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[Continue to next page to start course]

New York: Child Abuse and Maltreatment/Neglect for Mandated Reporters (365)

Contact hours: 2
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Price: $26

Course Description

Starting September 1, 2025, every person who is required by the NYS Education Department to take the mandated training related to child abuse, including those who have previously undergone this training, must complete a new and updated training course by November 17, 2026.

Section 413 of the Social Services Law requires the mandated Identification and Reporting of Child Abuse and Maltreatment/Neglect coursework to include the addition of guidance on identifying an abused or maltreated child when such child is an individual with an intellectual or developmental disability.

This is an approved course in the Identification and Reporting of Child Abuse and Maltreatment, as mandated by Chapter 56 of the Laws of the updated 2025 amended Social Services Law § 413. Approval #80805.

Credit Reporting

Teachers: we report course completions for teachers to your NYS Dept of Education TEACH account.

Medical professionals and Social Service professionals: we report your course completions to the NYS Office of the Professions.

Course Objectives

When you finish this course, you will be able to*:

1. Describe the problem of child maltreatment in the United States (U.S.) and New York State.
2. Summarize the process of reporting to the NY Statewide Central Register (SCR).
3. Explain the 5 components of Child Protective Services (CPS).
4. Recognize the impact of trauma and ACEs on children, families, and yourself.
5. Recognize the impact of bias on your decision-making.
6. Define “reasonable cause to suspect”.
7. Define child abuse and maltreatment/neglect in New York State.
8. Describe 3 indicators each for physical, emotional, and sexual child abuse.
9. Understand the indicators and signs associated with maltreatment in children with intellectual and developmental disabilities (IDD).
10. Understand legal requirements when working with limited English proficiency, Native American, and immigrant clients.

*__Please note__: Attainment of course objectives will be assessed in the course evaluation.

1. The Grave Problem of Child Abuse

The recognition of child abuse in its multiple forms—physical, sexual, emotional abuse, and neglect—continues to be a considerable social and public health problem throughout the world. While every state, the District of Columbia, and the U.S. Territories mandate reporting by certain individuals, and most require training for those reporters, underreporting of suspected child abuse continues to be a problem.

Underreporting is often related to confusion, uncertainty, lack of knowledge about the signs of mistreatment, or the belief that the family can fix the problem on its own. A mandated reporter may genuinely feel that intervention will negatively affect the family and the child.

When the suspected abuser is someone trusted or respected in the community, a reporter may fear not being believed. If the reporter is a friend or acquaintance of the suspected abuser, the reporter may not want to cause trouble for their friend. Unfortunately, an abuser may threaten the mandated reporter, or the reporter may be concerned that a report may cause the abuser to harm the child.

Protecting the child's safety and concern for a child's emotional or mental health are primary reasons for filing a report of child abuse. Legal obligation is another reason to report suspected child abuse.

In 2023, the *Administration for Children and Families* (ACF) reported that more than 3 million children in the United States received either an investigation response or alternative response. Nearly 550,000 were determined to be victims of child abuse and neglect. Three-quarters of child victims experienced neglect, 17% were physically abused, more than 10% were sexually abused, nearly 7% were psychologically maltreated, and 0.2% were sex trafficked. Nationally, 2,000 children died from abuse and neglect (DHHS, 2025).

In New York State (2023), more than 190,000 referrals of child abuse or neglect received an investigation; nearly 57,000 were substantiated* victims. In 2021, two-thirds of child fatalities were younger than 3 years; close to one-half of child fatalities were younger than 1 year. Although the victimization rates are higher for girls, boys have a higher child fatality rate than girls (DHHS, 2023).

***Substantiated**: An investigation disposition that concludes that the allegation of maltreatment or risk of maltreatment was supported or founded by state law or policy.

American Indian/Alaska Native children have the highest rate of child victimization followed by Black children. Child **fatality rates** are highest among Black/African American populations, followed by American Indian/Alaska Natives, and Native Hawaiian/Pacific Islanders (DHHS, 2025).

It is believed that overall, the numbers underestimate how many children are affected by maltreatment because many cases go unreported or undetected. Physical and emotional scars can last a lifetime and are linked to higher rates of alcoholism, drug abuse, depression, smoking, multiple sexual partners, suicide, and chronic disease.

2. Reporting to the Statewide Central Register (SCR)

The *Child Protective Services Act of 1973* established the SCR as the primary recipient of calls regarding suspected abuse and maltreatment of children in New York State. Trained Child Protective Specialists receive calls through the toll-free telephone lines 24 hours a day, 7 days a week, 365 days a year [Social Services Law (SSL) §422(2)(a)].

Calls to the SCR come through the:

- Mandated Reporter Line (1-800-635-1522)
- Public Line (1-800-342-3720)
- Mandated Reporter Fax Line (1-800-635-1554)
- Hearing Impaired TTY Line (1-800-638-5163)

The SCR is equipped to receive calls from those who are Limited English Proficient (LEP) on either the public or mandated reporter line by use of a telephone language interpretation service. SCR functions as a single contact for reporting child abuse or maltreatment while child protective services (CPS) offices are found in each local department of social services.

Within 48 hours of an oral report, mandated reporters must file a signed, written report called: *Report of Suspected Child Abuse or Maltreatment* (LDSS-2221A). If as a mandated reporter you believe that a child is in immediate danger, call 911 or your local police department.

While anyone may make a report of suspected abuse, reports made by mandated reporters are more likely to be **registered**—accepted by the SCR for further investigation. It is likely because of better reporting based on training and professional awareness.

For more information see: https://ocfs.ny.gov/programs/cps/manual/.

New York Mandated Reporters

The following persons are mandated to report or cause a report to be made when they have reasonable cause to suspect that a child coming before them in their professional capacity is an abused or maltreated child [SSL §413(1)(a)].

(List periodically revised and updated through legislation)

Any physician	Licensed marriage and family therapist
Registered physician assistant	Licensed mental health counselor
Surgeon	Licensed psychoanalyst
Medical Examiner	Licensed behavior analyst
Coroner	Certified behavior analyst assistant
Dentist	Hospital personnel engaged in the admission, examination, care, or treatment of persons
Dental hygienist	A Christian Science practitioner
Osteopath	School official, which includes, but is not limited to, any school administrator, teacher, psychologist, social worker, nurse, guidance counselor, or other school personnel required to hold a teaching or administrative license or certificate
Optometrist	Full- or part-time compensated school employee required to hold a temporary coaching license or professional coaching certificate
Chiropractor	Employee or volunteer in a residential care facility for children that is licensed, certified, or operated by OCFS
Podiatrist	Mental health professional
Resident	Substance abuse counselor
Intern	Alcoholism counselor
Psychologist	All persons credentialed by the Office of Alcoholism and Substance Abuse Services
Registered nurse	Peace officer
Social Worker	Police officer
Emergency medical technician	District attorney or assistant district attorney
Licensed creative arts therapist	Investigator employed in the office of a district attorney
Social services worker (See Section A.2, Reporting requirement applicable to social services workers only of this chapter for special requirements applicable to social services workers only)	Other law enforcement official
Employee of a publicly funded emergency shelter for families with children	
Director of a children's overnight camp, summer day camp or traveling summer day camp, as such camps are defined in Section 1392 of the Public Health Law	
Day care center worker	
School-age child care worker	
Provider of family or group family day care	

Source: NYSOCFS, 2025.

2.1 What Is a Mandated Reporter's Role?

[Unless otherwise noted, this section is from NYS Social Services Law §413.]

While acting in their professional or official capacity, a mandated reporter's role is to:

Report suspected incidents of child abuse or maltreatment/neglect.

Make the report to the Statewide Central Register immediately upon the development of *reasonable cause to suspect* child abuse or maltreatment.

A report is required when:

A reporter has reasonable cause to suspect that a child coming before the reporter in his or her professional or official capacity is an abused or maltreated child.

A reporter has reasonable cause to suspect that a child is an abused or maltreated child where the parent, guardian, custodian, or other person legally responsible for the child comes before them in their professional official capacity and states—from personal knowledge—facts, conditions, or circumstances that, if correct, would render the child an abused or maltreated child.

The law also states that (1) whenever a mandated reporter is required to report as a member of the staff of a medical or other public or private institution, school, facility, or agency, he or she shall make the report as required—reports must contain the names of all other staff persons with direct knowledge of the allegations—but the law does not require more than one report from the agency for a single incident; and, (2) no retaliatory personnel action is allowed.

2.2 Institutions with Multiple Mandated Reporters

[Unless otherwise noted, the following section is from [NYSOCFS, 2025].

Whenever someone is required to report in their capacity as a member of the staff of a medical or other public or private institution, school, facility, or agency, they shall make the report and immediately notify the person in charge of such institution, school, facility, or agency, or their designated agent [SSL §413(1)(b)].

The mandated reporter law is not intended to require more than one report from any institution, school, facility or agency on any one incident of suspected child abuse or maltreatment [SSL §413(1)(b)].

No institution, school, facility or agency is permitted to take any retaliatory personnel action against an employee who made a report to the SCR or to impose any conditions, including prior approval or prior notification, upon a member of its staff mandated to report suspected child abuse or maltreatment [SSL 413(1)(c)].

The Office of Children and Family Services (OCFS) has provided guidance specifying how mandated reporters and organizations may fulfill their responsibility to report in situations in which there are multiple mandated reporters with direct knowledge of the situation. This guidance can serve to both facilitate the communication to the SCR of all pertinent information and relieve the burden for every mandated reporter with direct knowledge of the situation to call in separate reports.

Any person, institution, school, facility, agency, organization, partnership, or corporation that employs mandated reporters will provide all current and new employees with written information explaining reporting requirements. The employers are responsible for the costs associated with printing and distributing the written information.

Any state or local governmental agency or authorized agency that issues a license, certificate, or permit to an individual to operate a family daycare home or group family daycare home shall provide each person currently holding or seeking such a license, certificate, or permit with written information explaining the reporting requirements.

Any organization or person that employs mandated reporters, and whose employees, in the normal course of their employment, travel to locations where children reside, shall provide all such current and new employees with information on recognizing the signs of an unlawful methamphetamine laboratory. The office of alcoholism and substance abuse services shall provide employers with information on recognizing the signs of unlawful methamphetamine laboratories.

The Office of Children and Family Services shall update training issued to persons and officials required to report cases of suspected child abuse or maltreatment to include protocols to reduce implicit bias in the decision-making processes, strategies for identifying adverse childhood experiences, and guidelines to assist in recognizing signs of abuse or maltreatment while interacting virtually (NYS Senate, 2024, November 11).

2.3 Additional Requirements for Social Service Workers

Social services workers **only** are additionally required to report or cause a report to be made when any person comes before them in their professional or official capacity with information from personal knowledge that causes them to have reasonable cause to suspect that a child is an abused or maltreated child [SSL §413(1)(d)]. All other mandated reporters are required to report or cause a report to be made only when confronted with a child whom they suspect to be abused or maltreated or when a parent, guardian, custodian or other person legally responsible for a child provides information which, if true, would mean that child was abused or maltreated [SSL §413(1)(a)]. Further, any person is permitted to report any reasonable suspicion of abuse or maltreatment no matter how that information is brought to their attention [SSL §414], and OCFS encourages such reporting (NYSOFCS, 2025).

