a
- Worker in the Colorado Department of Human Services.

In addition to those persons specifically required to report known or suspected child abuse or neglect, and circumstances or conditions which might reasonably result in abuse or neglect, **any other person may report** known or suspected child abuse or neglect, and circumstances or conditions which might reasonably result in child abuse or neglect, to the local law enforcement agency or the county department of human services.

What should I do for a child who discloses abuse/neglect?

Do	Don't
Believe the child and listen carefully to the child.	Promise confidentiality.
Find a private place to talk.	Panic or express shock.
Reassure the child that she or he had done the right thing by reporting.	Ask leading or suggestive questions.
Rephrase important thoughts; use the child's vocabulary.	Make negative comments about the perpetrator.
Tell the child help is available.	Suggest the abuse did not happen or the child is mistaken.
Let the child know you must report to someone who can help him/her.	
Report the incident immediately to the local department of human services.	

From the American Association for Protecting Children, *Guidelines of School*, American Humane Association, Denver, Colorado

When should I report child abuse and neglect?

You should make a report immediately when you have reasonable cause to know or to suspect that a child has been subjected to abuse or neglect, or have observed the child being subjected to circumstances or conditions which would reasonably result in abuse or neglect. Remember, it is not the responsibility of the reporter to prove that the child has been abused or neglected. It is the responsibility of the county department of human services and/or local law enforcement to investigate the case and to arrive at a definitive decision regarding follow-up.

How do I report child abuse and neglect?

Reports of known or suspected child abuse or neglect should be made immediately to the county department of human services or the local law enforcement agency and should be followed promptly by a written report prepared by those persons required to report. Child abuse reporting hotlines or phone numbers vary by county: <http://>

www.cdhs.state.co.us/cyf/Child_Welfare/County_Phone_Numbers.htm. Learn the process for reporting child abuse and neglect for your community by calling your county department of human services or local law enforcement agency. Another resource for information on how and where to file a report of suspected child abuse and neglect is the Childhelp USA ® National Child Abuse Hotline. Childhelp can be reached 7 days a week, 24 hours a day, at its toll-free number, 1-800-4-A-CHILD (1-800-422-4453).

What information should I provide when I make a report of child abuse and neglect?

- The name, address, age, sex, and race of the child;
- The name and address of the person responsible for the suspected abuse or neglect;
- The nature and extent of the child's injuries, including any evidence of previous cases of known or suspected abuse or neglect of the child or the child's siblings;
- The names and addresses of the persons responsible for the suspected abuse or neglect, if known;
- The family composition;
- The source of the report and the name, address, and occupation of the person making the report;
- Any action taken by the reporting source;
- Any other information that the person making the report believes may be helpful.

Can I make an anonymous report or do I have to provide my name?

You are not required to give your name or contact information, however, knowing the identity of the reporter can help the child welfare worker gather information during the investigative process to ensure the child's safety. It is also important to note that states are required to preserve the confidentiality of all child maltreatment reports, except in certain limited circumstances. Confidentiality refers to protecting the information from public view, including protecting the identity of the reporter from the person suspected of abuse or neglect.

What happens after I make a report of child abuse and neglect?

The county department of human services and local law enforcement often work together in child abuse investigations, but their roles are very different.

Law enforcement agencies investigate for the purpose of identifying criminal activity and bringing offenders to justice. If their investigation results in criminal charges and an arrest, the district attorney will be asked to prosecute the accused.

The child protective services staff members at the county department of human services are interested in identifying the alleged abuser but for different reasons. County staff are focused on serving the needs of the child, attempting to protect the child from further

abuse, and offering services to the child and the child's family to assist in their recovery. If county staff members conclude that an abusive incident occurred, they will file that information with the Central Registry of Child Protection. The Central Registry has developed as a database to record limited information on child abuse incidents and the victims and perpetrators of abuse.

All reports of child abuse and neglect are documented with a record maintained by child protective services. Information provided in a report may lead to a referral for further investigation. You are responsible for reporting child abuse and neglect. The county department of human services and the local law enforcement agency are responsible for deciding what follow-up should occur.

Is there any liability for a person who makes a report of child abuse and neglect?

Any person making a report in good faith is immune from any civil or criminal liability, or termination of employment that otherwise might result from such reporting. The law does not give immunity to a person who knowingly makes a false report.

Is there any liability for a person who fails to make a report of child abuse and neglect?

Any mandated reporter who willfully fails to report a case of suspected or known child abuse, or circumstances which may reasonably result in child abuse, may be found guilty of a Class Three misdemeanor and thus may be held liable for damages caused.

Where can I find sample agency policies for reporting child abuse and neglect?

Agency policies for reporting child abuse and neglect can help to define roles and responsibilities and to provide step-by-step intervention procedures. They may include:

- Roles and responsibilities of professionals for reporting
- Steps for reporting and time frames required
- Concrete/practical tips for reporting

Refer to Attachment One **(coming soon!)** for sample policies and procedures for reporting child abuse and neglect for several jurisdictions:

- Boulder County Department of Social Services
- Cheyenne County Nursing Services
- Denver County
- Jefferson County Department of Health and Environment
- Tri-County Health Department
- Sample school protocols

Health Insurance Portability and Accountability Act

How does the Health Insurance Portability and Accountability Act (HIPAA) impact reporting child abuse and neglect?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was signed into law on August 21, 1996. This law has two key purposes. The first (Title I) protects health insurance coverage for workers and their families when they change or lose their jobs. The second (Title II) requires the U.S. Department of Health and Human Services (HHS) to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses, through new protections, the "security and privacy" of patient health data. This last area, regarding the protection of health information, raises some important questions about how information-sharing practices in child maltreatment cases may be affected by HIPAA's privacy provisions.

HIPAA includes various changes, such as limiting exclusions for preexisting conditions; prohibiting discrimination against employees and dependents based on their health status; promising renewability and availability of health coverage to certain employers and individuals; and protecting many workers who lose health coverage by providing better access to individual health insurance coverage.

The primary goal of HIPAA is administrative simplification. It achieves that simplification through regulation in four areas: transaction code sets to standardize on data types; unique identifiers to act as an "index" for information; security and electronic signature standards to implement controls that guarantee confidentiality and integrity; and privacy standards to protect patient sensitive information. The broad privacy provisions are intended to protect the confidentiality of patient health records. HHS rules give individuals added control over how their protected health information is used and disclosed (Davidson, H. 2004).

HIPAA specifically permits reporting child abuse in the Privacy Rule. These will be formally incorporated into the Code of Federal Regulations as 45 C.F.R., parts 160 and 164. Until these are published, the text of the regulations may be accessed at this Web site: <http://www.hhs.gov/ocr/hipaa/finalreg.html> (Davidson, H. 2004).

Section 164.512 provides for disclosing information without first obtaining a signed authorization, and specifically addresses two areas that apply to child abuse:

(b)(1) *Permitted disclosures.* A covered entity may disclose protected health information for the public health activities and purposes described in this paragraph to: (i) A public health authority that is authorized by law to collect or

receive such information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions; or, at the direction of a public health authority, to an official of a foreign government agency that is acting in collaboration with a public health authority; (ii) A public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;

Section §164.512 (a) also provides for reporting as required by law:

(a) (1) A covered entity may use or disclose protected health information to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.

Who does HIPAA apply to?

HIPAA's privacy requirements apply only to information and records maintained by "covered entities." For example, a physical health care or mental health care "provider" that conducts certain transactions in electronic form (e.g., via Internet or intranet) is a covered entity.

In addition, any person, business, or agency that furnishes, bills, or receives payment for such care, in their normal course of business, where they also transmit relevant transactions electronically, are covered entities. Medicaid and Child Health Insurance Programs (CHIP) also are covered entities. If programs or entities are not providing health care, billing for it, or transmitting information related to such care or billing via electronic means, it appears the HIPAA privacy provisions do not govern them.

For those covered entities, HIPAA requires that patients receive written notice of their privacy rights. Patients usually must give specific authorization before these entities can share their information or records.

How does HIPAA impact Child Protective Services?

HIPAA's privacy protections will have important effects for child protective services agencies, other entities involved in child welfare work, and advocates when they seek – in child maltreatment cases – records or information on adults or children from "covered" hospitals, clinics, physicians, psychologists, psychiatrists, etc. As explained below, HHS has provided exceptions to make clear that health care providers suspecting child maltreatment still must report it. The exceptions, however, more clearly exempt disclosure of certain *child victim* records than they do physical or mental health information pertaining to *perpetrators of child maltreatment, parents of child maltreatment victims generally, other adults or children in the child's home, or*

prospective adult caretakers (e.g., foster or kinship care providers). Therefore, it is important that those seeking health information on such adults for child safety-related purposes become familiar with HIPAA privacy protections generally, as well as the scope of the exceptions (Davidson, H. 2004).

Exceptions that apply to child maltreatment are addressed in three sections of the HIPAA regulations: sections 160.203; 164.502(g)(5); and 164.512, which are posted online at: <http://www.hhs.gov/ocr/combinedregtext.pdf>.

Section 160.203 sets forth the series of HIPAA privacy requirements that clarify that HIPAA generally overrides state laws where those laws are contrary to HIPAA.

Section 160.203(c) states that HIPAA rules do not apply when the "provision of State law, including State procedures established under such law, as applicable, provides for the reporting of disease or injury, child abuse, birth, or death, or for the conduct of public health surveillance, investigation, or intervention." This might be construed to allow, assuming relevant authorization in State legislation, the sharing of both health records and information concerning adults and children, since this broadly worded exception to HIPAA's privacy protections not only permits "reporting" but also appears to authorize disclosure of public health-related case information on child maltreatment and child fatalities to those conducting activities related to "investigation" and "intervention" in such cases (Davidson, H. 2004).

Section 164.502(g)(5) addresses situations in which a "personal representative" of an individual entitled to HIPAA protections (e.g., a parent of a child patient) need *not* be provided access and control over the individual's records. Such situations exist when there is a "reasonable belief" that the individual "has been or may be subjected to domestic violence, abuse, or neglect by such person" or where treating that person as the personal representative "could endanger the individual." Before restricting such access and control, there must be a professional judgment that "it is not in the best interest of the individual to treat the person as the individual's personal representative." These are important provisions that can help keep a maltreated child's medical information out of the hands of an abusive parent.

Section 164.512 addresses a range of situations in which a patient's authorization or opportunity to agree or object to the release of information (i.e., the subject's consent) may not be required. There are three relevant subsections:

- **164.512(a)** provides exceptions when uses and disclosures of information are "required by law."
- **164.512(b)(1)** permits disclosure of information for "public health activities," which include prevention of injuries as well as disclosures to an "appropriate government authority authorized by law to receive reports of child abuse or neglect."

- **164.512(c)** addresses information on victims, and permits disclosure of information (beyond mere reporting) about victims of child maltreatment or domestic violence to appropriate government authorities – even if otherwise "protected health information" is disclosed – only if:
 1. Such disclosure would be authorized or required by law or regulations; and
 2. Disclosure of information on the victim is considered necessary to prevent serious harm to the victim or to other potential victims; or
 3. The victim consents to the disclosure.

Final Facts on HIPAA

- HIPAA does not inhibit reporting of child abuse and neglect.
- The disclosure of health information for public health prevention, surveillance, investigation, and intervention activities are activities HIPAA supports.
- HIPAA provides protections for the child victim's personal health information, but disclosures still can be made with the victim's consent or when it is necessary to prevent serious harm to the child or other potential child victims.
- The ability to access health information is given to relevant agencies, such as courts, law enforcement, and those determining the cause of child deaths.
- When contrary to the child's best interests, HIPAA will protect health information from being disclosed to parents or other adult representatives.

Ambiguities within HIPAA's privacy exception do require clarification. There are questions about how many exceptions will apply in practice and about how extensive the information health care providers will provide on children's families. The answers are unclear. More guidance is needed, but more information may be obtained from fact sheets and other materials provided by the U.S. Department of Health and Human Services Office on Civil Rights. Visit its Web site at <http://www.hhs.gov/ocr/hipaa>.

Successful Implementation of HIPAA

- Health care providers or "covered entities" under HIPAA will require training and educational materials about the sharing of information in child maltreatment cases.
- Judges and attorneys who handle child maltreatment proceedings must receive education on HIPAA privacy protections and their exceptions.
- Child welfare agencies must collaborate with health and mental health providers to minimize the adverse impact of HIPAA on accessing critical child safety-related patient records and other information. Staff also will require some HIPAA training.

- State and legislative changes may be necessary to meet disclosure provisions contained in the HIPAA privacy regulations that require a state law authorizing or requiring sharing of information.

Family Educational Rights and Privacy Act (FERPA)

Does FERPA prevent school records from being disclosed when reporting child abuse and neglect?

Ordinarily, parental consent is required before information contained in school records can be released. However, there are exceptions that can apply in cases of suspected child abuse and neglect. Prior parental consent is not required when disclosing information from school records if a “health or safety emergency” exists. Federal officials interpreting the Family Educational Rights and Privacy Act (FERPA) concluded that child abuse and neglect generally may be considered a “health or safety emergency” if the state definition of child abuse and neglect is limited to situations in which a child’s health or safety is endangered. That responsibility for determining whether a “health or safety emergency” exists must be made by the school official involved, on a case-by-case basis. Thus if a school official determines that an emergency exists, information in school records can be disclosed without parental consent and without violating the provisions of FERPA.

For more information on FERPA, as well as reporting child abuse and neglect in school settings, please refer to the Colorado Department of Education’s on-line resources:

http://www.cde.state.co.us/cdesped/download/pdf/nurChild_Abuse.pdf

Current Topics in Child Maltreatment

Failure to Thrive

Maltreatment of Children with Disabilities

Shaken Baby Syndrome

Cultural Considerations Related to Child Maltreatment

The Link Between Domestic Violence and Child Abuse

Child Maltreatment in Drug-Endangered Homes

**Intrauterine Drug/Alcohol Exposure
Fetal Alcohol Spectrum Disorders**

Failure to Thrive (FTT)

The Colorado Children's Code requires mandated reporters to report failure to thrive (FTT) to the Department of Human Services immediately when not justifiably explained. While the Colorado Children's Code does not define failure to thrive, it is generally considered to be a description applied to children whose current weight or rate of weight gain is significantly below that of other children of similar age and sex.

Organic FTT occurs when there is an underlying medical cause. Nonorganic FTT is defined as a decelerated or arrested physical growth associated with poor developmental and emotional functioning. Nonorganic failure to thrive occurs in a child who is usually younger than 2 years old and has no known medical condition that causes poor growth. A combination of organic and nonorganic failure to thrive may also occur.

Nonorganic FTT: This condition usually results from various environmental and psychosocial factors. It often is associated with abnormal interactions between the caregiver and the infant or child. This can result in an inadequate provision of food and/or inadequate intake of food. Nonorganic FTT can begin prenatally and/or occur postnatally.

Prenatal causes of nonorganic FTT: Mothers who are malnourished often have babies who are malnourished and small. Some evidence exists that, if mothers do not bond with their unborn babies, those babies undergo FTT in utero as well. Lower birth weights also are associated with teen pregnancies, lower socioeconomic level, and multiple gestations. Maternal eating disorders, such as anorexia and bulimia, certainly can affect the growth of fetuses as well.

