The California Child Abuse REPORTING LAW

Issues and Answers for Professionals

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THE FACTS

Abuse and exploitation of children have existed throughout history, yet it is only since the sixties that professionals have labelled certain parental behavior "abusive" and have set clear guidelines for legal intervention to protect the child.

The term "battered child syndrome" was coined by Dr. C. Henry Kempe in the early 1960's and since then much attention has been given to determining causes of parental/caretaker abuse, and developing preventive approaches.

Child abuse has reached serious proportions. Statistics are merely estimates of the true incidence of abuse, since so many cases go undetected or unreported. See Appendix A.

INTRODUCTION

WHY REPORT???

This pamphlet is written to assist mental health professionals and others in the helping fields to think through their reporting responsibilities and take action when needed.

Making a report of suspected child abuse is difficult. There are always nagging doubts about how the parents will react, what the outcome will be, and whether or not the report will put the child at greater risk from angry parents.

The best way to minimize the difficulty of reporting is to be fully prepared for the experience, and to feel reasonably comfortable with the reporting requirements and the mechanism that is triggered by making a report.

The mental health professional can often use the reporting responsibility therapeutically, in the best interest of the child and family.

People who abuse children are out of control. For varied reasons, their internal controls are unavailable. Therefore, they need as many **external** controls as possible, until they are better able to utilize their own restraints. The reporting law is an opportunity to set an external control which clearly states, "the *(abusive)* behavior is unacceptable, and must stop."

The most frequent question about reporting is, "Does reporting sever the trust the client must establish in therapy?" **Not** reporting has a greater potential to sever trust because the clients who are abusing children are showing, in action, or words, that they need help. How can clients trust you if you fail to recognize their needs and avoid helping them?

Finally, working with abusive clients is extremely demanding work. The therapist is often called upon to help make decisions such as: "Can the child stay safely in the home?"; "Is the family ready for the child to return home?"; "What is the likelihood of abuse recurring?" It is easier to make these recommendations while working in concert with other professionals who also have ongoing contact with the family. The multi-disciplinary approach with shared responsibility has been found to be the most effective way of working with abusive families.

THE REPORTING LAW

The first reporting law in California was enacted in 1963. By 1966 all states had a reporting law. These early laws mandated only physicians to report physical abuse.

Over the years, numerous amendments have expanded the definition of child abuse and the persons required to report. Procedures for reporting categories of child abuse have also been clarified.

In California, there are a number of child-contacting professionals required to report known or suspected child abuse. Other citizens, not designated by law to report, **may** also do so.

It is important for mental health professionals and others to keep updated on periodic amendments in the law. Your local Child Abuse Council or Child Protective Agency (see Resources) has current reporting law information.

1. Why Must You Report?

The primary intent of the reporting law is to **protect the child.** Protecting the identified child may also provide the opportunity to protect other children in the home or yet unborn children. It is equally important to **provide help for the parents** and respond to their "action language". Parents may be unable to ask for help directly, and child abuse may be their way of calling attention to family problems.

2. What Do You Report?

The following types of abuse must be reported by all legally mandated reporters, when the victim is a child (a person under the age of 18) and the perpetrator is any person (including a child). The California Child Abuse Reporting Law is found in Penal Code Section 11165-11174.5.

a. A **physical injury** inflicted by other than accidental means on a child. (P.C. 11165(g).)

b. **Sexual abuse including sexual assault** and **sexual exploitation.** Sexual assault includes sex acts with children and child molestation, and does not require force or lack of consent. Sexual exploitation includes child pornography and child prostitution. (P.C. 11165(b)(1)(2)(B)(A)(C), P.C. 11165.3(a).)

c. **Willful cruelty or unjustifiable punishment,** including inflicting or permitting unjustifiable physical pain or mental suffering, or the endangerment of the child's person or health. (P.C. 273a, P.C. 11165(d).) "Mental suffering" in and of itself is excepted from the duty to report. However, it **may** be reported. (P.C. 11166(b).)

d. **Corporal punishment or injury,** willfully inflicted, resulting in a traumatic condition. (P.C. 273d, P.C. 11165(e).)

e. **Neglect** of a child, whether "severe" or "general", must also be reported if the perpetrator is a person responsible for the child's welfare. It includes acts or omissions harming or threatening to harm the child's health or welfare. (P.C. 11165(c)(1)(2).)

f. Any of the above types of abuse or neglect occurring in out-of-home care. (P.C. 11165(f).)

3. Who Reports?

Legally mandated reporters include "child care custodians", "health practitioners", "employees of a child protective agency", and "commercial film and photographic print processors", defined as follows:

a. **"Child care custodian"** means a teacher; an instructional aide, a teacher's aide, or a teacher's assistant employed by any public or private school, or a classified employee of any public school, who has been trained in the duties imposed by the Penal Code; administrative officer, supervisor of child welfare and attendance, or certificated pupil personnel employee of any public or private school; an administrator of a public or private day camp; a licensee, an administrator or an employee of a community care facility or a child day care facility licensed to care for children; headstart teacher; a licensing worker or licensing evaluator; public assistance worker; an employee of a child care institution including, but not limited to, foster parents, group home personnel and personnel of residential care facilities; a social worker or a probation officer or any person who is an administrator or presenter of, or a counselor in, a child abuse presentation/prevention program in any public or private school. (P.C. 11165(h), 11165.1, 11165.5, 11165.6(b).)

b. **"Health practitioner"** means a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, marriage, family, and child counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, any emergency medical technician I or II, paramedic, a person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, a psychological assistant registered pursuant to Section 2913 of the Business and Professions Code, a marriage, family and child counselor trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code, an unlicensed marriage, family and child counselor intern registered under Section 4980.44 of the Business and Professions Code, a state or county public health employee who treats a minor for venereal disease or any other condition, a coroner, or a religious practitioner who diagnoses, examines, or treats children. (P.C. 11165.2.)

c. **"Child protective agency"** means a police or sheriff's department, a county probation department, or a county welfare department. (P.C. 11165(k).)

d. **"Commercial film and photographic print processor"** means any person who develops exposed photographic film into negatives, slides, or prints, or who makes prints from negatives or slides, for compensation. The term includes any employee of such a person; it does not include a person who develops film or makes prints for a public agency. (P.C. 11165(l).)

"Commercial film and photographic print processors" must report depictions of a child under age 14 in an act of sexual conduct. (P.C. 11166 (c).)

4. When Do You Report?

Child abuse must be reported "when one acquires knowledge of or observes a child under conditions which give rise to a reasonable suspicion of child abuse or when one has knowledge of or observes a child whom he or she knows has been the victim of child abuse." (P.C. 11166(a).) "Reasonable suspicion" occurs when "it is objectively reasonable for a person to entertain such a suspicion, based upon facts that could cause a reasonable person in a like position, drawing when appropriate on his or her training and experience, to suspect child abuse". (P.C. 11166(a).) Although wordy, the intent of this definition is: if you suspect, report.

