

Social Work Ethics Course

3 Hours/Units

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1. NASW Code of Ethics for Social Workers: Summary of Major Principles

1a. The Purpose of the NASW Code of Ethics:

1. Establish the core values upon which social work is based.
2. Identify ethical standards that guides social work practice through the core values.
3. Assist social workers in assessing professional considerations when ethical uncertainties arise.
4. Identify ethical standards to which the social workers can be held accountable.
5. Help assimilate new social workers to the profession's mission, values, and ethical principles.
6. Identify standards by which the social work profession can assess if a social worker has engaged in unethical conduct.

The term "ethics" is characterized by behavior, practices, and standards considered "right and good" and established by professional organizations (e.g. NASW & APA). The provisions for enforcement include social or professional sanctions including suspension, revocation, or loss of license. Failure to comply with or act in the spirit of professional ethical standards can expose a social worker to legal liability and charges of negligence or unprofessional conduct.

Important tasks associated with professional ethical behavior include, but are not limited to:

- Establishment and maintenance of professional boundaries in an effort to protect the welfare of the client. Examples: the regulation of physical contact in the counseling setting, providing a therapeutic frame with consistent session times, and commonly understood office policies, roles and responsibilities.
- Avoidance of dual relationships by not entering into business or social relationships with clients.
- Obtaining a client's informed consent for treatment by providing necessary information about the nature of the therapeutic process so that the client can make meaningful decisions for or against treatment.

The following includes recommended, although not required by law, elements of informed consent:

- 1) The process of treatment
- 2) The limitations of confidentiality
- 3) The potential risks, drawbacks, and benefits of services.

- 4) Client access to records
- 5) Length of time the social worker retains records
- 6) Alternatives to treatment, which may include no treatment at all
- 7) Applicable NASW Ethical Standards regarding the patient social worker relationship
- 8) The social workers professional qualifications
- 9) The length of time the social worker has been in practice
- 10) The expected length of sessions and treatment
- 11) The mutual right to terminate services by both the client and the social worker
- 12) Procedures for collecting and raising fees
- 12) Cancellation policy
- 13) Telephone policy
- 14) Social worker availability between sessions, for vacations, and in emergencies

1b. NASW Social Work Code of Ethics Summary

Social Workers strive to ensure the well being of others while emphasizing the needs of those who are oppressed. Social workers also strive to support social justice and change on behalf of those they are serving. They are aware of cultural sensitivity and strive to incorporate this into social work practice. There are several core values that encapsulate this social worker profile including:

- ✓ service
- ✓ social justice
- ✓ dignity and worth of the individual
- ✓ importance and centrality of human relationships
- ✓ integrity
- ✓ competence

These core values are the foundation of social work and its role with individuals, groups, and society.

The Code of Ethics serves several purposes including but not limited to:

- ✓ social work's mission based on core values
- ✓ identification of ethical standards used to guide social work practice.

- ✓ identification of issues when professional obligations conflict
- ✓ a code by which the social work profession accountable.
- ✓ acclimating new practitioners to social work's mission, values, ethical principles, and ethical standards.
- ✓ identification of standards used to determine if social workers have engaged in unethical conduct.

Ethical Principles

NASW Social Work Code of Ethics

The NASW Code of Ethics is composed of thematic sections emphasizing the social worker's responsibility to clients, colleagues, employers, broader society, and the profession in general.

Social workers must:

- Maintain high standards of personal conduct.
- Strive to maintain a high degree of professionalism.
- Value service as a priority of social work.
- Strive to maintain a high degree of professional integrity.
- Participate in learning to maintain competence.
- Practice according to evidence and scholarly based practices.

1c. Ethical Standards

The following outlines ethical standards in relationship to social work practice including:

- Ethical responsibilities to clients
- Ethical responsibilities to colleagues
- Ethical responsibilities in practice settings
- Ethical responsibilities as professionals
- Ethical responsibilities to the social work profession
- Ethical responsibilities to society as a whole

***The following is a summary of social work ethical guidelines and NASW Code of Ethics. To access the complete NASW Code of Ethics in its entirety, please visit <https://www.socialworkers.org/pubs/code/code.asp>*

1d. Ethical Responsibilities to Clients

- Social workers:
- Make clients their primary responsibility.
- Foster self-determination in clients.
- Respect the privacy of clients and maintain confidentiality.
- Charge fair and considerate fees for services.
- Uphold, represent, and advance the values of the social work profession.
- Help the profession make social services available to the general public.
- Educate themselves to become culturally competent and understanding of diversity.

Fundamentally, social work promotes advocating and furthering the general welfare of society by representing those who are the most vulnerable. Providing social services is sometimes challenging and overwhelming. The Code of Ethics assists social workers in managing these challenges and provides structure for required standards. The following includes a summary of the ethical responsibilities social workers have to their clients:

- ✓ **Wellbeing:** It is the Social workers' responsibility to ensure and promote the wellbeing of clients.
- ✓ **Self Determination:** Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals.
- ✓ **Informed Consent:** Social workers provide services to clients in a professional relationship which includes valid informed consent. The informed consent must include clear statements to inform clients of the purpose of the services, risks related to the services, limits to services, relevant costs, reasonable alternatives, clients' right to refuse or withdraw consent, and the time frame covered by the consent. Social workers should provide clients with an opportunity to ask questions.
- ✓ **Competence:** Social workers represent themselves as competent within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience. Social workers use clinical approaches that are new to them only after completing relevant study, training, consultation, and supervision from people who are competent in those interventions or techniques.

- ✓ **Cultural Competence:** Social workers have an understanding of their clients' cultures and diversity.
- ✓ **Conflict of Interest:** Social workers are aware of and avoid conflicts of interest that interfere with sound clinical judgement.
- ✓ **Exploitation:** Social workers do not take advantage of professional relationships or engage in exploitation in order to further their own interests.
- ✓ **Dual Relationships:** Social workers do not engage in dual or multiple relationships with clients or former clients in which there is a risk of exploitation or potential harm to the client.
- ✓ **Clear Client Identification:** When social workers provide services to two or more people who have a relationship with each other (for example, couples, family members), social workers should clarify with all parties which individuals will be considered clients.
- ✓ **Privacy:** Social workers respect client's privacy and don't gather client's private information unless it's necessary to providing services.
- ✓ **Confidentiality:** Social workers may disclose confidential information when appropriate with valid consent from a client or a person legally authorized to consent on behalf of a client.
- ✓ **Limits to Confidentiality:** Social workers protect the confidentiality of client information except when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or another identifiable person. When necessary, social workers disclose as little information as possible and directly relevant to the purpose for which the disclosure is made.
- ✓ **Informing Clients:** Social workers should inform clients, to the extent possible, about the disclosure of confidential information and the potential consequences, when feasible before the disclosure is made. This applies whether social workers disclose confidential information on the basis of a legal requirement or client consent.
- ✓ **Third Party Payers:** Social workers do not disclose confidential information to third party payers unless disclosure has been authorized.
- ✓ **Private Settings:** Social workers do not discuss confidential information in any setting unless it is private. public or semipublic areas such as hallways, waiting rooms, elevators, and restaurants are not appropriate for discussing confidential information.
- ✓ **Legal Proceedings:** Social workers maintain client confidentiality during legal proceedings to the extent permitted by law.
- ✓ **Media Requests:** Social workers protect client confidentiality when responding to media requests.
- ✓ **Records:** Social workers protect their client's confidentiality and records. Social workers take reasonable steps to ensure that clients' records are stored in a secure location and that clients' records are not available to others who are not authorized to have access.
- ✓ **Electronic Transmission:** Social workers ensure the confidentiality of information transmitted

through computers, email, fax machines, telephones and answering machines, and other electronic transmission. Communicating identifying information should be avoided when possible.

- ✓ **Record Disposal:** Social workers dispose of client records while protecting confidentiality and is consistent with state statutes.
- ✓ **Practice Termination:** Social workers protect client confidentiality in the event of the social worker's termination of practice, incapacitation, or death.
- ✓ **Consultation and Training:** Social workers refrain from disclosing identifying information when discussing clients for training or consultation purposes unless the client has consented.
- ✓ **Access to Records:** Social workers provide clients with reasonable access to their records while protecting the confidentiality of other individuals identified in these records.
- ✓ **Sexual Activities:** Social workers do not engage in sexual activities with current clients or their relatives. Social workers do not engage in sexual activities with former clients due to potential harm to the client. Social workers do not provide clinical services to those with they have had a prior sexual relationship.
- ✓ **Physical Contact:** Social workers do not engage in physical contact with clients when there is a possibility of harm to the client as a result of the contact (such as cradling or caressing clients).
- ✓ **Sexual Harassment:** Social workers do not sexually harass clients including but not limited to sexual advances, sexual solicitation, requests for sexual favors, and other sexually verbal or physical behavior.
- ✓ **Fees:** Social workers ensure that the fees are fair, reasonable, and commensurate with services performed while considering the client's ability to pay.
- ✓ **Bartering:** Social workers avoid accepting goods or services from clients in exchange for professional services.
- ✓ **Continuity of Services:** Social workers should make reasonable efforts to ensure continuity of services in the event that services are interrupted.
- ✓ **Termination and Client Abandonment:** Social workers terminate services in a professional and responsible manner when services are no longer needed or serve the client's best interests. Steps to avoid abandoning clients who are still in need of services are always taken. Social workers may terminate services for clients who are not paying an overdue balance if the financial contractual arrangements have been made clear to the client, if the client does not pose an imminent danger to self or others, and if the clinical and other consequences of the current nonpayment have been addressed and discussed with the client.

1e. Social Worker's Ethical Responsibilities to Colleagues

Responsibility to Colleagues and Employers

Social workers:

- Treat colleagues with respect, fairness, and courtesy.
- Adhere to professional obligations as determined by their employers.

- ✓ **Respect:** Social workers treat colleagues with respect and avoid unwarranted negative criticism of colleagues in any and all communications.
- ✓ **Cooperation:** Social workers cooperate with social work and other colleagues especially when cooperation serves the wellbeing of clients.
- ✓ **Confidentiality:** Social workers protect confidential information shared by colleagues in the course of their professional relationships.
- ✓ **Collaboration:** Social workers who collaborate with an interdisciplinary team contribute to decisions that affect the wellbeing of clients by drawing on the perspectives, values, and experiences of the social work profession.
- ✓ **Disputes:** Social workers do not take advantage of a disputes between colleagues and employers in an effort to advance their own interests. Social workers do not exploit clients in disputes with colleagues.
- ✓ **Consultation:** Social workers seek the input of colleagues whenever such consultation is in the best interests of clients while disclosing the least amount of client information necessary.
- ✓ **Referrals:** Social workers refer out clients when other professionals' specialized knowledge or expertise is needed and/or when they are not being effective. Social workers who refer clients take steps to facilitate an orderly transfer of responsibility. Social workers who refer clients disclose, with clients' consent, all pertinent information to the new service providers. Social workers do not give or receive payment for a referral.
- ✓ **Sexual Relationships:** Social workers who assume the role of supervisors or educators do not engage in sexual activities with supervisees, students, trainees, or other colleagues over whom they exercise professional authority. Social workers avoid engaging in sexual relationships with colleagues when there is potential for a conflict of interest. Social workers who become involved in, or anticipate becoming involved in, a sexual relationship with a colleague have a duty to transfer professional responsibilities, when necessary, to avoid a conflict of interest.
- ✓ **Sexual Harassment:** Social workers do not sexually harass supervisees, students, trainees, or colleagues.
- ✓ **Impairment:** Social workers who have knowledge of a social work colleague's impairment that interferes with professional effectiveness should consult with that colleague when feasible and provide assistance. When the colleague has not taken adequate steps to

address impairment, the social worker takes action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations.

- ✓ **Incompetence:** Social workers who have direct knowledge of a social work colleague's incompetence should consult with that colleague when feasible and assist the colleague in taking remedial action. When the colleague has not taken adequate steps to address impairment, the social worker takes action through appropriate channels established by employers, agencies, NASW, licensing and regulatory bodies, and other professional organizations.
- ✓ **Unethical Conduct:** Social workers take necessary measures to discourage, prevent, expose, and correct the unethical conduct of colleagues.

1f. Social Worker's Ethical Responsibilities in Practice Settings

- ✓ **Consultation:** Social workers who provide supervision or consultation have the necessary knowledge and skill and do so within their areas of knowledge and competence. Social workers who provide supervision or consultation establish clear, appropriate, and culturally sensitive boundaries.
- ✓ **Dual Relationships:** Social workers do not engage in any dual relationships with supervisees in which there is a risk of exploitation of or potential harm to the supervisee.
- ✓ **Education and Training:** Social workers who are educators or trainers provide instruction only within their areas competence as well as the most current information available.
- ✓ **Client Records:** Social workers take steps to maintain accurate documentation and store records for the number of years required by state statutes or relevant contracts.
- ✓ **Billing:** Social workers should establish and maintain billing practices that accurately reflect the nature and extent of services provided and that identify who provided the service in the practice setting.
- ✓ **Administration:** Social workers who are administrators take steps to ensure that adequate agency or organizational resources are available to provide appropriate staff supervision. Social work administrators take steps to ensure that the working environment for which they are responsible is consistent with and encourages compliance with the *NASW Code of Ethics*. Social work administrators should take reasonable steps to eliminate any conditions in their organizations that violate, interfere with, or discourage compliance with the *Code*.
- ✓ **Continuing Education:** Social work administrators and supervisors take steps to provide or arrange for updated continuing education and staff development for all staff for whom they are responsible.

1g. Social Worker's Ethical Responsibilities as Professionals

- ✓ **Competence:** Social workers accept professional responsibilities on the basis of existing competence or the intention to acquire the necessary competence. They strive for proficiency in professional functions and practice.

- ✓ **Discrimination:** Social workers do not engage in any form of discrimination on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical disability.
- ✓ **Personal Problems:** Social workers do not allow personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties to interfere with their professional judgment and performance. Social workers whose personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties interfere with their professional judgment and should immediately take action by seeking professional help, making adjustments in workload, terminating practice, or taking any other steps necessary to protect clients and others.
- ✓ **Misrepresentation:** Social workers differentiate between private and professional statements. Social workers who speak on behalf of professional social work organizations accurately represent the official and authorized positions of the organizations. Social workers ensure that representations are accurate and claim only legitimate professional credentials.
- ✓ **Solicitation:** Social workers do not participate in uninvited solicitation of potential clients who are vulnerable to undue influence. Social workers do not engage in solicitation of testimonial endorsements.
- ✓ **Acknowledgement:** Social workers only take credit for work they have performed while acknowledging the work and contributions made by others.

1h. Social Worker's Ethical Responsibilities to the Social Work Profession

- ✓ **Integrity:** Social workers strive to maintain and promote high standards of practice. Social workers protect the integrity of the profession through study and research, active discussion, and responsible criticism of the profession. Social workers strive to prevent unauthorized and unqualified practice.
- ✓ **Evaluation:** Social workers evaluate policies, the implementation of programs, and practice interventions while contributing to the development of knowledge. Social workers engaged in evaluation or research obtain informed consent from participants and protect confidentiality.

1i. Social Worker's Ethical Responsibilities to the Broader Society

- ✓ **Social Welfare:** Social workers promote the general welfare of society, from local to global levels, and the development of people, their communities, and their environments. Social workers promote living conditions conducive to the fulfillment of basic human needs as well as social, economic, political, and cultural values.
- ✓ **Participation:** Social workers facilitate informed participation by the public in shaping social policies and institutions.
- ✓ **Emergencies:** Social workers provide services in public emergencies.
- ✓ **Social and Political Involvement:** Social workers engage in social and political action that seeks to ensure that all people have equal access to the resources, employment, services,

and opportunities they require to meet their basic human needs and to develop fully. Social workers advocate conditions that encourage respect for cultural and social diversity while striving to prevent and eliminate domination of, exploitation of, and discrimination against any person, group, or class on the basis of race, ethnicity, national origin, color, sex, sexual orientation, gender identity or expression, age, marital status, political belief, religion, immigration status, or mental or physical disability.