2.4 Alternatives to Reporting

Families in crisis may not meet the legal criteria required to call the SCR and may be better served by being connected to a variety of community services in their area. An *alternative response* is a response other than an investigation that determines if a child or family needs services. Alternative responses usually include the voluntary acceptance of CPS services. The term “disposition” is used when referring to both investigation response and alternative response (DHHS, 2023).

In New York, *Family Assessment Response* (FAR) is the state’s alternative Child Protective response to some reports of child maltreatment. FAR does **not** require an investigation and determination of allegations and individual culpability for families reported to the SCR (NYSOCFS, 2025).

2.4.1 Family Assessment Response (FAR)

To allow for a more flexible response to families reported to the SCR, New York State enacted a law authorizing a dual track child protective system [SSL §427-a]. The law prescribes the broad parameters of *Family Assessment Response* (FAR) and allows local departments of social services (LDSSs) that are authorized to establish a FAR program considerable flexibility to develop approaches that best match local resources, staffing capacity, and needs of families (NYSOCFS, 2025).

FAR is an alternative child protective response to reports of child abuse and maltreatment in which no formal determination is made as to whether a child was abused or maltreated and is based on principles of family involvement and support consistent with maintaining the safety of the child. In FAR, the family and CPS jointly participate in a comprehensive assessment of the family's strengths, concerns, and needs, and plan for the provision of services that are responsive to the family's needs and promote family stabilization, for the purpose of reducing risks to children in the family [18 NYCRR 432.13(a)(1)] (NYSOCFS, 2025).

2.4.2 H.E.A.R.S.

The OCFS H.E.A.R.S. program **h**elps, **e**mpowers, **a**dvocates, **r**eassures, and **s**upports families by providing resources and referrals to a variety of services such as food, clothing, housing, childcare, parenting education, and more. Representatives are available to help Monday through Friday 8:30am-4:30pm. If you know a family that could use support, please ask them to call the OCFS HEARS family line at 888-554-3277.

2.4.3 NY Project Hope

NY Project Hope provides emotional support for New York State residents. This includes an Emotional Support Helpline (1-844-863-9314), Online Wellness Groups, and a website filled with supportive resources (NYProjectHope.org).

2.4.4 Prevent Child Abuse New York

Prevent Child Abuse New York also has a prevention and parent helpline available for parents and caregivers. It is confidential and multi-lingual and can refer or connect caregivers to community-based services. This helpline is available Monday through Friday from 9am-4pm at 1-800-CHILDREN.

2.4.5 Calling 211

Parents and caregivers may also call 2-1-1, operated by the United Way, for health and human services information, referrals, assessments, and crisis support to help them find the assistance they need to address the everyday challenges of living, as well as those that develop during times of disaster or other community emergencies. 2-1-1 is multi-lingual and available 24 hours a day 7 days a week.

3. Child Protective Services

Each state has mandatory reporting laws that require certain professionals and institutions to report suspected child maltreatment to a **child protective services (CPS)** agency. These mandated reporters are in a unique position to recognize and report abuse and neglect.

The *New York State Child Protective Services Act of 1973* encourages more complete reporting of child abuse and maltreatment, provides for the swift and competent investigation of such reports, protects children from further abuse and maltreatment, and provides rehabilitative services [SSL §411].

CPS has five fundamental components:

1. State Central Register (SCR) of reports.
2. Third-party recognition of children in danger, including mandatory and voluntary reporting of suspected child abuse and maltreatment.
3. Child Protective Services to:
    a. verify reports,
    b. provide immediate protection of children, and
    c. provide rehabilitative and ameliorative services to help families.
4. Emergency protective custody of children in “imminent danger”.
5. When necessary, family court action to remove a child, remove the allegedly abusive or neglectful parent from the child’s residence, impose treatment and/or criminal court action (by referring the perpetrator to law enforcement for prosecution).

The laws that guide New York CPS services are Article 6, Title 6 of the Social Services Law.

3.1 When You Make the Call

When you make a call, it will be answered by a CPS specialist trained to help you through the process of making a report. Be prepared to articulate your concerns clearly and concisely, and to provide as much information as you can to help the CPS specialist make a determination of abuse.

3.2 The LDSS-2221A Form

The LDSS-2221A form helps you organize your thoughts and gather the information you need in preparation for making the call. Although the child’s welfare is the top priority rather than completing the form, a CPS specialist will help you complete the form and ask you many of the same questions that appear on the form (NYSOCFS, 2024 April).

While gathering information to make a report, ask yourself the following questions:

- What is the role of the parent (or the person legally responsible)?
- What information can I provide to show who is responsible?
- Is this situation part of an ongoing pattern?
- Where is the child now?
- What do I know about the child's siblings?
- Does the child have any special needs? If so, what are they?
- Is an interpreter needed?
- Is the child on any medications?
- Are there any other related issues that could be helpful for a local caseworker to know?
- Are there personal safety issues for a local CPS case worker (ie, dogs, guns in the home, etc.)?
- When and how can I best be reached, including after hours?

The CPS specialist will want to know your suspicions and concerns relative to the child and if the child has been subjected to harm and why. Close and consistent contact with a child may give you an advantage in assessing the situation. In addition, you will need to provide some identifying information so the local CPS agency will be able to locate the child (SSL §415; NYSOCFS, 2024 April).

Just because you are calling as a mandated reporter does not mean your report will automatically be registered. If your report is not registered, the reason should be clearly explained to you, and you should be offered the opportunity to speak with a supervisor. Some reports are not registered because CPS intervention is not the appropriate response. In those cases, preventive services may be needed, and you can call the local CPS directly to obtain a referral for the family.

If your report is registered, be sure to ask for and write down the call identification number assigned to your report and the full name of the CPS specialist who took your report. You can also request a "Summary of Findings": a brief report made by the local agency after the investigation and its outcome are complete (NYSOCFS, 2024 April).

3.3 CPS Response

[Unless otherwise indicated, the following information is from NYSOCFS, 2024 April]

When a report is registered, it is immediately transmitted to the local CPS agency, which must begin an investigation within 24 hours. Some reports may require emergency action, but these are often difficult decisions, and the local caseworker will usually consult with a supervisor and the source of the report to make such a decision.

The investigation will encompass two interrelated and simultaneous processes:

- Investigation to determine if there is some credible evidence of abuse or maltreatment.
- Development of a service plan.

During its investigation, caseworkers, in addition to visiting the family, may call or visit relatives, schools, doctors, hospitals, police, and any other service provider or agency that might have information about the child. The local CPS must assess the safety, risk, and well-being of the child identified in the report and any other children living in the home. After evaluating all information collected, caseworkers will make a determination.

If a report is determined to be unfounded—no credible evidence was found—it is sealed and will be expunged ten years after receipt. In some situations, unfounded cases may be referred for community services.

If the investigation reveals credible evidence—evidence "worthy of belief"—the report remains on file at the agency. If a service plan was developed, provision of the services is monitored, and once services are no longer needed, the case is closed.

3.4 Following Up the Call

[Unless otherwise indicated, the following information is from NYSOCFS, 2024 April]

There may be times when you have very little information on which to base your suspicion of abuse or maltreatment, but this should not prevent you from calling the SCR if you believe you have reasonable cause. A trained specialist at the SCR will help to determine if the information you are providing can be registered as a report.

If your report is registered you will be given a call identification number, which you will need to note in the space marked at the upper right corner of the form LDSS-2221A. If the SCR staff does not register the child abuse or maltreatment report, the reason for their decision should be clearly explained to you. You may also request to speak to a supervisor, who can help make determinations in difficult or unusual cases.

As soon as you complete your call to the SCR you must immediately notify the person in charge (or their designated agent) at your institution, school, facility, or agency and give them the information you reported to the SCR, including the names of other persons identified as having direct knowledge of the alleged abuse or maltreatment and other mandated reporters identified as having reasonable cause to suspect. Once people in charge (or their agents) have been notified of the report to the SCR, they become responsible for all subsequent administration concerning the report, including preparation and submission of the form LDSS-2221A.

Remember

Crimes committed against children should be directly reported to law enforcement. If you are not certain if an action is criminal, you may contact someone at SCR who is trained to make the appropriate distinctions and can make a **Law Enforcement Referral (LER).**

In cases of imminent danger, it may be necessary to contact law enforcement.

4. Trauma and Adverse Childhood Experiences (ACEs)

4.1 Trauma

Trauma is the result of experiencing a frightening, dangerous, or violent event that poses a threat to an adult or child's life, safety, or bodily integrity. Witnessing a traumatic event that threatens the life or physical security of a loved one can also be traumatic. This is particularly important for young children as their sense of safety depends on the perceived safety of their parents of caregivers.

Traumatic experiences often initiate strong emotions and physical reactions that can persist long after the event. Children may feel helplessness, fear, and physiological reactions such as heart pounding, vomiting, or loss of bowel or bladder control. Children who feel unable to protect themselves or who lack protection from others to avoid the consequences of the traumatic experience may also feel overwhelmed by the intensity of physical and emotional responses (NCTSN, nd).

4.1.1 Complex Trauma

Complex trauma describes both a child's exposure to multiple traumatic events—often of an invasive, interpersonal nature—and the wide-ranging, long-term effects of this exposure. Abuse or profound neglect are severe and pervasive especially when they occur early in life. They can disrupt many aspects of the child's development and the formation of a sense of self. Since these events often occur with a caregiver, they interfere with the child's ability to form a secure attachment. Many aspects of a child's healthy physical and mental development rely on this primary source of safety and stability (NCTSN, nd).

4.1.2 Early Childhood Trauma

Early childhood trauma generally refers to the traumatic experiences that occur to children aged 0-6. Because an infant's or young child's reactions may be different from those of older children, and because they may not be able to verbalize their reactions to threatening or dangerous events, many people assume that young age protects children from the impact of traumatic experiences (NCTSN, nd).

A growing body of research has documented that young children can be affected by events that threaten their safety or the safety of their parents or caregivers. These traumas can be the result of intentional violence—such as physical or sexual abuse, domestic violence, or the result of natural disasters, accidents, or war. Young children may also experience traumatic stress in response to painful medical procedures or the sudden loss of a parent or caregiver (NCTSN, nd).

4.1.3 Historical Trauma

Trauma due to systemic racism and discrimination, the impact of multigenerational poverty, and limited educational and economic opportunities intersect and exacerbate adverse childhood experiences. Historical power imbalances have had a profound effect on certain racial and ethnic groups: early deaths, unnecessary disabilities, and enduring injustices and inequalities (Global Health 50/50, 2020).

Structural racism is rooted in a hierarchy that privileges one race over another, influencing institutions that govern daily life, from housing policies to police profiling to incarceration (Muramatsu and Chin, 2022). Over centuries, structural racism has become entrenched, influencing the way medicine is taught and practiced as well as the functioning of healthcare organizations (Geneviève et al., 2020).