Postnatal causes of nonorganic FTT: Traditionally it was thought that nonorganic postnatal causes of FTT were due to maternal rejection or neglect. In 1985, Skuse suggested that clinicians inquire about more than just the nutrition offered to children. He found behavior at meals and psychosocial issues to be important variables affecting whether children obtain sufficient energy. Poor parenting and family dysfunction can negatively affect a child's energy intake. Families characterized by less adaptive relationships, higher levels of family conflict, and less emotional support for the mother have an increased percentage of children with FTT. The term psychosocial deprivation was created for these types of situations.

Nonorganic causes of FTT are summarized as follows:

- Poor feeding or feeding-skills disorder
- Dysfunctional family interactions
- Difficult parent-child interactions

- Lack of support (no friends, no extended family)
- Lack of preparation for parenting
- Family dysfunction (divorce, spouse abuse, chaotic family style)
- Difficult child
- Child neglect
- Emotional deprivation syndrome
- Feeding disorders (anorexia, bulimia)

Combined organic and nonorganic FTT: FTT in a patient can result from the combination of both organic and nonorganic reasons. In one study, half of the cases with organic etiology had a psychosocial factor contributing to FTT. This is caused by a number of reasons. It is clear that illnesses in children, particularly chronic illnesses, can take their toll on families. Stresses from coping with chronic illnesses may lead to parental dysfunction, such as depression, alcohol or drug abuse, divorce, or chaotic home environments. Parental dysfunction and the resultant negative atmosphere in which children are reared affect their food intake. In addition, children may undergo personality changes when they have chronic diseases. Medications, such as steroids, are well known to cause behavioral changes, but the mere presence of a chronic illness also can result in resistance or noncompliance in many aspects of a child's life, including consumption of proper energy intake.

Reference

Retrieved from Reda Bassali and John Benjamin (2004), *Failure to Thrive*. Full text can be found at www.emedicine.com.

Sample Guidelines for Identifying and Reporting FTT to Child Protective Services

Indicators of Inadequate Growth:

1. Newborn has not regained birth weight by 1 month of age AND one or more "at-risk" psychosocial factors are present and identified.

OR

2. The infant is less than 5 months of age and the infant's growth chart indicates no growth or a declining weight* over a two month period AND one or more "at-risk" psychosocial factors are present and identified.

OR

3. The child is five months of age or older and the child's growth chart indicates no growth or a declining weight* over a three month period AND one or more "at-risk" psychosocial factors are present and identified**.

OR

4. The infant/child has a flat growth curve or a deceleration of growth leading to a fall of two major growth percentile lines on standard growth chart AND one or more "at-risk" psychosocial factors are present and identified.

OR

5. The child is below the 5th percentile weight for age or less than 5th percentile weight for length or less than 5th percentile both weight and length for age on the growth chart which has been adjusted for gestational age AND one or more “at-risk” psychosocial factors are present and identified and/or there is no adequate explanation**.

*Declining weight is defined as a flat growth curve or a deceleration of growth greater than two major growth percentiles, also known as channels or parameters (i.e., 90% -> 50%; 25% -> 5%; 75% ->25%; 60% -> 20%).

In the event of an acute illness, the following inadequate growth indicators apply: If the child's weight falls after an acute illness AND the child does not regain sufficient weight to reach the child's previous growth curve within six to eight weeks of being symptom-free AND one or more “at-risk” psychosocial factors are present and identified.

“At-Risk” Psychosocial Factors:

1. Repeated observations of inappropriate parent-child interaction.
2. Domestic violence.
3. Signs of physical deprivation.
4. History of abuse or neglect of other children, including a history of children being removed from the home.
5. Parental substance abuse, including alcohol and/or illegal drugs.
6. Diagnosed mental illness or cognitive impairment of the parent.
7. Suspicion of neglect or physical abuse of the child.
8. Suspicion of sexual abuse of the child.
9. Significant development delay without adequate explanation, especially motor.
10. Lack of medical care, which endangers child's health or well-being.
11. Dangerous environment and/or unsafe housing.
12. Existing Department of Social Services Child Protection client.
13. Other combinations of the above.

Reference

Adapted from Boulder County Public Health's Failure to Thrive Reporting Guidelines

Maltreatment of Children with Disabilities

National Resource Center On Child Abuse and Neglect Fact Sheet

It is generally believed that children with disabilities are abused more frequently than children in the general population. Currently, studies are underway to determine more precisely the association between maltreatment and disability.

How common is abuse among children with disabilities in the United States?

Researchers have not been able to gather precise information to determine the extent of abuse among children with disabilities. However, National Center on Child Abuse and Neglect research found that children with disabilities are maltreated at 1.7 times the rate of other children (1993).

All research studies indicate that underreporting is a major concern. Even if a case is reported to the state central registry, most state child protective service reporting agencies do not gather information on children with disabilities as part of the data collection process for abused children.

Some researchers suggest that children with disabilities may have increased vulnerability to abuse because of society's response to the disability, rather than the disability itself.

Children with disabilities may be perceived as less valuable than other children. Their reports may not be considered trustworthy. Discipline may be more punitive and accompanied by a lack of respect.

Other factors leading to abuse among children with disabilities are the same as those found in the general population, i.e., single parents, teen parents, various levels of stress. Families with children with disabilities can experience additional stressors including:

- Feeling unprepared to handle the care of a disabled child, including acceptance of that child as being "different";
- Having financial or time limits stretched as additional medical/educational activities are suggested; and
- Lacking necessary social supports or networks to work through the many concerns and situations that arise in providing care for this child and the rest of the family.

All of these can result in increased vulnerability to abuse. A child with difficult to handle behavior patterns, or communication difficulties, may become a target for physical abuse. Children who are unable to communicate their needs may experience greater instances of neglect. The child with disabilities also can develop more extensive relationships of trust with greater numbers of people, and be unable to distinguish when boundaries are being crossed, resulting in potential sexual abuse.

There is no research available that clearly documents the greater prevalence of one form of abuse compared to others involving children with disabilities. However, studies continue to document high counts of sexual abuse involving individuals with disabilities. Individuals diagnosed with behavior or adjustment problems are often found to have associated traumatic sexual abuse incidents in their childhood. An inability to discuss those events can often lead to diagnoses, which may only partially explain their behavior. Ongoing work needs to be done to identify at-risk factors for the various types of abuse.

Who is the perpetrator?

The perpetrator of abuse to the child with disabilities, like the perpetrator of abuse to the child in the general population, is known to the victim in almost all cases. Persons who abuse children range from family members, to professionals, to paraprofessionals.

Prosecuting abusers of children in general can be difficult in the best of circumstances. Societal influences are clearly at play when cases involve children with disabilities. The degree to which a child will be viewed as "credible" or "reliable" in court is often based on whether the physical, intellectual, or communication abilities are perceived to match the expectations of the court.

The reliability of communication in non-standard forms (e.g., interpreters, facilitated communication, communication boards) is often questioned – not necessarily because of the person responding but because of the person who is witnessing it, who may have limited experience with individuals with disabilities. Convictions in these cases, no different from others, also must involve corroborating evidence, beyond child testimony, for successful prosecution.

Is it more difficult to identify abuse in the child with disabilities?

Indicators of abuse for children with disabilities are the same as indicators of abuse for their peers in the general population. Along with physical signs, two of the primary ways of identifying abuse are the child's reports and behavioral indicators. Children with disabilities may exhibit behavioral indicators of abuse that are not recognized as abusive by their caregivers.

Changes in behavior may be attributed to their ongoing problems or to their inability to communicate appropriately. Injuries resulting from physical abuse may be ignored if a child has visual or physical limitations. If a child has intellectual limitations, responsible adults may wrongly assume that the child is untrustworthy or easily suggestible, especially if the report involves instances of abuse that seem unbelievable or improbable considering the circumstances of the child. Unless a child can communicate what happened, and "be believed," indicators of abuse for children with disabilities can be more difficult to recognize.

In the general population, child victims of abuse are at high risk for multiple problems, including depression, anxiety and low self-esteem. Consequences of abuse may be more pronounced in children with disabilities because of their already vulnerable physical and psychological state.

Research has shown that the longer abuse has gone on, the more damage may result. Since the child with disabilities who is abused is less likely to be identified, he or she is likely to suffer more damage because of long-term abuse. Abuse may exacerbate existing disabilities and cause additional permanent disabilities.

How can abuse be prevented?

One of the major ways to prevent abuse is for society to believe that abuse can occur with all populations of children. The goal of prevention is to intervene before abuse and neglect can occur. Several approaches have proven helpful. Teaching children personal safety skills to discourage abuse, and making others aware of the child's knowledge, can greatly reduce the risk of abuse. Recognizing that the child is very dependent on the caregiver, parents should get to know all persons working with the child, and observe interactions. The caregiver is in a position to provide or withhold daily necessities, and the child may have trouble communicating this information to the parent. Since parents as well as other caregivers may be perpetrators of abuse, everyone who has a role in caring for the child with disabilities can participate in prevention training programs as well as programs for early identification and intervention. Forming relationships with local developmental disability councils and other local schools and agencies serving individuals with disabilities can strengthen the network of those who can provide assistance to families. If abuse does occur, early detection is most helpful. Encouraging the child to report and learning to recognize indicators of abuse can result in early intervention and treatment.

A parent's response upon learning about abuse has a profound impact on the child. A parent, caregiver, or other supportive adult can best help the child if he or she:

- Remains calm;
- Believes the child;
- Assures the child that he or she did nothing wrong; and

- Encourages the child to talk about his or her feelings.

Family participation in a recommended treatment program is very helpful. The goal of treatment is that the child regains his/her prior state of mental and psychological health, and that the family members recover together.

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Abuse and Neglect of Children with Disabilities ARCH National Resource Center for Respite and Crisis Care Services

Fact Sheet Number 36

Background

JoAnne, a fourteen-year-old girl, lives in a skilled nursing facility. She has profound mental retardation and multiple disabilities, including seizure disorder and cerebral palsy. She requires assistance for all her daily living activities. When she was discovered to be eight months pregnant, facility staff reported suspected child abuse. The perpetrator was never identified. Of the remaining ninety-eight residents living in the same facility, over 80% tested positive for a variety of venereal diseases. Child abuse and neglect was identified as a "national epidemic" in the 1991 report of the U.S. Advisory Board on Child Abuse and Neglect. In 1993, the National Committee to Prevent Child Abuse (NCPA) determined that approximately 2.9 million children were identified and/or reported as victims of child abuse and neglect throughout the United States. Until recently, however, the number of children with disabilities who have been abused and neglect has not been well documented.

In November 1993, the National Center on Child Abuse and Neglect (NCCAN) released a study regarding the abuse of children with disabilities. This first national effort to determine the incidence of abuse among this population found that children with disabilities are abused at approximately twice the rate of children without disabilities (WESTAT, 1993). Other studies document an increased risk of abuse for children with disabilities between four to ten times that of the generic population (Baladerian, 1990).

All forms of abuse, including multiple types of abuse with the same child, multiple perpetrators of abuse, and multiple victims within a grouping of children, are found within the population of children with disabilities. The vast majority of the perpetrators are well known to the abuse victim. Perpetrators may include family members and service providers such as teachers, doctors, administrators, direct care providers, therapists, and transportation providers.

Abuse Can Cause Disabilities

Sammy, now thirteen years old, had mild mental retardation and cerebral palsy. In counseling he revealed that he was thinking about his future, including marriage and parenthood. Afraid that his children would "be retarded like me," he was asked the cause of his disability. "I was born normal. My Dad used to come home drunk and get real mad. I remember he would throw me against the wall. My head hurt a lot. This happened all the time, when I was little. Now I'm retarded." Although Sammy understood the origin of his disability, he did not understand genetics or heredity. When told that his children would probably be born just like he had been, he was happy. He said, "I would never hurt my kids like my Dad [did] (sic)."

In addition to the fact that children with disabilities are at increased risk of abuse is the fact that child abuse can cause disabilities. The exact number of abuse-caused disabilities is unknown, but it is estimated to represent 25% of all developmental disabilities (Baladerian, 1992). In addition, more than 50% of the child victims of severe neglect sustain permanent disabilities, including mental retardation and other forms of learning and cognitive disabilities.

According to a 1990 study, 53% of child abuse related fatalities were children under one year of age, and 90% of the children were under five years of age (April 1994 Carnegie Report). Head trauma is the leading cause of death for children who die from child abuse (Michael Durfee, 1994). It is unknown how many more children suffer "near misses" and retain serious permanent disabilities due to head and neck trauma. Specific causes of brain and other central nervous system injuries may result from the "shaken baby syndrome," blows to the head (e.g., slapping, hitting, child tossing), as well as asphyxiation (due to suffocation or strangling).

Identification

The signs of abuse characteristic of children in the general population are pertinent to children with disabilities. These signs include the following:

- Physical injuries including unexplained bruises, welts, broken bones, burns
- Frequent unexplained injuries
- Aggressive or withdrawn behavior
- Unusual fears
- Craving for attention
- Wary of physical contact
- Afraid to go home
- Destructive to self and others
- Poor social relations
- Fatigue
- Lack of concentration
- Unusual knowledge of sex

Unfortunately, for children with severe disabilities, discovery of their abuse is usually dependent upon the emergence of incontrovertible physical signs (e.g., death, pregnancy, venereal disease, physical injury) and/or obvious behavioral signs (e.g., sudden changes in behavior that re-enact the abuse). Less obvious behavioral signs do not necessarily alert the untrained caregivers to possible abuse. Even more problematic is that professionals providing services to children with disabilities have too often attributed clear signs of abuse to a disability. This oversight has left children in abusive situations, in some cases for several years.

In addition, many people have difficulty believing that children with disabilities can be victims of abuse and neglect. This misperception creates an exaggerated level of vulnerability, as children with disabilities, and their families, are not prepared psychologically, intellectually, or physically to resist or respond to abuse. One woman, who has a severe disability, recently stated that, "Until as an adult I was sexually abused, I never thought that persons with disabilities were rape victims. I'd never heard of it. Of course I know about sexual abuse, but it never occurred to me that people with disabilities were abused. I was so naive."

Prevention

Parents of children with disabilities often receive a lot of information about disabilities, child care, child development, and community resources, but are rarely prepared or trained on the subject of physical or sexual abuse or neglect. While abuse prevention programs exist in various forms throughout the country, these are rarely offered to children with disabilities and their families. When programs are offered, they are not always age appropriate, as when programs designed for younger children are presented to older children with disabilities.

Programs that are designed with the "No-Go-Tell" concept as their base are not, in general, useful for the child with a disability. These programs teach children to tell the potentially abusive adult, "No!," then to go to someone they trust, and tell them about the other adult's behavior. Telling an adult, "no," is difficult for any child; children with disabilities, however, may have even greater difficulty as they are usually taught to strongly respect the authority of almost any adult or person who is "in charge." In addition, most persons who abuse children with disabilities are in positions of trust, authority, and relationship with the children (e.g., parents, professionals, paraprofessionals, or other family friends). Thus the ability to socially resist an abuse is diminished.

So, what does work? First, the parents and family members of children with disabilities should be informed that their children, like other children, are at risk. Frequently parents, and the children themselves, believe that due to the disability they cannot become abuse victims. Second, parents should talk directly to their children about abuse awareness, and develop a communication cue that will alert the parent that something has happened. Parents need to be empowered to take firm action to apprehend the identified perpetrator.

