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ABSTRACT

This resource manual synthesizes recent information about physical, sexual, and emotional abuse of children; physical neglect; the family system; intervention; and the child victim. Physical and sexual abuse of children with disabilities is the focus of another chapter, as is institutional abuse. A final chapter reviews the child protection system, evaluating its effectiveness and outlining prevention strategies for the future. A 15-page bibliography; answers to questions that teachers frequently ask about the child protection system; lists of printed, audiovisual, and organizational resources for use by teachers, parents, and children/adolescents; and a copy of the Child Abuse Prevention and Treatment Act are also included. (PB)

A RESOURCE MANUAL ON CHILD ABUSE

PACER CENTER

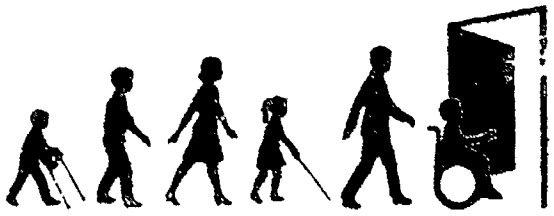
LET'S PREVENT ABUSE

Project

A RESOURCE MANUAL

ON

CHILD ABUSE



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The 17 organizations involved in the PACER Coalition are listed in the Appendix.

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PREFACE TO RESOURCE MANUAL ON CHILD ABUSE

Child abuse is a highly complex issue, reflecting diverse and often conflicting views about its probable causes, victims and offenders.

Great controversy exists about the most effective and valid means of identification, intervention, and treatment for both victims and offenders. This is partially because the study of child abuse encompasses a field whose origins have socio-cultural, economic, legal, psychological and medical components.

This resource manual comes at a time when new research and statistics, each purporting to prove a particular and sometimes opposing perspective, are being published at a rapid pace. Reports of child abuse continue to rise dramatically each year. One aspect of the study of child abuse which does remain consistent is the disproportionate and alarming percentage of children with some type of handicap who appear in the child abuse figures.

PACER Center, the Parent Advocacy Coalition for Educational Rights, located in Minneapolis, has been in existence since 1976. It has been a successful catalyst and initiator in the development of parent advocacy skills, parent training, and community education about disabilities and special education laws, as well as a referral source to community resources. A significant portion of PACER's energy and time has been directed to the dissemination of current information about handicapping conditions through their COUNT ME IN program, where volunteers, using child-size puppets, teach school-age children about handicaps. To date, this highly successful program has been viewed by over 100,000 students. Evaluations have indicated that their knowledge about handicaps has increased and, even more importantly, their attitudes about people with disabilities have changed from fear and misunderstanding to acceptance and trust.

In 1984, a new program entitled LET'S PREVENT ABUSE was piloted. The PACER program about child abuse uses these same puppets to teach children in special education and regular education classes about child abuse, self protective strategies, feelings associated with abuse, and how to get help.

In a sensitive and often humorous fashion, using children's language, these puppets teach children, and often the adults present as well, about concepts which may otherwise be difficult to verbalize. PACER has found this program to be highly successful. Although some children may already be familiar with the information, the puppets not only reinforce important self-protective strategies, but they provide children with credibility, and they validate their experience. Follow-up evaluation has shown that, immediately following the show, children have reported abuse to mandated reporters identified during the program. Often children who have been abused in the past share their experiences with the puppets and with their peers.

A special series of scripts have been developed for students with mental retardation and hearing impairments. Since 1984, PACER's program on child abuse has reached nearly 20,000 students ages 6-11.

This manual represents a synthesis of some of the most recent information about child abuse. Given the nature of PACER's ongoing commitment to the needs of children with disabilities, a great emphasis has been placed on the vulnerability of children with disabilities.

This resource manual is directed to professionals who have regular interactions

with all children with disabilities (including teachers, guidance counselors, child care workers, psychologists, social workers, and nurses) and, of course, to parents.

As an organization dedicated to the concept of parents helping parents, PACER feels that by providing valuable current information about abuse, we can make education a cornerstone in prevention efforts for all children.

With more effective and accurate recognition of these complex circumstances, a concerted effort can result in early detection and intervention for both the child and the family. Clearly, the need to act as effective advocates for children when managing child abuse issues is crucial.

ABUSE OF A CHILD WITH A DISABILITY: A PARENT TALKS

Four years ago when "Liz" was 10 years old, we realized that we were at a watershed in identifying what kind of educational programming would be appropriate for her. Faced with a 10-year-old child who is mentally retarded and hearing impaired, we were unable to find a suitable educational program that would be stimulating, and at the same time, would provide an environment with good structure. Our experience with educational placements at this time had been very poor. We found that Liz's hyperactive behavior had surfaced and her class situation was chaotic at best. Her behavior and skills were regressing rapidly, both at home and at school. Our relationship with Liz had always been close but tumultuous. There were frequent disagreements within the family about issues relating to discipline. I had always tried to maintain a balance of meeting Liz's needs while helping her to assume an active role within the family.

After some thorough investigation of our placement options (which were indeed very limited) we reluctantly placed her in a facility several hours' distance from our city. Having her leave was a traumatic decision for us all.

We placed her in a facility which had been highly recommended. There had been some dissension within the family about how often Liz should come home, but despite this, I picked her up every Friday so that she could spend her weekends with the family. It was considered unusual to make this long weekly trek, but I felt it was necessary in order for Liz to maintain the emotional support and bond with the family.

It was obvious, right from the beginning, that Liz did not want to return to the facility when the time came every weekend. Over a four-year period these feelings surfaced repeatedly, with Liz crying at night, having symptoms of illness, stomach pains and other excuses to stay home.

With hindsight and knowledge, of course, I am able to look back and know that I should have intervened...but because of the lack of agreement within the family about options for Liz, and since I felt acutely vulnerable and "unfit" as a parent because I had chosen to send her away rather than care for her in the family setting, I could not effectively intervene for Liz. I was not asking the right questions of Liz nor was I persistent when my inquiries at the facility were not appropriately addressed.

The supervisors in the facility felt it was my problem, and that I was creating confusion for Liz. As far as they were concerned she was having no problems. At the residence my questions were met with suspicion, anger and doubts about my own credibility as a parent. Liz was unable to articulate the specific events that made her so upset. Even questions and the appearance of genital soreness and puffiness were discounted by the residence staff and other family members, as minor medical irritation. No one wanted to believe that sexual abuse was occurring. I have still not forgiven myself for not intervening more aggressively at this time.

As the symptoms escalated, however, so did my anxiety, and one weekend we reached a true understanding of our daughter's plight. Liz came home and her anxiety and unhappiness were much more intense. She was exhibiting obvious signs of sexual knowledge and inappropriate sexual behavior. She was having terrible stomach cramps, crying and was really distraught. I took her to our pediatrician who, in turn, brought in a gynecologist. It was determined that she had been involved in a

sexual relationship. She was also physically injured. The doctor and our family initiated an investigation through county protection, the facility, and the police. We were in shock. We could not comprehend the enormity of what had happened. I blamed myself for not acting sooner, for not responding to some "obvious" signs. We were fortunate enough to be linked up with a counselor for hearing impaired persons whose clients included many disabled persons who had been abused. This skilled counselor, using signing, anatomically correct dolls and drawings, was able to elicit a shocking account from Liz. She had been sexually abused over a long period of time by another older resident in the facility, one who himself was a victim of sexual abuse. This resident was placed in the facility by social service agencies who had not provided Liz's facility with any information about this history. She had also been abused by another adult who has yet to be identified.

She had run away from the facility and was abducted enroute, bound, beaten and sexually abused by an unknown assailant. When she was brought back to the facility after this episode, her supervisors severely reprimanded her for running away. In their estimation, she had been a bad girl.

Liz felt and internalized the blame for all that happened to her. The message Liz was given of her own responsibility for this hurtful chain of events was too much. It was the final straw. Her behavior deteriorated so much that it precipitated the symptoms which caused me to take her to a physician.

Liz now lives at home. We are fortunate to have the help of a competent in-home counselor provided through waivered services, who has worked with Liz and all of us so that she is secure in the knowledge that she has a valued role and contribution to make within the family unit.

We know a great deal now, thanks to the help of Liz's counselors, time, patience, and much soul searching. It has been more than a year and Liz continues to suffer psychological and physical pain related to the abuse. We have been told that it may take years, and she may never recover from the trauma she experienced. It has been an extremely painful time for us as a family while we worked through the healing process.

Abuse of a child with handicaps impacts on the family in a powerful way. It has been our experience that the legal system intensifies the vulnerability of children with a disability because they have no credibility as court witnesses. We have not found legal justice through the courts, county protection, or the police or the facility. None have fulfilled their obligation to us.

We must move on, however. Liz has a long way to go, as does our family. Our guilt, pain and anger have abated only slightly as she has progressed. You can't live with hate and vengeance.

ABUSE OF A CHILD WITH A DISABILITY: A CHILD'S STORY

"Darlene," a 15 1/2 year old girl with a hearing impairment, agreed to an interview with PACER staff to talk about the sexual abuse she experienced over a 2 1/2 year period. Speaking primarily through a therapist who has helped Darlene for the past 1 1/2 years, and who is also skilled in interpreting, she described the feelings of inadequacy, frustration and guilt she felt over this period of time.

In the interview Darlene appeared to be a warm, engaging and intelligent girl; she spoke of the anguish and confusion she felt without hesitation.

Darlene's history reads like a classic chapter in child abuse literature. Her biological mother is a single parent who had a long history of chemical dependence. She herself had been physically and sexually abused as a child. Darlene's biological father was never a presence in her life.

Darlene's childhood was characterized by neglectful and emotionally abusive behavior on the part of her mother, who for example routinely took her along bar hopping, and always made her feel like a burden. Her hearing impairment was a further source of ridicule in an already chaotic relationship.

After many different men in her life, the mother became involved with an equally emotionally and chemically dependent man, "Roger."

Over a 7-month period Roger made sexual advances to Darlene, touched her inappropriately, threatened her and generally acted in a manipulative manner, mocking her, taunting her and acting on any opportunity to find her alone. The mother did not acknowledge the abusive behavior in an assertive manner. She was jealous of the attention paid to her daughter, and preferred to see the daughter as provocative.

Roger went too far one day when he attempted to fondle two of Darlene's friends who, in turn, reported the abuse to their parents, who called Darlene's mother. Roger denied the incidents, but after physically abusive behavior towards the mother, she reported it to the police. Roger was jailed for 90 days, with no resolution or action at the time planned for the family upon his release.

Just prior to his release, Child Protection gave the mother several options for the family:

a) Treatment; which they couldn't afford.
b) Foster placement for Darlene if Roger were to return home.
c) Divorce - an option that her mother was not prepared to take.

The mother chose Roger over Darlene, and agreed to foster placement. Darlene came to her foster home devastated by her mother's decision. While the abuse was going on in her home she had made some half-hearted suicidal attempts. She considered this once again while in foster placement. Darlene was fortunate, however, in having a warm, sensitive foster placement and referral to a competent therapist who could sign, and therefore determine the depth of her experience and frustration.

The court had ordered that Roger not see Darlene, that her relationship with her mother could not include him. This was not successfully achieved as Roger was able to manipulate her mother into bringing Darlene home when he was there. He then continued to abuse her. This time, however, she had

the internal strength to report him immediately, whereupon any further contact with her mother had to be monitored by a social worker.

Darlene sees her mother in a supervised setting once a month and her therapist feels that many issues have not been resolved. At the moment Darlene, her therapist, and her foster family are primarily hoping for Darlene to achieve the emotional growth that will enable her at age 16 to determine if and when she will see her mother at all any more.

Darlene, unlike many other children, was able to benefit from intervention. She was empowered sufficiently to act on her own behalf and was able to benefit from the county protective system. Despite this, she will likely be dealing with her experiences at an emotional level for many years. It has altered her perception about relationships, parenting, men, and motherhood. Hopefully with time and love she will be able to work through these difficult personal issues and continue to grow in the direction she chooses.

CHILD ABUSE: AN OVERVIEW

The histories described in the previous pages are not atypical descriptions of abusive incidents. What is more atypical is that some positive intervention and resolution was accomplished for the victims.

Recently, parents and professionals have been inundated with information about child abuse. The media has devoted a vast amount of time to describing significant widespread reported cases of abuse in "typical" communities. In all of the cases, the victims had allegedly been physically or sexually abused by trusted persons in authority, including family members, friends, teachers, or therapists. In some cases, despite what seemed to be clear evidence to the contrary. the suspected perpetrator(s) were vindicated. Some of the reasons included: insufficient or inadmissible evidence, legal technicalities based on court procedure, inconsistencies in the child's testimony, or breakdowns in the system's handling of both the children and the perpetrators from the initial report until their presence in court.

Cases such as those in Jordan Minnesota, and the McMartin Day Care Center in California are examples of the difficulties and complexities involved in identifying and dealing with child abuse cases through the courts.

The American Humane Society has maintained a continuing data bank on the number of reported incidents of child abuse and neglect. In 1976 it was estimated that 669,000 cases of abuse and neglect were reported, or 10.1 per 1,000 children. [1] By 1985, this figure had risen to 1,793,050 cases. [2]

In 1984, a state-by-state telephone survey conducted by the National Committee for Prevention of Child Abuse revealed that in 42 states, the number of reports of child abuse and neglect cases had increased from 1% to 190%. Thirty states projected an increase as high as 121% in the number of sexual abuse reports. [3]

While it is clear that greater public knowledge about child abuse as well as a better understanding of the liability involved in not reporting contributed to the increased figures, this is tempered by the fact that most experts agree that a high percentage of abuse remains unreported. Moreover, many more cases are never legally prosecuted because of technicalities.

Questions persist about what really constitutes abuse. Certainly physical injury and sexual exploitation are easier to define because of the presence of specific evidence. Neglect and emotional abuse, each of which cause long term, often irreversible damage, are more difficult to define and almost impossible to measure and review.

In Minneapolis public schools alone, the number of referrals for child abuse intervention increased from 25 cases in 1977-78 to 193 cases in 1985-86. [4] Nearly 47% of those children were recipients of some type of special education services. [5] These statistics reflect one aspect of the complex web of abuse, cause and effect. Is the "special need" of the child a factor in precipitating the abuse, or is the student's performance impaired as a result of the abuse? Both factors indeed exist. The issue of the impact of disabilities will be dealt with in a subsequent chapter.

Needless to say, the cost to society of the effects of child abuse is incalculable. The cost of investigation, prosecution, rehabilitation and treatment is staggering. This does not begin to take into account the human suffering and tragedy. Furthermore, current research reflects a high correlation between child abuse and juvenile delinquency, prostitution and youthful suicide, as well as adult criminal and homicidal behavior. The ongoing cost to society of these tragic life styles is immense.

Child abuse is an age-old problem, but it is only relatively recently that it has acquired a medical definition and scientific follow-up.

In a 1946 study, Dr. John Coffey referred to the "whiplash shaken infant syndrome" [6] where he determined that infants can be so severely and repeatedly shaken that permanent brain damage and mental retardation could result.

In 1962, Dr. Henry Kempe described the "battered baby syndrome," [7] in a scientific paper describing the death of an infant by non-accidental means. The term referred to a case study, where x-rays showed fractures and bruising in various stages of healing, indicating they were imposed at different times and were a result of direct force as opposed to accidental injury. In 1967, a paper by Elmer & Gregg identified the correlation between abuse and neurological, developmental and psychological disturbances. [8]

A major criticism of the literature is that much of it is based on a lower income population -- a significant proportion of whom can be described as multi-problem families. This population tends to depend more heavily on social service agencies, emergency rooms, and clinics, whose staff, in turn, is more alert (some say too much) to signs of abuse. This population has become the laboratory for much of the definitive research to date.

Middle and upper income people generally depend primarily on private physicians; it has been suggested that private physicians are more reluctant to intervene in abuse cases for a number of reasons: 1) they fear losing the family as patients, 2) they believe that they can be more effective in preventing further abuse by continuing to treat the family and possibly reverse the destructive cycle, and 3) they have a healthy cynicism about the efficacy of the human service system and the criminal justice authorities.

Despite the inequities which may be reflected as a result of this socioeconomic bias, it is important to remember that child abuse is not uniquely a problem of the poor, of persons with handicaps, the urban dweller, the single parent, blacks, Hispanics, or teenage parents. It transcends socioeconomic, cultural, and demographic lines. **Child abuse is everyone's problem.**

The term child abuse and neglect is a broad one, encompassing at least four specific types of mistreatment:

a. physical abuse
b. sexual abuse
c. emotional abuse
d. neglect (almost always occurs in combination with one of the above)

Physical Abuse

The National Committee for the Prevention of Child Abuse defines physical abuse as an injury or a pattern of injuries to a child that is nonaccidental. This may include welts, burns, contact with hand or instrument, bites, strangulations, broken bones, scars, internal injuries, cigarette burns, immersion burns or dry burns. [9]

Typically, physical abuse is easier to detect because of the presence of visible signs of injury, and some indication of the frequency with which these injuries may appear. Injuries may be observed in various stages of healing, indicating that they could not have all occurred at any one particular time, or that possibly, they have not been treated. They generally appear to represent a pattern of chronic repetitive injury at the hands of someone stronger than the child.

Indicators are particularly telling if they are:

a. repeated and consistent over time
b. long lasting (i.e. as one injury heals, a newer injury is in a more recent stage of healing)
c. pervasive (all parts of the body frequently show evidence of injury)

Emotional Abuse

James Garbarino, a noted contributor in the field of child abuse, defines emotional abuse

as the "willful destruction or significant impairment of a child's competence." [10] It is a clear description of a concept which is often difficult to define or measure.

Emotional abuse is the most difficult abuse to define because of its insidious nature. It is a pattern of behavior which takes place over an extended period of time, characterized by an overall withholding of the love and nurturing a child needs to develop socially, intellectually and personally. Interactions between the parent and child tend to be characterized by a pattern of predominantly negative rather than positive verbal exchanges.

Specific examples of emotional abuse may include:

a. excessive criticism of the child's personality, looks, abilities
b. inappropriate excessive demands of a child; withholding of communication
c. an inability to foster the development of the child's positive self-esteem by routinely labelling or humiliating a child.

Very few states have laws regarding emotional abuse as it is difficult to categorize and measure. Yet the most recent literature states that consistent emotional abuse has the most long-term irreversible impact.

Typical behavioral indicators of consistent and severe emotional abuse may include:

a. developmental lags, physical, mental, or emotional lags
b. habits such as rocking, biting, sucking
c. speech disorders
d. excessive infantile behavior
e. extreme depression, suicide attempts
f. hypochondria and
g. passiveness/ aggressiveness.

All of these characteristics may also result from other causes.

Physical Neglect

The term "neglect" describes a pervasive situation where parents/guardians do not or cannot provide the necessary food, shelter, medical care, supervision, and/or education to children under the age of 18. It may also include an absence of love, security, and the stimulation necessary for attachment and development. Overall, the parents or care givers are uninvolved in the child's normal day-to-day development at any level. Neglect of children is often found in cases of physical or emotional abuse. Many experts in the field of child development believe that the long-term effects of neglect are even more devastating than other forms of abuse. [11]

Medical neglect is not uncommon, particularly among children with handicaps where parents or caregivers fail to carry out prescribed treatment plans, resulting in exacerbation of the child's problems. When considering disabilities, issues such as medical knowledge and follow-through are particularly difficult when children are placed in foster care or multiple settings over time. They may be placed with persons who are not knowledgeable of their needs, and there may be no continuity of care, and/or coordination of services.

A well-documented symptom of extreme neglect is the "failure to thrive" syndrome, where a child's physical and mental growth is significantly arrested with no organic cause present. Studies have shown that if the cycle of neglect and accompanying abuse is stopped, the child can make physical and mental gains. [12]

Sexual Abuse

The terms child sexual abuse, child sexual assault, and child molestation refer to the exploitation of a child for the sexual gratification of an adult." [13]

The National Center on Child Abuse and Neglect refers to incest as "intrafamily sexual abuse," and defines it as "that abuse which is perpetrated on a child by a member of the child's family groups and includes not

only sexual intercourse but also any act designed to stimulate a child sexually, or to use a child for sexual stimulation; either of the perpetrator, or of another person." [14] The sexual contact could include parents, step-parents, siblings, or grandparents, etc.

Sexual abuse can also include fondling, exposure, masturbation, intercourse, rape, sexual games, child pornography, child prostitution, and obscene calls. **It should not be confused with the normal loving, warm physical interchange between an adult and child.** Central to the concept of sexual abuse is the use of coercion, deceit and manipulation to achieve power over the child.

Generally sexual abuse of children is not associated with the violence involved in adult rape. The perpetrator is always in a position of power and/or control over the child. The manipulation and deceit characteristic of sexual abuse is often sufficient to control the child. Sexual abuse can also involve touching of the breasts, anus, genital touching, oral-genital contact, or exposure. It may include the child undressing or viewing the genitals of another person older than he/she. Sexual intercourse does not always occur. Most sexual abuse is committed by persons who know the child.

The subject of child sexual abuse is a highly emotional one. In considering the nature and classifications of various types of child maltreatment, it is difficult to determine which is the most disturbing. but sexual abuse is perhaps the greatest crime against children. The misuse of children for sexual gratification takes place in secrecy; children are bound to silence by threats, fear of reprisals, shame, guilt, and the sense that they will not be believed. It is estimated that for every case of sexual abuse revealed, nine are hidden from authorities. All statistics on sexual abuse, therefore, must be seen as reflecting an underreporting of the real truth.

The projected national number of reported cases of sexual abuse for 1984 was 1,200,000. [15]

Common Misconceptions or Myths About Sexual Abuse of Children

A number of popular myths have impeded substantial progress in assessing the scope of sexual abuse, obtaining appropriate medical attention, and implementing effective preventative strategies. These include:

1. **The typical offender is easily identified; he looks "weird."** There is no "typical" offender. Abusers are found in every socioeconomic class, every ethnic group, and all professional walks of life. Potential abusers may gravitate towards some type of work with youth groups, teaching, etc. It would be impossible to instinctively pick out a sex offender by outward appearance.

2. **Strangers are responsible for sexual abuse.** It is estimated that more than 80% of sexual abusers (pedophiles) are known to the victim; some studies indicate that more than 50% occur in families. [16] Offenders may include neighbors, family friends, babysitters, teachers. These statistics are even higher for persons with disabilities because of their greater dependence on care givers.

3. **Sexual abuse occurs because of the seductive or affection-seeking behavior of the child.** If and when children's seductive behavior does develop, it is generally a result of the abuse rather than the precipitating factor. The child is always victimized.

4. **Only girls are abused.** Both boys and girls are vulnerable to sexual abuse, but statistics on male victims seem to be considerably less accurate. Current statistics state that one out of four girls will be a victim of sexual assault before age 18, and one of ten boys will experience some type of sexual assault. [17] Boys are more reluctant to report abuse because of a greater sense of shame, a greater tendency to accept blame for the sexual involvement. This discrepancy between the sexes probably reflects the reluctance of males to report the abuse.

5. **Teenagers are the most likely victims.** A number of studies report that children under six years of age are involved in 15-25% of cases of sexual abuse. [18]

6. **Children fantasize about sexual involvement, even if it does not occur.** Children rarely fantasize about sexual involvement, and unless there are significant other factors such as mental illness or psychosis they are usually credible reporters.

7. **Abuse or incest happens only as a "sporadic" impulsive incident.** Offenders rarely act only once. One report shows that on the average, an offender will have molested more than 70 children before being caught; [19] in families, the tendency is for the offender to stop once the child reaches adolescence; and where possible, another child is chosen as the next unwilling partner.

8. **Homosexuals are primarily responsible for sexual crimes.** Sexual abuse is generally a crime by heterosexuals.

9. **Most offenders are psychopaths and they cannot tell right from wrong.** In 80% of cases offenders know what they are doing is wrong. Their actions represent a way of releasing sexual tension with a vulnerable younger victim.

10. **Most abuse takes place at night in a dark alley or remote area.** Most child sexual abuse takes place in daylight, more likely in the victim's home.

All sexual relations between adults and young children must be viewed as a form of rape since the child's immaturity prevents any possibility of a consensual relationship. Since most cases occur between children and someone familiar to them, the bond of "trust" that exists enables the adult in charge to take advantage, to threaten, bribe, cajole, and/or trick a child into submission. Generally, younger children are not able to instinctively say "no" to someone they love, a parent or a relative, and faced with threats or trickery they cannot conceptualize that they can resist or be believed. Older child abuse victims are afraid of what their confessions could precipitate if it is an incestuous relationship, perhaps the break-up of a family, the loss of a relationship with both the mother and father, possibly a statement of their "contribution" to the assault or the sexual involvement.

It is difficult to portray an accurate profile of a "typical" child abuser, but a number of characteristics are common. Unfortunately these traits are not observable and identifiable until the abuser is apprehended and they are traits which are common not only among child molesters.

Studies have shown that a significant proportion of male offenders suffered some type of sexual trauma as children. Characteristically, they had a poor relationship with their father, and were raised in an atmosphere lacking in normal physical intimacy and contact. They suffer from poor self esteem, isolation, and the need for immediate gratification. As adults they look to children to provide them with a solution for their immaturely developed needs for affection. Alcohol and drug abuse can be a contributing factor in approximately 30-40% of the cases of sexual abuse, although some therapists believe that drug and alcohol abuse is given as an excuse for acts only when a perpetrator is caught.