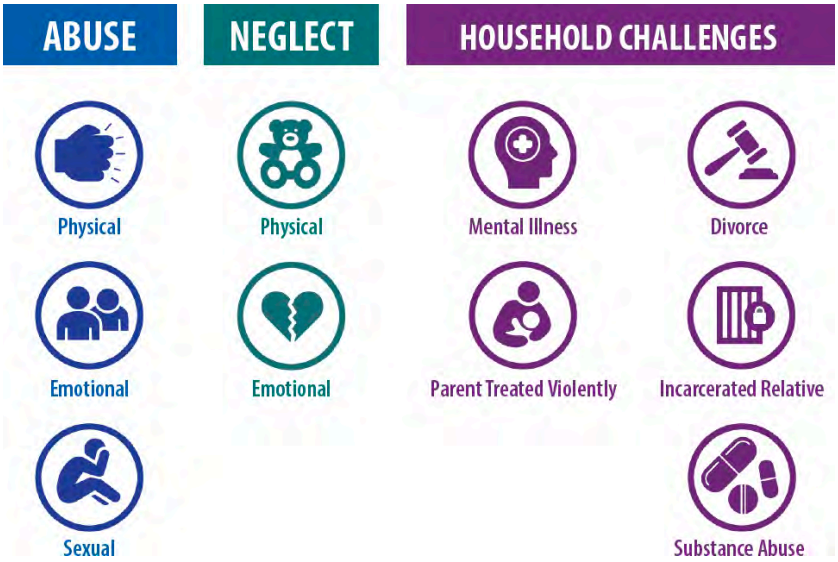
The unequal burden of COVID-19 on underserved populations has forced the medical community to reckon with uncomfortable truths about its role in perpetuating structural racism in modern society. A race-conscious conversation in medicine is evolving that acknowledges race as a social construct that creates and upholds barriers underlying health disparities (Santos, Dee, and Deville, 2021).

4.2 Adverse Childhood Experiences (ACEs)

Adverse childhood experiences, or ACEs, are preventable, potentially traumatic events that occur in childhood. These experiences can be caused by neglect, experiencing, or witnessing violence, or having a family member attempt suicide or die by suicide. Abuse and neglect, substance use, family members with mental health problems, parental separation or incarceration, and household violence can also undermine a child's sense of safety, stability, and bonding (NCTSN, nd).

These experiences, and their negative impact on health over time—including the intersection of ACEs, suicide, and overdose—are interrelated and preventable. Living in under-resourced or racially segregated neighborhoods, frequently moving, being subjected to homelessness, or experiencing food insecurity can be traumatic and exacerbate the effects of other ACEs (NCTSN, nd).

Adverse childhood experiences are common across all socioeconomic groups. Children who have been subjected to a higher number of adverse events, particularly in the absence of protective factors, are more likely to experience ongoing trauma, negative health outcomes, and increases in chronic health conditions such as obesity, diabetes, and heart disease.



Source: CDC, Public Domain.

Source: CDC, Public Domain.

4.3 Trauma Informed Practice

> Trying to implement trauma-specific clinical practices without first implementing trauma-informed organizational culture change is like throwing seeds on dry land.
>
> Sarah Bloom, MD
>
> Advancing Trauma-Informed Care

Trauma-informed practice is a model for engaging with individuals and families that recognizes the impact and influence that trauma may have on the individuals and families you serve. An important part of a trauma-informed practice is to avoid the inadvertent re-traumatization of individuals through your own interactions with them and to understand that trauma may have an impact on a person's behavior.

4.3.1 Key Elements of Trauma-Informed Practice

Including the patient in all treatment decisions is a key element of trauma-informed care. Additional key elements include:

- Screening for trauma
- Training staff in trauma-specific care
- Creating a safe environment

Trauma-informed practice assists you in identifying when your own past experiences or trauma may impact the way you evaluate an incident you encounter in your professional role.

4.3.2 Protective Factors

In the past, child maltreatment prevention and intervention strategies have focused on eliminating risk factors—conditions, events, or circumstances that increase a family's chances for poor outcomes. This emphasis on family risks, such as maternal depression, family violence, or history of maltreatment often left families feeling stigmatized or unfairly judged (CWIG, 2020).

A "protective factors approach" to the prevention of child maltreatment focuses on positive ways to engage families by emphasizing their strengths. It focuses on what parents and caregivers are doing well by identifying areas where families have room to grow with support (CWIG, 2020).

A protective factors approach includes strategies to mitigate the long-term consequences of adverse experiences by:

1. Strengthening economic supports for families.
2. Promoting social norms that protect against violence and adversity.
3. Ensuring a strong start for children.
4. Enhancing skills to help parents and youths handle stress, manage emotions, and tackle everyday challenges.
5. Connecting youths to caring adults and activities.
6. Intervening to lessen immediate and long-term harms.

Using this approach, agencies can build capacity and partnerships with other service providers—such as early-childhood and youth-service systems—that are likely to enhance support for children and families and promote their well-being. Children, youth, and families can build resilience and develop skills, characteristics, knowledge, and relationships that offset risk exposure and contribute to both short- and long-term positive outcomes (CWIG, 2020).

Families, communities, practitioners, and advocates can help foster social and emotional competencies at the individual, family, and community levels. These strategies help children who experience adversity develop resilience and skills. Adverse childhood experiences can be mitigated by positive childhood experiences, and more children can have healthy environments in which to play, learn, and grow into mentally, emotionally, and physically healthy adults (CWIG, 2020).

Source: CDC, Public Domain.

5. The Impact of Bias on Decision Making

5.1 Implicit (and Explicit) Bias

A bias is a personal and sometimes unreasoned judgment against a person, place or thing. Implicit biases are a biases or prejudices that are present but not consciously held or recognized so we are often unaware of them.

An explicit bias is a personal and unreasoned judgement that we have about a person, place or thing on a conscious level. Both implicit and explicit biases can show up as prejudice, discrimination or oppression on individuals, groups or within a system.

Decades of research have demonstrated that discrimination, driven by implicit bias, impacts healthcare access, trust in clinicians, care quality, and patient outcomes (Dirks et al, 2022). Implicit bias is widespread, even among individuals who explicitly reject prejudice (Payne et al., 2019). The troubling thing for healthcare professionals is the possibility that biased judgment, and biased behavior can affect patient care (FitzGerald et al., 2019).

5.2 Decision Making and Diagnostic Bias

> The use of racial terms to describe epidemiologic data perpetuates the belief that race itself puts patients at risk for disease, and this belief is the basis for race-based diagnostic bias. Rather than presenting race as correlated with social factors that shape disease or acknowledging race as an imperfect proxy for ancestry or family history that may predispose one to disease, the educators we observed portrayed race itself as an essential—biologic—causal mechanism.
>
> Amutah, et al., 2021
>
> New England Journal of Medicine

Healthcare providers are vulnerable to a range of biases when making decisions, particularly diagnostic and treatment decisions. Many biases have been described in the healthcare literature, and many of these have been shown to influence decisions (Featherston et al., 2020).

Patient-provider interactions, treatment decisions, patient adherence to recommendations, and patient health outcomes can be influenced by bias. This can lead to an unintentional form of discrimination that affects decision-making structurally and systematically and is hard to identify and uncover (Nápoles et al., 2022).

Studies have shown that implicit racial bias profoundly influences clinical decision-making. It affects nonverbal behaviors such as eye contact and posture and has been shown to influence the quality of a provider's interpersonal communications and, in turn, the patient's trust and perception of the provider (van Ryn et al., 2015).

5.3 The Impacts of Bias in Child Welfare

Significant disparities exist throughout the child welfare system. Research has shown that mandated reporters' decisions to report a family to the Statewide Central Register is often influenced by biases and personal beliefs. An implicit bias may even sway you to make a report against one parent or caregiver and not another even when the objective facts and information are the same.

Research also shows that these biases contribute to a disproportionate number of reports being called into the SCR on specific individuals or groups—including communities of color and Black communities in particular—more than others. This leads to a disproportionate level of CPS involvement in certain communities that can have long-lasting and devastating impacts on families and communities (NYSOCFS, 2024).

Once reported, cases involving Black children are more likely than others to:

- be accepted for investigation,
- be confirmed,
- be brought to court, and
- result in removal of the children from their families. (Palusci and Botash, 2021).

Furthermore, it is likely that family separations in these cases will be longer, and the cases will take longer to be closed. Multiple points in this process are subject to bias, but the process begins with reporting (Palusci and Botash, 2021).

When assessing information received about a child and their family, instead of making assumptions or jumping to conclusions that a child is being maltreated or abused, mandated reporters must evaluate potential biases that affect their decision to report (NYSOCFS, 2024).

For example, would your decision to call the Statewide Central Register with a report of suspected child maltreatment or abuse change if any of the following were different?

- race or ethnicity
- primary spoken language
- age
- neighborhood where they reside
- occupation
- presence of a disability
- socioeconomic status of the family
- gender identity or expression
- sexual orientation or sexual expression
- culture and/or immigration status
- religion (NYSOCFS, 2024)

Similarly, when considering **not** to report, check if these thoughts are coming up: "they are such a good family," "I have known them since they were children," "my patients would never do that," or similar emotional reasoning (Palusci and Botash, 2021).

Keep in mind that you can support a family without having to a report them by approaching the situation with empathy, compassion, care, and curiosity. Also consider if the needs of the family can be met through other means outside of the CPS system.

6. General Framework

6.1 Who Is Mandated to Report?

Mandated reporters are those individuals who are required by law to report suspected child abuse or maltreatment to the Statewide Central Register of Child Abuse and Maltreatment (SCR), operated by the New York State Office of Children and Family Services (OCFS) [SSL §413] (NYSOCFS, 2025).

Mandated reporters are mandated to make a report, or cause a report to be made, when they have *reasonable cause to suspect* that a child coming before them in their *professional or official capacity* is abused or maltreated, or when they have reasonable cause to suspect that a child is an abused or maltreated child where the parent, guardian, custodian or person legally responsible for the child comes before them in their professional or official capacity and states from personal knowledge facts, conditions, or circumstances which, if correct, would render the child an abused or maltreated child (NYSOCFS, 2025).

6.1.1 What Is Reasonable Cause to Suspect?

Reasonable cause to suspect child abuse or maltreatment means that, based on your factual observations, professional training, and experience, you have a suspicion that a parent or other person legally responsible for a child is responsible for harming that child or placing that child in imminent danger of harm. Your suspicion can be as simple as distrusting an explanation for an injury (SSL §413; NYSOCFS, 2024 May 2).

Distrust or doubt is enough; inconsistent explanations that do not match your observations or knowledge may be the cause of reasonable suspicion. You do not have to be positive, nor do you have to have proof the abuse or maltreatment is occurring or has occurred. When you have reasonable cause to suspect, it is your duty as a mandated reporter to call the SCR immediately and make a report.

Your duty is not relieved because another agency or individual has filed or may have filed a report. You **must** file a report as well. The sooner an incident is reported, the sooner protection for the child and assistance to the family can be provided. In addition, what you observe may be different from what others report, and all the information together is relevant to the SCR to determine whether to register a report.

