

Child Abuse Identification and Reporting: The Pennsylvania Requirement

This course is approved by the Pennsylvania Department of Human Services to fulfill the requirement for 3 hours of Child Abuse Recognition and Reporting (Act 31) training for healthcare professionals applying for licensure. Provider number CACE000020.

This course is approved by the Pennsylvania Department of Human Services to fulfill the requirement for 2 hours of Child Abuse Recognition and Reporting (Act 31) training for healthcare professionals renewing their license. Provider number CACE000020.

HOW TO RECEIVE CREDIT

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

Faculty

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

Faculty Disclosure

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

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

Audience

This course is designed for all Pennsylvania physicians, physician assistants, nurses, social workers, counselors, pharmacists, and allied health professionals required to complete child abuse education.

Accreditations & Approvals



JOINTLY ACCREDITED PROVIDER
INTERPROFESSIONAL CONTINUING EDUCATION

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

As a Jointly Accredited Organization, NetCE is approved to offer social work continuing education by the Association of Social Work Boards (ASWB) Approved Continuing Education (ACE) program. Organizations, not individual courses, are approved under this program. Regulatory boards are the final authority on courses accepted for continuing education credit.

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

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

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

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

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

NetCE is recognized by the New York State Education Department's State Board for Mental Health Practitioners as an approved provider of continuing education for licensed marriage and family therapists. #MFT-0015.

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

Designations of Credit

NetCE designates this enduring material for a maximum of 3 AMA PRA Category 1 Credit(s)[™]. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Successful completion of this CME activity, which includes participation in the evaluation component, enables the participant to earn up to 3 MOC points in the American Board of Internal Medicine's (ABIM) Maintenance of Certification (MOC) program. Participants will earn MOC points equivalent to the amount of CME credits claimed for the activity. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABIM MOC credit. Completion of this course constitutes permission to share the completion data with ACCME.

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

This activity has been approved for the American Board of Anesthesiology's[®] (ABA) requirements for Part II: Lifelong Learning and Self-Assessment of the American Board of Anesthesiology's (ABA) redesigned Maintenance of Certification in Anesthesiology Program[®] (MOCA[®]), known as MOCA 2.0[®]. Please consult the ABA website, www.theABA.org, for a list of all MOCA 2.0 requirements. Maintenance of Certification in Anesthesiology Program[®] and MOCA[®] are registered certification marks of the American Board of Anesthesiology[®]. MOCA 2.0[®] is a trademark of the American Board of Anesthesiology[®].

Successful completion of this CME activity, which includes participation in the activity with individual assessments of the participant and feedback to the participant, enables the participant to earn 3 MOC points in the American Board of Pediatrics' (ABP) Maintenance of Certification (MOC) program. It is the CME activity provider's responsibility to submit participant completion information to ACCME for the purpose of granting ABP MOC credit.

This activity has been designated for 3 Lifelong Learning (Part II) credits for the American Board of Pathology Continuing Certification Program.

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

NetCE designates this continuing education activity for 3 ANCC contact hours.



IPCE CREDIT[™]

This activity was planned by and for the health-care team, and learners will receive 3 Interprofessional Continuing Education (IPCE) credits for learning and change.

NetCE designates this continuing education activity for 3.6 hours for Alabama nurses.

AACN Synergy CERP Category B.

AACN Synergy CERP Category B. NetCE designates this activity for 3 hours ACPE credit(s). ACPE Universal Activity Numbers: JA4008164-0000-22-013-H04-P and JA4008164-0000-22-013-H04-T.

Social workers completing this intermediate-to-advanced course receive 3 Clinical continuing education credits.

NetCE designates this continuing education activity for 3 CE credits.

NetCE designates this continuing education activity for 1.5 NBCC clock hours.

Individual State Nursing Approvals

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

Individual State Behavioral Health Approvals

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

Special Approvals

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

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About the Sponsor

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

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

Disclosure Statement

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

Course Objective

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

Learning Objectives

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

1. Summarize the historical context of child abuse.
2. Discuss the emergence of the child welfare system in Pennsylvania.
3. Define child abuse and neglect and identify the different forms of child abuse and neglect.
4. Discuss the scope of child abuse and neglect in the United States and specifically in Pennsylvania.
5. Review the mandatory reporting process and mandated reporters in the state of Pennsylvania, including possible barriers to reporting suspected cases of child abuse.

Pharmacy Technician Learning Objectives

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

1. Outline the history, scope, and definition of child abuse.
2. Describe the requirements for reporting child abuse in Pennsylvania.



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

HISTORICAL CONTEXT

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

In many cases, the physical abuse of children has been linked to punishment. Throughout history, physical child abuse was justified because it was believed that severe physical punishment was necessary to discipline, rid the child of evil, or educate [2; 13]. It was not until 1861 that there was a public outcry in the United States against extreme corporal punishment. This reform was instigated by Samuel Halliday, who reported the occurrence of many child beatings by parents in New York City [2].

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

The first public case of child abuse in the United States that garnered widespread interest took place in 1866 in New York City. Mary Ellen Wilson was an illegitimate child, 10 years of age, who lived with her foster parents [3]. Neighbors were concerned that she was being mistreated; however, her foster parents refused to change their behaviors and said that they could treat the child as they wished [2]. Because there were no agencies established to protect children specifically, Henry Berge, founder of the Society for the Prevention of Cruelty to Animals, intervened on Mary’s behalf [3]. He argued that she was a member of the animal kingdom and deserved protection. The case received much publicity, and as a result, in 1874 the New York Society for the Prevention of Cruelty to Children was formed [3]. Because of this case, every state now has a system in place for reporting child abuse. The Pennsylvania Department of Public Welfare (now known as the Department for Human Services) was established in 1921 and part of its original intent was to care for “dependent, defective, and delinquent children” [7].

As a result of Berge’s advocacy for children’s safety, other nongovernmental agencies were formed throughout the United States, and the establishment of the juvenile court was a direct result of the Society for the Prevention of Cruelty to Children [13]. By 1919, all but three states had juvenile courts. However, many of these nongovernmental agencies could not sustain themselves during the Depression [13].

The topic of child abuse and neglect received renewed interest in the 1960s, when a famous study titled “The Battered-Child Syndrome” was published [1; 4]. In the study, researchers argued that the battered-child syndrome consisted of traumatic injuries to the head and long bones, most commonly to children younger than 3 years of age, inflicted by parents [1; 4]. The study was viewed as the seminal work on child abuse, alerting both the general public and the academic community to the problems of child abuse [1; 2]. Soon, all 50 states required physicians to report child abuse [14]. In the early 1970s, Senator Walter Mondale noted that there was no official agency that spent its energies on preventing and treating child maltreatment [13]. Congress passed the Child Abuse Prevention and Treatment Act (CAPTA) of 1974, which targeted federal funds to improve states’ interventions for the identification and reporting of abuse [13]. In 2010, additional prevention and treatment programs were funded through CAPTA, and in 2012, the Administration on Children, Youth, and Families began to focus on protective factors to child abuse and neglect [61].