Physical symptoms of sexual abuse include:

a. difficulty in walking or sitting
b. torn, stained or bloody underwear
c. pain or itching in genital, vaginal, or anal areas
d. venereal disease
e. persistent vaginal infections and
f. early pregnancy.

Behavioral indicators may include:

For Young Children

a. wariness of physical contact, especially when initiated by an adult
b. fear of night, the dark
c. seductive behavior for approval by adults
d. sex play, masturbation, excessive curiosity about sex

e. bedwetting and/or soiling
f. inappropriate sophisticated sexual behavior or knowledge
g. excessive irrational fears
h. changes in mood--extreme withdrawal, or hyperactivity
i. learning problems where none had previously existed
j. regressive behavior

In Older Children and Teenagers

a. seductive behavior
b. increasing isolation from peers, activities
c. depression, suicidal attempts
d. runaway behavior
e. truancy
f. neglect of appearance
g. promiscuity
h. drug/alcohol abuse
i. hypochondria
j. lessening interest in academic achievement
k. self mutilation
l. eating disorders including overeating, anorexia, bulemia
m. delinquent behavior
n. extremes in behavior--severe depression, aggressive behavior

The long term results of untreated sexual abuse include depression, suicidal attempts, promiscuity, prostitution, sexual problems as adults, (affecting choice of mate and ultimate marital stability), eating disorders, chemical dependency, poor self esteem, and multiple chronic psychosomatic and psychological illnesses.

The Family System

The various types of child abuse and neglect provide a disturbing perspective of the many serious factors that deny children a carefree and peaceful childhood. Historically child abuse has always existed, as children were perceived as chattel, the property of their parents or guardians. The family unit has been regarded as sacrosanct; what goes on in the privacy of one's home in the name of discipline and control, as part of the "normal" family interchange, has been considered immune to challenge by those outside the domain of the immediate family.

While over time the civil rights of the family have, for the most part, been maintained, the rights of the child have generally been ignored. Symptomatic of this attitude is the inability of children to exert any power even when physical discipline is excessive, or inappropriate sexual overtures or actions take place.

Consider the fact that it is only relatively recently, since 1968, that all states have incorporated legislation regarding child abuse and neglect.

At the same time, the typical American nuclear family has been dramatically weakened. Families are more mobile and less dependent on extended family for help; pressures relating to divorce and single parenting are increasing. The number of young single mothers living in poverty is high. Increasingly, responsibility for monitoring questions of abuse and neglect has been directed to schools and county social service agencies.

In order to understand the dynamics of child abuse, who is more likely to commit abuse or be victimized, it is essential to remember that:

a. Appropriate nonabusive parenting is not "natural" for everyone. Parenting has to be learned or proper role models must be provided.
b. Both girls and boys are vulnerable to abuse.
c. Most often a particular child within a family system is singled out for abuse.
d. Specific characteristics of the child can make him or her more vulnerable to abuse, i.e. the child may be strong-willed, or may remind the parent of a spouse who left, or, correctly or incorrectly, may be perceived as different, or difficult. These characteristics can precipitate a cycle of abusive behavior.

While the characteristics of what constitutes physical abuse (repeated nonaccidental injury) are fairly clear, the factors involved in precipitating the occurrence of an abusive pattern are multiple and highly complex.

It is important to remember that **we may all have the potential for some form of physical and emotional abuse if our life situations, our coping mechanisms and the degree of external and internal pressure we are experiencing are sufficiently taxed.**

Before a child is even born, certain characteristics of his/her parents, combined with the family life situations, may predispose the child to being abused and, later, as adults, possibly be abusive to his/her own children. **The most compelling factor in predicting abuse is the parent's own experience as a child.** It is commonly agreed that a high percentage of known abusive parents were abused as children. The cycle of abuse is, therefore, initiated by a poor, negative role model from one's own parent. Studies have shown certain characteristics common to abusive mothers; they include immaturity, low self esteem, hostile, impulsive and aggressive behavior, inflexibility, and inconsistency. [20]

Typically, abusive parents are emotionally and/or socially isolated, inconsistent in behavior, and uninformed about child development. They depend on the security of absolute control and discipline. Because of their lack of knowledge, they have unrealistic expectations for the child, who cannot fulfill these needs or expectations, thereby causing frustration, which, in turn, is vented on the child by damaging physical, verbal, or rejecting actions or behavior.

The parents' immaturity, low self esteem, and social isolation may prevent them from making friends easily; ultimately they do not choose a suitable mate who can counteract their poor self image, but rather a person who reinforces it, often someone who is also dependent, immature and abusive. Abusive parents are noted to have a lower threshold to stress, so that when relatively minor or even trivial events occur, the abusive parent overreacts and physically or psychologically harms the child.

In more than 50% of cases, the child is unplanned and/or unwanted, [21] thereby intensifying the ambivalence. In many instances the child represents the only possibility for providing the love and nurturing that the parents themselves did not receive as children. A demanding, crying infant, an inquisitive toddler, and an impulsive teenager cannot possibly fulfill that need for love. If the parent has an unhappy, abusive marital situation or is alone, the child becomes "the cause"; if the child reminds the parent of the spouse who is abusive or rejecting, that child bears the brunt of the parent's anger.

Intervention

It is not surprising, therefore, that intervention and help is difficult to initiate, even when it is offered in a positive, helpful and non-threatening manner.

According to authorities, when an attempt at intervention is made, most often when children initially come in contact with schools and teachers, a number of types of responses tend to occur:

1. Both child and parent deny the abuse, each independently offering impossible, often inconsistent and contradictory explanations of how the injury occurred.

2. The child is described by the parent as being bad, unmanageable, clumsy, stupid, accident prone, or requiring harsh discipline to behave.

3. The child is frequently absent from school as the injuries heal.

The Child Victim

It is well known that a high percentage of children who are physically and sexually abused are under the age of 5, with the most dangerous period being from 3 months to 3 years. [22] Children at this age are less

resilient, less able to communicate, and as isolated as their parent(s); they are, therefore, less likely to come to the attention of authorities. As each developmental milestone approaches, each representing a greater attempt at autonomy, the frustration of the parent increases. By the time the child reaches adolescence, this type of abusive parenting has left an indelible mark for a future generation.

Given the temperamental and social factors common to abusive parents, it is understandable how external stresses such as a lack of financial security or unemployment can contribute to and in fact intensify the abusive cycle. Unless some intervention is initiated, the prognosis for child victims is indeed gloomy.

A significant percentage of sexually abused children is never identified, and subsequently may not receive the medical and psychological attention they so desperately require. They may deny the incident(s) and retract previously made impulsive admissions of sexual involvement because of fears of punishment, a perceived notion of their own contribution to the incident(s) (usually initiated by the abuser), and feelings of shame and guilt. The intensity of the trauma associated with sexual abuse is directly related to the intensity of the relationship with the perpetrator, with incestuous contacts obviously being the most traumatic. The long-term effects depend on whom the sexual contact was with, the nature of the contact, its duration and when, if at all, intervention and/or resolution took place.

Children raised in an abusive atmosphere respond most predictably to their circumstances over which they have little or no control. Besides exhibiting the outward physical signs of repeated abuse, they tend to exhibit the extremes in behavior; they are usually more aggressive, hostile, reckless and impulsive, or decidedly passive, fearful and withdrawn. In either case, they are generally mistrustful. They are either attention seeking (negatively so), or attention avoidant. They show an excessive reluctance to respond to physical contact, particularly when initiated by an adult. They have a general wariness of adults, particularly their parents, and often they prefer not to go home. Not surprisingly, they show no expectation of comfort when the situation warrants it. They have been described as being in a state of "frozen watchfulness." [23] Without intervention their future will be not unlike that of their parents.

There is a high correlation between abuse and illegitimacy, juvenile delinquency, alcoholism, and drug abuse, truancy, running away, and emotional disorders. Some of the long-term effects of abuse can include mental retardation, brain damage, cerebral palsy, physical retardation, learning disabilities, neurological impairment, lower IQ ratings and growth failure. A high percentage of abused children have been shown to be functioning in grades below their age or intellectual level, and more than one study reports that a significant percentage were in classes for the mentally retarded. [24] Another study showed that 42% of children in psychiatric hospitals were seriously abused prior to admission. [25]

The issue of child abuse and children with disabilities will be described in a separate chapter, but it is important to indicate that just as abusive parents perceive their "normal" children to be difficult to manage, the needs of children with disabilities pose an even greater stress in terms of increased responsibility, knowledge, patience, financial burden, and acceptance. Given the potential for abuse, these children are at even greater risk.

ABUSE OF THE CHILD WHO HAS A DISABILITY

In the previous sections, the nature and scope of child abuse and the factors which may contribute to the abusive cycle have been described. A case has been made for the vulnerability of all children in situations where they lack the power, the strength, or knowledge to defend themselves. Most children do not have the ability to stop the abusive cycle. In considering the issue of the abuse of children with disabilities, it is important to realize that these children are at twice the risk.

Great variability exists in the financial, emotional, medical and educational resources available to parents of children with special needs. Many parents lacking in any or all of these resources are loving, caring parents. Yet these children are overrepresented in statistics on abuse. The lingering question is why? Are those children who have disabilities and happen to have the misfortune of being born to parents with an abusive tendency primarily at risk, or is the presence of a handicap in a child the overwhelming factor which stretches the adult beyond the edge that separates control from abuse? It is a question which has not been satisfactorily answered. Certain factors, however, are well established:

1. Children with disabilities are generally less able to defend themselves physically.

2. Children with certain types of disabilities may be less able to articulate the fact of the abuse.

3. Some children with disabilities may be unaware that they are being abused. They may be unable to differentiate between appropriate and inappropriate physical contact, whether it is violent or sexual in nature. They do not know that there are any other options.

4. Because many children with profound disabilities are more dependent on others for assistance or care, they tend to be more trusting. This basic dependency and trust often becomes translated into compliance and passivity.

5. Because many of these relationships they have established are of a dependent nature, children with disabilities may be more reluctant to report instances of abuse for fear of losing vital linkages to care providers.

6. Some children with disabilities have even greater difficulty, once they report abuse, in establishing their credibility as valid reporters. This is particularly true in cases which are tried in criminal court.

It is important to underscore the fact that the possibility of physical abuse of children with special needs is significantly greater if parents have not come to terms with their feelings about, and expectations of, a child with a handicap. Feelings of denial, anger, and/or guilt normally accompany the birth or subsequent diagnosis of a child with a disability. Greater understanding of the parents' feelings, some direction for both parents and child around issues concerning acceptance are all necessary at the initial diagnostic juncture. Additional information about the child's potential should be made available on an ongoing basis at crucial developmental stages.

Children with profound physical disabilities, chronic illnesses, those requiring some type of ongoing health care, specialized care in feeding or hygiene may require intensive physical, financial and emotional commitment, sometimes beyond the capacity of the family. If it is not quickly addressed, the overriding feelings of the loss of a "normal" child may create a type of

While health care professionals may provide a great deal of clinical knowledge about the nature of the problem, they are not always able to clearly identify or advise parents of the social and educational options and/or the community based supportive services so crucial for the family. Parents are often not knowledgeable about their child's capabilities, how to work with their child to achieve their maximum potential, or how to contend with the complex medical, educational and social service network.

The tendency on the part of professionals has been to be reactive rather than proactive. Instead of anticipating the stress, confusion and depression that may be experienced by parents and helping them handle the stages of emotions, professionals have often left parents alone to cope with the stress involved in having a child who is disabled. Studies have shown that these families have greater difficulty in maintaining harmony in marital relationships, issues relating to child rearing, in relationships between the child with a disability and siblings, and in social interactions with relatives, neighbors and friends. One study of parents of children with spina bifida showed that the divorce rate was twice that of the control group and also of the general population. [26]

It must be emphasized that the presence of disabilities is not sufficient alone to precipitate an abusive pattern, nor are all children with disabilities singled out as victims of molestation. With proper knowledge of the disability, access to a full range of medical, community, and educational resources, and sufficient emotional support, most families and children with disabilities can experience family relations and disciplinary patterns indistinguishable from those of families without the presence of disabilities.

Physical Abuse

As has been mentioned earlier, there is a clear relationship between severe physical abuse as a crucial factor in the development of disabilities, including cerebral palsy, developmental delays, permanent brain damage and some forms of mental retardation. The concern in this chapter, however, is the vulnerability of children known to already have disabilities prior to physical and sexual abuse.

The profile of an abuse-prone adult describes an individual who is socially isolated, immature, impulsive, unrealistic about child development, and prone to scapegoating of one child, particularly one who appears to be different or difficult. The perception of the "difference" or difficulty may begin at birth, especially if that child is premature.

Studies of battered babies, the age group with the highest mortality rate as a result of abuse, indicate that a high proportion (23.5% in one study of battered babies) [27] have been premature. Their particular vulnerability is attributable to a number of factors:

(a) the lack of maternal bonding or interest in the child. The premature child may spend a significant proportion of his/her first weeks or months in a neonatal nursery, with little or any opportunity for the mother to establish the necessary maternal bonding.

(b) Premature infants are often more difficult to nurture or parent, are more colicky, sometimes less responsive and generally more in need of attention. An insecure, abuse-prone parent may perceive such a child to be abnormal by the very fact of its premature birth and may feel more rejected and incompetent if the child is not responsive. The child may then be viewed as bad, unloving, and deserving of "discipline," no matter how young.

In 1971 David Gil, in a pioneering work on factors which lead to violence directed at children, identified 29% in a group of 6,000 patients as exhibiting some prior form of deficit functioning ranging from retardation to physical anomalies. [28]

Another study of 60 battered children showed 25% to be mentally retarded with a significant percentage exhibiting some type of learning disability and/or behavioral problems. [29]

Consistent with patterns identified in an abusive cycle, the children were scapegoated and singled out as the source of family difficulties. A child can never respond adequately in such a situation. The abuse further reinforced the children's low self-esteem and led to more behavioral problems and thus more punishment.

In a number of studies of abused children, the number of children with IQ's below 70 was found to be as much as 10 times as great as in the general population. [30] Moreover, numerous scientific studies indicate a higher percentage of children known to be abused and/or neglected in special education programs.

It is difficult to determine what percentage of these children can achieve a higher level of functioning if the cycle of abuse is broken. If you consider the fact that a high percentage of youthful criminal behavior is caused by youth with learning disabilities, and much youthful criminal behavior is committed by persons with long histories of familial abuse, disabilities and long-term outcome become more entangled in the complex web of abuse. The statistics are further compromised by the fact that they represent to a greater degree a low-economic, multi-problem group within society.

The risk of physical and emotional abuse to children with disabilities is greater in the population known to have the "invisible disabilities," including neurological impairments, behavioral disturbances and learning disabilities.

A higher incidence of abuse among this population is attributable to a complex series of factors. Some of these children are more sensitive to stress, and may require a different kind of parenting, communication pattern, and structure.

Temperamentally, their ability to deal with frustration may be more limited; they may be hyperactive and/or unable to focus on specific tasks or goals, and have more limited social skills. These children come home from school having already dealt with a great deal of frustration with learning, and problems in acceptance by their peers. At home they can trigger further stress in a vulnerable parent. The combination of a difficult child and poor parenting skills can result in abuse.

Children with hearing and speech impairments deal with the daily frustration of communication. Their speech is different and can be difficult to understand; communication may be strained, even with close family members, leading to some isolating types of behaviors. They may be perceived as less intelligent because of their difficulties in communicating. In a mainstreamed population they may cope with cruelties from other children and difficulties in communicating with teachers.

Some experts maintain that children who are deaf have a greater tendency to exhibit poor impulse control, [31] thereby exacerbating any difficulties already present in communication. In turn, it has been suggested that hearing parents are more physical with their children who are deaf. [32] While the physical nature of interaction may be a necessary compensation for the lack of speech, it may lead to more inappropriate, injurious behavior.

Children who have mental retardation are also at greater risk for abuse. Generally it takes longer for this child to learn skills, and, at some point this learning curve plateaus. As the child grows up, the gap between his/her chronological age and abilities becomes more pronounced. If other conditions are present such as seizure disorders, behavioral management issues, and/or medical problems common to children who are mentally retarded, their functioning may be additionally impeded. In an environment characterized by unrealistic, unfair expectations, guilt, and limited knowledge, the presence of a child who is retarded can be stressful and

frustrating, and place the child in double jeopardy for battering and/or neglect.

For many families the opportunities for some relief, for homemaking assistance, respite care, health aides or personal care attendants are not always available. There appears to be no relief - a situation which can lead to tension, frustration and some breakdown in internal controls.

A series of studies conducted in a group of children with cerebral palsy indicated that recurrence of abuse was a major problem. This may be attributable to the fact that criminal proceedings were initiated in only 3 out of 37 cases of child abuse. [33] Moreover, the study showed that these children experienced multiple placement out of their biological home settings. [34] Like many other children with disabilities, they "fell between the slats" in the system. They were multiple victims, not only of abuse and lack of a permanent home, but also of the attendant difficulties in developing attachment and trust as well as consistent medical care.

Sexual Abuse

In assessing the vulnerability of children with special needs to physical abuse, it is clear that external stresses, as well as character traits in the adult caregiver, each contribute to the potential for harm. In examining the issue of sexual abuse and children with disabilities, issues which are less amenable to sociological or psychological rationalization are identified.

In an earlier section of this manual, some time has been spent describing the profile of a typical sex offender and common myths about sexual abuse. Another statement that could be included in any list of myths about sexual abuse is:

"Sex offenders never select children in wheelchairs, children who have mental retardation, or those with other disabilities." In fact these children are more at risk of being victimized. They are perceived by a sexual abuser as weaker, less knowledgeable, less credible as reporters, less communicative, more dependent, and, therefore, more compliant. A 1980 study showed the risk to children who are mentally retarded to be 3-10 times as high as for children without retardation. [35]

Professionals who specifically counsel victims of sexual assault who are disabled report a number of disturbing factors:

1. Although it is estimated in the general population that as high as 80% of abusers are known to the victim, at least one study, conducted in Seattle, stated that 99% of cases of reported sexual abuse on persons with disabilities were committed by persons known to the victim. [36]

2. While it is speculated within the general population that possibly only 10% of all sexual abuse is ever reported, within the population of children with disabilities this figure may be even lower.

In general, children with disabilities may be perceived as easy targets for sexual abuse because of many factors besides the obvious physical, mental or emotional limitations:

1. They have had limited opportunity to learn self-protective strategies. These strategies may range from verbal self-protective skills to karate.

2. Many children with disabilities have no knowledge about normal sexuality. They are unable to make the inference between positive and negative sexual acts.

3. Some children who are dependent on caregivers for their most personal, intimate aspects of personal hygiene are reluctant to report sexual abuse for fear of losing that necessary care provider.

4. Children with more profound disabilities may exhibit a greater level of trust and affection to more individuals. This may develop into an abusive pattern.

5. Children with disabilities may be unable to comprehend the fact of the abuse and/or articulate it to a responsible adult.

6. Children with disabilities, especially mental retardation, profound hearing impairments, or emotional disturbances, are not perceived as credible reporters of abuse.

7. Some parents of children with disabilities are so overprotective and fearful for their child that their child is ill equipped for achieving independence as an adult. They lack empowerment and are therefore perceived as a victim; this victim-like effect makes them more vulnerable to abuse.

How Can We Even Begin to Address the Problem?

We must provide children with disabilities with the information necessary to identify what constitutes physical and sexual abuse. This includes sex education, the range of appropriate physical and sexual touch, and assertiveness training. This information must be provided in a manner which is compatible within the limitations of the disability. An integral part of this education must be the attainment of self-protective skills.

Parents or caregivers responsible for children with disabilities must be alerted to both profound and subtle signs of sexual abuse, and must be encouraged to act upon these signs as quickly as possible. It is essential to continuously and vigorously advocate for children, particularly these children.

In the past 10 years, the horizons for children with disabilities have been significantly advanced. The greater emphasis on independence, the acquisition of more innovative and adaptive skills, have allowed more children to be mainstreamed and have access to fulfilling and meaningful roles in the workplace. If we are going to extend this effort even further, we must also be alert to their vulnerability, share the appropriate knowledge and strategies with them, and provide the intervention and attention when abuse occurs.

INSTITUTIONAL ABUSE - THE FORGOTTEN MINORITY

It was demonstrated in the previous chapter that the factors which make children with disabilities more vulnerable targets for physical, sexual, and emotional abuse are varied. The overriding misuse of authority, the inappropriate use of physical violence, and the sexual compromising of children who may be unable to comprehend what is happening or to protect themselves is even more serious when the limitations imposed by their handicap are considered.

Children with disabilities who are mainstreamed and integrated into a broader social and educational system have some opportunity to be identified by professionals in the community as being at risk if they have been abused. Intervention for both child and family may then be a possibility. For some children, however, a broader social framework is not available. Some children with more severe physical, communicative, cognitive, behavioral and emotional disorders may not be able to remain at home. For these children and their families, institutional, group home or foster care settings may be the only alternative available.

In the past 10 to 15 years, in a reversal of the prevailing institutional model, a dominant philosophy in the long-term treatment of persons with severe disabilities has been promoting de-institutionalization, while, at the same time, providing the necessary medical, educational and social services through the home and/or the community. For example, in Minnesota, in compliance with the Welsch Act [37] the state can admit children who are mentally retarded to state hospitals only when no other community placement is available. Moreover, their hospital stay could not exceed a period of one year. The hope has been that the responsibility for care would shift so that most children with disabilities could remain in a more home-like environment; community resources would then be the primary service provider. A complex formula to include federal, state and local funding was developed so that there are financial incentives for service provision at the local level.

While in theory this represents a positive change both in philosophy and direction, its efficacy is predicated on other factors working well together. They include:

a. Are a sufficient number of alternative residences available, whether group home, alternative living or foster placement?
b. Is adequate attention given to matching service and resident?
c. Are these placements staffed by persons knowledgeable about disabilities?
d. Is some follow-up of these residents and their adaptation done by trained, knowledgeable people at the county level?
e. Is there ongoing involvement in the resident's progress from a relative or other significant adult?
f. Are the needs of children with disabilities being met once they are released into the community?

Any or all of the answers to these questions may have impact on who is vulnerable to abuse in an out-of-home setting.

Questions arise about the vulnerability of children with disabilities living out of the home, primarily because of the insular nature of their environment, the absence of significant persons who might advocate on behalf of a child exhibiting signs of abuse, and the greater difficulty in identifying abuse in a special population.

Who within the population of people with disabilities is more vulnerable to abuse and why?

Is it the child with profound retardation who may have diminished ability to comprehend and/or to defend him/herself?

Is it the child who uses a wheelchair, possibly multiply handicapped, more dependent on caregivers for every personal and physical need?

Is it the child with deafness who has difficulty in interpreting and/or communicating critical messages?

Is it the child who has autism and has emotional/behavioral disorders who, without stringent "controls," may be self-abusive or violently abusive towards others?

In each of these populations the factors which may precipitate abuse and prevent its discovery are significant. While we have determined that the presence of a biological parent does not guarantee a unique bond which might prevent abuse to a child in a home situation, how are institutions, group homes, foster homes, or alternative residential settings more problematic?

Increasing Risk of Abuse in Institutions

Every alternative residential option has the potential to replicate an abusive family situation. While the hope in placing a child with a disability out of home is that they will be in an environment which can respond to their needs more completely or provide a safe haven, such is not always the case. Children in institutions may pose a unique type of stress for their caregivers, particularly if the care providers are not sufficiently knowledgeable about their needs, their potential, and how to work with them. With the implementation of the Welsch Decree in 1972 in Minnesota, the number of intermediate care facilities (ICF/MR) increased dramatically, many funded through Federal Medicaid funding. In the rush to de-institutionalize, and given the availability of federal funding, service providers appeared where none had existed before.

The Evaluation Division of the Legislature has published a report raising serious questions about these facilities as well as the state institutions. On a national scale, Senator Lowell Weicker headed a committee which published a massive condemnatory report about institutional abuse in the summer of 1985. We might ask:

Are staff sufficiently skilled to provide the specialized programming and care required by children with disabilities? How do staff respond to the stress of working with these special children?

Residents are generally dependent on a range of caregivers, some of whom may not be as well trained and therefore as tolerant of the disabilities; some may only provide a marginal type of custodial care. The Evaluation Division report describing facilities for those with mental retardation supports this claim:

"Direct care staff were not trained adequately and often did not understand the purposes behind the skill training and behavior modification program they were expected to implement...Maladaptive behaviors were often ignored or dealt with by tranquilizing the residents." [38]

Staff turnover tends to be high in institutional/residential settings. Child care staff generally work long hours, often with limited supervisory staff support. The stress level is great, pay is generally low and the interaction with residents can be difficult and not always obviously rewarding, especially when dealing with autistic, severe emotional and behavioral disturbance or profound retardation.

One study of direct caregivers who worked in facilities for dependent (many of whom were abused) neglected and disturbed children had some interesting results. The study goal was to determine the relationship between a number of social factors and

attitudes of direct caregivers towards use of physical force on children. A substantial number had been in their jobs less than one year, which attests to their lack of experience, and few were in the 30-45 year age range, the most common age for parents of children in this particular facility. Many had never had children.