When analyzing a situation for reasonable cause to suspect child abuse or maltreatment, organize your thinking by asking yourself these four questions:

1. What indicators are present?
2. Is there reasonable cause to suspect abuse or maltreatment?
3. Is there a parent or other person responsible for the suspected abuse or maltreatment?
4. What are my next steps?

6.1.2 What Is Professional Capacity?

Mandated reporters are required to report suspected child abuse or maltreatment when they are presented with a reasonable cause to suspect child abuse or maltreatment in a situation where a child, parent, or other person legally responsible* for the child is before the mandated reporter when the mandated reporter is acting in their official or professional capacity (NYSOFCS, 2024 April).

***Other person legally responsible**: a guardian, caretaker, or other person 18 years of age or older who is responsible for the care of the child.

Individuals operating in their professional role are legally mandated to report suspected child abuse or maltreatment whenever they are practicing their profession. For example, a doctor who is examining a child in their practice and has a reasonable suspicion that the child is experiencing abuse must report their concern (NYSOFCS, 2024 April).

In contrast, a doctor who witnesses child abuse when riding her bike while off-duty is not legally mandated to report that abuse but may choose to report. The mandated reporter's legal responsibility to report suspected child abuse or maltreatment ceases when the mandated reporter stops practicing their profession (NYSOFCS, 2024 April).

Scenario

A 7-year-old boy comes to the doctor's office for a physical. He has a bruise on the left side of his face and scratches along his left arm. The boy claims he fell off his bicycle. He lives with his mother, a single parent. His mother says he is very active and sometimes is a behavior challenge at school.

What indicators are present?

Bruises and scratches

Is there reasonable cause to suspect abuse or maltreatment?

No, the story is consistent with a bike injury. Injuries from an accidental fall would be along one side of the body.

Is there a person responsible for the suspected abuse or maltreatment?

No

What are your next steps?

Treat the child's injuries as needed

Note: Please see also other cases in Module 11: Scenarios for Mandated Reporters to Consider.

6.2 Person Legally Responsible

Knowing who has caused harm to a child is a significant factor in determining how to proceed. According to the Family Court Act (Fam. Ct. Act §1012(g)), persons legally responsible include the child's custodian, guardian, or any other person 18 years old or older responsible for the child's care at the relevant time. Custodian may include any person continually or at regular intervals found in the same household as the child when the conduct of such person causes or contributes to the abuse or maltreatment of the child.

The SCR only registers a report against a parent, guardian, or other person eighteen years of age or older who is legally responsible for the child. Once the SCR registers a report, the person named as causing the harm to the child becomes the subject of the report.

Teachers in most public or private schools do not qualify as subjects of reports when they are acting as teachers. They may be subjects when the incident involves their own child or a child for whom they have legal responsibility outside their role as a teacher.

6.3 Liability and Immunity

A mandated reporter's willful failure to report suspected child abuse or maltreatment is a Class A misdemeanor (punishable by up to a year in jail and/or a fine of up to $1,000) and the mandated reporter can also be held civilly liable for the damages proximately caused by the failure to report [SSL 420]. When a commissioner of social services in a LDSS has reasonable cause to suspect that a mandated reporter has willfully failed to report a case of suspected child abuse or maltreatment, the commissioner must inform the district attorney of the suspected failure [18 NYCRR 432.8] (NYSOFCS, 2025).

CPS is required by law to refer to the appropriate law enforcement agency or district attorney, any case where CPS suspects the reporter knowingly made a false report of child abuse or maltreatment. Any person making a child abuse or maltreatment report who knows the information reported to be false or baseless may be guilty of a class A misdemeanor.

6.3.1 Immunity from Liability

All mandated reporters who have reported suspected child abuse or maltreatment are presumed to have done so in good faith if they made the report during the discharge of their duties and within the scope of their employment. Mandated reporters who report, take photographs, take protective custody of a child, or disclose CPS information in compliance with the Social Services Law are immune from both civil and criminal liability for actions taken in good faith [SSL §419]. This immunity does not prevent civil or criminal proceedings from being filed, but presumed good faith provides a defense against libel, slander, invasion of privacy, false arrest and other types of law suits that might be filed by persons who feel that their rights were violated, provided that the person was acting without willful misconduct or gross negligence [SSL §419; FCA §1024(c)] (NYSOCFS, 2025).

6.3.2 Source Confidentiality

Social Services Law provides confidentiality for mandated reporters and all sources of child abuse and maltreatment reports. The Office of Child and Family Services and local CPS units are not permitted to release to the subject of the report any data that would identify the source of a report unless the source has given written permission for them to do so. Information regarding the source of the report may be shared with court officials, police, and district attorneys, but only in certain circumstances (NYSOFCS, 2024 April).

6.3.3 Protection from Retaliatory Personnel Action

Section 413 of the Social Services Law specifies that no medical or other public or private institution, school, facility, or agency shall take any retaliatory personnel action against an employee who made a report to the Statewide Central Register. Furthermore, no school, school official, childcare provider, foster care provider, or mental health facility provider shall impose any conditions, including prior approval or prior notification, upon a member of their staff mandated to report suspected child abuse or maltreatment (NYSOFCS, 2024 April).

6.4 Imminent Danger

Imminent danger means that a child is unsafe or at immediate risk or substantial risk of harm. Imminent danger considers the distance between a child and the harm created by a parent's (or other person legally responsible) actions or failure to act. The danger to the child must be immediate or nearly immediate.

When assessing imminent danger, apply the standard of reasonableness: Ask yourself, "Is it reasonable to believe an intervention could occur?" If the answer is yes, then there is no immediate danger. If the answer is no, then it is reasonable to assume that harm could occur and there is imminent danger.

For example, if a parent swings an object at a child's head and misses, the danger is imminent. The only additional thing needed for injury would have been for the parent to succeed rather than miss. In this instance, it is reasonable to believe this could have happened.

If a child is in imminent danger, first call 911 or the police department, and then call the Statewide Central Registry (SCR). Scenarios in which such action might be appropriate could include a parent who arrives to pick up their child from an appointment, is driving their own car, smells of alcohol, and has clearly been drinking; or a home visit reveals several young children fighting while in the care of a 12-year-old sibling who cannot control them and has no idea where the parents are.

6.5 Law Enforcement Referrals

If a call to the SCR provides information about an immediate threat to a child or a crime committed against a child, but the perpetrator is not a parent or other person legally responsible for the child, the SCR staff will make a **Law Enforcement Referral** (LER). The relevant information will be recorded and transmitted to the *New York State Police Information Network* or to the *New York City Special Victims Liaison Unit*. This is not a CPS report, and local CPS will not be involved (NSOCSF, 2024 April).

6.5.1 When to Report to the Justice Center

The *Protection of People with Special Needs Act* (Act) requires persons who are mandated reporters to report abuse, neglect, and significant incidents involving vulnerable persons to the *Vulnerable Persons' Central Register* (VPCR) operated by the NYS Justice Center for the Protection of People with Special Needs (http://www.justicecenter.ny.gov/).

Under the Act, mandated reporters to the SCR are also mandated reporters to the VPCR, except for daycare providers and staff. Daycare providers and staff are mandated reporters to the SCR, but not to the VPCR.

Effective June 30, 2013, persons who are mandated reporters under the Act have a legal duty to:

- Report to the Justice Center, by calling the VPCR at 855 373 2122, if they have reasonable cause to suspect abuse or neglect of a Vulnerable Person, including any person receiving residential services in a facility operated by, or provider agency facility licensed or certified by, the Office of Children and Family Services (OCFS).
- Report all Significant Incidents regarding vulnerable persons to the Justice Center by calling the VPCR at: 855 373 2122.
- Continue to call the SCR if they have reasonable cause to suspect abuse or maltreatment of children in family and foster homes, as well as day care settings. Suspicion of child abuse or maltreatment in a day care setting, foster care, or within a family home must continue to be reported to the SCR at 800 635 1522.

Note: If you are confused about where to call, the trained professionals at either location can help you get to the right place. The most important thing is to **make the call!**

6.5.2 Mandated Reporter Records

Upon request, CPS may obtain from the mandated reporter any records that are essential to a full investigation of alleged child abuse and maltreatment. The mandated reporter must determine which records are essential to the full investigation and provide those records to CPS when requested to do so. Within 60 days of initiating the investigation, CPS will determine whether the report is indicated or unfounded. Mandated reporters may ask to be informed of the outcome of the report (NYSOFCS, 2024 April).

Written reports from mandated reporters are admissible in evidence in any proceedings relating to child abuse or maltreatment. It is important to be aware that *Health Insurance Portability and Accountability Act of 1996* (HIPAA) regulations state that HIPAA privacy rules do not apply to reporting of child abuse. Exceptions stipulate that healthcare providers suspecting child abuse or maltreatment must make a report and provide material in accordance with state law.

The mandated reporter makes the first determination of what information being sought by CPS is essential to its investigation. If CPS is requesting additional information that the reporter is unwilling to release, CPS should clearly explain how the records are pertinent. If the reporter still does not produce the reports, CPS can provide an appropriate authorization or release or obtain a court order requiring the records be produced.

6.6 The Abandoned Infant Protection Act

New York State's *Abandoned Infant Protection Act* (AIPA) allows a person who abandons an infant to avoid criminal liability. The person must, however, act in a safe manner that will not result in physical harm to the infant.

In 2010, the law removed criminal liability for the crimes of *Abandonment of a Child and Endangering Welfare of a Child* when a parent, guardian, or other legally responsible person abandons an infant under the following conditions:

1) The abandoned infant is no more than 30 days old;
2) The person who abandons the infant intends that the infant will be safe from physical injury and appropriately cared for;
3) The person leaves the infant with an appropriate person **or** leaves the baby in a suitable location and immediately notifies an appropriate person of the infant's location; and
4) The person must intend to wholly abandon the infant by relinquishing responsibility for and rights to the care and custody of the infant (NYSOCFS, 2016).

AIPA does not affect the responsibilities of a mandated reporter, amend the law regarding mandated reporters, nor does it change or lessen a reporter's obligations. Mandated reporters who learn of an abandoned infant, even if they do not know the name of the person leaving the child, must make a report to the SCR (NYSOCFS, 2016).

7. Defining Maltreatment and Abuse / Neglect

The *Federal Child Abuse Prevention and Treatment Act* (CAPTA), defines **child abuse and neglect** as, at minimum:

- Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or
- An act or failure to act which presents an imminent risk of serious harm.

This definition of child abuse and neglect refers specifically to parents and other caregivers. A "child" under this definition generally means a person who is younger than age 18 or who is not an emancipated minor.

Under New York law, children are defined as individuals from birth up to 18 years of age. Prenatal abuse cannot be reported, but if a child is born with neonatal drug withdrawal, a report can then be made. Youth no more than 21 years of age who have handicapping conditions and are in residential care in certain New York schools for the blind or deaf or in private residential schools for special education services may also be reported to the SCR.

To qualify as abuse, there needs to be harm or substantial likelihood of harm related to the actions or inactions of the person responsible for the child. You do not need to know if the incident is abuse or maltreatment to make a report. That determination will be made by the SCR or by the local CPS during its investigation.

