NJAAP CHILD ABUSE AND NEGLECT PREVENTION AND INTERVENTION GUIDANCE FOR PEDIATRICIANS AND PEDIATRIC CLINICIANS IN NEW JERSEY

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
New Jersey Chapter

New Jersey Department of Children and Families

Acknowledgements

The NJAAP Child Abuse and Neglect Prevention and Intervention Guidance for Pediatricians and Pediatric Clinicians in New Jersey was developed to provide guidance to pediatricians and pediatric clinicians about what constitutes child abuse and neglect in New Jersey, what to do if child abuse or neglect is suspected, and how to support children and families.

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WHAT TO DO WHEN YOU SUSPECT CHILD ABUSE OR NEGLECT

1 Call the Statewide Central Registry (24-hour DCP&P hotline) at **1-877-NJABUSE (652-2873)** to make a report. This is the 24-hour telephone reporting system. Trained and qualified screeners are available to take calls. Ideally, you should provide the following information about the child, but do not hesitate to call if you do not have all of the information.

- Name and address
- Age
- Present location
- Name and address of parent/ caregiver and siblings (if different)
- Household composition
- Where the suspected abuse/ neglect occurred
- Why you suspect the child is being abused/neglected
- Name of alleged perpetrator and the relationship to the victim
- Nature of the child's condition, including evidence of previous injuries or disabilities
- Risk of immediate danger

2 All reports, regardless of the time of day, are to be reported to **1-877-NJABUSE (652-2873)**. If you feel the child is unsafe in going home, you can decide if the child should be hospitalized for three court days until a protective environment can be provided. Only hospitals have statutory authority to take children into emergency protective custody, outside of law enforcement and DCP&P

3 Call the police when...

- The child or healthcare staff is in immediate danger
- The child was injured by means of a weapon, whether by themselves or someone else
- The child was sexually abused
- A clear chain of custody of the evidence is needed to maintain the integrity of the evidence for further court proceedings
- The child was injured by a person who is NOT a caregiver

NEW JERSEY CHILD PROTECTIVE SERVICES LAW

Every person, including employees of a physician practice, must make a report or inform the person in charge if he/she has reasonable cause to suspect a child has been abused, according to the NJ Child Protective Services Law (Mandated Reporting Law).

Call the Statewide Central Registry at **1-877-NJABUSE (652-2873)** to make a report to the 24- hour DCP&P hotline.

The mandated reporting law SUPERSEDES *HIPAA Privacy Rule.* (1) HIPAA is superseded by the mandatory reporting statute, and (2) there is a risk of penalties when a mandatory reporter does not report suspected child abuse or neglect. The obligation to protect the confidentiality of patient communication as dictated by the HIPAA Privacy Rule is superseded by the mandate to report whenever one has reason to suspect child abuse or neglect. Release of medical information does not require parental consent when reporting suspicion of abuse. ***NJ Statute 9:6-8.10***

Penalties for Not Reporting

A healthcare provider who willfully fails to report a case of suspected child abuse faces risk of:

- Licensing penalties
- Disorderly persons offense (NJ Statute 9:6-8.14)
- Civil liability in malpractice claim if the child sustains further injuries

Protection of Liability

Even if a report is investigated and determined to be unfounded, pediatricians and other pediatric healthcare clinicians acting in good faith are immune from civil and criminal liability when…

- Making a report
- Cooperating with the investigation
- Testifying in a child abuse proceeding

Reporter Confidentiality ***NJ Statute 9:6-8.13***

Names of people who make reports of suspected child abuse are kept confidential. However, when DCP&P refers a case of suspected child abuse and neglect to law enforcement officials for criminal investigation, they are required to provide the name of the reporter. In the event that DCP&P files for court action, the names of reporters may be revealed in discovery.

DEFINITION OF CHILD ABUSE

NJ Statute 9:6-8.21 – Child abuse is the non-accidental physical, mental or emotional injury, sexual abuse, or negligent treatment of a child by a person responsible for a child's welfare.