"It was found that the amount of force selected by direct caregivers to manage the challenging child care situations could be expected to increase if they were older, had a lower amount of educational training, were or had been warned, were reared in a smaller community, participated seldom or never in decision making in the facility, "lived in" on a 24-hour basis, worked in a living unit where the activities of everyday life were not managed in resident-oriented ways (more attention given to resident needs than to meeting the needs of the organization), and experienced a higher degree of resentment toward the children...Five factors were found to be uniquely associated with willingness to use force:

1. Amount of resentment toward the children.
2. Management of routines of everyday life in an organization-centered way.
3. Seldom or never participating in decision-making in the facility.
4. Size of the community in which the direct caregiver was reared.
5. Age of the caregiver." [39]

The following questions have been commonly raised regarding the safety of children with disabilities who reside out of their home:

1. Does a group living situation perpetuate the isolated environment inherent in an abusive system?

2. Are institutions and community placements advised of any history of abuse by residents or staff prior to placement?

3. How adequately are community-based placement possibilities actually evaluated prior to selection for a particular child?

4. Are state and county agencies monitoring the community programs adequately?

5. Is it in the state's best interest to allow these programs to remain relatively free of state intervention? If any facility is closed because of widespread allegations of abuse, the state or county will have to assume responsibility, not an easy task in this population.

6. Are staff knowledgeable in determining the most current techniques in working with children with disabilities?

7. Are staff trained to recognize abuse?

A report filed by the Evaluation Division, Office of the Minnesota Legislative Auditor, addressed some of these issues in its analysis of problems in the de-institutionalization of mentally retarded persons, including a significant number of children. "Staff lacked training and the individual programs which they developed were not adequate to teach skills to residents and solve their behavior problems, and staff lacked data which would allow them to evaluate programs and determine what changes were needed." [40]

While formal safeguards to prevent and/or respond to abuse are generally in place by law, accountability and adherence are often difficult to determine, monitor and enforce. Some children with more profound disabilities may be unable to comprehend and/or communicate that abuse has taken place, and may be dependent on their "abusers" for day-to-day care and sustenance. The potential for misuse of the system which is in place to protect children in residential care is very great.

In addressing the question of the vulnerability of children in institutions, more questions are examined than can be adequately answered. It is a statement about the closed nature of institutional life. It is difficult to extrapolate accurate figures from county rosters on what percentage of cases

of reported abuse occur to children with disabilities who are not residing at home. There is speculation that a significant number of these cases may never be reported.

As PACER has become more involved in the area of child abuse, a number of parents have called to relate abusive experiences their child, who resides out of their parents' home, has had. In each case, the abuse had taken place over an extended period of time, allegedly without knowledge of staff and without intervention. The cases involved teenagers with mental retardation in privately funded group homes. The abuse was ultimately discovered and reported to county authorities. In some cases, once one resident had divulged that he or she had been abused, other residents were able to admit that it had happened to them as well. In many of these cases, parents did not receive adequate explanations of what had happened, nor did they receive much guidance about what action to take next, or even what their options were.

Why did it take so long to discover the abuse?

In those cases where staff were the perpetrators, why were staff histories not checked more thoroughly prior to employment?

Why were facilities not informed that a resident had either experienced abuse prior to placement or had a history of committing abuse.

Why were residents known to have been abused or to have abused others not supervised more closely and/or provided with therapy which might stop the abusive pattern?

Why did the county not act more aggressively in helping both child and family?

Why, once the abuse was discovered, was the major concern of the institution the fear of a lawsuit rather than intervention and rehabilitation?

The optimal goal in residential settings is to provide an atmosphere conducive to developmental growth in a safe and secure setting. It is realistic to suggest also that achievement of this goal is dependent, at least in part, on behavioral control and limit-setting. Controversy exists about the utility of techniques such as isolation rooms, the use of restraints, behavior modification techniques and the excessive use of medication to control behavior. While no attempt will be made here to debate their relative efficacy or proper usage, numerous cases of permanent injury and death have resulted from improper use of these techniques. Ironically, in some cases, where residential facilities have been closed by the state as a result of such incidents, parents have lobbied vigorously for their reinstatement as they provide the only option for difficult to manage patients who cannot be cared for at home. Clearly the use of these measures by inexperienced staff can lead to potential harm, particul rly for children whose behavior is aggressive, difficult to control and less responsive to alternative methods. But what choices exist for parents? Not enough.

Institutional life, by its very nature, focuses on the total group rather than the individual. The concept of privacy is more difficult to teach in this type of living arrangement as residents live dormitory style, showering, eating and interacting together as a group.

It is generally accepted that children with severe disabilities are not sufficiently familiar with the dynamics of physical and sexual abuse. If they have not been provided with information about appropriate and inappropriate tou and self-protective skills, or if they can comprehend what these concepts even mean, the ability to empower these special children becomes subject to question.

These children, however, do have normal sexual impulses, which may not be as well controlled because of their lack of social skills, temperament and comprehension; as a result provocative sexual behavior may be displayed by residents. It is a situation which requires knowledgeable staff,

patience, and clearly defined policy on how staff should respond.

One psychiatrist interviewed, described a situation in an institution for children with hearing impairments where indiscriminate sexual activity was taking place between residents and staff. A staff person had initiated the sexual abuse with a resident, who in turn abused another resident. The cycle continued for an extended period of time with no intervention. The youngest victim was 8 years of age. The institution was subsequently closed temporarily and reopened only when substantive changes and an ongoing therapeutic process was initiated, including intensive education about sexuality, and appropriate and inappropriate touch.

The topic of sexuality and persons with disabilities is a sensitive one, one which demands better training for staff and residents about the nature of relationships, appropriate sexual contact, and with whom, and how to reinforce these messages on a regular basis with children.

If the current orientation is towards de-institutionalization and independent living, surely we must also provide and enforce the knowledge which can protect children the most in these settings.

Parental Factors in Institutional Abuse

Many children who live in residential facilities maintain a close relationship with their biological or foster families. It is possible then for parents to monitor their child's progress and determine if their behavior reflects any subtle or significant changes. For some parents the out-of-home placement may represent the only opportunity to provide appropriate care. It may be easier for some to deny the evidence of abuse and accept inadequate explanations as fact. Many adults, however, no matter how caring and sincere are not sufficiently knowledgeable to identify notable behavioral changes as symptoms of abuse. Some symptoms which may indicate an abusive situation, particularly **if they were not present before residential placement**, may include:

* persistent rocking
* food stealing, obsession with food
* excessive anxiety and fear of returning to facility after conclusion of home visits
* more primitive communication skills
* unexplained physical symptoms and complaints
* soiling, smearing
* bedwetting
* head banging
* inappropriate sexual knowledge or behavior.

If these symptoms do appear persistently, and are unusual for the child, it would be advisable for parents to question the child's program in the residential setting. If they continue, parents should become more aggressive about finding out why. They may or may not, in fact, represent the presence of abuse. It is crucial in these cases to accommodate the child by having someone the child trusts present at the interview, and, if necessary, an interpreter or other aide helpful to the child.

If abuse is suspected, closer involvement by parents/significant others and the state monitoring agencies responsible for investigating abuse must be initiated, and efforts to find alternative placement for the child must be attempted. In addition, these victims of abuse must be provided with therapy to combat the harmful effects.

Most parents of children with severe and/or multiple handicaps are familiar with the difficulty of obtaining necessary services. It is not always possible to obtain the necessary home services; state or county funding is not always available, particularly in rural areas. It is often frustrating to advocate for more services for their children. This lack of options available makes it more difficult to respond effectively. We must continue to advocate for these children even in the face of a seeming lack of support or options.

Summary

It is obvious that the existing system is only beginning to deal with the multiplicity of problems associated with child abuse. Clearly, the vulnerable population of children and young adults who live in out-of-home settings has greater susceptibility and fewer opportunities to attract attention and receive help. They too must be protected; they must be assured of a life free from physical harm. As a society we owe these children a commitment to provide safe institutions and residential alternatives. This will require more stringent selection of staff people, better supervision and training for primary caregivers, more effective monitoring of facilities and a more aggressive response to abusive situations.

THE CHILD PROTECTION SYSTEM: DOES IT WORK?

Any analysis of the child protection system is likely to engender a highly volatile response from a diverse community of concerned and involved parents and professionals. Inasmuch as child abuse as a social and medical problem is characterized by conflicting opinions, most professionals agree that we are in the midst of a critical period in our ability to respond in an adequate social and legal way to the needs of abused children. Moreover, the difficulty in responding stems from system-wide problems.

There has been an effort to balance the need to protect children with the preservation of the rights of all concerned, including the accused offender(s), and to make the responsibility for reporting abuse incumbent upon a wider variety of sources. Unintentionally, the effort may sometimes have placed children in greater jeopardy. Frequently this precarious balancing act cannot be maintained. When this happens, neither the child nor family receives the help and direction they so desperately require. We are not even certain about the goals of child protection. Are they:

to prevent further abuse?
to protect children?
to intervene?
to rehabilitate?
to prosecute?
or to exact revenge?

Elements of each are involved in the legally mandated structure as carried out through child protection and the juvenile and criminal courts.

It is unrealistic to expect that the existing child protection system can adequately monitor, protect and rehabilitate abused and at-risk children and perpetrators. Mandated reporters including teachers, physicians and other health professionals consistently express frustration with the child protection system. At best, they feel that we are dealing with a punitive, inconsistent and subjective social and legal structure. The optimal goal of a child protection system appears to be to protect children and to keep families intact. It has become increasingly difficult to achieve both.

How the child protection system operates, the legal framework and the reporting process will be described in this chapter. Questions relating to its efficacy are raised and some suggestions for its improvement are discussed.

The Legal Structure

Legislation pertaining to child abuse can be found at both the federal and state levels of government. It is noteworthy that the federal initiative for child welfare legislation was not created until the early 60's when states were mandated to establish child welfare services. Specific child abuse legislation was not established until 1974, when the Child Abuse Prevention and Treatment Act (P.L. 93-247) was passed. The Act provides for a broad spectrum of concerns, including:

a. The identification and definition(s) of child abuse and neglect.

b. The creation of a child abuse reporting system.

c. Guaranteed immunity for identified mandated reporters.

d. The National Center for Child Abuse and Neglect was established as a resource and funding source for those states which had complied with the directives for a reporting system; the National Center would concentrate on innovative projects research and scientific inquiry into

the area of child abuse at the federal level and via state projects. By 1978, all states had complied and were, therefore, eligible for federal funding.

P.L. 93-247 is found in Appendix A. State by state comparisons of the reporting laws are found in Appendix B. Minnesota statutes have recently been amended and a current copy may be obtained from the Department of Human Services (DHS).

In Minnesota, the state law has been expanded and amended in the past decade to reflect both the changes which have occurred in the definitions of child abuse as well as the court's interpretation of these definitions. Under the terms of the reporting law, an increasing variety of mandated reporters, including physicians, educators, clergy and friends "who may know or have reason to believe" abuse or neglect is taking place, can report abuse without fear of civil or criminal liability and without fear that their identity will be revealed if a report is made in good faith. This includes abuse and neglect which occurs in a licensed facility. Upon request, a summary of the report may be provided to the reporter unless the release of such information is detrimental to the best interests of the child. Failure to report results in a misdemeanor charge. The state statutes represent the basis for the determination of child abuse cases through the juvenile and criminal courts.

Juvenile Court is the court which has responsibility for hearing neglect and dependency and juvenile delinquency cases. These may include extreme neglect and sibling abuse. It has no jurisdiction for prosecution of parents and is, therefore, considered non-punitive in its orientation except for those cases of delinquency. In those cases, decisions pertaining to termination of parental rights and removal of children from their parents may be determined in juvenile court. It does not require evidence beyond a reasonable doubt. There is, therefore, greater flexibility in how a child may testify.

Cases pertaining to intrafamilial sexual abuse, sexual abuse, and willful child abuse and neglect cases must be tried in criminal court. In criminal court, guilt must be proven beyond a reasonable doubt. The orientation is punitive and places the child in a situation where he/she must face the accused (who may be someone close to them), and be subjected to cross examination, and essentially be treated in the same way as adults. One attorney estimated that only 50% of cases go to trial because of the nature of the evidence required, the process for the child and the questionable outcome. That is not to say that abuse did not take place, only that it could not be prosecuted.

The Child Protection System

By federal and state law, child protection staff and services must be provided through the county. Depending on the size of the community, child protection staff may work independently and utilize the services of the police and county attorney where necessary, or may routinely work as a part of a multi-disciplinary team. Child protection staff (CPS) must assess all verbal and written reports of child abuse, determine whether they warrant further investigation and, if so, what is to be provided. They are authorized to interview the child, the reporter, the suspected offender and any other persons who may have evidence of abuse and neglect; they must make judgment calls as serious as whether a court order should be sought to remove the child immediately to protective custody, or whether to implement a treatment and rehabilitation plan. They may determine that the report does not warrant any further investigation. In cases involving child sexual abuse and severe physical abuse or neglect it is "required" that a police investigation take place preferably in coordination with the Child Protection staff, and that a report be submitted to the county attorney, who is responsible for prosecution involved in all substantiated cases of sexual abuse and more extreme cases of physical abuse and neglect. The county attorney represents the county protection agency in the criminal disposition

of all such cases. A typical Assessment Process and Criterion is found in Appendix C.

Reports of abuse and neglect are handled on a 24-hour basis by county child protection workers. If children are considered to be in life threatening situations, calls must be responded to immediately. Typically, in an emergency, staff could include a Child Protection worker and police officer who would determine if a child should be removed to a temporary shelter. Child Protection workers are required to consider physical abuse reports within 24 hours and questions of neglect within 72 hours. Assessments are then made as to which course should be implemented and whether criminal charges are necessary. The comprehensive dimension of all the circumstances in each case is stressed in the investigation, including the severity of the injury, age of child, family history, other family members, and the resources available, etc. A treatment plan is developed with provisions made for follow-up and continued involvement by the Child Protection staff.

If a child has been removed from the home, then a priority in the ongoing treatment is not only rehabilitation but the reuniting of the family. It is difficult to find sufficient quality foster care, and removing children from their home, no matter how necessary, is an action which brings its own problems. Most often abused children want to be with their families, even though the home situation may be problematic.

In theory, the mechanisms established to identify, monitor and deal with cases of child maltreatment are well integrated in our society, with the authority to act on behalf of and in the best interests of children. But with each year, each sensational case and further amendments to the law, more criticism and frustration with the system is expressed. Why?

Problems in the Child Protection System

1. The number of cases reported are rising dramatically, both as a result of greater knowledge about abuse as well as a greater knowledge of repercussions in not reporting. Child Protection must spend more time in assessment and investigation rather than in providing treatment and managing those cases which have already come to their attention. One researcher, Douglas Besharov, has suggested that the reporting law has made it difficult to provide adequate protection for the children who need it most "because too much time is spent investigating cases which cannot be substantiated." [41] In many cases, parents feel they have been unfairly victimized and harassed. Professionals familiar with child abuse who work outside of the CPS process often feel that too many children never get the help or intervention they need. The dilemma appears to be a Catch 22, where the requirement to report is in conflict with the system's ability to respond effectively.

   Does a weakness exist in how we substantiate claims of child abuse? A high percentage of child abuse cases are never reported and cannot be substantiated because of the secrecy involved, the lack of witnesses, the difficulty for children to come forth, and the grueling, lengthy nature of the investigative process.

   Great variability exists in the extent and the type of injury termed serious enough to be considered as "substantiated" in child abuse assessments, and ultimately through the rehabilitative and/or court system. Whereas in some counties, cases are determined to be serious if less severe injury or neglect is observed, in other counties action is not taken at all unless injury is extensive and requires immediate intervention. Does consistency and agreement exist about how severe injury has to be before intervention occurs?

2. In smaller communities, reporters are more reluctant to come forward because of the difficulty in maintaining anonymity; a more protective attitude exists toward members of the community irrespective of what the charges may be. In addition, a greater identification exists with the person charged, who might be a life-long friend or community leader. In larger urban areas, questions arise regarding reporting because of the concerns about follow-through in a larger more complex system. Reporters fear for the safety of the child if charges are not substantiated; some professionals rely on the reporting law only as a guide; their own professional judgment is the standard by which they determine when and how to get involved in child abuse cases. Overall, suspicion exists about the child welfare system and the prospect of "outsiders" becoming involved in private family dynamics.

3. Debate exists about whether the court process is flexible enough to fairly consider the child witnesses. In many instances, criminal prosecution of sexual abuse cases may protract the trauma of the abuse and re-victimize the child. In a recent case in California where seven defendants were charged with numerous counts of sexual abuse, 400 children were interviewed in pretrial hearings; most of the charges were dropped. The rigorous cross examination, what some child advocates describe as a process of putting the victims on trial, was a painful one for all the children involved. According to written reports, the pretrial took 20 months; the cost was high; the process and outcome did not help the children deal with their traumatic experiences. It made children constantly defend and re-state their testimony, a process which is even difficult for most adults. And at the end, charges were dropped against most of the alleged offenders.

"The courtroom exposes (the child) to a psychological threat by virtue of the physical presence of the defendant a few feet away, and the defense lawyer who does his best to make the child look like a liar or otherwise discredit him." [42]

In criminal court, provisions are not consistently made for the age of the child, their language, the trauma they may have endured, or children's understanding of the consequences of their testimony. Children may retract testimony about abuse, not because it did not happen, but because of their guilt and fear of the consequences.

In the case of children with handicaps, particularly developmental disabilities, and/or lack of verbal skills, the issue of credibility and compliance in cases of sexual abuse are often more complex.

4. Children have difficulty in establishing credibility in the investigative and court process. "The law is skeptical of the capacity of children to observe and recall events accurately, to appreciate the need to tell the truth, and to resist the influence of other people. Children are commonly thought to have great difficulty distinguishing fantasy from reality, and to be readily confused by an exaggerated curiosity about sexuality." [43] Nurcomb goes on to say..."there is no evidence that they are more likely than adults to make false accusations." [44]

Trials may occur six months to a year after the incident, casting doubt on testimony, clouding some recollections, creating long term anxiety and apprehension about testimony and the consequences for the children. The infamous Jordan, Minnesota, case has set back the issue of children's credibility and has not resulted in clear determination of who was more victimized, the children or the alleged offenders. The investigation appears to have been poorly handled, and a resolution was not achieved. The county now faces millions of dollars in lawsuits, children who may have been abused and were then returned home to parents they testified against, other children who may have been unfairly removed from their

homes, and parents and families who feel that they have been victimized by an arbitrary investigative process.

The issues of credibility and flexibility are even more contentious when assessing how children with disabilities can be best served through the existing child protection system.

One teacher of adolescents who have mental retardation shared the following case with PACER. It was known that a young student had been repeatedly sexually involved with a man in the neighborhood. Because the boy had complied, even when a formal report was filed, nothing could be done. The fact that the victim was clearly much younger, sexually naive, with mental retardation, indicated that the perpetrator had taken advantage of the boy. However, the question of compliance was the crucial factor. In the court, issues of credibility, questions of accurate memory of events, and compliance, especially in terms of children with disabilities and how they are perceived, can interfere with the ability to prove beyond reasonable doubt.

5. No matter how qualified and competent the individual, the job of a child protection worker is a difficult one. Because of the stressful nature of the job, there is a high attrition rate among Child Protection staff, resulting not only in a lack of consistency in case follow-through, but also in a dependence on more inexperienced staff who must make critical judgment calls. Caseloads are very heavy, particularly in rural areas, where the necessary support services are also not readily available, families are more isolated, and where currently stress is very high because of difficult economic times.

6. A lack of coordination among child protection, county prosecutors, community agencies, and schools exists in many counties. Each party involved in providing help to families in distress has its own agenda; each feels its goals are paramount, and each is concerned by the roadblocks in effecting change for the child, the family, the offender and the child protection system.

7. Teachers interviewed in the past year, after the PACER abuse program, expressed that they have become an additional source for investigating and monitoring child abuse, a role which they are not trained for, have little time to carry through, and sometimes are more than reluctant to undertake. They are left with fear for their students, fear of some parents, frustration with child protection, and anger with the legal system. They are in contact with their students for a large block of time, they are witnesses to their difficulties, they must cope with the behavior which accompanies abuse, and often times they see the system fail the child, with more disastrous results.

What Should Be Our Goals?

In this manual there has been an attempt to consistently portray the issue of child abuse as a multi-faceted problem with few long-term solutions.

Some experts in the child abuse field suggest that reform in child abuse cannot come without first achieving greater reform in society - an effective attack on poverty, hunger, unemployment, the development of family support systems, earlier and better parenting education, more quality day care programs, innovative job training and job placement. Current economic trends and social attitudes, however, do not appear to support significant change in all these areas. But what can be done? How can we protect children more effectively? By removing offenders from circulation, we may lessen harm to children, but we must also deal with the consequences of breaking up families, creating guilt and shame in the fragmented remains, and possibly precipitating a damaging cycle of poverty, stress and frustration. We must also deal with the

impact of the investigative process on children.

Some goals that are being suggested by advocates in the field include:

Advocate for system-wide reform for children who must testify. This could include:

a. the acceptance of innovative measures, such as video-taping at disclosure
b. closed testimony for children
c. the presence of trusted persons included interpreters, therapists or teachers available to the child during court proceedings
d. questioning by a neutral expert instead of opposing attorneys, and shorter time spans between investigation and trial.

2. We recognize that children with disabilities have unique needs and greater difficulty in establishing their credibility in the investigative and court proceedings. These children may require that testimony and evidence be presented in a less traditional manner and/or with the assistance of a special advocate. They should not be further victimized in court because they do not have the necessary skills to prove their credibility.

3. More research must be funded to examine possible treatment for sex offenders. Punishment through the courts does not necessarily include rehabilitation. Agreement does not exist about what treatment is effective, but criminal prosecution has questionable long-term results, and is not a proven deterrent.

4. Greater uniformity must be achieved to determine at what point reported cases merit further investigation and intervention. This should be a priority for mandated reporters, child protection staff and county prosecutors.

5. More support and education must be provided to teachers who as a professional are feeling overwhelmed by the responsibilities involved in the child protection process. Optimally, responsibility for these issues should be shared by a multi-disciplinary team of professionals to include teacher, social worker, principal, nurse and/or psychologist. This system is not uniformly integrated in school systems.

The question of providing an equitable court process for both the alleged victim and the alleged offender is complex, an issue which can best be debated and resolved by legal scholars. However, what is clear at the present time is that in the opinion of many who work with abused children, the child protection and court system is inconsistent and inequitable. If we examine the goals in the court system used at the outset of this chapter we can respond that children are not always protected, and may continue to live in an abusive situation; depending on the county, rehabilitative resources are not necessarily available or affordable for either victim or offender, and prosecution has not been proven as an effective deterrent to abusers.

While reform in the child protection system is indeed a goal, more than anything else we must begin to look to prevention as the goal for the reduction of child abuse. In so doing, we must first develop and use more comprehensive community-wide resources to assist families in distress. With prevention a major focus for positive change, the court process will cease to be the only option for children, and hopefully lead to a more fair, less traumatic resolution for all parties involved. As advocates for children, we must all make the system work.

PREVENTION STRATEGIES, OUR HOPE FOR THE FUTURE

It is difficult not to feel a sense of despair and frustration about the fate of abused children and the prognosis for them and for their families. While there is no question that child abuse is a problem of epidemic dimensions, the alternatives available for remediation are difficult to agree upon, implement and monitor. Before the incidence of child abuse can be successfully reduced, however, professionals, legislators and parents must view prevention as the primary focus. Prevention efforts should be concentrated in a number of areas. They include:

1. More widespread public knowledge about child abuse. Clear, specific information must be provided about the causes, the signs and symptoms, long-term outcomes of child abuse and prevention strategies. The media has, to a great degree, concentrated on the more sensational aspects of child abuse and in that manner has succeeded in bringing the problem to the public's attention. However, the public does not have really an understanding of the insidious nature of child abuse, or realize that it happens in many "all-American" families.

   Information about child abuse and parenting must also be made available in the workplace through staff education, awareness projects, parenting skills classes, in-house counseling and referral services, and in the community through service organizations, community groups, etc.

2. Prenatal education. A greater effort must be made in prenatal education. In some high risk populations, abuse may begin in the womb, with poor prenatal nutrition, prenatal alcohol and drug abuse, and lack of knowledge about maternal bonding, infant care, child development, the responsibilities of being a parent, and expectations for infant and child behavior.

3. Family planning information. Despite the relatively easy accessibility of birth control information, 50% of abused children are the products of unplanned, unwanted pregnancies, many to young teens, children themselves. Why aren't they using birth control? More effort must be made in working closely with pregnant adolescents, not only to ensure good prenatal medical care, but also to help them consider alternative options to keeping their child. Many of these girls are not only young and uneducated, they may also be poor, alone and themselves products of an abusive family system.

   A number of sites in the U.S., including Minneapolis and St. Paul, have a special high school program available for pregnant teens and young parents. It has not only enabled them to finish high school, but also provides day care, parenting classes and counseling. Those who are fortunate enough to participate in this program have benefited greatly.

4. Parenting skills education through the schools. Parenting skills classes should begin as early as kindergarten and continue through junior and senior high school. Children should have some "hands on" experience in what it means to be responsible for a child. At the same time, they could learn about child development, appropriate/inappropriate discipline, and possibly, if they themselves are being abused, learn that there are alternatives, that abuse and discipline are not synonymous.