1j. Application of Social Work Ethical Principles to Guide Professional Practice Approaches

Social workers have an obligation to conduct themselves ethically and to engage in ethical decision making. Social workers are knowledgeable about the value base of the profession, its ethical standards and relevant law.

Knowledge

- Have a strong working knowledge of how the NASW Code of Ethics supports health equity.
- Understand the basic principles and concepts of equity and health.
- Understand the Universal Declaration of Human Rights, and, as applicable, the IFSW/ IASSWE Ethics in Social Work.
- Have a basic knowledge of ethical principles from related behavioral health disciplines.

Practice Behaviors

Social workers will:

Manage personal values in a way that allows professional values to guide practice.

- Apply social work values and ethical principles in practice approaches to address behavioral health disparities that reflect health and wellness as a social justice and human rights issue.
- Practice ethically, using a cultural humility and social justice practice paradigm.
- Integrate the ethical codes for practice from multiple professions when using a trans- disciplinary approach to reduce behavioral health disparities.
- Apply strategies of ethical reasoning across social and ecological systems to arrive at principled decisions towards preventing, reducing and eventually eliminating behavioral health disparities.

2. Suspected Abuse Reporting and Client Safety

Elder Abuse

Elder mistreatment includes intentional or neglectful acts by a caregiver or trusted person that harm a vulnerable older person. It can occur in a variety of settings. One out of 10 older adults experiences some form of abuse or neglect by a caregiver each year, and the incidence is expected to increase. Although the U.S. Preventive Services Task Force found insufficient evidence that screening for elder abuse reduces harm, physicians in most states have professional

and legal obligations to appropriately diagnose, report, and refer persons who have been abused. Screening or systematic inquiry can detect abuse. A detailed medical evaluation of patients suspected of being abused is necessary because medical and psychiatric conditions can mimic abuse. Signs of abuse may include specific patterns of injury. Interviewing patients and caregivers separately is helpful. Evaluation for possible abuse should include assessment of cognitive function. The Elder Abuse Suspicion Index is validated to screen for abuse in cognitively intact patients. A more detailed two-step process is used to screen patients with cognitive impairment. The National Center on Elder Abuse website provides detailed, state-specific reporting and resource information for family physicians.

The National Center on Elder Abuse defines elder abuse as “intentional or neglectful acts by a caregiver or ‘trusted’ individual that lead to, or may lead to, harm of a vulnerable elder.”¹ Although some authors draw distinctions among mistreatment, abuse, and neglect, this article uses the terms inclusively and interchangeably.

Abuse appears to occur most often in domestic home situations, and may be perpetrated by adult caregivers, family members, or other persons.³ It may also occur in institutional settings such as long-term care facilities, nursing homes, or hospice.^{4,5} Older patients (older than 75 years) tend to have more risk factors (i.e., shared living arrangements, cognitive impairment with disruptive behaviors, social isolation from family and friends, caregiver mental illness [e.g., major depression], alcohol misuse, and caregiver dependency on the older person [e.g., financial]).⁶ These same risk factors can be barriers to detection of abuse. Not all patients who experience abuse readily demonstrate or express risk factors, and, conversely, many patients with risk factors are not being mistreated.

A Growing Problem

Over the next 20 years, the geriatric proportion of the U.S. population is projected to increase from 12% to 31%.^{10–12} Family physicians can expect more instances of elder abuse because larger numbers of older persons will need medical care. As more states mandate reporting by physicians (most already do), there will be increasing obligations for detection and assessment. Despite this expected increased demand for expertise, physicians generally lack training, experience, education, and adequate guidelines for the assessment and management of abuse. Less than 2% of reports of elder abuse and neglect to state APS agencies come from physicians. A survey of family physicians and internists found that more than 80% of them could not recall any medical school or residency training in this area. Another survey showed that 44% of residency program directors report actively screening patients for elder abuse.

Screening

The U.S. Preventive Services Task Force found that current evidence is insufficient to assess the balance of harms and benefits of screening all older or vulnerable adults for abuse and neglect. At this time, there does not appear to be supportive evidence that screening and early detection of elder abuse and neglect reduce exposure to abuse, or physical or mental harm from abuse. The Joint Commission, National Center on Elder Abuse, National Academy of Sciences, and

American Academy of Neurology recommend routine screening, and the American Medical Association recommends routine inquiry. Identification of and intervention in abuse are considered by many to be a professional responsibility for physicians and are an accreditation requirement for hospitals. The University of Maine Center on Aging, Maine Partners for Elder Protection recommends screening once or twice yearly.

It is not clear if using specific screening protocols decreases the incidence or impact of elder abuse any more than simply having a generally increased threshold of suspicion.⁵ Validated screening instruments are available for physicians to consistently and systematically inquire about abuse. If a family physician chooses, preventive health visits may function as a reasonable occasion for screening.

THE ELDER ABUSE SUSPICION INDEX

Few instruments designed to detect risk of or suspected abuse have been validated in primary care settings. The Elder Abuse Suspicion Index (EASI) was validated in a primary care setting and can be used by physicians to screen cognitively intact patients during routine visits (Figure 1). It has a sensitivity of 0.47 and a specificity of 0.75. The EASI includes five patient-answered items, plus one physician question that can identify patients who are at risk. At least one “yes” response to questions 2 through 6 indicates a need for further assessment.

The Elder Abuse Suspicion Index (EASI).

Screening older patients for mistreatment may follow a one- or two-step process, depending on the patient's level of cognitive function. When the physician has known a normally functioning, cognitively intact patient over time, one-step screening using the EASI is recommended. When the physician does not know the patient or suspects dementia, the two-step process begins with screening for cognitive impairment with the Mini-Cog. It can be administered in less than five minutes and has comparable sensitivity and specificity to the well-known Mini-Mental State Examination. If the Mini-Cog is negative for dementia, the physician may administer the EASI. If the Mini-Cog is positive, further assessment should clarify cognitive impairment before screening for abuse. Cognitive deficits may be limited to specific domains, and a patient may retain memory and capacity in others.

Physical Signs of Abuse

Physical findings specific to abuse are rare. Patterns of injury such as ligature marks; multiple burns; and bruises on the abdomen, neck, posterior legs, or medial arms do not generally originate from unintentional trauma such as falls. Physicians might not be able to accurately determine the age of bruises or burns; however, particular sizes, patterns, and locations may suggest intentional injury. The presence of unusual or unexplained fractures (e.g., spiral long bone fractures, first rib fractures) requires a more thorough skeletal survey and evaluation for metabolic bone disease.

Signs and Symptoms of Possible Elder Abuse or Neglect

- Bruising in unusual locations (not over bony prominences; on lateral arms, face, or back;

larger than 5 cm).

- Burns in patterns inconsistent with unintentional injury or with the explanation provided (e.g., stocking or glove pattern, suggesting forced immersion).
- Decubitus ulcers, unless the result of unavoidable decline.
- Dehydration, fecal impaction.
- Evidence of sexual abuse.
- Soft tissue injuries.
- Malnutrition, medically unexplained weight loss.
- Missing medications.
- Patterned injuries such as hand slap or bite marks; ligature marks or scars around wrists, ankles, or neck suggesting inappropriate restraint.
- Poor control of medical problems despite a reasonable medical plan and access to medication.
- Hemorrhage.
- Traumatic alopecia or scalp swelling.
- Unexplained fractures.
- Unusual delay in seeking medical attention for injuries.
- Urine burns (similar to severe diaper rash), dirty clothing, or other signs of inattention to hygiene

Management and Intervention

Depending on the acuity of the presentation, hospitalization may be necessary to provide treatment and protection during further evaluation or pending legal investigation. In the case of positive results on screening tests or other suspicion of abuse, actions are dictated by statutory reporting requirements. Family physicians will need to involve local social services and APS to determine options for disposition.

No consensus exists for a single standard algorithm for the evaluation and management of elder abuse. However, the general algorithm provided in Figure 2 is acceptable for most practice settings. Physicians may insert the statutory requirements for their practice location into the appropriate sections. A safety plan is an important element of the care plan in all situations.

Management of Suspected Elder Abuse

Algorithm for the management of suspected elder abuse. (EASI = Elder Abuse Suspicion Index.)

Safety Plan for Older Patients Who Have Been Abused

A safety plan helps identify options for the patient and provides ideas to increase his or her safety. Each plan should be individualized, written down, stored in a safe place, and reviewed regularly by the physician, the patient, and a trusted friend or family member. A safety plan may include:

- Safe places to go, such as the home of a friend or family member, a shelter, or the hospital.
- Strategies for reducing harm if the patient is going to continue to have contact with the abuser.

- A checklist of essential items to keep together in a safe place.
- Telephone numbers of family, friends, community organizations, and emergency service providers.
- Special considerations, such as transportation needs, if the patient lives in a rural area.
- A follow-up appointment with the family physician or referrals to other services

The Administration on Aging's National Center on Elder Abuse website (<http://www.ncea.aoa.gov>) is the most comprehensive online resource available on elder abuse. It provides specific information on each state's laws defining elder abuse and mandatory reporting requirements; information on local contact agencies and numbers; links for state or local intervention resources; and information for caregivers and patients. Specific resources for each state are also available weekdays via the Eldercare Locator (telephone: 800-677-1116). Even when APS or law enforcement becomes involved, family physicians still bear significant responsibility for follow-up medical care of patients. Relationship continuity can support the patient and family in the process of healing and recovery.

Elder Abuse Assessment and Reporting

Throughout the past three decades, significant progress has been made in increasing awareness of abusive relationships. Nonetheless, child abuse and domestic violence continue to receive more recognition than elder abuse and more attention in both public and medical settings. Due to the growing number of older Americans, the number of elder abuse cases will increase. The impact of elder abuse as a public health issue will likely grow in the future. Abuse victims have twice as many physician visits compared with the general US population.

Elder abuse encompasses a range of behaviors, events, and circumstances. Elder abuse usually consists of repetitive incidences including any act of commission or omission that result in harm or threatened harm to the health and welfare of an older adult. The US National Academy of Sciences defines elder abuse as follows: “Intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended), to a vulnerable elder by a caregiver or other person who stands in a trusted relationship to the elder. Failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm”.

However, terms may vary among professionals and researchers, and usage is not consistent in the laws of different states. For example, the age at which a person is considered elderly, usually 60 or 65 years, varies. Seven categories of elder abuse have been described by the National Center on Elder Abuse (NCEA) including:

- “Physical abuse - Any act of violence that causes pain, injury, impairment, or disease, including striking, pushing, force-feeding, and improper use of physical restraints or medication
- Emotional or psychological abuse - Conduct that causes mental anguish including threats, verbal or nonverbal insults, isolation, and humiliation. Some legal definitions require identification of at least 10 episodes of this type of behavior within a single year to constitute

abuse.

- Financial or material exploitation - Misuse of an elderly person's money or assets for personal gain. Acts such as stealing (money, social security checks, possessions) or coercion (changing a will, assuming power of attorney) constitute financial abuse.
- Neglect - Failure of a caretaker to provide for the patient's basic needs. As in the previous examples of abuse, neglect can be physical, emotional, or financial. Physical neglect is failure to provide eyeglasses or dentures, preventive health care, safety precautions, or hygiene. Emotional neglect includes failure to provide social stimulation (leaving an older person alone for extended periods). Financial neglect involves failure to use the resources available to restore or maintain the well-being of the aging adult.
- Sexual abuse - Nonconsensual intimate contact or exposure or any similar activity when the patient is incapable of giving consent. Family members, friends, institutional employees, and fellow patients can commit sexual abuse.
- Self-neglect - Behavior in which seniors compromise their own health and safety, as when an aging adult refuses needed help with various daily activities. When the patient is deemed competent, many ethical questions arise regarding the patient's right of autonomy and the physician's oath of beneficence.
- Abandonment - The desertion of an elderly person by an individual who has assumed responsibility for providing care for an elder, or by a person with physical custody of an elder.”

(Source: National Center on Elder Abuse (NCEA))

Occurrence

A report from the National Research Council suggests that 1-2 million Americans age 65 years or older have been injured, exploited, or otherwise mistreated. Other studies suggest that 3-10% of elders are abused or neglected. Several variables contribute to the underestimation of abused elders including fear, shame, guilt, and/or lack of information. A variety of professionals underreport elder abuse due to lack of recognition and awareness of reporting requirements. A significant amount of research excludes specific demographics such as persons unable to respond to a survey, speakers of languages other than English, and persons with mental illness. Studies have shown that only 1 in 6 victims are likely to self-report mistreatment to the appropriate legal authorities.

Elder physical abuse victims, caregiver neglect, or self-neglect have triple the mortality of those never abused. Proactive detection and intervention by professionals could potentially lead to decreased mortality.

Race

Elder abuse exists throughout all racial, socioeconomic, and religious backgrounds. The NCEA found the following racial and ethnic distribution among older persons who had been abused:

White, non-Hispanic – 66.4%

Black – 18.7%

Hispanic – 10%

Other – 4.9%

Gender

Women are believed to be the most common victims of abuse, perhaps because they report abuse at higher rates or because the severity of injury in women typically is greater than in men.

Numerous studies, however, have found no differences based on sex.

Age

By definition, elder abuse occurs in the elderly, although there is no universally accepted definition of when old age begins. Typically, 60 or 65 years is considered the threshold of old age.

Risk factors of elder abuse include:

- Shared living situation with abuser, likely due to an increased opportunity for contact
- Dementia
- Social isolation
- Pathologic characteristics of perpetrators such as mental illness and alcohol misuse

It would be helpful for providers to consider these "red flags" while providing services for the elderly. The presence of red flags is an indicator that a more in-depth history and/or assessment are necessary. While evaluating a client for possible elder abuse, the provider may want to consider simple and direct questions which are posed in a nonjudgmental or nonthreatening manner. It is also helpful to interview the patient and caregiver both together and separately to detect disparities offering clues to the diagnosis of abuse. Accurate and objective documentation of the interview is important partially because findings may be entered as evidence in criminal trials or in guardianship hearings. Documentation must be complete, thorough, and legible. It is helpful to quote direct statements made by the client.

Physical

In a systematic summary of the published work on forensic markers of elder abuse with respect to physical findings, there is a paucity of primary data.

Most research on clinical findings purported to be common in elder abuse derives from anecdotes, case reports, or small case series. Although not guided strongly by evidence, a number of clinical findings and observations make elder abuse a strong possibility, including the following:

- Several injuries in various stages of evolution

- Unexplained injuries
- Delay in seeking treatment
- Injuries inconsistent with history
- Contradictory explanations given by the patient and caregiver
- Laboratory findings indicating under dosage or over dosage of medications
- Bruises, welts, lacerations, rope marks, burns
- Venereal disease or genital infections
- Dehydration, malnutrition, decubitus ulcers, poor hygiene
- Signs of withdrawal, depression, agitation, or infantile behavior

Causes

Many theories have been developed to explain abusive behavior toward elderly people. Clearly, no single answer exists to explain behavior in an abusive relationship. A number of psychosocial and cultural factors are involved.

Theories of the origin of mistreatment of elders have been divided into 4 major categories, as follows: physical and mental impairment of the patient, caregiver stress, trans-generational violence, and psychopathology in the abuser.

Physical and mental impairment of the patient

- Recent studies have failed to show direct correlation between patient frailty and abuse, even though it had been assumed that frailty itself was a risk factor for abuse.
- Physical and mental impairment nevertheless appear to play an indirect role in elder abuse, decreasing seniors' ability to defend themselves or to escape, thus increasing vulnerability.

Caregiver stress

- This theory suggests that elder abuse is caused by the stress associated with caring for an elderly patient, compounded by stresses from the outside world.
- The effect of stress factors (e.g., alcohol or drug abuse, potential for injury from falls, incontinence, elderly persons' violent verbal behavior, employment problems, low income on the part of the abuser) may all culminate in caregivers' expressions of anger or antagonism toward the elderly person, resulting in violence.
- This theory, however, does not explain how individuals in identically stressful situations manage without abusing seniors in their care. Stress should be seen more as a trigger for abuse than as a cause.