Many children with disabilities can benefit from self defense programs with individually tailored defense and response techniques, depending on the child's disability. Programs are in effect all across the country, and in Europe, teaching self defense techniques to children with intellectual, communication, mobility, and sensory disabilities. Practicing communication cues and self defense techniques is important. Equally important is teaching and implementing assertion and personal empowerment skills. If a child is only

encouraged to be assertive when and if an assault is in progress, success is unlikely. Only when the child is assertive in all areas of life can it be expected to be successful in the face of assault.

Unfortunately, in many cases a child cannot stop or avoid the abuse. In these cases, the child and parents must be encouraged to "do everything possible," which may include identifying the event as abuse and reporting it immediately. Such a response can be empowering for both the child and the family, ameliorating the effects of the abuse itself.

Challenges to Effective Intervention

Recently the fields of child abuse protection and disabilities have begun to recognize their common interest in working to prevent abuse of children with disabilities. Both fields have much to learn to become competent to deal with the specific issues of abuse for this population. This collaboration is thought by many to be the key to successful intervention and amelioration of maltreatment of children with disabilities.

In reducing the risk of abuse for children with disabilities, and in providing effective and sensitive intervention services, professionals will need to develop working relationships in a structure that allows for cross referral, cross training, consultation across a variety of agency lines, and increased accessibility and understanding for the disabled community. This will require changes for both abuse protection and disability service agencies.

Increasingly child abuse response professionals, program administrators, and the law enforcement community are seeking skills to help in the identification, reporting, interviewing, and adjudication of suspected child abuse for children with disabilities. With this interest and a matching commitment on the part of funding sources, the specialized training they seek can be provided. Additionally, disability specialists and service providers are seeking the expertise of those in the child abuse community to learn how to recognize and respond effectively and appropriately to the epidemic of child abuse.

Intervention includes a myriad of services, ranging from the initial observation and report taking to assessment and interviewing, placement, court, treatment, and monitoring. As therapists skilled in providing treatment for severely disabled abuse victims become more available, CPS workers will more easily make referrals for the children they serve.

These changes will take time, but with increasing interest in this population, and the availability of good training programs as well as models for inter-agency collaboration, it is likely that these changes can be in place in the near future.

Recommendations

States may want to follow the leadership of Florida, Washington, and California, where some legislation and activities are in place to address the issue of abuse of children with disabilities. For example, in California the state chapter of the National Committee to Prevent Child Abuse (NCPCA) has attempted to develop liaisons at the local, state, and national levels by writing to all NCPCA chapters alerting them to the problems of child abuse and neglect for children with developmental disabilities. They have encouraged the chapters to contact their State Councils on Developmental Disabilities to establish working relationships. A similar letter was sent to each of the State Councils. In the past five years, awareness of the problem of abuse and neglect of children with disabilities has begun to increase. It is important to foster greater awareness of this issue. This can be done through comprehensive public awareness campaigns by adding a few critical facts to the generic child abuse awareness campaigns.

- Child abuse happens to children with disabilities.
- Child abuse and neglect can *cause* disabilities.
- Children with disabilities can resist abuse attempts when given information and skills development training.
- Parents of children with disabilities can learn to distinguish signs of abuse and disability related problems.
- Children with disabilities are competent to communicate their abuse experience.
- Children with disabilities can be acknowledged as credible witnesses to their own experience.

Summary

The problem of abuse of children with disabilities is a serious issue, but is still not largely recognized by service agencies. Prevention and abuse awareness programs need to include information about the heightened risk of abuse of children with disabilities, and the onset of a permanent disability as a consequence of abuse. The utilization of training programs for children, parents, families, and child abuse response and disability services providers, will play a unique and critical part in the reduction of risk for children with disabilities.

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Maltreatment Of Children With Disabilities
The following are excerpts of working paper number 860
National Committee to Prevent Child Abuse (NCPCA)
By Robert T. Ammerman, Ph.D. and Nora J. Baladerian, Ph.D.

Maltreatment

Abuse is generally recognized as the non-accidental and intentional infliction of pain upon the child. Abuse can result in physical injury. According to the National Committee to Prevent Child Abuse (NCPCA), abuse includes physical acts that result in injury, sexual molestation and exploitation and emotional abuse (verbal attacks that impinge on the child's emotional development and diminish sense of self-worth). Neglect is failure to provide the child with basic necessities such as food, shelter, and education. Abuse and neglect are usually expressed as a pattern of similar acts, demonstrating repetition. Single instances may be excluded from being identified as abuse or neglect, based on an evaluation of the event and its consequences.

When blows to the body are injurious to the child, either physically or psychologically, abuse must be clearly identified. If a child is chronically being belittled or humiliated, this would be considered abuse. Infrequent "blow ups" within the context of normal family living, however, would usually not be viewed as abuse.

Disability

The definition is taken from the definition used in the Americans with Disabilities Act (PL 101-336-7/90), commonly referred to as the ADA. The ADA is the most significant piece of civil rights legislation affecting individuals with disabilities. This is its definition:

The "disability" means, with respect to an individual:

- A physical or mental impairment that substantially limits one or more of the major life activities of such individual;
- Record of such impairment; or
- Being regarded as having such an impairment.

This, then, includes children with all types of disabilities, including physical disabilities, intellectual or learning disabilities, sensory and motor disabilities, mental illness, or any other type of emotional mental, or physical impairment. This broad definition assists in the effort to be inclusive and to address the needs of all children, and avoid the pitfalls that can accrue when definitional limitations or lists are used to describe one's target population.

Epidemiology

All types of abuse are found in children with disabilities. While it is generally believed that children with disabilities are abused more frequently than their generic counterparts, no national studies have been released to date that validate this belief. Indeed arriving at precise epidemiological data regarding abuse of children with disabilities has thus far been elusive. However, several investigations suggest that children with disabilities may be maltreated at a rate between four to ten times that of the generic population. Efforts are currently underway to obtain more precise epidemiological data on the prevalence of disabilities among children who are reported to be abused and neglected, and this should more clearly delineate the association between maltreatment and disability. However, extant data are alarming, and underscore that many children with disabilities can be expected to become abuse survivors.

Abuse Victims

Studies of maltreated children without disabilities indicate that boys as well as girls are abuse victims, and that perpetrators include both men and women, as well as siblings and significant others. Few prevention programs exist that are implemented on a regular basis in schools or other day programs, either for children or adults with disabilities. Although state and national data on abuse and neglect of children are now kept, information on children with disabilities is not generally a part of the data collection process, as are data on other culturally and demographically distinct groups, including differentiations for race, ethnicity, gender, socioeconomic level, and urban/rural populations. Efforts are currently underway to include children with disabilities in the data collection systems of child protective service agencies. For example, California has included them since 1986, and one can access information concerning abuse and disability by county, type of abuse, and age of the child, the incidence of abuse or neglect among children with disabilities.

Children with disabilities grow up and retain the disability. Some also retain a high level of vulnerability to abuse, and will continue to need support and educational services to maintain abuse-prevention awareness. Laws against abuse of "dependent adults" have now been joined with the Elder Abuse Reporting Laws in most states, in recognition of the continued vulnerability of children with developmental disabilities into their adult years. It is critical to keep in mind, however, that children with disabilities do not "disappear" once they reach the age of majority, but continue to require the attention and intervention of persons dedicated to stopping abuse.

Abuse Perpetrators

Research also indicates that, in the general population, the perpetrators are known to the victim in approximately 60 % of the cases. In the population of children with

disabilities, the perpetrator is familiar with and trusted by the victim in the vast majority of cases. As has been described above, children with disabilities have a larger number of persons involved in their regular life activities than generic children. Each of these persons is trusted by the parents to be safe with their child and becomes familiar to the child, and is therefore trusted by the child. Having achieved a position of trust and authority, the perpetrator in frequent contact with the child has a perfect opportunity to abuse the child. Persons who are perpetrators, and who are not family members, are known to seek employment or volunteer positions that provide this type of access to children with disabilities.

Believing that children with disabilities are unlikely to identify them as abusers, or that the child will be unable to communicate about the abuse, they believe that their victimization will continue indefinitely without discovery. Further, since prejudice against disabilities is so ingrained in many persons, frequently even those in a position to protect children from abuse fail to identify clear signs of abuse due to unexamined thought processes that lead them to think that children with disabilities will not be abused. Thus, clear signs of abuse are mistaken, and identified as functions of the disability. This type of thinking further acts to protect the perpetrator from discovery.

Although perpetrators may be identified, the status of prosecution in these cases is poor. Because (a) there may be no "hard signs" of the abuse, (b) the child with a disability may use alternative communications systems, and/or (c) many courts have not yet overcome their own prejudices against children with disabilities, few cases reach successful criminal prosecution (impediments to prosecution of child abuse are evident in many [cases], regardless of whether the child has a disability). Child protective service agencies, which require a lower standard of proof, may be able to successfully prove that the perpetrator is guilty. However, the consequences of this level of proof only serve to protect the child in question, or to support the removal of the individual from his or her job or position. The perpetrator is then free, with no criminal record, to seek employment or volunteer positions in other agencies in the same or other states. Efforts are being made at this time to not only improve employment-screening systems but court procedures and requirements, to allow for children with disabilities to be heard and believed when they communicate in their own way what they know took place.

Identification

Identification of abuse and neglect in children is critical for three reasons. First, recognition of maltreatment at an early stage can prevent an escalation of violence and a worsening of a neglectful environment. Second, identification should lead to referrals to social service and mental health agencies that will provide needed intervention. And third, early identification of abuse and neglect may prevent the known negative outcomes in children associated with prolonged experiences of maltreatment.

There are several impediments to the identification of maltreatment in children with disabilities. Those children with communication limitations pose significant challenges in identification, in that they are unable to report incidents of abuse to responsible adults. This is especially evident in the case of sexual abuse, in which overt physical signs of victimization may be absent. In fact, child reports of sexual abuse are the primary means whereby molestation is identified. For example, a recent study found that in 66% of a sample of sexually abused children, the abuse was discovered through children's reporting. Identification of physical abuse is also compromised if the child is unable to communicate the circumstances surrounding the occurrence of suspicious injuries.

On the whole, indicators of maltreatment in children with disabilities are similar to those of their peers without disabilities. Symptoms of physical abuse include bruises and injuries accompanied by implausible explanations. Injuries that occur on parts of the body not usually damaged as part of a fall (e.g., back, thighs) are suggestive of mistreatment. Signs of neglect include unkempt appearance, poor hygiene, malnutrition, and developmental delays. Sexual molestation can result in tissue damage and contraction of sexually transmitted diseases. Often, however, there are no physical signs of maltreatment, and identification is based upon the child's report combined with behavioral or circumstantial indicators. There are a variety of behavioral indicators that are suggestive of maltreatment. These include sudden changes in behavior, regression to earlier developmental stages, enuresis and encopresis, social withdrawal, aggressiveness and deterioration in academic performance. In children with disabilities, these behavioral signs of abuse may be subtle, and their recognition can only be made by individuals who know the child well. It is generally believed that sudden and unexplained changes in behavior are suggestive of maltreatment, particularly sexual abuse. Such milder changes may be misattributed to be a feature of the disability, rather than a sign of maltreatment. Furthermore, victims of maltreatment may become shy, hyper-vigilant, and resistant to being touched. They may also be anxious and distressed in the presence of the perpetrator.

Causes of Abuse and Neglect

In general, the causes of abuse and neglect of children with disabilities are the same as those for children as a whole. At the cultural level, acceptance of physical violence to resolve conflicts contributes to the acceptance of abuse. Societal influences include policies that fail to protect children, or fail to effectively address problems that contribute to abuse and neglect (e.g., poverty, unemployment, inadequate educational opportunities). Parental rights to privacy and autonomy in child raising resist interference by society even when their practices injure, disable, or cause the death of their children. At the community level, crowded housing and inadequate community supports are associated with a higher incidence of maltreatment.

Because some children with disabilities have special medical and educational needs, they are more prone to be neglected in the form of failure to obtain or administer

needed medications, receive inadequate and infrequent medical care, and experience inappropriate educational placements. These forms of neglect can cause serious damage, both acute and permanent, physically, emotionally and mentally.

Prevailing societal attitudes toward children with disabilities further add to the problem. Persons with disabilities have often been devalued, depersonalized, and dehumanized. This is seen in our language (e.g., "vegetable") and delays in societal response to the needs of individuals with disabilities, such as access to the community. Such negative attitudes permeate all levels of society and can contribute to the occurrence of abuse and neglect, both within the family and in institutional settings.

Consequences of Maltreatment

The consequences of maltreatment are varied and depend upon numerous factors. Extent, severity, and length of maltreatment all can influence outcome. In addition, children's vulnerability or resilience to adverse circumstances may increase or decrease the likelihood of psychosocial problems. Many children with disabilities are especially likely to develop difficulties secondary to abuse and neglect given their already vulnerable physical and psychological state.

Disabilities can be caused and/or exacerbated as a function of abuse. In fact, some recent studies suggest that up to 25% of abused children may retain permanent disabilities as a direct result of abuse. Approximately 52% of neglected children may suffer permanent disabilities. This is not difficult to understand, once we consider the impact of head trauma and malnutrition, the primary contributors to this problem. Head trauma, caused by blows to the head, shaking the child, throwing the child or other acts often results in permanent brain damage. Other actions that cause brain damage include those that stop oxygen from getting to the brain, such as suffocation, and attempted drowning. Damage to the brain can cause permanent intellectual difficulties as well as neurological problems, including learning disabilities, mental retardation, memory problems, speech and language problems, blindness, deafness, epilepsy, and motor impairments such as cerebral palsy. Disabilities resulting from abuse have profound effects on multiple areas of functioning, including economic, social, educational, religious, medical and vocational realms.

Prevention and Treatment

The goal of prevention is to intervene before abuse and neglect occur. The physical, emotional and financial costs of abuse and neglect are so great as to make prevention the number one priority in the effort to eliminate maltreatment of children. There are three approaches that are most often used in the prevention of abuse and neglect in children with disabilities. These are: (1) teaching children personal safety skills so as to discourage maltreatment and to facilitate early disclosure by children who are victims; (2) training parents, other caregivers and professionals to recognize indicators of

potential or actual maltreatment in order to bring about early identification and rapid intervention by social service agencies; and (3) intervention with children and their families following the discovery of abuse. Since in many cases it is not possible to prevent abuse from occurring, the term "risk reduction" is being widely adopted as more descriptive.

Programs that teach children with disabilities about abuse are powerful tools in abuse prevention. Parents can train their children to recognize abuse. They generally include the following points in their content: defining abuse (e.g., physical, sexual, verbal, emotional), learning how to identify abuse (e.g., unwelcome sexualized touching or talking), learning how to respond to the abuser (using techniques individualized to the child's abilities and strengths), identifying ways that the child can tell others about the abuse, and identifying feelings the child and her family may experience should abuse be attempted or completed. Although there is no evidence that such training actually prevents abuse, it will at least facilitate disclosure.

Treatment of the Child and Family

Intervention following the discovery of abuse is vital to the healing and strengthening of the child. How parents respond to the child upon learning of the abuse and how professionals respond have a great deal to do with not only the child's healing, but preparation for additional abuse attempts, should they occur. It is generally recognized that the parent's response to the child upon learning about the abuse has a profound impact on the child. If the parent remains calm, assures the child that he or she did not do anything wrong, the parent loves the child, and wants to "hear all about it," the child has a good chance for recovery. It is the parent who becomes excited, threatens to kill the abuser, begins to rant and rave, who does a disservice to the child who needs to receive comforting and loving attention, assurances of continued help, and sees the parent take rational and reasonable steps to get help for the family, as well as take the proper legal steps against the perpetrator.