Child abuse means a child under the age of 18 years whose parent or caregiver acts or fails to act and:

- Inflicts, or allows to be inflicted, physical injury and/or severe mental injury
- Creates, or allows to be committed, an act of sexual abuse
- Fails to supply adequate food, clothing, shelter, education, medical or surgical care though financially able
- Inflicts, or allows to be inflicted, excessive corporal punishment or excessive physical restraint
- Willfully abandons

Sexual Abuse: Child sexual abuse is the involvement of children in sexual activities that:

- they cannot understand
- they are not developmentally prepared for
- they cannot give informed consent for
- violate societal taboos

NJ Statute NJSA 9:6-8.9 defines neglect as a child whose physical, mental, or emotional condition has been impaired or is in imminent danger of becoming impaired as a result of the failure of his/her parent or guardian to exercise a minimum degree of care.

Neglect:

- failure to adequately supply basic needs though financially able
- failure to provide proper supervision

FAMILIES AT RISK FOR ABUSE

Everyone is at risk of abusing children. The most common perpetrators of child abuse are mothers, fathers, relatives, babysitters, and non-related household members. Child abuse occurs in all types of families, regardless of economic status, race, ethnic heritage, or religious faith.

Although child abuse is more often reported in minority and poor families, abusive head trauma is more likely to be missed in very young Caucasian infants from two-parent families and children without respiratory compromise or seizures. The following risk factors, which are neither all-inclusive nor necessarily antecedents to abuse, place a child at a high level of risk for abuse or neglect:

Child Characteristics

- Premature birth
- Colic
- Physical disabilities
- Developmental disabilities
- Chronic illness
- Emotional/ behavioral difficulties
- Unwanted child
- Gender identity

Social/Situational Stresses- Family Factors

- Isolation
- Family/domestic violence
- Nonbiologically- related person in the home
- Poverty/ food insecurity
- Unemployment/ financial problems
- Large number of dependent children
- Major life events
- Inadequate housing

Parental Characteristics

- Low self esteem
- Depression (maternal/paternal)
- Poor impulse control
- Substance use
- History of abuse
- Single or teenage parent
- Unrealistic expectations of child's behavior
- Negative view of themselves and their children
- Punitive childrearing style
- Poor parent-child relationship

Triggering Situations

- Crying baby
- Child's misbehavior
- Discipline gone awry
- Argument/family conflict
- Toilet training
- Major life transitions

HOW TO RECOGNIZE CHILD ABUSE AND KNOW WHEN TO MAKE A REPORT

1 ANY TIME you observe a traumatic childhood injury, ask yourself "could this be abuse?"
Then ask yourself these questions:

Do I think that the child before me was harmed by the actions or the inactions of the child's caregiver? If I allow this child to leave my office without making a report, will I be putting this child at significant risk of further harm?

If the answer is "yes," you have reached a threshold for reporting suspected child abuse.

2 Be objective and thorough when evaluating all patients with trauma.

3 You must consider abuse to diagnose abuse. The diagnosis of child abuse can be made only if the possibility of abuse is considered. Include it in your differential diagnosis.

Histories that Indicate a Possible Diagnosis of Abuse

- History inconsistent with injuries
  - History of minor trauma with extensive physical injury
  - History of NO trauma with evidence of injury
- Significant injury from an "un-witnessed" event
- History incompatible with child's development
- History that changes with time
- Delay in seeking treatment
- Unusual type or location of injury

If you suspect child abuse or neglect, call the NJ Child Abuse Hotline at
1-877-NJ ABUSE
(1-877-652-2873)

You do not need to be certain that abuse occurred. You only need to have a reasonable cause to suspect that abuse could have occurred. Your decision to make a report will be aided by the history, physical findings, laboratory and x-ray data, and your observed interactions.

INDICATORS OF PHYSICAL ABUSE

Head Trauma

Head trauma is the leading cause of morbidity and mortality from child physical abuse. The hallmarks of non-accidental head trauma include altered mental status along with some or all of these other findings: intracranial hemorrhages, (subdural and/or subarachnoid hemorrhages), retinal hemorrhages, and skull fractures. Subtle bruises or other injuries can clue you in to the possibility of injury, but many babies have NO external injury to suggest trauma. Be aware of the possibility of trauma in infants with sudden emesis, changes in mental status, unexplained apnea, seizures, apparent life threatening events, etc.