5. Family Support Groups. The factors fairly common to abusive parents are their sense of isolation, and their lack of knowledge about child growth and development.. Support groups for parents should be established and publicized through county child protection, hospital maternity departments, physicians, schools, social service agencies, and public health channels. Often it is a relief to know that others are having the same concerns and stresses in being a parent. For many adults the sense of shame common in abuse is overwhelming. What they may need most is some clarification of appropriate expectations. Some groups work best when led by professionals; in others, trained nonprofessionals may elicit greater rapport and trust. Groups such as Parents Anonymous have had great success with those families who become involved voluntarily and accept that they, and not the child, must assume responsibility for the abuse.

6. Early childhood screening programs. An aggressive effort should be made to have mandatory comprehensive early childhood screening programs. (Minnesota is one state where this has been incorporated.) This would not only assist in determining who is abused or at risk, but also serve as a means of getting help for children and families.

7. Crisis care programs. Child abuse hotlines, domestic violence hot lines--these resources provide advice as well as anonymity to persons who fear they might abuse their child. Trained staff are available to help diffuse the immediate crisis and suggest alternative means of relieving tensions, as well as direct families to supportive services.

8. Respite care, crisis care nurseries. Short-term havens are available for children who may be in danger of harm if their parent(s) are in crisis or do not have a place to leave them.

9. Therapeutic day care centers. Children who have been abused require a special kind of nurturing and interaction. This type of program helps children by providing a stress-free learning experience, works on issues of self esteem and anger, helps alleviate stress and fear and works at rebuilding the child's world.

10. Basic personal safety skills must be taught from an early age by parents, teachers and volunteer groups. A partial list of important information to share with children includes:

    a. Children must understand and be comfortable with knowledge about the difference between bad touch, confusing touch and good touch.

    b. They must learn that some parts of their bodies are private and not to be touched or viewed by anyone other than a parent or doctor, and then only under circumstances which are appropriate and/or understandable for the child.

    c. The difference between secrets and surprises must be clearly taught to children. Children need to know that some secrets are not fun and they can be harmful.

    d. How to say no even to someone you know or love if they are manipulating you into some action, touch or activity which makes you feel uncomfortable, confused or afraid.

    e. How to indicate emphatically and persistently if they have been abused, and how to respond if they are not believed.

    f. How not to be deceived by bribes or tricks, and how to use trickery in self defense. Introduce role playing, and possibly puppets or other visual aids in demonstrating the concept of "what if..." and how to respond. Practice and rehearsals in preparing children to respond to difficult situations can be useful.

g. Children must be taught that people they know and love, like relatives, friends, babysitters, or teachers, and not necessarily strangers, could be abusive.

h. Children who use wheelchairs should refuse unnecessary requests to help them and be encouraged to be as self-sufficient as possible.

i. Children can be taught a "password" known only to their immediate family. No one can pick them up or take them home without first relating the password.

11. Children's Trust Fund. In a Children's Trust Fund Model, a certain dollar amount from state-generated fees is earmarked for the development of child abuse prevention projects. The majority of states have now adopted trust fund legislation. If your state has not yet passed legislation to establish a children's trust fund, then advocate for it.

12. Groups representing various disabilities, both in the public and private sectors, should provide training for parents of children with disabilities, and for staff and volunteers who work with children with disabilities on the subject of child abuse. It is essential that they be able to recognize the more discreet signs and symptoms of abuse in these populations, and encourage children to divulge if they have been abused.

We are living in difficult and stressful economic and social times. Some experts believe that in order to remedy social problems such as child abuse, we must call for a return to a social philosophy reminiscent of the 60's and 70's. Our experiences in that decade, however, were not all positive--social change and a more broad distribution of medical, social and support services can be very costly and difficult to administer. The preventative services described in this chapter and in the appendix have the advantage, however, of costing far less than the long-term treatment and/or common antecedents of abuse such as juvenile and adult crime, chemical abuse and suicide.

It is inherent upon those of us committed to the physical and mental health and welfare of children and the stability of families to work towards the development and utilization of preventative models. We must educate society to anticipate needs, not merely respond to crises, and we must do it soon.

A detailed list and description of local and national programs which provide help for parents and children can be found in the Bibliography.

In addition, a listing of visual and written resources for both children and adults can be found in the Bibliography.

SUMMARY

Despite significant progress in acquiring empirical, clinical and statistical information about child abuse, and despite a recognition of the magnitude of the problem, these gains are not equaled by progress in the identification, intervention, treatment and rehabilitation of children and families, particularly those children who are handicapped.

The causes of and response to the multi-faceted nature of child abuse are rooted in the community. While the dynamics of family life have changed radically in the last 20 years, the family unit remains our basic social institution. Strengthening and supporting the family unit, therefore, in whatever form it may exist is essential. Implicit in this is the development and implementation of effective preventative programs.

To date prevention efforts have not been sufficiently developed. A broad range of strategies in the area of public policy, research and social services is necessary to replace the ad hoc responses which have been the norm.

It is clear that the conventional child protection system has been overburdened by the deluge of cases, and has not been able to respond in an effective manner. Moreover, current and projected funding appropriations fall short of the actual need for services, particularly for families of children with special needs.

The special needs posed by children with disabilities who are more vulnerable to abuse, more difficult to identify as victims, and for whom intervention is more complex, must be addressed.

We cannot continue to tackle the consequences of these complex issues without giving equal attention to prevention efforts. Prevention for all children must be the focus and the challenge in the next decade.

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Clearinghouse on Child Abuse and Neglect Information

National Center on Child Abuse and Neglect Children's Bureau, Administration for Children, Youth & Families Dept. of Health and Human Services, P.O. Box 1182, Washington, DC 20013.

Operated by: Herner and Company, 1700 N. Moore St., Arlington, VA 22209, (703) 558-8222.

QUESTIONS COMMONLY RAISED BY TEACHERS REGARDING THE CHILD PROTECTION SYSTEM

QUESTION: What do I do when the system fails and a report of abuse goes nowhere? This has happened numerous times in my school.

ANSWER: Many teachers raise this issue. First of all, it is essential that you continue to document your specific concerns if you feel abuse is persisting and/or has not been properly dealt with. Continue to monitor the child and let him/her know that you care. If enough evidence accumulates, you can re-initiate a report. You may be the child's only advocate, so do not give up.

QUESTION: What do I do if there seems to be no strong support system in my school such as a reliable principal and/or social worker to work with on issues of child abuse?

ANSWER: Minnesota Statutes regarding child abuse are very specific. Even if those professionals are not supportive, you are required by law to report suspected abuse. If the report is made in good faith, you are not liable to any suit or investigation if the charges are proven to have no basis in court. You are not responsible for determining if abuse has taken place. Child protection must make those determinations.

If a good child protection system is not in place, advocate for the development of child protection teams in your school to include the principal, teacher, social worker and the school district nurse. Raise this issue at staff meetings; if necessary speak to the school board representative to see that this occurs. Contact other schools to find out what their policy is and how it was implemented.

QUESTION: How do I deal with an angry parent whose child may have just reported abuse and who blames me for bringing it to the attention of the authorities?

ANSWER: Don't get into an argument with the parent. Understand their anger and fear. If you feel the parent could be violent or destructive, inform your principal, social worker, and county protection. Let the parent know that your report was made in good faith, out of concern for both the child and the family. Suggest to the parent that the social worker would be willing to meet with them and make every effort to arrange such a meeting.

QUESTION: What do I do if the reporting child/adult changes his/her mind?

ANSWER: Typically, children may think twice after initially reporting. Most often it is not because their original statement was false, but because they fear the consequences of their action. Don't blame the child for retracting. Continue to be supportive, and let the child know that you will listen when he/she is ready. Also, be sure and document the retraction and the circumstances.

QUESTION: I feel frustrated by the fact that once I make a formal report, and after much soul searching, I don't know what happens; there's no follow-up--even if the child remains in the class and may continue to behave in a disturbing manner, I have no sense of what is happening.

ANSWER: Recent amendments in the child abuse reporting law provide that:"...the local welfare agency give mandated reporters a summary of the disposition of the report made by that reporter at the person's request, and a concise summary to voluntary reporters, at their request, if the release doesn't harm the child's best interest."

Questions about how much information about specific cases should be released is one of many "grey" areas within the reporting process. Disclosure is a difficult question, particularly in view of issues such as confidentiality and civil rights of the child. A great deal of time is involved in maintaining contact with the social worker assigned to the cases. The process from the time of reporting until resolution in court or through counseling is long, sometimes as long as six months to a year. The major concern is to remain supportive and helpful to the child and to maintain a close working relationship with the social workers assigned to the case.

QUESTION: Why bother reporting?

ANSWER: The binding legal issue has been addressed in this resource manual. It is the law. However, teachers whose experience with the reporting process has been discouraging vow that they won't become involved again. While the flaws in the system are obvious, it is incumbent upon all professionals working with children to advocate for them and to work at improving the child protection process.

When suspected abuse is not reported, there is no chance for intervention on behalf of the child and the family.

PRINTED RESOURCES FOR PARENTS AND TEACHERS

Adams, Carin & Fay, Jennifer. (1981). No More Secrets. Impact Publishers.

Informational book for parents, educators and lay persons interested in teaching children about sexual abuse.

Are Children With Disabilities Vulnerable to Sexual Abuse? (1983). Minnesota Program for Victims of Sexual Assault, Minnesota Department of Corrections, 430 Metro Square Building, St. Paul, MN 55101, (612) 296-7084.

This brochure gives facts about the vulnerability of children with disabilities to sexual abuse, some steps to take to help your child understand and prevent sexual abuse, behaviors and symptoms of sexual abuse, and information regarding the laws on sexual abuse.

Basic Facts About Sexual Child Abuse. National Committee for Prevention of Child Abuse, Publishing Department, Suite 1250, 332 S. Michigan Ave., Chicago, IL 60604-4357.

This brochure dispels myths and provides facts and definitions on sexual child abuse.

Blinde, Beverly & Burns, Mary Dooley. (1983). The Bruises Don't Always Show: A Child Abuse and Neglect Training Module. Developed for adult vocational parent and family education. Funded by: Minnesota State Department of Education, Division of Vocational-Technical Education.

This curriculum project was designed for several purposes. The manual can be used as an adjunct to a seminar on understanding and working with abusive parents, as a resource for parent trainers to use when presenting on the topic of child abuse and as a resource for parent group leaders and others working with families.

Bulkley, J., Ensminger, J., Fontana, V., Summit, R. (1982). Dealing With Sexual Child Abuse. National Committee for Prevention of Child Abuse, Publishing Department, 332 S. Michigan Ave., Suite 1250, Chicago, IL 60604-4357, (312) 563-3520.

This booklet addresses the questions in sexual child abuse such as: Who can help abused children? Is there any hope that offenders can change their behavior? What should you do if you suspect sexual child abuse? What happens to a child, an offender and the family if sexual child abuse is discovered?

Child Abuse and Neglect Resource Guide. The Child Abuse and Neglect Association in the Hennepin County Community, P.O. Box 15601, Mpls., MN 55415.

The first section of the guide includes basic information about prevention, treatment of child abuse and neglect, what happens when an incident is reported, how sexual abuse examinations are handled and how the police and the schools serve as resources.

The second section of the guide is a directory of agencies and organizations working in the field of child abuse and neglect.

Child Sexual Abuse...It Is Happening. (1982). Minnesota Program for Victims of Sexual Assault, Minnesota Department of Corrections, 430 Metro Square Bldg., St. Paul, MN 55101, (612) 296-7084.

A useful brochure with facts regarding incidence and symptoms of sexual abuse, impact on the child, tips for parents about prevention as well as how to handle it if it happens to your child, and a brief overview of sexual abuse laws.

Children Need Protection. (1980). Carver County Program for Victims of Sexual Assault, 401 E. 4th St., Chaska, MN 55318.

This booklet is a guide for talking to children about sexual assault. It defines sexual abuse and the Criminal Sexual Conduct Law. It also provides examples of how to talk to children, what they need to know and games to use in teaching concepts of sexual abuse prevention.

Cohn, Anne H. (1982). It Shouldn't Hurt To Be A Child. NCPCA, Minnesota Chapter, 123 E. Grant St., Mpls., MN 55403.

This brochure defines child abuse, discusses facts and misconceptions about abusers and presents information about how each of us can help prevent child abuse.

Cohn, Anne H. (1983). Physical Child Abuse. National Committee for Prevention of Child Abuse, Minnesota Chapter, 123 E. Grant St., Mpls., MN 55403.

This pamphlet explores the magnitude and causes of the problem of physical child abuse in the U.S. It discusses legal responses to the problem and approaches to treatment and prevention.

Colao, Flora & Hosansky, Iamar. (1983). Your Children Should Know. Bobbs-Merrill Co.

A book with information strategies that will help keep children safe from assault and crime.

Garbarino, James & Garbarino, Anne C. Emotional Maltreatment of Children. National Committee for Prevention of Child Abuse, Publishing Dept., 332 S. Michigan Ave., Suite 1250, Chicago, IL 60604-4357, (312) 663-3520.

This booklet defines emotional maltreatment and describes parental and children's characteristics involved in this type of abuse. It uses case histories to give examples of emotional abuse and its impact.

Gordon, Dr. Thomas. (1975). What Every Parent Should Know. National Committee for Prevention of Child Abuse Publishing Department, Suite 1250, 332 S. Michigan Ave., Chicago, IL 60604-4357, (312) 663-3520.

This booklet is a condensed version of the child-rearing philosophy contained in Dr. Gordon's book P.E.T. (Parent Effectiveness Training). He has distilled 15 principles from his book which might serve as blueprints for parents who want to become more effective in rearing healthy and responsible children.

Hanson, Ranae. (1982). Institutional Abuse of Children and Youth. New York: Haworth Press.

Defines institutional abuse from a variety of perspectives. Looks at corporal punishment, responses to the problem of institutional abuse, and concerns of direct care workers.

Harrison, Rebecca & Edwards, Jean. Child Abuse, A Personal Account by One Who Hurt: A Guide for Teachers and Professionals. Ednick Communications, Box 3612, Portland, OR 97208.

This book includes personal accounts of abuse, facts professionals need to know, the educator's role, teaching about sexual abuse and the health professional's role in prevention of child abuse.

Hart-Rossi, Janie. (1984). Protect Your Child From Sexual Abuse: A Parent's Guide. Parenting Press, Inc.

This book accompanies It's My Body, a book for preschoolers about appropriate touch and how to say no. It is an excellent resource for parents and teachers working with young children on self protection skills. Provides background information on sexual abuse as well as exercises for adults to get in touch with their own "touch continuum."

Haskins, Jim. (1982). The Child Abuse Help Book. Addison-Wesley Publishing Co.

Focuses on causes of abuse, types of abuse and how to get help if you know of someone who is abused.

"He Told Me Not To Tell." King County Rape Relief Volunteers and Staff. For copies contact: "He Told Me Not To Tell," DPW 2487 (11-80), Minnesota Department of Public Welfare, B-20 Centennial Office Building, St.Paul, MN 55155.

This booklet focuses on the definitions of child sexual assault, where parents can start in helping protect their child, what children are up against, ways children may communicate their need for help, and what to do if a child has been assaulted.

Keller, Eileen. (Ed.) Sexual Assault: A Statewide Problem. Minnesota Program for Victims of Sexual Assault, 430 Metro Square Building, St. Paul, MN 55101, (612) 296-7084.

A procedural manual designed by and for law enforcement, medical, human services and legal personnel. The manual defines and describes the interdependent functions and procedures of each of these disciplines.

Kline, Donald F. (1984). The Disabled Child and Child Abuse. NCPCA, 332 S. Michigan Ave., Suite 1250, Chicago, IL 60604-4357.

A brochure with facts about the susceptibility of children with disabilities to child abuse, this presents the concept that a first step in prevention of abuse of the child with disabilities is to increase the public's knowledge about disabling conditions.

May, Gary. Child Discipline: Guidelines for Parents. National Committee for Prevention of Child Abuse, Minnesota Chapter, 123 E. Grant St., Mpls., MN 55403.

This pamphlet clarifies the difference between discipline and abuse and encourages the development of good parent-child relationships. It is written to help break destructive parenting cycles and to replace those methods with constructive ones. Discusses discipline from infancy through adolescence.

May, Gary. (1984). Understanding Sexual Child Abuse. National Committee for Prevention of Child Abuse, 332 S. Michigan Ave., Suite 1250, Chicago, IL 60604-4357.

A booklet that defines various forms of sexual abuse, the effects of sexually abusive relationships on children, who the offenders are, and parents' responses to learning about an incestuous relationship in the family.

"No-Go-Tell." Lexington Center, Inc., Lexington Center Foundation/Lexington School for the Deaf, 30th Avenue & 75th Street, Jackson Heights, N.Y. 11370, (718) 899-8800.

A child protection curriculum designed specifically for preschool and early elementary school-aged children with disabilities.

O'Day, Bonnie. Preventing Sexual Abuse of Persons With Disabilities. Sexual Abuse Education for Disabled Adolescents Project, Minnesota Program for Victims of Sexual Assault, a Project of the Department of Corrections, 430 Metro Square Bldg., St. Paul, MN 55101, (612) 296-7084.

This curriculum for students with hearing impairments, physical disabilities, blindness and mental retardation has been developed for professionals who work with persons with disabilities.

Protecting Minnesota's Children: Public Issues. League of Women Voters of Minnesota, 55 Wabasha Street, St. Paul, MN 55102, (612) 224-5445.

Resource manual with an overview of issues on child abuse, including legislation, the child protection system, problem areas, reforms, questions and proposals.

Sanford, Linda Tschirhart. Come Tell Me Right Away. Ed-U Press, Inc., P.O. Box, 583, Fayetteville, N.Y. 13066.

This booklet outlines the basics of a positive approach to the prevention of child sexual abuse and touches on the broader subjects of healthy child development. Much insight into sexual abuse and how to approach prevention with children.

Special Education Curriculum on Sexual Exploitation, A Curriculum for Developing an Awareness of Sexual Exploitation and Teaching Self-Protective Techniques. Seattle Rape Relief, Developmental Disabilities Project, 1825 S. Jackson, Suite 102, Seattle, WA 98144.

Teacher Training Manual, Sexual Abuse of Persons With Disabilities. Disabilities Project, Seattle Rape Relief, 1825 S. Jackson, Suite 102, Seattle, WA 98144, (206) 325-5531 (Voice/TDD).

A school-based approach to developing a special education program concerning sexual exploitation. Includes guidelines for training of professionals and parents about sexual exploitation of individuals with disabilities.

PRINTED MATERIALS
FOR USE WITH CHILDREN OR ADOLESCENTS*

Please note: PACER does not endorse or promote any particular book or curriculum listed. Before you use any of these materials we urge you to personally review the books or curricula described. Prior to selecting these materials, it would be helpful for parents and professionals to have a clear idea of their individual goals and objectives.

*Code: (A) = Pre-teen and adolescent
(E) = Elementary
(P) = Preschool
(C) = Coloring book or comic

A Crack in the Mirror Child Abuse Program. Commission for Racial Justice, United Church of Christ, 105 Madison Ave., New York, NY 10016. (A)

A booklet for ages 11 to 14 which gives an overview of child abuse and neglect. Three case studies help illustrate neglect, physical abuse and incest.

A Little Bird Told Me About My Feelings. Kidsrights, 401 S. Highland, P.O. Box 851, Mt. Dora, FL 32757, 1-800-892-KIDS. (C, P, E)

This is a story and coloring book which helps children say no to inappropriate touching by trusting their own feelings. Ages 4-10.

Amazing Spider-Man and Power Pack. NCPCA Publishing Dept., 332 South Michigan Ave., Suite 1250, Chicago, IL 60604-4357, (312) 663-3520. (C, E)

Two stories teach children how to protect themselves from sexual abuse. Marvel Comics helped NCPCA create this full-color comic book. Teacher's guide available.

Amerson, Ruth. Hi! My Name is Sissy. Social Worker II, Lee County Dept. of Social Services, P.O.Box 1066, Sanford, NC 27330, (919) 774-4955. (E)

This coloring book for children, K-3, tells the story of Sissy who is sexually abused by her uncle. Sissy manages to get help for herself and her uncle.

Anderson, Mary. Step On A Crack. Brattleboro, VT: The Book Press. (A)

Sarah has severe problems with nightmares and compulsive stealing. A friend helps her discover the underlying causes for this questionable behavior--early experiences in an abusive home. Suitable for adolescents 11 to 15.

Armstrong, Louise. (1980). Saving the Big-Deal Baby. New York: E.P. Dutton. (A)

This story of a young couple and their baby shows how stress and crisis create an abusive situation. The situation is resolved as they get help. Suitable for young adults, low-functioning parents.

Bass, Ellen & Betz, Marti. (1981). I Like You to Make Jokes With Me, But I Don't Want You To Touch Me. Lollipop Power, Inc., P.O. Box 1171, Chapel Hill, NC 27514. (P)

Sara, a pre-schooler, narrates this well-illustrated story of a little girl who learns to say no to touching when it makes her feel uncomfortable. Book would make a good lead-in for the parent or teacher who wants to address "good" and "bad" touching.

Bassett. My Very Own Special Body Book. C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect, 1205 Oneida Street, Denver, CO 80220, (303) 321-3963. (C, P)

Approaches sexual abuse prevention in a positive way. For preschool through grade three. $3.75.

Bateman, Py. Acquaintance Rape: Awareness and Prevention for Teenagers. Alternatives to Fear, 1605 17th Ave., Seattle, WA 98122, (206) 328-5347. (A)

Various exercises help teenagers identify possible rape situations.

Berg, Eric. (1985). Stop It! Network Publications, 1700 Mission St., Suite 203, P.O. Box 1830, Santa Cruz, CA 95061-1830. (E)

This booklet, using cartoons, focuses on teaching children that adults may not always be right. Children are given permission to trust their feelings and act on them. Adult's guide available.

Berg, Eric. (1985). Tell Someone! Network Publications, 1700 Mission Street, Suite 203, P.O. Box 1830, Santa Cruz, CA. 95061-1830, (408) 429-9822. (E)

Children learn how to build a support system with those they trust. They learn to feel comfortable about telling someone of embarrassing experiences. For ages ten to twelve. Adult's guide available. Good illustrations.

Berg, Eric. (1985). Touch Talk. Network Publications, 1700 Mission St., Suite 203, P.O. Box 1830, Santa Cruz, CA 95061-1830. (P, E)

With the aid of charming, cartoon-like illustrations, this booklet teaches children to be aware of the wide range of different kinds of touch, good, bad and confusing. It is to be read with children. Adult's guide available.

Berry, Joe. Sexual Abuse, Alerting Kids to the Danger Zones. Kidsrights, 401 S. Highland, P.O. Box 851, Mt. Dora, FL 32757, 1-800-892-KIDS. (E)

Types and causes of sexual abuse are discussed frankly. Children can learn to maintain their safety by using guidelines for assertive behavior. Fine illustrations. Ages 6-10. $5.95.

Buschman, Janis & Hunley, Debbie. Strangers Don't Look Like the Big Bad Wolf. Chas. Franklin Press, 7821 175th St. S.W., Edmonds, WA 98020, (206) 774-6979. (E)

Four-year-old Molly experiences a number of situations where she learns to be responsible for her own personal safety. This is an abduction-prevention book for preschoolers.

Chetin, Helen. Frances Speaks Out: My Father Raped Me. New Seed Press, P.O. Box 3016, Stanford, CA 94301.

This is a sensitively written paperback. It might be appropriate to read to youthful victims under eight years old.

Cunningham, Julia. (1977). Come To the Edge. New York: Pantheon Books. (A)

A boy is placed in a foster home on a farm by his father. His father later brutally rejects him. This is a compelling psychological novella. Appropriate for junior and senior high.

Danny's Difficult Days. Child Abuse Program Commission for Racial Justice, United Church of Christ, 105 Madison Ave., New York, NY 10016. (C, E)

This is a comic/workbook for children, ages 8 to 10. A school nurse uncovers and reports that Danny has been abused. His family gets help, resulting in strengthened bonds and increased happiness.

Dayee, Frances. Private Zone. Charles Franklin Press, 18409 90th Ave. W., Edmonds, WA 98020, (206) 774-6979. (P, E)

This read-aloud book for young children teaches youngsters about their private zones and encourages discussion between the adult and child reading the book together. Ages 4-10. $3.00.

Dreyer, Lynn, & Haseltine, Beth. (1986). The Woodrow Project. (Curriculum). Rape & Abuse Crisis Center of Fargo-Moorhead. Fargo, ND.

Fay, Jennifer & Flerchinger, Billie Jo. (1982). Top Secret: Sexual Assault Information for Teenagers Only. King County Rape Relief, 305 S. 43rd St., Renton, WA 98055, (206) 226-5062. (A)

Information is provided on sexual assault and self-protection is emphasized. For adolescents, ages 12-17.

Feeling Free, Ednick Communications, Box 3612, Portland, OR 97208.

This publication is a social/sexual training guide for those who work with youth who have hearing and visual impairments.

Freeman, Lory. (illus. by Deach, Carol). (1984). It's My Body, A Book To Teach Young Children How to Resist Uncomfortable Touch. Seattle: Parenting Press. Network Publications, 1700 Mission Street, Suite 203, P.O. Box 1830, Santa Cruz, CA 95061-1830, (408) 429-9822. (P)

Simple text and attractive illustrations help adults teach preschoolers two "touching codes." A parent's guide by Janie Hart-Rossi called Protect Your Child From Sexual Abuse is also available.