Trans-generational violence: This theory asserts that family violence is a learned behavior that is passed down from generation to generation. Thus, the child who was once abused by the parent continues the cycle of violence when both are older.

Psychopathology in the abuser: This theory focuses on a psychological deficiency in the development of the abuser. Drug and alcohol addiction, personality disorders, mental retardation, dementia, and other conditions can increase the likelihood of elder abuse. In fact, family members with such conditions are most likely to be primary caretakers for elderly relatives because they are the individuals typically at home due to lack of employment.

Other risk factors in abuse are (1) shared living arrangements between the elder person and the abuser, (2) dependence of the abuser on the victim, and (3) social isolation of the elder person.

A mandated reporter must report a known or suspected instance of elder or dependent adult abuse when, in his or her professional capacity, or within the scope of his or her employment, he or she (1) has observed or has knowledge of an incident that reasonably appears to be physical abuse, neglect, financial abuse, abandonment, abduction, or isolation; (2) is told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, neglect, financial abuse, abandonment, abduction, or isolation; or (3) reasonably suspects abuse.

Optional Reports: Mandated reporters may report a known or suspected instance of elder or dependent adult abuse when they have knowledge of or reasonably suspect that a form of elder or dependent adult abuse for which a report is not mandated has been inflicted upon an elder or dependent adult or that the elder or dependent adult's emotional well-being is threatened in any other way.

- Definition of Elder: An “elder” is a person who is age 65 years or older.
- Definition of Dependent Adult: a dependent adult is a person, between the ages of 18 years and 64 years, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights.

Mandated reporters, including therapists, are now required to report the following:

- Known and reasonably suspected physical abuse of an elder or dependent adult.
- Instances of known and reasonably suspected neglect, financial abuse, abandonment, abduction, and/or isolation of an elder or dependent adult, and any other treatment that results in physical harm, pain, or mental suffering.

As a mandated reporter, a social worker is required to make a report of known or suspected elder or dependent adult abuse when, in his or her professional capacity, or within the scope of his or her employment, he or she has observed or has knowledge of an incident that reasonably appears to be abuse, is told by an elder or dependent adult that he or she has experienced behavior constituting abuse; and/or reasonably suspects abuse.

Abuse of an elder or dependent adult includes the following categories: Physical abuse, neglect, financial abuse, abandonment, abduction, isolation, and any other form of treatment that results in physical harm, pain, or mental suffering. Mental suffering may consist of fear, confusion, severe depression, agitation, or other serious emotional distress caused by threats, harassment, or other forms of intimidating behavior.

Physical Abuse includes assault, assault with a deadly weapon or with force likely to cause great bodily injury; battery; sexual assault, unreasonable physical restraint; prolonged or continual deprivation of water or food; and the use of physical or chemical restraint for punishment, for a period of time beyond that for which the medication was ordered through instructions from a licensed physician or surgeon caring for the elder or dependent adult, and/or for any purpose not authorized by the elder or dependent adult’s physician or surgeon.

Neglect refers to the negligent failure of any person having the care or custody of an elder or dependent adult to exercise that degree of care that a reasonable person in a similar position would provide. Neglect also includes self-neglect, the negligent failure of an elder or dependent adult to provide a reasonable degree of care to himself or herself.

Specific examples of neglect include the failure to assist in personal hygiene or in the provision of food, clothing, or shelter as well as the failure to provide medical care for physical or mental health needs and the failure to prevent malnutrition or dehydration.

Financial Abuse means concealing, taking, or appropriating an elder or dependent adult's property or money to any wrongful use or with the intent to defraud. Abandonment, desertion or willful abandonment by a person having the care or custody of the elder or dependent adult person under circumstances in which a reasonable person would continue to provide care and custody. Isolation, deliberately preventing an elder or dependent adult from receiving his or her mail or phone calls, false imprisonment; and/or the physical restraint of an elder or dependent adult for the purpose of preventing him or her from meeting with his or her visitors. Reports of known or reasonably suspected elder or dependent adult abuse must be filed by telephone immediately or as soon as practically possible. A written report must then be sent within two working days.

Reporters should generally make reports to their county's adult protective agency or a local law enforcement agency. There are two exceptions to this, however: First, if the abuse occurred in a state mental health hospital or state developmental center, the report should be made to designated investigators of the State Department of Mental Health or the State Department of Developmental Services or to the local law enforcement agency. Second, if the abuse occurred in a long-term care facility (other than a state mental hospital or a state developmental center), reports should be made to the local ombudsman or to the local law enforcement agency. Any person legally required to report elder or dependent adult abuse who knowingly fails to report can be found guilty of a misdemeanor that is punishable by not more than six months in the county jail or a fine not to exceed \$1,000 or both imprisonment and a fine. A therapist who fails to make a timely mandated elder or dependent adult abuse report may also face disciplinary action by their governing board and civil action for damages.

The law provides that no person required making a report of elder or dependent adult abuse shall be criminally or civilly liable for such a report, as long as it cannot be proven that the report was made falsely.

Elder Abuse Resources

Please find all of the following links at the National Center for Elder Abuse here <http://www.centeronelderabuse.org/resources.asp>

Government

Administration on Aging (AoA) on Elder Rights and Resources
Administration on Aging Strategic Action Plan 2007-2012 (PDF) April 2007
Clearinghouse on Abuse and Neglect of the Elderly (NCEA)
Consumer Finance Protection Bureau
National Long Term Care Ombudsman Resource Center (NORC)
National Adult Protective Services Association (NAPSA)
National Association of States United for Aging and Disabilities (NASUA)
National Center on Elder Abuse (NCEA)
Office for Victims of Crime (OVC)
Office on Violence Against Women (OVW)

Directory of Regional Centers (Department of Developmental Services)

Adult Protective Services Training Academy: Bay Area Academy
Archstone Foundation Elder Abuse & Neglect
California Social Work Education Center (CalSWEC) Aging Initiative
California Elder Justice Coalition (click CEJC)
California Council on Geriatrics and Gerontology (CCGG)
Archstone Foundation Fault Lines in the Shifting Landscape

Child Abuse

The criteria in identifying suspected child abuse and when a mandatory reporter should report varies among states. Typically, a report must be made when the reporter, in his or her official capacity, *suspects* that a child has been abused. Another standard frequently used is when the reporter has knowledge of, or observes a child being subjected to, conditions that would reasonably result in harm to the child (*Source: Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse'*)

State Reporting Laws

All 50 States and the District of Columbia have statutes that protect children from abuse and neglect by their parents or others. There are criminal statutes prohibiting certain acts (or failures to act), violation of which may lead to imprisonment. There are also civil statutes that prohibit abuse and neglect. If these statutes are violated, the court may impose requirements that parents accept certain kinds of help (such as substance abuse treatment, parenting classes, or anger management training), that their children be removed from the home, or that their parental rights be terminated (*Source: SAMHSA*)

Most States define abuse as an act or failure to act that result in non-accidental physical injury or

sexual abuse of a child. Neglect generally includes the denial of adequate food, shelter, supervision, clothing, or medical care when such resources or services are available. Each state defines abuse and neglect differently, and the conditions considered to be neglect or abuse in one state may not be the same in others. Because state law often requires that treatment providers report suspected abuse and neglect, treatment staff should become familiar with their state's definitions of abuse and neglect. Staff can contact the State's CPS agency for information on current laws. (If the abuse occurred in another state, or if the perpetrator is currently living in another state, it is wise to check on the laws in the other state to ensure compliance. At times, there may be a need to report in both states.) Readers can also find state statutory child abuse and neglect definitions on the Internet at <http://www.calib.com/nccanch/services/statutes.htm>. Federal definitions of these terms appear in the Child Abuse Prevention and Treatment Act, 42 U.S.C. §5106(g). In some cases, the CPS agency can be consulted regarding whether or not a report must be made in a particular situation without divulging confidential (i.e., identifying) information. Consultation with the CPS agency must be done with great care, and this communication can be noted in the client's chart (*Source: SAMHSA*).

Although each state's laws are different, the following conditions are reportable in most states:

- The child has been seriously physically injured by a parent or other adult by other than accidental means.
- The child appears injured or ill to the point that a reasonable person would seek medical attention, but the parent has not sought medical attention, refuses to consider it, or fails to follow medical advice, putting the child at risk.
- An adult has sexually touched (or made the child sexually touch the adult), abused, or exploited the child.
- The child is not registered for or attending school, and the parent refuses to remedy the situation (home schooling must be adequately documented).

Although the behaviors outlined above are the most blatant examples of child abuse or neglect, other parental behaviors or practices may put children at risk. For example, the following may also constitute child abuse or neglect:

- Leaving a young child alone and unsupervised
- Inappropriate punishment that puts a child at risk (e.g., locking a young child out of the house as a punishment)
- Depriving a young child of food for an extended period of time
- Treating one child, the "bad one," far more harshly than others

Whether behaviors like these are reportable depends, in part, on how State statutes define abuse and neglect, the seriousness of the behavior or incident, its impact on the child, and the counselor's perception of the client's overall behavior with the child and of the client's willingness to correct inappropriate behavior (*Source: SAMSHA*).

Mandated reporters are those who, in the course of their work and because they have regular

contact with children, are required to make a suspected child abuse report whenever physical, sexual or other types of abuse has been observed or is suspected, or when there is evidence of neglect, knowledge of an incident, or an imminent risk of serious harm. Abuse occurs when a victim has suffered physical injury inflicted other than by accidental means, has injuries, or is in a condition resulting from mistreatment, such as malnutrition, sexual molestation or exploitation, deprivation of necessities, emotional abuse or cruelty. Neglect may be defined as abandonment, denial of proper care and attention physically, emotionally, or morally, or living under conditions, circumstances or associations injurious to well-being (*Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse'*).

Mandated reporters also include persons who have assumed full or intermittent responsibility for the care or custody of a child, dependent adult, or elder, whether or not they are compensated for their services. The report must be made to a "child protective agency." Including a county welfare or probation department or a police or sheriff's department. Exceptions are reports by commercial print and photographic print processors, which are made to the law enforcement agency having jurisdiction. The mandated reporter must report the known or suspected incidence of child abuse to a child protective agency immediately or as soon as practically possible by telephone (*Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse'*).

The identity of all reporters is considered confidential and is disclosed only between child protective agencies. Mandated reporters have immunity from criminal and civil liability for reporting as required. Any other person who reports a known or suspected case of child abuse is also protected from civil and criminal liability, unless it can be proven that the person deliberately made a false report. The Child Abuse Reporting Law takes precedence over laws governing the psychotherapist-patient privilege. A failure to report known or suspected child abuse when mandated to do so is considered a misdemeanor and is punishable by a term in jail not to exceed six months or by a fine not to exceed \$1,000 or by both (*Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse'*).

RAINN maintains a database of mandatory reporting regulations regarding children and the elderly by state, including who is required to report, standards of knowledge, definitions of a victim, to whom the report must be made, information required in the report, and regulations regarding timing and other procedures.

Summary of State Laws

Alabama

Professionals Required to Report: Doctors, medical examiners, dentists, nurses, or pharmacists, school teachers or officials, law enforcement officials, daycare workers or social workers, members of the clergy, and any other person called upon to render aid or medical assistance to a child

Reporting by Other Persons: Any other person who has reasonable cause to suspect that a child is being abused or neglected may report.

Standards for Making a Report: A report must be made when the child is known or suspected of being a victim of abuse or neglect.

Privileged Communications: Only the clergy-penitent and attorney-client privileges are permitted.

Inclusion of Reporter's Name in Report: Not specifically required by statute
Disclosure of Reporter Identity. The department will not release the identity of the reporter except under court order when the court has determined that the reporter knowingly made a false report.

Alaska

Professionals Required to Report: Health practitioners, administrative officers of institutions, school teachers and administrators, childcare providers, social workers, paid employees of domestic violence and sexual assault programs, and crisis intervention and prevention programs; paid employees of organizations that provide counseling or treatment to individuals seeking to control their use of drugs or alcohol, peace officers; officers of the Department of Corrections, persons who process or produce visual or printed matter, either privately or commercially, members of a child fatality review team or the multidisciplinary child protection team

Mandated reporters may report cases that come to their attention in their non-occupational capacities: Any other person who has reasonable cause to suspect that a child has been harmed may report.

Standards for Making a Report: When, in the performance of their occupational duties, they have reasonable cause to suspect that a child has suffered harm as a result of abuse or neglect, when they have reasonable cause to suspect that visual or printed matter depicts a child engaged in the unlawful exploitation of a minor.

Privileged Communications: Neither the physician-patient nor the husband-wife privilege is recognized.

Inclusion of Reporter's Name in Report: Not specifically required by statute
disclosure of reporter identity not addressed in statutes reviewed

Arizona

Professionals Required to Report: Physicians, physician's assistants, optometrists, dentists, behavioral health professionals, nurses, psychologists, counselors or social workers, peace officers, members of the clergy, priests, or Christian Science practitioners
parents, stepparents, or guardians, school personnel or domestic violence victim advocates, and any other person who has responsibility for the care or treatment of the minor.

Reporting by Other Persons: Any other person who reasonably believes that a minor is a victim of abuse or neglect may report.

Standards for Making a Report: When they reasonably believe that a minor is a victim of abuse or neglect

Privileged Communications: Only the attorney-client and the clergy-penitent privileges are recognized.

Inclusion of Reporter's Name in Report: Not specifically required by statute

Disclosure of Reporter Identity: Not addressed in statutes reviewed

Arkansas

Professionals Required to Report: Physicians, surgeons, osteopaths, resident interns, coroners, dentists, nurses, or medical personnel, teachers, school officials or counselors, daycare center workers, childcare workers, foster care workers, social workers, foster parents, or department employees, mental health professionals, domestic violence shelter employees or volunteers, law enforcement personnel, peace officers, prosecuting attorneys, domestic abuse advocates, judges, Court Appointed Special Advocate (CASA) program staff or volunteers, juvenile intake or probation officers, any members of clergy, including ministers, priests, rabbis, accredited Christian Science practitioners, or other similar functionary of a religious organization

Reporting by Other Persons: Any other person with reasonable cause to suspect child maltreatment may report.

Standards for Making a Report: When they have reasonable cause to suspect child maltreatment. When they have observed the child being subjected to conditions or circumstances that would reasonably result in child maltreatment.

Privileged Communications: No privilege is granted except the attorney-client and clergy-penitent (including a Christian Science practitioner).

Inclusion of Reporter's Name in Report: Not specifically required in statute

Disclosure of Reporter Identity: The identity of the reporter shall not be disclosed unless a court determines that the reporter knowingly made a false report.

California

Professionals Required to Report: Penal Code 11166; 11165.7: Teachers, teacher's assistants, administrative officers, certificated pupil personnel employees of any public or private school administrators and employees of public or private day camps, youth centers, youth recreation programs, or youth organizations, employees of childcare institutions, including, but not limited to, foster parents, group home personnel, and personnel of residential care facilities. Social workers, probation officers, or parole officers. Any person who is an administrator or a counselor

in a child abuse prevention program in any public or private school. District attorney investigators, peace officers, firefighters, except for volunteer firefighters. Physicians, surgeons, psychiatrists, psychologists, dentists, licensed nurses, dental hygienists, optometrists, marriage counselors, family and child counselors and clinical social workers. Emergency medical technicians I or II or paramedics, state or county public health employees, coroners or medical examiners, commercial film and photographic print processors, child visitation monitors, animal control officers or humane society officers, clergy members, which includes priests, ministers, rabbis, religious practitioners, or similar functionary of a church, temple, or recognized denomination or organization. Any custodian of records of a clergy member. Employees or volunteers of Court Appointed Special Advocate programs

Reporting by Other Persons: Penal Code 11166: Any other person who reasonably suspects that a child is a victim of abuse or neglect may report.