Family therapy is a widely recommended form of treatment, as it permits all family members to share in the healing process together, and provides an opportunity for the family members to observe how the therapist interacts with the child in a therapeutic approach that can be continued at home. It is also possible to treat the children of the family together, and the parents together in separate sessions, to deal with specific issues they may need to resolve not in the presence of the children.

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Resources

There are a large number of persons, organizations, and written materials now available on the abuse and neglect of children with disabilities, to help both parents and professionals. Few resources, however, are available for the individual with a developmental disability.

At the present time, there are few agencies that provide information on the "mix" of abuse and disabilities. However, abuse-related agencies and organizations can be extremely helpful resources to learn about abuse in all of its aspects. Disability related organizations, likewise, provide extremely helpful information on issues of disability. Many persons have found that they must review information from each of these types of agencies. Then combine it, in their way, to become adequately informed on the issue.

The following agencies and organizations have information about prevention, intervention, treatment and research on child-abuse and disabilities.

Disability-Related Resources

National Association of Protection and Advocacy Systems

900 Second St. NE, #211
Washington, D.C. 20002
(202) 408-9514
FAX (202) 408-9520
TDD (202) 408-9521

National Information Center for Children and Youth with Disabilities
P.O. Box 1492
Washington, D.C. 20013-1492
(703) 893-6061
(800) 999-5599
FAX (703) 893-1741
TDD (703) 893-8614

National Organization on Disability
910 16th St. NW, Suite 600
Washington, D.C. 20006
(202) 293-5960
FAX (202) 293-7999
TDD (202) 293-5968

Disability Rights Education and Defense Fund
2212 Sixth St.
Berkeley, CA 94710
(510) 644-2555

National Center for Law and the Deaf
Gallaudet University
800 Florida Ave., NE
Washington, D.C. 20002
(202) 651-5373 (Voice/TDD)
FAX (202) 651-5381

DIRECT LINK for the Disabled, Inc.
P.O. Box 1036
Solvang, CA 93464
(805) 688-1603
FAX (805) 686-5285
(805) 688-1603 (Voice/TDD)

National Association of Developmental Disabilities Councils
1234 Massachusetts Ave., NW, Suite 103
Washington, D.C. 20005
(202) 347-1234

FAX (202) 347-4023

American Association of University Affiliated
Programs for the Developmentally Disabled
8630 Fenton St. #410
Silver Spring, MD 20910
(301) 588-8252
FAX (301) 588-2842
TDD (301) 588-3319

National Association for the Dually Diagnosed
110 Prince St.
Kingston, NY 12401
(914) 331-4336
(800) 331-5362
FAX (914) 331-4569

Sexuality-Related Resources

Sex Information and Education Council of the U.S.
130 West 42nd St., #2500
New York, NY 10036
(212) 819-9770
FAX (212) 819-9776

Coalition on Sexuality and Disability
122 East 23rd St.
New York, NY 10010
(212) 242-3900

Abuse-Related Resources

National Committee to Prevent Child Abuse
332 S. Michigan Ave., Suite 1600
Chicago, IL 60604
(312) 663-3520
TDD (312) 663-3540

American Humane Association
63 Inverness Drive East
Englewood, CO 80112-5117
(303) 792-9900

DRAFT 6.17.05

FAX (303) 792-5333

National Center for Prosecution of Child Abuse
99 Canal Center Plaza, #510
Alexandria, VA 22314
(703) 739-0321
FAX (703) 836-3195

National Institute of Justice
P.O. Box 6000
Rockville, MD 20850
(800) 627-6872

National Resource Center on Child Sexual Abuse
107 Lincoln St.
Huntsville, AL 35801
Office: (205) 534-6868
Information Service: (800) 543-7000
FAX (205) 534-6883

American Professional Society on the Abuse of Children
332 S. Michigan, Suite 1600
Chicago, IL 60604
(312) 554-0166

National Abuse and Disabilities Specialists

National Coalition on Abuse and Disability
P.O. Box "T"
Culver City, CA 90230-0090
(303) 391-2420 Ext.333
FAX (310) 390-6994
TDD (310) 398-7225

Disability, Abuse and Personal Rights Project
P.O. Box "T"
Culver City, CA 90230-0090
(310) 391-2420 Ext. 333
FAX (310) 390-6994
TDD (310) 398-7225

Shaken Baby Syndrome

What is shaken baby syndrome?

Shaken baby syndrome is one form of abusive head trauma. Head trauma, as a form of child abuse, can be caused by direct blows to the head, dropping or throwing the child, or shaking the child. Head trauma is the leading cause of death in child abuse cases in the United States.

Unlike other forms of abusive head trauma, shaken baby syndrome results from injuries caused by someone vigorously shaking an infant. An infant's brain is relatively small in relation to its head and an infant's head is one-fourth to one-third of his/her body weight. In addition, an infant's neck muscles are not yet strong enough to fully support the neck. So, if a baby is shaken violently, the neck is jerked, the head snaps back and forth similar in fashion to a whiplash. Shaking a baby may cause injuries that lead to any of the following conditions:

- Blindness
- Deafness
- Learning disabilities or delay in normal development
- Paralysis
- Seizures
- Death

What are some of the signs and symptoms of shaken baby syndrome?

- Subdural hematomas (internal brain bleeding) and edema (brain swelling) that can be seen on a CT scan of the head. The infant might have:
 - Swelling soft spot
 - Larger than normal head size
 - Bleeding in the eyes
- Irritability
- Excessive drowsiness
- Sluggish behavior
- Seizures
- Projectile vomiting
- Unresponsiveness, limpness, abnormal breathing or apnea (stops breathing)

If you suspect that a baby is suffering from shaken baby syndrome, consult with a health care provider or a social worker immediately. Proper diagnosis is critical in starting appropriate treatment. If the diagnosis is positive, local law enforcement officials and the Department of Social Services should be notified.

How is shaken baby syndrome diagnosed?

Shaken baby syndrome is difficult to diagnose, unless someone accurately describes what happens. Physicians often report that a child with possible shaken baby syndrome is brought for medical attention due to falls, difficulty breathing, seizures, vomiting, altered consciousness or choking. The caregiver may report that the child was shaken to try to resuscitate it. Babies with severe or lethal shaken baby syndrome are typically brought to the hospital unconscious with a closed head injury.

To diagnose shaken baby syndrome, physicians look for retinal hemorrhages (bleeding in the retina of the eyes), subdural hematoma (blood in the brain) and increased head size indicating excessive accumulation of fluid in the tissues of the brain. Damage to the spinal cord and broken ribs from grasping the baby too hard are other signs of shaken baby syndrome. Computed tomography (CT) and magnetic resonance imaging (MRI) scans can assist in showing injuries in the brain, but are not regularly used because of their expense.

A milder form of this syndrome also can be observed and may be missed or misdiagnosed. Subtle symptoms, which may be the result of shaken baby syndrome, are often attributed to mild viral illnesses, feeding dysfunction or infant colic. These include a history of poor feeding, vomiting or flu-like symptoms with no accompanying fever or diarrhea, lethargy and irritability over a period of time. Often the visit to the medical facility does not occur immediately after the initial injury. Without early medical intervention, the child may be at risk for further damage or even death, depending on the continued occurrences of shaking.

How many children are affected by shaken baby syndrome?

An estimated 1,200 to 1,400 cases occur each year in the United States. One shaken baby in four dies as a result of this abuse (Poissant & Linn, 1997). Head trauma is the most frequent cause of permanent damage or death among abused infants and children, and shaking accounts for a significant number of those cases (Showers, 1992). Some studies estimate that 15 percent of children's deaths are due to battering or shaking and an additional 15 percent are possible cases of shaking. The victims of shaken baby syndrome range in age from a few days to 5 years, with an average age of 6 to 8 months (Showers, 1997).

Who is responsible for shaking babies?

While shaken baby abuse is not limited to any special group of people, males tend to predominate as perpetrators in 65 to 90 percent of cases. In the United States, adult males in their early 20s who are the baby's father or the mother's boyfriend are typically the shaker. Females who injure babies by shaking them are more likely to be baby-sitters or child care providers than mothers (Showers, 1997).

Frustration from a baby's incessant crying and toileting problems have been described as events leading to severe shaking. The adult shaker also may be jealous of the attention that the child receives from his or her partner.

How is Shaken Baby Syndrome prevented?

Parents should receive information about shaken baby syndrome prevention in the hospital and/or from their child's health care provider. Health care providers and other professionals who interact with infants and their families should talk to them about their level of stress and how they respond to a crying infant who cannot be readily calmed. Finding ways to alleviate the parent or caregiver's stress at the critical moments when a baby is crying can significantly reduce the risk to the child. One method that may help is author Dr. Harvey Karp's "five S's":

- Shushing (using "white noise," or rhythmic sounds that mimic the constant whir of noise in the womb, with things like vacuum cleaners, hair dryers, clothes dryers, a running tub, or a white noise CD);
- Side/stomach positioning (placing the baby on the left side – to help digestion – or on the belly while holding him or her then putting the sleeping baby in the crib or bassinet on his or her back);
- Sucking (letting the baby breastfeed or bottle feed, or giving the baby a pacifier or finger to suck on);
- Swaddling (wrapping the baby up snugly in a blanket or help him or her feel more secure); and
- Swinging gently (rocking in a chair, using an infant swing, or taking a car ride to help duplicate the constant motion the baby felt in the womb).

Remember that babies do cry for a variety of reasons: they need to be changed or fed or they are just adjusting to life. It can be very frustrating, so try some of the following suggestions:

- Feed slowly and burp often.
- Offer a pacifier.
- Place the baby in a crib; leave the room for a few minutes.
- Hold the baby against your chest and walk or rock.

- Put on soft music or sing.
- Take the baby for a ride in the stroller or car.
- Put the baby in a baby swing.
- Avoid eating onion or drinking coffee, tea and colas if you are breast-feeding.
- Check for the discomfort of diaper rash, teething or fever.
- Ask a friend to "take over" for a while.
- Don't pick the baby up until you feel calm.

References

This information was adapted from the Child Abuse Prevention Council, Ogden, UT 84401, (801)-399-8016 and The Arc's Q & A Web page, revised October 1998: <http://www.thearc.org/faqs/shaken.html> and Kids Health at <http://www.kidshealth.org>.

Cultural Considerations Related to Child Maltreatment

Although ideas about child rearing vary from culture to culture, it is understood that no matter what culture it is, there is no excuse for hurting a child. Community members in every culture understand that they have a responsibility to intervene if a child is being hurt. Problems tend to arise, however, when there is disagreement about certain behaviors. Traditions Westerners may label as abusive or neglectful may appear just the opposite to someone from Asia or Africa. When working with a family from another culture, it is important to be mindful of differences and become knowledgeable about various cultural practices. (National CASA, Court Appointed Special Advocates for Children, Volunteer Training Curriculum, Unit 3 Cultural Awareness, <http://www.casenet.org/program-management/diversity/cultural-child.htm>).

Identifying Cultural Healing Marks

There are cultures in which certain things that are done to children out of caring create the appearance of child abuse. In some cultures, rituals are performed. These same rituals may be unacceptable in the country in which you live. In general, the laws of the country in which you live are the laws that must be obeyed. When in doubt about whether or not to report child abuse and neglect, consult with your local child protective services office.

Some examples of cultural healing practices:

Coining: The Vietnamese name for this folk practice is Cao Gio (pronounced “Cow Zow”). This practice is used to reduce fever, chills and headaches. The skin on the chest and back is massaged with oil and stroked with the edge of a coin until bruising occurs. The linear bruises that it causes are often mistaken for abusive marks.

Burns: Some Mexican-Americans use a practice called “cupping,” for respiratory ailments in which ignited alcohol is placed in a cup and held directly on the skin. When the heated skin area cools, the skin is sucked into the cup causing redness and burns. Some Southeast Asians practice a healing method in which burning strings are lowered onto a child’s abdominal area to cure stomach pain or fever. These types of burns often resemble cigarette burns.

Head Injuries: A Mexican-American folk remedy for “fallen fontanelle” can cause a subdural hematoma. This practice is used when the baby’s soft spot on the head has “collapsed” or is concave, often when a baby is dehydrated from an illness. To bring it back, the area is sucked vigorously, often causing a hematoma.

General Considerations When Working with Families from Various Cultures

- Do not assume:
 - That because your client is of certain ethnicity, you then will know about cultural norms and practices of that client.
 - Do not assume you know the ethnicity of your client. ASK!
 - Don't assume the client is an immigrant.
- There is great opportunity to build on the strengths of the ethnic culture your client is from. Each one is rich in spiritual, communal and emotional qualities that can support an abuse victim/survivor's journey.
- A culturally sensitive assessment takes into account level of acculturation, language preferences, immigration history, family structure, economic status and the patient's age.
- Consider building trust through conversation, using an opening dialogue such as:
 - *"How long have you been in the U.S.?" and "How are the children doing?"*
 - *"Do you need help with the children?" Then listen to your client.*
- Share information about yourself.
- Engage clients in telling their stories.
- Focus on supporting self-esteem, the right to do things for themselves and their children, positive reinforcement, self-care and the value of connecting with advocacy services.
- Remember that some clients may have had negative experiences with social services or the health care environment.

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This information was retrieved from Partners for Violence Prevention and was funded by a health disparity grant initiative of the Minnesota Department of Health, Office of Minority and Multicultural Health, 2002.

The Link Between Child Abuse and Domestic Violence

A growing body of research points to a definite link between adult domestic violence and child abuse. These connections are pervasive. Forty-five to 70 percent of battered women in shelters report that their batterers have also committed some form of child abuse. Even using the more conservative figure, child abuse is 15 times more likely to occur in households where adult domestic violence is also present. Women who have been beaten by their spouses are, in turn, reportedly twice as likely as other women to abuse a child. It is also estimated that 3.3 million to 10 million children witness domestic violence each year. Many child witnesses of domestic violence experience increased problems themselves.

These connections make it important for those working in the field of child abuse and neglect to understand the connection between spousal abuse and child abuse and to respond with treatment and protective resources that recognize the link. Cooperation between professionals working with battered women and abused or neglected children is essential. In practice, formal connections between the two fields are not often in place. They are sorely needed, however, beginning with the initial intake contact with the abused child or battered woman, and continuing through assessment of the precipitating incident and family interaction, treatment, planning, intervention strategies, and evaluation of client progress.

A variety of family dynamics are at work in homes in which spousal abuse leads to child abuse or neglect. Sometimes a child is the unintended victim when he or she attempts to intervene in an attack on a parent. In other instances, a child is accidentally struck by a blow directed at the mother. However, many children are deliberate targets in violent households. The severity of wife beating is also predictive of the severity of child abuse, and the manner in which children are abused bears a strong resemblance to the type of maltreatment experienced by their mothers.

