

American Medical Association

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Diagnostic and Treatment

Guidelines on

Child Physical Abuse and Neglect

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These guidelines are not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all the facts and circumstances involved in an individual case and are subject to change as scientific knowledge and technology advance and patterns of practice evolve. These guidelines reflect the views of scientific experts and reports in the scientific literature as of March 1992.

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Introduction

Child maltreatment has been endemic for generations. It is serious and life-threatening, affecting not only children but families and society as well. Every year, approximately two million children in the United States are seriously abused by their parents, guardians, or others, and at least 1000 children die as a result of their injuries.

Physicians are in a unique position to detect the injuries and behavioral problems resulting from child abuse and neglect. Physicians and other professionals providing services to children are required by state law to report suspected incidents of child abuse and neglect. Virtually all jurisdictions impose a civil or criminal penalty for failure to report, and as mandated reporters, physicians are afforded legal immunity from liability for good faith reports.

Children who are abused or neglected must be identified for their own protection. However, while much research has been conducted, knowledge concerning the dynamics and effective prevention and treatment of child abuse and neglect is not comprehensive, and our current understanding of child abuse as a symptom of family dysfunction and a problem with complex, variable origins suggests that no one person or profession can be solely responsible for the management of these cases. Disciplines other than medicine must contribute to the diagnosis and development of case management plans involving the child and other family members.

A multidisciplinary team should include representatives from the medical, mental health, social services, and legal professions who can provide consultation and case review to primary providers. Child protection teams are active in many communities and are mandated by law in some states. If a multidisciplinary team is not available, the physician can be a powerful advocate for team development.

In addition, physicians are encouraged to foster relationships with relevant government agencies and to participate in community efforts and professional societies to coordinate activities that promote child abuse prevention, intervention, and treatment. Interactions with nonmedical agencies may be puzzling and frustrating unless such personal relationships are developed, thereby allowing continued, open communications. Physicians are well positioned to participate as part of an assessment team and to engage in prevention strategies in their offices and communities.

Physicians in all practice settings will see abused children, and to protect them from further harm, physicians should:

- Identify the signs and symptoms of abuse and neglect
- Provide medical evaluation and treatment of injuries or conditions resulting from abuse and/or neglect

- Take emergency measures needed to protect the child from further injury. Where permissible by law, a physician should arrange for the custodial care of an abused or neglected child when there is risk of further injury. The child at risk can either be hospitalized or placed in emergency foster care
- Provide an accurate and complete medical evaluation and record
- Remain objective and professional toward child and caretakers
- When appropriate, attempt to establish or maintain a therapeutic alliance with the family. Often the physician is the only professional who maintains contact with the family after other care is terminated
- Attempt to secure medical evaluation of other children present in the household
- Report all cases of suspected child abuse and/or neglect in accordance with state and local legal requirements
- Be willing and available to give evidence in court

Facts about Child Abuse and Neglect

Although child abuse was identified as a social problem in the last century, it took almost 100 years for violence toward children to be considered a major national problem. In the 1940s, through the use of diagnostic x-ray technology, physicians began to notice patterns of healed fractures in young children that could have resulted only from repeated blows. Although pediatric radiologists were diagnosing child abuse, it was not until C. Henry Kempe and his associates published their classic work, "The Battered Child Syndrome," in the *Journal of the American Medical Association* in 1962 that battering and abuse became a focal point of public attention. As a result, model legislation for child abuse reporting was proposed by four groups: the US Children's Bureau, the Children's Division of the American Humane Association, the American Medical Association, and the Council of State Governments. By the end of that decade, all states had passed laws requiring the reporting of child abuse and neglect and had initiated efforts to treat abused children and their families. In 1974, the US government established the National Center on Child Abuse and Neglect to provide a mechanism for increasing knowledge about the causes of child abuse and neglect and to identify steps toward prevention and treatment.

The causes of child abuse and neglect are complex and varied. Child maltreatment can be inflicted by anyone responsible for caring for children, and it occurs in all types of families and settings. Children of all ages may be physically abused. Although infants and young children are more likely to receive serious or life-threatening injuries, adolescent abuse also occurs and often is unrecognized.