Today, child abuse and neglect are considered significant social problems with deleterious consequences. As noted, a system has been implemented in all 50 states to ensure the safety of children, with laws defining what constitutes abuse and neglect and who is mandated to report.

CHILD WELFARE IN PENNSYLVANIA

The Children’s Aid Society of Pennsylvania, one of the first organizations to advocate for children and their welfare in the United States, was founded in 1882 [62]. In the following years, the Children’s Aid Society was instrumental in educating the public about the unsanitary and unsafe conditions in almshouses, which were sometimes used for orphaned or abandoned children. Subsequently, legislation was passed in Pennsylvania to ensure that children were not permanently placed in almshouses [62].

In the state of Pennsylvania, Act 91 was passed in 1967 and gave child welfare agencies in all counties the responsibility to investigate child abuse reports made by physicians [18]. Three years later, Act 91 was modified to include school nurses and teachers as mandated reporters [18].

Pennsylvania was also the first state to take a non-criminal view of child abuse [22; 26]. In 1975, the Child Protective Services Law was enacted, which established a child abuse hotline and a statewide central registry in Pennsylvania in order to encourage the reporting of child abuse [18; 26].

The child welfare system in Pennsylvania is supervised by the state but administered by the different local counties [27]. This means that there are a total of 67 county agencies that administer the child welfare and juvenile justice services [27]. Aside from frank abuse, reports of other acts that might affect the well-being of a child are also accepted. The State of Pennsylvania delineates two functions for the local agencies: child protective services (CPS) and general protective services (GPS).

In 2016, SB1311 (Act 115) was signed and went into effect. This Act provides for additional grounds for involuntary termination of parental rights, provides for an additional grounds for aggravated circumstances, allows for the release of information in confidential reports to law enforcement when investigating cases of severe forms of trafficking in persons of sex trafficking, and adds a category of child abuse to include human trafficking. In 2017, Governor Tom Wolf approved Act 68 (also known as the Newborn Protection Act) to increase the number of locations for parents to give up their newborn without criminal liability [63]. In 2018, Act 29 was signed and expanded the definition of child abuse in Pennsylvania to include leaving a child unsupervised with a sexual predator [64]. That same year, Act 54 was signed and required mandatory notification when a medical provider has determined that a child (younger than 1 year of age) was born affected by substance use or withdrawal symptoms resulting from prenatal drug or alcohol exposure. This Act also mandates the development of “interagency protocols” to support local multidisciplinary teams

to identify, assess, and develop a plan of safe care for infants born affected by substance use or withdrawal symptoms. In 2019, Act 88, relating to penalties for failure to report or refer, was enacted.

CHILD PROTECTIVE SERVICES

CPS is in place to address acts that are “non-accidental serious physical or mental injury, sexual abuse, or exploitation, or serious physical neglect caused by acts or omissions of the parent or caretaker” [32]. In other words, these are cases in which there is reasonable cause to suspect child abuse and conduct an investigation.

Case Scenario

A young boy comes into the community health clinic for a physical exam. The boy’s mother hovers and does not seem to want to let her son answer any questions. During the exam, in the process of taking blood, the nurse notices some bruises and lacerations on the boy’s arm. Later, bruises in the shape of a belt are observed on the boy’s back as well. Upon questioning, the boy will only say that he was “bad.”

In this case, the nurse should make a report to ChildLine. This would be classified as a CPS case, and an investigation would be conducted. More information will be presented about reporting in later sections of this course.

GENERAL PROTECTIVE SERVICES

GPS is involved in non-abuse cases or acts that involve “non-serious injury or neglect” [38]. This includes children who experience “inadequate shelter, food, clothing, health care, truancy, inappropriate discipline, lack of supervision, hygiene issues, abandonment, or other problems that threaten a child’s opportunity for healthy growth and development” [38]. One of the following criteria must be met for GPS to be involved [55]:

- Lack of parental control
- Deprivation of the essentials of life
- Illegal placement for adoption or care
- Abandonment by parents or guardians
- Chronic truancy
- Habitual disobedience
- Formal adjudication

- Commitment of a delinquent act at an age younger than 10 years
- Defined as ungovernable
- Born to parents with terminated parental rights

Case Scenario

Ms. J, a neighbor, notices E (5 years of age) and S (6 years of age) running around their front yard at 8 p.m. The front door of the house is wide open, and Ms. J asks if their mother is home. S states that her mother went out with her girlfriend to a party. Ms. J asks if a babysitter is at the house, and S answers “no” again. This is not the first time neighbors have noticed that the kids are left at home alone. The neighbors report that the mother often comes home late, intoxicated.

In this case, a bystander (likely Ms. J or one of the neighbors) could call ChildLine, the local county agency, or even the police, and the case would be addressed by GPS. More information will be presented about reporting in later sections of this course.

DEFINITIONS OF CHILD ABUSE AND NEGLECT

The federal definition of child abuse is evident in CAPTA, published as a product of federal legislation. CAPTA defines a child to be any individual younger than 18 years of age, except in cases of sexual abuse. In cases of sexual abuse, the age specified by the child protection laws varies depending on the state in which the child resides [5]. CAPTA defines child abuse as, “any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act that presents an imminent risk of serious harm” [6].

In Pennsylvania, the child abuse law takes a very comprehensive approach to defining of child abuse [26]. According to Pennsylvania law, child abuse refers to intentionally, knowingly, or recklessly doing any of the following [43; 54]:

- Causing bodily injury to a child through any recent act or failure to act
- Fabricating, feigning, or intentionally exaggerating or inducing a medical symptom or disease that results in a potentially harmful medical evaluation or treatment to the child through any recent act
- Causing or substantially contributing to serious mental injury to a child through any act or failure to act or a series of such acts or failures to act
- Causing sexual abuse or exploitation of a child through any act or failure to act
- Creating a reasonable likelihood of bodily injury to a child through any recent act or failure to act
- Creating a likelihood of sexual abuse or exploitation of a child through any recent act or failure to act
- Causing serious physical neglect of a child
- Engaging in any of the following recent acts:
 - Kicking, biting, throwing, burning, stabbing, or cutting a child in a manner that endangers the child
 - Unreasonably restraining or confining a child, based on consideration of the method, location, or duration of the restraint or confinement
 - Forcefully shaking a child younger than 1 year of age
 - Forcefully slapping or otherwise striking a child younger than 1 year of age
 - Interfering with the breathing of a child
 - Causing a child to be present at a location while a violation relating to the operation of methamphetamine laboratory is occurring, provided that the violation is being investigated by law enforcement