Girard, Linda R. My Body is Private. Kidsrights, 401 S. Highland, P.O. Box 851, Mt. Dora, FL 32757, 1-800-892 KIDS. (E)

This introduction to the topic of sexual assault attempts to be non-frightening. A child narrator helps the reader understand that the private parts of any child's body are not for touching by others. Well illustrated. $9.25.

He Told Me Not to Tell. (1979). King County Rape Center, 1025 S. 3rd St., Renton, WA 98055, (206) 226-0210. (E)

Informs parents about how and when to talk to children even before a problem occurs. Parents learn what to do if they suspect molestation.

Hindman, Jan. A Very Touching Book. McClure Hindman Books, P.O. Box 208, Durkee, OR 97905, (503) 877-2430. (P, E)

Children are taught to recognize appropriate and inappropriate touching. K-6.

Hubbard, Kate & Berlin, Evelyn. Help Yourself to Safety, A Guide to Avoiding Dangerous Situations with Strangers and Friends. The Chas. Franklin Press, 7821 175th St. S.W., Edmonds, WA 98020, (206) 774-6979. (E)

This book includes a "read-aloud" section for children which stresses personal safety tips and numerous "what if" situations designed to teach safety concepts. Forward by John and Reve Walsh. Ages 5 to 11 and adult. $3.95.

Hunt, Irene. (1976). The Lottery Rose. Scribner. (E)

Written and illustrated with sensitivity, this book helps elementary age school children understand child abuse.

Hutchinson, Barbara & Chevelier, Elizabeth. (1982). My Personal Safety Coloring Book. Fridley Police Dept., 6431 University Avenue N.E., Fridley, MN 55432, (612) 571-3457. (C, P, E)

Teaches concepts of good and bad touching through pictures to be colored with sad or happy faces drawn in, depending on the touch. Good questions about feelings associated with the pictures. Preschool through third grade.

Hyde, Margaret O. Cry Softly! The Story of Child Abuse. Kidsrights, 401 S. Highland, P.O. Box 851, Mt. Dora, FL 32757, 1-800-892-KIDS. (A)

"Cry softly, so the neighbors can't hear you," a parent warns. This book answers questions about where a child can go for help and what are a child's rights. "...should be studied by every boy and girl as soon as he or she can read."--Publishers' Weekly. Ages 11-15.

Hyde, Margaret O. Sexual Abuse: Let's Talk About It. Kidsrights, 401 S. Highland, P.O. Box 851, Mt. Dora, FL 32757, 1-800-892-KIDS. (A)

A youngster can avoid bad touching by an adult. Such touching should be reported and stopped. Both the victim and the offender can be helped. Ages 10-17. $8.95.

Ish-Kishor, Sulamith. (1969). Our Eddie. New York: Pantheon, New York. (A)

This is the story of a boy and his stern, abusive father. It focuses on family life and the feelings of the family members as the family deteriorates. Fifth through ninth grades.

Jance, Judith A. (1985). It's Not Your Fault. Chas. Franklin Press, 18409 90th Ave. W., Edmonds, WA 98020, (206) 774-6979. (E)

Excellent illustrated booklet with readable story teaching "It's not your fault," as well as sexual molestation prevention skills. Read-aloud section for ages 4-11. Class or family discussion questions. Referral to national organizations and resource list. $3.00, discount available in bulk.

Kent, C. (1980, February). "The Touch Continuum." In Child Care Resources. Vol. 4, No. 2, pp. 1-5, Hennepin County Attorney's Office, Child Sexual Abuse Prevention Project, C-2100 Government Center, Mpls., MN 55487, (612) 348-3091. (P, E, A)

"The Touch Continuum" defines the entire spectrum of touching from lack of touch to exploitive touch.

Kerns Kraizer, Sherryl. The Safe Child Book. Dell Trade paperback. (E)

This book is dedicated to having children be safe and feel unafraid, nurtured, comfortable. The effort is to strike a balance. Simple guidelines are given.

Kyte. (1983). Play It Safe: The Kids' Guide to Personal Safety and Crime Prevention. C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect, 1205 Oneida Street, Denver, CO, 80220, (303) 321-3963. (E)

Mackey, Gene and Swan, Helen. Dear Elizabeth. Children's Institute of Kansas City, 9412 High Dr., Leawood, KS 66206. (A)

An adolescent writes a diary, relating experiences of sexual abuse.

MacPherson, Margaret. (1967). The Rough Road. San Diego, CA: Harcourt. (E)

This is the story of a boy who is abused by foster parents. He doesn't learn there is another way until a man befriends him. He has a courageous struggle to earn a place for himself in a hostile world.

Major, Kevin (1978). Hold Fast. New York: Delacorte Press. (A)

A modern-day "Huckleberry Finn" story of a boy who runs away from an abusive uncle. Grades 5-8.

Maksym, Diane, & Goudge, Joy. (1986). Project Get Set. (Curriculum). Canadian Association for the Mentally Retarded. Nova Scotia, Canada.

McGovern, Kevin & McGovern, Cathy. (1985). Alice Doesn't Babysit Anymore. McGovern & Mulbacker Books. Kidsrights, 401 S. Highland, P.O. Box 851, Mt. Dora, FL 32757, 1-800-892-KIDS. (E)

This book is meant to be read to children. It points out how individuals in trusted positions may take unfair advantage of unaware children. Though it makes an example of this particular relationship--that of the child and babysitter--it is applicable to other situations. Ages 5-10.

Adult reader will need to guide listeners appropriately as no judgments are made about actions of the babysitter until the end.

Meyer, Linda D. Safety Zone. The Chas. Franklin Press, 18409 90th Ave. W., Edmonds, WA 98020, (206) 774-6979. (P, E)

This book teaches skills to children for preventing child abduction. Hypothetical situations, safety tips and games are used. Adult's text includes information about resource organizations and what to do if your child is abducted. Ages 4-11. $3.00 paperback.

Montgomery, Becky, Grimm, Carol & Schwandt, Peg. (1983). Annie - Once I Was a Little Bit Frightened. Rape and Abuse Crisis Center of Fargo-Moorhead, P.O. Box 2984, Fargo, ND 58108, (701) 293-7273. (E)

Booklet with text tells the story of Annie. Someone she knew was touching her in a way that scared and hurt her. Annie told and felt much better! Pictures can be colored. $2.95. Ages 5-8.

Morgan, Marcia. (1984). My Feelings. Eugene, OR: Equal Justice Consultants & Education Products. Network Publications, 1700 Mission Street, Dept. P, P.O. Box 8506, Santa Cruz, CA 95061-8506, (408) 429-9822. (C, P, E)

Sexual abuse information for children in the form of a coloring book. It is designed to teach children to identify and trust their own instincts about good and bad touch. Ages 4-10.

Parents Anonymous. What's the Matter With Kelly? Kidsrights, 401 S. Highland, P.O. Box 851, Mt. Dora, FL 32757, 1-800-892-KIDS. (E)

This book carefully recounts the events of an incest case. The effects on family, friends, and victim alike are noted. This book has been used successfully by many help groups. Ages 5-10.

Peck, Richard. Are You in the House Alone? Learn Me, 642 Grand Avenue, St. Paul, MN 55105, (612) 291-7888. (A)

Appropriate for teenagers, this paperback reports the occurrence of a young girl's rape and relates her feelings as a victim.

Polese, Carolyn. Promise Not to Tell. Kidsrights, 401 S. Highland, P.O. Box 851, Mt. Dora, FL 32757, 1-800-892-KIDS. (E)

This courageous story shows clearly and with sensitivity the dynamics of sexual assault of children. The young reader comes to understand the confused feelings which unfortunately may prevent the victim from telling. Helpful to parents and professionals for prevention and therapy.

Roberts, Willo Davis. (1977). Don't Hurt Laurie. New York: Atheneum.

Laurie is physically abused by her mother. She wants help, but is afraid nobody will believe her. She finally gains the support of other adults, as the dynamics of abuse become apparent.

School Report Packet. C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect, 1205 Oneida Street, Denver, CO, 80220, (303) 321-3963. (P, E)

Basic information on child abuse for students through 8th grade. $3.00 postpaid.

Sexual Abuse: Information for Preteens and Teenagers. Austin Child Guidance and Evaluation Center, Texas Abuse Services Div., 612 W. 6th Street, Austin, TX 78701, (512) 476-6015. (A)

This booklet provides an overview of sexual abuse of preteens and teenagers and discusses means for preventing abuse and treating victims.

Smith, Doris Buchanan. (1974). Tough Chauncey. New York: Wm. Morrow & Company. (A)

A thirteen-year-old boy struggles with physical abuse by his grandfather and neglect by his mother. A friend helps him find resources in the community. Fifth through ninth grade.

Stanek, Muriel. All Alone After School. Kidsrights, 401 S. Highland, P.O.Box 851, Mt. Dora, FL 32757, 1-800-892-KIDS. (E)

Safety rules and tips are covered in story form as told by a child narrator, a "latchkey" child. Generously illustrated. Ages 6-10.

Stanek, Muriel. Don't Hurt Me, Mama. Kidsrights, 401 S. Highland, P.O. Box 851, Mt. Dora, FL 32757, 1-800-892-KIDS. (E)

A straightforward story, told by the victim, on the events which prompted an incident of physical abuse by the mother. The book is helpful in its explanation, showing that abuse can be stopped and relationships reestablished. Ages 6-9.

Stop, Don't Hurt Me. American Humane Association, 9725 East Hampden, Denver, CO 80231, (303) 695-0811. (E, A)

This is an informational brochure for children and adolescents. Child abuse and neglect are addressed by responding to children's questions. Information on local community resources is listed. Order in lots of 1,000 and brochure will be modified to identify state resources. (1,000 at $200, 2,000 at $240, 3,000 at $300)

Stowell, Jo & Dietzel, Mary. (1989). My Very Own Book About Me. Lutheran Social Services of Washington, Rape Crisis Resource Library, N. 1226 Howard, Spokane, WA 99201, (509) 327-7761. (P, E)

Designed to be a tool in diagnosing, preventing and treating child sexual abuse, this workbook uses a positive, experiential approach. Appropriate for preschool through sixth grade. Comes with a parent's guide. Guides for teachers and therapists also available.

Sweet, Phyllis E. (1981). Something Happened to Me. Racine, WI: Mother Courage Press. Network Publications, 1700 Mission St., Suite 203, P.O. Box 1830, Santa Cruz, CA 95061-1830, (408) 429-9822. (E)

This book is meant to help the professional who is working with children who have been sexually abused. The child is encouraged to speak of his or her experiences and to realize he or she is not to blame.

Terkel, Susan & Rench, Janice. (1984). Feeling Safe, Feeling Strong: How to Avoid Sexual Abuse and What to Do If It Happens to You. Minneapolis: Lerner Publications. Network Publications, 1700 Mission Street, Suite 203, P.O. Box 1830, Santa Cruz, CA 95061-1830, (408) 429-9822. (A)

This book contains six stories, told by youngsters in the first person. The fictionalized accounts, relating various incidents such as rape and incest, would be appropriate for adolescents.

Trust Your Feelings. C.A.R.E. Productions Association, Box L., #8 12th Street, Blaine, WA 98230, (604) 581-5116 or write to Box 183, Surrey, British Columbia V3T 4W8, CANADA. (E)

This colorfully illustrated book defines good and bad touching and suggests actions in response to bad touching.

Wachter, Oralee. (1983). No More Secrets For Me. Boston: Little Brown and Co. Trade Sales Dept., 34 Beacon Street, Boston, MA 02106, (617) 227-0730. (E)

This book includes four stories about children facing sit[illegible] involving sexual abuse.

Wakcher, Bridget. Child Abuse-Is It Happening to You? Kidsrights, 401 S. Highland, P.O. Box 851, Mt. Dora, FL 32757, 1-800-892-KIDS. (P, E)

An honest book which tells children what basic needs should be met by parents. It approaches difficult situations through illustrations of what is not acceptable behavior by parents and other adults. Ages 3-8.

"What If" Game, Kidsrights, 401 S. Highland, P.O. Box 851, Mt. Dora, FL, 32757, 1-800-892-KIDS. (P,E)

This game's design helps children interact with open discussion of the problem of sexual abuse. A group of game cards ask "what if" questions concerning possible and actual sexual abuse situations. Ages 4-12, adults.

What If I Say No. Kidsrights, 401 S. Highland, P.O. Box 851, Mt. Dora, FL 32757, 1-800-892-KIDS. (C, P, E)

This coloring book teaches children about their right to say, "No!" Various situations are used as examples, and stories and activities on the same theme are included. Ages 4-10.

Wheat, Patte. The Standoffs. Winston Press, 430 Oak Grove, Minneapolis, MN 55403.

A pamphlet about touching for young children

Williams, J. (1980). Once I Was A Little Bit Frightened. Rape and Abuse Crisis Center, P.O. Box 1655, Fargo, ND 58107, (701) 293-7273. (E)

This illustrated booklet is an aid to parents, teachers, and professionals who are attempting to elicit information from children about possible sexual abuse. Kindergarten through fifth grade.

Williams, J. (1980). Red Flag Green Flag People. Rape and Abuse Crisis Center, P.O. Box 1655, Fargo, ND 58107, (701) 293-7273. (C, P, E)

A coloring book with self-protection information and examples of good touch and bad touch, through the use of "red flag" or "green flag" people. Appropriate for preschool through third grade.

CURRICULA FOR USE WITH CHILDREN AND ADOLESCENTS

Please note: PACER does not endorse or promote any particular book or curriculum listed. Before you use any of these materials we urge you to personally review the books or curricula described. Prior to selecting these materials, it would be helpful for parents and professionals to have a clear idea of their individual goals and objectives.

AGE GUIDE: (A) = Adolescent
(E) = Elementary
(P) = Preschool

Anderson, J. and Benson, J. Respond: Teaching Children Self-Protection-Course Guide. Kidsrights, 401 S. Highland, P.O. Box 851, Mt. Dora, FL 32757, 1-800-892-KIDS. (E)

This ten-lesson curriculum addresses the student's self-esteem, assertiveness and response to danger at home and away. Children are taught to recognize and avoid abduction, physical abuse and sexual abuse. Ages 9-12. $12.50. A student's handbook which aids in presenting the ten lessons is also available.

No Easy Answers. Illusion Theatre of Minneapolis, 528 Hennepin Ave., Suite 704, Mpls., MN 55403, (612) 339-4944 or Kidsrights, 401 S. Highland P.O. Box 851, Mt. Dora, Florida 32757, 1-800-892-KIDS. (A)

Curriculum for junior and senior high school students prepared by the theatre's director, Cordelia Kent. It is a twenty-lesson program to develop students' skills in communicating feelings and also to help develop protection and prevention skills.

"No-Go-Tell." Lexington Center, Inc., Lexington Center Foundation/Lexington School for the Deaf, 30th Avenue & 7th St., Jackson, Heights, N.Y. 11370, (718) 899-8800.

A child protection curriculum designed specifically for disabled preschool and early elementary school-aged children.

Nurturing Program--A Group Based Program for Parents and Children Ages 4 to 12 Years Family Development Resources, Inc., 767 Second Avenue, Eau Claire, WI 54703, (715) 833-0904. (P,E)

For use by professionals. Includes all facets of positive parenting. Coloring book, games and A-V scripts are among the materials in the program. For example, "Red, White, and Bruises" is an A-V script which discusses the limitations of hitting as a form of controlling children's behavior. See description of similar program for young children.

Nurturing Program for Parents and Young Children, Birth to 5 Years Old. Family Development Resources, Inc., /67 Second Ave., Eau Claire, WI 54703, (715) 833-0904. (P)

For use by social workers, psychologists, elementary and special education teachers, counselors, parent educators, etc. Includes "Ellie and Benny," a set of pictures illustrating inappropriate physical hurting touch, as well as "Scary Touch" Dolls, to be used in a discussion of inappropriate sexual touch with children. Items can be ordered separately or for $127 for the entire children's program.

O'Day, Bonnie. (1983). Preventing Sexual Abuse of Persons with Disabilities--A Curriculum for Hearing Impaired, Physically Disabled, Blind, and Mentally Retarded Students. Minnesota Program for Victims of Sexual Assault, 300 Bigelow Bldg., 450 N. Syndicate St., St. Paul, MN 55104. (612) 642-0256. (A, E)

Professionals who work with disabled persons should find this curriculum useful. It contains chapters on the vulnerability of handicapped children, sexual assault education for instructors, parent training, and curricula for the individual handicaps. It also contains a chapter on suggested modifications for younger students. Activities for lessons are practical.

Personal Safety and Decision Making. The Committee for Children, 172 20th Ave., Seattle, WA 98122, (206) 322-5050. (E, A)

Teaches young people to be assertive, resist peer pressure and sexual exploitation. Techniques such as group discussions, role playing and analysis of story scenarios are used in helping this age group understand sexual abuse. Comes with teacher's guide and reproducible homework sheets, $55. Recommended grade levels: 5 - 8.

Plummer, Carol. Preventing Sexual Abuse. Kidsrights, 401 S. Highland, P.O. Box 851, Mt. Dora, FL 32757, 1-800-892-KIDS. (E)

This curriculum offers activities and strategies for working with children and adolescents. Separate curriculum guides for elementary, secondary and special school populations are included.

Special Education Curriculum on Sexual Exploitation, A Curriculum for Developing an Awareness of Sexual Exploitation and Teaching Self-Protective Techniques, Seattle Rape Relief, Developmental Disabilities Project, 1825 S. Jackson, Suite 102, Seattle, WA 98144.

Strategies for Free Children. Kidsrights, 120-A, W. Fifth P.O. Box 851, Mt. Dora, FL 32757, 1-800-892-KIDS. (E)

Teaches children to prevent verbal, physical and sexual assault. Workshops for parents and teachers as well as a classroom workshop for children six to twelve are included. $25.

Talking About Touching. The Committee for Children, 172 20th Ave., Seattle, WA 98122, (206) 322-5050. (E)

Photographs and stories serve as a basis for classroom discussion. Teacher's guide helps teachers recognize indicators of abuse. Supersize, $110, compact size, $70. Recommended grade levels K-4

Talking About Touching With Preschoolers. The Committee for Children, 172 20th Ave., Seattle, WA 98122, (206) 322-5050. (P)

This program contains 30 weekly lessons which have also been used with EMR and LD students with success. Simple and effective illustrations or photographs aid in helping the teacher use the self-contained teaching units. Guide notes on the back of each story or picture clarify specific objectives. The teacher comfortably can use suggestions to guide discussion. Super size, $80, compact size, $45.

Talking to Children/Talking to Parents About Sexual Assault. King County Rape Center, 305 South 43rd, Renton, WA 98055, (206) 226-0210. (E)

This curriculum was nationally presented in the 1985 PBS TV series, "Child Sexual Abuse: What Your Children Should Know." A resource for teachers, parents and professionals, it can be used with ages 6 to 12. Includes the manual, "He Told Me Not to Tell." (See Children's Bibliography.)

Teacher Training Manual, Sexual Abuse of Persons with Disabilities, Disabilities Project, Seattle Rape Relief, 1825 S. Jackson, Suite 102, Seattle, WA 98144 (206) 325-5531 (Voice/TDD).

A school-based approach to developing a special education program concerning sexual exploitation. Includes guidelines for training of professionals and parents about sexual exploitation of individuals with disabilities.

FILMS AND VIDEOS ON PHYSICAL AND SEXUAL ABUSE FOR USE WITH CHILDREN AND ADOLESCENTS

Please Note: PACER does not endorse or promote any particular film or video listed. Before you use any of these audiovisual materials, we urge you to personally review the materials. It would be helpful for parents and professionals to have a clear idea of their individual goals and objectives.

*Code: (A) = Adolescent
(E) = Elementary
(P) = Preschool

Abused Adolescents Speak Out. 1/2" videotape, 26 min. Face to Face, 730 Mendota, St. Paul, MN 55106, (612) 772-2557 or 2539. (A)

This is a group discussion with four abused adolescents and a counselor. They emphasize the need for support.

Acquaintance Rape. 16 mm, four 8-minute segments, color. To purchase: O.D.N. Productions, 114 Spring Street, New York, NY 10012, $490. Also available through Minnesota Victims of Sexual Assault, 300 Bigelow Bldg., 450 Syndicate St., St. Paul, MN 55104, (612) 642-0256. (A)

Designed to help in prevention of acquaintance rape. Sex role stereotypes, teenage sexuality, and communication breakdowns are covered. Suitable for high school students.

Better Safe Than Sorry-III. 19 min., Film Fair Communications, 10900 Ventura Boulevard, Box 1728, Studio City, CA 91604, (818) 985-0244. (A)

Adolescent boys and girls are taught about the possible dangers of sexual abuse, as well as how to avoid potentially dangerous situations. Sequences are dramatized and common sense rules for personal safety are taught.

Bubbylonian Encounter: A Film for Children About the Sense of Touch. (1983). 16 mm, 1/2" or 3/4" video. Kansas Committee for Prevention of Child Abuse, 435 S. Kansas, 2nd Floor, Topeka, KS 66603, (913) 354-7738. (E)

This film uses "Bub," a tourist from the planet Bubbylonia, to humorously teach about positive and negative touch, as well as forced sexual touch. Positive examples are promoted so that good choices can be made.

Child Molestation: A Crime Against Children. 11 min. AIMS Media, 6901 Woodley Ave., Van Nuys, CA 91406, (818) 785-4111 or (800) 367-2467. (E, A)

The children in this film have been sexually molested by relatives and have been helped by counseling. They help others to understand what is sexual molestation and what is not. Kids are taught to be careful without paranoia. Ages 9-15.

Child Molestation: When to Say "No". (1978). 16 mm or video, 13 1/2 minutes. AIMS Media, 6901 Woodley Ave., Van Nuys, CA 91406, (818) 785-4111 or (800) 367-2467. (E, A)

In four different examples, sexual abuse is avoided because the child has learned to say "no." Ages 10-16.

Child Sexual Abuse-What Your Children Should Know. WTTW, Chicago, 16 mm and video. Indiana University Audio-Visual Center, Bloomington, IN 47405, (812) 335-8087. (E, A)

This is a series of five programs, each for a different age or group--parents, grades K-3, grades 4-7, grades 7-12, and one on "Touch." With Lindsay Wagner, Cordelia Anderson Kent, and the Seattle Illusion Theatre, a small group of children discuss and demonstrate different kinds of touch. Adult film uses studio audience. User guide available.

Don't Get Stuck There. 16 mm, color film, 14 min. Purchase from: Research Use and Public Service Division, Boys Town Center, Boys Town, NE 68010. Available for rent from: Face to Face, 730 Mendota, St. Paul, MN 55106, (612) 772-2557 or 2539. (A)

For use with teenagers, this film, through actual interviews with abused youngsters, summarizes physical, sexual, and emotional abuse.

Feeling Yes, Feeling No, #1. 13 min. National Film Board of Canada. Perennial Education, 930 Pitner, Evanston, IL 60203, (312) 328-6700. (E)

Film #1 in this series portrays positive and negative touching scenes as done by the Green Thumb Theatre Group, followed by lively discussion. The film teaches basic skills in self-worth, self-confidence, and good judgment.

Feeling Yes, Feeling No, #2. 14 min. National Film Board of Canada. Perennial Education, 930 Pitner, Evanston, IL 60202, (312) 238-6700. (E)

Film #2 teaches children how to recognize sexual assault by strangers. "Yes" and "no" feelings are stressed. Children learn that not every stranger is dangerous, but are taught to identify potentially harmful situations.

Feeling Yes, Feeling No, #3. 15 min. 40 sec. National Film Board of Canada. Perennial Education, 930 Pitner, Evanston, IL 60202, (312) 328-6700. (E)

The Green Thumb players role play children's reactions to common family member assault situations. Children respond with self-help suggestions. Children learn of sexual assault by family members or other trusted persons.

Goodwin, Tom, Wurzburg, Geraldine & KTCA TV. Your Children Our Children: Neglect and Abuse. (1984). 1/2" or 3/4" video. KTCA TV, 1640 Como Ave., St. Paul, MN 55108, (612) 646-4611. (A)

This tape is one of five in a series devoted to issues relating to children. It addresses the topics of emotional abuse, sexual abuse, physical abuse and neglect. The narrator of the series is John Merrow of National Public Radio's "Options in Education." Also suitable for adults. Teacher's guide for series available free by writing P.B.S. Inside Delivery, 475 L'Enfant Plaza S.W., Washington, D.C. 20024.

How Do You Tell. 13 min. J. Gary Mitchell Film Company, MTI Teleprograms, Inc., 108 Wilmot Road, Deerfield, IL 60015, (312) 940-1260 or (800) 323-5343. (E)

This film helps kids to realize that positive peer pressure can help when they face tough decisions. Children are led in the direction of independence, maturity and caring.

It Shouldn't Hurt To Be a Kid. 27 min. California Attorney General Office, AIMS Media, 6901 Woodley Ave., Van Nuys, CA 91406, (818) 785-4111 or (800) 367-2467. (E)

Ricky Schroder and John Houseman narrate a film that defines child abuse, teaches how to recognize it, explains how to report a suspected case, and tells what will happen after the report is made.