You must make a report immediately (or as soon as practically possible) by phone. A written report must be forwarded within 36 hours of receiving the information regarding the incident. (P.C. 11166(a).) Written reports **must** be submitted on Department of Justice forms, which can be requested from your local child protective agencies (police or sheriff's department, a county probation department, or a county welfare department). (P.C. 11168.) See Appendix B.

5. To Whom Do You Report?

The report must be made to a "child protective agency": a county welfare or probation department or a police or sheriff's department. (P.C. 11165(k), P.C. 11166(a).) Exceptions are reports by commercial print and photographic print processors, which are made to the law enforcement agency having jurisdiction. (P.C. 11166(c).)

6. Immunity

Those professionals legally required to report suspected child abuse have immunity from criminal or civil liability for reporting as required or authorized. (P.C. 11172(a).)

This does not mean that a reported person will not attempt to sue. Any person can file a civil complaint against you for making a report; however, the suit should be dismissed.

The law provides that mandated reporters may recover from the state reasonable attorney's fees, at an hourly rate not greater than that charged by the Attorney General, for a total not greater than $50,000 for the defense of such a lawsuit. (P.C. 11172(c).)

Any other person who reports suspected child abuse has immunity unless it can be proven that the report was false and the person reporting knew it was false. (P.C. 11172(a).)

The immunity provisions of P.C. 11172 do not apply to reports submitted by a child protective agency to the Department of Justice. (P.C. 11165.6(c)(2), P.C. 11169.)

7. Other Protections for Reporter

No supervisor or administrator may impede or inhibit a report or subject the reporting person to any sanction. (P.C. 11166(f).)

Any supervisor or administrator who violates this code section is guilty of a misdemeanor which is punishable by confinement in the county jail for up to six months or by a fine of not more than $1,000 or by both. (P.C. 11166.1).)

Non-professionals who report are not required to include their names. (P.C. 11167(d).)

Reports are confidential and may be disclosed only to specified persons and agencies. (P.C. 11167.5.)

Professionals are not liable civilly or criminally for photographing the victim. (P.C. 11172(a).)

8. Liabilities for Failure to Make Required Report

A professional failing to make a required report is guilty of a misdemeanor punishable by up to six months in jail and/or up to a $1,000 fine. (P.C. 11172(e).) He or she may also be found civilly liable for damages, especially if the child-victim or another child is further victimized because of the failure to report. (**Landeros** vs. **Flood** (1976) 17C.3d 399)

9. Responsibilities of Agency Employing Mandated Reporter

Any mandated reporter entering employment on or after January 1, 1985 shall sign a statement, provided and retained by the employer, to the effect that he or she has knowledge of the reporting law and will comply with its provisions. (P.C. 11166.5 (a).) See Appendix C for sample of form.

Commercial film and photographic print processors and persons employed by child protective agencies as members of the support staff or maintenance staff and who do not work with, observe, or have knowledge of children as part of their official duties are not required to sign such statements. (P.C. 11166.5 (a).)

10. Licensing Requirement

On or after January 1, 1986, the state agency issuing a license to a person who is required to report child abuse will either send a statement to the licensee which cites reporting requirements and the penalty for failure to report or print the information on all application forms for a license or certificate printed on or after January 1, 1986. (P.C. 11166.5 (b)(c).)

11. Feedback to Reporter

After the investigation is completed or the matter reaches a final disposition, the investigating agency must inform the reporting professional of the results of the investigation and any action the agency is taking. (P.C. 11170(b)(2).)

IDENTIFICATION

Identifying families where abuse occurs requires the helping professional first of all to **believe** that child abuse can occur in **any** family, regardless of socio-economic status, religion, education, ethnic background, or other factors. Secondly, there must be a willingness to inquire into the possibility of abuse. This inquiry can be done as part of a standard repertoire of questions asked by the therapist (see Assessment section).

There are four basic aspects to identification: Environmental Problems, Parental Clues, Physical Indicators in the Child, and Behavioral Indicators in the Child. A brief overview of these **warning signals** follows. This is not an all-inclusive list. You may become aware of these factors through interview, observation, or third-party reporting of these concerns.

ENVIRONMENTAL PROBLEMS

Unsafe, hazardous conditions (broken windows, faulty electrical fixtures, etc.)

Health risks (presence of rats, feces, no running water, no heat, etc.) or unsanitary conditions

Extreme dirt or filth affecting health

PARENTAL CLUES

Parent is unable/unwilling to meet child's basic needs and provide a safe environment
Parent tells you of homicidal thoughts/feelings toward child
Parent tells you of use of objects (belts, whips, clothes hanger) to discipline the child
Parent is unable to describe positive characteristics of child
Parent has unrealistic expectations of child (e.g., toilet-training a 6-month-old)
Parent uses "out of control" discipline
Parent is unduly harsh and rigid about childrearing
Parent singles out one child as "bad", "evil", "beyond control"
Parent berates, humiliates, belittles child constantly
Parent turns to child to have his/her own needs met
Parent is impulsive, unable to use internal controls
Parent cannot see child realistically, attributes badness to child, or misinterprets child's normal behavior (e.g., a 2-week-old baby is crying because he hates the mother)
Parental indifference to child

PHYSICAL INDICATORS OF ABUSE

Physical Abuse

Fractures, lacerations, bruises that cannot be explained, or explanations which are improbable given extent of injury

Burns (cigarette, rope, scalding water, iron, radiator)

Facial injuries (black eyes, broken jaw, broken nose, bloody or swollen lips) with implausible or nonexistent explanations

Subdural hematomas, long-bone fractures, fractures in different stages of healing

Pattern of bruising (e.g., parallel or circular bruises) or bruises in different stages of discoloration, indicating repeated trauma over time

Neglect

Failure to thrive (child of extremely small size)
Malnutrition or poorly balanced diet (bloated stomach, extremely thin, dry, flaking skin, pale, fainting)
Inappropriately dressed for weather
Smells to the point that others leave when child enters room
Dirty, unkempt
Unattended medical conditions (e.g., infected minor burns, impetigo)

Sexual Abuse

Bruising around genital area
Swelling or discharge from vagina/penis
Tearing around genital area, including rectum
Visible lesions around mouth or genitals
Complaint of lower abdominal pain
Painful urination, defecation

Emotional Abuse

Small size
Dirty, unkempt

BEHAVIORAL INDICATORS OF ABUSE

Children react differentially to being abused. There is no one single reaction that can be clearly associated with child abuse; however, there are a number of possible behaviors which have been found consistently correlated to abuse.

While some of these behaviors occur more with one type of abuse than another, they may overlap.