- Leaving a child unsupervised with an individual, other than the child's parent, who the actor knows or reasonably should have known a) is required to register as a Tier II or Tier III sexual offender, where the victim of the sexual offense was younger than 18 years of age when the crime was committed; b) has been determined to be a sexually violent predator; or c) has been determined to be a sexually violent delinquent child
 - Causing the death of the child through any act or failure to act
 - Engaging a child in a severe form of trafficking in persons or sex trafficking, as those terms are defined under section 103 of the Trafficking Victims Protection Act of 2000
- In addition, the Code explicitly excludes specific acts and injuries from the definition of child abuse. Effective December 31, 2014, the following are considered exclusions to the definition of child abuse [44]:
- Environmental factors: No child shall be deemed to be physically or mentally abused based on injuries that result solely from environmental factors, such as inadequate housing, furnishings, income, clothing, and medical care, that are beyond the control of the parent or person responsible for the child's welfare with whom the child resides. This shall not apply to any child-care service, excluding an adoptive parent.
 - Practice of religious beliefs: If, upon investigation, the county agency determines that a child has not been provided needed medical or surgical care because of sincerely held religious beliefs of the child's parents or relative within the third degree of consanguinity and with whom the child resides, which beliefs are consistent with those of a bona fide religion, the child shall not be deemed to be physically or mentally abused. In such cases the following shall apply:
 - The county agency shall closely monitor the child and the child's family and shall seek court-ordered medical intervention when the lack of medical or surgical care threatens the child's life or long-term health.
 - All correspondence with a subject of the report and the records of the department and the county agency shall not reference child abuse and shall acknowledge the religious basis for the child's condition.
 - The family shall be referred for general protective services, if appropriate.
 - This subsection shall not apply if the failure to provide needed medical or surgical care causes the death of the child.
 - This subsection shall not apply to any child-care service as defined in this chapter, excluding an adoptive parent.
 - Use of force for supervision, control, and safety purposes: Subject to the rights of parents, the use of reasonable force on or against a child by the child's own parent or person responsible for the child's welfare shall not be considered child abuse if any of the following conditions apply:
 - The use of reasonable force constitutes incidental, minor, or reasonable physical contact with the child or other actions that are designed to maintain order and control.
 - The use of reasonable force is necessary to quell a disturbance or remove the child from the scene of a disturbance that threatens physical injury to persons or damage to property; to prevent the child from self-inflicted physical harm; for self-defense or the defense of another individual; or to obtain possession of weapons or other dangerous objects or controlled substances or paraphernalia that are on the child or within the control of the child.

- Rights of parents: Nothing in this chapter shall be construed to restrict the generally recognized existing rights of parents to use reasonable force on or against their children for the purposes of supervision, control, and discipline of their children. Such reasonable force shall not constitute child abuse.
- Participation in events that involve physical contact with child: An individual participating in a practice or competition in an interscholastic sport, physical education, recreational activity, or extracurricular activity that involves physical contact with a child does not, in itself, constitute contact that is subject to the reporting requirements of this chapter.
- Defensive force: Reasonable force for self-defense or the defense of another individual shall not be considered child abuse.
 - Child-on-child contact: Harm or injury to a child that results from the act of another child shall not constitute child abuse unless the child who caused the harm or injury is a perpetrator. Notwithstanding this, the following shall apply: Acts constituting any of the following crimes against a child shall be subject to the reporting requirements: rape, involuntary deviate sexual intercourse, sexual assault, aggravated indecent assault, indecent assault, and indecent exposure.
 - No child shall be deemed to be a perpetrator of child abuse based solely on physical or mental injuries caused to another child in the course of a dispute, fight, or scuffle entered into by mutual consent.
 - A law enforcement official who receives a report of suspected child abuse is not required to make a report to the department if the person allegedly responsible for the child abuse is a nonperpetrator child.

It is important to note that exclusions are utilized by the CPS agency when investigating suspected abuse and should not be considered exclusions from reporting suspected abuse.

For the purposes of this course, a perpetrator is defined as a person who has committed child abuse. According to the Pennsylvania Code, the term includes only [42; 54]:

- A parent of the child
- A spouse or former spouse of the child's parent
- A paramour or former paramour of the child's parent
- A person 14 years of age or older and responsible for the child's welfare, including a person who provides temporary or permanent care, supervision, mental health diagnosis or treatment, or training or control of a child in lieu of parental care, supervision, and control
- An individual 14 years of age or older who resides in the same home as the child
- An individual 18 years of age or older who does not reside in the same home as the child but is related within the third degree of consanguinity or affinity by birth or adoption to the child
- An individual 18 years of age or older who engages a child in severe forms of trafficking in persons or sex trafficking, as those terms are defined under section 103 of the Trafficking Victims Protection Act of 2000

In a significant revision to the definition of perpetrator, school personnel and other childcare providers are considered "individuals responsible for the child's welfare" and may be perpetrators of child abuse; there is no longer a separate definition for student abuse [42]. As such, a perpetrator may be any such person who has direct or regular contact with a child through any program, activity, or services sponsored by a school, for-profit organization, or religious or other not-for-profit organization.

In addition, only the following may be considered a perpetrator for failing to act [42; 54]:

- A parent of the child
- A spouse or former spouse of the child's parent
- A paramour or former paramour of the child's parent
- A person 18 years of age or older and responsible for the child's welfare or who resides in the same home as the child

FORMS OF CHILD ABUSE AND NEGLECT

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

Bodily Injury

Bodily injury, or physical abuse injuries, can range from minor bruises and lacerations to severe neurologic trauma and death. Physical abuse is one of the most easily identifiable forms of abuse and the type most commonly seen by healthcare professionals. Physical injuries that may be indicative of abuse include bruises/welts, burns, fractures, abdominal injuries, lacerations/abrasions, and central nervous system trauma [8; 34].

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

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

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

Fractures that result from abuse might be found on the child's skull, ribs, nose, or any facial structure. These may be multiple or spiral fractures at various stages of healing. When examining patients, note bruises on the abdominal wall, any intestinal perforation, ruptured liver or spleen, and blood vessel, kidney, bladder, or pancreatic injury, especially if accounts for the cause do not make sense. Look for signs of abrasions on the child's wrists, ankles, neck, or torso. Lacerations might also appear on the child's lips, ears, eyes, mouth, or genitalia. If violent shaking or trauma occurred, the child might experience a subdural hematoma [8; 34].



According to the American College of Radiology, fractures highly suggestive of physical abuse include rib fractures, classic metaphyseal lesions, those unsuspected or inconsistent with the history or age of the child, multiple fractures involving more than one skeletal area, and fractures of differing ages.

(<https://acsearch.acr.org/docs/69443/Narrative>.

Last accessed July 26, 2022.)