Krause, Elaine. For Pete's Sake, Tell! 35 mm or video, 10 min., Spanish version available. Krause House, P.O. Box 880, Oregon City, OR 97045 or Kidsrights, 401 S. Highland, P.O. Box 851, Mt. Dora, FL 32757, 1-800-892-KIDS. (P, E)

Pete and Penelope Mouse help children learn how to avoid sexual abuse. Teaching guide, related book and puppets available. Ages 3-9.

Never Say Yes to a Stranger. 25 min. MTI Film and Video & Cook County Sheriff's Police Dept., MTI, 108 Wilmot Rd., Deerfield, IL 60015, (312) 940-1260 or (800) 323-5343. (E)

Alex Karras and Susan Clark from TV's "Webster" help teach children important safety rules. Animated and live action situations are taken from the book by Susan Newman.

No Easy Answers. (1983). 16 mm, 1/2 " or 3/4" video, 50 min. Illusion Theater, 528 Hennepin Ave., Suite 704, Mpls., MN 55403, (612) 339-4944. (A)

This is the adaptation of a theatrical presentation which answers teenagers questions concerning sexual abuse prevention and sexuality.

No More Secrets. 13 min. ODN Productions, 74 Varick St., New York, NY, 10013. (E)

Animated sections are used to deal with sexual abuse in a sensitive and specific manner. The aim is child sexual abuse prevention. The adult film, "Talking Helps," should be used by teacher/adult prior to use of this film for children.

Some Secrets Should Be Told. 10 min. Family Information Systems, Inc., 452 Pleasant St., Watertown, MA 02172, (617) 232-3737 or MTI Teleprograms, Inc., 108 Wilmot Rd., Deerfield, IL 60015, (800) 323-5343. (E)

A puppeteer helps children to be aware of the problem of sexual abuse. Children learn to distinguish such abuse from normal affection. The film stresses that telling an adult whom they trust will take away unwarranted guilt. Professional counseling is promoted.

Sometimes It's OK to Tattle. 12 min. Family Information Systems, Inc., 452 Pleasant St., Watertown, MA 02172, (617) 232-3737. (E)

A puppeteer discusses child abuse and neglect. Kids are advised to tell the teacher or another trusted adult. Grades K-6.

Strong Kids, Safe Kids. 43 min. Paramount Video, VHS, $29.95, local video stores or NCCE (National Committee for Citizens in Education), 410 Wilde Lake Village Green, Columbia, MD 21044, (301) 997-9300. #BL753. (E)

Henry Winkler, "Fonzie" from "Happy Days," helps teach skills to prevent abduction and child molestation. For school-age children and parents as well, this is a well-produced and informative effort. Utilizes cartoon characters, child development experts and TV personalities to good advantage.

Too Smart for Strangers. Video. Walt Disney, Distributed by Disney Studios, Burbank, CA 91521.

Touch. (1984). 16 mm, 32 min. Illusion Theater, 528 Hennepin Ave., Suite 704, Mpls., MN 55403, (612) 339-4944. MTI Teleprograms, 108 Wilmont Rd., Deerfield, IL 60015, (312) 940-1260 or (800) 323-5343. (E)

Young children are taught fundamental rules to protect themselves. Music, live action and puppetry skillfully remind children about strangers, threatening touches and scary secrets.

Who Do You Tell. 16 mm, color, 11 min. To purchase: Motorola Teleprograms, Inc., 4825 North Scott St., Schiller Park, IL 60176. Available to use through: Minnesota Program for Victims of Sexual Assault, 300 Bigelow Bldg., 450 N. Syndicate St., St. Paul, MN 55101 (612) 296-7084 or MTI Teleprograms, 108 Wilmot Rd., Deerfield, IL 60015, (800) 323-5343. (E)

Using "real" and animated characters, this film helps children discuss scary and uncomfortable situations and what they would do about them.

The Wizard of No. 18 min. J. Gary Mitchell Film Company, MTI Teleprograms, Inc., 108 Wilmot Road, Deerfield, IL 60015, (312) 940-1260 or (800) 323-5343. (E, A)

The "Wizard" acknowledges how difficult it is to make the correct decisions. "No" can be used for a strategy for success. This offbeat, fun film offers much wisdom. Grades 1 - 8.

Yes, You Can Say No. 19 1/2 min. Seattle Institute for Child Advocacy, Committee for Children, 172 20th Avenue, Seattle, WA 98122, (206) 322-5050. (E)

David, a ten-year-old, using inner resources and help from friends, learns to be assertive in handling his problem with exploitive touch.

REFERENCE BOOKS/CHILD ABUSE AND NEGLECT

Adams, Caren & Fay, Jennifer. (1981). No More Secrets. Impact Publishers. (Informational book for parents, educators, lay persons guide to teaching children about sexual abuse.)

Bass, Ellen & Thornton, Louise. (1983). I Never Told Anyone. Writings by Women Survivors of Child Sexual Abuse. Harper, Colophon Books.

Chess, Stella & Thomas, Alexander. (1974). Annual Progress in Child Psychiatry and Child Development. New York: Brunner/Mazel.

Colao, Flora & Hosansky, Tamar. (1983). Your Children Should Know. Bobbs-Merrill. Teach your children the strategies that will keep them safe from assault and crime.

Erickson, Edsel L. (1984). Child Abuse and Neglect, A Guidebook for Educators and Community Leaders. Learning Publications.

Fraiberg, Selma. (1980). Clinical Studies in Infant Mental Health, The First Year of Life. Basic Books.

Garbarino, James & Gilliam, Gwen. (1980). Understanding Abusive Families. DC. Heath & Co.

Gossage, Richard & Gunton, Melvin. (1982). A Parent's Guide to Streetproofing Children. Bantam-Seal.

Haskins, Jim. (1982). The Child Abuse Help Book: How to Understand and Cope with Violence in the Home. Addison-Wesley. (Causes of abuse, kinds of abuse and how to get help.)

Helfer, Ray & Kempe, C. Henry. (1976). Child Abuse and Neglect, The Family and the Community. Ballinger Publishing.

Herbruck, Comstock, Christine. (1979). Breaking the Cycle of Child Abuse. Winston Press.

Kempe, C. Henry & Helfer, Ray E. (1980). The Battered Child. (3rd ed.). University of Chicago Press. (Comprehensive volume on the battered child for professionals and laymen.)

Kempe, C. Henry & Ruth S. (1978). Child Abuse, The Developing Child. Harvard University Press, Cambridge, MA.

Kempe, Ruth S. & C. Henry. (1984). The Common Secret, Sexual Abuse of Children and Adolescents. New York: W. H. Freeman & Co.

O'Brien, Shirley. (1980). Child Abuse, A Crying Shame. Brigham Young University Press. (History, definitions, statistics, characteristics of child abuse.)

Polansky, Norman. (1981). Damaged Parents, An Anatomy of Child Neglect. University of Chicago Press.

Sanford, Tschirhart, Linda. (1980). The Silent Children, A Parent's Guide to the Prevention of Child Sexual Abuse. McGraw-Hill

ten Bensel, Robert W. Training Manual in Child Abuse and Neglect. Public Health 5640, University of Minnesota, School of Public Health, 420 Delaware St., Mpls., MN 55455.

Young, Leontine. Wednesday's Children: A Study of Child Neglect and Abuse. (Documentary study of children abused or neglected by their parents.)

LOCAL AND GREATER OR OUTSTATE MINNESOTA RESOURCES ON CHILD ABUSE

This resource guide represents only a partial listing of available resources dealing with child abuse.

LOCAL RESOURCES

PROGRAM	TYPE OF SERVICE
Advocate for the Blind Suite 304, Parkdale Plaza 1660 S. Highway 100 Minneapolis, MN 55416 (612) 546-9303	Advocacy on behalf of clients who are blind and visually impaired whose legal issue deals with the visual impairment.
Alfred Adler Institute Suite 344, 1001 West Hwy. 7 Hopkins, MN 55343 (612) 933-9363	Education sessions on parenting. They will also provide a moderator for other groups in the community for parenting education.
Association for Retarded Citizens of Hennepin County 2344 Nicollet Avenue South Minneapolis, MN 55404 (612) 874-6650	Counseling of families, children and adolescents with mental retardation who have been physically or sexually abused. Individual and family therapy.
Association for Retarded Citizens of Minnesota 3225 Lyndale Avenue South Minneapolis, MN 55408 (612) 827-5641 TOLL-FREE 1-800-582-5256 HOTLINE 1-800-233-7027	24-hour hotline for people who have questions regarding aversive and deprivation procedures, questions to be asked before using such procedures and when they should be stopped.
The Bridge for Runaway Youth, Inc. 2200 Emerson Avenue South Minneapolis, MN 55405 (612) 377-8800	Early intervention with physically and sexually abusive families. Family and individual counseling. Support groups. Shelter for youth in crisis.
Carver County Community Court House Box 7 Chaska, MN 55318 (612) 448-3661	Parent support groups for families of children with handicaps.

PROGRAM	SERVICES
Catholic Charities 404 South 8th Street Minnepaolis, MN 55404 (612) 340-7500	Individual and group counseling, family therapy and marriage counseling. Foster care program; adoption program; St. Joseph's Home for Children; temporary shelter; job service; refugee resettlement; women's employment program
CCATCH Comprehensive Clinic for Abused and Traumatized Children University of MN Hospitals 6th Floor Mayo Building, Box 95 Minneapolis, MN 55454 (612) 626-6577 (Intake)	An outpatient mental health clinic dealing with the impact of abuse and psychological trauma. It includes a comprehensive service of evaluation, treatment, education and crisis relief support. Also provides an inpatient program.
Child Net 906 Northdale St. Paul, MN 55103 (612) 488-6457	Children's platform, legislative resource, library and child abuse advocacy.
Children's Home Society of Minnesota **Crisis Nursery** 2230 Como Avenue St. Paul, MN 55108 Administrator (612) 646-6393 Crisis Line: (612) 641-1300	Crisis intervention resource for the entire family. Provides a safe and nurturing environment for children of families in crisis who need a temporary placement outside of the home. The placement is confidential, free, and offered 24 hours a day for a maximum of 3 days. Temporary day care is available for up to 10 days. Services offered to residents of Washington, Ramsey and Dakota counties.
Chrysalis 2550 Pillsbury Avenue South Minneapolis, MN 55404 (612) 871-2672	Individual and group counseling. Special children's groups and individual counseling for children. Prevention and intervention programs in the schools (various topics such as drugs, touch, self-esteem, social skills). Sliding fee scale.
C.L.U.E.S. - Chicanos Latinos Unidos En Servicios 220 South Robert Street St. Paul, MN 55107 (612) 292-0117	Crisis Intervention; sexual abuse and behavioral problems; controlled differences; family and sexual abuse treatment; individual and family counseling; counseling group for sexually assaulted women.
Community University Health Care Center Refugee Mental Health Program 2016 16th Avenue South Minneapolis, MN 55404 (612) 627-4774	Services to Southeast Asian families which include services to child physical and sexual abuse victims, the offender and families.
Courage Center 3915 Golden Valley Road Golden Valley, MN 55422 (612) 520 52, x152	Individual and family counseling. Psychological testing. Social and emotional support groups offered at various times. Family focus program.

PROGRAM	SERVICES
Division of Indian Work 3045 Park Avenue Minneapolis, MN 55407 (612) 827-1795	Counseling and support groups for sexually abused children and support group for children who have experienced family violence.
Epilepsy Foundation of MN 672 Transfer Road St. Paul, MN 55114 (612) 646-8675	Counseling specifically related to epilepsy. Short-term crisis intervention, referral and follow-up for child abuse.
Fairview Southdale Hospital Fairview Treatment Program 6401 France Avenue South Edina, MN 55435 (612) 924-5900	Individual and group counseling. Family counseling - children's services are free.
Family and Children Services 414 South 8th Street Minneapolis, MN 55404 (612) 340-7494	Individual, marital, parent, child, financial counseling, family life education, gay and lesbian programs for people living or working in Hennepin or Anoka counties. (No fee)
FIRST CALL FOR HELP (East Metro Area) 100 South Robert Street St. Paul, MN 55107 (612) 291-4666 TDD (612) 291-4630	Information and referral service of Minneapolis United Way (Washington, Dakota and Ramsey counties).
"Professional line" (612) 291-4692	Information, referral and consultations for professionals and groups regarding community resources.
FIRST CALL FOR HELP (West Metro Area) 404 South 8th Street United Way Center Minneapolis, MN 55404 (612) 335-5000 24-hour service	Information and referral service of Minneapolis United Way area (West metro area counties).
Genesis II for Women 3036 University Avenue SE Minneapolis, MN 55414 (612) 348-2762	Program for women facing legal intervention for abuse or neglect of their children. Specialized groups for child sexual abuse perpetrators and prostitutes. T.P.R. group: black women's therapy group, Indian and women's therapy groups.
Gillette Children's Hospital 200 East University Avenue St. Paul, MN 55101 (612) 291-2848	Referrals for parents of children with disabilities to support groups, respite and residential care, and other community services.

PROGRAM	SERVICES
Harriet Tubman Shelter P.O. 7026 Powderhorn Station Minneapolis, MN 55407 (612) 827-6105	Shelter for battered women and their children. Support groups for both women and children around abuse and violence issues. Community education in training professionals and lay people working with the effects of violence and abuse of children. They also provide education in the schools on sexual abuse and violence prevention.
Hearing Impaired Program St. Paul Ramsey Hospital 640 Jackson Street St. Paul, MN 55101 (612) 221-2747	Individual and family counseling for the hearing impaired. Child abuse case resolution support services.
Hennepin County Community Services Child Abuse and Neglect Reporting Juvenile Justice Center - 1st Floor 626 South 6th Street Minneapolis, MN 55415 (612) 348-3552 S.O.S. (612) 348-8144	24-hour service. The hotline is for reporting child abuse, a place to get help and/or referral to other agencies.
Illusion Theater 528 Hennepin Avenue Minneapolis, MN 55403 (612) 339-4944	Community outreach programs: sexual abuse prevention programs for school children. Curriculum available. New program for adults is also available.
Indian Health Board Mental Health Unit 1315 East 24th Street Minneapolis, MN 55404 (612) 721-3200	Family assessment. Individual and family counseling. Parent support groups. Family violence program. Sliding fee scale.
Jewish Family & Children's Services 1500 South Lilac Drive Golden Valley, MN 55416 Director (612) 546-0616	Individual and family counseling. Sliding fee scale. Big Brother and Sister program for children with special needs.
Jewish Family Service 1546 St. Clair Avenue St. Paul, MN 55105 Coordinator (612) 698-70 ,7	Individual, couple, family, and group counseling. Sliding fee scale.
Lutheran Social Service 2414 Park Avenue Minneapolis, MN 55404 Intake (612) 871-0221	Individual and family counseling services: support groups on various issues such as single parenting, parenting a child with handicaps, teenage sex offenders; teen and parent program; apartment program for young, single and expectant mothers.

PROGRAM	SERVICES
MELD (Minnesota Early Learning Design) Suite 804 123 North 3rd Street Minneapolis, MN 55401 (612) 332-7563	Family program for new parents and "young moms," (13 - 20). Groups for parents of children with special needs (0 - 3); parents with hearing impairments and Hispanic parents.
Mental Health Association of Minnesota 328 Hennepin Avenue E Minneapolis, MN 55414-1016 (612) 331-6840 1-800-862-1799	Focuses on self-esteem and mental health promotion. Pamphlets and audio visual materials on child abuse and neglect. Program on self-esteem, "Nobody Else Like You" for elementary school children.
Midwest Children's Resource Center Suite 200 360 Sherman Street St. Paul, MN 55102 (612) 228-0105	Child physical and sexual abuse and neglect evaluation (both medical and psychological), treatment and referral. Statewide professional consultation via telephone on medical, psychological, legal and treatment issues related to child abuse and neglect.
Minneapolis Children's Medical Center 2525 Chicago Avenue South Minneapolis, MN 55404 Parent Warm Line (612) 863-6336	(Non-crisis, non-medical) A free consultation service for parer ts who need support and practical information about the behavior and development of their young children.
(F.I.P.) Family Intervention Project (612) 863-5003	Providing diagnostic and therapeutic services to children, adolescents and their families who have experienced abuse or neglect
Midwest Children's Resource Center Suite 200 360 Sherman Street St. Paul, MN 55102 (612) 228-0105 24-Hour Consultation line 1-800-422-0879	Center for diagnosis and treatment of physical, sexual and emotionally abused and neglected children. Pediatric, forensic and pathological consultations. Expert testimony and consultations for medical, psychological and legal services.
Minneapolis Crisis Nursery (612) 824-8000	A safe, temporary shelter for children. The purpose of placement is to prevent child abuse and neglect in a family crisis situation. Placement is voluntary and free (must be made by legal guardian) for children through age 6. It is open 24 hours a day and 7 days a week. There is a 3-day maximum stay. They will consider children with moderate disabilities.
Minneapolis Public Schools 254 Upton Avenue South Minneapolis, MN 55405 Health Services and Chemical Awareness (612) 627-3083	Prevention curricula for students and inservice training on child abuse for teachers. S.W. Crisis Team: Crisis team, friendship groups, and interface with medical and mental health community.

PROGRAM	SERVICES
Minneapolis Youth Diversion Program 1905 - 3rd Avenue South Minneapolis, MN 55404 (612) 871-3613	Individual youth counseling.
Minnesota Chippewa Tribe Human Services Division 1315 East 24th Street Minneapolis, MN 55404 (612) 721-3151	Information and referral services.
Minnesota Coalition for Battered Women Physicians Plaza, #201 570 Asbury Street St. Paul, MN 55104 (612) 646-6177	Provides direct services to more than 65 shelters and direct service advocacy programs who have organized to provide safety and support to battered women and their families.
Minnesota Committee for Prevention of Child Abuse Suite S-191 1821 University Avenue West St. Paul, MN 55104 (612) 641-1568	A statewide organization which provides services in primary prevention of child maltreatment including: public awareness, public education (workshops, inservices), assistance to groups attempting to coordinate local prevention efforts (resource packets available for community use). Policy advocacy.
Minnesota Migrant Council 220 South Robert Street St. Paul, MN 55107 (612) 222-2121	Services to sexual abuse victims and their families. Information and referral services. Child sexual abuse prevention education.
Minnesota State Council on Disability Metro Square Building Suite 145 7th and Jackson Street St. Paul, MN 55101 (612) 296-6785 TOLL-FREE - 1-800-652-9741	Information and referral resource.
Minnesota's Comprehensive Epilepsy Program Suite 106 2701 University Avenue SE Minneapolis, MN 55414 (612) 227-6611	Full range of pediatric neurology services. Outpatient and inpatient counseling services. Inpatient services connected with Gillette Children's Hospital.
Minnesota's Indian Women's Resource Center 1900 Chicago Avenue Minneapolis, MN 55404 (612) 872-8211	Counseling and assistance to Native American families on chemical dependency and abuse.

PROGRAM	SERVICES
Model Cities Health Center Inc. 430 North Dale St. Paul, MN 55103 (612) 222-6029	Sexual assault services, information and referral services.
National Federation of the Blind Chamber of Commerce Building Suite 715 15 South 5th, Minneapolis, MN 55402 (612) 332-5414	Support groups for sighted parents of children who are blind, support groups for blind parents with sighted children. Phone support, information, referral, and legal advice. Working with parents to sort out issues of blindness and abuse.
Parents Anonymous 265 Oneida St. Paul, MN 55102 (612) 298-5731	Self-help group for parents who feel they are abusing their child or fear the possibility of doing so. Children's groups and child care available. No fee.
PHASE (Program for Healthy Adolescent Sexual Expression) East Communities Family Center 1709 North McKnight Road Maplewood, MN 55109 (612) 777-8060	Treatment groups and individual counseling for male sexual abuse victims. Intensive outpatient evaluation and treatment program for male and female adolescent sex offenders.
Program in Human Sexuality University of Minnesota 2630 University Avenue SE Minneapolis, MN 55414 Intake (612) 627-4360	Individual, family, and group therapy. Various support groups. Work with children, including the disabled. Training and education programs for both professionals and lay people.
Ramsey County Community Human Services Child Protection Reporting 160 East Kellogg Boulevard St. Paul, MN 55101 (612) 266-5655 (612) 291-6795 (24 Hours)	Child protection service. Information and referrals.
Ramsey County Mental Health Clinic 529 Jackson Street St. Paul, MN 55101 (612) 298-4737	Individual and family counseling. Will work with families with children with handicaps. Sliding fee scale for residents of Ramsey County.
Rape and Sexual Assault Center (NIP) 2431 Hennepin Avenue South Minneapolis, MN 55405 (612) 825-2409 (612) 823-4357 (HELP) - 24-Hour HOTLINE	Individual and family counseling for victims of sexual assault. Various support groups (for nonoffending parents of abused children, teenagers, adults). Advocacy services for victims. Incest treatment program for all or part of the family, beginning at age 3. Will work with individuals with handicaps. Community outreach, education, and prevention of sexual abuse. Sliding fee scale.

PROGRAM	SERVICES
Responses, Inc. Responses to End Abuse of Children, Inc. Health Association Center Suite 423 2221 University Avenue SE Minneapolis, MN 55414 **(612) 922-7106**	A public, non-profit corporation whose mission is to engage businesses, labor and private health care in working together with public agencies in order to combat family violence, child abuse and neglect.
St. Joseph's Home for Children 1121 East 46th Street Minneapolis, MN 55407 (612) 827-6241	Central intake for all children in Hennepin County who are homeless (5 - 17 years old). Provides short-term shelter, residential programs for children who are emotionally disturbed, and a day treatment program for K - 6th grade.
St. Paul American Indian Center 341 University Avenue West St. Paul, MN 55103 (612) 222-0690	Information and referral services. Recruitment and licensing of Indian foster homes.
Scott County Human Services Court House 300 Shakopee, MN 55379-1375 Social Intake Dept. (612) 445-7751	Infant stimulation program, child abuse investigation and foster care placement. Family reunification program.
Sexual Abuse Treatment Program **Human Services, Inc.** 7066 Stillwater Boulevard N. Oakdale, MN 55119 Intake: (612) 777-5222 Hotline: (612) 777-1117	Family sexual abuse program. Individual and group counseling, including young children, adolescents, siblings and adults. Advocacy services for victims. Community outreach including speakers in the school system with programs on "touch" and prevention of sexual abuse. Clients with handicaps welcome. Sliding fee scale - open to residents of Washington County.
Sexual Offense Services of Ramsey County (S.O.S.) #201 1619 Dayton Ave. St. Paul, MN 55104 (612) 298-5898	S.O.S. provides 24-hour crisis line for victims of sexual assault. Face to face counseling of victims and family members. Advocacy for victims with police, court and protective services. Outreach through community education on sexual abuse prevention. Professional training and parent training on sexual abuse.
Sexual Violence Center 1222 West 31st Street Minneapolis, MN 55408 Business line: (612) 824-2864 24 Hour Crisis Line: (612) 824-5555	Individual and family counseling for victims of sexual abuse. Full-range individual advocacy. Various support groups offered. Experience working with individuals with disabilities and/or their families. Community outreach and education for prevention of sexual abuse, including people with mental and physical handicaps.

PROGRAM	SERVICES
Sexual Violence Center in Carver County (612) 448-5425	Individual and family counseling for victims of sexual abuse. Full-range individual advocacy. Various support groups offered. Experience working with individuals with disabilities and/or their families. Community outreach and education for prevention of sexual abuse, including people with mental and physical handicaps. Supervised internship volunteer opportunities.
Southside Family Nurturing Center 2448 18th Avenue South Minneapolis, MN 55404 (612) 721-2762	Therapeutic preschool and family school for parents whose lives have been affected by physical, emotional, sexual abuse and neglect.
Southside Life Care Center 4250 Upton Avenue Minneapolis, MN 55410 (612) 922-6900	Provides pregnancy testing and counseling; pre-natal care for low-income women.
Twin City Society for Children with Autism 253 East 4th Street St. Paul, MN 55101 (612) 228-9074	Parent support group and sibling support group. Family counseling.
United Cerebral Palsy Association of Minnesota Suite 233 South 1821 University Avenue St. Paul, MN 55104 (612) 646-7582	Information, referral and advocacy, including child abuse resources. Nutrition program, community aid/loan bank. Used equipment referral service.
Upper Midwest Sexual Abuse Consortium 401 Groveland Avenue Minneapolis, MN 55403 (612) 879-0154	A collective of services providers in the area of child sexual abuse. A publication and resource directory of providers is available.
Uptown Mental Health Center 2215 Pillsbury Avenue South Minneapolis, MN 55404 (612) 871-1111	Psychological evaluation and therapy - for individuals and/or families experiencing sexual abuse. Therapy groups for victims and offenders. Staff available to speak to professionals and/or parent groups about child abuse.
Wilder Foundation Child Guidance Clinic 2480 White Bear Avenue Maplewood, MN 55109 Director (612) 770-1222	Counseling for abused children and their families. Various support groups offered. Sliding fee scale.

PROGRAM	SERVICES
Wilder Foundation Refugee Program 91 East Arch Street St. Paul, MN 55101 (612) 222-2875	Services to Southeast Asian families. Provides services relating to child physical abuse.