7.1 Minimum Degree of Care

Parents and persons legally responsible in New York State must provide their children with the "minimum degree of care", which includes any of the following: adequate food, clothing, shelter, medical care; basic dental care; mental health services; and drug or alcohol misuse treatment. Parents and persons legally responsible for a child must also provide adequate education, adequate supervision, and must refrain from excessive corporal punishment.

The minimum degree of care regarding adequate food, clothing, shelter and medical care must be considered relative to whether the parent or person legally responsible was financially able to do so or was offered other financial or reasonable means to do so.

7.1.1 Adequate Education

The minimum degree of care regarding adequate education is measured by looking at the conduct of the parent after considering any efforts previously made by the school or CPS. Parents must ensure the children in their care are actively enrolled in school, which does not mean a child has to be earning high grades, participating in activities or have impeccable attendance.

7.1.2 Adequate Supervision

Parents and persons legally responsible in New York State must provide their children with adequate supervision. There is no provision in New York State law or regulation that dictates how old a child must be to be left alone without adult supervision.

Determining whether a child can be safely left alone is made on a case-by-case basis. A child left alone in a residence or in the community must be able to demonstrate that they have the knowledge and skills necessary to properly respond to a potential emergency and to care for themselves. Just because an individual child may be left safely alone does not mean that child has the necessary skills to supervise other children without an adult present.

7.1.3 Excessive Corporal Punishment

New York State law permits parents to use corporal (physical) punishment to discipline their children, but it cannot be excessive. Excessive corporal punishment includes when:

- The child lacks the capacity to understand the corrective quality of the discipline.
- A less severe method is available and likely to be effective.
- The punishment is inflicted due to the parent's rage.
- The child receives injuries or bruises as a result.
- The length of punishment surpasses the child's endurance

New York State allows *reasonable* physical correction of a child, but *excessive* corporal punishment is an indicator of neglect. As of October 25, 2023, corporal punishment is prohibited in every school within the state and is classified as child abuse (Education Law §1125 and §305). Defining excessive corporal punishment is always on a case-by-case consideration, and you do not have to be able to define it in order to make a report to the SCR.

Determinations about excessive corporal punishment may consider whether it was inflicted using devices (cords, brushes, wooden spoons, or other implements) and to a part of the body that is more vulnerable, such as the head, face, abdomen, especially if it results in identifiable markings as a result ("pattern injuries," such as ligature marks, cord marks, brush patterns, burns, bite marks).

If you have **reasonable cause to suspect** child maltreatment, make the report. Trained personnel will then investigate and make the appropriate determination.

Beginning with the 2024-2025 school year, each public school district, *Board of Cooperative Educational Services*, charter school, State-operated school pursuant to Articles 87 and 88 of the Education Law, and private residential school operated pursuant to Article 81 of the Education Law, must submit an annual report to the *New York State Education Department* on the use of physical restraint and timeout, substantiated and unsubstantiated allegations of use of prohibited interventions, corporal punishment, mechanical restraint and other prohibited aversive interventions, prone physical restraint, and seclusion (NYSED, 2024 October 9).

7.2 Maltreatment/Neglect

The terms *maltreatment* and *neglect* are often used interchangeably. Both terms have legal foundation in the CPS system. **Maltreatment** refers to the quality of care a child is receiving from those responsible for the child. It occurs when a parent or other person legally responsible for the care of a child harms a child or places a child in imminent danger of harm by failing to exercise the minimum degree of care.

Under New York State law, a child is maltreated when:

- A parent or other person legally responsible for the child fails to provide the minimum degree of care, and that failure results in impairment or imminent danger of impairment to the child's physical, mental or emotional condition, **or**
- A parent or other person legally responsible for the child causes a non-accidental, serious physical injury to the child.

It is important to note actual impairment or harm is not required. Poverty in and of itself is not maltreatment.

Abandonment of a child or failing to provide adequate supervision is also considered to be maltreatment. A child may be maltreated if a parent engages in excessive use of drugs or alcohol if it interferes with their ability to adequately supervise the child.

Neglect is the failure of a parent or caretaker to provide needed food, clothing, shelter, medical care, or supervision to the degree that the child's health, safety, and well-being are threatened with harm.

7.3 Abuse

Under New York State law, a child is abused when a parent or person legally responsible for a child inflicts (or allows someone else to inflict) a non-accidental serious injury which causes:

- a substantial risk of death
- serious or protracted disfigurement
- protracted loss or impairment of the function of any bodily organ, **or**

When a parent or person legally responsible for a child creates (or allows to be created) a substantial risk of non-accidental physical injury which would be likely to:

- cause death
- serious or protracted disfigurement
- protracted loss or impairment of the function of any bodily organ, **or**

A parent or person legally responsible commits (or allows someone else to commit) a sex crime against a child.

8. Indicators of Child Abuse, Maltreatment, or Neglect

Indicators, or signs, of child abuse or maltreatment are physical or behavioral acts that cause you to be concerned about the presence of abuse. When evaluating a situation to determine if there is reasonable cause to suspect child abuse or maltreatment/neglect based on injuries to the child:

- Know the likely areas for normal versus suspicious injuries.
- Consider the size and shape of the injury.
- Consider the child's developmental stage and related likely injuries.

Accidental childhood injuries usually involve bony areas such as shins, elbows, and knees. Toddlers learning to walk often fall and skin or bruise these areas, just as older children may do the same thing while learning to ride a bicycle. Suspicious injuries usually occur in areas that are not susceptible to accidental injuries, given the age of the child, and may include the back, buttocks, and backs of thighs or calves.

If an injury was serious but appropriate treatment was delayed or omitted, especially in a case where the mechanism of injury does not match the injuries as seen, there may be reasonable cause to suspect child abuse or maltreatment/neglect.

Do **not** view indicators in isolation. Each indicator must be considered in relation to the child's current age and circumstances and in the context of their physical condition or behavior. You may need to assess if there is an explanation for the presenting concern and whether the explanation is consistent with the observed physical and behavioral indicators.

Abuse or maltreatment should never be assumed. Consider your prior experiences with this child and whether there is a difference in what you are currently observing. It is important to make an objective assessment that is free from any implicit or explicit bias.

8.1 Indicators of Physical Abuse

8.1.1 Physical Indicators of Physical Abuse

[The following material is from NYSOCFS, 2020, unless otherwise cited.]

Physical indicators of child maltreatment and abuse include unexplained bruises, fractures, burns, welts or lacerations or suspicious injury or bruising including where:

- the location of the injury may be atypical
- the explanation provided for the injury doesn't match the pattern of injury
- the bruise or laceration is shaped like an object (such as a handprint or looped cord)

Unattended physical problems, medical or dental needs, pain or itching in the genital area, and lags in physical development or growth are also physical indicators of child maltreatment and abuse.

Unexplained bruises and welts can be strong indicators of child abuse. When doing a physical exam, note bruises or welts on the face, lips, mouth, torso, back, buttocks, or thighs—especially in various states of healing.

Bruises that are clustered, form regular patterns, or reflect shape of article used to inflict, such as an electric cord or belt buckle are cause for concern. Also consider bruises that regularly appear after absence, weekend, or vacation.

Unexplained burns are another cause for concern. Cigars or cigarettes can be used to create burn patterns on a child's soles, palms, back, and buttocks. Burns in sock-like, glove-like, or doughnut-shaped patterns on buttocks or genitalia (immersion burns), or patterned burns from an electric burner or iron, as well as rope burns on arms, legs, neck, or torso are indicators of abuse.

Unexplained lacerations or abrasions to a child's mouth, lips, gums, eyes, ears, or external genitalia are also indicators of abuse. Consider lacerations on the backs of a child's arms, legs, or torso, human bite marks, or frequent injuries that are "accidental" or unexplained.

8.1.2 Behavioral Indicators of Physical Abuse

Both children and adults often exhibit behaviors that can indicate the presence of abuse. A child may be wary of adult contact, frightened of parents or afraid to go home. They may be apprehensive or nervous when they hear other children cry and may exhibit extremes of behavior such as aggressiveness, withdrawal, or sudden changes in behavior.

Some children try to hide injuries by wearing long-sleeved shirts or pants or similar clothing. Others may have difficulties with emotional boundaries or seek inappropriate affection from an adult.

Parents and caregivers also often engage in behaviors that can indicate the presence of abuse. They may seem unconcerned about the child, attempt to conceal the child's injury, or take an unusual amount of time to obtain needed medical care. They may offer an inadequate, inconsistent, or inappropriate explanation for the child's injury. To conceal the abuse, they may take the child to a different doctor or hospital for each injury.

Adults who abuse children often have poor impulse control and may also have a personal history of abuse as a child. They may have a history of abuse of alcohol or other drugs or a history of mental illness. An adult may discipline the child too harshly considering the child's age or what they did wrong or describe the child as bad, evil, etc.

8.2 Maltreatment or Neglect

8.2.1 Physical Indicators of Maltreatment or Neglect

For children who are experiencing maltreatment or neglect, certain physical indicators may be present. They may be consistently hungry, have poor hygiene, or dress inappropriately. They often have unmet physical problems or medical or dental needs. These children often experience a lack of supervision for long periods of time. They may be left overnight or even abandoned.

8.2.2 Behavioral Indicators of Maltreatment or Neglect

For children experiencing maltreatment of neglect, certain behavioral indicators are present. They may state they have no caretaker and may beg for or steal food. They are often tired and fatigued and fall asleep in class. School attendance may be infrequent, or conversely, a child may try to stay in school, arriving early and staying late. Be aware of signs of alcohol and drug abuse.

For a parent or guardian, behavior indicators of neglect or maltreatment of a child include misuse alcohol or other drugs, evidence of limited intellectual capacity, a history of neglect as a child, or exposing the child to unsafe living conditions.

The parent may have a disorganized home life, be isolated from friends, relatives, and neighbors, and feel as though nothing will change. Be aware if the parent or caregiver has a long-term chronic illness. In some instances, the parent or caregiver is completely absent or cannot be found.

8.3 Emotional Maltreatment

8.3.1 Physical Indicators of Emotional Maltreatment

For children, physical indicators of emotional maltreatment overlap with other indicators. Physically, a child may lag in physical development and exhibit a failure to thrive.

Certain disorders are common in children experiencing emotional maltreatment:

- Conduct disorders (fighting in school, anti-social, destructive behaviors)
- Habit disorders (rocking, biting, sucking fingers)
- Neurotic disorders (tics, sleep problems, inhibition of play)
- Psychoneurotic reactions (phobias, hysterical reactions, compulsion, hypochondria)

8.3.2 Behavioral Indicators of Emotional Maltreatment

For a child, emotional maltreatment can cause mental and emotional developmental delays. Look for overly adaptive behaviors such as inappropriately adult or inappropriately infantile behavior. A child may exhibit extremes of behavior (compliant, passive, aggressive, demanding). Suicide attempts or gestures and self-mutilation are common.

In adults, behavioral indicators of emotional maltreatment of a child may be obvious to a healthcare provider. The adult may treat children in the family unequally or blame or belittle the child—even in public.