Level of Evidence: Expert Opinion/Consensus Statement

Sexual Abuse/Exploitation

According to the Pennsylvania Code, sexual abuse or exploitation is defined as [45]:

- The employment, use, persuasion, inducement, enticement, or coercion of a child to engage in or assist another individual to engage in sexually explicit conduct, which includes, but is not limited to, the following:
 - Looking at the sexual or other intimate parts of a child or another individual for the purpose of arousing or gratifying sexual desire in any individual
 - Participating in sexually explicit conversation either in person, by telephone, by computer, or by a computer-aided device for the purpose of sexual stimulation or gratification of any individual

- Actual or simulated sexual activity or nudity for the purpose of sexual stimulation or gratification of any individual
- Actual or simulated sexual activity for the purpose of producing visual depiction, including photographing, videotaping, computer depicting, or filming
- Any of the following offenses committed against a child:
 - Rape
 - Statutory sexual assault
 - Involuntary deviate sexual intercourse
 - Sexual assault
 - Institutional sexual assault
 - Aggravated indecent assault
 - Indecent assault
 - Indecent exposure
 - Incest
 - Prostitution
 - Sexual abuse
 - Unlawful contact with a minor
 - Sexual exploitation
- Child pornography: Taking photos of a child in sexually explicit poses or acts
- Exhibitionism: Exposing his/her genitals to the child or forcing the child to observe the adult or other children in sexual acts
- Molestation: Touching, fondling, or kissing the child in a provocative manner; for example, fondling the child's genital area or long, lingering kisses
- Sexual penetration: The penetration of part of the perpetrator's body (e.g., finger, penis, tongue) into the child's body (e.g., mouth, vagina, anus)
- Rape: Usually involves sexual intercourse without the victim's consent and usually involves violence or the threat of violence
- Commercial sex act: Any sex act on account of which anything of value is given to or received by any person

This does not include consensual activities between a child who is 14 years of age or older and another person who is 14 years of age or older and whose age is within four years of the child's age.

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

- Verbal: Obscene phone calls or talking about sexual acts for the purpose of sexually arousing the adult perpetrator
- Voyeurism: Watching a child get dressed or encouraging the child to masturbate while the perpetrator watches
- Child prostitution: Involving the child in sexual acts for monetary profit

Serious Physical Neglect

Pennsylvania law defines serious physical neglect of a child as repeated, prolonged, or egregious failure to supervise a child in a manner that is appropriate considering the child's developmental age and abilities, and/or the failure to provide a child with adequate essentials of life, including food, shelter, or medical care, when committed by a perpetrator that endangers a child's life or health, threatens a child's well-being, causes bodily injury, or impairs a child's health, development, or functioning. Due to the ambiguity of definitions of child abuse and neglect, CAPTA provides minimum standards that each state must incorporate in its definition of neglect. Examples of child neglect may include [6; 11; 12]:

- Failure to provide adequate food, clothing, shelter, hygiene, supervision, and protection
- Refusal and/or delay in medical attention and care (e.g., failure to provide needed medical attention as recommended by a healthcare professional or failure to seek timely and appropriate medical care for a health problem)

- Abandonment, characterized by desertion of a child without arranging adequate care and supervision. Children who are not claimed within two days or who are left alone with no supervision and without any information about their parents'/caretakers' whereabouts are examples of abandonment.
- Expulsion or blatant refusals of custody on the part of parent/caretaker, such as ordering a child to leave the home without adequate arrangement of care by others
- Inadequate supervision (i.e., child is left unsupervised or inadequately supervised for extended periods of time)
- Refusal or delay of psychological care: Failure or delay in obtaining services for the child's emotional, mental, or behavioral impairments
- Permitted chronic truancy: The child averages at least five days per month of school absence and the parent/guardian does not intervene
- Failure to enroll: Failure to enroll or register a child of mandatory school age or causing the child to remain at home for nonlegitimate reasons
- Failure to access special education services: Refusal or failure to obtain recommended services or treatment for remedial or special education for a child's diagnosed learning disorder

Serious Mental Injury

Under Pennsylvania law, serious mental injury (or emotional or psychological abuse) involves an act or failure to act by a perpetrator that causes non-accidental serious mental injury. Serious mental injury is "a psychological condition, as diagnosed by a physician or licensed psychologist, including the refusal of appropriate treatment, that renders a child chronically and severely anxious, agitated, depressed, socially withdrawn, psychotic, or in reasonable fear that his or her life or safety is threatened, or that seriously interferes with a child's ability to accomplish age-appropriate development and social tasks" [45].

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

- Verbal abuse: Belittling or making pejorative statements in front of the child, which results in a loss or negative impact on the child's self-esteem or self-worth
- Inadequate nurturance/affection: Inattention to the child's needs for affection and emotional support
- Witnessing domestic violence: Chronic spousal abuse in homes where the child witnesses the violence
- Substance and/or alcohol abuse: The parent/caretaker is aware of the child's substance misuse problem but chooses not to intervene or allows the behavior to continue

Trafficking and Exploitation

It can be difficult to identify and intervene to stop human trafficking and exploitation, because it is hidden and even people who interact with victims may not recognize that it is happening. However, in many cases, women and children are considered the typical victims of human trafficking. Trafficking and exploitation are real risks to child safety and well-being and are reportable as forms of abuse.

There are several different types of child or minor human trafficking, but the term is generally defined as the recruitment, transportation, provision, or obtaining of a child for labor or services through the use of force, fraud, or coercion. Severe forms of human trafficking include sex and labor trafficking, including debt bondage and slavery.

Labor Trafficking

Labor trafficking is defined as labor obtained by the use of threat of serious harm, physical restraint, or abuse of the legal process. Severe labor trafficking includes the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion, for the purpose of subjection to involuntary servitude, peonage (i.e., paying off debt through work), debt bondage (i.e., debt slavery, bonded labor or services

for a debt or other obligation), or slavery (i.e., a condition compared to that of a slave in respect of exhausting labor or restricted freedom).

Typically, children involved in forced labor are being given little or no pay. In the United States, forced labor is predominantly found in five sectors [57]:

- Prostitution and sex industry (46%)
- Domestic servitude (27%)
- Agriculture (10%)
- Sweatshops and factories (5%)
- Restaurant and hotel work (4%)

Among child victims, forced domestic servitude is a serious concern, particularly related to the provision of domestic services for 10 to 16 hours per day on activities such as child care, cooking, cleaning, and yard work/gardening.

Sex Trafficking

The Victims of Trafficking and Violence Protection Act defines sex trafficking as, “the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act” [58]. A commercial sex act is, “any sex act on account of which anything of value is given to or received by any person” [58]. In other words, it involves the illegal transport of humans to be exploited in a sexual manner for financial gains [59]. Victims of sex trafficking could be forced into prostitution, stripping, pornography, escort services, and other sexual services [60]. Under federal law, sex trafficking (such as prostitution, pornography, or exotic dancing) does not require there be force, fraud, or coercion if the victim is younger than 18 years of age.

The term “domestic minor sex trafficking” has become a popular term used to connote the buying, selling, and/or trading of children for sexual services within the country, not internationally [60]. In the United States, the children most vulnerable to domestic minor trafficking are [60]:

- Youth in the foster care system
- Youth who identify as LGBTQIA+
- Youth who are homeless or runaway

- Youth with disabilities
- Youth with mental health or substance abuse disorders
- Youth with a history of sexual abuse
- Youth with a history of being involved in the welfare system
- Youth who identify as native or aboriginal
- Youth with family dysfunction

EPIDEMIOLOGY OF CHILD ABUSE AND NEGLECT

NATIONAL PREVALENCE

In 2020, there were 3.9 million referrals to child protective agencies in the United States [15]. More than 2.1 million (or 54%) were assessed to be appropriate for a response, and 27.6% of reports were made by health, social service, and/or mental health professionals [15]. Girls tend to be victims at a slightly higher rate (8.9 per 1,000 population) compared with boys (7.9 per 1,000 population) [15]. The most common perpetrators were parents; 90.6% of victims are maltreated by one or both parents [15]. Specifically, mothers are more often perpetrators compared with fathers (58.3% of victims were abused by a mother vs. 44.3% of victims were abused by a father) [15].