SERVICES IN GREATER OR OUTSTATE MINNESOTA

PROGRAM	SERVICE
Arrowhead Psychological Associates Medical Arts Building Room 829 324 West Superior Street Duluth, MN 55805 (218) 723-8153	Child sexual abuse victims treatment to female victims, schoolage and adolescent male victims. Provides group, individual and family counseling.
Center for Parents and Children 810 - 4th Avenue South Moorhead, MN 56560 (218) 233-6158	Adolescent offenders, child and adolescent victims, and families.Child abuse and neglect issues.
Center for Psychological Health 210 West Superior Street Duluth, MN 55802 (218) 722-4866	Family and individual counseling for sexual and emotional abused adolescents and their families. A licensed psychologist and licensed consulting psychologist on staff.
Central Minnesota Sexual Abuse Treatment Program **Central Minnesota Mental Health Center** 1321 North 13th Street St. Cloud, MN 56301 (612) 252-5010	Incest victims, offenders, families; serves Stearns, Sherburn, Benton and Wright counties.
Duluth InterAgency Sexual Abuse Consortia Program for Aid to Victims of Sexual Assault 202 Ordean Buliding Duluth, MN 55802 (218) 726-4751	Organization of community professionals meeting to address issues of sexual abuse and develop community incest treatment program. Currently the consortia provides a forum for community professionals to coordinate the services offerred by various comunity agencies. Provides referrals to appropriate agencies treating child sexual abuse.
Exchange Clubs 285 - 18th Street SE Owatonna, MN 55060 (507) 455-1190 1-800-642-0089	Exchange Club Center for the prevention of child abuse in Southern Minnesota.
Family Awareness and Development Program Upper Mississippi Mental Health Center P.O. Box 649 1125 - 6th Street SE Bemidji, MN 56601 (218) 751-3282	Family sexual abuse; serves Beltrami and surrounding counties.

PROGRAM	SERVICE
Family Sexual Abuse Treatment Program West Central Community Services Center 1125 S.E. 6th Street, Box 787 Willmar, MN 56201 (612) 235-4613	Victims and offenders, all ages; serves Chippewa, Kandiyohi, LacQuiParle, Meeker, Renville and Swift counties.
Family Sexual Abuse Program Lakeland Mental Health Center 126 East Alcott Avenue Fergus Falls, MN 56537 (218) 736-6987	Victims and offenders, families; serves n IV counties.
Family Sexual Abuse Program Program for Aid to Victims of Sexual Assault 2 East 5th Street Duluth, MN 55805 (218) 727-4353	Victims and offenders; all ages.
Family Sexual Abuse Treatment Program Dakota Mental Health 744 - 19th Avenue North South St. Paul, MN 55075 (612) 455-9651	Incest program offers counseling for mothers, victims and perpetrators. Peer groups for perpetrators. Separate program for women who have been incest victims or abused. One-on-one counseling.
Family Violence Treatment Program Zumbro Valley Mental Center P.O. Box 1116 Rochester, MN 55902 (507) 288-1873	Adult incest offenders, families, victims and family members.Group and individual counseling. Survivors Group is for adult women abused as children. Provide services for adolescent perpetrators. Provide general assessment of family situations. Works with Southeast Asian families. Public speaking on child abuse issues.
Fargo-Moorhead Family Sexual Abuse Treatment Program P.O. Box 1064 Fargo, ND 58107-1064 (701) 234-0127	Program offers counseling for mothers, victims and perpetrators. Individual counseling.
Five County Mental Health Center Box 287 521 Broadway Avenue North Braham, MN 55006 (612) 396-3333	Sexual abuse program provides counseling for perpetrators/offenders, victims and families. Individual, family and child counseling.
Human Development Center 1401 East First Street Duluth, MN 55805 (218) 728-4491	Mental health center with programs that provide group and individual treatment to male adolescent and adult sex offenders and victims. Provides public education and training on sexual abuse issues.

PROGRAM	SERVICE
Hutchinson Mental Health Unit 1095 Highway 15 South Hutchinson, MN 55350 (612) 587-2148, x254	Provides inpatient, outpatient, day treatment, crisis intervention and sexual abuse counseling progam. Services to victim, family and perpetrator. Individual and group counseling.
Lutheran Social Services 600 Ordean Building Duluth, MN 55802 (218) 726-4769	Services to adolescent sexual abuse victims.
Mayo Clinic Department of Psychiatry and Psychology Rochester, MN 55905 (507) 284-2933, x5849	Assessment and treatment of sexually abused and sexually aggressive children.
Midwest Children's Resource Center Suite 200 360 Sherman Street St. Paul, MN 55102 (612) 228-0105 (Twin Cities area) 1-800-422-0879 (Minnesota)	Child physical and sexual abuse and neglect evaluation (both medical and psychological), treatment and referral. Statewide professional consultation via telephone on medical, psychological, legal and treatment issues related to child abuse and neglect.
Minnesota Coalition for Battered Women 570 Asbury Street St. Paul, MN 55104 (612) 646-6177	Provides direct services to more than 65 shelters and direct service advocacy programs who have organized to provide safety and support to battered women and their families.
Minnesota Migrant Council Box 1231 35 Wilson Avenue North St. Cloud, MN 56302-1231 (612) 253-7020	Information and referral and assistance provided to child abuse, sexual assault, and domestic violence victims and their families. Public education and prevention education.
Northern Pines Mental Health Center County Service Building Lower Level Brainerd, MN 56401 (218) 829-3235	Incest offenders, victims and families. Individual counseling.
Northern Pines Mental Health Center Second Floor 808 - 3rd Street SE Little Falls, MN 56345 (612) 632-6647	Incest offenders, victims.

PROGRAM	SERVICE
Parents Anonymous of Minnesota Room 202 265 Oneida St. Paul, MN 55104 (612) 298-5731	State office of Parents Anonymous. Provides self-help groups for parents who feel they are abusing or at risk of abusing their child or fear the possibility of doing so. P.A. has chapters across the country with weekly support groups with other parents who have similar difficulties. Members can call upon one another for support, and encouragement. P.A. also provides written materials and referrals for persons concerned about abuse and resources for starting P.A. groups throughout the state.
Psychological Health Services 8 North Second Avenue East Duluth, MN 55802 (218) 722-1254	Child sexual abuse treatment services to adult offenders, victims, both individual and group. Provides services to adults abused as children and child physical abuse victims. Provides treatment to developmentally delayed sex offenders.
Range Family Sexual Abuse Treatment Program Range Mental Health Center P.O. Box 1188 624 South 13th Street Virginia, MN 55792 (218) 749-2881	Victims and offenders, families.
Rape and Abuse Crisis Center Box 2984 Fargo, North Dakota 55108-2984 (701) 293-7273	RED FLAG GREEN FLAG (Grades 1 - 4) WOODROW PROJECT (Developmentally Disabled Children) T IS FOR TOUCHING (Pre-schoolers)
St. Louis County Social Services Government Services Center 320 West 2nd Street Duluth, MN 55802 (218) 727-6348	County agency responsible for responding to reports of suspected child abuse and neglect. Provides information and referral services to families and children seeking services for identified problems.
South Central Human Relations Center, Inc. 215 South Oak Street Owatonna, MN 55060 (507) 451-2630	Outpatient treatment for family and children. Home treatment for families. Provides one-on-one counseling for perpetrators, victims, siblings, and parents of physical and sexual abuse.
Upper Mississippi Mental Health Center 722 15th Street, Box 646 Bemidji, MN 56601 (218) 751-3280	In-house EBD level placement at Bemidji schools. Assessment on child sexual and physical abuse. Family sexual abuse treatment. Adolescent perpetrators boys group. Adolescent victims counseling for boys and girls, preadolescent counseling for girls. Personal body safety group. Initial assessment is individual; group counseling.

PROGRAM	SERVICE
West Central Community Services Center 1125 6th Street S.E. P.O. Box 787 Willmar, MN 56201 (612) 235-4613	Child sexual abuse treatment services to adult offenders and victims; individual counseling.
Western Human Services Center P.O. Box 450 1106 East College Drive Marshall, MN 56258 (507) 532-3236	Child sexual abuse treatment services to adult offenders, families and victims; individual counseling. Serve adult women with past abuse history. Workshops and public speaking.
Winona Marriage and Family Service 157 Lafayette Street Winona, MN 55987 (507) 452-7292	Adult incest offenders; victims and families.

MINNESOTA TRIBAL SOCIAL SERVICES

CHIPPEWA

Social Service Director
Minnesota Chippewa Tribe
P.O. Box 217
Cass Lake, MN 56633
(218) 335-2252

Social Service Director
Red Lake Reservation
Red Lake, MN 56671
(218) 679-3341

Health and Human Service Director
Fond du Lac Reservation
Min-No-Aya-Win Clinic
927 Trettel Lane
Cloquet, MN 55720
(218) 879-1251

Social Service Director
Leech Lake Reservation
Route 3, Box 100
Cass Lake, MN 56633
(218) 335-2207/2208

Social Service Director
Bois Forte Reservation
P.O. Box 25
Nett Lake, MN 55772
(218) 757-3261

Director of Health and Human Services
P.O. Box 418
White Earth, MN 56591
(218) 983-3285

Social Service Director
Grand Portage Reservation
Grand Portage, MN 55605
(218) 475-2279/2277

SIOUX

Social Service Director
Mille Lacs Reservation
Star Route, Box 194
Onamia, MN 56359
(612) 532-4181

Social Service Director
Lower Sioux Community
P.O. Box 308
Morton, MN 56270
(507) 697-6185

Social Service Director
Upper Sioux Community
P.O. Box 147
Granite Falls, MN 56241
(612) 564-4504/4026

Social Service Director
Prairie Island Sioux Community
5750 Sturgeon Lake Road
Welch, MN 55089
(612) 388-8889

Social Service Director
Shakopee Sioux Community
2330 Sioux Trail Northwest
Prior Lake, MN 55372
(612) 445-8900

NATIONAL RESOURCES ON CHILD ABUSE

Adam Walsh Child Resource Center
Suite 306
1876 N. University Drive
Ft. Lauderdale, FL 33322
(305) 475-4847

This organization lobbies for child protection legislation and educates children about the prevention of abduction, abuse and neglect. It was founded in memory of Adam Walsh, whose abduction case attracted national notoriety.

Adults Molested as Children United (AMACU)
P.O. Box 952
San Jose, CA 95108
(408) 280-5055

This is a self-help program. Members work through weekly therapy groups to resolve the problems and conflicts that the sexual abuse has caused in their lives. To find a local AMACU group, call the San Jose office.

American Association for Protecting Children
A division of American Humane Association
9725 E. Hampden Avenue
Denver, CO 80231
(303) 695-0811

Provides educational material, program planning, consultation, training and research, and statistics on abuse in an effort to prevent the neglect, abuse, and sexual exploitation of children.

American Humane Association, Child Protection
P.O. Box 1266
Denver, CO 80201/1266
(303) 695-0811

Provides national leadership through training, consultation, research, advocacy and information dissemination.

Child Abuse Research & Education Productions Association
C.A.R.E. Productions
Box L #8-12th Street
Blaine, WA 98230
(604) 581-5116/or write directly to: Box 183, Surrey, V3T 4W8, British Columbia, CANADA.

C.A.R.E. is a nonprofit organization dedicated to the prevention of child sexual abuse. It gathers and distributes information, including curricula, on child sexual abuse for adults and children.

Center on Human Policy
Syracuse University
216 Ostrom Avenue
Syracuse, NY 13210
(315) 443-3851

The Center develops policy, conducts research and disseminates information on institutional care of individuals with handicaps. Deals primarily with adult issues.

C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect
1205 Oneida Street
Denver, CO 80220
(303) 321-3963

Provides diagnosis, treatment and research. Publications and annotated catalogues are available. Publishes topic searches. Conducts research in areas of child abuse.

Child Find
P.O. Box 277
New Paltz, NY 12561
(914) 255-1848 or
(800) 431-5005, to give information on a missing child

A service to help parents find their missing children. It publishes the Directory of Missing Children, distributed to hospitals, schools, police departments, etc.

Children's Defense Fund (CDF)
122 C Street N.W.
Washington, DC 20001
(202) 628-8787

Provides advocacy in the areas of education, health care and welfare legislation. Staff lawyers work on class action suits only. Publishes COF Reports as well as a listing of children's advocacy groups throughout the country.

Children's Legal Rights (CLR) Information and Training Program
2008 Hillyer Place N.W.
Washington, DC 20009
(202) 332-6575

Furnishes information on children's rights. Trains social service agency workers throughout the country. Publishes Children's Legal Rights Journal.

The Council for Exceptional Children
1920 Association Drive
Reston, VA 22091-1589
(703) 620-3660

Publishes Exceptional Children Journal, a professional journal dealing with education and advocacy issues regarding exceptional children. Conducts research and disseminates information.

National Center for Missing and Exploited Children
Suite 700
1835 K Street N.W.
Washington, DC 20006
(202) 634-9821

Provides child protection information, trains law enforcement and social services personnel and tracks missing children.

National Center on Child Abuse and Neglect
Children's Bureau
Administration for Children, Youth, and Families
Office of Human Development Services
P.O. Box 1182
Washington, DC 20013
(202) 755-0590

NCCAN (Nat'l Center on Child Abuse and Neglect) Child Abuse Clearinghouse
Aspen Systems
P.O. Box 1182
Washington, DC 20013
(301) 251-5157

The Clearinghouse is sponsored by the National Center on Child Abuse and Neglect, U.S. Department of Health and Human Services. Program information, literature searches, and statistical information are available upon request.

National Child Abuse Coalition
Thomas Birch, Director
Suite 300
1125 15th Street N.W.
Washington, DC 20005
(202) 293-7550

Involved in legal issues relevant to child abuse, including the rights of a child with disabilities in cases of abuse.

National Coalition Against Domestic Violence
Suite 506
2401 V Avenue N.W.
Washington, DC 20037
(202) 293-8860

A national membership organization composed of independently operated shelters fo battered women and their families. To locate or telephone a shelter in your area, wri telephone the coalition.

National Committee for Prevention of Child Abuse
Suite 1250
332 South Michigan Avenue
Chicago, IL 60604-4357
(312) 663-3520

The NCPCA is a vital organization which provides extensive resource lists, information, and creative impetus pertaining to all areas of child abuse prevention; promotes the growth of local NCPCA Chapters; and sponsors a national conference on child abuse and neglect as well as an annual national media campaign. It has a large publishing department which sells materials on a broad range of topics related to child abuse.

National Committee for Prevention of Child Abuse Publishing Department
P.O. Box 94283
Chicago, IL 60690
(312) 663-3520

Publishes materials on child abuse prevention and research findings; promotes public awareness of these issues.

National Directory of Children and Youth Services
P.O. Box 1837
1761 Cover Port
Longmont, CO 80502
(303) 776-7539

Includes listings of 2,500 licensed private providers of services--residential care, treatment and assistance--for victims of child abuse and neglect, sexual assault, rape, alcohol and drug abuse, plus help for troubled youths.

National Information Center for Handicapped Children and Youth (NICHCY)
P.O. Box 1492
Washington, DC 20013
(703) 522-3332

NICHCY is a free information service focusing on the needs of children and youth with handicaps. Services include: personal responses to specific questions, referrals/sources of help, information packets, special education career recruitment materials, state-of-the-art publications and technical assistance to parent and professional groups.

National Legal Resource Center for Child Advocacy and Protection
American Bar Association, Attn. Child Advocacy
1800 M Street NW, S-200
Washington, DC 20036
(202) 331-2250
Child Abuse Division: (202) 331-2234

A program of the American Bar Association, Young Lawyers Division. The Resource Center's objectives are to increase professional awareness and competency of the legal community in the area of child welfare issues. Develops publications relating to child abuse and neglect, sexual abuse, permanency planning, child custody, foster care and child and family development.

Office of Child Development-Region V
(Indiana, Michigan, Minnesota, Ohio, Wisconsin)
300 South Wacker Drive
Chicago, IL 60606
(312) 353-1781

Educational materials.

Parents Anonymous (P.A.)
6733 S. Sepulveda Boulevard
Los Angeles, CA 90045
(800) 421-0353 (Call toll free to locate a local P.A. group.)

An international self-help group for parents under stress who feel they are abusing their child or fear the possibility of doing so. P.A. has chapters across the country with weekly support groups with other parents who have similar difficulties. P.A. also provides written materials and referrals for persons concerned about abuse and resources for starting P.A. groups throughout the country.

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

A national self-help organization with local groups. Provides assistance to families involved in sexual child abuse and sponsors self-help groups for adults who were sexually abused as children. Provides help to child victims of sexual abuse whose parents are in the Parents United program. Parents United also sponsors the Institute for the Community As Extended Family, which trains professionals to set up child sexual abuse treatment programs.

Regional Child Abuse Center-Midwest Parent/Child Welfare Resource Center
Center for Advanced Studies in Human Services
School of Social Welfare
University of Wisconsin, Milwaukee
Milwaukee, WI 53201
(414) 963-4651

Information, training and consultation.

St. Joseph Service League Center for Abused Handicapped Children
Boys Town National Institute
555 North 30th Street
Omaha, NE 68131
(402) 449-6600

A broad range of services including: Evaluation, assessment, prescriptive intervention and comprehensive treatment recommendations for abused children with disabilities to parents, agencies, institutions and private therapists across the country. Produces instructional materials for schools, agencies and institutions to be used in self-study, workshops and seminars.

Seattle Rape Relief Disabilities Project
Suite 102
1825 S. Jackson
Seattle, WA 98144,
(206) 325-5531 (Voice & TDD)

A nationwide resource and consultation center dealing with sexual assault of persons with disabilities. Written resources and curricula available as well as counseling and advocacy for assault victims who are disabled.

APPENDICES

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Human Development Services
Administration for Children, Youth and Families

APPENDIX B

Public Law 93-247
as Amended

Child Abuse Prevention and Treatment Act

DHHS Publication No. (OHDS) 85-30343

Public Law 93–247, as amended

(Includes the Child Abuse Amendments of 1984,
Pub. L. 98–457, October 9, 1984 (42 U.S.C. 5101, note))

An Act

To provide financial assistance for a demonstration program for the prevention, and treatment of child abuse and neglect, to establish a National Center on Child Abuse and Neglect, and for other purposes.

Child Abuse Prevention and Treatment Act. 42 USC 5101

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Child Abuse Prevention and Treatment Act," as amended.

THE NATIONAL CENTER ON CHILD ABUSE AND NEGLECT

Center.

SEC. 2 (a) The Secretary of Health and Human Services (hereinafter referred to in this Act as the "Secretary") shall establish an office to be known as the National Center on Child Abuse and Neglect (hereinafter referred to in this Act as the "Center").

(b) The Secretary, through the Center, shall—

Annual research summary.

(1) compile, analyze, publish, and disseminate a summary annually of recently conducted and currently conducted research on child abuse and neglect;

Information clearinghouse.

(2) develop and maintain an information clearinghouse on all programs, including private programs, showing promise of success, for the prevention, identification and treatment of child abuse and neglect;

(3) compile, publish and disseminate training materials for personnel who are engaged or intend to engage in the prevention, identification, and treatment of child abuse and neglect;

Technical Assistance.

(4) provide technical assistance (directly or through grant or contract) to public and nonprofit private agencies and organizations to assist them in planning, improving, developing and carrying out programs and activities relating to the prevention, identification and treatment of child abuse and neglect;

Research

(5) conduct research into the causes of child abuse and neglect, and into the prevention, identification, and treatment thereof;

Study.

(6) study and investigate the national incidence of child abuse and neglect and make findings about any relationship between nonpayment of child support and between various other factors and child abuse and neglect, and the extent to which incidents of child abuse and neglect are increasing in number and severity, and, within two years after the date of the enactment of the Child Abuse Amendments of 1984, submit such findings to the appropriate Committees of the Congress together with such recommendations for administrative and legislative changes as are appropriate; and

Reports.

(7) in consultation with the Advisory Board on Child Abuse and Neglect, annually prepare reports on efforts during the preceding two-year period to bring about coordination of the goals, objectives, and activities of agencies and organizations which have responsibilities for programs and activities related to child abuse and neglect, and, not later than March 1, 1985, and March 1 of each second year thereafter, submit such a report to the appropriate Committees of the Congress.

Research priorities for grants or contracts; Publication in Federal Register

The Secretary shall establish research priorities for making grants or contracts under clause (5) of this subsection and, not less than sixty days before establishing such priorities, shall publish in the Federal Register for public comment a statement of such proposed priorities.

Review.

(c) The functions of the Secretary under subsection (b) of this section may be carried out either directly or by way of grant or contract. Grants may be made under subsection (b)(5) for periods of not more than three years. Any such grant shall be reviewed at least annually by the Secretary, utilizing peer review mechanisms to assure the quality and progress of research conducted under such grant.

(d) The Secretary shall make available to the Center such staff and resources as are necessary for the Center to carry out effectively its functions under this Act.

(e) No funds appropriated under this Act for any grant or contract may be used for any purpose other than that for which such funds were specifically authorized.

DEFINITION

SEC. 3. For purposes of This Act—

(1) the term "child abuse and neglect" means the physical or mental injury, sexual abuse or exploitation, negligent treatment, or maltreatment of a child under the age of eighteen, or the age specified by the child protection law of the State in question, by a person (including any employee of a residential facility or any staff person providing out-of-home care) who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened thereby, as determined in accordance with regulations prescribed by the Secretary; and

(2)(A) the term "sexual abuse" includes—

(i) the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or having a child assist any other person to engage in, any sexually explicit conduct (or any simulation of such conduct) for the purpose of producing any visual depiction of such conduct, or

(ii) the rape, molestation, prostitution, or other such form of sexual exploitation of children, or incest with children,

under circumstances which indicate that the child's health or welfare is harmed or threatened thereby, as determined in accordance with regulations prescribed by the Secretary; and

(B) for the purpose of this clause, the term "child" or "children" means any individual who has not or individuals who have not attained the age of eighteen.

(3) the term "withholding of medically indicated treatment" means the failure to respond to the infant's life-threatening conditions by providing treatment (including appropriate nutrition, hydration, and medication) which, in the treating physician's or physicians' reasonable medical judgment, will be most likely to be effective in ameliorating or correcting all such conditions, except that the term does not include the failure to provide treatment (other than appropriate nutrition, hydration, or medication) to an infant when, in the treating physician's or physicians' reasonable medical judgment, (A) the infant is chronically and irreversibly comatose; (B) the provision of such treatment would (i) merely prolong dying, (ii) not be effective in ameliorating or correcting all of the infant's life-threatening conditions, or (iii) otherwise be futile in terms of the survival of the infant; or (C) the provision of such treatment would be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane.

DEMONSTRATION OF SERVICE PROGRAMS AND PROJECTS

SEC. 4. (a) The Secretary, through the Center, is authorized to make grants to, and enter into contracts with, public agencies or nonprofit private organizations (or combinations thereof) for demonstration or service programs and projects designed to prevent, identify, and treat child abuse and neglect. Grants or contracts under this subsection may be—

(1) for training programs for professional and paraprofessional personnel in the fields of medicine, law, education, social work, and other relevant fields who are engaged in, or intend to work in, the field of prevention, identification, and treatment of child abuse and neglect; and training programs for children, and for persons responsible for the welfare of children, in methods of protecting children from child abuse and neglect;

(2) for the establishment and maintenance of centers, serving defined geographic areas, staffed by multidisciplinary teams of personnel trained in the prevention, identification, and treatment of child abuse and neglect, including direct support and supervision of satellite centers and attention homes, as well as providing advice and consultation to individuals, agencies and organizations which request such services;

(3) for furnishing services of teams of professional and paraprofessional personnel who are trained in the prevention, identification, and treatment of child abuse and neglect cases, on a consulting basis to small communities where such services are not available; and

(4) for such other innovative programs and projects, including programs and projects for parent self-help, and for prevention and treatment of drug-related child abuse and neglect, that show promise of successfully preventing or treating cases of child abuse and neglect as the Secretary may approve.

Grants to States

(b)(1) The Secretary, through the Center, is authorized to make grants to the States for the purpose of assisting the States in developing, strengthening, and carrying out child abuse and neglect prevention and treatment programs.

(2) In order for a State to qualify for assistance under this subsection, such State shall—

(A) have in effect a State child abuse and neglect law which shall include provisions for immunity for persons reporting instances of child abuse and neglect from prosecution, under any State or local law, arising out of such reporting;

(B) provide for the reporting of known and suspected instances of child abuse and neglect;

(C) provide that upon receipt of a report of known or suspected instances of child abuse or neglect an investigation shall be initiated promptly to substantiate the accuracy of the report, and, upon a finding of abuse or neglect, immediate steps shall be taken to protect the health and welfare of the abused or neglected child, as well as that of any other child under the same care who may be in danger of abuse or neglect;

(D) demonstrate that there are in effect throughout the State, in connection with the enforcement of child abuse and neglect laws and with the reporting of suspected instances of child abuse and neglect, such administrative procedures, such personnel trained in child abuse and neglect prevention and treatment, such training procedures, such institutional and other facilities (public and private), and such related multidisciplinary programs and services as may be necessary or appropriate to assure that the State will deal effectively with child abuse and neglect cases in the State;

(E) provide for methods to preserve the confidentiality of all records in order to protect the rights of the child, and the child's parents or guardians;

(F) provide for the cooperation of law enforcement officials, courts of competent jurisdiction, and appropriate State agencies providing human services;

(G) provide that in every case involving an abused or neglected child which results in a judicial proceeding a guardian ad litem shall be appointed to represent the child in such proceedings;

(H) provide that the aggregate of support for programs or projects related to child abuse and neglect assisted by State funds shall not be reduced below the level provided during fiscal year 1973, and set forth policies and procedures designed to assure that Federal funds made available under this Act for any fiscal year will be so used as to supplement and, to the extent practicable, increase the level of State funds which would, in the absence of Federal funds, be available for such programs and projects;

(I) provide for dissemination of information to the general public with respect to the problem of child abuse and neglect and the facilities and prevention and treatment methods available to combat instances of child abuse and neglect;

(J) to the extent feasible, insure that parental organizations combatting child abuse and neglect receive preferential treatment; and

(K) within one year after the date of the enactment of the Child Abuse Amendments of 1984, have in place for the purpose of responding to the reporting of medical neglect (including instances of withholding of medically indicated treatment from disabled infants with life-threatening conditions), procedures or programs, or both (within the State child protective services system), to provide for (i) coordination and consultation with individuals designated by and within appropriate health-care facilities, (ii) prompt notification by individuals designated by and within appropriate health-care facilities of cases of suspected medical neglect (including instances of withholding of medically indicated treatment from disabled infants with life-threatening conditions), and (iii) authority, under State law, for the State child protective service system to pursue any legal remedies, including the authority to initiate legal proceedings in a court of competent jurisdiction, as may be necessary to prevent the withholding of medically indicated treatment from disabled infants with life-threatening conditions.