Abdominal Trauma

Abdominal injury is under-recognized, but is the second leading cause of death due to physical child abuse. Half of all children with serious abdominal trauma do NOT have bruising on the abdomen to alert you to the diagnosis. This is because the internal organs, and not the skin, are being crushed between the abusers fist, foot, etc. and the rib cage or back of the child. Use laboratory data to help assess for abdominal trauma.

Fractures

Although there is no SINGLE fracture that is diagnostic of abuse, the following are more specific for the diagnosis and should raise your suspicion:

- Rib fractures, especially when multiple and bilateral
- Metaphyseal fractures
- Multiple fractures
- Fractures at different ages
- Complex skull fractures
- Long bone fractures in young infants
- Diaphyseal fractures in older children

Bruises

Children, especially toddlers, tend to get some mild to moderate bruises on their shins, knees, and elbows. However, bruises that should make you suspicious are:

- Patterned: rope, belt or electric cord marks, hand or finger patterns, etc.
- Unusually distributed over non-bony surfaces of the body
- Centrally located
- Seen in non-ambulatory infants
- Of different ages

Burns

Burns related to child abuse include:

- Immersion burns
- Patterned contact burn

"Children do not bruise until they cruise"

Age is an important factor when considering the cause of a fracture or bruise. Ask yourself, "Is this infant/child capable of inflicting this injury by him/herself?" Infants (without underlying metabolic disorders) who are not yet mobile CANNOT self-inflict serious injuries.

TEN-4 BRUISING RULE*

Be aware of bruising on infants

Bruising is the most overlooked sign of abuse.

Bruising is very rare in infants under 1 year of age and those who are not yet pulling up or taking steps while holding onto furniture and hands.*

A bruise on an infant could mean the child has been abused and needs to be fully evaluated right away. For questions or consultation, call the NJ State Central Registry 24 hours a day, seven days a week, at **1-877-NJ-ABUSE (652-8273)**

By law, all individuals are mandated to report suspicions of child abuse.

Information and artwork provided by

Norton Children's Hospital

American Academy of Pediatrics
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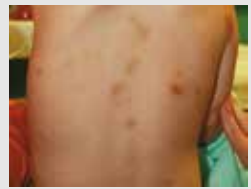
New Jersey Chapter

New Jersey Department of Children and Families

* Sugar NF, Taylor JA, Feldman KW et al. Bruises in infants and toddlers: those who don't cruise rarely bruise. *Arch Pediatr Adolesc Med.* 1999;153(4):399-403.

Be aware of any bruising to the:

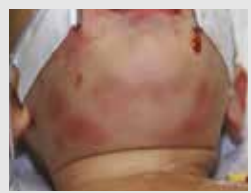
TORSO



EARS

NECK

On a child



4 YEARS OR YOUNGER

or ANY bruising on an infant 4 months or younger.

Pierce MC, Kaczor K, Aldridge S, O'Flynn J, Lorenz DJ. Bruising characteristics discriminating physical child abuse from accidental trauma. *Pediatrics* 2010;125(1):67-74. Epub Dec. Erratum in *Pediatrics* 2010;125(4):861.

INDICATORS OF CHILD SEXUAL ABUSE

Sexual abuse can be violent or non-violent, isolated or ongoing, and can involve both non-contact activities and physical contact with the child. Most often, the abuse has gone on for a long period before it is disclosed.

Child sexual abuse is the involvement of children in sexual activities that:

- they cannot understand
- they are not physically prepared for
- they cannot give informed consent for
- violate social taboos

Perpetrators are typically relatives or other individuals who:

- are known to the child
- have no intention to physically injure the child
- strive to maintain secrecy

Presentation for Medical Care

- disclosure of inappropriate sexual contact
- behavioral changes
- genital or anal complaints

A specific disclosure of inappropriate sexual contact is key to the diagnosis of child sexual abuse. Disclosures need to be taken seriously because most sexually abused children have a normal exam with no physical findings.