The presence of any of these indicators does not prove the child is being abused, but should serve as a warning signal to **LOOK FURTHER.**

Physical Abuse

Hostile, aggressive behavior toward others
Extreme fear or withdrawn behavior around others
Self-destructive (self-mutilates, bangs head, etc.)
Destructive (breaks windows, sets fires, etc.)
Verbally abusive
Out-of-control behavior (seems angry, panics, easily agitated)

Sexual Abuse

Sexualized behavior (has precocious knowledge of explicit sexual behavior, and engages self or others in overt, repetitive sexual behavior)
Hostile, agressive
Fearful, withdrawn
Self-destructive (self-mutilates)
Pseudo-mature (seems mature beyond chronological age)
Eating disorders
Alcoholism/drug abuse
Running away
Promiscuous behavior

Neglect

Clingy, indiscriminate attachment
Isolates self
Seems depressed, passive

Emotional Abuse

Lacks self-esteem; puts self down constantly
Seeks approval to an extreme
Seems unable to be autonomous, makes few choices, fears rejection
Hostile, verbally abusive, provocative

The best source of information is not what the child **tells you** but what the child **shows you.** As helping professionals we must stay alert and responsive to child behaviors described above. Children will rarely report they are being abused, but unable to stop it, they frequently develop coping mechanisms and behaviors which bring them to the attention of others. These children tend to be fiercely loyal to their parents often demonstrating a pathological dependency on the parents, and they may try to adapt and comply in order to please the parents, serve as caretakers to the parents, or avoid another attack, or rejection.

GUIDELINES FOR ASSESSMENT

Making an assessment implies collecting information in order to assess what the problem is, who is involved, and in which direction to proceed. The assessment process is dynamic; that is, it does not stop after a number of questions have been asked. It requires active involvement on the part of the therapist to interpret clues, observe non-verbal communication, develop and test hypotheses. Most importantly, the ability to assess presumes a willingness and ability to **inquire further.**

An assessment can be done in such a way that it naturally evolves into collecting information about physical and sexual abuse, neglect and emotional suffering. Several examples and suggestions for assessing abuse are presented.

ASSESSMENT WITH A VERBAL CHILD

Two things are important when interviewing a child who is able and willing to be verbal; first, creating an environment that seems safe to the child; and second, providing opportunities for spontaneous disclosure through verbal and non-verbal messages.

It is helpful to set a confidentiality policy with a child, as you would with an adult. For instance, use the phrase, "Everything that we discuss in here is private. But if I think you are going to hurt yourself, if I think you are hurting someone else, or if someone else, including your parents, is hurting you, then what we talk about will not be confidential."

Be careful about promising something you cannot provide. Often children will say there is a secret they will share ONLY IF YOU PROMISE NOT TO TELL ANYONE ELSE. You cannot keep this promise. If you assure the child, and later break the confidence, the child will likely feel betrayed and trust will be jeopardized.

Assessment can occur over a number of weeks. Building rapport is essential to this process. Proceed by asking the child to talk a little about him/herself. Depending on how verbal the child is, gentle prodding may be necessary. It it helpful to start with the least threatening questions, such as "What's your favorite sport?"; "Who's your favorite movie star, or sports star?"; "What do you like to watch on TV?"; "Who is your favorite singer, teacher, etc.?". Asking about school, friends, and then the home environment will provide additional information about the child's interests, fears, concerns, habits, hobbies and significant people.

Ask the child to describe a typical day at home...you want to get a picture of what goes on at home. Tell the child to start by describing the house and who lives there. Then ask the child to take you through a typical day. Who gets up first, who wakes whom up, do people eat breakfast, does someone make it, who goes where, does anyone stay at home, etc. Go through the coming home at night as well. See if you can determine any patterns of who spends more time with whom, are certain people isolated. Notice if the child's voice or affect seem to change when specific family members are discussed.

The presence of physical abuse can be evaluated by asking what happens at home when people get angry...does someone yell - who? Is there any throwing of objects...by whom? Does anyone ever get mad enough to hit out at someone else? For example, does mom hit dad? Do brothers and sisters hit each other? Do mom or dad hit the kids? If they do hit, do they use hands, fists or belts or other objects? Does anyone ever get hit hard enough that it leaves bruises or they bleed? How often does this happen? Is it scary?

You can assess for sexual abuse by asking about touching and affection in the family. Is the family huggy-kissy? Do they sit together and hug a lot? Do people bathe together or sleep together? Does anyone in or outside the family ever touch the child in private places (explain what those are: genitals, breasts, anus, mouth) in a sexual way (if the child is old enough to understand what that means) or in a way that makes the child feel confused, uncomfortable or scared?

In addition to listening to the content, it is important to observe changes in affect, tone of voice, body movements, breathing, eye contact and if the child changes the subject prematurely.

If the child cannot give you any information, or cannot tolerate the topic of discussion, stop the line of questioning and shift back to the non-threatening information, telling the child that this seems uncomfortable to talk about, and come back to it at a later time.

If the child has given you information that leads you to "reasonably suspect" that the child is being abused, you need to let the child know you are concerned about what is going on at home (describe what the child has explained) and that it is important for the family to get some help. You need to tell the child how you will proceed, (i.e., calling parents, the Emergency Response Unit in the Child Protective Agency (ER), etc.) once you decide.

Do not make any guarantees to the child about what will happen, but let the child know as much as you can. It's helpful to make the referral to the Child Protective Agency while the child can listen, so your reliability is confirmed.

You are not legally required to inform parents you are making a referral, particularly if this seems contra-indicated (e.g., parent's tendency to flee or exhibit violent, erratic or psychotic behavior). There are instances in which a child may be at risk due to "telling". Advise the ER child welfare staff if a child is afraid to go home, may be in danger of reabuse or threats, or may be under pressure to change or retract his or her statement. Dr. Roland Summit has written an article "The Child Sexual Abuse Accommodation Syndrome" which clearly explains the child's process of disclosure. (See Bibliography) The ER child welfare staff can evaluate the need for the child to be in protective custody.

In most instances, however, you will want to let the parents know you are making a referral. If the child is at risk due to disclosure, it is important to discuss this with the parents and make a statement about further harm to the child — "I know it probably

makes you angry or a little afraid that I've made this referral. You may even feel angry at your child, but it's not OK to hit or hurt the child for telling." Tell the parents why you are making the referral — "You seem to be behaving in an out-of-control way and I'm concerned you are hurting your child."

ASSESSMENT WITH A NON-VERBAL CHILD

When children are not able to speak, they frequently will "act out" their concerns in play. It is important to assess abuse based on extreme or persistent behaviors that are consistent with indicators of abuse. A child who is physically abused may be very physically abusive of dolls or other play materials, and have themes of violence or death in his or her play or drawings. A sexually abused child may focus on the doll's genitals, and engage dolls in explicit sexual play.

ASSESSMENT WITH THE FAMILY

If you are able to meet with the entire family, the same kinds of descriptions of daily activities undertaken with the verbal child can be applied. If abuse is going on, the parents may comment freely. Frequently, individual sessions with the children are helpful to gain additional information.

If the parents make statements such as "we know how to take care of him", "we have a sure-fire cure for that", or "we just clean out his clock", or "ring his chimes", it is absolutely vital to get a clear behavioral description.

You may find that "cleaning out his clock" and "ringing his chimes" refer to swift blows across the head of the child. Parents often use belts, bats, pots and pans, telephone cords, etc. The use of objects increases the likelihood of the child sustaining injuries.

Some parents, abused themselves as children, may not recognize their behavior as abusive. They may not hide this behavior since to them it is normal and acceptable. Other abusive parents may think of their behavior as abusive, and may seek to hide it, making up stories, or getting their children to protect them. The latter are obviously more difficult to assess, but looking at the entire family picture, and interviewing the children alone, may help with data collection.