Physicians must always remain alert to the possibility that abuse may be occurring, even when the child says nothing or says that she or he has never been hurt because children frequently do not complain about the abuse they are receiving. Current research has found that the following child and family characteristics may be risk factors for child abuse and/or neglect:

Child characteristics:

- The child was born prematurely
- The child has disabilities or abnormalities
- The child exhibits certain behaviors of infancy and childhood, such as persistent crying

Family characteristics:

- There is other violence in the home (in particular, the father abuses the mother or siblings abuse one another)
- Substance abuse, including alcohol abuse, by the parents or caretakers
- The parents or caretakers lack the necessary maturity to care for the child
- Parental expectations are inconsistent with the child's developmental abilities
- The caretaker is socially isolated (i.e., has no external support systems)
- The family is experiencing high levels of stress from events such as loss of a job, increased financial burdens, serious illness, death in the family, separation or divorce
- Adult members of the family have themselves been abused as children, either physically or sexually

These risk factors are not necessary antecedents to abuse, however, and physicians must consider abuse or neglect whenever physical or behavioral signs are suggestive, regardless of the presence or absence of the foregoing risk factors. Otherwise, instances of abuse may not be identified.

In situations where the physician provides care for all members of the family, knowledge of the medical and social histories of the child's parents or caretakers will help ensure that fewer cases of child abuse elude detection. Different forms of abuse can and do coexist in families. Moreover, abusive behavior often occurs in successive generations of families, a phenomenon known as the "cycle of violence."

Although some studies have indicated a correlation between child abuse and factors such as income, race, education, and marital status, some of these studies may have been subject to bias since physicians may be more likely to consider child abuse when the family has a lower income or is non-white.

Ethical Considerations

When a physician who has a prior professional relationship with a family suspects that a child is being abused by the parent(s), a conflict will likely arise between the physician's duty to report the abuse and the parents' desire to keep that concern between the physician and family. Physicians resolve this problem by calling parents' attention to the reporting mandate and by being neutral in their attitudes. Nonetheless, many parents may decide to terminate their relationship with the reporting physician. If the physician not only identifies the suspected abuse but also carries out the "definitive" medical assessment for abuse, she/he must be prepared to testify against the parent in an adversarial proceeding, making a continued physician-patient relationship involving the parent or other caretaker extremely difficult.

Most primary care physicians resolve this problem by referring the child for the definitive forensic medical assessment and continuing to offer supportive and medical services to the child and family. If the primary physician is also the most qualified provider of definitive assessments, referral of the family to a new primary physician may be necessary. The problem cannot legally be resolved by failing to report the suspected abuse because this can endanger the child.

Diagnosis of Abuse

Physical abuse is defined as inflicted injury to a child and can range from minor bruises and lacerations to severe neurologic trauma and death. In making the diagnosis, the physician must conduct a thorough health assessment, including a history, physical examination, and developmental assessment, on any child who may be a victim of abuse. Laboratory studies (e.g., x-ray, CT scan, bone scan, coagulation studies) are useful in delineating the nature and extent of current trauma, in defining the presence of previous trauma, and in excluding other medical causes.

During the diagnostic process, the physician should:

- Assess the child's immediate medical needs
- Obtain the past medical and social history of the child and family members
- Assess the plausibility of the history being provided in light of any pre-existing medical conditions
- Determine the level of risk to the child if she or he returns home

Certain types of injuries are more commonly associated with abuse: the injuries are not explained by the history provided, are often located on multiple body sites and often are in different stages of healing. However, the medical recognition of child abuse may be based on the existence of a single injury.

The following physical findings may be indicative of physical abuse:

Bruises and Welts

- Forming regular patterns, often resembling the shape of the article used to inflict the injury (e.g., hand, teeth, belt buckle, electrical cord)

Burns

- Cigar or cigarette burns, especially on the soles, palms, back, or buttocks
- Immersion burns (stocking or glove-like without splash burns on extremities, doughnut-shaped on buttocks or genitals)
- Patterned burns resembling an electrical appliance (e.g., iron, burner, grill)

Lacerations or Abrasions

- Rope burns, particularly on wrist, ankles, neck, torso
- Palate, mouth, gums, lips, eyes, ears
- External genitalia

Fractures

- Skull, ribs, long bones, metaphyseal

Abdominal Injuries

- Bruises of the abdominal wall
- Intramural hematoma of duodenum or proximal jejunum
- Intestinal perforation
- Ruptured liver or spleen
- Ruptured blood vessels
- Kidney or bladder injury
- Pancreatic injury

Central Nervous System Injuries

- Subdural hematoma (often reflective of blunt trauma or violent shaking)
- Retinal hemorrhage
- Subarachnoid hemorrhage (often reflective of shaking)
- Cerebral infarction, secondary to cerebral edema

Other Indications

- Münchausen syndrome by proxy
- Symptoms of suffocation
- Chemical abuse

Deprivational Syndromes

Deprivation related disorders develop when the basic needs of the child are not being met: adequate nutrition, clothing, shelter, emotional support, love and nurturing, education, safety, and medical and dental care. The reasons for parental failure to meet these needs may be multifactorial and include lack of resources, inadequate access to care, parental substance abuse, parental psychopathology (e.g., depression), parental priorities which relegate the needs of the child to a lower rank, or even a history of abuse of the caretaker when she or he was a child. In the latter case, the psychological effects may limit the caretaker's recognition of neglect as maltreatment. The major symptomatology displayed by the deprived child may be global or may reflect an area of isolated deprivation.