As of 2020, 8.4 of every 1,000 children in the United States were victims of abuse and/or neglect [15]. This is the unique rate, meaning each child is counted only once regardless the number of times a report may have been filed for abuse/neglect. The fatality rate for 2020 was 2.38 deaths per 100,000 children [15].

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

CHILD ABUSE VICTIMIZATION IN THE UNITED STATES ACCORDING TO RACE/ETHNICITY, 2020	
Race/Ethnicity	Child Abuse Rate per 1,000 Children
Native American/Alaska Native	15.5
African American	13.2
Multi-race	10.3
Pacific Islander	9.0
Hispanic	7.8
White	7.4
Asian American	1.6
<i>Source: [15]</i>	

Table 1

PENNSYLVANIA STATE PREVALENCE

According to the Annual Child Protective Services Report, a yearly statistical report that documents child abuse cases in Pennsylvania, the child abuse hotline registered a total of 39,093 reports of suspected abuse or neglect in 2022 [27]. Approximately 12.8% of these cases were substantiated, which translates to 4,992 cases of child abuse in 2022 [27]. This is an increase of 6,174 reports (18.7%) compared with 2020, a decline attributed to the end of COVID-19 precautions and the return to usual contact between children and mandated reporters [27]. Of the substantiated child abuse cases, there were 60 fatalities, 13 less than in 2020 [27]. More than half (50.1%) of perpetrators of child abuse in 2022 were the parent of the child victim [27].

RECOGNIZING WARNING SIGNS

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

- Inappropriate delay in bringing the child to a health facility
 - Unwillingness to provide information or the information provided is vague
 - History of family violence in the home
 - Parental misuse of substances and/or alcohol
 - Minimal knowledge or concern about the child's development and care
 - Environmental stressors, such as poverty, single parenthood, unemployment, or chronic illness in the family
 - Unwanted pregnancy
 - Early adolescent parent
 - Expression that the parent(s) wanted a baby in order to feel loved
 - Unrealistic expectations of the child
 - Use of excessive physical punishment
 - Healthcare service "shopping"
 - History of parent "losing control" or "hitting too hard"
- Child risk indicators include [8; 10; 12; 16]:
- Multiple school absences
 - Learning or developmental disabilities
 - History of multiple, unexplained illnesses, hospitalizations, or accidents
 - Poor general appearance (e.g., fearful, poor hygiene, malnourished appearance, inappropriate clothing for weather conditions)
- Recounting of events that do not conform either with the physical findings or the child's physical and/or developmental capabilities

- Stress-related symptoms, such as headaches or stomachaches
- Frozen watchfulness
- Mental illness or symptoms, such as psychosis, depression, anxiety, eating disorders, or panic attacks
- Regression to wetting and soiling
- Sexually explicit play
- Excessive or out-of-the-ordinary clinging behavior
- Difficulties with concentration
- Disruptions in sleep patterns and/or nightmares

In addition, warning signs specifically associated with victims of child trafficking and/or exploitation include (but are not limited to):

- A youth that has been verified to be younger than 18 years of age and is in any way involved in the commercial sex industry or has a record of prior arrest for prostitution or related charges
- An explicitly sexual online profile
- Excessive frequenting of Internet chat rooms or classified sites
- Depicting elements of sexual exploitation in drawing, poetry, or other modes of creative expression
- Frequent or multiple sexually transmitted infections or pregnancies
- Lying about or not being aware of their true age
- Having no knowledge of personal data (e.g., age, name, date of birth)
- Having no identification
- Wearing sexually provocative clothing
- Wearing new clothes of any style, getting hair and/or nails done with no financial means
- Being secretive about whereabouts
- Having late nights or unusual hours
- Having a tattoo that s/he is reluctant to explain

- Being in a controlling or dominating relationship
- Not having control of own finances
- Exhibiting hypervigilance or paranoid behaviors
- Expressing interest in or being in relationships with adults or much older men or women

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

CONSEQUENCES OF CHILD ABUSE

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

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

In examining some of the effects of physical abuse, it is helpful to frame the consequences along a lifespan perspective [3]. During infancy, physical abuse can cause neurologic impairments. Most cases of infant head trauma are the result of child abuse [19]. Neurologic damage may also affect future cognitive, behavioral, and developmental outcomes. Some studies have noted that, in early childhood, physically abused children show less secure attachments to their caretakers compared to their non-abused counterparts [20].

By middle to late childhood, the consequences are more notable. Studies have shown significant intellectual and linguistic deficits in physically abused children [3]. Other environmental conditions, such as poverty, may also compound this effect. In addition, a number of affective and behavioral problems have been reported among child abuse victims, including anxiety, depression, low self-esteem, excessive aggressive behaviors, conduct disorders, delinquency, hyperactivity, and social detachment [3; 8; 10; 12].

Surprisingly, there has been little research on the effects of childhood physical abuse on adolescents [3]. However, differences have been noted in parents who abuse their children during adolescence rather than preadolescence. It appears that lower socioeconomic status plays a lesser role in adolescent abuse as compared with abuse during preadolescence [21]. In addition, parents who abuse their children during adolescence are less likely to have been abused as children themselves compared with those parents who abused their children during preadolescence [21]. It is believed that the psychosocial effects of physical abuse manifest similarly in late childhood and adolescence.

Research findings regarding the effects of childhood physical abuse on adult survivors indicate an increased risk for major psychiatric disorders, including depression, post-traumatic stress disorder, and substance abuse [36]. Some adult survivors function well socially and in terms of mental and physical health, even developing increased resilience as a result of their experiences, while others exhibit depression, anxiety, post-traumatic stress, substance abuse, criminal behavior, violent behavior, and poor interpersonal relationships [3; 17; 46]. A meta-analysis found that adult survivors of child abuse were more likely to experience depression than non-abused counterparts, with the rates varying according to the type of abuse sustained (1.5-fold increase for physical child abuse, 2.11-fold increase for neglect, and 3-fold increase for emotional abuse) [24]. Similar results were found in a longitudinal study that compared a child welfare cohort to a group with no child welfare involvement. The child welfare group was twice as likely to experience moderate-to-severe depression and generalized anxiety

compared with the control group [25]. There is some evidence that vulnerability to long-term effects of maltreatment in childhood may be at least partially genetically mediated [50].

Although not all adult survivors of sexual abuse experience long-term psychological consequences, it is estimated that 20% to 50% of all adult survivors have identifiable adverse mental health outcomes [23]. Possible psychological outcomes include [10]:

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

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

In more recent years, research has focused on the impact of adverse childhood experiences (ACEs) in general. ACEs are defined as potentially traumatic experiences that affect an individual during childhood (before 18 years of age) and increase the risk for future health and mental health problems (including increased engagement in risky behaviors) as adults [47]. Abuse and neglect during childhood are clear ACEs, but other examples include witnessing family or community violence; experiencing a family member attempting or completing suicide; parental divorce; parental or guardian substance abuse; and parental incarceration [47]. Adults who experienced ACEs are at increased risk for chronic illness, impaired health, violence, arrest, and substance use disorder [28; 52].