Parents are frequently frightened and angry when the referral is made to the authorities. But most parents love their children and do not want to hurt them. They are being abusive because they are out of control. They may also immediately or eventually feel relieved that you have taken steps to protect their children.

Giving parents a confidentiality policy (see Appendix B) and being matter-of-fact and confident about what abuse is, will help tremendously in undertaking the emotional and difficult task of reporting. Also, be clear that your responsibility is to make the assessment, determine if you have "reasonable suspicion" and then report. YOU ARE NOT RESPONSIBLE TO INVESTIGATE OR COLLECT EVIDENCE. The investigation is conducted by Child Protective Agencies, not you.

When in doubt, call the Emergency Response Unit in the Child Protective Agency and discuss the situation.

CONFIDENTIALITY

The statutory duty to report is not excused or barred by the patient-psychotherapist privilege or professional confidentiality or ethics. Mental health professionals frequently have the following concerns:

Denial: Many professionals refuse to believe child abuse exists. They may think it happens only to the poor, the psychotic, the uneducated, or certain racial groups. This is simply not true.

When professionals do not acknowledge the possibility of abuse, they miss the opportunity to be useful to the family. It is important to believe that abuse can happen in any family and ask those questions designed to elicit this concern from a family.

Rationalizing: Another danger is the mental health professional's acceptance of unrealistic explanations for how the injury occurred. If you have any doubts, no matter how small, continue with your assessment, and/or seek a consultation.

Betrayal: Many professionals feel they are doing a nasty thing to the parents, "turning them in to a fate worse than death" when they report. If they feel this way, they are likely to present themselves in a way that gives the parents the sense they are being punished. A more useful approach is to consider the reporting as helpful to the family because it will protect the child (and the parents in the long run) by getting them needed services. Do not try to convince the parents that you are being helpful because it is difficult for them to see a report as helpful at the initial stage.

The fear that reporting will destroy the trust in the therapeutic relationship is understandable, but if the reporting is done in a clear and nonthreatening way, clients will not be as likely to feel betrayed.

Family Breakup: Comparatively few reports lead to the child's removal from the home. The current philosophy is to keep the family intact by providing concrete services. The child will be removed if child protective professionals assess that there is imminent danger to the child or if the parents are unable or unwilling to provide a safe environment for the child.

THE THERAPIST'S REACTIONS TO WORKING WITH ABUSE

It is crucial for mental health professionals to examine their own attitudes and feelings toward abusive parents and abused children.

Everyone has a reaction to child abuse. Some cringe with disgust and anger and others cry with sadness and empathy. Depending on an individual's upbringing, religious beliefs, life views and moral positions, reactions will differ.

It is possible (and advisable) for mental health professionals to acknowledge the discomfort or anger about the abuse, and yet prevent these feelings from interfering with their ability to be useful to the family.

Treatment may be ineffective if angry and judgmental feelings are expressed toward the client, further reinforcing a sense of "badness" or unworthiness. Most abusive parents have fragile egos and are very susceptible to criticism. This does not preclude the therapist making very strong, clear statements about the abusive behavior, but these should be made in a way the client is likely to hear them. An effective phrase would be, "I know you love your children, and you want them to turn out to be productive citizens, but it is not OK for you to hurt them, in order to teach them." It is, of course, crucial for the mental health professional to provide clients with clear alternatives to abusive behavior. The tendency to resort to old, familiar (abusive) behavior will persist, and part of the therapeutic goal is to **replace** the old behavior with new techniques.

Another pitfall in working with abusive families is for the therapist to see him/herself as a "rescuer" of the child. The therapist must remain sensitive to the competitive relationship that can be inherent between the abusive parent and the therapist.

If trust is established in the therapeutic relationship, the client may see the therapist as a parent figure. The client may test the therapist's ability to set limits, and the more trust that is developed the greater the need to pull away and make demands. The client's dependency needs may also surface, which may cause a therapeutic crisis in a needy and frightened client. The client needs to experience and build trust and then needs to be directed toward other people in his or her life where a similar experience can be created.

Confidentiality Policy: It is recommended that parents and children be given a confidentiality statement at the beginning of therapy. Contrary to popular belief, making these statements does not seem to either scare clients away or inhibit them.

It is suggested that these statements be made both verbally and in writing. (See Appendix D.) The confidentiality statements are best when included with other guidelines regarding the therapeutic relationship. Some therapists have told me that they have the clients sign a copy of the confidentiality statements and keep them in their files. The clients may or may not ask questions related to confidentiality.

Suggested verbal statements for both a parent and a child are:

To Parent: What we discuss in therapy is confidential with two exceptions: one, if I think you're going to hurt yourself; two, if I think you're going to hurt someone else, including your child. If either of those two events seems likely, I will need to take protective action, which will include calling appropriate authorities.

To Child: What we discuss in therapy is confidential with three exceptions: one, if I think you're going to hurt yourself; two, if I think you're going to hurt someone else; and three, if I think someone or something is hurting you, including your parents. When any of those things are going on, I'll need to let someone know and try to get additional help for you.

As you can see in these confidentiality statements, the therapist is including the areas of child abuse, suicide, homicide and threat of homicide (as per the Tarasoff vs. Regents of the University of California (1976) 17 Cal.3d 425 decision which holds that a therapist may be liable for injuries resulting from a failure to warn). These are all circumstances in which the therapeutic and legal arenas overlap, and the therapist must take substantive action in the best interest of the client or intended victim.

The Use of Contracts: Contracts are written agreements between the therapist and client that specify goals of therapy, with clear behavioral descriptions of expected outcomes.

The structure a contract provides is helpful for many reasons when working with abusive families. Families in crisis respond well to clearly specified objectives, and in addition, families can feel a greater sense of control if they are able to understand what behavior on their part will lead to **their** desired outcome.

Often the clients are court-mandated to attend therapy, and in those cases it is particularly fruitful to use contracts, so it is clear among all agencies and individuals concerned what is expected from the clients.

Limit Setting: Reporting suspected child abuse is often an effective way of setting a firm limit regarding unacceptable behavior. Parents may feel cared for when limits are set on self-destructive or self-defeating behaviors. Most abusive parents do not want to hurt their children, and hurting them affects their own self worth (by reinforcing their worst fears about themselves).

As the therapist begins to model the setting of limits, the parents may become better able to do the same with their children in a nonpunitive or nonhurtful way.

Use of Your Own Authority: Many mental health professionals are trained to moderate their influence on clients in order to encourage clients to draw conclusions or insight and choose their own direction. In abuse situations, however, the therapist must feel comfortable with his/her own use of authority and employ it to maximize safety for both parent and child. Making a seemingly unpopular decision to report and stating it clearly is not synonymous with rigid authoritarianism, but it takes time for some mental health professionals to become comfortable with this idea. When the decision is presented in a firm, supportive manner, you can let the clients know you recognize their feelings of helplessness and anger and that you will be available to help them take some control over their lives.