Historical Findings

- Lack of appropriate well-child care, including immunizations
- Lack of appropriate medical care of chronic illness
- Absence of necessary health aids such as eyeglasses or hearing aids
- Absence of appropriate dental care

Physical Findings

- Undernutrition (on examination or as evidenced by plotting on appropriate growth curves)
- Poor hygiene, such as being extremely filthy or having extraordinarily severe diaper rash
- Developmental delay
- Untreated medical conditions
- Rampant dental caries

Behavioral Findings

- Depression
- Anxiety
- Enuresis
- Sleep disturbances
- Excessive masturbation
- Impaired interpersonal relations (e.g., lack of cuddliness, gaze avoidance, preference for inanimate objects)
- Discipline problems, aggressive behavior
- Poor school performance
- "Role reversal," in which child assumes caretaker role
- Excessive household responsibilities, including child care

Like the risk factors for abuse, these findings are not specific to cases of neglect. In cases of neglect, the finding may be related to the omission of basic needs or the failure to protect, while in other cases, there is inflicted emotional abuse, including unreasonable

parental demands, constant or persistent harassment, belittling or verbal attacks. Such forms of emotional maltreatment are particularly difficult to document, and consultation with mental health experts may be useful.

Interviewing Process

When abuse is suspected, the physician must gather a detailed medical history from the child, if possible, and the caretakers. This history should follow the format of a thorough pediatric health assessment with special attention to the injuries and to factors that may help in determining continued risk to the child. In abuse cases, the explanation of an injury frequently is implausible or changes over time. The locally designated child protection agency and/or the police must be informed.

If possible, the child should be interviewed separately. The interviewer must be sensitive to the child's possible fears and apprehension when discussing the home situation and should tailor the interview to the child's developmental level. Although repetitive interviews can be problematic, the physician must gather the basic information necessary to help make decisions that are in the best interest of the child. When talking with younger children, it is best for the interviewer to sit at the child's eye level. Questions beginning with "How come..." are more productive than questions beginning with "Why..."

Local child protection service personnel or teams may be involved in the initial interview if requested. In cases of severe abuse, parents may flee with the child; thus it is advisable to contact the mandated reporting agency prior to informing the parents of the suspected diagnosis. *Above all else, the primary concern is to protect the child.*

When interviewing the child:

- Attempt to obtain pertinent information from others prior to the interview, including the specifics of the abuse—the date, exact time, place, sequence of events, people present, and time lag before seeking medical attention—and a complete social history, including where the child resides, length of residence, other household members, support systems available to the family, and child care arrangements
- Sit near the child, not across a desk or table, and at the child's eye level
- Attempt to establish an empathic, trusting relationship
- Conduct the interview in private and without the caretaker being present
- Have the child interviewed by the most experienced professional(s) available
- Find out who else has questioned the child
- Explain the purpose of the interview to the child in language appropriate to her/his developmental level
- Use the child's own words and terms in discussing the situation whenever feasible
- Always ask the child if she/he has any questions and answer them
- Carefully explain to the child the reason and nature of her/his removal from the home, if imminent
- Ask the child to explain words or terms that are unclear

- Acknowledge that the situation must have been a difficult one for the child and emphasize that the child was not at fault

Do not:

- Suggest answers to the child
- Press the child for answers that she/he is unwilling to give
- Criticize the child's choice of language
- Suggest that the child feel blame or guilt for the situation
- Leave the child unattended or with unknown persons
- Display shock or horror concerning the child or the situation
- Offer rewards to the child

Maintaining a professional approach with the family, although not always easy, can facilitate the interviewing process. Explaining the reporting process and what the parents can expect to happen is often helpful. A nonaccusatory statement such as "I am required by law to make a report to the child protective service agency whenever I see a child with an injury (a condition) like this one" should be used.