Standards for Making a Report: Penal Code 11166; 11165.7

When in his or her professional capacity, he or she has knowledge of or observes a child whom the reporter knows or reasonably suspects is the victim of abuse or neglect. Commercial film and photographic print processors when they have knowledge of or observe any film, photograph, videotape, negative, or slide depicting a child under the age of 16 years engaged in an act of sexual conduct.

Privileged Communications: Penal Code 11166: Only the clergy-penitent privilege is permitted.

Inclusion of Reporter's Name in Report: Penal Code 11167: Reports of mandated reporters shall include: The name, business address, and telephone number of the mandated reporter; The capacity that makes the person a mandated reporter; Reports of other persons do not require the reporter's name.

Disclosure of Reporter Identity: Penal Code 11167: The identity of the reporter shall be confidential, and shall be disclosed only to agencies investigating the report, when the person waives confidentiality, and/or by court order

Colorado

Professionals Required to Report: Physicians, surgeons, physicians in training, child health associates, medical examiners, coroners, dentists, osteopaths, optometrists, chiropractors, podiatrists, nurses, hospital personnel, dental hygienists, physical therapists, pharmacists, registered dietitians, public or private school officials or employees, social workers, Christian Science practitioners, mental health professionals, psychologists, professional counselors, marriage and family therapists, veterinarians, peace officers, firefighters, or victim's advocates, commercial film and photographic print processors, counselors, marriage and family therapists, or psychotherapists, clergy members, including priests; rabbis; duly ordained, commissioned, or licensed ministers of a church; members of religious orders; or recognized leaders of any religious bodies, and workers in the state department of human services

Reporting by Other Persons: Any other person may report known or suspected child abuse or neglect.

Standards for Making a Report: When they have reasonable cause to know or suspect child abuse or neglect, when they have observed a child being subjected to circumstances or conditions that would reasonably result in abuse or neglect. Commercial film and photographic print processors when they have knowledge of or observe any film, photograph, videotape, negative, or slide depicting a child engaged in an act of sexual conduct.

Privileged Communications: 19-3-304; 19-3-311, the clergy-penitent privilege is permitted. The physician-patient, psychologist-client, and husband-wife privileges are not allowed as grounds for not reporting.

Inclusion of Reporter's Name in Report: 19-3-307, the report shall include the name, address, and occupation of the person making the report.

Disclosure of Reporter Identity: 19-1-307, the identity of the reporter shall be protected.

Connecticut

Professionals Required to Report: 17a-101, physicians or surgeons, nurses, medical examiners, dentists, dental hygienists, physician assistants, pharmacists, or physical therapists, psychologists or other mental health professionals, school teachers, principals, guidance counselors, or coaches, social workers, police officers, juvenile or adult probation officers, or parole officers, members of the clergy, alcohol and drug counselors, marital and family therapists, professional counselors, sexual assault counselors, or battered women's counselors, emergency medical services providers, any person paid to care for a child in any public or private facility, child daycare center, group daycare home, or family daycare home that is licensed by the State Employees of the Department of Children and Families and the Department of Public Health who are responsible for the licensing of child daycare center, group daycare homes, family daycare homes, or youth camps, the Child Advocate and any employee of the Office of Child Advocate.

Reporting by Other Persons: 17a-103, any mandated reporter acting outside his or her professional capacity or any other person having reasonable cause to suspect that a child is being abused or neglected may report.

Standards for Making a Report: 17a-101a, when, in the ordinary course of their employment or profession, they have reasonable cause to suspect or believe that a child has been abused or neglected.

Inclusion of Reporter's Name in Report: 17a-101d; 17a-103, the reporter is not specifically required by statute to include his or her name in the report. The Commissioner shall use his or her best efforts to obtain the name and address of the reporter.

Disclosure of Reporter Identity: 17a-28, the identity of the reporter shall not be released to the subject of the report unless there is reasonable cause to believe that the reporter knowingly made a false report.

Delaware

Professionals Required to Report: Tit. 16, 903, physicians, dentists, interns, residents, osteopaths, nurses, or medical examiners, school employees, social workers or psychologists.

Reporting by Other Persons: Tit. 16, 903, any person who knows or in good faith suspects child abuse or neglect shall make a report.

Standards for Making a Report: Tit. 16, 903, when they know or in good faith suspect child abuse or neglect.

Privileged Communications: Tit. 16, 909, only the attorney-client and clergy-penitent privileges are recognized.

Inclusion of Reporter's Name in Report: Tit. 16, 905, although reports may be made anonymously, the division shall request the name and address of any person making a report.

Disclosure of Reporter Identity: Not addressed in statutes reviewed.

Florida

Professionals Required to Report: 39.201, physicians, osteopaths, medical examiners, chiropractors, nurses, or hospital personnel, other health or mental health professionals, practitioners who rely solely on spiritual means for healing, school teachers or other school officials or personnel, social workers, daycare center workers, or other professional childcare, foster care, residential, or institutional workers, law enforcement officers or judges.

Reporting by Other Persons: 39.201, any person who knows or has reasonable cause to suspect that a child is abused, abandoned, or neglected shall report.

Standards for Making a Report: 39.201, when they know or have reasonable cause to suspect that a child is abused, abandoned, or neglected.

Privileged Communications: 39.204, only the attorney-client and clergy-penitent privileges are permitted.

Inclusion of Reporter's Name in Report: 39.201, the professionals who are mandated reporters are required to provide their names to hotline staff.

Disclosure of Reporter Identity: 39.201; 39.202, the names of reporters are held confidential and may be released only: To the department, the central abuse hotline, law enforcement, or the

appropriate State attorney (if the reporter consents to release in writing).

Georgia

Professionals Required to Report: 19-7-5; 16-12-100, physicians, hospital and medical personnel, podiatrists, dentists, or nurses, school teachers, administrators, guidance counselors, school social workers, or psychologists, counselors, social workers, or marriage and family therapists, child welfare agency personnel (including any child-caring institution, child-placing agency, maternity home, family daycare home, group daycare home, and daycare center), child-counseling personnel, or child service organization personnel, law enforcement personnel, persons who process or produce visual or printed matter.

Reporting by Other Persons: 19-7-5, any other person who has reasonable cause to believe that a child has been abused may report.

Standards for Making a Report: 19-7-5; 16-12-100, when they have reasonable cause to believe that a child has been abused, when they have reasonable cause to believe that the visual or printed matter submitted for processing or producing depicts a minor engaged in sexually explicit conduct.

Privileged Communications: 19-7-5, no privileged communications are permitted for mandatory reporters.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 49-5-41, any release of records shall protect the identity of any person reporting child abuse.

Hawaii

Professionals Required to Report: 350-1.1, physicians, physicians in training, psychologists, dentists, nurses, osteopathic physicians and surgeons, optometrists, chiropractors, podiatrists, pharmacists, and other health-related professionals, medical examiners or coroners. employees or officers of any public or private school; childcare employees; employees or officers of any licensed or registered childcare facility, foster home, or similar institution. Employees or officers of any public or private agency or institution, or other individuals, providing social, medical, hospital, or mental health services, including financial assistance. Employees or officers of any law enforcement agency, including, but not limited to, the courts, police departments, correctional institutions, and parole or probation offices. Employees of any public or private agency providing recreational or sports activities.

Reporting by Other Persons: 350-1.3, any other person who becomes aware of facts or circumstances that cause the person to believe that child abuse or neglect has occurred may report.

Standards for Making a Report: 350-1.1, when, in their professional or official capacity, they

have reason to believe that child abuse or neglect has occurred or that there exists a substantial risk that child abuse or neglect may occur in the reasonably foreseeable future.

Privileged Communications: § 350-5, the physician-patient, psychologist-client, husband-wife, and the victim-counselor privileges are not grounds for failing to report.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 350-1.4, every reasonable good faith effort shall be made by the department to maintain the confidentiality of the name of a reporter who requests that his or her name be confidential.

Idaho

Professionals Required to Report: 16-1619, physicians, residents on hospital staffs, interns, nurses, or coroners, school teachers or daycare personnel, social workers or law enforcement personnel.

Reporting by Other Persons: 16-1619, any person who has reason to believe that a child has been abused, abandoned, or neglected is required to report.

Standards for Making a Report: 16-1619, when they have reason to believe that a child has been abused, abandoned, or neglected. When they observe a child being subjected to conditions or circumstances which would reasonably result in abuse, abandonment, or neglect.

Privileged Communications:, 16-1619; 16-1620, any privilege between a husband and wife and any professional and client, except for the clergy-penitent or attorney-client privilege, shall not be grounds for failure to report.

Inclusion of Reporter's Name in Report: Not addressed in statutes reviewed.

Disclosure of Reporter Identity: Not addressed in statutes reviewed.

Illinois

Professionals Required to Report: Ch. 325, 5/4; Ch. 720, 5/11-20.2, physicians, hospital administrators and personnel, surgeons, physician assistants, osteopaths, chiropractors, genetic counselors, dentists, coroners, medical examiners, emergency medical technicians, nurses, acupuncturists, respiratory care practitioners, or home health aides. School personnel, directors or staff of nursery schools or child daycare centers, recreational program or facility personnel, childcare workers, or homemakers. Substance abuse treatment personnel, crisis line or hotline personnel, social workers, domestic violence program personnel, psychologists, psychiatrists, or counselors, social services administrators, foster parents, or field personnel of the Illinois Department of Public Aid, Public Health, Human Services, Corrections, Human Rights, or Children and Family Services, truant officers, law enforcement officers, probation officers, funeral home directors or employees, clergy members, commercial film and photographic print

processors.

Reporting by Other Persons: Ch. 325, 5/4, any other person who has reasonable cause to believe that a child is abused or neglected may report.

Standards for Making a Report: Ch. 325, 5/4; Ch. 720, 5/11-20.2, when they have reasonable cause to believe that a child known to them in their professional capacity may be abused or neglected, commercial film and photographic print processors when they have knowledge of or observe any film, photograph, videotape, negative, or slide that depicts a child engaged in any sexual conduct.

Privileged Communications: Ch. 325, 5/4; Ch. 735, 5/8-803, the privileged quality of communication between any professional person required to report and his patient or client shall not apply to situations involving abused or neglected children and shall not constitute grounds for failure to report. A member of the clergy shall not be compelled to disclose a confession or admission made to him or her apart of the discipline of the religion.

Inclusion of Reporter's Name in Report: Ch. 325, 5/7.9, the report shall include the name, occupation, and contact information of the person making the report.

Disclosure of Reporter Identity: Ch. 325, 5/11.1a, any disclosure of information shall not identify the person making the report.

Indiana

Professionals Required to Report: 31-33-5-2. Any staff member of a medical or other public or private institution, school, facility, or agency.

Reporting by Other Persons: 31-33-5-1. Any person who has reason to believe that a child is a victim of abuse or neglect must report.

Standards for Making a Report: 31-33-5-1; 31-33-5-2. When they have reason to believe that a child is a victim of abuse or neglect.

Privileged Communications: 31-32-11-1. The following privileges are not permitted, and shall not be grounds for failing to report:

Husband-wife privilege

Health care provider-patient privilege

Therapist-client privilege between a certified social worker, certified clinical social worker, or certified marriage and family therapist and a client of any of these professionals

Any privilege between a school counselor or psychologist and a student

Inclusion of Reporter's Name in Report: 31-33-7-4. The written report must include the name and contact information for the person making the report.

Disclosure of Reporter Identity: 31-33-18-2. The identity of the reporter is protected whenever the report is made available to the subject of the report.

Iowa

Professionals Required to Report: 232.69; 728.14. Health practitioners, Social workers, school employees, certified para-educators, coaches, or instructors employed by community colleges, employees or operators of health care facilities, childcare centers, Head Start programs, family development and self-sufficiency grant programs, substance abuse programs or facilities, juvenile detention or juvenile shelter care facilities, foster care facilities, or mental health centers, employees of Department of Human services institutions, peace officers, counselors, or mental health professionals, commercial film and photographic print processors.

Reporting by Other Person: 232.69. Any other person who believes that a child has been abused may report.

Standards for Making a Report: 232.69; 728.14. When, in the scope of professional practice or their employment responsibilities, they reasonably believe that a child has been abused. A commercial film and photographic print processor who has knowledge of or observes a film, photograph, videotape, negative, or slide that depicts a minor engaged in a prohibited sexual act or in the simulation of a prohibited sexual act.

Privileged Communications: 232.74. The husband-wife or health practitioner-patient privilege does not apply to evidence regarding abuse to a child.

Inclusion of Reporter's Name in Report: 232.70. The report shall contain the name and address of the person making the report.

Disclosure of Reporter Identity: 232.71B. The department shall not reveal the identity of the reporter to the subject of the report.

Kansas

Professionals Required to Report: 38-1522. Physicians, dentists, optometrists, nurses, chief administrative officers of medical care facilities, or emergency medical services personnel, teachers, school administrators, or other school employees, licensed childcare providers, Psychologists, clinical psychotherapists, marriage and family therapists, social workers, clinical marriage and family therapists, professional counselors, or alcohol and drug abuse counselors, firefighters, mediators, law enforcement officers, or juvenile intake and assessment workers.

Reporting by Other Persons: 38-1522. Any other person who has reason to suspect that a child has been injured as a result of maltreatment may report.

Standards for Making a Report: 38-1522. When they have reason to suspect that a child has been injured as a result of maltreatment, When they know of the death of a child.

Privileged Communications: Not addressed in statutes reviewed.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 38-1507. Authorized disclosures of information shall not identify a reporter of a child in need of care.

Kentucky

Professionals Required to Report: 620.030. Physicians, osteopathic physicians, nurses, coroners, medical examiners, residents, interns, chiropractors, dentists, optometrists, emergency medical technicians, paramedics, or health professionals, teachers, school personnel, or child-caring personnel, social workers or mental health professionals, peace officers.

Reporting by Other Persons: 620.030. Any person who knows or has reasonable cause to believe that a child is dependent, neglected, or abused shall immediately report.

Standards for Making a Report: 620.030. When they know or have reasonable cause to believe that a child is dependent, neglected, or abused.

Privileged Communications: 620.050. Neither the husband-wife nor any professional-client/patient privilege, except the attorney-client and clergy-penitent privilege, shall be a ground for refusing to report.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 620.050. The identity of the reporter shall not be disclosed except: To law enforcement officials, the agency investigating the report, or to a multidisciplinary team, under court order, after a court has found reason to believe the reporter knowingly made a false report.

Louisiana

Professionals Required to Report: Children's Code art. 603. Physicians, surgeons, physical therapists, dentists, residents, interns, hospital staff members, podiatrists, chiropractors, licensed nurses, nursing aides, dental hygienists, emergency medical technicians, paramedics, optometrists, coroners, or medical examiners, psychiatrists, psychologists, marriage or family counselors, or social workers, members of the clergy, including priest, rabbi, deacons or ministers, christian science practitioners, or other similar functionary of a religious organization, teachers, childcare providers, school principals, teacher's aides, school staff members, foster home parents, or group home or other childcare institutional staff members, personnel of residential home facilities, daycare providers, or any individuals who provide such services to children, police officers, law enforcement officials, or probation officers, commercial film or photographic print processors, mediators.

Reporting by Other Persons: Children's Code art. 609. Any other person who has cause to

believe that a child's health is endangered as a result of abuse or neglect may report.

Standards for Making a Report: Children's Code art. 609; 610. When they have cause to believe that a child's health is endangered as a result of abuse or neglect, commercial film or photographic print processors when they have knowledge of or observe any film, photograph, videotape, negative, or slide depicting a child that constitutes child pornography.

Privileged Communications: Children's Code art. 603. Only the clergy-penitent privilege is permitted. No claim to privilege by other professionals is permitted.

Inclusion of Reporter's Name in Report: Children's Code art. 610. The report must include the name and address of the reporter.

Disclosure of Reporter Identity: Rev. Stat. 46:56. The identity of the reporter shall not be released unless a court finds that the reporter knowingly made a false report.