Most parents will feel relief because external controls or limits have been introduced to stop the abuse. Offering a matter-of-fact, caring approach counters the parents' sense of secrecy and shame about the incident. In contrast, not responding to the parents' clues or action language gives the message that the abuse is so repugnant it must be kept hidden, or that you do not take the abuse seriously or believe it will go away by itself.

Facing Denial: It is common for abusive parents to deny that they have been abusive. This is to be expected. They have a great deal to protect and they are usually feeling judged and exposed. The author has found it helpful to initially expect and ignore the denial, and proceed with the therapy as if an admission had just been obtained. In other words, if the admission is not forthcoming immediately, I find it best to proceed beyond the "who done it?" stage, focusing on assessment of the individual's strengths, weaknesses, and concerns based on my understanding of the underlying family dynamics.

If the denial persists past a set time frame (usually 4-6 months) the prognosis becomes more bleak. It is essential for the therapist to create a safe, trusting environment conducive to self-disclosure, while consistently raising the issue of denial.

The therapist is not the long arm of the law, particularly regarding investigation. While the therapist can use the legal system effectively and cooperatively, it is not the therapist's job to prove culpability or collect evidence.

Some clients will never admit to the abuse, and therefore make the possibility of obtaining therapeutic help minimal.

"Stay With" the Client: After you make a report, it is important to continue supportive contact with the parent, rather than assume your part of the job is done. The child will benefit greatly from having access to the therapist, since frequently he or she is propelled into a system which can be insensitive and demanding beyond the child's understanding. The child can then be dealing not only with the abuse, but the process of investigation and prosecution of the abuser.

The clients may need you to answer questions about the investigatory or Court processes and may blame all authority figures in order to continue the denial. The client needs you as an ally, and it is helpful if you can avail yourself of as much information as possible to relay to the family.

Telling the Clients You are Reporting: You are not required by law to tell the parents you are making a report. However, in the majority of cases, telling the client you are reporting is therapeutically advisable.

First of all, the therapist is employing clinical leverage by using authority to set a firm and necessary limit. Reporting responds to the parents' nonverbal plea for help. The therapist can reassure the clients that steps will be taken to help the parents regain control so that the abuse does not lead to serious injury of the child.

Secondly, if the therapist does not mention the report, there is secrecy and tension which may result in the clients' feelings of suspicion, isolation, or betrayal.

In some cases, reporting may elicit an extreme response from the clients. It is contra-indicated to inform people you are reporting if the individual seems psychotic, has poor impulse control coupled with a history of violent behavior, has a problem with alcohol or drugs, or is likely to flee town.

It can be very beneficial to give clients the opportunity to make the reports themselves in your presence. Telling the clients to report themselves does not negate the therapist's mandate to report.

Consultation/Coordination: Abusive parents are frequently "needy" people, and "team treatment" can insure the optimal provision of services and monitoring.

Coordination of services can result in less disruption to the family in crisis and optimal use of each agency's limited resources. Case conferences allow the opportunity to define expectations for change in areas of concern, and allow for definition of roles by the many professionals involved in each case. When a specific plan of action is designed by a multi-disciplinary team and defines the key players, it is easier to provide clear direction to the parents. Therapists are bound by confidentiality and should obtain client release forms, waiving confidentiality on specific information. If no waiver is obtained the therapist can attend case management meetings and listen.

The private mental health therapist has traditionally stayed out of case coordination, feeling the restrictions of confidentiality, time constraints, or unfamiliarity with community services and legal systems. The author has found that frequently the therapist can be pivotal in obtaining supportive services.

NON-HELPFUL INTERVENTIONS

Threats: Threatening the clients with a report gives the impression that reporting is a punishment and may further alienate the client from seeking needed services.

Bargaining With Clients: ("I won't report you this time, but if you do it again...I'll have to") gives the message that sometimes it is all right to be abusive, but other times it is not. The parents may find the double message confusing, and their behavior may escalate.

Threats and bargaining are not options for the reporter. The reporting law states that reports must be made by legally mandated professionals when there is reasonable suspicion, knowledge or observation of child abuse.

Hit and Run — Abandoning the Client: It is important to provide ongoing support to the client throughout the investigation and follow-up services.

Arguing: Many parents will argue that they are not abusive since their own parents did worse things to them. They are probably right about their parents' behavior. Have clients describe previous abuse and then explain that the reporting laws have changed. Their parents would be reported these days.

1. **Who am I to say what's abusive?**

Therapists often feel reticent to label behavior abusive. They may feel they have no right to pass judgment on other people. The bottom line is the protection of the child and compliance with the law. This protective action is beneficial to the parents as well, who may not recognize their behavior as abusive, or may be reluctant to seek help.

2. **What if I make a mistake?**

Dr. C. Henry Kempe, a pioneer in the field of child abuse prevention, once said he would rather apologize to a parent because he made a mistake about reporting the abuse, than apologize to a brain-damaged child because he did not report. It is better to err in the direction of over-reporting than under-reporting. Also you are immune pursuant to statute if you make a report, but you are liable if you fail to report when you had reasonable suspicion.

3. **What is the fine line between abuse/discipline?**

If the discipline is excessive or forceful enough to leave injuries, physical abuse has occurred. The use of instruments and the young age of a child increase the likelihood of injuries being incurred. The intent of the reporting law is not to interfere with appropriate parental discipline, but to respond to extreme or inappropriate discipline which is abusive.

Some parents hit their children in places where injuries are not visible (the buttocks, the thighs, the back) and yet may tell the therapist they use belts, whips or other potentially dangerous instruments. If you have reasonable suspicion of abuse, even with no visible signs, you are required to report.

In some cases you will be concerned that abuse is likely in the future, but it has not yet occurred. The matter is not yet reportable, but presents a crisis that the therapist should try to resolve with counseling and other voluntary services.

4. **What if the abuse occurred in the past?**

There are no time limitations regarding the reporting of child abuse. If a victim is under age 18, the abuse must be reported. If the information causes you to reasonably suspect that someone who is still a minor has been abused, you must report.

5. **What about testifying in court?**

The majority of cases do not go to trial. In cases where you may be required to testify, it is important to remember that your testimony may be essential for the protection of the child. Your effectiveness and comfort as a witness may be greatly increased by meeting with the attorney at the earliest opportunity.

6. **What age of child is most at risk of abuse?**

All children are at risk of abuse, but infants and toddlers are most likely to sustain serious injuries due to their fragility. The mortality rate is highest for children 0-2.

Some people have certain beliefs that predispose them to responding to one age of child versus another. For example, sexual abuse of infants is more difficult to fathom than sexual abuse of adolescents, yet it does occur. Adolescents are at a disadvantage in that most people believe they may be provoking the abuse, or better able to run away or protect themselves. Although their bodies are frequently bigger and stronger, they are just as vulnerable to physical, sexual and emotional abuse and neglect.

7. **If two minors are sexually active, or if a minor is sexually active with an adult, are these reportable conditions?**

"Consensual" sex between minors 14 and over is not in and of itself a reportable condition. If the 14-17-year-old is having sexual contact with an unrelated adult, this is also not in and of itself a reportable condition. However, the issue of "consent" must be carefully evaluated, and an assessment must be made regarding the possibility of sexual abuse. The presence of child sexual abuse is increased by threat, force, coercion, or lack of maturity which prevents a consensual choice by one party. In addition, children who have been previously abused may be more vulnerable to abusive or exploitive relationships.