An adult may be cold and rejecting and not seem to care much about the child's problems. Emotionally controlling adults often exhibit inconsistent behavior toward the child.

8.4 Sexual Abuse

Under New York Penal Law, sexual abuse is a considered to be a form of abuse or maltreatment. Sexual abuse by an adult involving a child is described as sexual misconduct, persistent sexual abuse, forcible touching, incest, rape, facilitating a sex offense with a controlled substance, or encouraging a child to engage in any act that would render a child a victim of sex trafficking.

Sexual abuse also includes criminal sexual acts, aggravated sexual abuse, sexual conduct against a child, female genital mutilation, and promoting prostitution. The use of a child in a sexual performance, promoting an obscene sexual performance by a child, promoting a sexual performance by a child, possessing an obscene sexual performance by a child, or possessing a sexual performance by a child is considered to be sexual abuse.

Signs of sexual abuse of a child. Source: WikiHow. Creative Commons. https://creativecommons.org/licenses/by-nc-sa/3.0/. From: https://www.wikihow.life/Identify-a-Victim-of-Child-Abuse#/Image:Identify-Emotional-Abuse-Step-2-Version-2.jpg #3

8.4.1 Physical Indicators of Sexual Abuse

A child who has been sexually abused may come to the emergency department because of an injury caused by the abuse. Look for signs such as difficulty in walking or sitting, torn, stained, or bloody underclothing, pain or itching in genital area, or bruises or bleeding in external genital, vaginal, or anal areas.

Other indicators of child sexual abuse include pregnancy, especially in early adolescent years, and sexually transmitted diseases, venereal diseases, and oral infections (especially in pre-adolescent age group).

8.4.2 Behavioral Indicators of Sexual Abuse

For children, there are a number of behavioral indicators of sexual abuse. Some may be obvious while others are more subtle. For example, a child may directly report a sexual assault by caretaker. They may exhibit bizarre, sophisticated, or unusual sexual behaviors or knowledge for their age. They may have an exaggerated fear of closeness or physical contact, often with the perpetrator.

Withdrawal, fantasy, or infantile behavior is often common in children who are being sexually abused. Self-injurious behaviors or suicide attempts may be the reason a child ends up in the emergency department.

Some behavioral indicators of sexual abuse may be less obvious—especially during a healthcare appointment. A child who is being sexually abused may have poor peer relationships, may be unwilling to change for, or participate in, physical education classes, exhibit aggressive or disruptive behaviors, may run away from home, or refuse to attend school.

For parents or caregivers, behaviors that indicate sexual abuse of a child are varied. They may be overly protective or jealous of child, have low self-esteem, or misuse alcohol or other drugs. Parents may be geographically isolated or lack social and emotional contacts outside the immediate family. A sexually abusive parent or caretaker may encourage the child to engage in prostitution or sexual acts in the presence of the caretaker.

Sometimes evaluating possible child abuse or maltreatment will be straightforward. For example, a baby born with a positive toxicology, a child with the handprint of a slap showing on their face, or a direct disclosure made by a child give clear support for reasonable cause to suspect. However, more often the situation will require that you pull together several indicators or clusters of indicators. Although the above lists identify many common indicators of possible abuse or maltreatment, these should not be considered in isolation from the child's current condition or circumstances (how they look and act). In addition, signs may sometimes appear contradictory.

8.5 Child Abuse in a Virtual Setting

Technology-facilitated abuse is defined as the misuse of digital systems such as smartphones or other internet-connected devices to harm an individual. The proliferation of these devices, exacerbated by the COVID19 pandemic, has increased the risks of technology-facilitated abuse for vulnerable members of society. These forms of abuse are on the rise, with perpetrators using digital technologies such as GPS Tags and device spyware tools to monitor and control another person (Straw and Tanczer, 2023).

Victims, including children and young adults, experience a range of abuses, including general harassment, digital surveillance using spyware and tracking devices, and sextortion (having intimate images or videos shared without their consent). GPS trackers have been a growing phenomenon in domestic violence cases, including reports of trackers being placed in children's toys and strollers. The harm from this type of abuse is significant, causing anxiety and trauma, a heightened risk for future psychological symptoms, self-injury, and suicidal ideation (Straw and Tanczer, 2023).

Online sexual abuse is very common. It is often related to unwanted sexual approaches, especially by an adult who contacts children for sexual purposes. Even if an interaction is voluntary, many users report being persuaded or coerced into sexual activity (Jonsson et al., 2019).

In a Swedish study of 14–15-year-old children, sexual approaches were experienced more often by girls than boys and were also more common among older adolescents and those defining themselves as gay, bisexual, or as being unsure about sexual orientation. The group most vulnerable to sexual approaches and grooming tend to consist of high-risk youths with a prior history of sexual abuse. Individuals who use chatrooms, communicate with people online, engage in sexual behavior online, and share personal information online are also at risk (Jonsson et al., 2019).

Common online behaviors that can lead to abuse include sharing contact information, looking for someone to talk to about sex (or have sex with), sending nude pictures, and posting nude pictures on a community or internet site. Because of this, healthcare providers working with children and young adults should screen their patients for online behavior and online abuse (Jonsson et al., 2019).

> In the United Kingdom police are investigating a landmark case of an alleged rape in a virtual reality game after a teenage girl was “sexually attacked” by a group of strangers in the online metaverse. The girl, allegedly under the age of 16, is said to have been left traumatized after her avatar—her personalized digital character—was “sexually attacked” by a group of online strangers. The victim, wearing a headset, remained unharmed as there was no physical assault (Farrant 2024).

9. Understanding Intellectual and Developmental Disabilities in Children (IDD)

Children with intellectual and developmental disabilities (IDD) are at a significantly higher risk of experiencing maltreatment compared to their typically developing peers. Studies consistently show that these children are more vulnerable to neglect, physical, sexual, and emotional abuse (Legano et al., 2021). In general, many factors leading to abuse among children with intellectual and developmental disabilities are the same as those found in the general population, i.e., single parents, teen parents, financial difficulties, lack of support, and various levels of stress.

Children with certain disabilities are more prone to maltreatment than others. For example, children born with congenital anomalies such as spina bifida or Down syndrome have an increased likelihood of maltreatment during the first month of life. Children with disabilities that affect conduct, such as attention deficit/hyperactivity disorder, may be vulnerable to physical abuse by parents or caregivers who may become frustrated by their behavior. Children who rely on adults for their care, as well as children who are nonverbal or hearing impaired, may be more likely than others to experience neglect or sexual abuse (CWIG, 2018).

Children with intellectual and developmental disabilities often have poor health outcomes due to lack of access to sufficient medical care and exclusion from public health and preventive care. A lack of training for care of patients with IDD has been reported across healthcare professions in medicine, dentistry, occupational and physical therapy, psychology, and nursing (Vi et al., 2023). Knowing the characteristics of a child’s disability can help you understand the barriers that these children face and better recognize and respond to those challenges.

9.1 Causes of IDD

Low birthweight, premature birth, multiple birth, and infections during pregnancy are associated with an increased risk for many developmental disabilities. Children who have a sibling with autism spectrum disorder are at a higher risk of also having autism spectrum disorder (CDC, 2025).

Untreated newborn jaundice (high levels of bilirubin in the blood during the first few days after birth) can cause a type of brain damage known as kernicterus. Children with kernicterus are more likely to have cerebral palsy, hearing and vision problems, and problems with their teeth. Early detection and treatment of newborn jaundice can prevent kernicterus (CDC, 2025).

Metabolic disorders affect how the body uses food and other materials for energy and growth. Problems with these processes can upset the balance of materials available for the body to function properly. Too much of one thing, or too little of another can disrupt overall body and brain functions. Phenylketonuria (PKU) and congenital hypothyroidism are examples of metabolic conditions that can lead to IDDs (NICHD, 2021).

Individuals with degenerative disorders may seem or be typical at birth and may meet usual developmental milestones for a time, but begin to experience disruptions in skills, abilities, and functions as the disorder progresses. In some cases, the disorder may not be detected until the child is an adolescent or adult and starts to show symptoms or lose abilities. Some degenerative disorders result from other conditions, such as untreated problems of metabolism (NICHD, 2021).

Other examples include:

- Epilepsy
- Prader-Willi syndrome
- Familial dysautonomia
- Neurological impairment

9.2 Defining Intellectual and Developmental Disability IDD

According to the *Individuals With Disabilities Education Act* (IDEA), the term “child with a disability” means a child (1) with intellectual disabilities, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbance, orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities and (2) who, by reason thereof, needs special education and related services (CWIG, 2018).

Intellectual and developmental disabilities are usually present at birth and can affect the trajectory of an person’s physical, intellectual, and/or emotional development. Many of these conditions affect multiple body parts or systems (NICHD, 2021). At least 25% of hearing loss among babies is due to maternal infections during pregnancy, such as cytomegalovirus (CMV) infection, complications after birth, and head trauma.

9.2.1 Intellectual Disability (ID)

Intellectual disability (ID) is characterized by both intellectual and adaptive functioning deficits in conceptual, social, and practical skills. Onset typically occurs during the developmental period (childhood and adolescence).

The *Diagnostic and Statistical Manual of Mental Disorders Fifth Edition* (DSM-5), classifies the severity of intellectual disability by the level of support required:

- mild if a person can live independently with minimal levels of support,
- moderate if a person can live independently with moderate levels of support,
- severe if a person needs daily assistance for self-care activities and safety supervision, and
- profound if a person needs 24-hour care (Morinaga et al., 2024).

Globally, intellectual disability ranks as the third leading cause of *Disability-Adjusted Life Years* for mental disorders among children aged 0 to 14 years and the seventh leading cause among all ages (Morinaga et al., 2024).

Some of the most common known causes of intellectual disability include fetal alcohol spectrum disorders; genetic and chromosomal conditions, such as Down syndrome and fragile X syndrome; and certain infections during pregnancy (CDC, 2025).

People with intellectual disabilities often experience communication difficulties, societal stigma, discrimination, and a lack of social support. These factors may be associated with greater risk for victimization by strangers, direct support staff, or family members (Brendli, Broda, and Brown, 2022).

9.2.2 Developmental Disability

The term "developmental disability" is a broader category of often lifelong challenges that can be intellectual, physical, or both. Developmental disabilities are a group of conditions due to an impairment in physical, learning, language, or behavior areas. These conditions begin during the child's developmental period, may impact day-to-day functioning, and usually last throughout a person's lifetime. Most developmental disabilities begin before a baby is born, but some can happen after birth because of injury, infection, or other factors (CDC, 2025).

Most developmental disabilities are thought to be caused by a mix of factors. These factors include genetics:

- parental health and behaviors (such as smoking and drinking) during pregnancy;
- complications during birth;
- infections the mother might have during pregnancy or the baby might have very early in life; and
- exposure of the mother or child to high levels of environmental toxins, such as lead (CDC, 2025)

9.3 Physical Indicators of Child Maltreatment and Abuse in Children with IDD

Physical indicators of child maltreatment and abuse in children with I/DD can include:

- Unexplained bruises, scratches, marks or burns
- Bruising or bleeding in the genital area
- Poor hygiene
- Malnutrition or dehydration
- Medical neglect
- Physical restraint marks
- Difficulty walking or sitting

9.4 Behavioral Indicators of Child Maltreatment and Abuse in Children with IDD

Behavioral signs of abuse may be more obvious than physical signs of abuse in children with I/DD. Sudden or gradual changes in behavior, including increased aggression, withdrawal, fear, or changes in eating or sleeping habits are common behavioral indicators of maltreatment or abuse.