BEHAVIORAL INDICATORS OF ABUSE

The following behavioral problems should alert you to a child's feelings of distress and possible trauma and the need for further assessment:

- Depression, anxiety, low self-esteem
- Excessive/ inappropriate fears
- Sleep and appetite disturbances
- Behavioral extremes
- Developmental regression
- Habit disorders (excessive nail biting, rocking)
- Poor peer relationships
- Poor school performances
- School avoidance/truancy
- Self-mutilation
- Running away
- Sexually acting out behaviors
- Knowledge of sexual acts that exceed expectations for age group

1. **Screening for domestic violence and offering information/referrals for community resources to parents who screen positive is one of the most effective and active means of preventing child abuse.**
2. **Children whose parents are assaulted are also more likely to be victims.**
3. **Primary care providers should routinely screen for domestic violence when parents bring their children to appointments.** Abused parents often seek health care for their children, while ignoring their own injuries. Victims of violence may disclose abuse to a provider, especially if consistently asked about it.

Exposure to domestic violence include seeing or hearing:

- The adult victim being injured
- The adult victim's injuries
- The destruction of property
- The abuser's threats
- The domestic violence act
- The adult victim's screams and cries

Physical injuries to children, children may be:

- Accidently caught in a crossfire
- Intentionally injured while protecting their parent or caregiver
- Abused by their parents' or caregivers' partners
- Over-disciplined or abused by stressed, anxious, and depressed parent, caregiver or victimized parent.

Psychological effects of domestic violence on children

Even if children are not physically injured, there may be long-term psychological effects of witnessing family violence which include:

- Depression and anxiety
- Low self-esteem
- Self-destructive behaviors
- Disordered eating
- Eating disturbances
- Sleeping problems
- Somatic complaints
- Cognitive difficulties
- School problems
- Aggression, hostility and delinquency
- Damaging adult relationship

The AAP recognizes that family and intimate partner violence is a pediatric issue because it is harmful to children. The AAP recognizes that pediatricians are able to recognize abused caregivers in pediatric settings. The AAP recommends that pediatricians should attempt to recognize evidence of family or intimate partner violence in the office setting and should intervene in a sensitive, skillful manner that maximizes the safety of parent or caregiver and children victims.

HOW TO CONDUCT A MEDICAL ASSESSMENT WHEN YOU SUSPECT ABUSE

Take a detailed history. This is the most important evidence you will collect during the medical assessment because many cases of abuse and neglect have non-specific, ambiguous or NO physical findings.

If possible, interview the child and caregiver separately, and have a witness present during both interviews and examinations to help ensure that observations and documentation are accurate and unbiased.

Use age-appropriate language and open-ended questions when interviewing the child. Use direct questions to gain specific information, such as:

- *Tell me what happened.*
- *What happened next?*
- *Did anything else happen?*
- *Tell me more about that.*
- *Where were you?*
- *Upstairs or downstairs?*
- *Which room?*
- *Where was Mommy? Daddy? Grandma?*

Examine the ENTIRE child, including the genitals. Be objective and thorough.

Document EVERYTHING clearly and legibly in a detailed, objective, and professional manner. Copy statements made by the child or caretaker "word for word" when appropriate. Accurate documentation helps protect the child and helps protect you from liability.

Order diagnostic tests, document and track them until completion. These studies are used to help rule out medical conditions that may simulate child abuse and help confirm the diagnosis of child abuse.

CHEAT SHEET FOR THE INITIAL EVALUATION OF SUSPECTED CHILD PHYSICAL ABUSE †

Consider abuse in any child from any family with any injury when:

- Multiple injuries to multiple organ systems
- Denial of trauma in child with significant injury
- History inconsistent with injury
- History incompatible with child's development
- History that changes with time
- Unexpected and unexplained delay in seeking treatment

Suspected Abusive Head Trauma (including "Shaken Baby Syndrome")

- Brain CT or MRI
- Skeletal survey* for child under age 2
- Retinal exam (preferably by pediatric ophthalmologist)
- Standard labs**
- Hospital admission to pediatric center
- Report to Child Protective Services***