The question of whether sex with a child under 14 is always reportable is at issue and will be decided as a result of current litigation. However, in the interim, reporting is appropriate for such children only where there is reason to suspect "actual child abuse" rather than voluntary consensual sexual activity.

8. **Are clergy mandated to report?**

Clergy are not legally mandated reporters **unless** they are also acting in the capacity of a mandated reporter (e.g., psychologist, teacher, marriage, family and child counselor) when they receive the information that causes them to suspect child abuse.

9. Are alcohol programs exempt from reporting child abuse?

Currently, a federal law **prohibits** federally funded alcoholism/drug programs from reporting suspected child abuse, in an effort to guard confidentiality of records for these programs. Federal legislation is pending to revise this. In the meantime, legal agreements or court orders may allow for reporting in specific instances.

Non-federally funded programs treating alcoholism are required to make appropriate child abuse reports.

10. May I make an anonymous report?

No, mandated reporters must provide identifying information. However, persons not legally required to report (non-professionals) may make anonymous reports.

11. What happens after a report is made?

Child Protective Agencies (county welfare or probation department, police or sheriff's department) are responsible for managing the referral once it is made. Emergency Response (ER) staff from the child welfare or probation agency and law enforcement will work together, although their investigations will be separate. ER's emphasis in intervention is to assure the safety of a child and provide services to keep families together. Removal of a child from the home is only accomplished if no other option exists. Services provided may range from counseling to respite care or the placement of a family care worker in the home to provide role modeling and assistance to parents. If removal becomes necessary the Juvenile Court has several options for placement including the non-custodial parent, relatives, foster homes and group homes, in that order, depending upon the specific needs of the child. Parents should be reassured that the Court's removal standards are stringent, and that the Court will order that the Child Protective Agency which provides child welfare services and parents work together to effect reunification as quickly as possible.

A report in which the alleged abusers are not family (for example, a stranger molesting a child) is made in the same manner. Once the Child Protective Agency determines that the child is protected and that the parents did not contribute to the abuse or neglect, referrals for counseling or medical care can be made to appropriate local community resources and the case is generally closed by the welfare or probation department. Law enforcement usually will conduct its separate investigation.

Procedures in Child Protective Agencies vary from county to county. Therefore, understanding the local system that is set in motion by a report is valuable.

CONCLUSIONS AND RECOMMENDATIONS

Child abuse is a complicated problem with many intrapsychic, social and interpersonal aspects. It is usually "action language". Parents and individuals cannot always recognize and verbalize their needs and may use behavior rather than words to get help for themselves.

It is important that the mental health professional not let denial, fear, or ignorance of laws or procedures interfere with providing help to the family.

Not everyone is cut out to work with these families. The responsible therapist faces his/her limitations or preferences, and, when appropriate, REFERS OUT to others better able or willing to provide treatment for these families.

Most parents who abuse their children can be successfully treated. The helping professional can become the appropriate and safe parent figure, the educator and limit-setter to the abusive parent. No one person can do the job alone. The responsibility can be shared.

The therapist is advised to familiarize him/herself with the social service/legal system, the laws and the helping agencies in the community. Frequently, coordinating the therapy with other helping services will result in enhanced treatment.

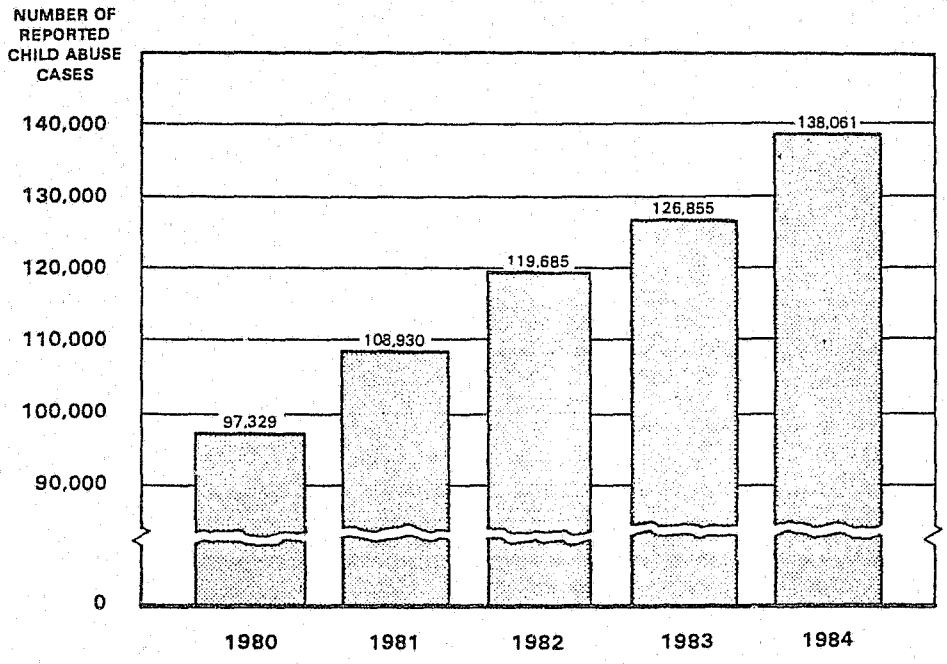
Training and consultation are also highly encouraged for any professional working with child abuse. There are many excellent written materials (see Appendix E), training programs, seminars and/or conferences, as well as local expertise, which can be consulted on the specifics of a case. The therapist is also advised to build a support system of peers with whom to discuss his/her own feelings as well as problematic aspects of a case.

There are many effective community services which can be complementary to individual or group therapy, and are invaluable to the clients who often have varied needs. Examples of community services (Appendix E) and statewide services (Appendix F) are included at the end of this pamphlet. Your local Child Abuse Council or Child Protective Agency will be familiar with existing local services.

This booklet was prepared by Eliana Gil, Ph.D. Dr. Gil is a family therapist who has had extensive experience working with families where there is physical and sexual abuse, and with child and adult victims of abuse. Dr. Gil is a faculty member of the California Graduate School of Marital and Family Therapy, San Rafael, where she teaches a course on Child Therapy. She has written numerous journal articles and pamphlets, and her recent publication is OUTGROWING THE PAIN: A Book for and about Adults Abused As Children, Launch Press, 1984. She is a frequent lecturer/trainer on many child abuse related topics.

Dr. Gil welcomes your written comments and suggestions regarding this booklet.