Maine

Professionals Required to Report: Tit. 22, 4011-A. Allopathic and osteopathic physicians, emergency medical services persons, medical examiners, podiatrists, physicians' assistants, dentists, dental hygienists and assistants, chiropractors, nurses, home health aides, medical or social service workers, teachers, guidance counselors, school officials, children's summer camp administrators or counselors, or childcare personnel, social workers, psychologists, or mental health professionals, Court Appointed Special Advocates, guardians ad litem, homemakers, law enforcement officials, fire inspectors, municipal code enforcement officials, or chairs of licensing boards that have jurisdiction over mandated reporters, commercial film and photographic print processors, clergy members acquiring the information as a result of clerical professional work except for information received during confidential communications, humane agents employed by the Department of Agriculture, Food and Rural Resources.

Reporting by Other Persons: Tit. 22, 4011-A. Any other person who knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected may report.

Standards for Making a Report: Tit. 22, 4011-A. When the person knows or has reasonable cause to suspect that a child is or is likely to be abused or neglected.

Privileged Communications: Tit. 22, 4011-A. A member of the clergy may claim privilege when information is received during a confidential communication.

The husband-wife and physician and psychotherapist-patient privileges cannot be invoked as a reason not to report.

Inclusion of Reporter's Name in Report: Tit. 22, 4012. The report shall include the name,

occupation, and contact information for the person making the report.

Disclosure of Reporter Identity: Tit. 22, 4008. The identity of the reporter is protected in any release of information to the subject of the report.

Maryland

Professionals Required to Report: Fam. Law 5-704. Health practitioners, educators or human service workers, police officers.

Reporting by Other Persons: Fam. Law 5-705. Any other person who has reason to believe that a child has been subjected to abuse or neglect must report.

Standards for Making a Report: Fam. Law 5-704; 5-705. When, acting in a professional capacity, the person has reason to believe that a child has been subjected to abuse or neglect.

Privileged Communications: Fam. Law 5-705. Only the attorney-client and clergy-penitent privileges are permitted.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: Not addressed in statutes reviewed.

Massachusetts

Professionals Required to Report: Ch. 119, 51A. Physicians, hospital personnel, medical examiners, emergency medical technicians, dentists, nurses, chiropractors, optometrists, or psychiatrists, teachers, educational administrators, daycare workers or persons paid to care for or work with children in facilities that provide daycare or residential services, family daycare systems and childcare food programs, or school attendance officers psychologists, social workers, licensed allied mental health and human services professionals, drug and alcoholism counselors, clinical social workers, or guidance or family counselors, probation officers, clerk or magistrates of district courts, parole officers, foster parents, firefighters or police officers, priests, rabbis, clergy members, ministers, leaders of any church or religious body, accredited christian science practitioners, persons performing official duties on behalf of a church or religious body, leader of any church or religious body, or persons employed by a church or religious body to supervise, educate, coach, train, or counsel a child on a regular basis.

Reporting by Other Persons: Ch. 119, 51A. Any other person who has reasonable cause to believe that a child is suffering from abuse or neglect may report.

Standards for Making a Report: Ch. 119, 51A. When, in his or her professional capacity, the person has reasonable cause to believe that a child is suffering injury from abuse or neglect that inflicts harm or a substantial risk of harm.

Privileged Communications: Ch. 119, 51A. A clergy member shall report all cases of abuse, but need not report information gained in a confession or other confidential communication. Any other privilege relating to confidential communications shall not prohibit the filing of a report.

Inclusion of Reporter's Name in Report: Ch. 119, 51A. Reports shall include the name of the reporter.

Disclosure of Reporter Identity: Not addressed in statutes reviewed

Michigan

Professionals Required to Report: Physicians, physician assistants, dentists, dental hygienists, medical examiners, nurses, persons licensed to provide emergency medical care, or audiologists, school administrators, counselors, or teachers, regulated childcare providers, psychologists, marriage and family therapists, licensed professional counselors, social workers, or social work technicians, law enforcement officers, members of the clergy, department employees, including eligibility specialists, family independence managers, family independence specialists, social services specialists, social work specialists, social work specialist managers, or welfare services specialists.

Reporting by Other Persons: 722.624. Any other person, including a child, who has reasonable cause to suspect child abuse or neglect, may report.

Standards for Making a Report: 722.623. When they have reasonable cause to suspect child abuse or neglect.

Privileged Communications: 722.631. Only the attorney-client or clergy-penitent privilege can be grounds for not reporting.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 722.627. The identity of the reporter is protected in any release of information to the subject of the report.

Minnesota

Professionals Required to Report: 626.556, Subd. 3. A professional or professional's delegate who is engaged in the practice of the healing arts, hospital administration, psychiatric treatment, childcare, education, psychological treatment, social services, or law enforcement, members of the clergy.

Reporting by Other Persons: 626.556, Subd. 3. Any other person may voluntarily report if the person knows, has reason to believe, or suspects that a child is being neglected or subjected to sexual or physical abuse.

Standards for Making a Report: 626.556, Subd. 3 When they know or have reason to believe that a child is being neglected or sexually or physically abused.

Privileged Communications: 626.556, Subd. 3 & 8. A member of the clergy is not required by this subdivision to report information that is otherwise privileged under 595.02, subdivision 1, paragraph (c). No evidence relating to the neglect or abuse of a child or to any prior incidents of neglect or abuse involving any of the same persons accused of neglect or abuse shall be excluded in any proceeding on the grounds of privilege set forth in section 595.02, subdivision 1, paragraph (a) [husband-wife], (d) [medical practitioner patient], or (g) [mental health professional-client].

Inclusion of Reporter's Name in Report: 626.556, Subd. 7. The report must include the name and address of the reporter.

Disclosure of Reporter Identity: 626.556, Subd. 11. The name of the reporter shall be kept confidential while the report is under investigation. After the investigation is complete, the subject of the report may compel disclosure of the name only upon the reporter's consent or a finding by the court that the report was false and made in bad faith.

Mississippi

Professionals Required to Report: 43-21-353. Physicians, dentists, interns, residents, or nurses, public or private school employees or childcare givers, psychologists, social workers, or child protection specialists, attorneys, ministers, or law enforcement officers.

Reporting by Other Persons: 43-21-353. All other persons who have reasonable cause to suspect that a child is abused or neglected must report.

Standards for Making a Report: 43-21-353. When they have reasonable cause to suspect that a child is abused or neglected.

Privileged Communications: Not addressed in statutes reviewed.

Inclusion of Reporter's Name in Report: 43-21-353. The department's report shall include the name and address of the reporter, if known, and whether he or she is a material witness to the abuse.

Disclosure of Reporter Identity: 43-21-353. The identity of the reporting party shall not be disclosed to anyone other than law enforcement officers or prosecutors without an order from the appropriate youth court.

Missouri

Professionals Required to Report: 210.115; 568.110; 352.400. Physicians, medical examiners, coroners, dentists, chiropractors, optometrists, podiatrists, residents, interns, nurses, hospital and clinic personnel, or other health practitioners, daycare center workers or other childcare workers, teachers, principals, or other school officials, psychologists, mental health professionals, social workers, ministers, which includes clergyperson, priest, rabbi, christian science practitioner, or other person serving in a similar capacity for any religious organization, juvenile officers, probation, parole officers, or peace officers, law enforcement officials, or jail or detention center personnel, other persons with responsibility for the care of children, commercial film and photographic print processors, computer providers, installers, or repair persons, or Internet service providers.

Reporting by Other Persons: 210.115. Any other person who has reasonable cause to suspect that a child has been subjected to abuse may report.

Standards for Making a Report: 210.115; 568.110. When they have reasonable cause to suspect that a child has been subjected to abuse or neglect, when they observe a child being subjected to conditions or circumstances that would reasonably result in abuse or neglect, commercial film and photographic print processors when they have knowledge of or observe any film, photograph, videotape, negative, slide, or computer-generated image or picture depicting a child engaged in an act of sexual conduct.

Privileged Communications: 210.140. Only the attorney-client or clergy-penitent privilege may be grounds for failure to report.

Inclusion of Reporter's Name in Report: 210.130. The report must include the name, address, occupation, and contact information for the person making the report.

Disclosure of Reporter Identity: 210.150. The names or other identifying information of reporters shall not be furnished to any child, parent, guardian, or alleged perpetrator named in the report.

Montana

Professionals Required to Report: 41-3-201. Physicians, residents, interns, members of hospital staffs, nurses, osteopaths, chiropractors, podiatrists, medical examiners, coroners, dentists, optometrists, or any other health professionals, school teachers, other school officials, employees who work during regular school hours, operators or employees of any registered or licensed day-care or substitute care facility, or any other operators or employees of child care facilities, mental health professionals or social workers, christian science practitioners or religious healers, foster care, residential, or institutional workers, members of clergy, guardians ad litem or court appointed advocates authorized to investigate a report, peace officers or other law enforcement officials.

Reporting by Other Persons: 41-3-201. Any other person who knows or has reasonable cause to

suspect that a child is abused or neglected may report.

Standards for Making a Report: 41-3-201. When they know or have reasonable cause to suspect, as a result of information they receive in their professional or official capacity, that a child is abused or neglected.

Privileged Communications: 41-3-201. A person listed as a mandated reporter may not refuse to make a report as required in this section on the grounds of a physician-patient or similar privilege. A member of the clergy or priest is not required to make a report under this section if the communication is required to be confidential by canon law, church doctrine, or established church practice.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 41-3-201. The identity of the reporter shall not be disclosed in any release of information to the subject of the report.

Nebraska

Professionals Required to Report: 28-711. Physicians, medical institutions, nurses, school employees, social workers.

Reporting by Other Persons: 28-711. All other persons who have reasonable cause to believe that a child has been subjected to abuse or neglect must report.

Standards for Making a Report: 28-711. When they have reasonable cause to believe that a child has been subjected to abuse or neglect. When they observe a child being subjected to conditions or circumstances that reasonably would result in abuse or neglect.

Privileged Communications: 28-714. The physician-patient, counselor-client, and husband-wife privileges shall not be grounds for failing to report.

Inclusion of Reporter's Name in Report: 28-711. The initial oral report shall include the reporter's name and address.

Disclosure of Reporter Identity: 28-719. The name and address of the reporter shall not be included in any release of information.

Nevada

Professionals Required to Report: 432B.220. Physicians, dentists, dental hygienists, chiropractors, optometrists, podiatrists, medical examiners, residents, interns, nurses, or physician assistants, emergency medical technicians, other persons providing medical services, or hospital personnel, coroners, school administrators, teachers, counselors, or librarians, any persons who maintain or are employed by facilities or establishments that provide care for

children, children's camps, or other facilities, institutions, or agencies furnishing care to children, psychiatrists, psychologists, marriage and family therapists, alcohol or drug abuse counselors, athletic trainers, or social workers, clergymen, practitioners of christian science, or religious healers, unless they have acquired the knowledge of the abuse or neglect from the offenders during confessions, persons licensed to conduct foster homes, officers or employees of law enforcement agencies or adult or juvenile probation officers, attorneys, unless they have acquired the knowledge of the abuse or neglect from clients who are, or may be, accused of the abuse or neglect, any person who is employed by or serves as a volunteer for an approved youth shelter, any adult person who is employed by an entity that provides organized activities for children, any person who maintains, is employed by, or serves as a volunteer for an agency or service that advises persons regarding abuse or neglect of a child and refers them to services.

Reporting by Other Persons: 432B.220. Any other person may report.

Standards for Making a Report: 432B.220. When, in their professional capacity, they know or have reason to believe that a child is abused or neglected, when they have reasonable cause to believe that a child has died as a result of abuse or neglect.

Privileged Communications: 432B.220; 432B.250. The clergy-penitent privilege applies when the knowledge is gained during religious confession. The attorney-client privilege applies when the knowledge is acquired from a client who is or may be accused of abuse. Any other person who is required to report may not invoke privilege for failure to make a report.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 432B.290. The identity of the reporter is kept confidential.

New Hampshire

Professionals Required to Report: 169-C:29. Physicians, surgeons, county medical examiners, psychiatrists, residents, interns, dentists, osteopaths, optometrists, chiropractors, nurses, hospital personnel, or christian science practitioners, teachers, school officials, nurses, or counselors, daycare workers or any other child or foster care workers, social workers, psychologists or therapists, priests, ministers, or rabbis, law enforcement officials.

Reporting by Other Persons: 169-C:29. All other persons who have reason to suspect that a child has been abused or neglected must report.

Standards for Making a Report: 169-C:29. When they have reason to suspect that a child has been abused or neglected.

Privileged Communications: 169-C:32. Only the attorney-client privilege is permitted.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: Not addressed in statutes reviewed.

New Jersey

Professionals Required to Report: None specified in statute.

Reporting by Other Persons: 9:6-8.10. Any person having reasonable cause to believe that a child has been subjected to child abuse or acts of child abuse shall report.

Standards for Making a Report: 9:6-8.10. When they have reasonable cause to believe that a child has been subjected to abuse.

Privileged Communications: Not addressed in statutes reviewed.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 9:6-8.10a. The identity of the reporter shall not be made public. Any information that could endanger any person shall not be released.

New Mexico

Professionals Required to Report: 32A-4-3. Physicians, residents, or interns, law enforcement officers or judges, nurses, teachers or school officials, social workers, members of the clergy.

Reporting by Other Persons: 32A-4-3. Every person who knows or has a reasonable suspicion that a child is an abused or a neglected child shall report the matter immediately.

Standards for Making a Report: 32A-4-3. When they know or have a reasonable suspicion that a child is abused or neglected.

Privileged Communications: 32A-4-3; 32A-4-5. A clergy member need not report any information that is privileged. The report or its contents or any other facts related thereto or to the condition of the child who is the subject of the report shall not be excluded on the ground that the matter is or may be the subject of a physician patient privilege or similar privilege or rule against disclosure.

Inclusion of Reporter's Name in Report: Not specifically required in statute

Disclosure of Reporter Identity: 32A-4-33. Any release of information to a parent, guardian, or legal custodian shall not include identifying information about the reporter.

New York

Professionals Required to Report: Soc. Serv. Law 413. Physicians, physician assistants, surgeons, medical examiners, coroners, dentists, dental hygienists, osteopaths, optometrists,

chiropractors, podiatrists, residents, interns, nurses, hospital personnel, emergency medical technicians, or christian science practitioners, school officials, social workers, social services workers, daycare center workers, providers of family or group family daycare, employees or volunteers in a residential care facility, or any other childcare or foster care worker, psychologists, therapists, mental health professionals, substance abuse counselors, or alcoholism counselors, police officers, district attorneys or assistant district attorneys, investigators employed in the office of a district attorney, or other law enforcement officials.

Reporting by Other Persons: Soc. Serv. Law 414. Any other person who has reasonable cause to suspect that a child is abused or maltreated may report.

Standards for Making a Report: Soc. Serv. Law 413. When they have reasonable cause to suspect that a child coming before them in their professional or official capacity is an abused or maltreated child. Where the parent, guardian, custodian, or other person legally responsible for the child comes before the reporter and states from personal knowledge facts, conditions, or circumstances that, if correct, would render the child an abused or maltreated child.

Privileged Communications: Not addressed in statutes reviewed.

Inclusion of Reporter's Name in Report: Soc. Serv. Law 415. The report shall include the name and contact information for the reporter.

Disclosure of Reporter Identity: Soc. Serv. Law 422-a. Any disclosure of information shall not identify the source of the report.

North Carolina

Professionals Required to Report: 7B-301. Any institution

Reporting by Other Persons: 7B-301. All persons who have cause to suspect that any juvenile is abused, neglected, or dependent, or has died as the result of maltreatment, shall report.

Standards for Making a Report: 7B-301. When they have cause to suspect that any juvenile is abused, neglected, or dependent, or has died as the result of maltreatment.

Privileged Communications: 7B-310. No privilege shall be grounds for failing to report. Only the attorney-client privilege shall be grounds for excluding evidence of abuse in any judicial proceeding.