REPORTING SUSPECTED CHILD ABUSE

Pennsylvania has a delineated process in place to facilitate the reporting of suspected child abuse. In addition, in 2014, Governor Corbett signed four new bills intended to streamline and clarify the child abuse reporting process in Pennsylvania. These bills were spurred by the Sandusky child sexual abuse case.

PERMISSIVE REPORTERS

There are two general categories of child abuse reporters: mandated reporters and permissive reporters. Permissive reporters are individuals who report an incident of suspected child abuse. These persons are not required to act or intervene in cases of suspected abuse. Put plainly, permissive reporters can report abuse while mandated reporters must report. However, it is important to note that any person is encouraged to report suspected child abuse or cause a report of suspected child abuse to be made to the department, county agency, or law enforcement, if that person has reasonable cause to suspect that a child is a victim of child abuse. Reasonable cause to suspect is a determination made based on training/experience and all known circumstances. Some indicators may be more apparent than others depending on the type of abuse and/or depending on the child's health, developmental level, and well-being. For example, some indicators may be visible on the child's body while other indicators may be present in the child's behaviors.

MANDATED REPORTERS

In Pennsylvania, a mandated reporter is required to make a report of suspected child abuse when he or she has reasonable cause to suspect that a child is a victim of child abuse if [48]:

- The mandated reporter comes into contact with the child in the course of employment, occupation, and practice of a profession or through a regularly scheduled program, activity, or service.
- The mandated reporter is directly responsible for the care, supervision, guidance, or training of the child, or is affiliated with an agency, institution, organization, school, regularly established church or religious organization, or other entity that is directly responsible for the care, supervision, guidance, or training of the child, regardless of the setting of the disclosure of abuse (within or outside of the reporter's professional role).
- A person makes a specific disclosure to the mandated reporter that an identifiable child is the victim of child abuse either within or outside of the reporter's professional role.
- An individual 14 years of age or older makes a specific disclosure to the mandated reporter (either within or outside of the reporter's professional role) that the individual has committed child abuse.

The mandated reporter is not required to interrogate the victim or identify the person responsible for the child abuse in order to make a report of suspected child abuse.

By law, individuals who come into contact with children on a frequent and consistent basis due to their work are legally required to report any suspected child abuse [39]. Mandated reporters in the state of Pennsylvania include, but are not limited to, [39]:

- Physicians (including osteopaths)
- Medical examiners
- Coroners
- Funeral directors
- Dentists
- Optometrists
- Chiropractors
- Podiatrists
- Interns
- Registered nurses
- Licensed practical nurses
- Hospital personnel engaged in the admission, examination, care, or treatment of persons

- Christian Science practitioners
- Members of the clergy
- School administrators
- School teachers
- School nurses
- Social services workers
- Day-care center workers or any other child-care or foster-care workers
- Mental health professionals
- Peace officers or law enforcement officials

Senate Bill 21 and House Bill 436 were two of the bills signed into law and enacted in 2014. These bills elucidate that mandated reporters are “to include anyone who comes in contact with a child, or is directly responsible for the care, supervision, guidance, or training of a child” [51]. Under this expanded definition, additional individuals who are also classified as mandatory reporters include [39]:

- A person licensed or certified to practice in any health-related field under the jurisdiction of the Department of State
- A school employee
- A foster parent
- An individual, paid or unpaid, who, on the basis of the individual’s role as an integral part of a regularly scheduled program, activity, or service, accepts responsibility for a child
- An employee of a social services agency
- An employee of a public library
- Those who are supervised by mandated reporters
- An independent contractor with direct contact with children
- An attorney affiliated with an agency, institution, or organization that is responsible for the care, supervision, guidance, or control of children

It has long been debated whether attorneys should be included as mandated reporters. With this new definition, there is a seeming compromise, limiting the mandate to attorneys who are affiliated with an organization that is responsible for the care or supervision of children [37].

Privileged communication between any mandated reporter and his or her patient or client does not apply in cases of child abuse, and failure to report this information is considered a violation of the law [39]. There are exceptions: confidential communication made to an ordained member of the clergy (within the scope of 42 Pennsylvania CS §§ 5943), and confidential communications made to an attorney so long as they are within the scope of 42 Pennsylvania CS §§ 5916 (relating to confidential communications to attorney) and 5928 (relating to confidential communications to attorney), the attorney work product doctrine, or the rules of professional conduct for attorneys [39]. Notwithstanding any other provision of law, a mandated reporter who makes a report of suspected child abuse or who makes a report of a crime against a child to law enforcement officials shall not be in violation of the Mental Health Procedures Act by releasing information necessary to complete the report.

The Pennsylvania Code states that whenever a person is a mandated reporter in his or her capacity as a member of the staff of a medical or other public or private institution, school, facility, or agency, that person shall report immediately and immediately thereafter notify the person in charge of the institution, school, facility, or agency (or the designated agent) [48]. Upon notification, the person in charge or the designated agent is responsible for facilitating the cooperation of the institution, school, facility, or agency with the investigation of the report.

Not surprisingly, more than three-quarters (80%) of suspected child abuse reports are made by mandated reporters [27]. More specifically, the majority of child abuse reports come from mandated reporters in public/private social services agencies.

THE PROCESS OF REPORTING CHILD ABUSE IN PENNSYLVANIA

In Pennsylvania, mandated reports of potential child abuse (CPS or GPS cases) are made either in writing (through the online portal) or orally to ChildLine. The ChildLine is available seven days per week, 24 hours per day at 800-932-0313 or 412-473-2000. In 2020, ChildLine answered 163,215 calls, including suspected child abuse cases, referrals for GPS, and inquiries for general information to services [27]. Electronic submission of suspected child abuse reports may be made in lieu of calling ChildLine.

All mandated reporters who report via telephone shall also make a written report, which may be submitted electronically, within 48 hours [51]. The written reports are made through the Child Welfare Information Solution (CWIS) Portal, available online at <https://www.compass.state.pa.us/cwis>. The written report will include all of the following information, if known [55]:

- The names and addresses of the child, the child's parents, and any other person responsible for the child's welfare
- Where the suspected abuse occurred
- The age and sex of each subject of the report
- The nature and extent of the suspected child abuse, including any evidence of prior abuse to the child or any sibling of the child
- The name and relationship of each individual responsible for causing the suspected abuse and any evidence of prior abuse by each individual
- Family composition
- The source of the report
- The name, telephone number, and e-mail address of the person making the report
- The actions taken by the person making the report, including collection of evidence, protective custody, or admission to hospital
- Any other information required by federal law or regulation

- Any other information that the department requires by regulation

According to Pennsylvania law, a person or official required to report cases of suspected child abuse may take or request photographs of the child who is subject to a report and, if clinically indicated, request a radiologic examination and other medical tests on the child [56]. If completed, medical summaries or reports of the photographs, x-rays, and relevant medical tests should be sent along with the written report or within 48 hours after a report is made electronically. Persons who have reasonable cause to suspect a child is a victim of child abuse are NOT required to identify the person responsible for the abuse in order to make a report of suspected child abuse.