When interviewing the caretakers:

- Reserve judgment until all facts are known
- Tell them the reason for the interview
- Advise them of the physician's legal obligation to report cases of suspected abuse
- Conduct the interview in private or, when indicated, with appropriate personnel (e.g., child protection service personnel)
- Attempt to be objective
- Reassure the caretakers of the physician's continued availability
- Explain further actions that will be required
- Answer questions honestly

Do not:

- Attempt to prove abuse or neglect
- Display anger, horror, or disapproval of the caretakers or situation
- Place blame or make judgments
- Give feedback on the caretakers' explanation of how the injury occurred since this will permit them to change an implausible explanation based on your feedback

In cases where the caretaker was abused as a child and has unresolved issues related to her or his own trauma, the physician may encounter some resistance to questioning, necessitating a separate evaluation. In addition, resistance may be more likely in those

cases where violence is ongoing within the home, particularly where the mother is being abused: child abuse reportedly occurs in one third to one half of all cases of domestic violence.

It is not unusual for caretakers who were themselves abused as children to relive their victimization experiences during the investigation process. Female caretakers, for example, have been known to regain once-repressed memories of their own abuse after the traumatic discovery that their children have been victimized. It is also possible that a prior unresolved history of abuse may affect the caretaker's ability to recognize injurious behavior as abuse or to detect evidence of abuse, even when it occurs within the caretaker's household. Consequently, physicians must remain sensitive to the needs of all family members.

Physical Examination

A thorough physical examination should be performed on every child suspected of being physically abused. The goals of the examination should be to identify trauma or conditions requiring medical attention, to document evidence of abuse, and to reassure the child or parents that the child will be all right. The physical examination should:

- Be conducted separately from the initial history-taking
- Be conducted in a gentle and sensitive manner
- Be conducted with the consent of the child
- Utilize no restraint or force
- Take sufficient time for the child to be comfortable

Photographs

Photographs are particularly valuable as evidence. State laws vary with respect to the taking of photographs by physicians or other designated parties; some authorize photographs being taken without the parents' consent and many states provide authorized persons with statutory immunity from liability in the taking of photographs. In any case, photographs do not replace a careful, written description of the injury.

- When possible, take photographs before medical treatment is given
- Use color film, but photograph bite marks in black and white as well as in color, if possible
- Photograph from different angles, full body, and close-up
- Hold up a coin, ruler, or other object to illustrate the size of an injury
- Include the child's face in at least one picture
- Take at least two pictures of every major trauma area
- Precisely mark all photographs with the child's name, the date, location of injury, name of photographer, and others present
- Use a color standard

Imaging

X-rays and other forms of imaging are often essential in diagnosing the injuries associated with abuse. Radiologists skilled in the diagnosis of maltreatment should be consulted, and studies of areas not obviously injured may be indicated. State laws that apply to the taking of photographs usually apply to x-rays as well.

Documentation

If court evidence becomes necessary, well-documented medical records may eliminate or reduce the time a physician may be required to spend in judicial proceedings. Medical records provide the most concrete and sometimes only evidence of abuse of a child. The significance of a statement or piece of evidence is not always clear at the time it is revealed, so it is crucial to keep an organized record of everything that may be needed as proof in a case involving a child. The records should be kept in a precise, professional manner and should include the following:

- A standard, thorough pediatric health assessment, including a medical history and relevant social history
- Statements made by the child and caretaker, including any taped interviews
- Observed behavior
- The location of the alleged abusive event(s)
- A detailed description of the injuries, including type, number, size, degree of healing, possible causes, explanations given, and location recorded on a body chart or drawing
- An opinion on whether the injuries were adequately explained
- Results of all pertinent laboratory and other diagnostic procedures
- Photographs and imaging studies, if applicable
- Any other significant facts or materials that address the who, what, where, when, and why of the injuries

For medical records to be admissible in court, the physician should be prepared to testify:

- That the records were made during the “regular course of business” at the time of the examination or interview
- That the records were made in accordance with routinely followed procedures
- About the care, custody of, and access to the records

Reporting Requirements

All states have mandatory reporting laws for physical abuse of children. If a person required by statute to report such cases suspects that a child has been abused or neglected, the proper authorities must be notified. Reporting laws apply to all physicians, not only to those treating children. Physicians may be obligated to report suspected abuse even if they have never seen the child (e.g., when an adult patient makes a revelation involving abuse of a child).