Some individuals with I/DD may engage in self-abusive behaviors or be prone to accidental injuries, making it more challenging to distinguish between self-harm and abuse. Additional behavioral signs can include:

- Regression in previously acquired skills
- Agitation, anxiety or stress around particular caregivers
- Inappropriate sexual behavior
- Atypical attachment
- Noncompliance

9.5 Communication Changes in Children with IDD

A child who has difficulty communicating their wants and needs may become a target for physical abuse and neglect. The disabled child 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.

Children with I/DD are often unable to report an abusive incident, making behavioral and circumstantial indicators important for identification. Communication challenges may also make it difficult for children with intellectual or developmental disabilities to seek help for maltreatment.

- Difficulty communicating
- Changes in vocalization
- Non-verbal cues

9.6 Behavioral Indicators of Caregivers to Children with IDD

Families with children with disabilities may feel unprepared to handle the care of a disabled child, including accepting that the child has a disability. It is important for professionals to understand the effects that raising a child with disabilities can have on family dynamics. Such knowledge can help medical professionals and service providers assess risk factors, family support systems, family functioning, and the additional risks associated with poverty (CWIG, 2018).

Family and parental risk factors include:

- stress and physical health
- lack of support
- family functioning
- poverty
- teen parenthood
- single parenthood

Pay attention to caregiver behaviors, such as refusal to follow directions, controlling attitudes, or attempts to isolate the child. Also note inconsistent explanations, a dismissive attitude toward the child or other people involved in the child's care, anger, frustration, and isolation.

10. Special Populations

10.1 Limited English Proficiency (LEP) Services

Title VI of the Civil Rights Act of 1964 requires all recipients of federal funds to provide meaningful access to services and programs for persons with limited English proficiency (LEP). Those with limited proficiency in English are individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English.

Agencies must offer LEP persons involved in child protective cases with appropriate, free, and timely language assistance by providing oral interpretation and translation of "vital documents." All agencies receiving any federal funding, directly or indirectly, are mandated to comply with these requirements. This includes all local social service departments and agencies with which they contract to provide protective services.

10.2 Compliance with the Indian Child Welfare Act

The federal Indian Child Welfare Act (ICWA) protects the best interests of Native American children by supporting their cultural identity in issues pertaining to foster care, termination of parental rights, emergency removals, and adoption proceedings. The law establishes minimum federal standards for the removal of Native American children from their families.

The *Office of Children and Family Services* addresses the requirements for implementation of ICWA in child custody proceedings, including voluntary and involuntary foster care and termination of parental rights proceedings, emergency proceedings, and the voluntary relinquishment (surrender) of parental rights involving Indian children.

In every case, inquiries regarding the child's status as a Native American child must be made of the family and, depending on age and capacity, the child. If there is reason to know that the child is American Indian or Alaska Native, all protections afforded under ICWA apply until it has been determined by the court that the child does not meet the definition of an Indian child.

In each child custody proceeding initiated by a social services official, the official must notify the child's parent or Indian custodian (and each tribe or nation in which the Native American child is a member or citizen or may be eligible for membership or citizenship) of the pending proceeding and of the right of the parent/Indian custodian/tribe to intervene in that proceeding. The notification must be made by registered or certified mail with return receipt requested. Treating the child as a Native American child from the early stages of a case prevents delays and possible changes in foster care placement.

Federal statutory and regulatory standards limit application of ICWA only to Indian children who are members or citizens of federally recognized tribes or nations, or are eligible for membership or citizenship, and the biological child of a member or citizen of a federally recognized tribe or nation. New York State extends the application of most of the provisions of ICWA to children who are members/citizens of state-only recognized Indian tribes/nations.

There are nine tribes/nations in New York State:

1. St. Regis Mohawk Tribe (located in Franklin County, New York, also known by its Mohawk name, Akwesasne)
2. Cayuga Nation (a member of the Haudenosaunee Confederacy, located between the Seneca Nation to the west and the Onondaga Nation to the east)
3. Seneca Nation of Indians (located in western New York)
4. Tuscarora Nation (located in Niagara County)
5. Onondaga Nation (located south of Syracuse, a member of the Haudenosaunee Confederacy)
6. Tonawanda Band of Senecas (one of two federally recognized Seneca tribes in Western New York)
7. Oneida Indian Nation (headquartered in Verona, New York)
8. Shinnecock Indian Nation (based at the eastern end of Long Island)
9. Unkechaug Nation (located on the Poospatuck Reservation in Suffolk County)

Both federal and state laws allow the emergency removal of a Native American child from the custody of his or her parents or Native American custodians, or the emergency placement of such child in a foster home or childcare facility to prevent **imminent physical damage or harm** to the child. ICWA has established preference provisions for both foster care and adoption placements:

- first preference is placement with a member of the child's extended family;
- second preference is with a member of the child's tribe/nation; and the third preference is with other Native American families.

10.3 Working with Immigrant Families

It is not uncommon for caregivers who are not documented citizens of the U.S. to have their legal status used against them. Members of these communities may be distrustful of state agencies and law enforcement officials for many reasons, one of which may be related to negative experiences with government agencies in their countries of origin.

CPS may need to use intervention strategies for families dealing with immigration issues that are different from the intervention strategies used in cases where immigration status is not a factor. This includes preparing a safety plan that considers the cultural expectations and realities that a family may be experiencing. All plans should be tailored to fit the specific needs of the family while promoting a safe environment for the child. The safety plan is vital in preventing the unnecessary placement of children into foster care if their parents or caretakers are detained by Immigration Customs Enforcement or deported to their countries of origin.

In New York State, a caregiver's lack of proper immigration status is neither an allegation of abuse or neglect nor a violation of the minimum degree of care. However, whenever CPS responds to a report of suspected child abuse or maltreatment, they must be alert and sensitive to the possibility that the caregivers may lack proper immigration status. The family does not have to reveal their immigration status, nor should they feel pressured into doing so as a condition of an impartial CPS investigation.

A caregiver may not be ready or able to discuss the existence of an immigration issue because of the fear of the potential consequences, such as deportation, and they may have worries about how CPS might act regarding their children. It is important to show concern for the caregiver's well-being along with the required CPS focus on the safety of the children in the home and their level of risk of harm.

CPS personnel should set aside any biases they may have regarding immigration and the immigrant community. It is important to suspend judgment and understand that one solution, such as returning to their country of origin is not always the safest strategies for the caregivers or the children. It is important that CPS personnel recognize the limitations of their knowledge and draw upon available resources, such as a supervisor, an immigration advocate, or materials from the *New York State Office for New Americans* or some other community resource.

11. Scenarios for Mandated Reporters to Consider

Hospital

You are a nurse working in an urban emergency department. A 13-month-old girl is brought in by her mom her and her mom's boyfriend with swelling and pain to the left leg and hip and a bruise on her forehead. The mom reports that her daughter won't stop crying. During your examination, you notice bruising of various sizes and colors on her trunk, including the abdomen and back.

The boyfriend reports that the child fell off her highchair earlier in the day while his girlfriend was at work. He seems overly protective and won't allow the mom to answer any questions. She manages to timidly say, "she's my daughter, you haven't been living with us for very long and don't know her." The child is crying uncontrollably and screams and pulls away from the boyfriend when he tries to touch her.

You send a nurse and the mom for an x-ray of the girl's leg and hip, which shows a buckle fracture of the tibia. You ask the boyfriend to wait in the room, but he is becoming increasingly agitated and impatient and says he is going to take "his daughter" home. When the girl returns from his x-ray, the doctor recommends that she be admitted for more tests.

Discussion

You are concerned that the child is being abused. You and your colleagues feel the child is also in imminent danger due to the leg fracture, bruising of different levels of healing, depth of bruising, and bruising in atypical locations*, as well as the child's fearful reaction to the boyfriend.

*Atypical bruising caused by inflicted trauma includes bruises inconsistent with the mechanism of injury, bruises on soft parts of the body such as the ears or neck, patterned or clustered bruises, and bruises that are not consistent with a child's developmental level (Chapple, 2015).

Your suspicions are aroused further when the boyfriend tells you he is going to get a cup of coffee. On his way out he says, "there's nothing wrong with the kid—she's just being a baby." The boyfriend does not return.

What Action Do You Take?

a. Monitor the situation.

b. Report your concerns to the hospital administrator.

c. Make an immediate report to the Statewide Central Register.

d. Ask the sheriff to arrest the father for leaving the hospital.

Answer: C

You correctly decide to make an immediate report to the Statewide Central Register. Because you feel the child is imminent danger, you also call the police. Unfortunately, law

enforcement does not arrive in a timely manner. Until law enforcement arrives, hospital personnel are in a bind. The mother can leave at this point against medical advice although this will not look good for her if there is a CPS or criminal hearing. The situation is fraught with ethical and legal issues for healthcare providers.

The bottom line: Do your duty, make your report to the Statewide Central Register, call the police, and continue with your work.

Neonatal Drug Withdrawal

A mother delivers a baby who has neonatal drug withdrawal. When talking to the mother, you learn she has not prepared for the baby to come home. You additionally learn that she has been using drugs throughout her pregnancy and did not see a healthcare provider at all during the pregnancy.

What indicators are present?

- Neonatal drug withdrawal
- No plan for the baby

In your role as a mandated reporter, is there reasonable cause to suspect abuse or maltreatment?

Yes

Is there a person responsible for the suspected abuse or maltreatment?

Mother

What are your next steps?

Call in a report to the Statewide Central Register

12. Conclusion / Resources

The impact of child abuse and neglect is often discussed in terms of physical, psychological, behavioral, or societal consequences; in reality, however, it is impossible to separate them completely. Physical consequences such as damage to a child's growing brain can have psychological implications such as cognitive delays or emotional difficulties. Psychological problems often manifest as high-risk behavior.

Depression and anxiety may make a person more likely to smoke, abuse drugs or alcohol, or overeat. High-risk behaviors, in turn, can lead to long-term physical health problems such as sexually transmitted infections, cancer, or obesity. Furthermore, children who are abused are at increased risk of abusing their own children.

The State of New York requires that certain professionals intercede on behalf of the helpless victims of child abuse by making an official report when they have reasonable cause to suspect that such abuse may be taking place. These professionals, called mandated reporters, are in a unique position to help interrupt the complex and damaging cycle of violence that results from child abuse and maltreatment/neglect.

Since the COVID pandemic, healthcare organizations have come to recognize the incredible impact bias can have on child abuse reporting, medical decision-making, and diagnoses. Now, instead of making assumptions or jumping to conclusions that a child is being maltreated or abused, mandated reporters are encouraged to evaluate potential biases that can affect their decision to report or not report.