Except as allowed by Pennsylvania law, reports made to CPS, including, but not limited to, report summaries of child abuse and any other information obtained, reports written, or photographs or X-rays taken concerning alleged instances of child abuse, shall be confidential. Mandated reporters must identify themselves when reporting [54]. However, their names are usually not released; only the Secretary of the Department of Human Services has this authority. If a mandated reporter so chooses, he/she can sign a consent form that gives consent to have his/her name released [54].

A specialist at ChildLine will interview the caller to determine what the next step should be. This includes assessing if the report will be forwarded to a county agency for investigation as CPS or GPS; if a report should be forward directly to law enforcement officials; or if the caller will be referred to local services [53].

For both GPS and CPS cases, the appropriate county agency is contacted immediately [35]. The county agency is then responsible for its investigation, completing both a "risk assessment" and a "safety assessment." In CPS cases, the agency sees and evaluates the child within 24 hours of receiving the report. The primary goal of the evaluations are to assess the nature and extent of the abuse reported; to evaluate the level of risk or harm if the child were to stay in the current living situation; and to determine action(s) needed to ensure the child's safety [53].

A GPS referral will be assessed for any further needs, and appropriate referrals for services may be made for the child and family. If it is a CPS case, further investigation will be conducted. During the investigation, the agency may take photographs of the child and his/her injuries for the files. All investigations must be completed within 30 days from the date the report is taken at ChildLine [27]. Mandated reporters have a right to know of the findings of the investigation and the services provided to the child and may follow the case [33].

SUBSTANCE USE EXPOSURE AND PLANS OF SAFE CARE

Healthcare professionals in Pennsylvania, including those involved in the delivery or care of an infant affected by substance use or withdrawal symptoms (including fetal alcohol spectrum disorder) or encountering infants younger than 1 year of age outside a hospital setting, are required to notify the Pennsylvania Department of Human Services so that a Plan of Safe Care can be developed. It is important to note that this notification is not considered a child abuse report. In this context, healthcare provider or professional is defined as a licensed hospital or healthcare facility or person who is licensed, certified, or otherwise regulated to provide healthcare services under the laws of Pennsylvania, including physicians, podiatrists, optometrists, psychologists, physical therapists, certified nurse practitioners, registered nurses, nurse midwives, physician assistants, chiropractors, dentists, pharmacists, or individuals accredited or certified to provide behavioral health services. This is a notable shift from the previous law, which limited notification to only cases including illegal substance use and included an exception to reporting if the pregnant woman was receiving active treatment for a substance use disorder.

In 2019, the Pennsylvania Department of Health, Pennsylvania Department of Drug and Alcohol Programs, and Pennsylvania Department of Human Services published the Pennsylvania Plan of Safe Care Guidance addressing a framework for respond-

ing to the health and substance use disorder treatment needs of infants born affected by substance use disorder and/or withdrawal symptoms and affected family or caregivers [65]. This publication includes definitions and evidence-based screening tools, based on standards of professional practice, to be utilized by healthcare providers to identify a child born affected by substance use or withdrawal symptoms resulting from prenatal drug exposure or a fetal alcohol spectrum disorder. The plan of safe care typically includes [65]:

- A release of information to allow for the collaboration among entities
- Referrals to treatment programs, mobile engagement and peer recovery specialists
- Education on neonatal abstinence syndrome, effects of substance use during pregnancy, and reporting requirements for substance exposed infants
- A relapse plan that includes child safety considerations and identified family supports
- Coordination between the obstetrician and the prescribing practitioner(s)
- Development of a birth plan, including pain management options
- Education and guidance on breastfeeding and substance use
- Stigma-reducing practices designed to engage the patient in consistent prenatal care
- Referrals to Family Strengthening, Early Head Start, Family Check Up for Children, Healthy Families America, Nurse-Family Partnership, Parents as Teachers, Family Group Decision Making (FGDM), Women Infant Children (WIC), public assistance, transportation assistance, counseling, housing assistance, domestic violence programs, and/or food banks
- Referral to ChildLine if there are concerns with mother's ability to be a caretaker for other children

After notification of a child born affected by substance use or withdrawal symptoms resulting from prenatal drug exposure or a fetal alcohol spectrum disorder, a multidisciplinary team meeting will be held prior to the child's discharge from the healthcare facility. For the purpose of informing the plan of safe care, this team may include public health agencies, maternal and child health agencies, home visitation programs, substance use disorder prevention and treatment providers, mental health providers, public and private children and youth agencies, early intervention and developmental services, courts, local education agencies, managed care organizations and private insurers, and hospitals and medical providers. The meeting will inform an assessment of the needs of the child and the child's parents and immediate caregivers to determine the most appropriate lead agency for developing, implementing, and monitoring a plan of safe care. The child's parents and immediate caregivers must be engaged to identify the need for access to treatment for any substance use disorder or other physical or behavioral health condition that may impact the safety, early childhood development, and well-being of the child.

Depending upon the needs of the child and parent(s)/caregiver(s), ongoing involvement of the county agency may not be required.

PROTECTIONS FOR REPORTERS

Reporters are afforded protections after reporting a suspected incidence of child abuse. Any person or institution who, in good faith, makes a report of child abuse, cooperates with a child abuse investigation, or testifies in a child abuse proceeding is considered immune from civil and criminal liability [44]. Mandated reporters who make a report in good faith and then later face discrimination in their workplace can take legal action [44]. (This protection from discrimination does not apply to an individual making a report who is found to be a perpetrator or to any individual who fails to make a required report.) For the most part, the reporter's identity is kept confidential. If a case is referred to law enforcement, then the name of the reporter must be given upon request; however, reporters are treated as confidential informants [49].

PENALTIES FOR FAILURE TO REPORT

According to Pennsylvania statutes, a person or official required to report a case of suspected child abuse or to make a referral to the appropriate authorities who willfully fails to do so commits a misdemeanor of the third degree for the first violation and a misdemeanor of the second degree for a second or subsequent violation [44; 54]. An offense is a felony of the third degree if all three of the following are true:

- The person or official willfully fails to report.
- The child abuse constitutes a felony of the first degree or higher.
- The person or official has direct knowledge of the nature of the abuse.

A person who commits a second or subsequent offense commits a felony of the third degree, except if the child abuse constitutes a felony of the first degree or higher, in which case the penalty for the second or subsequent offenses is a felony of the second degree. In addition, if a person's willful failure continues while the person knows or has reasonable cause to believe the child is actively being subjected to child abuse, the person commits a felony of the third degree; if the child abuse constitutes a felony of the first degree or higher, the person commits a felony of the second degree [44; 54]. The statute of limitations for an offense under this section shall be either the statute of limitations for the crime committed against the minor child or five years, whichever is greater.

BARRIERS TO REPORTING

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

- Professionals may not feel skilled in their knowledge base about child abuse and neglect. In addition, they lack the confidence to identify sexual and emotional abuse.