Inclusion of Reporter's Name in Report: 7B-301. The report must include the name, address, and telephone number of the reporter.

Disclosure of Reporter Identity: 7B-302. The department shall hold the identity of the reporter in strictest confidence.

North Dakota

Professionals Required to Report: 50-25.1-03. Physicians, nurses, dentists, optometrists, medical examiners or coroners, or any other medical or mental health professionals or religious practitioners of the healing arts, school teachers, administrators, or school counselors, addiction counselors or social workers, daycare center or any other childcare workers, police or law enforcement officers, members of the clergy.

Reporting by Other Persons: 50-25.1-03. Any other person who has reasonable cause to suspect that a child is abused or neglected may report.

Standards for Making a Report: 50-25.1-03. When they have knowledge of or reasonable cause to suspect that a child is abused or neglected if the knowledge or suspicion is derived from information received by that person in that person's official or professional capacity.

Privileged Communications: 50-25.1-03; 50-25.1-10. A member of the clergy is not required to report such circumstances if the knowledge or suspicion is derived from information received in the capacity of spiritual adviser. Any privilege of communication between husband and wife or between any professional person and the person's patient or client, except between attorney and client, cannot be used as grounds for failing to report.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 50-25.1-11. The identity of the reporter is protected.

Ohio

Professionals Required to Report: 2151.421. Physicians, residents, interns, podiatrists, dentists, nurses, other health care professionals, speech pathologists, audiologists, coroners, licensed school psychologists; administrators or employees of child daycare centers, residential camps, or child day camps; school teachers, employees, or authorities licensed psychologists, marriage and family therapists, social workers, professional counselors, or agents of county humane societies, persons rendering spiritual treatment through prayer in accordance with the tenets of a well recognized religion, CEU Superintendent, board member, or employee of a county board of mental retardation; investigative agent contracted with by a county board of mental retardation; or employee of the department of mental retardation and developmental disabilities Attorneys.

Reporting by Other Persons: 2151.421. Any other person who suspects that a child has suffered or faces a threat of suffering from abuse or neglect may report.

Standards for Making a Report: 2151.421. When a mandated person is acting in an official or professional capacity and knows or suspects that a child has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child.

Privileged Communications: 2151.421. The attorney-client or physician-patient privilege is waived if the client or patient is a child who is suffering or faces the threat of suffering any physical or mental injury. The physician-patient privilege shall not be a ground for excluding evidence regarding a child's injuries, abuse, or neglect, or the cause of the injuries, abuse, or neglect in any judicial proceeding resulting from a report.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 2151.421. The name of the person who made the report shall not be released.

Oklahoma

Professionals Required to Report: Tit. 10, 7103-7104; Tit. 21, § 1021.4. Physicians, surgeons, residents, interns, dentists, osteopaths, nurses, or other health care professionals, teachers, commercial film and photographic print processors.

Reporting by Other Persons: Tit. 10, 7103. Any person who has reason to believe that a child is a victim of abuse or neglect must report.

Standards for Making a Report: Tit. 10, 7103-7104; Tit. 21, 1021.4. When they have reason to believe that a child is a victim of abuse or neglect, when a health care professional treats the victim of what appears to be criminally injurious conduct, including, but not limited to, child physical or sexual abuse, when a health care professional attends the birth of a child who tests positive for alcohol or a controlled dangerous substance, when any commercial film and photographic print processor has knowledge of or observes any film, photograph, video tape, negative, or slide, depicting a child engaged in an act of sexual conduct.

Privileged Communications: Tit. 10, 7103. No privilege shall relieve any person from the requirement to report.

Inclusion of Reporter's Name in Report: Tit. 10, 7108. Reports may be made anonymously.

Disclosure of Reporter Identity: Tit. 10, 7109. The department shall not release the identity of the person who made the initial report unless a court orders the release of information for good cause shown.

Oregon

Professionals Required to Report: 419B.005. Physicians, interns, residents, optometrists, dentists, emergency medical technicians, naturopathic physicians, or nurses, employees of the Department of Human Resources, State Commission on Children and Families, Childcare Division of the Employment Department, the Oregon Youth Authority, a county health department, a community mental health and developmental disabilities program, a county

juvenile department, a licensed child-caring agency, or an alcohol and drug treatment program, school employees, childcare providers, psychologists, members of clergy, social workers, foster care providers, counselors, or marriage and family therapists, peace officers, attorneys, firefighters, or court appointed special advocates, members of the legislative assembly.

Reporting by Other Persons: 419B.015: Any person may voluntarily make a report.

Standards for Making a Report: 419B.010. When any public or private official has reasonable cause to believe that any child with whom the official comes in contact has suffered abuse.

Privileged Communications: 419B.010. A psychiatrist, psychologist, member of the clergy, or attorney shall not be required to report if such communication is privileged under law. An attorney is not required to make a report of information communicated to the attorney in the course of representing a client, if disclosure of the information would be detrimental to the client.

Inclusion of Reporter's Name in Report: Not specifically required in statute

Disclosure of Reporter Identity: 419B.035. The name, address, and other identifying information about the person who made the report may not be disclosed.

Pennsylvania

Professionals Required to Report: Ch. 23, 6311. Physicians, osteopaths, medical examiners, coroners, funeral directors, dentists, optometrists, chiropractors, nurses, hospital personnel, or christian science practitioners, members of the clergy, school administrators, teachers, or school nurses, social services workers, daycare center workers, or any other childcare or foster care workers, or mental health professionals, peace officers or law enforcement officials.

Reporting by Other Persons: Ch. 23, 6312. Any person who has reason to suspect that a child is abused may report.

Standards for Making a Report: Ch. 23, 6311. When, in the course of their employment, occupation, or practice of their profession, they have reasonable cause to suspect, on the basis of their medical, professional, or other training and experience, that a child coming before them is an abused child.

Privileged Communications: Ch. 23, 6311. Except for confidential communications made to an ordained member of the clergy that are protected under 42 Pa.C.S. 5943 (relating to confidential communications to clergymen), the privileged communication between any professional person required to report and the patient or client of that person shall not apply to situations involving child abuse and shall not constitute grounds for failure to report.

Inclusion of Reporter's Name in Report: Ch. 23, 6313. Mandated reporters must make a written report that includes their name and contact information.

Disclosure of Reporter Identity: Ch. 23, 6340. The release of the identity of the mandated reporter is prohibited unless the secretary finds that the release will not be detrimental to the safety of the reporter.

Rhode Island

Professionals Required to Report: 40-11-6. Any physician or duly certified registered nurse practitioner.

Reporting by Other Persons: 40-11-3(a). Any person who has reasonable cause to know or suspect that a child has been abused or neglected must report.

Standards for Making a Report: 40-11-3(a); 40-11-6. When they have reasonable cause to know or suspect that a child has been abused or neglected. When any physician or nurse practitioner has cause to suspect that a child brought to them for treatment is an abused or neglected child or when they determine that a child under the age of 12 years is suffering from any sexually transmitted disease.

Privileged Communications: 40-11-11. The privileged quality of communication between husband and wife and any professional person and his or her patient or client, except that between attorney and client, shall not constitute grounds for failure to report.

Inclusion of Reporter's Name in Report: Not specifically required in statute

Disclosure of Reporter Identity: Not addressed in statutes reviewed

South Carolina

Professionals Required to Report: 20-7-510. Physicians, nurses, dentists, optometrists, medical examiners, or coroners, any other medical, emergency medical services, or allied health professionals, school teachers or counselors, principals, or assistant principals, childcare workers in any childcare centers or foster care facilities, mental health professionals, social or public assistance workers, or substance abuse treatment staff, members of the clergy including christian science practitioners or religious healers, police or law enforcement officers, judges, funeral home directors or employees, persons responsible for processing films or computer technicians.

Reporting by Other Persons: 20-7-510. Any other person who has reason to believe that a child's physical or mental health or welfare has been or may be adversely affected by abuse and neglect may report.

Standards for Making a Report: 20-7-510. When in their professional capacity they have received information which gives them reason to believe that a child has been or may be abused or neglected.

Privileged Communications: 20-7-550. The privileged quality of communication between husband and wife and any professional person and his patient or client, except that between attorney and client or clergy member, including Christian Science Practitioner or religious healer, and penitent, does not constitute grounds for failure to report.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 20-7-510. The identity of the person making a report pursuant to this section must be kept confidential by the agency or department receiving the report and must not be disclosed.

South Dakota

Professionals Required to Report: 26-8A-3. Physicians, dentists, osteopaths, chiropractors, optometrists, nurses, coroners, teachers, school counselors or officials, child welfare providers, mental health professionals or counselors, psychologists, social workers, chemical dependency counselors, employees or volunteers of domestic abuse shelters, or religious healing practitioners, parole or court services officers or law enforcement officers, any safety-sensitive position, as defined in 23-3-64

Reporting by Other Persons: 26-8A-3. Any person who knows or has reasonable cause to suspect that a child has been abused or neglected may report.

Standards for Making a Report: 26-8A-3. When they have reasonable cause to suspect that a child has been abused or neglected.

Privileged Communications: 26-8A-15. The following privileges may not be claimed as a reason for not reporting: Physician-patient, husband-wife, school counselor-student, social worker-client.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 26-8A-11.1. The name of the reporter is not disclosed unless: The report is determined to be unsubstantiated within 30 days, the subject of the report requests disclosure of the reporter's identity. A hearing is held to determine whether the report was made with malice and without reasonable foundation and that release of the name will not endanger the life or safety of the reporter.

Tennessee

Professionals Required to Report: 37-1-403; 37-1-605. Physicians, osteopaths, medical examiners, chiropractors, nurses, hospital personnel, or other health or mental health professionals, school teachers, other school officials or personnel, daycare center workers, or other professional childcare, foster care, residential, or institutional workers, social workers, practitioners who rely solely on spiritual means for healing, judges or law enforcement officers, neighbors, relatives, or friends.

Reporting by Other Persons: 37-1-403; 37-1-605. Any person who has knowledge that a child has been harmed by abuse or neglect must report.

Standards for Making a Report: 37-1-403; 37-1-605. When they have knowledge that a child has been harmed by abuse or neglect, when they are called upon to render aid to any child who is suffering from an injury that reasonably appears to have been caused by abuse, when they know or have reasonable cause to suspect that a child has been sexually abused.

Privileged Communications: 37-1-411. The following privileges may not be claimed: Husband-wife, Psychiatrist-patient or psychologist-patient

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 37-1-409. The name of the reporter shall not be released, except as may be ordered by the court.

Texas

Professionals Required to Report: Fam. Code 261.101. A professional, for purposes of the reporting laws, is an individual who is licensed or certified by the state or who is an employee of a facility licensed, certified, or operated by the state and who, in the normal course of official duties or duties for which a license or certification is required, has direct contact with children, teachers or daycare employees, nurses, doctors, or employees of a clinic or health care facility that provides reproductive services, juvenile probation officers or juvenile detention or correctional officers.

Reporting by Other Persons: Fam. Code 261.101. A person who has cause to believe that a child has been adversely affected by abuse or neglect shall immediately make a report.

Standards for Making a Report: Fam. Code 261.101. When they have cause to believe that a child has been adversely affected by abuse or neglect.

Privileged Communications: Fam. Code 261.101: No privilege may be claimed to exempt a person from the duty to report.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: Fam. Code 261.201. The identity of the reporter is confidential and may not be disclosed to the subject of the report.

Utah

Professionals Required to Report: 62A-4a-403. Any person licensed under the Medical Practice Act or the Nurse Practice Act.

Reporting by Other Persons: 62A-4a-403. Any person who has reason to believe that a child has been subjected to abuse or neglect must report.

Standards for Making a Report: 62A-4a-403. When they have reason to believe that a child has been subjected to abuse or neglect, when they observe a child being subjected to conditions or circumstances that would reasonably result in sexual abuse, physical abuse, or neglect.

Privileged Communications: 62A-4a-403. The requirement to report does not apply to a clergyman or priest, without the consent of the person making the confession, with regard to any confession made to him in his professional character in the course of discipline enjoined by the church to which he belongs.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 62A-4a-412. The name and contact information of the reporter shall be deleted prior to any release of records to the subject of the report.

Vermont

Professionals Required to Report: Tit. 33, 4913. Physicians, surgeons, osteopaths, chiropractors, physician's assistants, hospital administrators, nurses, medical examiners, dentists, psychologists, or other health care providers, school superintendents, school teachers, school librarians, daycare workers, school principals, school guidance counselors, mental health professionals, or social workers, probation officers, police officers, camp owners, camp administrators or counselors, members of the clergy.

Reporting by Other Persons: Tit. 33, 4913. Any other person who has reasonable cause to believe that a child has been abused or neglected may report.

Standards for Making a Report: Tit. 33, 4913. When they have reasonable cause to believe that a child has been abused or neglected.

Privileged Communications: Tit. 33, 4913. A member of the clergy is not required to report if the knowledge comes from a communication that is required to be kept confidential by religious doctrine.

Inclusion of Reporter's Name in Report: Tit. 33, 4914. Reports shall contain the name and address of the reporter.

Disclosure of Reporter Identity: Tit. 33, 4913. The name of the person making the report shall be confidential unless: The person making the report requests disclosure. A court determines that the report was not made in good faith.

Virginia

Professionals Required to Report: 63.2-1509. Persons licensed to practice medicine or any of the healing arts, hospital residents or interns, nurses, or duly accredited christian science practitioners, teachers or other persons employed in public or private schools, kindergartens, or nursery schools; persons providing childcare full-time or part-time for pay on a regularly planned basis, social workers, mental health professionals, or any person responsible for the care, custody, and control of children, probation officers, law enforcement officers, mediators, or court-appointed special advocates.

Reporting by Other Persons: 63.2-1510. Any person who suspects that a child is abused or neglected may report.

Standards for Making a Report: 63.2-1509. When, in their professional or official capacity, they have reason to suspect that a child is abused or neglected.

Privileged Communications: 63.2-1519. The physician-patient or husband-wife privilege is not permitted.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: Not addressed in statutes reviewed.

Washington

Professionals Required to Report: 26.44.030. Practitioners, county coroners or medical examiners, pharmacists, or nurses, professional school personnel or childcare providers Social service counselors or psychologists, employees of the State Department of Social and Health Services, juvenile probation officers, law enforcement officers, personnel of the Department of Corrections, or placement and liaison specialists, responsible living skills program staff, HOPE center staff, State family and children's ombudsman, or any volunteer in the ombudsman's office, any adult with whom a child resides.

Reporting by Other Persons: 26.44.030. Any person who has reasonable cause to believe that a child has suffered abuse or neglect may report.

Standards for Making a Report: 26.44.030. When they have reasonable cause to believe that a child has suffered abuse or neglect.

Privileged Communications: 26.44.060. Making a report shall not be considered a violation of any of the following privileges: clergy-penitent, physician or optometrist-patient, psychologist-client.

Inclusion of Reporter's Name in Report: 26.44.030. The department shall make reasonable efforts to learn the name, address, and telephone number of the reporter.

Disclosure of Reporter Identity: 26.44.030. The department shall provide assurances of appropriate confidentiality of information in the report.

West Virginia

Professionals Required to Report: 49-6A-2. Medical, dental, or mental health professionals; emergency medical services personnel, school teachers or other school personnel; childcare workers or foster care workers, christian science practitioners or religious healers, social service workers, peace officers or law enforcement officials, circuit court judges, family law masters, employees of the division of juvenile services, or magistrates, members of the clergy.

Reporting by Other Persons: 49-6A-2. Any person who has reasonable cause to suspect that a child is abused or neglected may report.

Standards for Making a Report: 49-6A-2. When they have reasonable cause to suspect that a child is abused or neglected. When they observe the child being subjected to conditions that are likely to result in abuse or neglect. When they believe that a child has suffered serious physical abuse or sexual abuse or sexual assault.

Privileged Communications: 49-6A-7. The privileged quality of communications between husband and wife and between any professional person and his patient or his client, except that between attorney and client, cannot be invoked in situations involving suspected or known child abuse or neglect.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: Not addressed in statutes reviewed.