Suspected Abusive Fracture(s)

- Skeletal survey* for child under age 2
- Standard labs** plus calcium, phosphorus, alkaline phosphate
- Brain CT or MRI for infants (<1 y/o) and consider brain CT or MRI for 1-2 y/o
- Consider hospital admission
- Report to Child Protective Services***

Suspected Abusive Burns

- Skeletal survey* for child under age 2
- Photo-document if possible
- Consider standard labs** plus electrolytes
- Consider hospital admission/pediatric burn center
- Report to Child Protective Services***

† Adapted from the Pennsylvania Chapter, American Academy of Pediatrics

CHEAT SHEET FOR THE INITIAL EVALUATION OF SUSPECTED CHILD PHYSICAL ABUSE †

Suspected Abusive Abdominal Trauma

- Skeletal survey* for child under age 2
- Abdominal imaging
- Standard labs**
- Brain CT or MRI for infants (<1 y/o) and consider brain CT or MRI for 1-2 y/o
- Hospital admission
- Report to Child Protective Services***

Suspected Abusive Bruising

- Skeletal survey* for child under age 2
- Photo-document, if possible
- Standard labs**
- Consider brain CT or MRI
- Consider hospital admission
- Report to Child Protective Services***

* **Skeletal survey** (not a babygram) as per the American College of Radiology standards (www.acr.org). Look for rib fractures, metaphyseal fractures, skull fractures, long bone fractures. Consider repeat skeletal survey in 2-3 weeks to better identify rib and metaphyseal fractures.

** **Standard labs include:** CBC with platelet count, PT/PTT/INR, LFTs, amylase, lipase, U/A.

*** **Child Protective Services referral:**
New Jersey: 1-877-652-2873

For free child abuse education, visit www.njaap.org/programs/child-abuse-neglect/education/

† Adapted from the Pennsylvania Chapter, American Academy of Pediatrics

HOW TO INFORM THE FAMILY

Some healthcare clinicians are understandably hesitant to let the family know that they are making a referral to DCP&P. It is important to let the family know that you are making a referral to DCP&P and why. Focus on the common ground that you and the parents share – concern for the child. Most parents, even those who may have abused or neglected their children, want their child to thrive.

Informing the Family

- Ensure safety of the child, yourself, and office staff
- Be honest, non-judgmental, direct
- Review findings
- Avoid confrontation
- Tell the family it's your suspicion, not a certainty
- Mention your legal obligation but don't hide behind it
- Tell the parents your recommendations for follow-up medical care

When parents present a history that does not fit their child's physical findings, you might say:

"Mr. and Mrs. Smith, what you are telling me is puzzling in that we see many children each year who fall off beds and they don't have the type and severity of injury that Megan has. Is there anything else you can think of that might have injured her?"

To inform the family about a child abuse report, you might say:

"Your child does have an unusual (fractures, head injury, burns, etc.) which makes me worried that she may have suffered from a non-accidental injury, that someone hurt her. Is there anything more you can tell me about this injury? Is there anyone that you can think who may have recently been around your child who might have hurt her? This is a kind of injury (or finding) that as a medical provider I must report to DCP&P."

Explain to the family who the DCP&P is, and the process that will ensue. Explain that a report does NOT necessarily mean that the child will be taken away from the family, and that cooperation with DCP&P and possible law enforcement is needed to try to find out what happened to the child. Explain that you and the medical team need to work together to make things safe for the child. Explain the roles of the various people who will be involved in further evaluation.

While you may be angry and distressed about discovering possible abuse and having to report it, keep your feelings child-focused. Be non-judgmental. You are there to help the child; you want the child to remain in your care. Be supportive if families are initially angry or scared about findings and the need to report. You may want to add other thoughts, such as "I know that you love your child and are concerned about his/her safety. I also want to make sure that your child is safe."

WHAT HAPPENS AFTER A REPORT IS MADE

DCP&P begins a CPS investigation either immediately or within 24 hours of the report and CWS assessments either immediately or within 72 hours to:

Child Protective Service (CPS) — allegations of child abuse/neglect regarding the alleged abuse or neglect of a child by a caretaker or other person responsible for the child's well-being.