Although child abuse and neglect laws vary among jurisdictions, all statutes include definitions of child abuse and neglect; descriptions of reporting procedures, including the designation of an agency to investigate reports (usually social services or law enforcement); and grants of immunity from liability for mandatory reporters who make reports in good faith. Initial reports usually can be made orally, but they must be made immediately or as soon as possible in order to protect the child quickly. Written reports prepared within a few days of the oral report also may be required. The required contents of reports vary but normally include the names of the child and parents or caretakers and a description of the injuries. Physicians are advised to obtain copies of their jurisdiction's child abuse and neglect reporting laws from their medical society or local child protection service agency.

As with laws requiring reporting of certain infectious diseases, overriding interests of individual safety can limit some physician-patient rights of confidentiality. Protecting patient confidentiality does not legally justify a failure to report. Most state statutes allow physicians to share confidential information with people working on a child abuse case without violating the physician-patient privilege. Furthermore, virtually all states specify that the physician-patient privilege does not provide grounds for excluding testimony at trial.

To encourage reporting, all states provide mandatory reporters with immunity from liability. Such immunity may be either absolute or qualified. Absolute immunity protects reporters even when their reports are made negligently or with knowledge of their falsity. Qualified immunity is the more common type; it protects physicians who make reports in good faith and prevents them from being held civilly or criminally liable even when no abuse or neglect is ultimately found to have occurred. Unfortunately, however, the immunity that protects the reporting physician from liability does not mean that a lawsuit cannot be filed.

Most states also impose criminal penalties for failure to report such cases. Failure to report is usually classified as a misdemeanor, punishable by a fine and/or jail sentence. Physicians who fail to report also are at serious risk for civil action by the child or the child's family if a court determines that a reasonable physician should have suspected abuse based on the symptoms, signs, or history.

More significant than the legal penalties, however, are the potential adverse effects on the child when someone fails to report a case of suspected child abuse. A number of states require mandated reporters to sign statements demonstrating their awareness of their duty to report and their intention to fulfill that duty, and some states require mandated reporters to take training courses.

What to report:

- Suspected incidents of physical abuse, sexual abuse, neglect and emotional cruelty
- Instances in which the child is deprived of adequate nurturing, health, education, and safety
- A few states also require reporting of newborn infants who suffer from fetal alcohol syndrome or other fetal drug syndromes

If the physician is in doubt about the appropriateness of a report, informal peer consultation can be useful.

Once a report has been filed, the child protection service agency will conduct an investigation. If the suspected incident of child abuse or neglect is substantiated, several outcomes are possible. Depending upon the circumstances, counseling or psychotherapy may be provided, and foster placement may be arranged. Criminal charges alleging a crime may be filed, although criminal indictments occur in only a small percentage of cases. Civil and juvenile courts are charged with assuring the protection of children, and their standards of proof are not as high as those of criminal courts. Participation by physicians at both levels is essential as part of advocacy for children. The physician should maintain contact with the protective services agency by telephone or written correspondence in order to coordinate follow-up care, though in practice this may be difficult. Some agencies are required by statute to communicate their actions to the person who reported the abuse.

Obtaining an Order of Temporary Custody

When a physician has reason to believe that a child will be in imminent danger if released to the caretaker, the appropriate authority as designated by law should be contacted immediately. Most states authorize certain parties, such as hospitals, physicians, child protection agencies, or the police to detain children in emergency situations. Physicians should check their local statutes or hospital protocol to determine the appropriate agency to call. The period of protective custody is usually no longer than 72 hours and the appropriate court must be notified of the action, sometimes before taking the child into custody.

Testimony

Some physicians are concerned about the time and inconvenience of a court appearance. In some cases, medical records may be admitted without requiring the physician's in-court testimony. However, if testimony is required, it may be possible to place the physician "on call" so that she or he need appear only when it is time to testify.

The physician may testify about general observations of behavior or statements made, a function that is distinct from the use of the doctor as an expert. A physician should never feel insulted if called to give only this type of layperson" testimony or to testify about a nonmedical issue because this may be the only way to get such information before the court. When called as an expert witness, the physician may be requested to give an opinion on whether the explanation given is consistent with the injury.

For any testimony, the following guidelines should be followed:

- Insist on pre-trial preparation by the attorney presenting you as a witness
- Determine the legal and factual issues and how your testimony relates to these issues
- Determine what demonstrative evidence (e.g., photographs) should be part of your testimony
- If testifying as an expert witness, propose questions for the attorney to ask
- Brief the attorney on questions to ask the opposing expert
- Answer only the question asked
- If a question is not understood, ask that it be repeated; explain when a one-word answer is not enough
- Do not volunteer information
- Calmly correct an attorney who misstates prior testimony

Risk Management

Most physicians will encounter cases of child abuse in their practices. Physicians must be aware of their obligations in these cases, as well as their potential liability for failing to diagnose and report the abuse and neglect. In general, doing what is medically best or most appropriate is good risk management.