More difficult for many to understand is the battered woman who abuses or neglects her children. According to those who work with battered women, several explanations are possible. In an effort to forestall further violence, some battered women devote all their attention to their abusers or they withdraw from the family, even the children, in an effort to protect themselves. Both responses may result in child neglect. The tremendous stress associated with living in a violent situation may also prompt physical abuse of children by those women at risk for such behaviors. Some physical or emotional abuse of children also results from battered women who are so fearful of their spouse's reaction to childhood behavior that they over discipline in an attempt to protect the children from what they perceive to be the greater danger from the batterer.

Even in households in which children are not themselves physically abused or neglected, they can be victimized by witnessing spousal abuse. Because children do not fully understand the dynamics of domestic violence, they may come to view power and control, aggression and violence as the only means of getting one's needs met. Children may also imitate the violent adult behavior they observe by victimizing younger siblings, peers, and animals. Other children may adopt the victim role, becoming passive and withdrawn in their interactions with other people. Child witnesses of domestic violence may also display an inability to control and express emotion or to delay gratification.

Only recently have helping professionals begun to coordinate interventions in child abuse and domestic violence. Further work is needed to develop joint screening mechanisms to identify families in which both types of abuse play a role in family dynamics. Assessments must also consider whether a parent has the capacity to care for her children outside of a violent situation.

Intervention strategies must recognize the need for safety for victims of both spousal abuse and child abuse through services such as legal advocacy and shelter resources. When both women and children are victims, treatment modalities must not reinforce the idea that the battered spouse is somehow to blame for the violence within the family, e.g., by labeling her a poor parent and mandating attendance at parenting classes. Individual or unisex group counseling may be the more effective treatment modality and may be less risky than joint family counseling when the spouse is also a victim. Most importantly, professionals working in both fields must not lose sight of their ultimate goal – ending violence within families.

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The Relationship Between Domestic Violence and Child Abuse

Researchers have long been aware of the link between domestic violence and child abuse. Even if children are witnesses to acts of violence and not the intended targets, they can be affected in the same way as children who are physically and sexually abused.¹ Since domestic violence is a pattern of behavior, not a single event, episodes may become more severe and more frequent over time, resulting in an increased likelihood that the children will become victims.

What is Domestic Violence?

Domestic violence is a pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion, that adults or adolescents use against their intimate partners. The U.S. Department of Justice estimates that 95 percent of reported assaults on spouses or ex-spouses are committed by men against women.²

What is Child Abuse?

The National Committee to Prevent Child Abuse (NCPA) defines child abuse as a non-accidental injury or pattern of injuries to a child. Child abuse is damage to a child for which there is not “reasonable” explanation. Child abuse includes non-accidental physical injury, neglect, sexual molestation, and emotional abuse.

How Common Are These Problems?

Domestic violence is a widespread problem with long-term consequences to the victim and all family members as well as to the abuser. Recent surveys indicate that increased public awareness about domestic violence, along with a more understanding attitude toward victims, has encouraged women to come forward.³ In a survey conducted in early 1995, 31 percent of women said they had personally faced abuse while, in a similar survey conducted in July 1994, only 24 percent said they had been abused.³

Child abuse has become a national epidemic. More than 1 million children are confirmed each year as victims of child abuse and neglect by state departments of child protective services⁴. And every day a minimum of three children die as a result⁴. Violence in the home has been listed as a major factor contributing to the growth of reports of child abuse and neglect.⁴

How Does Domestic Violence Affect Children?

Domestic violence often includes child abuse. The child may be victimized and threatened as a way of punishing and controlling the adult victim of domestic violence.

Or they may be injured unintentionally when acts of violence occur in their presence. Often episodes of domestic violence expand to include attacks on children. However, even when children are not directly attacked, they can experience serious emotional damage as a result of living in a violent household. Children living in this environment come to believe that this behavior is acceptable.

The estimated overlap between domestic violence and child physical or sexual abuse ranges from 30-50 percent.^{5, 6} Some shelters report that the first reason many battered women give for fleeing the home is that the perpetrator was also attacking the children.⁸

Are there similarities between families involved in domestic violence and families involved in child abuse? The two populations share several similarities as well as some important differences. Both forms of abuse cross all boundaries of economic level, race, ethnic heritage, and religious faith. Neither child abuse nor domestic violence is a phenomenon of the 20th century. Children have been physically traumatized, deprived of the necessities of life, and molested sexually by adults since the dawn of human history.⁹ Traditionally, parents claimed ownership of their children and society hesitated to interfere with the family unit. Similarly, society in the past, has sanctioned the belief that men have the right to use whatever force is necessary to control the behavior of women. Those in intimate relationships as well as those who abuse children often are repeating learned behaviors transmitted intergenerationally. Both forms of abuse are identified by patterns. Neither domestic violence nor child abuse is an isolated event. Adults who were abused as children have an increased risk of abusing their children, and adults who grew up in a violent home are more likely to become perpetrators or victims of domestic violence. For a number of reasons, including shame, secrecy, and isolation, both types of abuse are underreported.

Domestic violence and child abuse also differ in some significant ways. Parental stress is an important factor in instances of child abuse, but this link has not been established in cases of domestic violence. Reported perpetrators of child maltreatment are equally men and women, but the majority of perpetrators of domestic violence are men.

How Can We Prevent These Problems?

Domestic violence and child abuse proliferate in an environment that accepts the lesser status of women and children. Shrouding the violence in secrecy allows this behavior to continue. Educating the public about the extent of the problem established a foundation that has permitted victims to come forward. Prevention efforts that reach parents before or soon after the birth of their baby, and that provide intensive services on a moderately long-term basis, can greatly reduce the incidence of child abuse as well as identify other problems such as domestic violence. Home visitors using a comprehensive approach can tailor their services to match a family's needs.

After establishing a trusting relationship with the family, the home visitor will be able to identify problems. While the home visitor may not be able to offer intervention services, he or she can provide resources and ensure the safety of the children.

Other prevention efforts include the following:

- Educate health and child welfare agencies about the prevalence of domestic violence and its effects on children.
- Involve the community in a multidisciplinary approach to provide intervention and prevention services to those families in need.
- Educate the public about domestic violence and child abuse and the long-term costs to society.
- Provide access to self-help groups and other supportive services for all perpetrators, victims, and survivors of abuse.
- Educate all who work with children and families – including teachers, service providers, and health care professionals – about the interplay between domestic violence and child abuse.

References

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The "Greenbook" Initiative

When addressing the interface between domestic violence and child abuse and neglect, it is important to be familiar with the "Greenbook" Initiative.

What is the "Greenbook"?

Effective Intervention in *Domestic Violence & Child Maltreatment Cases: Guidelines for Policy and Practice*, also known as the "Greenbook," is a set of recommendations designed to help dependency courts and child welfare and domestic violence agencies better serve families experiencing violence. The Family Violence Department of the National Council of Juvenile and Family Court Judges brought together a diverse, expert committee to develop the "Greenbook" over many months. Its recommendations are being used, formally and informally, by hundreds of communities across the nation and around the world.

Why is the "Greenbook" necessary?

Some studies show that as many as half of men who abuse their spouses also abuse their children. When domestic violence coincides with child maltreatment, courts and child welfare and domestic violence agencies may all be called upon to help. These groups have different protocols and different goals, and often fail to coordinate effectively. The result can be ineffective interventions and additional trauma to families that are already under great stress. In worst-case scenarios, the systems work at cross-purposes and children can be taken from their battered mother, who is blamed for allowing them to be exposed to violence. The "Greenbook" offers recommendations that can help communities respond more effectively and do much more to protect and support families experiencing violence.

How does the "Greenbook" project aim to change the status quo?

Too often, women and children in violent situations are victimized twice: first by the abuser and, second, by the very systems that are designed to help them. The "Greenbook" recommendations are designed to promote safety by teaching judicial, child welfare and domestic violence workers to coordinate more effectively. The goal is to keep women and children safe, allow women in violent relationships to access services without fear of losing custody of their children, and in most cases to prevent the removal of a child from a non-abusive parent. When social service and court workers coordinate, all family members are more likely to receive the counseling and support that they need.

How were the sites chosen for the "Greenbook" Initiative?

Six counties are receiving \$1.05 million each in federal grants over three years to implement new collaborations.

These counties – Grafton County, New Hampshire; El Paso County, Colorado; Lane County, Oregon; Santa Clara County, California; San Francisco County, California; and St. Louis County, Missouri – are also receiving ongoing technical assistance and support. The six counties were selected from more than 100 applicants in a rigorous selection process run by the U.S. Department of Health and Human Services and the U.S. Department of Justice. Many other sites that did not receive federal funding are using the "Greenbook" to improve collaboration across agencies and to alter their policies and practices.

Have the jurisdictions that are part of the "Greenbook" test program had positive results?

The six federally funded counties that are part of the "Greenbook" project are discovering new ways for juvenile courts and child welfare and domestic violence agencies to work together to aid and support families. They are succeeding in breaking down barriers and overcoming long-standing mistrust between departments. But the work is still in progress, and no evaluations or results are available yet.

Are other jurisdictions implementing all or part of the "Greenbook" strategies?

The National Council of Juvenile and Family Court Judges has distributed more than 22,000 copies of the "Greenbook" to judges, domestic violence advocates, child welfare workers and others around the country in response to requests, which continue to pour in. The council will continue to make it available and to share the results of its work in order to help other communities to better address the intersection of child maltreatment and domestic violence.

Child Maltreatment in Drug-Endangered Homes

There are several aspects of child abuse and neglect in drug-endangered homes. The environments themselves are frequently so dangerous that simply allowing a child to live there constitutes child endangerment. Substance abuse also affects the caregiver's ability to parent, placing the child at additional risk for abuse and neglect.

It has been shown that a large portion (80-90%) of caretakers involved in the child welfare system for child abuse issues have substance abuse as one of the major personal issues that they face. Substance abuse is believed to cause or exacerbate 7 out of 10 cases of child abuse and neglect. In fact, children whose parents abuse drugs and alcohol are three times more likely to be abused and four times more likely to be neglected (*No Safe Haven: Children of Substance-Abusing Parents*, The National Center on Addiction and Substance Abuse at Columbia University, January 1999).

Clandestine methamphetamine labs ("meth labs") create an environment that is so dangerous that some states have made allowing children to live there even part of the time to constitute child endangerment/abuse/neglect. About 30-35% of meth labs seized are in residences where children live. Children are at an increased risk in a meth lab environment because of their physiologic status (higher rates of growth, metabolism, respiration, and development) and their behaviors (hand-to-mouth behaviors and increased contact with their physical environment). At least two reports have demonstrated that 35-70% of children removed from labs have a urine drug screen that is positive for methamphetamine at the time of removal from the home.

The specific hazards to children living in these labs are numerous. The children are exposed to toxic chemicals and are at risk of inhalation of toxic fumes. Clothing and skin contact of improperly stored chemicals, chemical waste dumped in play areas, and potential explosions and fires (the specific risks of the different chemicals are outlined in the Clandestine Lab section) are also possible. They are frequently exposed to a hazardous environment, which often includes accessible drugs, exposure to drug users, cooks and dealers, hypodermic needles within reach of children, accessible glass smoking pipes, razor blades and other drug paraphernalia, weapons left accessible and booby traps placed to "protect" the clandestine laboratory and its contents from intruders.

The use of illegal drugs or excessive amounts of alcohol affects the caregiver's judgment, rendering them unable to provide the consistent, supervision and guidance that children need for appropriate development. Therefore, substance abuse in adults is a critical factor in the child welfare system. With specific reference to methamphetamine, children are frequently neglected during their caregiver's long periods of sleep while "crashing" from a drug binge. The caregivers also frequently display inconsistent and paranoid behavior, especially if they are using

methamphetamine. They are often irritable and have a "short fuse" which may ultimately lead to physical abuse. Children in these homes are often exposed to violence as well as unsavory individuals. Unfortunately, these caregivers were often not parented well themselves and therefore did not learn effective parenting skills. Finally, the caregiver's ability to provide a nurturing home for a child is complicated by the caregiver's own mental health issues which may have contributed to or resulted from substance abuse.

Children whose caregivers are substance abusers are frequently neglected. They often do not have enough food, are not adequately groomed, do not have appropriate sleeping conditions, and usually have not had adequate medical or dental care. These children are frequently not well supervised, placing them at additional risk of injury. Children raised by substance-abusing caregivers are often exposed to pornographic material, often emotionally abused and have a heightened risk for sexual abuse. Additionally, they frequently do not get the appropriate amount of support, encouragement, discipline, and guidance they need to thrive.

It is clear for many reasons that caregivers who are using illegal substances or excessive amounts of alcohol are not able to provide safe and nurturing homes for their children. It is for this reason that multiple agencies (law enforcement, fire departments, EMS, social services, the medical community, public health departments, the judicial system, legislators, substance abuse and mental health treatment providers and our entire communities) need to work together to first and foremost assure that these children are safe and then work to break the cycle to improve the futures for our children, our families, and our communities.

Retrieved from Kathryn Wells, MD
 Medical Director, Denver Family Crisis Center
<http://www.colodec.org/decpapers/childabuseandneglect.htm>

Detection Periods for Drugs of Abuse in Blood and Urine

Drug	Detection Period
Alcohol/Ethyl	3-10 hours
Amphetamines	1-2 days
Barbituates	Secobarbital: 24 hours Phenobarbital: 2-6 weeks
Benzodiazepines	3-5 days (Heavy Use: 3-6 weeks)
Cocaine	5 hours Benzoyllecgonine (Cocaine Metabolite): 2-4 days
Codeine	1-2 days
Heroin	1-2 days

Hydromorphone (Dilaudid)	1-2 days
LSD	8 hours
Methaqualone (Quaaludes)	2 weeks
Methadone (Dolophine)	2-3 days
Morphine	1-2 days
PCP	2-8 days
Propoxyphene (Darvon)	6 hours Propoxyphene Metabolites: 6-48 hours
THC Metabolite (Marijuana)	1 joint, urine: 2 days 3 times weekly, urine: 2 weeks daily, urine: 3-6 weeks; blood: 8 hours

Retrieved from Medtox Scientific, Inc., St. Paul, MN.

Intrauterine Drug/Alcohol Exposure

Some physical changes to look for in children:

- Positive toxicology screen
- High-pitched cry, especially in infants
- Sweating
- Small stature; reduced weight, height and head size
- Abnormal features of the face and head
- Infant mortality/increased risk for sudden infant death syndrome (SIDS)
- Birth defects
- Difficulty in breathing
- Reduced muscle tone/lack of muscle control or muscle stiffness and rigidity
- Lethargy/abnormal drowsiness
- Bacterial infections
- Vomiting
- Stuffy nose
- Diarrhea
- Skin abrasions on the knees, toes, elbows and nose (from excessive movement against bed clothes)
- Skin discoloration
- Venereal diseases/sexually transmitted diseases
- Hepatitis
- Pneumonia in infants
- HIV positive
- Red and/or watery eyes
- Frequent yawning
- Brain damage (due to poor brain growth and strokes)
- Cerebral palsy
- Tremors/convulsions

Some behavioral changes to look for:

- Hyperactivity
- Short attention span
- Abnormal speech

Fetal Alcohol Spectrum Disorders (FASD)

Background: Fetal alcohol spectrum disorder is an umbrella term describing a range of effects that may occur in an individual whose mother drank alcohol during pregnancy. Effects may include physical, mental, behavioral, and/or learning disabilities with possible lifelong problems. This term is not intended for use as a clinical diagnosis. An individual would not receive the diagnosis of FASD since diagnoses such as FAS (fetal alcohol syndrome), partial FAS and ARND (alcohol-related neurodevelopmental disorder) fall under the larger term FASD.