Child Welfare Service (CWS) — assesses concerns for a child that do not rise to the level of abuse or neglect, i.e. parenting capability, clothing, housing conditions, medical concerns, child behavioral or psychiatric issues. Services and assessments mandated by statute.

If sent to a Local Office, Centralized Screening codes the call as follows:

For CPS Investigations:

- Assess the safety of a child and all children in the household
- Determine if the child was abused or neglected
- Determine what services are needed by the child and family

For CWS Assessments:

- Assess the well-being of a child and all children in the household
- Determine what services are needed by the child and family
- Assist the family with linkages to appropriate services

The investigation or CWS assessment is completed within 60 days.

WHAT HAPPENS AFTER A REPORT IS MADE

Following are legal definitions of what is determined by DCP&P for reported incidences of abuse/neglect:

Substantiated: The child has been harmed or placed at risk of harm by a parent of caregiver- and the perpetrator's name is placed on the central registry.

Established: An allegation shall be "established" if the preponderance of the evidence indicates that a child is an "abused or neglected child" as defined in *N.J.S.A. 9:6-8.21*, but the act or acts committed or omitted do not warrant a finding of "substantiated"
as defined in (c)1 above – the perpetrator's name is not placed on the central registry.

Not Established: An allegation shall be "not established" if there is not a preponderance of the evidence that a child is an abused or neglected child as defined in *N.J.S.A. 9:6-8.21*, but evidence indicates that the child was harmed or was placed at risk of harm.

Unfounded: There is no evidence of conduct that would pose risk to the child.

Abuse or neglect cannot be proven by a preponderance of evidence, and evidence does not indicate that a child was exposed to harm or the risk thereof.

The available information indicates that the actions of the parent or caregiver were necessary and reasonable, and the incident was an accident.

DCP&P will work with families where abuse or neglect has been substantiated to decrease risk factors by providing them with counseling, education, and other supportive services. Contact your local DCP&P office if you have concerns about a family and are unsure whether services can be provided.

The paramount focus for children involved with DCP&P includes safety, permanency and well-being. Ideally, the family is preserved whenever possible; however, if the child's safety cannot be maintained in the home, DCP&P may place the child outside the home. In instances when it is necessary to remove the child from the home, efforts are made to place the child with relatives or people the child knows. When these resources are not available, the child may be placed in other settings.

REFER FAMILES TO COMMUNITY RESOURCES

There are resources available to help you support and strengthen families:

Aunt Bertha | Aunt Bertha provides instant access to comprehensive, localized listings with hundreds of programs in every zip code in the US. The platform helps both organizations and individuals with social needs find and make referrals to appropriate programs and services for food, shelter, healthcare, work, financial assistance, and more. The tools make it easy for making and managing referrals and coordinating care with community providers. Website: https://www.auntbertha.com/

Division of Child Protection & Permanency 1-877-NJ ABUSE (652-2873) | Child Protection and Permanency's mission is to ensure the safety, permanency, and well-being of children and support families. CP&P is responsible for investigating allegations of child abuse and neglect and, if necessary, arranging for the child's protection and the family's treatment.

Family Help-Line: 1-800-THE-KIDS (800 843 5437) | A toll-free 24-hour anonymous helpline established by the New Jersey Task Force on Child Abuse and Neglect. Trained volunteers answer questions on child abuse and its prevention and make referrals to other agencies that can help with parenting needs.

Family Support Organizations: 1-877-652-7624 | A program of the Department of Children and Families that establishes family-run, county-based organizations that provide direct family-to-family peer support, education, advocacy and other services to family members of children with emotional and behavioral problems. Website: http://www.nj.gov/dcf/families/support/support/

Family Success Centers | A program of DCF, these are "one-stop" shops that provide wrap-around resources and supports for families before they find themselves in crisis. Family Success Centers (FSC) offer primary child abuse prevention services to families and bring together concerned community residents, leaders, and community agencies to address the problems that threaten the safety and stability of families and the community. There is no cost to access services provided by FSCs. Website: http://www.state.nj.us/dcf/families/support/success/

New Jersey Domestic Violence Hotline: 1-800-572-SAFE (800-572-7233) | The New Jersey Domestic Violence Hotline is a 24-hour information and referral service. Callers are provided with general information about domestic violence and may request literature on the general topic of domestic violence. The hotline refers callers with specific questions to the county DV services.