In every state, a potential cause of action exists for a physician's failure to diagnose and report child abuse. If an injured child is treated by a physician, returned to the parents care, and subsequently sustains further injuries, the physician may be held liable. In legal terms, the physician breached a duty owed to the child, and her or his failure to take action was the proximate cause of the child's injuries.

Specialists must adhere to the standards of their specialty rather than those of general practitioners. In diagnosing and treating victims of child abuse or neglect, every physician should:

- Have a thorough knowledge of the reporting laws in her/his state of practice
- Be aware of the “battered child syndrome”
- Be aware of behavioral signs that suggest abuse, including sexual abuse
- Be alert to signs of neglect
- Be aware of populations at high risk for abuse and psychosocial risk factors for abuse
- Arrange for physical examinations and interviews as appropriate
- If uncomfortable with a situation, request a specialist to examine or interview the child
- Get a second opinion in unclear situations
- Provide follow-up medical care for the child
- Be sensitive to the problems of abusive parents
- Be familiar with related abuse problems

Even after taking all possible measures to handle all cases correctly, a physician may become a defendant in a medical malpractice suit. The physician should:

- Not panic
- Immediately contact her/his attorney or insurance carrier
- Not discuss the case with anyone else until after speaking with her/his attorney
- Record the circumstances involved in the serving of a summons
- Have clear documentation

Trends in Treatment and Prevention

The physician’s role in the treatment of child abuse and neglect historically has been one of detection, medical diagnosis, and treatment or referral. However, the role of the physician can be greatly expanded. Physicians may serve on hospital child protection teams, provide medical services to private service agencies, participate on community multidisciplinary review boards, and participate on advisory boards of voluntary agencies (e.g., Parents Anonymous). Physicians also may work with local child protection agencies to develop a follow-up mechanism for reported cases.

Physicians can participate in the primary prevention of child abuse and neglect as well. Comprehensive prevention strategies should be directed at increasing parents’ (or future parents’) knowledge of child development and the demands of parenting. Parent-child bonding, emotional ties and family communications, and home and child management issues should be addressed. These same strategies may be used to strengthen parents’ skills in coping with the stresses of infant and child care and, in particular, caring for children with special needs. Approaches to prevention should attempt to reduce the burden of child care, family isolation, and long-term consequences of poor parenting. Increased access to

health and social services for all family members is another goal of any prevention effort, and physicians can actively participate in national, state, or community programs that are directed at achieving these goals.

State Reporting Agencies

Alabama

Information:

Department of Human Resources
Bureau of Family & Children Services
South Gordan Persons Building
50 Ripley Street
Montgomery, AL 36130
205 242-9500

Reporting:

County office of Department of
Human Resources

Alaska

Information and reporting:

Local office of Family and Youth
Services or call statewide 24-hour hot
line: 800 478-4444

Arizona

Information and reporting:

Regional office of child protection
services under the Arizona Department of
Economic Security (32 regional offices;
each has 24-hour hot line)
Phoenix hot line: 800 541-5781

Arkansas

Information and reporting:

Department of Human Services
Central Registry
PO Box 1437, Slot 830
Little Rock, AR 72203
800 482-5964 (information, reporting,
and parents under stress, 24-hour)

California

Information:

Department of Social Services
Office of Child Protective Services
916 657-2030

Reporting:

Abuse by family member:
County Child Protective Services (under
Department of Social Services); each
county has a 24-hour hot line. Abuse by
non-family: Local police department

Colorado

Information and reporting:

County office of Department of
Social Services
Denver County: 24-hour hot line
303 727-3000
Other counties: After hours call
sheriffs office (on-call social worker)

Connecticut

Information:

Department of Human Resources
Department of Children and Youth
Services
170 Sigourney Street
Hartford, CT 06105
203 566-3661

Reporting:

Regional office of Department of
Human Resources
800 842-2288, 24-hour hot line will
refer to regional offices

Delaware

Information:

Department of Services for Children,
Youth & Their Families
Child Protective Services
62 Rockford Road
Wilmington, DE 19806
302 577-2163

Reporting:

County office where child is resident
24-hour hot line 800 292-9582

District of Columbia

Information and reporting:

DC Police Department
Youth Division
1700 Rhode Island Avenue, NE
Washington, DC 20018
To report child abuse: 202 576-6762
To report child neglect: 202 727-0995