Some Statistics:

- More than 60% of prisoners are likely affected by alcohol in utero.
- It costs \$120,000 year to “house” a young offender and \$82,000 for an adult offender. Neurological damage is not cured in prison.
- Each year, 40,000 babies are born with FASD, costing the nation about \$4 billion.
- At least 5,000 infants are born each year with FAS; another 50,000 children show symptoms of ARND.
- FAS, ARBD (alcohol-related brain damage) and ARND are widely under diagnosed. Some experts believe that between one-third and two-thirds of all special education children have been irreversibly affected by alcohol in some way.

Fetal Alcohol Syndrome

This is the name given to a combination of mental and physical defects that are present at a baby's birth and continue throughout the rest of the child's life. The defects are a direct result of a woman drinking alcohol while she is pregnant. Even when a woman is in the earliest weeks of conception, a fetus is still susceptible to the effects of alcohol. Therefore, no amount of alcohol consumption is considered safe. FAS is the leading known cause of preventable mental retardation.

Symptoms include:

- Prenatal alcohol exposure
- Growth deficiency < 10th percentile (shorter size, underweight, small head, deformed fingers and toes)
- Unique cluster of minor facial anomalies (small eyes, smooth philtrum, thin upper lip), physical malformations in the face and cranial areas
- Central nervous system damage (neurological, structural, and/or functional impairment) that may result in learning disabilities and lower IQ
- Birth defects of the heart, brain, eyes, kidneys, ears, and joints

- Children may experience behavioral and mental problems which progress into adulthood
- Permanent brain damage

Other facts about FAS:

- FAS is a problem found in all races and socio-economic groups.
- FAS produces irreversible physical and mental damage.
- "The total lifetime cost per typical case of FAS for a child born in 1980 was estimated to be \$596,000..." (Stratton, K, et al., *Fetal Alcohol Syndrome: Diagnosis, Epidemiology, Prevention, and Treatment*, p.19 Institute of Medicine, National Academy Press, 1996.)
- 40% of children will not experience the full syndrome of FAS, and will display only portions of the disorder. A significant percentage of those described as learning disabled and behavioral difficulties are believed to have alcohol-related neurodevelopment disorder (ARND).
- Behavioral and mental health problems of alcohol-exposed children can be just as severe as those of FAS children.
- Many children with FAS are not able to understand cause and effect relationships and long-term consequences.
- Many children with FAS are poorly coordinated, have short attention spans, are hyperactive and exhibit behavioral problems.
- Children with FAS and ARND have been described as having similar behavioral characteristics. Many of the above described difficulties of an FAS child also can be true for a child with alcohol exposure.
- Even one drink risks an unborn baby's health.
- Fetal alcohol spectrum disorders can be completely prevented by a woman not drinking alcohol while she is pregnant.

Partial FAS

A diagnostic classification for patients who present characteristics of FAS, but not all of them:

- Most, but not all, of the growth deficiency and/or facial features of FAS
- Central nervous system damage (structural, neurological, and/or functional impairment)
- Prenatal alcohol exposure.

Alcohol-Related Neurodevelopmental Disorder (ARND):

ARND is a lesser set of the same symptoms that make up FAS. A diagnostic classification coined by the Institute of Medicine in 1996 for patients who present:

- Central nervous system damage (structural, neurological and/or functional impairment)
- Prenatal alcohol exposure

Fetal Alcohol Effects (FAE)

A term introduced in 1978 to describe abnormalities that were compatible with those caused by prenatal alcohol exposure, but a pattern was not complete to render a diagnosis of FAS. (Not used by the FASD Diagnostic Code).

Terms used in lieu of ARND or FAE

Static Encephalopathy (alcohol exposed): The term, “encephalopathy” means “any significant condition of the function or structure of the brain tissues” (Anderson, 2002). “Static” means abnormalities in the brain are unchanging; neither progressing nor regressing. Symptoms present include:

- Central nervous system damage (structural, neurological, and/or significant functional abnormalities)
- Prenatal alcohol exposure

Neurobehavioral Disorder (alcohol exposed): Diagnostic outcome for patients present with:

- Central nervous system dysfunction (mild functional impairment with no evidence of structural or neurological abnormalities)
- Prenatal alcohol exposure

Outcomes such as ARND, static encephalopathy and neurobehavioral disorder are far more prevalent than FAS or partial FAS.

In general, the central nervous system damage/dysfunction observed in individuals with ARND or static encephalopathy (alcohol exposed) are frequently as severe as those observed in individuals with FAS.

Retrieved from FAS Diagnostic and Prevention Network:

<http://depts.washington.edu/fasdpn/>

Appendices

Appendix One: References to Child Maltreatment in Colorado Statute

- Colorado Children's Code
- Colorado Human Services Code
- Colorado Criminal Code
- Colorado Criminal Proceedings Code

Appendix Two: Parent Frequently Ask Questions About Child Maltreatment

Appendix Three: Medical Terms Glossary

Appendix Four: Legal Terms Glossary

Appendix Five: Child Maltreatment Bibliography

Appendix Six: Child Maltreatment Internet Resources

Appendix Seven: American Humane Association Fact Sheets

Attachment 1: Sample reporting forms and policies for local agencies **(Coming soon!)**

- Boulder County
- Cheyenne County
- Jefferson County
- Tri-County (Adams, Arapahoe, Douglas)
- Denver County

Appendix One: References to Child Maltreatment in Colorado Statute

Aspects of child abuse and neglect are defined in Colorado law in the:
Colorado Children's Code (Title 19);
Colorado Human Services Code (Title 26);
Colorado Criminal Code (Title 18); and
Criminal Proceedings Code (Title 16).

Online: <http://198.187.128.12/colorado/lpext.dll?f=templates&fn=fs-main.htm&2.0>

Click on the "+" next to Colorado Statutes on the left side of the webpage.

Click on the specific Title to view desired statute.

Colorado Children's Code Title XIX 19-1-103 Definitions

As used in this title or in the specified portion of this title, unless the context otherwise requires:

- (1) (a) "Abuse" or "child abuse or neglect", as used in part 3 of article 3 of this title, means an act or omission in one of the following categories that threatens the health or welfare of a child:
- (I) Any case in which a child exhibits evidence of skin bruising, bleeding, malnutrition, failure to thrive, burns, fracture of any bone, subdural hematoma, soft tissue swelling, or death and either: Such condition or death is not justifiably explained; the history given concerning such condition is at variance with the degree or type of such condition or death; or the circumstances indicate that such condition may not be the product or an accidental occurrence;
 - (II) Any case in which a child is subjected to unlawful sexual behavior as defined in 16-22-102 (9), C.R.S.;
 - (III) Any case in which a child is a child in need of services because of the child's parents, legal guardian, or custodian fails to take the same actions to provide adequate food, clothing, shelter, medical care, or supervision that a prudent parent would take. The requirements of this subparagraph (III) shall be subject to the provisions of section 19-3-103.
 - (IV) Any case in which a child is subjected to emotional abuse. As used in this subparagraph (IV), "emotional abuse" means an identifiable and substantial impairment of the child's intellectual or psychological functioning or development or a substantial risk of impairment of the child's intellectual or psychological functioning or development.
 - (V) Any act or omission described in section 19-3-102 (1) (a), (1) (b), or (1) (c);
 - (VI) Any case in which, in the presence of a child, or on the premises where a child is found, or where a child resides, a controlled substance, as defined in section 18-18-102 (5), C.R.S., is manufactured or attempted to be manufactured.

(b) In all cases, those investigating reports of child abuse shall take into account accepted child-rearing practices of the culture in which the child participates including, but not limited to, accepted work-related practices of agricultural communities. Nothing in the subsection (1) shall refer to acts that could be construed to be a reasonable exercises of parental discipline or to acts reasonably necessary to subdue a child being taken into custody pursuant to section 19-2-502 that are performed by a peace officer, as described in section 16-2.5-101, C.R.S., acting in the good faith performance of the officer's duties.

Colorado Human Service Code Title XXVI 26-3.1-101 Definitions

(4) "Mistreatment" means an act or omission which threatens the health, safety, or welfare of an at-risk adult, as such term is defined in subsection (1) of this section, or which exposes the adult to a situation or condition that poses an imminent risk of death, serious bodily injury, or bodily injury to the adult. "Mistreatment" includes, but is not limited to:

(a) Abuse which occurs:

- (I) Where there is infliction of physical pain or injury, as demonstrated by, but not limited to, substantial or multiple skin bruising, bleeding, malnutrition, dehydration, burns, bone fractures, poisoning, subdural hematoma, soft tissue swelling, or suffocation;
- (II) Where unreasonable confinement or restraint is imposed; or
- (III) Where there is subjection to nonconsensual sexual conduct or contact classified as a crime under the "Colorado Criminal Code", title 18, C.R.S.;

(b) Caretaker neglect which occurs when adequate food, clothing, shelter, psychological care, physical care, medical care, or supervision is not secured for the at-risk adult or is not provided by a caretaker in a timely manner and with the degree of care that a reasonable person in the same situation would exercise; except that the withholding of artificial nourishment in accordance with the "Colorado Medical Treatment Decision Act", article 18 of title 15, C.R.S., shall not be considered as abuse;

(c) Exploitation which is the illegal or improper use of an at-risk adult for another person's advantage.

Colorado Criminal Code Title XVIII 18-6-401 Definitions

(1) (a) A person commits child abuse if such person causes an injury to a child's life or health, or permits a child to be unreasonably placed in a situation that poses a threat of injury to the child's life or health, or engages in a continued pattern of conduct that results in malnourishment, lack of proper medical care, cruel punishment, mistreatment, or an accumulation of injuries that ultimately results in the death of a child or serious bodily injury to a child.

Criminal Proceedings Code Title 16-22-102 Definitions

(9) "Unlawful sexual behavior" means any of the following offenses or criminal attempt, conspiracy, or solicitation to commit any of the following offenses:

- (l) Sexual assault, in violation of section 18-3-402, C.R.S.; or
 - (II) Sexual assault in the first degree, in violation of section 18-3-402, C.R.S., as it existed prior to July 1, 2000;
- (a) Sexual assault in the second degree, in violation of section 18-3-404, C.R.S.; as it existed prior to July 1, 2000;
- (b) (I) Unlawful sexual contact, in violation of section 18-3-404, C.R.S.; or
 - (II) Sexual assault in the third degree, in violation of section 18-3-404, C.R.S., as it existed prior to July 1, 2000;
- (c) Sexual assault on a child, in violation of section 18-3-405, C.R.S.;
- (d) Sexual assault on a child by one in a position of trust, in violation of section 18-3-405.5, C.R.S.;
- (e) Sexual assault on a client by a psychotherapist, in violation of section 18-3-405.5, C.R.S.;
- (f) Enticement of a child, in violation of section 18-3-305, C.R.S.;
- (g) Incest, in violation of section 18-6-301, C.R.S.;
- (h) Aggravated incest, in violation of section 18-6-302, C.R.S.;
- (i) Trafficking in children, in violation of section 18-6-402, C.R.S.;
- (j) Sexual exploitation of children, in violation of section 18-6-403, C.R.S.;
- (k) Procurement of a child for sexual exploitation, in violation of section 18-6-404, C.R.S.;
- (l) Indecent exposure, in violation of section 18-7-302, C.R.S.;
- (m) Soliciting for child prostitution, in violation of section 18-7-402, C.R.S.;
- (n) Pandering of a child, in violation of section 18-7-403, C.R.S.;
- (o) Procurement of a child, in violation of section 18-7-403.5, C.R.S.;
- (p) Keeping a place of child prostitution, in violation of section 18-7-404, C.R.S.;
- (q) Pimping of a child, in violation of section 18-7-405, C.R.S.;
- (r) Inducement of a child prostitution, in violation of section 18-7-405.5 C.R.S.;
- (s) Patronizing a prostituted child, in violation of section 18-7-406, C.R.S.;
- (t) Engaging in sexual conduct in a penal institution, in violation of section 18-7-701, C.R.S.;
- (u) Wholesale promotion of obscenity to a minor, in violation of section 18-7-102 (1.5), C.R.S.;
- (v) Promotion of obscenity to a minor, in violation of section 18-7-102 (2.5), C.R.S.

Legal Definition of Unlawful Sexual Behavior and Sexual Abuse

Colorado Children's Code 19-1-103

Any case in which a child is subjected to unlawful sexual behavior as defined in section 16-22-102 (9), C.R.S.

Colorado Criminal Code 16-22-102 (9)

- (9) "Unlawful sexual behavior" means any of the following offenses or criminal attempt, conspiracy, or solicitation to commit any of the following offenses:
- (a) (I) Sexual assault, in violation of section 18-3-402, C.R.S.; or
(II) Sexual assault in the first degree, in violation of section 18-3-402, C.R.S., as it existed prior to July 1, 2000;
 - (b) Sexual assault in the second degree, in violation of section 18-3-404, C.R.S.; as it existed prior to July 1, 2000;
 - (c) (I) Unlawful sexual contact, in violation of section 18-3-404, C.R.S.; or
(II) Sexual assault in the third degree, in violation of section 18-3-404, C.R.S., as it existed prior to July 1, 2000;
 - (d) Sexual assault on a child, in violation of section 18-3-405, C.R.S.;
 - (e) Sexual assault on a child by one in a position of trust, in violation of section 18-3-405.5, C.R.S.;
 - (f) Sexual assault on a client by a psychotherapist, in violation of section 18-3-405.5, C.R.S.;
 - (g) Enticement of a child, in violation of section 18-3-305, C.R.S.;
 - (h) Incest, in violation of section 18-6-301, C.R.S.;
 - (i) Aggravated incest, in violation of section 18-6-302, C.R.S.;
 - (j) Trafficking in children, in violation of section 18-6-402, C.R.S.;
 - (k) Sexual exploitation of children, in violation of section 18-6-403, C.R.S.;
 - (l) Procurement of a child for sexual exploitation, in violation of section 18-6-404, C.R.S.;
 - (m) Indecent exposure, in violation of section 18-7-302, C.R.S.;
 - (n) Soliciting for child prostitution, in violation of section 18-7-402, C.R.S.;
 - (o) Pandering of a child, in violation of section 18-7-403, C.R.S.;
 - (p) Procurement of a child, in violation of section 18-7-403.5, C.R.S.;
 - (q) Keeping a place of child prostitution, in violation of section 18-7-404, C.R.S.;
 - (r) Pimping of a child, in violation of section 18-7-405, C.R.S.;
 - (s) Inducement of a child prostitution, in violation of section 18-7-405.5 C.R.S.;
 - (t) Patronizing a prostituted child, in violation of section 18-7-406, C.R.S.;
 - (u) Engaging in sexual conduct in a penal institution, in violation of section 18-7-701, C.R.S.;
 - (v) Wholesale promotion of obscenity to a minor, in violation of section 18-7-102 (1.5), C.R.S.;
 - (w) Promotion of obscenity to a minor, in violation of section 18-7-102 (2.5), C.R.S.

Appendix Two: Parents Frequently Asked Questions About Child Maltreatment

How can I reasonably discipline a child?