NJ-2-1-1: 2-1-1 | NJ 2-1-1 connects people in need of help with services and resources in their community. They connect people to day care facilities, shelters, affordable housing units, social services, employment training programs, senior services, medical insurance, and more. Website: https://www.nj211.org/

Parents Anonymous Inc.: 1-800-THE-KIDS (800 843 5437) | Parents Anonymous provides free, weekly, community-based family strengthening groups for parents under stress and in need of information and support. The sessions are focused on helping parents learn new skills, transform their attitudes and behaviors, and create long-term positive changes in their lives. Website: http://parentsanonymous.org/network/new-jersey/

PerformCare: 1-877-652-7624 | PerformCare can help a parent or guardian connect their child to behavioral health, substance use and developmental disability services. Associates are available 24 hours a day, 7 days a week. Their services include in-home counseling, needs assessment, summer camp tuition assistance, family support, care management, substance use treatment, behavioral support, functional family therapy and habilitation services.Website: www.performcarenj.org

Prevent Child Abuse New Jersey: 1-800-CHILDREN (800-244-533) | A private, nonprofit organization committed to strengthening parenting practices, healthy child development and preventing child abuse. PCA-NJ operates many programs and trainings that benefit and collaborate with professionals, educators, parents, healthcare, child care and social service providers and employers. Trainings are offered to the public for a nominal fee. Website: www.preventchildabusenj.org.

SPAN Parent Advocacy Network: 1-800-654-SAFE (800 654 7726) | SPAN Information Specialists assist parents, educators, and service providers in attaining appropriate education and health care services for children. SPAN offers extensive publications related to education, law and advocacy, school reform, health and disability issues. Bilingual training and information is available. Website: www.spanadvocacy.org

Do you know what to do when you suspect child abuse and neglect?

New Jersey Division of Child Protection & Permanency New Jersey law requires EVERYONE to report suspected child abuse and neglect by calling the NJ Abuse Hotline, 1-877-NJ ABUSE (1-877-652-2873).

Regional Diagnostic & Treatment Centers New Jersey has legislated Regional Diagnostic and Treatment Centers (RDTCs) to evaluate and treat child abuse & neglect. RDTCs provide the following services:

- Evaluation, treatment, and prevention of physical and emotional injuries caused by child abuse and neglect
- Consultation when a young child presents with a genital complaint and the question of sexual abuse is raised
- Concerns of child on child sexual acting out behaviors
- Training and consultation
- Emergency telephone consultation
- Referrals to a wide spectrum of mental health services
- Research and training for medical and mental health personnel dedicated to the identification and treatment of child abuse and neglect

NEW JERSEY REGIONAL DIAGNOSTIC & TREATMENT CENTERS

Bergen, Hudson, Morris, Passaic, Sussex & Warren

Audrey Hepburn Children's House

Hackensack University Medical Center

Paulett Diah, MD, FAAP, Medical Director

(201) 996-2271

Northeast New Jersey: Essex

Metro Regional Child Abuse Diagnostic & Treatment Center

Children's Hospital of NJ at Newark Beth Israel Medical Center

Monica Weiner, MD, FAAP, Medical Director

(973) 926-4500

Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester & Salem

Child Abuse Research Education & Service (CARES) Institute

Rowan University-School of Osteopathic Medicine

Martin Finkel, DO, FACOP, FAAP, Medical Director

(856)-566-7036

Hunterdon, Mercer, Middlesex, Monmouth, Ocean, Somerset, Union

Dorothy B. Hersh Child Protection Center

The Children's Hospital at St. Peter's University

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For the most up-to-date information, please see www.njaap.org/programs/child-abuse-neglect/resources/