Florida

Information and reporting:

Florida Abuse Registry
800 962-2873
(904 487-2625)

Georgia

Information:

Department of Human Resources
Child Protective & Placement
Services Unit
878 Peachtree Street
Atlanta, GA 30308
404 894-5672

Reporting:

County office of Department of Human
Resources

Hawaii

Information and reporting:

Department of Social Services
Family and Children Services
24-hour hot line: 808 832-5300 or report
to island police department

Idaho

Information:

Department of Health and Welfare

Reporting:

Regional offices (26 field offices!
7 regions). For information and referral
to regional office, call 208 334-5700

Illinois

Information:

Department of Children and Family
Services
Division of Child Protection
State Central Register
406 East Monroe Street
Springfield, IL 62701
217 785-4010

Reporting:

24-hour hot line for reporting and
parents under stress
800 252-2873

Indiana

Information and reporting:

Indiana Family and Social
Services Administration
Division of Family and Children
402 West Washington Street, Rm W364
317 232-4431

Hot line for reporting institutional abuse/
neglect of children
800 562-2407

Iowa

Information and reporting:

Local office of Department of Human Services (there are 8 district offices) or call state hot line: 800 362-2178

Kansas

Information:

Department of Social and Rehabilitative Services
Child Protection and Family Services
Youth Services
913 296-4657

Reporting:

Regional office of Department of Social and Rehabilitative Services
24-hour hot line: 800 922-5330

Kentucky

Information and reporting:

Local Department for Social Services or statewide hot line: 800 752-6200
In Jefferson County call 502 581-6184
Parents Anonymous: 800 432-9251

Louisiana

Information and reporting:

Regional offices of Child Protection Services or call 24-hour hot line: 504 925-4571

Maine

Information:

Department of Human Services
Childrens' Emergency Services
207 289-2983

Reporting:

Business hours: County office of Department of Human Services
After hours: 800 452-1999 (24-hour)

Maryland

Information and reporting:

County office of Department of Social Services
Each office has 24-hour hot line
Baltimore City hot line: 301 361-2235

Massachusetts

Information:

Information packet for mandated reporters available through Department of Social Services
24 Farnsworth Street Boston, MA 02210
617 727-0900 (x573)

Reporting:

Make reports to area office of Department of Social Services where child is resident
24-hour state hot line 800 792-5200

Michigan

Information and reporting:

Each county protective services (under Department of Social Services) has 24-hour hot line
Private hot line run by GATEWAYS can direct to county offices and provide information: 800 942-4357

Minnesota

Information and reporting:

County office of Department of Human Services
Each office has 24-hour hot line

Mississippi

Information:

Department of Human Services
601 354-6659

Reporting:

County office of Department of Human Services or to 24-hour hot line: 800 222-8000

Missouri

Information:

Department of Social Services
Child Abuse and Neglect
Broadway State Office Building
PO Box 88
Jefferson City, MO 65 103
314 751-3448
Parental Stress Helpline: 800 367-2543

Reporting:

800 392-3738 (24-hour)

Montana

Information:

Department of Family Services
Child Abuse & Neglect Program
PO Box 8005
Helena, MT 59604
406 444-5900

Reporting:

Local Department of Family Services or
800 332-6100 (24-hour)

Nebraska

Information:

Department of Social Services
Child Protective Services
1001 O Street
Lincoln, NE 68508-3649
402 471-7000

Reporting:

800 652-1999 (24-hour)

Nevada

Information:

Department of Human Resources
Division of Child and Family Services
711 East 5th Street
Carson City, NV 89710
702 687-5982

Reporting:

Local child protection agency or
800 992-5757 (all areas except Clark
County)
702 399-0081 (Clark County)

New Hampshire

Information:

Department of Health and Welfare
Division for Children and
Youth Services
Health & Welfare Building
6 Hazen Drive
Concord, NH 03301
603 271-4451

Reporting:

800 562-2340 (eastern area)
800 624-9701 (western area)
800 458-5542 (central and northern
areas)
800 852-3388 (24-hour helpline)

New Jersey

Information:

Division of Youth and Family Services
50 East State Street - CN717
Trenton, NJ 08625

Reporting:

800 792-8610 (24-hour)

New Mexico

Information:

Department of Human Services
Social Services Division
Pollon Plaza
Santa Fe, NM 87504
505 827-8400

Reporting:

Local Department of Human Services or
800 432-6217 (24-hour, information and
referral)

New York

Information:

Department of Social Services
Division of Family and Child Services
40 North Pearl Street
Albany, NY 12243
518 474-9003 (public information)

Reporting:

800 342-3720 (24-hour)

North Carolina

Information:

Department of Human Resources
Division of Social Services
Child Protective Service Unit
325 North Salisbury Street
Raleigh, NC 27603
919 733-2580

Reporting:

County Department of Social Services
800 662-7030 (helpline)

North Dakota

Information:

Department of Human Services
Child Abuse and Neglect
State Capitol
Bismarck, ND 58505
701 224-2316

Reporting:

County Social Services

Ohio

Information:

Department of Human Services
Child Protective Services Unit
Bureau of Children Services
65 East State Street 5th floor
Columbus, OH 43215
614 466-9824

Reporting:

Local Department of Human Services

Oklahoma

Information:

Department of Human Services
Division of Child Welfare
PO Box 25352
Oklahoma City, OK 73125
405 521-2283

Reporting:

800 522-3511 (24-hour, all areas
except Oklahoma County)
800 841-0800 (24-hour, Oklahoma
County)

Oregon

Information:

Department of Human Resources
Children's Services Division
198 Commercial Street, SE
Salem, OR 97310
503 378-4722

Reporting:

County Child Protective Services or
503 378-4722

Pennsylvania

Information:

Department of Public Welfare
Child Abuse Central Registry
Lanco Lodge, 3rd floor
PO Box 2675
Harrisburg, PA 17120
717 783-8744 (administrative)

Reporting:

800 932-0313 (24-hour, reporting and
information)

Puerto Rico
Information:
Department of Social Services
Family Services
PO Box 11398
Santurce, PR 00910
809 724-0303
809 723-2127

Reporting:
809 724-1333 (24-hour)

Rhode Island
Information:
Department of Children, Youth,
and Families
610 Mount Pleasant Avenue
Providence, RI 02908
401 457-4708

Reporting:
800 742-4453 (24-hour, reporting and
information)

South Carolina
Information:
Department of Social Services
Division of Child Protective and
Preventive Services
1535 Confederate Avenue
PO Box 1520
Columbia, SC 29202
803 734-5670

Reporting:
County Department of Social Services

South Dakota
Information:
Department of Social Services
Child Protection Services
700 Governors Drive
Pierre, SD 57501-2291
605 773-3227

Reporting:
Local Department of Social Services

Tennessee
Information:
Department of Human Services
Child Protective Services
400 Deaderick
Nashville, TN 37248-9300
615 741-5927

Reporting:
County Department of Human
Services. After business hours, contact
local sheriffs department

Texas
Information:
Department of Human Services
Childrens' Protective Services
7901 Cameron Road
Building 3, 3rd floor
Austin, TX 78761
512 834-0034

Reporting:
800 252-5400 (24-hour)

Utah
Information:
Department of Human Services
Child Abuse
2835 South Main
Salt Lake City, UT 84101
801 538-4171

Reporting:
800 678-9399 (24-hour)
801 487-9811(24-hour investigation
line)

Vermont

Information:

Department of Social and Rehabilitation Services
Division of Social Services
103 South Main Street
Waterbury, VT 05671-2401
802 241-2131

Reporting:

Regional Department of Social and Rehabilitative Services during business hours
Emergency/after hours: 800 356-6552

Virginia

Information:

Department of Social Services
Child Protective Services Unit
8007 Discovery Drive
Richmond, VA 23229
804 662-9081

Reporting:

800 552-7096 (24-hour, within Virginia)
804 662-9084 (24-hour, from out of state)

Washington

Information:

Social and Health Services
Division of Child and Family Services
Childrens' Protective Services
Mail Stop 5710
Olympia, WA 98504
206 753-7002

Reporting:

800 562-5624 (24-hour)

West Virginia

Information:

Department of Health and Human Resources
Office of Social Services
State Capital Complex
Building 6, Room 850
Charleston, WV 25305
304 348-7980

Reporting:

800 352-6513 (24-hour)

Wisconsin

Information:

Department of Health and Social Services
Children, Youth, and Families Bureau
Office of Child Abuse and Neglect
I West Wilson Street
Madison, WI 53703
608 266-3036

Reporting:

Local county Department of Health and Social Services

Wyoming

Information:

Department of Family Services
Youth Services Division
Hathaway Building
2300 Capital Avenue
Cheyenne, WY 82002-0490
307 777-7150

Reporting:

Local county sheriff or police for on-call social worker

National Child Abuse Hot Line (Child Help USA): 800 422-4453