Wisconsin

Professionals Required to Report: 48.981. Physicians, coroners, medical examiners, nurses, dentists, chiropractors, optometrists, acupuncturists, other medical or mental health professionals, physical therapists, dietitians, occupational therapists, speech language pathologists, audiologists, or emergency medical technicians, school teachers, administrators or counselors, childcare workers in daycare centers, group homes, or residential care centers, or daycare providers, alcohol or other drug abuse counselors, marriage and family therapists, or professional counselors, social workers, public assistance workers, first responders, police or law enforcement officers, mediators, or court appointed special advocates, members of the clergy or a religious order, including brothers, ministers, monks, nuns, priests, rabbis, or sisters.

Reporting by Other Persons: 48.981. Any person, including an attorney, who has reason to suspect that a child has been abused or neglected or who has reason to believe that a child has been threatened with abuse or neglect and that abuse or neglect of the child will occur may report.

Standards for Making a Report: 48.981. When, in the course of their professional duties, they have reasonable cause to suspect that a child has been abused or neglected. When, in the course of their professional duties, they have reason to believe that a child has been threatened with abuse or neglect or that abuse or neglect will occur.

Privileged Communications: 48.981. A member of the clergy is not required to report child abuse information that he or she receives solely through confidential communications made to him or her privately or in a confessional setting.

Inclusion of Reporter's Name in Report: Not specifically required in statute.

Disclosure of Reporter Identity: 48.981. The identity of the reporter shall not be disclosed to the subject of the report.

Wyoming

Professionals Required to Report: None specified in statute.

Reporting by Other Persons: 14-3-205. All persons must report.

Standards for Making a Report: 14-3-205. When they know or have reasonable cause to believe or suspect that a child has been abused or neglected. When they observe any child being subjected to conditions or circumstances that would reasonably result in abuse or neglect.

Privileged Communications: 14-3-210. Only the clergy-penitent and attorney-client privileges are permitted.

Inclusion of Reporter's Name in Report: 14-3-206. The reporter is not specifically required to provide his or her name in the written report. If photographs or x-rays of the child are taken, the person taking them must be identified.

Disclosure of Reporter Identity: Not addressed in statutes reviewed.

Typical Minimum Reporting Requirements

Typically, minimum requirements for what must be reported include:

- A description of how the reporter learned of the injuries or neglect and of any actions taken to assist
- Information on previous injuries, assaults, neglect or financial abuses
- The date, time, nature, and extent of the abuse or neglect* The date of the report
- The perpetrator's name, address, and relationship to the (possible) victim
- The reporter's name, agency, position, address, telephone number, and signature

Abuse or neglect suspected at an institution or facility

Mandated reporters are required to file a report whenever there is reasonable cause to suspect or believe any resident of a care facility has been abused or neglected by a staff member of a public or private institution or facility that provides care. Whenever the results of an investigation leads to the conclusion that there is reasonable cause to believe that there has been abuse or neglect perpetrated by staff, then the institution, school or facility must provide records concerning the investigation to the appropriate investigating agency and/or to the agency that licensed the facility. An institution may suspend employee(s) during an investigation, or, at the conclusion of an investigation, may impose penalties in addition to any separate penalties resulting from civil litigation or criminal prosecution. Employers may not discharge, discriminate or retaliate against an employee for making a good faith report or for testifying at an abuse or neglect proceeding (*Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse'*).

Anonymity and immunity

Mandated reporters are usually required to identify themselves by name when making a report, but may request anonymity to protect their privacy. A mandated reporter who knowingly makes a false report will ordinarily have their identity disclosed to the appropriate law enforcement agency, and their identity may be disclosed to the alleged perpetrator of the reported abuse or neglect. A mandated reporter may be subject to penalties, though immunity from civil or criminal liability is granted to reporters who report in good faith. Immunity is also granted to reporters who, in good faith, have not reported. However, failure to report suspected abuse or neglect could result in fines or other sanctions, such as participation in a training program. Failure to act may result in even stiffer penalties, such as civil litigation or criminal prosecution with the prospect of potential imprisonment (*Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse'*).

Conflicts

Conflicts between a mandated reporter's duties and privileged communication statutes are common. It has been argued that the category of "mandatory reporters" should be expanded to members of the clergy; however in some more traditional denominations the conflict this creates with the "confessional" makes this unworkable. When such conflicts arise, professionals often choose not to report; e.g., in a large number of cases involving clergy, numerous alleged child sexual assaults have gone unreported (*Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse'*).

Informing family members and guardians

Mandated reporters typically are not obligated to inform parents, siblings or offspring that a report has been made. In many circumstances, however, it may be necessary and/or beneficial to do so. When a report is made at a care giving facility, the person in charge of a hospital, school or other institution is generally required to notify family members, or other caregiver(s) responsible for the (possible) victim, that a report has been made. Healthcare professionals or

members of the clergy, however, often must talk with family members or guardians to offer support and guidance, or to assess the cause of an injury. In cases of serious physical abuse or sexual abuse, it may be unwise to advise caregivers before a case is reported, as it may put a victim at greater risk and/or interfere with a criminal investigation (*Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse'*).

Investigation of reports

Law enforcement or public health agencies are responsible for immediately evaluating and classifying all reports of suspected abuse, neglect, or imminent risk. When reports contain sufficient information to warrant an investigation, authorities must make efforts within a reasonable time frame to begin an effective investigation, often within hours, particularly when there is an imminent risk of physical harm or another emergency; investigations must also be completed within a reasonable or specified time frame. The investigation also must include a determination of whether the report was warranted or unfounded (*Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse'*).

Agencies must coordinate activities to minimize impacts upon the (possible) victim. Consent to interview(s) of the (possible) victim often must be obtained from caregivers, family members or guardians, unless there is reason to believe such person is the alleged perpetrator. In cases where serious abuse or neglect is substantiated, local law enforcement, prosecutors or other public offices must be notified, and a copy of the investigation report must be sent (*Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse'*).

Professionals responsible for mandated reporting

In many US states, mandatory reporting requirements apply to all people in the state. In other states, mandated reporting requirements generally apply to staff members of a public or private institution or caregiving facility, as well as to a variety of public safety employees and medical professionals, or a public or private school responsible for the safety and well being of vulnerable persons. These generally include, but are not limited to the following:

- Adult protective service employees
- Child advocates
- Child protective service employees
- Chiropractors
- Clergy
- Commercial Film and Photographic Print Processors
- Dentists and dental hygienists
- Emergency medical service providers
- Marital and family therapists

- Medical examiners
- Mental health professionals
- Nurses
- Ombudsmen
- Optometrists
- Parole officers
- Pharmacists
- Physical therapists
- Physician assistants
- Physicians
- Podiatrists
- Police officers
- Probation officers
- Psychologists
- Public health service providers responsible for the licensing or monitoring of child day care centers, long term care and nursing facilities, group day care homes, family day care homes, and youth camps
- Professional counselors
- Resident medical interns
- School teachers, coaches, guidance counselors, paraprofessionals, and principals
- Sexual assault and battered women’s counselors
- Social workers
- Substance abuse rehabilitation counselors

Training is typically offered wherever mandated reporting laws are enforced, entailing matters such as recognition of abuse and neglect, what must be reported, how to report it, anonymity, immunity and penalties (*Mandated Reporter video and online training resource - 'Recognizing and Reporting Child Abuse and Child Sexual Abuse'*).

3. HIPAA and Third Party Privacy Considerations

The Health Insurance Portability and Accountability Act (HIPAA) was enacted by the U.S. Congress in 1996. According to the Centers for Medicare and Medicaid Services (CMS) website, Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. Title II of HIPAA, known as the Administrative Simplification (AS) provisions, requires the establishment of national standards for electronic health care transactions

and national identifiers for providers, health insurance plans, and employers. It helps people keep their information private (*Wilson J.* "Health Insurance Portability and Accountability Act Privacy rule causes ongoing concerns among clinicians and researchers"). The Administrative Simplification provisions also address the security and privacy of health data. The standards are meant to improve the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in the U.S. health care system.

Title II of HIPAA defines numerous offenses relating to health care and sets civil and criminal penalties for them. It also creates several programs to control fraud and abuse within the health care system. However, the most significant provisions of Title II are its Administrative Simplification rules. Title II requires the Department of Health and Human Services (HHS) to draft rules aimed at increasing the efficiency of the health care system by creating standards for the use and dissemination of health care information.

These rules apply to "covered entities" as defined by HIPAA and the HHS. Covered entities include health plans, health care clearinghouses, such as billing services and community health information systems, and health care providers that transmit health care data in a way that is regulated by HIPAA.

Per the requirements of Title II, the HHS has promulgated five rules regarding Administrative Simplification: the Privacy Rule, the Transactions and Code Sets Rule, the Security Rule, the Unique Identifiers Rule, and the Enforcement Rule.

The HIPAA Privacy Rule regulates the use and disclosure of certain information held by "covered entities" (generally, health care clearinghouses, employer sponsored health plans, health insurers, and medical service providers that engage in certain transactions.) It establishes regulations for the use and disclosure of Protected Health Information (PHI). PHI is any information held by a covered entity which concerns health status, provision of health care, or payment for health care that can be linked to an individual. This is interpreted rather broadly and includes any part of an individual's medical record or payment history. Covered entities must disclose PHI to the individual within 30 days upon request. They also must disclose PHI when required to do so by law, such as reporting suspected child abuse to state child welfare agencies (*Wilson J.*, "Health Insurance Portability and Accountability Act Privacy rule causes ongoing concerns among clinicians and researchers").

A covered entity may disclose PHI to facilitate treatment, payment, or health care operations or if the covered entity has obtained authorization from the individual. However, when a covered entity discloses any PHI, it must make a reasonable effort to disclose only the minimum necessary information required to achieve its purpose.

The Privacy Rule requires covered entities to take reasonable steps to ensure the confidentiality of communications with individuals. For example, an individual can ask to be called at his or her work number, instead of home or cell phone number. The Privacy Rule requires covered entities to notify individuals of uses of their PHI. Covered entities must also keep track of

disclosures of PHI and document privacy policies and procedures. They must appoint a Privacy Official and a contact person responsible for receiving complaints and train all members of their workforce in procedures regarding PHI.

An individual who believes that the Privacy Rule is not being upheld can file a complaint with the Department of Health and Human Services Office for Civil Rights (OCR). However, according to the Wall Street Journal, the OCR has a long backlog and ignores most complaints. "Complaints of privacy violations have been piling up at the Department of Health and Human Services. Between April 2003 and Nov. 30, the agency fielded 23,896 complaints related to medical-privacy rules, but it has not yet taken any enforcement actions against hospitals, doctors, insurers or anyone else for rule violations.

HIPAA covered entities such as providers completing electronic transactions, healthcare clearinghouses, and large health plans, must use only the National Provider Identifier (NPI) to identify covered healthcare providers in standard transactions. The NPI replaces all other identifiers used by health plans, Medicare (i.e., the UPIN), Medicaid, and other government programs. However, the NPI does not replace a provider's DEA number, state license number, or tax identification number. The NPI is 10 digits (may be alphanumeric), with the last digit being a checksum. The NPI is unique and national, never re-used, and except for institutions, a provider usually can have only one.

Some therapists may need to complete and store two sets of notes, learn HIPAA standards regarding patient's access to records, and develop new forms for Consent for Services and a HIPAA Acknowledgement. Also, revised standards now exist regarding the security of computer records. The recommendations discussed apply to solo practices or those of small groups and do not apply to hospitals or large clinics.

The Standards for Privacy of Individually Identifiable Health Information Privacy Rule establishes a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services Payment encompasses activities of a health plan to obtain premiums, determine or fulfill responsibilities for coverage and provision of benefits, and furnish or obtain reimbursement for health care delivered to an individual and activities of a health care provider to obtain payment or be reimbursed for the provision of health care to an individual. Health care operations are any of the following activities: (a) quality assessment and improvement activities, including case management and care coordination; (b) competency assurance activities, including provider or health plan performance evaluation, credentialing, and accreditation; (c) conducting or arranging for medical reviews, audits, or legal services, including fraud and abuse detection and compliance programs; (d) specified insurance functions, such as underwriting, risk rating, and reinsuring risk; (e) business planning, development, management, and administration; and (f) business management and general administrative activities of the entity, including but not limited to: de-identifying protected health information, creating a limited data set, and certain fundraising for the benefit of the covered entity. Most uses and disclosures of psychotherapy notes for treatment, payment, and health care operations purposes require an authorization as described below.

Obtaining consent (written permission from individuals to use and disclose their protected health

information for treatment, payment, and health care operations) is optional under the Privacy Rule for all covered entities. The content of a consent form, and the process for obtaining consent, are at the discretion of the covered entity electing to seek consent.

Required by Law

Covered entities may use and disclose protected health information without individual authorization as required by law.

Public Health Activities

Covered entities may disclose protected health information to: (1) public health authorities authorized by law to collect or receive such information for preventing or controlling disease, injury, or disability and to public health or other government authorities authorized to receive reports of child abuse and neglect; (2) entities subject to FDA regulation regarding FDA regulated products or activities for purposes such as adverse event reporting, tracking of products, product recalls, and post marketing surveillance; (3) individuals who may have contracted or been exposed to a communicable disease when notification is authorized by law; and (4) employers, regarding employees, when requested by employers, for information concerning a work-related illness or injury or workplace related medical surveillance, because such information is needed by the employer to comply with the Occupational Safety and Health Administration (OSHA), the Mine Safety and Health Administration (MSHA), or similar state law. See OCR Public Health Guidance; CDC Public Health and HIPAA Guidance.

Victims of Abuse, Neglect or Domestic Violence

In certain circumstances, covered entities may disclose protected health information to appropriate government authorities regarding victims of abuse, neglect, or domestic violence.

Health Oversight Activities

Covered entities may disclose protected health information to health oversight agencies (as defined in the Rule) for purposes of legally authorized health oversight activities, such as audits and investigations necessary for oversight of the health care system and government benefit programs.

Judicial and Administrative Proceedings

Covered entities may disclose protected health information in a judicial or administrative proceeding if the request for the information is through an order from a court or administrative tribunal. Such information may also be disclosed in response to a subpoena or other lawful process if certain assurances regarding notice to the individual or a protective order are provided.

Law Enforcement Purposes

Covered entities may disclose protected health information to law enforcement officials for law enforcement purposes under the following six circumstances, and subject to specified conditions: (1) as required by law (including court orders, court-ordered warrants, subpoenas) and administrative requests; (2) to identify or locate a suspect, fugitive, material witness, or missing

person; (3) in response to a law enforcement officials request for information about a victim or suspected victim of a crime; (4) to alert law enforcement of a person's death, if the covered entity suspects that criminal activity caused the death; (5) when a covered entity believes that protected health information is evidence of a crime that occurred on its premises; and (6) by a covered health care provider in a medical emergency not occurring on its premises, when necessary to inform law enforcement about the commission and nature of a crime, the location of the crime or crime victims, and the perpetrator of the crime, (*OCR Privacy Rule Summary 8*).

Decedents

Covered entities may disclose protected health information to funeral directors as needed, and to coroners or medical examiners to identify a deceased person, determine the cause of death, and perform other functions authorized by law.

Cadaveric Organ, Eye, or Tissue Donation

Covered entities may use or disclose protected health information to facilitate the donation and transplantation of cadaveric organs, eyes, and tissue.

Research

Research is any systematic investigation designed to develop or contribute to generalizable knowledge. The Privacy Rule permits a covered entity to use and disclose protected health information for research purposes, without an individual's authorization, provided the covered entity obtains either: (1) documentation that an alteration or waiver of individuals authorization for the use or disclosure of protected health information about them for research purposes has been approved by an Institutional Review Board or Privacy Board; (2) representations from the researcher that the use or disclosure of the protected health information is solely to prepare a research protocol or for similar purpose preparatory to research, that the researcher will not remove any protected health information from the covered entity, and that protected health information for which access is sought is necessary for the research; or (3) representations from the researcher that the use or disclosure sought is solely for research on the protected health information of decedents, that the protected health information sought is necessary for the research, and, at the request of the covered entity, documentation of the death of the individuals about whom information is sought. A covered entity also may use or disclose, without an individual's authorization, a limited data set of protected health information for research purposes (see discussion below). See OCR Research Guidance; NIH Protecting PHI in Research.