- Professionals may be frustrated with how little they can do about poverty, unemployment, drug use, and the intergenerational nature of abuse.
- Although professionals understand their legal obligation, they may still feel that they are violating patient confidentiality.
- Many professionals are skeptical about the effectiveness of reporting child abuse cases given the bureaucracy of the child welfare system.
- Practitioners may be concerned that they do not have adequate or sufficient evidence of child abuse.
- Practitioners may have a belief that government entities do not have the right to get involved in matters within the family.
- There may be some confusion and emotional distress in the reporting process.
- Practitioners may fear that reporting will negatively impact the therapeutic relationship.
- Some professionals have concerns that there might be negative repercussions against the child by the perpetrator.
- Some simply underestimate the seriousness and risk of the situation and may make excuses for the parents.

When interviewing children whose first language is not English, it is highly recommended that they be interviewed through the use of an interpreter. It can cause additional stress for children who struggle to find the right words in English, which can result in more feelings of fear, disempowerment, and voicelessness [41].

CASE SCENARIOS

In the following case scenarios, consider if the case should be reported as possible child abuse in accordance with Pennsylvania law.

A young girl, 2 years of age, is brought to the emergency department by her mother and stepfather for a scalp laceration. The girl is very quiet and appears listless and out of sorts. Her mother reports that she was injured when she fell onto a rock outside, but that the injury occurred when the girl was being watched by the stepfather. The girl undergoes assessment for traumatic brain injury, including assessment of function using the modified Glasgow Coma Score. The toddler is found to have mild impairment (a score of 13), and the follow-up test two hours later indicates normal functioning. The nurse notices that the toddler appears to be afraid of the stepfather, leaning away and crying when he is near her. The stepfather also appears to be easily frustrated with the child, saying that he does not know why she cries so much.

Aside from the physical injury, which could be consistent with the reported accident, this patient has some signs of bodily injury (e.g., flinches easily or avoids being touched) that may give a provider reasonable cause to suspect abuse. If the provider caring for this patient suspects that the stepfather may have neglected or physically abused her, they should make a report to ChildLine, which would initiate an investigation.

A boy, 13 years of age, is undergoing a routine physical exam with his family physician. The physician asks the boy if he is excited to start school in the next few weeks and how his baseball team is doing. The boy becomes quiet and states that he is nervous about an upcoming trip with his baseball team but does not give additional information. When asked directly, the boy says that he is uncomfortable with the new assistant coach, who watches pornography with them during out-of-town tournaments and supplies them with pornographic magazines. However, the boy states that he doesn't think it's a big deal and that "all of the other kids seem to really like it."

In this case, the physician should make a report to ChildLine. This would be classified as a CPS case, and an investigation would be conducted.

A girl, 6 years of age, visits the school nurse complaining of a stomach ache. She is disheveled in appearance, with torn, dirty clothing and unbrushed hair. She reports being hungry, as she did not have dinner the night before or breakfast this morning. She also reports that she has been sleeping in a car with her mother since they moved out of their apartment last month.

The signs in the case indicate poverty, not abuse. As such, a report should not be made to ChildLine. Instead, the patient and her family should be connected with available services and resources to assist in meeting their immediate needs.

CONCLUSION

Child abuse and neglect are considered significant social problems with deleterious consequences. As noted, a system has been implemented in all 50 states to ensure the safety of children, with laws defining what constitutes abuse and neglect and who is mandated to report. Healthcare professionals, regardless of their discipline or field, are in a unique position to assist in the identification, education, and prevention of child abuse and neglect. There are three key components of child abuse: a child victim and an act or failure to act (or series of acts or failures) engaged in intentionally, knowingly, or recklessly. The basis for reporting suspected child abuse is having reasonable cause to suspect a child is a victim of abuse. A person who has reasonable cause to suspect a child is a victim of child abuse is not required to identify the type of abuse they are reporting when making a report.

A mandated reporter must immediately make a report suspected child abuse to ChildLine if they have reasonable cause to suspect a child is a victim of child abuse under any of the following circumstances:

- The mandated reporter comes into contact with the child in the course of employment, occupation, and practice of a profession or through a regularly scheduled program, activity, or service.
- The mandated reporter is directly responsible for the care, supervision, guidance, or training of the child, or is affiliated with an agency, institution, organization, school, regularly established church or religious organization, or other entity that is directly responsible for the care, supervision, guidance, or training of the child.
- A person makes a specific disclosure to the mandated reporter that an identifiable child is the victim of child abuse.
- An individual 14 years of age or older makes a specific disclosure to the mandated reporter that the individual has committed child abuse.

It is not necessary for a child to come before the mandated reporter in order for the mandated reporter to make a report of suspected child abuse. In addition, the mandated reporter is not required to identify the person responsible for the child abuse in order to make a report. A person who has reasonable cause to suspect a child is a victim of abuse does not have to consider the exclusions from child abuse in order to make a report of suspected abuse. A mandated reporter is presumed to have acted in good faith when making a report.

It is the duty of all mandated reporters in the state of Pennsylvania to know their responsibilities and the laws that govern the reporting process. All reporters should adhere to the established laws and rules that govern child abuse reporting, taking into account the expanded definition of perpetrator, the updated processes in place for reporting cases of suspected child abuse, and the delineated roles of mandated reporters. Doing so will help ensure the safety of millions of children in Pennsylvania.

RESOURCES

ChildLine: Pennsylvania Child Abuse Hotline
1-800-932-0313

<https://www.dhs.pa.gov/keepkidssafe>

Child Welfare Information Gateway

330 C Street SW

Washington, DC 20201

1-800-394-3366

To report abuse: 1-800-422-4453

<https://www.childwelfare.gov>

Child Welfare League of America

727 15th Street NW, 12th Floor

Washington, DC 20005

202-688-4200

<https://www.cwla.org>

**National Council on Child Abuse
and Family Violence**

P.O. Box 5222

Arlington, VA 22205

202-429-6695

<https://www.preventfamilyviolence.org>

**Pennsylvania Chapter of Children's Advocacy
Centers and Multidisciplinary Teams**

P.O. Box 3323

Erie, PA 16508

814-431-8151

<https://penncac.org>

**Pennsylvania Child Welfare Information
Solution**

877-343-0494

<https://www.compass.state.pa.us/cwis>

Pennsylvania Department of Human Services

P.O. Box 2675

Harrisburg, PA 17105

1-800-692-7462

<https://www.dhs.pa.gov>

**University of Pittsburgh, Pennsylvania
Child Welfare Resource Center**

403 East Winding Hill Road

Mechanicsburg, PA 17055

717-795-9048

<http://www.pacwrc.pitt.edu>

FACULTY BIOGRAPHY

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

Previously acting as a faculty member at Capella University and Northcentral University, Dr. Yick Flanagan is currently a contributing faculty member at Walden University, School of Social Work, and a dissertation chair at Grand Canyon University, College of Doctoral Studies, working with Industrial Organizational Psychology doctoral students. She also serves as a consultant/subject matter expert for the New York City Board of Education and publishing companies for online curriculum development, developing practice MCAT questions in the area of psychology and sociology. Her research focus is on the area of culture and mental health in ethnic minority communities.

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