REPORTED CASES OF CHILD ABUSE STATEWIDE
1980 - 1984



TYPES OF CHILD ABUSE CASES STATEWIDE; 1984

REASON FOR REFERRAL	NUMBER	PERCENT
Physical Abuse	40,488	29.3
Sexual Abuse	25,876	18.8
Severe Neglect	9,815	7.1
General Neglect	39,217	28.4
Caretaker Absence or Incapacity	10,928	7.9
Emotional Abuse	4,617	3.3
Other	7,120	5.2
Total	138,061	100.0

Source: State Department of Social Services, Statistical Services Branch

SUSPECTED CHILD ABUSE REPORT
(11166 PC)

TO BE COMPLETED BY REPORTING PARTY

CASE IDENTIFICATION — *TO BE COMPLETED BY INVESTIGATING CPA*
VICTIM NAME: _____
REPORT NO./CASE NAME: _____
DATE OF REPORT: _____

A REPORTING PARTY

NAME/TITLE

ADDRESS

( ) PHONE _____ DATE OF REPORT _____ SIGNATURE OF REPORTING PARTY _____

B REPORT SENT TO

◯ POLICE DEPARTMENT ◯ SHERIFF'S OFFICE ◯ COUNTY WELFARE ◯ COUNTY PROBATION

AGENCY _____ ADDRESS _____

OFFICIAL CONTACTED _____ ( ) PHONE _____ DATE/TIME _____

C VICTIM

NAME (LAST, FIRST, MIDDLE) _____ ADDRESS _____ BIRTHDATE SEX RACE _____

PRESENT LOCATION OF CHILD _____ ( ) PHONE _____

SIBLINGS

1. _____ NAME _____ BIRTHDATE SEX RACE _____
2. _____
3. _____

4. _____ NAME _____ BIRTHDATE SEX RACE _____
5. _____
6. _____

D PARENTS

NAME (LAST, FIRST, MIDDLE) _____ BIRTHDATE SEX RACE _____
ADDRESS _____
( ) HOME PHONE _____ ( ) BUSINESS PHONE _____

NAME (LAST, FIRST, MIDDLE) _____ BIRTHDATE SEX RACE _____
ADDRESS _____
( ) HOME PHONE _____ ( ) BUSINESS PHONE _____

E INCIDENT INFORMATION

IF NECESSARY, ATTACH EXTRA SHEET OR OTHER FORM AND CHECK THIS CIRCLE. ◯

1. _____ DATE/TIME OF INCIDENT _____ PLACE OF INCIDENT *(CHECK ONE)* ◯ OCCURRED ◯ OBSERVED

IF CHILD WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE:
◯ GROUP HOME OR INSTITUTION ◯ FOSTER CARE ◯ OTHER PLACEMENT (SPECIFY _____)

2. TYPE OF ABUSE: *(CHECK ONE OR MORE)* ◯ PHYSICAL ◯ MENTAL ◯ SEXUAL ASSAULT ◯ NEGLECT ◯ OTHER

3. NARRATIVE DESCRIPTION: _____

4. SUMMARIZE WHAT THE ABUSED CHILD OR PERSON ACCOMPANYING THE CHILD SAID HAPPENED: _____

5. EXPLAIN KNOWN HISTORY OF SIMILAR INCIDENT(S) FOR THIS CHILD: _____

SS 8572 4/81 *INSTRUCTIONS ON REVERSE*

Police or Sheriff — WHITE Copy; DOJ — PINK Copy; County Welfare or Probation — BLUE Copy; District Attorney — GREEN Copy; Reporting Party — YELLOW Copy

THIS FORM, AS ADOPTED BY DEPARTMENT OF JUSTICE, IS REQUIRED UNDER PENAL CODE SECTIONS 11166 AND 11168

REPORTING RESPONSIBILITIES

- No child care custodian, medical practitioner or nonmedical practitioner reporting a suspected instance of child abuse shall be civilly or criminally liable for any report required or authorized by this article (California Penal Code Article 2.5). Any other person reporting a suspected instance of child abuse shall not incur civil or criminal liability as a result of any report authorized by this section unless it can be proved that a false report was made and the person knew or should have known that the report was false.

- Any child care custodian, medical practitioner, nonmedical practitioner, or employee of a child protective agency (CPA) who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment whom he or she reasonably suspects has been the victim of child abuse shall report such suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and shall prepare and send a written report thereof *within 36 hours* of receiving the information concerning the incident.

- Any child care custodian, medical practitioner, nonmedical practitioner, or employee of a child protective agency who has knowledge of or who reasonably suspects that mental suffering has been inflicted on a child or its emotional well-being is endangered in any other way, may report such suspected instance of child abuse to a child protective agency. Infliction of willful and unjustifiable mental suffering must be reported.

REPORTING PARTY DEFINITIONS

- "Child care custodian" means a teacher; administrative officer, supervisor of child welfare and attendance, or certificated pupil personnel employee of any public or private school; an administrator of a public or private day camp; a licensed day care worker, an administrator of a community care facility licensed to care for children, headstart teacher; public assistance worker; employee of a child care institution including, but not limited to, foster parents, group home personnel and personnel of residential care facilities; a social worker or a probation officer.

- "Medical practitioner" means a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

- "Nonmedical practitioner" means a state or county public health employee who treats a minor for venereal disease or any other condition; a coroner; a paramedic, a marriage, family, or child counselor, or a religious practitioner who diagnoses, examines, or treats children.

- "Child protective agency" means a police or sheriff's department, a county probation department, or a county welfare department.

INSTRUCTIONS

I CASE IDENTIFICATION (Upper Box) – *To Be Completed by Investigating Child Protective Agency*

Case Identification: Enter the victim name, report number or case name, and date of report.

II SUSPECTED CHILD ABUSE REPORT (11166 PC) – *To Be Completed by Reporting Party.*

A. Reporting Party: Enter name/title, address, phone number, and the date of report, and sign.

B. Report Sent To: 1) Check the appropriate child protective agency to whom this report is being sent; 2) Enter the name and address of the child protective agency to whom this report is being sent; 3) Enter the name of the official contacted at the child protective agency, phone number, and the date/time contacted.

C. Victim: Enter the name, address, physical data, present location, and phone number where victim is located (attach additional sheets if multiple victims).

Siblings: Enter the name and physical data of siblings living in the same household as the victim.

D. Parents: Enter the names, physical data, addresses, and phone numbers of father/stepfather and mother/stepmother.

E. Incident Information: 1) Enter the date, time, and place the incident occurred or was observed, and check the appropriate circles; 2) Check the type of abuse; 3) Describe injury or sexual assault (where appropriate, attach form DOJ 900, Medical Report – Suspected Child Abuse or any other form desired); 4) Summarize what the child or person accompanying the child said happened; 5) Explain any known prior incidents involving the victim.

III. DISTRIBUTION

A. Reporting Party: Complete form SS 8572, Suspected Child Abuse Report (11166 PC). Retain yellow copy for your records and submit top four copies to a child protective agency.

B. Investigating Child Protective Agency: Upon receipt of form SS 8572, Suspected Child Abuse Report (11166 PC), send white copy to police or sheriff, blue copy to county welfare or probation, and green copy to district attorney *within 36 hours.* Complete form SS 8573, Suspected Child Abuse Preliminary Investigation Report (11169 PC), attach pink copy to pink copy of SS 8572, and forward to DOJ *immediately*.