Serious Threat to Health or Safety

Covered entities may disclose protected health information that they believe is necessary to prevent or lessen a serious and imminent threat to a person or the public, when such disclosure is made to someone they believe can prevent or lessen the threat (including the target of the threat). Covered entities may also disclose to law enforcement if the information is needed to identify or apprehend an escapee or violent criminal.

Essential Government Functions

An authorization is not required to use or disclose protected health information for certain essential government functions. Such functions include: assuring proper execution of a military mission, conducting intelligence and national security activities that are authorized by law, providing protective services to the President, making medical suitability determinations for U.S. State Department employees, protecting the health and safety of inmates or employees in a correctional institution, and determining eligibility for or conducting enrollment in certain government benefit programs.

Workers Compensation

Covered entities may disclose protected health information as authorized by, and to comply with, workers compensation laws and other similar programs providing benefits for work-related injuries or illnesses. See OCR Workers Compensation Guidance.

(6) Limited Data Set. A limited data set is protected health information from which certain specified direct identifiers of individuals and their relatives, household members, and employers have been removed. A limited data set may be used and disclosed for research, health care operations, and public health purposes, provided the recipient enters into a data use agreement promising specified safeguards for the protected health information within the limited data set.

Authorized Uses and Disclosures

Authorization

A covered entity must obtain the individual's written authorization for any use or disclosure of protected health information that is not for treatment, payment or health care operations or otherwise permitted or required by the Privacy Rule. A covered entity may not condition treatment, payment, enrollment, or benefits eligibility on an individual granting an authorization, except in limited circumstances.

An authorization must be written in specific terms. It may allow use and disclosure of protected health information by the covered entity seeking the authorization, or by a third party. Examples of disclosures that would require an individual's authorization include disclosures to a life insurer for coverage purposes, disclosures to an employer of the results of a pre-employment physical or lab test, or disclosures to a pharmaceutical firm for their own marketing purposes. All authorizations must be in plain language, and contain specific information regarding the information to be disclosed or used, the person(s) disclosing and receiving the information, expiration, right to revoke in writing, and other data.

Psychotherapy Notes

A covered entity must obtain an individual's authorization to use or disclose psychotherapy notes with the following exceptions:

- The covered entity who originated the notes may use them for treatment.
- A covered entity may use or disclose, without an individual's authorization, the psychotherapy notes, for its own training, and to defend itself in legal proceedings brought by the individual, for HHS to investigate or determine the covered entities

compliance with the Privacy Rules, to avert a serious and imminent threat to public health or safety, to a health oversight agency for lawful oversight of the originator of the psychotherapy notes, for the lawful activities of a coroner or medical examiner or as required by law.

Marketing

Marketing is any communication about a product or service that encourages recipients to purchase or use the product or service. The Privacy Rule carves out the following health-related activities from this definition of marketing: Communications to describe health-related products or services, or payment for them, provided by or included in a benefit plan of the covered entity making the communication; Communications about participating providers in a provider or health plan network, replacement of or enhancements to a health plan, and health-related products or services available only to a health plans enrollees that add value to, but are not part of, the benefits plan; Communications for treatment of the individual; and Communications for case management or care coordination for the individual, or to direct or recommend alternative treatments, therapies, health care providers, or care settings to the individual. Marketing also is an arrangement between a covered entity and any other entity whereby the covered entity discloses protected health information, in exchange for direct or indirect remuneration, for the other entity to communicate about its own products or services encouraging the use or purchase of those products or services.

A covered entity must obtain an authorization to use or disclose protected health information for marketing, except for face-to-face marketing communications between a covered entity and an individual, and for a covered entities provision of promotional gifts of nominal value. No authorization is needed, however, to make a communication that falls within one of the exceptions to the marketing definition.

Limiting Uses and Disclosures to the Minimum Necessary

Minimum Necessary

A central aspect of the Privacy Rule is the principle of minimum necessary use and disclosure. A covered entity must make reasonable efforts to use, disclose, and request only the minimum amount of protected health information needed to accomplish the intended purpose of the use, disclosure, or request. A covered entity must develop and implement policies and procedures to reasonably limit uses and disclosures to the minimum necessary. When the minimum necessary standard applies to a use or disclosure, a covered entity may not use, disclose, or request the entire medical record for a particular purpose, unless it can specifically justify the whole record as the amount reasonably needed for the purpose.

The minimum necessary requirement is not imposed in any of the following circumstances: (a) disclosure to or a request by a health care provider for treatment; (b) disclosure to an individual who is the subject of the information, or the individuals personal representative; (c) use or disclosure made pursuant to an authorization; (d) disclosure to HHS for complaint investigation, compliance review or enforcement; (e) use or disclosure that is required by law; or (f) use or disclosure required for compliance with the HIPAA Transactions Rule or other HIPAA

Administrative Simplification Rules.

Access and Uses. For internal uses, a covered entity must develop and implement policies and procedures that restrict access and uses of protected health information based on the specific roles of the members of their workforce. These policies and procedures must identify the persons, or classes of persons, in the workforce who need access to protected health information to carry out their duties, the categories of protected health information to which access is needed, and any conditions under which they need the information to do their jobs.

Disclosures and Requests for Disclosures. Covered entities must establish and implement policies and procedures (which may be standard protocols) for routine, recurring disclosures, or requests for disclosures, that limits the protected health information disclosed to that which is the minimum amount reasonably necessary to achieve the purpose of the disclosure. Individual review of each disclosure is not required. For non-routine, non-recurring disclosures, or requests for disclosures that it makes, covered entities must develop criteria designed to limit disclosures to the information reasonably necessary to accomplish the purpose of the disclosure and review each of these requests individually in accordance with the established criteria.

Reasonable Reliance. If another covered entity makes a request for protected health information, a covered entity may rely, if reasonable under the circumstances, on the request as complying with this minimum necessary standard. Similarly, a covered entity may rely upon requests as being the minimum necessary protected health information from: (a) a public official, (b) a professional (such as an attorney or accountant) who is the covered entities business associate, seeking the information to provide services to or for the covered entity; or (c) a researcher who provides the documentation or representation required by the Privacy Rule for research.

Notice and Other Individual Rights

Privacy Practices Notice

Each covered entity, with certain exceptions, must provide a notice of its privacy practices. The Privacy Rule requires that the notice contain certain elements. The notice must describe the ways in which the covered entity may use and disclose protected health information. The notice must state the covered entities duties to protect privacy, provide a notice of privacy practices, and abide by the terms of the current notice. The notice must describe individuals rights, including the right to complain to HHS and to the covered entity if they believe their privacy rights have been violated. The notice must include a point of contact for further information and for making complaints to the covered entity. Covered entities must act in accordance with their notices. The Rule also contains specific distribution requirements for direct treatment providers, all other health care providers, and health plans.

Acknowledgement of Notice Receipt

A covered health care provider with a direct treatment relationship with individuals must make a good faith effort to obtain written acknowledgement from patients of receipt of the privacy practices notice. The Privacy Rule does not prescribe any particular content for the acknowledgement. The provider must document the reason for any failure to obtain the patients

written acknowledgement. The provider is relieved of the need to request acknowledgement in an emergency treatment situation.

Access

Except in certain circumstances, individuals have the right to review and obtain a copy of their protected health information in a covered entities designated record set. The designated record set is that group of records maintained by or for a covered entity that is used, in whole or part, to make decisions about individuals, or that is a providers medical and billing records about individuals or a health plans enrollment, payment, claims adjudication, and case or medical management record systems. The Rule excepts from the right of access the following protected health information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access, or information held by certain research laboratories. For information included within the right of access, covered entities may deny an individual access in certain specified situations, such as when a health care professional believes access could cause harm to the individual or another. In such situations, the individual must be given the right to have such denials reviewed by a licensed health care professional for a second opinion. Covered entities may impose reasonable, cost-based fees for the cost of copying and postage.

Amendment

The Rule gives individuals the right to have covered entities amend their protected health information in a designated record set when that information is inaccurate or incomplete. If a covered entity accepts an amendment request, it must make reasonable efforts to provide the amendment to persons that the individual has identified as needing it, and to persons that the covered entity knows might rely on the information to the individual's detriment. If the request is denied, covered entities must provide the individual with a written denial and allow the individual to submit a statement of disagreement for inclusion in the record. The Rule specifies processes for requesting and responding to a request for amendment. A covered entity must amend protected health information in its designated record set upon receipt of notice to amend from another covered entity.

Disclosure Accounting

Individuals have a right to an accounting of the disclosures of their protected health information by a covered entity or the covered entities business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request, except a covered entity is not obligated to account for any disclosure made before its Privacy Rule compliance date.

The Privacy Rule does not require accounting for disclosures: (a) for treatment, payment, or health care operations; (b) to the individual or the individuals personal representative; (c) for notification of or to persons involved in an individual's health care or payment for health care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law

enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to health oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Restriction Request

Individuals have the right to request that a covered entity restrict use or disclosure of protected health information for treatment, payment or health care operations, disclosure to persons involved in the individuals health care or payment for health care, or disclosure to notify family members or others about the individuals general condition, location, or death. A covered entity is under no obligation to agree to requests for restrictions. A covered entity that does agree must comply with the agreed restrictions, except for purposes of treating the individual in a medical emergency.

Confidential Communications Requirements

Health plans and covered health care providers must permit individuals to request an alternative means or location for receiving communications of protected health information by means other than those that the covered entity typically employs. For example, an individual may request that the provider communicate with the individual through a designated address or phone number. Similarly, an individual may request that the provider send communications in a closed envelope rather than a post card. Health plans must accommodate reasonable requests if the individual indicates that the disclosure of all or part of the protected health information could endanger the individual. The health plan may not question the individual's statement of endangerment. Any covered entity may condition compliance with a confidential communication request on the individual specifying an alternative address or method of contact and explaining how any payment will be handled.

4. Sex with Clients

It's likely that many social workers will encounter clients who have been sexually victimized by a previous clinician. A national study of 1,320 psychologists found that 50% reported working with at least one client who had been a victim of therapist-client sexual intimacies (*Pope & Vetter*). A national survey of Psychologists found that "nearly one out of ten participants reported engaging in sex with a client using the rationale of patient welfare or deeper moral value highlights the risks, ambiguities, and difficulties of evaluating the degree to which our own individual behavior is ethical" (*Pope and Bajt*).

Social Workers and Psychotherapists can be prosecuted both civilly and criminally for engaging in sexual relations with their clients. A client has a cause for civil action against a psychotherapist when sexual contact occurs during the course of therapy. Criminal liability can result if a therapist engages in sex with a current client or if he or she terminates a therapeutic relationship with a client for the purposes of beginning a sexual relationship with that client. In addition, under licensing laws, a social worker who has sex with a client can have his or her

license revoked.

Potential consequences of conviction include imprisonment for up to one year and fines. Under law, the first violation is treated as a misdemeanor and the second violation is treated as either a felony or a misdemeanor, according to the discretion of the court and district attorney. Further, the consent of the client may never be used as a defense.

Warning Signs

In most sexual abuse or exploitation cases, other inappropriate behavior comes first. While it may be subtle or confusing, it usually feels uncomfortable to the client. Some clues or warning signs are:

Telling sexual jokes or stories.

“Making eyes at” or giving seductive looks to the client.

Discussing the therapist’s sex life or relationships excessively.

Sitting too close, initiating hugging, holding the patient or lying next to the client.

Another warning sign is “special” treatment by a clinician, such as:

Inviting a client to lunch, dinner or other social activities.

Dating.

Changing any of the office’s business practices (for example, scheduling late appointments so no one is around, having sessions away from the office, etc.).

Confiding in a client (for example, about the clinician’s love life, work problems, etc.).

Telling a client that he or she is special, or that the therapist loves him or her.

Relying on a client for personal and emotional support.

Giving or receiving significant gifts.

Providing or using alcohol (or drugs) during sessions.

Signs of inappropriate behavior and misuse of power include:

✓ Hiring a client to do work for the clinician, or bartering goods or services to pay for services.

✓ Suggesting or supporting the client’s isolation from social support systems, increasing dependency on the clinician.

Any violation of the patient’s rights as a consumer (see Patient Bill of Rights).

Services are meant to be a guided learning experience, during which clinicians help clients to find their own answers and feel better about themselves and their lives. A client should never feel intimidated or threatened by a clinician’s behavior.

The following includes guidelines for social workers to assist clients in the event of sexual activity with a clinician:

What If It's Me?

If you have been sexually abused or exploited, you may be feeling confused. You may feel:

- Guilty and responsible — even though it's the clinician's responsibility to keep sexual behavior out of therapy.
- Mixed feelings about the clinician — protectiveness, anger, love, betrayal.
- Isolated and empty.
- Distrustful of others or your own feelings.
- Fearful that no one will believe you or understand what happened, or that someone will find out.
- Confused about dependency, control and power.

You may even have nightmares, obsessive thoughts, depression, or suicidal or homicidal thoughts. You may feel overwhelmed as you try to decide what to do or whom to tell. It's essential that you face what happened. This may be painful, but it is the first major step in healing and recovering from the experience. You may have positive and negative feelings at the same time, such as starting to feel personal control, being afraid of what may happen in the future, remembering the experience, and feeling relieved that the sexual relationship is over.

The second step in the healing process is to decide what YOU want to do next. Try to be open-minded about your options. Remember: It doesn't matter if you, the client, started or wanted the sexual involvement with the clinician. Clinicians are responsible for keeping sexual intimacy out of the therapy relationship and are trained to know how to handle a patient's sexual attractions and desires.

Where To Start

You may need to (1) talk to someone who will understand what you're going through, (2) get information on whether the clinician's behavior was illegal and/or unethical, and (3) find out what you can do about it. Three places to get help are:

Licensing Boards —

State and/or national licensing boards can give general information on appropriate behavior for clinicians and your rights for reporting what happened, as well as how to file a complaint.

Sexual Assault/Crisis Centers — These centers have staff trained in all types of sexual abuse and exploitation. They can provide general information on appropriate behavior for clinicians, crisis services, your rights for reporting what happened, and names of therapists and support groups that may be helpful. Look up services under "sexual assault center" or "crisis intervention service."

Professional Associations —Each licensed human service profession has at least one professional association. Associations can provide general information on appropriate behavior for clinicians, your rights for reporting what happened, and how to file a complaint. They can provide names of therapists who may be helpful.

What You Can Do

You can deal with your situation in several different ways. Take time to explore all of your rights and options. It may help to decide what your goals are:

Reporting the Clinician —Perhaps you want to prevent the clinician from hurting other clients. You may want to make it known that sexual exploitation is always wrong. If this is your decision, you have several reporting options. It is important to note that reporting misconduct is time-sensitive. What can be done in response to the report of misconduct usually depends on:

- Who the misconduct is reported to, and the length of time between the misconduct and when the report was filed. Such a time limit is called a “statute of limitations.” As you consider your options, be aware of these time limits.
- Your Recovery — You may also want to explore and process what happened between you and the therapist. If you decide to do this, you can look into therapy or support groups.
- Moving On — You may wish simply to move on past this experience as quickly as possible and get on with your life. Remember — you have the right to decide what is best for you.

Your Reporting Options

If you decide to report a clinician's behavior that you believe is unethical and illegal, there are four different ways to do so. All of these reporting options are affected by time limits, so you should consider reporting misconduct at the earliest appropriate opportunity. You may choose one or more of the options listed below:

- Administrative Action — File a complaint with the clinician's licensing board.
- Professional Association Action— File a complaint with the ethics committee of the clinician's professional association.
- Civil Action — File a civil lawsuit.
- Criminal Action— File a complaint with local law enforcement.

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