Being a parent is anything but easy. It takes patience, creativity, and an endless abundance of love. Some parenting skills come naturally, many are learned. The same can be said of children. Their curiosity is natural. But discipline must be learned. As parents, we are responsible for teaching discipline to our children. It takes time and practice... but it does get easier... as children learn to control their own behavior. And, it doesn't have to hurt you or your child.

What can I do when I feel out of control with my child?

Find a way to help yourself calm down so that you do not do or say something you will be sorry for later. Remember: What you do always teaches your children what to do. If you lash out, your children will learn to do the same. If you do lash out, apologize to your child; "I'm sorry" teaches them what to do if they offend others.

What is the difference between discipline and abuse?

No reasonable adult will deny the need for disciplinary action when raising a child. The form of discipline imposed, however, must be reasonable for the situation and understandable to the child (D. Besharov, *Recognizing Child Abuse* 66 (1990)). Colorado statutes recognize and "take into account accepted child-rearing practices of the culture in which the child participates" (CRS 19-3-303). Physical punishment should be restricted to those parts of the body that will not put a child's health in danger (Besharov, *supra* at 67). Even then, the punishment must not exceed certain limits. Examples of excessive punishment would be bruising or leaving cuts. The intent is to make the child understand a wrong behavior, not instill unreasonable fear. "A child's misbehavior, no matter how egregious, never justifies conduct whose reasonably foreseeable consequence was or could have been the child's serious physical injury." (Besharov, *supra* at 67, *emphasis in original*.)

What does the law say a parent's rights and responsibilities are to their child?

Parental rights include the idea of duties and obligations to the child and his/her welfare (CRS 19-4-102). While many consider the rights of a parent to be fundamental, they are not absolute (Prince, 321 U.S. 158). It is unacceptable conduct for a parent to purposely endanger the life or health of a child through physical, sexual, or psychological abuse (CRS 19-3-303). The legal system further reflects the basic societal belief that children should receive at least a minimum standard of care. Following is a list of factors which one court considered relevant to the question of whether a particular child was minimally well cared for. Does the parent:

1. Express love and affection for the child
2. Express personal concern over the health of the child
3. Supply necessary food, clothing, and medical care
4. Provide an adequate home

5. Give social and religious guidance

Conley v. Walden, 166 Mont. 369, 533 P.2d 955 (1975) Failure to provide this care at least minimally is considered neglect (CRS 19-3-102). Parents are also required by law to protect their children from any sort of harm whenever possible. Insufficient action on the part of the parent to protect or seek medical care for his/her child can be considered neglect (CRS 19-3-102 to 103).

In what ways do our laws respond to possible parental abuse or neglect of a child?

If investigation, conducted by a law enforcement officer, protective service worker, or other persons assigned by the court, provides enough information that a child has been abused and/or neglected, a treatment or punishment approach can be taken. Depending on the fact of the case, two different agencies can be involved: protective services and county attorneys work on civil child protection cases. Law enforcement and district attorneys prosecute child abuse as a crime.

While criminal cases, which are directed at punishing the perpetrator, are more likely to attract public concern, they are much less likely to occur than a civil child protection hearing. An adjudicatory hearing is held in a civil, juvenile, or family court to determine if a child is dependent or neglected (CRS 19-3-505). The terms "dependent" and "neglected" are used interchangeably and stand for a single concept which includes child abuse, *In re D.L.E.*, 614 P.2d 873 (Colo. 1980). This child protective services hearing is completely separate from the criminal system but may occur before, during or after any criminal case deemed necessary by the district attorney. At the civil adjudicatory hearing, the judge must first determine if a child is abused or neglected. Then later, if there is enough evidence of abuse or neglect, the court may order a treatment plan for the parents who must follow and complete it with some amount of success. The situation is reevaluated until a final decision is made as to the child's best interests.

Who can take a child out of the home?

Only a few public authorities can order removal of a child, and then only in limited, necessary circumstances. A court order to remove a child to foster care can be sought by protective services workers, law enforcement officers, hospital administrators, and physicians if they reasonably believe the child has been abused or neglected by a caretaker (CRS, 19-3-405). Judges in each district are available around the clock to grant the court order (CRS, 19-3-405).

If a child is in immediate danger, a law enforcement officer may take the child into protective custody without a court order has been upheld in such cases as *People v. Malczewski*, 744 P.2d 62 (Colo. 1987) and *Griffin v. Pate*, 644 P.2d 51 (Colo. App. 1981) when police officers removed children from what appeared to be harmful situations involving family members. The officer must then notify the parents as soon as

possible of the child's placement (CRS 19-3-405). A hearing must be held within forty-eight hours to determine whether further detention of the child is justified (CRS 19-3-405).

What happens if a child is taken into protective custody by a law enforcement officer or child protection worker?

After a child has been placed in protective custody, the child protection worker or law enforcement officer involved in the case must notify the parents of the child's placement and inform them of their right to a court hearing within forty-eight to seventy-two hours (CRS 19-3-405). A judge will then determine whether to detain the child further or return him/her home (CRS 19-3-405).

Once a child is removed, will the parent get him/her back?

Upon completion of an investigation, a child protection worker must decide whether the report of the child abuse is founded. If abuse is determined, the case worker can recommend a treatment plan to the parents (Besharov, supra at 186-188). Upon successful completion, the caseworker must decide if the behavior of the parents and the condition which created the abuse has been rectified.

When parents disagree with a case worker's recommendations the matter can be taken to court for an adjudicatory hearing (CRS 19-3-505). This is a civil hearing for a judge to determine if a child is dependent or neglected. If the child is deemed dependent or neglected, the judge can then order the parents to comply with a treatment plan (CRS 19-3-508). The parent(s) must convince the judge that the treatment is successful and the child will be safe at home.

Cooperation with a treatment plan, however, does not necessarily end intervention. If completion of the treatment does not assure the child's safety, a more drastic outcome may be sought (CRS 19-3-604). According to *In re D.M.W.*, 752 P.2d 587 (Colo. App. 1987) if substantial compliance with the treatment plan is not successful in correcting the conduct or condition which initially led to state intervention, termination of the parent-child relationship is proper.

How is it determined if a child is dependent, neglected, or abused?

The child protective worker plays a key role in child abuse cases. Upon deciding a case is founded, a case worker will recommend a treatment plan for the parents and child to rectify the abusive or dangerous situation (Besharov, supra at 186-188). Parents are under no obligation to cooperate with this plan, but it is often in their best interest to do so (Besharov, supra at 213-214). If parents refuse to accept treatment, the case worker can file a motion requesting a finding of dependency and neglect with a court (CRS 19-3-308). The result is an adjudicatory hearing in which a judge may declare the child dependent or neglected based on evidence given by the case worker (CRS 19-3-505), as well as the parents. The judge can then order the parent(s) to comply with a treatment plan (CRS 19-3-508), if appropriate.

A case worker has the power to close a case, thus ending intervention, if the parent(s) voluntarily sought successful treatment and the child is out of danger, and thus a court was not involved. If treatment was ordered by the court, a case worker can influence a judge's decision as to the success of the treatment and future safety of the child (CRS 19-3-509). In the cases where treatment is unsuccessful, a case worker can suggest the termination of the parent-child relationship as a last resort (CRS 19-3-604). The final decision on forced relinquishment of parental rights is up to the judge (CRS 19-3-602). (See question 12)

If the court finds that a child is dependent, neglected, or abused, what can the court do?

If a judge finds a child to be dependent or neglected, he/she may order a treatment plan for the parents. The court has a number of options in placing the child during the period of treatment. One or both of the parents may take legal custody with supervision by child protective services (CRS 19-3-508). If the child is in danger at home, the court can place him/her in foster care with relatives or an agency placement (CRS 19-3-508). A visitation schedule may be drawn up for the parents whose child is placed out of the home.

Once the treatment plan has been completed, the judge must evaluate its success. If further treatment is needed, the judge can order a continuation for six months (CRS 19-3-508). Successful completion of the treatment plan, and the assurance of the judge that the child will remain safe, ends intervention from child protective services. When it is apparent that no treatment will be successful, the judge may need to take a more drastic step.

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Appendix Three: Medical Terms Glossary

Abrasion: An area of the body surface denuded of skin or mucous membrane by a scrape.

Alopecia: Hair loss - traumatic alopecia is hair loss secondary to being pulled or yanked out.

Aneurysm: A weakness in the wall of a blood vessel causing an out pouching and increased risk for rupture.

Arachnoid membrane: The middle of 3 membranes covering the brain (between the dura and the pia mater).

Attenuation: Narrowing or wearing away of the tissue.

Bone: Regions or areas of long bones each derived from a separate growth center.

Epiphysis - the end

Metaphysis - between the end (above) and the shaft]

Diaphysis - the shaft

Periosteum - a thick fibrous membrane covering the entire bone surface

Bones:

Tibia, fibula - lower leg bones

Femur - thigh

Humerus - upper arm

Ulna - lower arm

Radius - lower arm

Bone Scan: an x-ray study involving injection of radio active agents in small amounts into the blood stream.

Accumulation of these agents can be seen at sites of injury or inflammation.

Burn: Stages of severity:

1st - superficial scorching/painful redness of the skin, e.g., sunburn-like (partial thickness)

2nd - blister formation (partial thickness)

3rd - destruction of deeper layers of skin; grafting needed to permit healing (full thickness)

Condyloma accuminatum: Venereal warts caused by the Human Papilloma Virus (HPV)

CT Scan or Cat Scan: Computerized axial tomography. A computerized diagram of internal structures of the body.

Dermis: Middle layer of skin including hair follicles and sweat glands.

Depressed (fracture): Fracture of skull resulting in a segment of bone being pushed inward toward the brain.

Differential diagnosis: The determination of which of two or more diseases or conditions a patient is suffering from, by systematically comparing and contrasting their clinical findings.

Distal: Remote, further from any point of reference as opposed to proximal.

Dry cupping: Oriental practice of heating glass jars and placing them in an inverted position on the skin to heal the sick. Leaves circular burns on the skin with central clearing.

Duodenum: The first portion of the small intestine from the stomach to the jejunum.

Dura: The thick, fibrous outermost covering of the brain and spinal cord.

Ecchymosis: A small hemorrhagic spot, larger than a petechia, in the skin or mucous membrane forming a non-elevated, rounded or irregular blue or purplish patch.

Edema: The presence of abnormally large amounts of fluid in the intercellular tissue spaces of the body; usually applied to demonstrable accumulation of excessive fluid in the subcutaneous tissues. Swelling of the soft tissue.

Enuresis: Involuntary passage of urine (nighttime enuresis--bed wetting).

Encopresis: Involuntary passage of feces: soiling

Epidermis: Outermost surface layers of cells of the skin.

Erythema: Redness, irritation.

Fimbriated: Finger-like projections - fringed processes causing a scalloped appearance.

Fissure: Superficial break in the skin that generally heals without scarring.

Fontanelle: A membranous interval at the angle of the cranial bones of the infant, the "soft spot" on top of

the infant's head, often depressed when child is severely dehydrated.

Fossa navicularis: A depression in the tissues between the hymenal ring and the posterior fourchette.

Fracture: simple – uncomplicated
compound - open wound of soft tissues that connects directly with the fracture site
comminuted - bone is broken into a number of pieces
spiral - line of break runs obliquely up one side of the bone, e.g., like a spiral staircase
torus - a folding, bulging or buckling fracture.
greenstick - oblique fracture similar to bending a green or fresh stick so that the side opposite fractures longitudinally
stellate (star-shaped) - used to describe a skull fracture from a direct blow with a small point of impact.
Transverse - straight across secondary to direct blow.

Frenulum: A fold of mucous membrane that either connects the lips with the gums or the tongue to the floor of the mouth.

Frontal: The forehead.

Fundoscopic Exam: Ophthalmic assessment of the retina to determine if irregularities or internal injuries to the eye exist, e.g., hemorrhage.

Hematoma: A massive, localized accumulation of blood, usually clotting in an organ, space or tissue, due to a break in the wall of the blood vessel.

Hematuria: Blood in the urine.

Hemophilia: A hereditary hemorrhagic tendency due to deficiency of coagulation Factor VIII, and

characterized by spontaneous or traumatic subcutaneous and intra-muscular hemorrhages; bleeding from the mouth, gums, lips and tongue.

Hemoptysis: Spitting or coughing up blood originating from the lungs or bronchial tubes.

Hemorrhage: the escape of blood from vessels. Small hemorrhages are classified according to size as petechia (very small), purpura (up to 1 cm), and ecchymoses (larger).

Hemorrhoid: A dilated vein forming an outpouching or bulge just under the surface of the skin.

Hemostasis screen: Lab studies performed to determine if a child has a bleeding or bruising tendency.

Includes Partial Thromboplastin Time (PTT), Prothrombin Time (PT), Platelet, and Bleeding Time.

Hemothorax: Bleeding into the chest cavity causing compression of the lung.

History of Present Illness (HPI): The pertinent history of the most recent events associated with the patient's chief complaint.

Hydrocephalus: Excessive accumulation of fluid around the brain and in the ventricles. Also known as water on the brain.

Hymen: Membranous tissue partially covering the opening into the vagina.

Hyphema: Blood in the anterior chamber of the eye.

Hypopigmentation: Abnormally diminished pigmentation, as distinct from complete loss of pigment.

Infarction: Tissue death resulting from interruption of blood supply.

Inflammation: Localized redness, warmth and swelling of tissues secondary to trauma or infection.

Impetigo: A bacterial skin infection, usually caused by Strep or Staph, that causes circular crusted lesions with or without blister formation. Can be confused with cigarette burns.

Intradermal hemorrhage: Bleeding within the skin: doesn't blanch with pressure.

Types

petechia - a round, discrete hemorrhage area less than 2 mm (or 3/22")

purpura - a discrete hemorrhage other than

petechiae - generally occurs in groups. They do not elevate the skin or mucosa (bruises)

ecchymosis - a hemorrhage area larger than (a) above (a "bruise")

Jejunum: That portion of the small intestine that extends from the duodenum to the ileum.

Lab tests:

partial thromboplastin time (PTT)

prothrombin time (PT) - Measure of clotting factors circulating in the blood.
platelet count - measure of the cellular component of blood involved in clotting
(PT, PTT)
urine analysis (UP) - examination of urine.
complete blood count (CBC) - measure of white and red cellular components in blood.
GC (gonorrhea cultures) - anal, vaginal, oral
VDRL/RPR - blood test for syphilis
chlamydia (culture) - culture for sexually transmitted organism

Labia majora: Large lips covering the genitalia and protecting the hymen from trauma.

Labia minora: Smaller lip between the labia majora and hymen.

Laceration: A torn, ragged, mangled wound, e.g., a cut.

Lesion: Loosely used to mean virtually any mark, scar, bump, etc.

Meatus: The external opening of a canal (as in urethral meatus).

Meninges: The membranes covering the brain and spinal cord.

Mesentery: A membranous fold attaching various organs to the body wall in the abdomen. Commonly used with specific reference to the peritoneal fold attaching the small intestine to the back of the body wall.

Mongolian spots: A flat hyperpigmented focal birthmark, often mistaken for bruising - found on buttocks, lower back and shoulders of newborns, Infants - present in 90% of Black and Asian babies, 50% of Hispanic babies, and 10% of white infants - can last up to three years of age.

Moxibustion: The Oriental and Asian healing practice of placing burning pieces of yarn or balls of Moxa herb on the skin. Leaves deep circular burns on skin.