Failure to obligate Funds.

If a State has failed to obligate funds awarded under this subsection within eighteen months after the date of award, the next award under this subsection made after the expiration of such period shall be reduced by an amount equal to the amount of such unobligated funds unless the Secretary determines that extraordinary reasons justify the failure to so obligate.

Waiver.

(3)(A) Subject to subparagraph (B) of this paragraph, any State which on the date of enactment of the Child Abuse Amendments of 1984 does not qualify for assistance under this subsection may be granted a waiver of any requirement under paragraph (2) of this subsection—

(i) for a period of not more than one year, if the Secretary makes a finding that such State is making a good-faith effort to comply with any such requirement, and for a second one-year period if the Secretary makes a finding that such State is making substantial progress to achieve such compliance; or

(ii) for a nonrenewable period of not more than two years in the case of a State the legislature of which meets only biennially, if the Secretary makes a finding that such State is making a good-faith effort to comply with any such requirement.

(B) No waiver under subparagraphs (A) may apply to any requirement under paragraph (2)(K) of this subsection. *Post.* p. 1752.

(4) Programs or projects related to child abuse and neglect assisted under part B of title IV of the Social Security Act shall comply with the requirements set forth in clauses (B), (C), (E), (F), and (K) of paragraph (2).* 42 USC 620.

Public information.

(c)(1) The Secretary is authorized to make additional grants to the States for the purpose of developing, establishing, and operating or implementing—

Ante. p. 1752.

(A) the procedures or programs required under clause (K) of subsection (b)(2) of this section;

(B) information and education programs or training programs for the purpose of improving the provision of services to disabled infants with life-threatening conditions for (i) professional and paraprofessional personnel concerned with the welfare of disabled infants with life-threatening conditions, including personnel employed in child protective services programs and health-care facilities, and (ii) the parents of such infants; and

(C) programs to help in obtaining or coordinating necessary services, including existing social and health services and financial assistance for families with disabled infants with life-threatening conditions, and those services necessary to facilitate adoptive placement of such infants who have been relinquished for adoption.

Contracts with U.S.

(2)(A) The Secretary shall provide, directly or through grants or contracts with public or private nonprofit organizations, for (i) training and technical assistance programs to assist States in developing, establishing, and operating or implementing programs and procedures meeting the requirements of clause (K) of subsection (b)(2) of this section; and (ii) the establishment and operation of national and regional information and resource clearinghouses for the purpose of providing the most current and complete information regarding medical treatment procedures and resources and community resources for the provision of services and treatment for disabled infants with life-threatening conditions (including compiling, maintaining, updating, and disseminating regional directories of

*Section 123(b) of Pub. L. 98-457 provides, "Section 4 of the Act is further amended by adding after paragraph (3) the following new paragra[illegible] as apparently a technical error. The new paragraph (4) should have been added after paragraph (3) of subsection (b).

42 USC 1749.

community services and resources (including the names and phone numbers of State and local medical organizations) to assist parents, families, and physicians and seeking to coordinate the availability of appropriate regional education resources for health-care personnel).

42 USC 5104.

(B) Not more than $1,000,000 of the funds appropriated for any fiscal year under section 5 of this Act may be used to carry out this paragraph.

Ante, p. 1749.

(C) Not later than 210 days after the date of the enactment of the Child Abuse Amendments of 1984, the Secretary shall have the capability of providing and begin to provide the training and technical assistance described in subparagraph (A) of this paragraph.

(d) Assistance provided pursuant to this section shall not be available for construction of facilities; however, the Secretary is authorized to supply such assistance for the lease or rental of facilities where adequate facilities are not otherwise available, and for repair or minor remodeling or alteration of existing facilities.

(e) The Secretary, in consultation with the Advisory Board on Child Abuse and Neglect, shall ensure that a proportionate share of assistance under this Act is available for activities related to the prevention of child abuse and neglect.

(f) For the purpose of this section, the term "State" includes each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, American Samoa, the Virgin Islands, Guam and the Trust Territories of the Pacific.*

(f) The Secretary shall establish criteria designed to achieve equitable distribution of assistance under this section among the States, among geographic areas of the Nation, and among rural and urban areas. To the extent possible, citizens of each State shall receive assistance from at least one project under this section.**

AUTHORIZATIONS

SEC. 5. There are hereby authorized to be appropriated for the purpose of this act $15,000,000 for the fiscal year ending June 30, 1974, $20,000,000 for the fiscal year ending June 30, 1975, $25,000,000 for the fiscal year ending June 30, 1976, and for the succeeding fiscal years, $25,000,000 for the fiscal year ending September 30, 1978, $27,500,000 for the fiscal year ending September 30, 1979, and $30,000,000 each for the fiscal year ending September 30, 1980, and September 30, 1981, respectively. There are hereby further authorized to be appropriated for the purposes of this Act $33,500,000 for fiscal year 1984, $40,000,000 for fiscal year 1985, $41,500,000 for fiscal year 1986, and $43,100,000 for fiscal year 1987. Of the funds appropriated for any fiscal year under this section except as provided in the succeeding sentence, (A) not less than $9,000,000 shall be available in each fiscal year to carry out section 4(b) of this Act (relating to State grants), (B) not less than $11,000,000 shall be available in each fiscal year to carry out sections 4(a) (relating to demonstration or service projects), 2(b)(1) and 2(b)(3) (relating to information dissemination), 2(b)(5) (relating to research), and 4(c)(2) (relating to training, technical assistance, and information dissemination) of this Act, giving special consideration to continued funding of child abuse and neglect programs or projects (previously funded by the Department of Health and Human Services) of national or regional scope and demonstrated effectiveness, (C) $5,000,000 shall be available in each such year for grants and contracts under section 4(a) for identification, treatment, and prevention of sexual abuse, and (D) $5,000,000 shall be available in each such year for the purpose of making additional grants to the States to carry out the provisions of section 4(c)(1) of this Act. With respect to any fiscal year in which the total amount appropriated under this section is less than $30,000,000, funds shall first be available as provided in clauses (A) and (B) in the preceding sentence and of the remainder one-half shall be available as provided for in clause (C) and one-half as provided for in clause (D) in the preceding sentence.

42 USC 5103.

42 USC 5101.

Post, p. 1753.

ADVISORY BOARD ON CHILD ABUSE AND NEGLECT

SEC. 6. (a) The Secretary shall, within sixty days after the date of enactment of this Act, appoint an Advisory Board on Child Abuse and Neglect (hereinafter referred to as the "Advisory Board"), which shall be composed of representatives from Federal agencies with responsibility for programs and activities related to child abuse and neglect, and not less than three members from the general public with experience or expertise in the field of child abuse and neglect. The Advisory Board shall assist the Secretary in coordinating programs and activities related to child abuse and neglect planned, administered, or assisted by the Federal agencies whose representatives are members of the Advisory Board. The Advisory Board shall also assist the Secretary in the development of Federal standards for child abuse and neglect prevention and treatment programs and projects. The Advisory Board may be available, at the Secretary's request, to assist the Secretary in coordinating adoption-related activities of the Federal Government.

Functions.

(b) Members of the Advisory Board, other than those regularly employed by the Federal Government, while serving on business of the Advisory Board, shall be entitled to receive compensation at a rate not in excess of the daily equivalent payable to a GS-18 employee under section 5332 of title 5, United States Code, including travel time; and, while so serving away from their homes or regular places of business, they may be allowed travel expenses (including per diem in lieu of subsistence) as authorized by section

Compensation.

*Commonwealth of Northern Mariana Islands added by P.L. 94-241 (48 USC 1681).

**Due to a technical error, Section 4 contains two subsections designated as (f). See Sections 103(c) and 123(a) of Pub. L. 98-457.

5703 of such title for persons in the Government service employed intermittently.

COORDINATION

SEC. 7. The Secretary shall promulgate regulations and make such arrangements as may be necessary or appropriate to ensure that there is effective coordination among programs related to child abuse and neglect under this Act and other such programs which are assisted by Federal funds.

Related Provisions of Public Law 98–457

REGULATIONS AND GUIDELINES

SEC. 124. (a)(1) Not later than 60 days after the date of the enactment of this Act, the Secretary of Health and Human Services (hereinafter in this part referred to as the "Secretary") shall publish proposed regulations to implement the requirements of section 4(b)(2)(K) of the Act (as added by section 122(3) of this Act). 42 USC 5103 note. *Ante*, p. 1752.

(2) Not later than 180 days after the date of the enactment of this Act and after completion of a process of not less than 60 days for notice and opportunity for public comment, the Secretary shall publish final regulations under this subsection.

(b)(1) Not later than 60 days after the date of the enactment of this Act, the Secretary shall publish interim model guidelines to encourage the establishment within health-care facilities of committees which would serve the purposes of educating hospital personnel and families of disabled infants with life-threatening conditions, recommending institutional policies and guidelines concerning the withholding of medically indicated treatment (as that term is defined in clause (3) of section 3 of the Act (as added by section 121(3) of this Act)) from such infants, and offering counsel and review in cases involving disabled infants with life-threatening conditions. *Ante*, p. 1752.

(2) Not later than 180 days after the date of the enactment of this Act and after completion of a period of not less than 60 days for notice and opportunity of public comment, the Secretary shall publish the model guidelines.

REPORT ON FINANCIAL RESOURCES

SEC. 125. The Secretary shall conduct a study to determine the most effective means of providing Federal financial support, other than the use of funds provided through the Social Security Act, for the provision of medical treatment, general care, and appropriate social services for disabled infants with life-threatening conditions. Not later than 270 days after the date of the enactment of this Act, the Secretary shall report the results of the study to the appropriate Committees of the Congress and shall include in the report such recommendations for legislation to provide such financial support as the Secretary considers appropriate. Study. 42 USC 1305.

42 USC 5103 note.

SEC. 126. Not later than October 1, 1987, the Secretary shall submit to the appropriate Committees of the Congress a detailed report on the implementation and the effects of the provisions of this part and the amendments made by it.

STATUTORY CONSTRUCTION

42 USC 5101 note.
29 USC 794

SEC. 127. (a) No provision of this Act or any amendment made by this Act is intended to affect any right or protection under section 504 of the Rehabilitation Act of 1973.

(b) No provision of this Act or any amendment made by this Act may be so construed as to authorize the Secretary or any other governmental entity to establish standards prescribing specific medical treatments for specific conditions, except to the extent that such standards are authorized by other laws.

Provisions held invalid

(c) If the provisions of any part of this Act or any amendment made by this Act or the application thereof to any person or circumstances be held invalid, the provisions of the other parts and their application to other persons or circumstances shall not be affected thereby.

EFFECTIVE DATES

42 USC 5102 note.

SEC. 128. (a) Except as provided in subsection (b), the provisions of this part or any amendment made by this part shall be effective on the date of the enactment of this Act.

(b)(1) Except as provided in paragraph (2), the amendments made by sections 122 and 123(b) of this Act* shall become effective one year after the date of such enactment.

Waiver

(2) In the event that, prior to such effective date, funds have not been appropriated pursuant to section 5 of the Act (as amended by section 104 of this Act) for the purpose of grants under section 4(c)(1) of the Act (as added by section 123(a) of this Act), any State which has not met any requirement of section 4(b)(2)(K) of the Act (as added by section 122(3) of this Act) may be granted a waiver of such requirements for a period of not more than one year, if the Secretary finds that such State is making a good-faith effort to comply with such requirements.

Ante, p. 1753
Ante, p. 1752

*Section 122 of Pub. L. 98-457 added section 4(b)(2)(K). Section 123(b) of Pub. L. 98-457 added section 4(b)(4).

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Table A—Who Reports Child Abuse

Who Must Report

States and Territories	"Any Person" or "Any Other Person"*	Physician	Nurse	Surgeon	Osteopath	Dentist	Resident	Intern	Hospital/Institution Personnel	Practitioner of Healing Arts	Chiropractor	Optometrist	Podiatrist	Pharmacist	Mental Health Professional	Coroner/Medical Examiner
Alabama		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Alaska		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Arizona		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Arkansas		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
California		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Colorado		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Connecticut	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Delaware	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
District of Columbia		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Florida	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Georgia		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Hawaii		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Idaho	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Illinois		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Indiana	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Iowa		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Kansas		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Kentucky	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Louisiana	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Maine		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Maryland		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Massachusetts		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Michigan		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Minnesota		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Mississippi		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Missouri		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Montana	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Nebraska	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Nevada		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
New Hampshire	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
New Jersey	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
New Mexico	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
New York		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
North Carolina		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
North Dakota		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Ohio		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Oklahoma	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Oregon		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Pennsylvania		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Rhode Island	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
South Carolina		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
South Dakota		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Tennessee	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Texas	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Utah	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Vermont		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Virginia		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Washington		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
West Virginia		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Wisconsin		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Wyoming	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
American Samoa		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Guam		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Puerto Rico	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Virgin Islands		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Numbers refer to explanatory notes following Table D

* A state that does not specify categories of professionals that must report, but instead requires that every person or any person report, is checked only in this column

Table A—Who Reports Child Abuse

Who May Report

States and Territories	"Teachers"	Other School Personnel	Social Services Worker	Law Enforcement Officer	Peace Officer	Police Officers	Probation Officer	Parole Officer	Religious Healing Practitioner*	Child Care Institution Worker	Clergyman	Attorney	Others*	Permissive Reporting
Alabama	X	X	X	X	X					X			X	•
Alaska	X	X	X		X	X			X	X	X		X	•
Arizona	X	X	X		X		X			X			X	•
Arkansas	X	X	X	X	X				X	X	X		X	•
California	X	X	X		X	X		X	X	X	X		X	•
Colorado	X	X	X						X	X			X	•
Connecticut	X	X	X	X		X			X	X	X		X	•
Delaware	X	X	X											
District of Columbia	X	X	X	X						X			X	•
Florida	X	X	X										X	•
Georgia	X	X	X	X	X					X				•
Hawaii	X	X	X											•
Idaho	X	X	X							X				
Illinois	X	X	X	X					X	X			X	•
Indiana	X	X	X											
Iowa	X	X	X		X					X				•
Kansas	X	X	X	X										•
Kentucky	X	X	X		X					X			X	•
Louisiana	X	X	X										X	•
Maine	X	X	X	X					X	X				•
Maryland	X	X	X	X		X	X	X					X	•
Massachusetts	X	X	X			X	X						X	•
Michigan	X	X	X	X						X			X	•
Minnesota	X	X	X	X						X				•
Mississippi	X	X	X	X						X	X			•
Missouri	X	X	X	X	X		X	X	X	X	X		X	•
Montana	X		X	X								X		•
Nebraska	X	X	X											•
Nevada	X	X	X							X	X	X		•
New Hampshire	X	X	X	X					X	X	X		X	•
New Jersey														
New Mexico	X		X	X										•
New York		X	X	X	X				X	X				•
North Carolina	X	X	X	X					X				X	•
North Dakota	X	X	X	X		X				X			X	•
Ohio	X	X	X						X	X		X	X	•
Oklahoma														
Oregon	X	X	X		X					X	X	X	X	•
Pennsylvania	X	X	X	X	X				X	X			X	•
Rhode Island														
South Carolina	X	X	X	X		X			X	X				•
South Dakota	X	X	X	X										•
Tennessee														
Texas														
Utah														
Vermont						X							X	•
Virginia	X	X	X	X			X		X	X			X	•
Washington	X	X	X						X	X			X	•
West Virginia	X	X	X	X	X				X	X			X	•
Wisconsin	X	X	X	X		X				X				•
Wyoming														
American Samoa	X	X	X	X	X				X	X				•
Guam	X	X	X	X	X				X	X			X	•
Puerto Rico	X	X	X							X				
Virgin Islands	X	X	X	X	X					X			X	•

Table B—Reporting Procedures

States and Territories	Orally, Followed By Writing	Time When Writing Is Due	As Soon As Possible (ASAP) or Hour Specified (HS)	Orally Only	Orally or In Writing	Orally, Then In Writing If Requested	Time When Due, If Requested	Procedure Not Specified	Record at Any Social Services Agency	Law Enforcement Agency	Other Agency
Alabama	X		NS					X	X*	X	X
Alaska								X	X	X	
Arizona									X		
Arkansas						X	48 hours		X		
California	X	36 hours							X	X	X
Colorado	X		NS						X	X	
Connecticut	X*	72 hours							X	X	
Delaware						X	NS*		X		
District of Columbia						X	NS		X	X	
Florida	X		ASAP						X		
Georgia					X	NS			X*		
Hawaii	X		ASAP						X		
Idaho								X*		X	
Illinois	X	24 hours							X		
Indiana				X					X	X	
Iowa	X*	48 hours							X		
Kansas						X	NS				X
Kentucky						X	48 hours		X*		
Louisiana	X	5 days							X	X	
Maine						X	48 hours		X		
Maryland	X	48 hours							X	X	
Massachusetts	X	48 hours							X		
Michigan	X	72 hours							X		
Minnesota	X		ASAP						X	X	
Mississippi	X		ASAP						X		
Missouri	X	48 hours							X		
Montana								X	X		X
Nebraska	X		NS							X	
Nevada	X		ASAP						X	X	X
New Hampshire						X	48 hours		X		
New Jersey								X	X		
New Mexico								X	X		X
New York	X	48 hours							X*		X
North Carolina					X				X		
North Dakota					X	X	48 hours		X		
Ohio						X	NS		X	X	X
Oklahoma	X		ASAP						X		
Oregon				X					X	X	
Pennsylvania	X	48 hours							X		
Rhode Island	X		NS						X		
South Carolina				X					X	X	
South Dakota				X					X		X
Tennessee								X	X	X	X
Texas	X	5 days							X	X	X
Utah						X	48 hours		X	X	
Vermont	X	7 days							X		
Virginia	X		NS						X		
Washington						X	NS		X	X	
West Virginia						X	48 hours		X		
Wisconsin						X	NS		X	X	
Wyoming						X	NS		X	X	
American Samoa						X	48 hours				X
Guam	X	48 hours							X		
Puerto Rico								48*	X		
Virgin Islands						X	48 hours				X

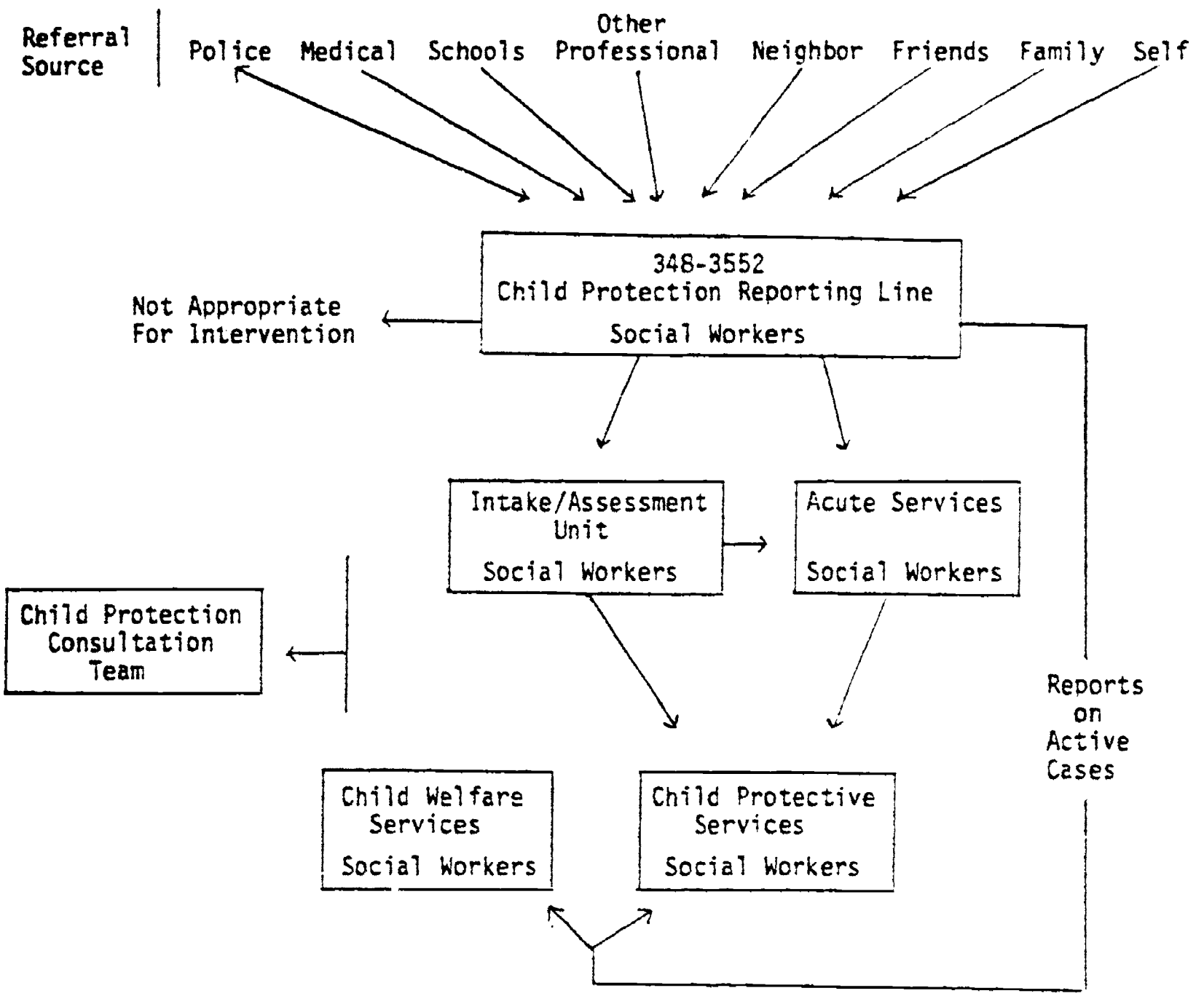
Numbers refer to explanatory notes following Table D

Table C—Immunity For Child Abuse Reporters

States and Territories	Civil and Criminal Immunity in Making of a Report	Immunity for the Taking of Photographs	Immunity for the Taking of X-rays	Immunity in Resulting Judicial Proceedings	Requirement of Good Faith	Good Faith Presumed
Alabama	X			X		
Alaska	X			X	X	
Arizona	X			X	X	
Arkansas	X	X				X
California	X			X	X	
Colorado	X	X	X	X		X
Connecticut	X			X	X	
Delaware	X			X	X	
District of Columbia	X			X	X	X
Florida	X	X	X	X		X
Georgia	X			X	X	
Hawaii	X			X	X	
Idaho	X			X	X	
Illinois	X	X	X	X		X
Indiana	X	X	X	X	X	X
Iowa	X			X	X	
Kansas	X			X	X	
Kentucky	X			X		
Louisiana	X			X	X	
Maine	X			X		X
Maryland	X			X	X	
Massachusetts	X				X	
Michigan	X	X*	X			X
Minnesota	X				X	
Mississippi	X			X		X
Missouri	X	X	X	X	X	
Montana	X			X		X
Nebraska	X			X	X	
Nevada	X			X	X	
New Hampshire	X			X	X	
New Jersey	X			X	X	
New Mexico	X			X		X
New York	X	X				X
North Carolina	X			X	X	
North Dakota	X				X	X
Ohio	X			X		
Oklahoma	X			X	X	
Oregon	X			X	X	
Pennsylvania	X	X		X	X	X
Rhode Island	X			X	X	
South Carolina	X			X	X	X
South Dakota	X			X	X	
Tennessee	X					X
Texas	X			X	X	
Utah	X	X	X		X	
Vermont	X			X	X	
Virginia	X			X	X	
Washington	X			X	X	
West Virginia	X	X*	X*		X	
Wisconsin	X	X			X	X
Wyoming	X	X*	X*		X	X
American Samoa	X	X			X	X
Guam	X	X		X	X	X
Puerto Rico	X					
Virgin Islands	X	X*	X*		X	

Numbers refer to explanatory notes following Table D

APPENDIX D



Response Time

Acute - 2 hours
Abuse - 24 hours
Neglect - 72 hours

CHILD PROTECTIVE SERVICES

INTAKE/ASSESSMENT PROCESS

HENNEPIN

Hennepin County Child Protection Program
A-15 Government Center
300 South Sixth Street
Minneapolis, MN 55487