THE CHILD ABUSE REPORTING LAW

P.C. 11166

REPORTER RESPONSIBILITIES

DEFINITIONS: The following situations are reportable conditions:
- Physical abuse
- Sexual abuse
- Child exploitation, child pornography and child prostitution
- Neglect
- Extreme corporal punishment resulting in injury
- Willful cruelty or unjustifiable punishment

WHO REPORTS: The following individuals are legally mandated reporters:
- Child care custodians
- Health practioners
- Commercial film or photographic print processors in specified instances
- Child Protective Agencies

WHEN TO REPORT: Reports are made immediately when the reporter observes, has knowledge of, or has reasonable suspicion. A written report, on a standard form, must be sent in 36 hours after the telephone report has been made.

TO WHOM DO YOU REPORT? You have a choice of reporting to the Police or Sheriff's Department or the Probation or Child Welfare agency. Each county has a preferred reporting procedure. Commercial film or photographic processors report only to law enforcement.

INDIVIDUAL RESPONSIBILITY: Any individual who is named in the reporting law must report abuse. If the individual confers with a superior and a decision is made that the superior file the report, one report is sufficient. However if the superior disagrees, the individual with the original suspicion must report.

ANONYMOUS REPORTING: Mandated reporters are required to give their names. Non-mandated reporters may report anonymously. Child protective agencies are required to keep the mandated reporter's name confidential, unless a court orders the information disclosed.

IMMUNITY: Any legally mandated reporter has immunity when making a report. In the event a civil suit is filed against the reporter, reimbursement for fees incurred in the suit will occur up to $50,000. No individual can be dismissed, disciplined or harassed for making a report of suspected child abuse.

LIABILITY: Legally mandated reporters can be criminally liable for failing to report suspected abuse. The penalty for this misdemeanor is up to six months in county jail, a fine of not more than $1,000 or both. Mandated reporters can also be civilly liable for failure to report.

NOTIFICATION REGARDING ABUSE: You are not legally required to notify the parents that you are making a report; however, it is often beneficial to let the parents know you are reporting for benefit of future relationship.

I understand that I am a legally mandated reporter. I have clarified any information listed above which I did not understand, and am now aware of my reporting responsibilities, and am willing to comply. I have also requested an explanation of reporting policies within this agency and understand them as well.

Employee's Name _____ Witness (Supervisor) _____

Date: _____

SAMPLE CONFIDENTIALITY POLICIES

The following confidentiality statement has been provided by David H. Ruja, Ph.D. of Beverly Hills and is part of a service agreement he uses.

What is discussed in therapy is confidential unless and until you give consent to its release, with two exceptions: I will need, and am compelled by law, to inform an appropriate other person(s) if I hear and believe that you are in danger of hurting yourself or someone else, and if there is reasonable suspicion that a child has been abused.

I have read the foregoing, understand its content and agree to the conditions stipulated therein.

PRINTED NAME: _____

SIGNATURE: _____

DATE: _____

The Redwood Center for Family and Individual Therapy at Berkeley, California, uses the following confidentiality policy in its Consumer Information Statement.

Confidentiality: All information between counselor and client is held strictly confidential unless: (1) the client authorizes release of information with a signature; (2) the counselor is ordered by a court to release information; (3) a client presents a physical danger to self or others; (4) child abuse/neglect are suspected. In these latter two cases, we are required by law to inform potential victims and legal authorities so that protective measures can be taken.

SAMPLE
COMMUNITY RESOURCES

PARENTS ANONYMOUS Self-help groups for potentially abusive or abusive parents. Facilitators consist of a professional and a formerly abusive parent. Usually no fee/low fee, child care and transportation provided.

PARENTS UNITED Self-help groups for sexually abusive families. Consists of groups for offenders, children, and mothers. Also have groups for Adults Molested as Children (AMAC). Comprehensive child sexual abuse program.

PARENTAL STRESS HOTLINES 24-hour Crisis Hotline for parents under stress. Telephone counseling primarily, but can also provide home visiting program and respite care. Usually offer parent rap groups and other services.

RESPITE CARE PROGRAMS Licensed homes which provide care for children when their parents "need a break." Not a baby-sitting service. Designed for high-risk parents. Voluntary.

EMERGENCY FAMILY CARE In-home based services. Workers literally "move in" with the family to provide concrete services. Frequently work with neglectful parents whose children might be removed without this service.

PARENT-INFANT BONDING (PERINATAL PROGRAMS) Designed to help new parents with bonding skills; provide parent education regarding tne child's need. Provides early intervention services.

CHILD ABUSE PREVENTION COUNCILS Provide information and referral; educational services including book and film library. Usually are multidisciplinary in nature, and help coordinate service delivery. Provide visibility to the problem.

PARENT EDUCATION CLASSES Designed to help parents gain better understanding of child development and skills for disciplining their children in a safe way.

PARENT RAP GROUPS Provide support and break isolation by having a forum in which parents can discuss their joys and stresses.

COMMUNITY MENTAL HEALTH DEPARTMENTS Provide low-fee therapeutic services to families and children. Available in every community. Frequently serve a broad range of abusive families.

CHILDCARE RESOURCE CENTERS Provide valuable childcare information to parents who may be overwhelmed by the demands of parenting. Information and referral. Education.

PRIVATE MENTAL HEALTH CLINICS/THERAPIST GROUPS There are many private therapists who now specialize in working with child abuse. Child Abuse Councils or Child Protective Agencies are usually familiar with good referral possibilities.

FAMILY SERVICE AGENCIES Many of these agencies have taken a leadership role in child abuse prevention/treatment services, and provide sliding scale therapeutic services.

STATEWIDE RESOURCES

Office of Child Abuse Prevention (OCAP)
State Department of Social Services
744 P Street, MS 9-100
Sacramento, CA 95814
(916) 323-2888

California Consortium of Child Abuse Councils
1401 Third Street, #13
Sacramento, CA 95814
(916) 448-9135

California Child Care Resource and Referral Network
809 Lincoln Way
San Francisco, CA 94122
(415) 661-1714

California Self Help Center
UCLA, 2349 Franz Hall
405 Hilgard Avenue
Los Angeles, CA 90024
(800) 222-5465

Multicultural Coordinating Council for Children and Families
390 Euclid Avenue
Oakland, CA 94610
(415) 832-2397

Parents Anonymous
6733 South Sepulveda Blvd., Ste. 270
Los Angeles, CA 90045
(800) 352-0386

Parents United, Inc.
Parents United/Daughters and Sons United
Adults Molested as Children United
P.O. Box 952
San Jose, CA 95108
(408) 280-5055

NATIONAL RESOURCES

National Center on Child Abuse and Neglect (NCCAN)
P.O. Box 1182
Washington, D.C. 20013
(202) 245-2856

National Committee for Prevention of Child Abuse (NCPCA)
332 S. Michigan Avenue, Suite 1250
Chicago, Illinois 60604
(312) 663-3520

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This pamphlet provides current information about the subject of Child Abuse reporting laws to assist mental health professionals and others in determining their reporting responsibilities. It is not intended to be and should not be considered legal advice. In the event there are questions about reporting responsibilities in a specific case, the advice of legal counsel should be sought.

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