Notch: A V or U-shaped defect in the tissue representing a healed transection.

Ossification: The formation of bone or of a bony substance; the conversion of fibrous tissues or of cartilage into bone or bony substance.

Osteogenesis imperfecta: An inherited condition, usually transmitted as an autosomal dominant trait, in which the bones are abnormally brittle and subject of fractures.

Osteomyelitis: Inflammation of bone caused by an infection. It may remain localized or may spread through the bone to involve the marrow, cortex, cancellous tissue and periosteum, (bone infection).

Osteoporosis: Reduction in the quantity of bone, seen most commonly in the elderly.

Pathognomonic: Specifically distinctive or characteristic of a disease or pathologic condition; assign or symptom on which a diagnosis is made.

Perineum: The space between the anus and scrotum or vagina.

Periosteal elevation: Elevation of the fibrous covering (periosteum) of the bone displacing it from the underlying bone by one of several processes that usually involve hemorrhage into the newly created space.

Pneumothorax: A hole in the lung tissue allowing air to escape the lung and fill the chest cavity - compressing the lung.

Posterior fourchette: Tissue just posterior to the fossa navicularis on the perineum.

Proximal: Nearest; closer to any point of reference, opposed to distal.

Purtscher retinopathy: Retinal hemorrhages alone - without associated intracranial injury.

Redundant (hymen): Excessive tissue that fold onto itself obliterating any view of the hymen.

Reference terms:

- anterior - toward front
- posterior - toward back
- lateral - toward side
- medial - toward center or mid-line
- proximal - near (near trunk)
- distal - far (relative to proximal)
- occipital - back of head
- temporal - side of head
- supine - lying on the back
- prone - lying on the abdomen

Retina: The innermost of the three linings of the eyeball, surrounding the vitreous body and continuous posteriorly with the optic nerve. Inner surface of the back of the eyeball.

Retinal hemorrhage: Bleeding from the inner lining of the eye.

Review of systems: (ROS) A history including all pertinent positives and negatives relating to each body system.

Rugae: Folds or puckers of skin - as around the anal opening or on the surface of the mature scrotum.

Scapula: The flat, triangular bone in the back of the shoulder; the shoulder blade/

Sclera: The tough white outer layer of the eyeball, covering approximately the posterior five-sixths of its surface.

Sexually Transmitted Disease (STD): Disease(s) transmitted by sexual contact including: chlamydia, trichomonas, gonorrhea, syphilis, hepatitis B and HIV. The presence of an STD should alert one to the possibility of sexual abuse; however, some STDs are passed to the fetus during pregnancy or the birthing process.

Shunt: A drainage tube; e.g., ventriculoperitoneal shunt used in the treatment of hydrocephalus. It runs from the brain ventricles to the peritoneal cavity.

Sprain: Injury to a joint without tearing ligaments and/or tendons.

Subarachnoid space: The space between the arachnoid and the pia mater. Coverings of the brain.

Subarachnoid: Bleeding that occurs between the pia and the arachnoid membranes of the central nervous system.

Subcutaneous (tissues): Layer of fat cells beneath the dermis layer of skin.

Subdural Hematoma: A collection of blood beneath the dura mater covering of the brain.

Shaken Baby Syndrome: One form of abusive head trauma. Injury to an infant or child resulting from the child's having been shaken, usually as a misguided means of discipline. The most common symptoms, that can be inflicted by extremely vigorous shaking, are bleeding and/or detached retinas and bleeding inside the head. Repeated instances of shaking and resultant injuries may eventually cause mental and developmental disabilities.

Suture: A type of joint of fibrous tissue that allows the various bony surfaces to unite.

Temporal: Referring to the side of the head.

Trauma: An internal or external injury or wound brought about by an outside force. Usually trauma means injury by violence, but may also apply to the wound caused by a surgical procedure. Trauma may occur accidentally or, as in the case of physical abuse, non-accidentally. Trauma is also a term applied to psychological discomfort or symptoms resulting from an emotional shock or painful experience.

Venereal Disease: (See Sexually Transmitted Disease).

Vital Signs: Blood Pressure, heart rate, respiratory rate and temperature.

Appendix Four: Legal Terms Glossary

Abuse: Definition according to Colorado Law of the Children’s Code, abuse includes the following acts or omissions by any persons:

1. mental or emotional injury to a child that results in an observable and material impairment in the child’s growth, development, or psychological functioning;
2. causing or permitting the child to be in a situation in which the child sustains a mental or emotional injury that results in an observable and material impairment, development, or psychological functioning;
3. physical injury that results to the child, or the genuine threat of substantial harm from physical injury to the child, including an injury that is at variance with the history or explanation given and excluding an accident or reasonable discipline by a parent, guardian, or managing or possessory conservator that does not expose the child to a substantial risk or harm; failure to make a reasonable effort to prevent an action by another person that results in physical injury that results in substantial harm to the child;
4. sexual contact harmful to a child’s mental, emotional or physical welfare;
5. failure to make a reasonable effort to prevent sexual contact harmful to a child;
6. compelling or encourage the child to engage in sexual conduct;
7. causing, permitting , encouraging, engaging in, or allowing the photographing, filming or depicting of the child if the person knew or should have known that the resulting photograph, film or depiction of the child is obscene or engaged in explicit sexual conduct.

Adjudicate: To hear and settle by judicial procedure.

Appeal: A written history of a trial which is submitted with argument to a higher court for the purpose of trying to obtain a difference outcome.

Appeal: A written history of a trial that is submitted with argument to a higher court for the purpose of reviewing a lower courts’ decisions.

Acquittal: A verdict by the jury or judge that the defendant is found not guilty after the evidence in presented.

Arraignment: The procedure in which an accused person appears before the court to hear the charges against him and responds by pleading guilty or not guilty.

Bail or Bond: Money that is paid to a court or bondsman as security to assure the court that an accused person will attend future court appointments.

Beyond a Reasonable Doubt: The level of burden of proof necessary for a jury or a judge to find a defendant guilty in a criminal case. It requires a high degree of evidence presented by a prosecution directly establishing proven facts that must by their own nature and weight, establish guilt.

Bound Over: County court rules that there is enough evidence and probably cause to refer the case to the District court. After a preliminary hearing, the case is bound over to District court.

CASA: Acronym that stands for Court Appointed Special Advocate

Concurrent Sentences: When there is more than one charge against a person and the sentence for each count is combined so they are served at one time.

County Court: The lower court of the circuit court system that hears criminal cases. First arraignment, bond setting, preliminary hearing and misdemeanor guilty pleas are heard at this level.

Court Supervision: The court establishes certain requirements that must be performed by the defendant who reports to the court as a condition of probation.

Credit for Time Served: The amount of time a person has spent in jail before sentencing can be deducted from the time the court has ordered the offender to serve.

Cross Examination: The questioning of a witness upon a hearing, deposition or trial by the party opposed to the one who produced him for the purpose of truthfulness or challenge.

Declined Charges: By prosecution. When a case lacks sufficient evidence to present to a judge or jury to prove a suspect guilty beyond a reasonable doubt.

Defendant: A suspect becomes a defendant after the prosecution has filed formal charges.

Defense Attorney: The lawyer representing a defendant to ensure the defendant due process.

Deferred Prosecution: The prosecution of a case is postponed. It may be subject to completion of a diversion or counseling program.

Deferred Sentence: When a person is given probation instead of a jail sentence and the opportunity to have no conviction on record at the end of the probation period if there are no violations of the probation.

Deposition: Sworn testimony given outside of court in which the attorneys involved in a case allowed to question a witness as they would in a court of law. This is a discovery tool, generally used in Civil court proceedings.

Direct Examination: The primary line of questioning by the attorney (either prosecutor or defense) who produces a witness for the purpose of testifying in trial.

Discovery: The process in which opposing parties exchange information that each possesses regarding a case.

Disposition: The final act of a court in any particular case. It may also refer to the plea agreement in a case.

District Court: The higher court that hears second arraignments, bond reviews, most felony guilty pleas, felony trials and felony revocation hearings.

Docket Call: A Docket is a list of cases as they appear on the court's calendar. A docket call is when one appears in court

Exhibits: Physical evidence or visual aids used to assist either side in a jury trial.

Felony: A term used to distinguish severe crimes which carry a penalty of six months or more in prison.

Grand Jury: A jury comprised of 12-23 people who are brought together and presented the evidence of a case in order to determine if there is sufficient cause to try a case. This process is an alternative to the filing of an information by the district attorney, followed by a preliminary hearing.

Guilty Plea: A plea negotiation in which a defendant pleads guilty in an open court and admits to the crime for which the defendant is charged.

Habitual Offender: One who has pleaded guilty or has been found guilty of two or more felonies committed at different times.

Hung Jury: A jury whose members cannot unanimously agree whether the accused is guilty or not guilty.

Indictment: A formal written accusation filed in court by a grand jury after an investigation that alleges a specific person has committed a specific crime.

Jury: A group of citizens selected by the prosecutor and the defense attorney. The jury is sworn to determine certain facts by listening to the evidence presented in a trial in order to decide whether the accused is guilty or not guilty.

Misdemeanor: A term used to distinguish less severe offenses that carry any type of penalty up to two years in jail, usually a county facility.

Mistrial: When a trial, for some specific reason, is not completed, and the jury is unable to provide either a guilty or not guilty verdict.

Motion in Limine: A motion made outside the hearing of the jury which asks the court not to allow certain information that is irrelevant, prejudicial or inadmissible during the trial process.

Neglect: SEE THE CHILDREN'S CODE FOR DEFINITIONS

Not Guilty: When a judge or jury decides the amount of evidence presented during a criminal trial is insufficient to meet the burden of proof - guilty beyond a reasonable doubt.

Not True Bill: A document issued by a grand jury when they have decided there is insufficient evidence to try a case.

Parole: A person given an early release from a county jail or prison and placed under the supervision of a parole officer for as long as the conditions of the release are obeyed.

Parole Board: A parole board reviews requests from incarcerated inmates, conducts mandatory review hearings and determines release dates.

Plea Agreement: The agreement reached as the result of plea negotiation between the prosecutor and the offender.

Preliminary Hearing: A hearing in a felony case which is held before a judge instead of a grand jury. The judge determines whether there is enough evidence to support charges against the accused person.

Presentence Investigation: A court ordered investigation by a probation/parole officer that contains a defendant's criminal and social background. Often the victim's input is considered in this report.

Pre-Trial Motion: Any motion made by the parties involved in a trial in which they request some type of action of the court before a trial commences.

Probable Cause: A level of burden of proof necessary to support criminal charges at the preliminary Hearing or grand jury stage of persecution. Probable cause must be presented by the prosecution showing a crime was committed, and it was committed by the defendant.

Probation: A person convicted of a crime may be placed under the supervision of a probation officer instead of being imprisoned as long as the conditions of the probation are obeyed.

Public Defender: An attorney employed by a government agency to represent defendants who are unable to hire private counsel.

Rebuttal: The time given for the prosecution to argue against the claims of the defense after both the prosecution and defense have rested (closed their portion of the case).

Release Date: The earliest possible time an inmate can be released from prison after serving the minimum amount of sentence by law.

Stipulation: Opposing attorneys agree on certain facts pertaining to a case so that it will not be necessary to reestablish them in court.

Subpoena: A written order requiring a person to appear in court to give testimony or evidence. Failure to appear is a punishable offense.

Summons: Written order by a judicial officer requiring a person to appear in a designated court at a specific time and place in order to serve as a witness in a case or bring material to the court.

Suspect: The person who is believed by criminal justice officials to be the one who committed a specific crime, but who has not been arrested or formally charged.

Suspended Sentence: When a person is charged, convicted and sentenced, but the sentence does not have to be served if the defendant successfully completes probation.

Testimony: Statements made in court by competent witnesses under oath.

Trial to the Court: A case in which there is not jury. A judge hears the evidence and makes a judgment.

True Bill: An indictment: The document a grand jury issues when they have decided there is sufficient evidence to try a case.

Victim's Bill of Rights: Legislation that allows specific rights and services to crime victim such as a right to be informed about their case; to be provided information on services and compensation, to appear at sentencing and parole hearings, to have property promptly returned, to have prompt case disposition, etc.

Voir Dire: The process in which attorneys are allowed to interview potential jurors in order to determine that the jurors chosen for trial will be fair and impartial.

Waive: When one voluntarily gives up a right or privilege.

Adapted March 2005 for Colorado from the State Child Fatality Review Team Committee, Child Death Investigation Protocols for Law Enforcement, Justices of the Peace, Medical Examiners, and The Texas Department of Protective and Regulatory Services. Texas Department of Protective and Regulatory Services, Texas Department of Health, Children's Trust Fund of Texas Council, May, 1996.

Appendix Five: Child Maltreatment Internet Resources

Administration for Children & Families www.acf.dhhs.gov

American Academy of Pediatrics www.aap.org

American Humane Association www.americanhumane.org

American Professional Society Against Child Abuse www.apsac.fmhi.usf.edu

Best Practices www.colorado.gov/bestpractices

Centers for Disease Control and Prevention www.cdc.gov

Child Abuse Prevention Foundation www.preventchildabuse.com

Child Abuse Prevention Network child-abuse.com

Child Quest International www.childquest.org

Child Welfare League of America www.cwla.org

Children's Defense Fund www.childrensdefense.org

Children's Safety Network www.edc.org/HHD/csn

Colorado Alliance for Drug Endangered Children www.colodec.org

Colorado Children's Code Online:

<http://198.187.128.12/colorado/lpext.dll?f=templates&fn=fs-main.htm&2.0>

Click on the "+" next to Colorado Statutes on the left side of the webpage.

Click on the Title 19: Colorado Children's Code.

Colorado Department of Human Services www.cdhs.state.co.us

Colorado Department of Public Health and Environment www.cdphe.state.co.us

International Society for the Prevention of Child Abuse and Neglect
www.ispcan.org

Kempe Center www.kempecenter.org

Maternal & Child Health Bureau www.mchb.hrsa.gov

National Center on Child Abuse and Neglect www.acf.dhhs.gov

National Center for Missing and Exploited Children www.missingkids.org

National Child Fatality Review www.ican-ncfr.org

National Children's Advocacy Centers www.nca-online.org

National Clearinghouse of Child Abuse and Neglect Information
<http://nccanch.acf.hhs.gov/>

National Resource Center for Health & Safety in Child Care nrc.uchsc.edu

State of Colorado www.state.co.us

United States Administration for Children and Families www.acf.dhhs.gov

Vanished Children's Alliance www.vca.org

Appendix Six: American Humane Association Fact Sheets

American Humane Association Fact Sheets are available on the following topics related to child abuse and neglect. These Fact Sheets may be reproduced and distributed without permission, however, appropriate citation must be given to the American Humane Association. To download fact sheets or for more information about the American Humane Association, go to <http://www.americanhumane.org>.

- Child Abuse and Neglect in America: What the Data Say
- Shaken Baby Syndrome
- Child Neglect
- Fatalities Due to Child Abuse and Neglect
- Child Physical Abuse
- Emotional Abuse
- Child Sexual Abuse
- Reporting Child Abuse and Neglect
- America's Children: How Are They Doing?
- Child Discipline
- Guidelines for Helping Children Experiencing Abuse or Neglect
- Understanding The Link Between Animal Abuse and Family Violence

Appendix Seven: Child Maltreatment Bibliography

Coming Soon!