Adverse childhood experiences and childhood trauma can have a negative impact on a child's health over time. A comprehensive approach to preventing adverse childhood experiences and trauma focuses on primary prevention, supporting families, and encouraging children to be involved in social activities. These sorts of protective factors can reduce the risk child abuse and violence, and moderate trauma-related distress.

It has become increasingly important for helping professionals to understand and embrace the diversity that is a vibrant part of American culture. Understanding Native cultures, immigrants, and people with limited English proficiency is fast becoming an essential skill for healthcare providers and other mandated reporters.

Resources

The OCFS H.E.A.R.S.
Help, Empower, Advocate, Reassure and Support—family line assists families by providing resources and referrals to a variety of services such as food, clothing, housing, childcare, parenting education and more. Representatives are available to help M-F 8:30am-4:30pm. If you know a family that could use support, please ask them to call the OCFS HEARS family line at 888-554-3277.

NY Project Hope
Provides emotional support for New York State residents. This includes an Emotional Support Helpline (1-844-863-9314), Online Wellness Groups, and a website filled with supportive resources (NYProjectHope.org).

The New York State Office for the Prevention of Domestic Violence
Has a website that provides resources for people who may be experiencing, or are survivors of, domestic violence: https://opdv.ny.gov/survivors-victims

New York State Office of Children and Family Services
To report abuse or neglect**:** 800 342 3720 TDD/TTY: 800 638 5163

Justice Center: 855 373 2122

Prevent Child Abuse New York

Provides information and resources for kids, parents, and concerned citizens.

Phone: 518 880 3592 Fax: 518 880 3566

Parent Helpline: 1-800-CHILDREN (800 244 5373) (9am–10pm daily)

http://www.preventchildabuseny.org

2-1-1
Parents and caregivers may also call 2-1-1, operated by the United Way, for health and human services information, referrals, assessments, and crisis support to help them find the assistance they need to address the everyday challenges of living, as well as those that develop during times of disaster or other community emergencies. 2-1-1 is multi-lingual and available 24 hours a day 7 days a week.

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[Continue to next page to start quiz]

Quiz: NY Child Abuse for Mandated Reporters (365)

A score of 80% or higher is required.

1. Statistics show that the largest percentage of cases of child maltreatment involve:

a. Sexual abuse.
b. Physical abuse.
c. Psychological maltreatment.
d. Neglect.

2. When are mandated reporters required to call the State Central Register to report suspected child abuse or maltreatment?

a. Immediately.
b. Within a week.
c. Within 48 hours.
d. Depends on the severity of the suspected injury.

3. When must a LDSS 2221A form be filed?

a. Depends on the severity of the injury.
b. Within five business days of making the oral report.
c. Within 48 hours of making an oral report.
d. The 2221A is no longer required.

4. An alternative response is a response other than an investigation that determines if a child or family needs services.

a. True
b. False

5. Child Protective Services:

a. Verifies reports of child abuse.
b. Provides immediate protection of children.
c. Provides rehabilitative and ameliorative services to help families.
d. All of the above.

6. Adverse childhood experiences can have a lasting impact on:

a. Children
b. Persons Legally Responsible (PLR) for children
c. Mandated Reporters
d. All of the above

7. Protective factors are the characteristics of a child, a family, or the environment that diminish the probability of suffering from adverse experiences such as child maltreatment, abuse, or neglect.

a. True
b. False

8. A mandated reporters' decisions to report a family to the Statewide Central Register (SCR) is often influenced by biases and personal beliefs.

a. True
b. False

9. Research on bias throughout the child welfare system shows:

a. An under representation of families of color.
b. An over-representation of families in poverty and families of color.
c. A mandated reporter's decision to make a report is hardly ever influenced by bias.
d. Bias does not have long lasting impacts on families and communities.

10. What should a mandated reporter do before reporting any allegations of abuse/neglect?

a. Have clear and sufficient evidence of the abuse or neglect.
b. Discuss the concerns with the parent or guardian of the child.
c. Talk to the child about what to say to the child protective services worker.
d. Have reasonable cause to suspect the child has been abused or neglected.

11. When a mandated reporter finds a family in crisis and the children are not in imminent danger of harm, it is best to:

a. Call the State Central Register and make a report just in case.
b. Assess the situation to see if the family could benefit from other community resources.
c. Do nothing.
d. Call law enforcement

12. Parents and persons legally responsible in New York State must provide their children with the "minimum degree of care", which includes adequate food, clothing, shelter, and medical care.

a. True
b. False

13. Under New York State law, child abuse is:

a. 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.
b. Any act of abuse committed by a child under the age of 10.
c. Limited to acts of a sexual nature on a child under 18.
d. Defined as applying to any child under 21 years of age.

14. Which is not a form of maltreatment?

a. Excessive corporal punishment
b. Lack of supervision
c. Poverty
d. Inadequate guardianship

15. When determining if a child shows indicators of maltreatment or abuse, it is important to remember:

a. Indicators will always be of a physical nature and will be visible.
b. Not to view indicators in isolation.
c. The explanation for the presenting concern is irrelevant.
d. Your prior experience with this child should not be factored in.

16. A behavioral indication of possible sexual abuse may be observed when the child:

a. Is dressed in old clothes or hand me downs.
b. Cries when she goes into an exam room.
c. Exhibits bizarre, sophisticated, or unusual sexual behaviors or knowledge for their age.
d. Clings to the parent.

17. Online sexual abuse is often related to unwanted sexual approaches, especially by an adult who contacts children for sexual purposes.

a. True
b. False

18. Children with intellectual and developmental disabilities (IDD) are at a significantly higher risk of experiencing maltreatment compared to their typically developing peers.

a. True
b. False

19. The Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) classifies the severity of ID by the level of support required.

a. True
b. False

20. The federal Indian Child Welfare Act (ICWA) protects the best interests of Native American children by supporting their cultural identity in issues pertaining to foster care, termination of parental rights, emergency removals, and adoption proceedings.

a. True
b. False

[Continue to next page for answer sheet]

Answer Sheet: NY Child Abuse for Mandated Reporters (365)

Name (Please print) _____

Date _____

Passing score is 80%

1. _____	15. _____
2. _____	11. _____
3. _____	12. _____
4. _____	13. _____
5. _____	14. _____
6. _____	16. _____
7. _____	17. _____
8. _____	18. _____
9. _____	19. _____
10. _____	20. _____

[Continue to next page for course evaluation]

Course Evaluation: NY: Child Abuse for Mandated Reporters (365)

Please use this scale for your course evaluation. Items with asterisks * are required.

1 = Strongly agree 2 = Agree 3 = Neutral 4 = Disagree 5 = Strongly disagree

*Upon completion of the course, I was able to:

1. Describe the problem of child maltreatment in the U.S. and New York State. 1 2 3 4 5
2. Summarize the process of reporting to the NY Statewide Central Register (SCR). 1 2 3 4 5
3. Explain the 5 components of Child Protective Services. 1 2 3 4 5
4. Recognize the impact of trauma and ACEs on children, families, and yourself. 1 2 3 4 5
5. Recognize the impact of bias on your decision-making. 1 2 3 4 5
6. Define “reasonable cause to suspect”. 1 2 3 4 5
7. Define child abuse and maltreatment/neglect in New York State. 1 2 3 4 5
8. Describe 3 indicators each for physical, emotional, and sexual child abuse. 1 2 3 4 5
9. Understand the indicators and signs of abuse in children with intellectual and developmental disabilities. 1 2 3 4 5
10. Understand legal requirements when working with limited English proficiency, Native American, and immigrant clients. 1 2 3 4 5

*The author(s) are knowledgeable about the subject matter. 1 2 3 4 5

*The author(s) cited evidence that supported the material presented. 1 2 3 4 5

*Did this course contain discriminatory or prejudicial language? Yes No

*Was this course free of commercial bias and product promotion? Yes No

*As a result of what you have learned, will make any changes in your practice? Yes No

If you answered Yes above, what changes do you intend to make? If you answered No, please explain why.

*Do you intend to return to ATrain for your ongoing CE needs?

_____Yes, within the next 30 days. _____Yes, during my next renewal cycle.

____Maybe, not sure. _____No, I only needed this one course.

*Would you recommend ATrain Education to a friend, co-worker, or colleague?

_____Yes, definitely. _____Possibly. _____No, not at this time.

*What is your overall satisfaction with this learning activity? 1 2 3 4 5

*Navigating the ATrain Education website was:

_____Easy. _____Somewhat easy. _____Not at all easy.

*How long did it take you to complete this course, posttest, and course evaluation?

_____60 minutes (or more) per contact hour _____59 minutes per contact hour

_____40-49 minutes per contact hour _____30-39 minutes per contact hour

_____Less than 30 minutes per contact hour

I heard about ATrain Education from:

_____Government or Department of Health website. _____State board or professional association.

_____Searching the Internet. _____A friend.

_____An advertisement. _____I am a returning customer.

_____My employer. _____Social Media

_____Other _____

Please let us know your age group to help us meet your professional needs.

_____18 to 30 _____31 to 45 _____46+

I completed this course on:

_____My own or a friend's computer. _____A computer at work.

_____A library computer. _____A tablet.

_____A cellphone. _____A paper copy of the course.

Please enter your comments or suggestions here:

[Continue to next page for registration and payment]

Registration and Payment: NY Child Abuse for Mandated Reporters (365)

Please answer all the following questions (* required).

*Name: _____

*Email: _____

*Address: _____

*City and State: _____

*Zip: _____

*Country: _____

*Phone: _____

*Professional Credentials/Designations:

_____

*License Number and State: _____

Teachers and Teaching Paraprofessionals: If you are a teacher or teaching paraprofessional and would like us to report your course completion to your TEACH account, the following information is required:

*Birthdate:_____

*Last 5 digits of your SS number:_____

Medical Professionals and Social Services: If you would like us to report your course completion to the NY State Office of the Professions, the following information is required:

*Birthdate:_____

*Profession code:

___ 05 MHP Creative Arts Therapist	___ 60 Medicine
___ 06 MHP Marriage and Family Therapist	___ 65 Podiatry
___ 10 LPN	___ 68 Psychology
___ 18 MHP Mental Health Counselors	___ 70 Chiropractic
___ 22 RN (also Nurse Practitioners)	___ 71 Licensed Behavioral Analyst
___ 23 Physician Assistant	___ 72 Licensed Master Social Worker
___ 24 Special Assistant	___ 73 Licensed Clinical Social Worker
___ 50 Dentist	___ 78 Certified Behavior Analyst Assistant

___ 51 Dental Hygienist ___ 56 Optometry	___ 79 Restricted Dental Faculty

___ **Other** (if your profession is not listed here, we are not required to report your course completion to the NYS Office of the Professions.

Payment Options

You may pay by credit card, check, or money order.

Fill out this section only if you are paying by credit card.

2 contact hours: $26

Credit card information

*Name: _____

Address (if different from above):

*City and State: _____

*Zip: _____

*Card type: Visa Master Card American Express Discover

*Card number: _____

*CVS#: _____ *Expiration date: _____