

Note to Instructor: This is an example of local state information. As previously noted, the instructor will need to tailor materials to the state in which the class is being conducted (or the variety of states the students represent).

South Carolina State Statutes

Child Abuse and Neglect

Definitions of Child Abuse and Neglect

To better understand this issue and to view it across States, download the PDF (665 KB) of this publication.

- **Physical Abuse**

Citation: Ann. Code § 63-7-20

Child abuse or neglect or harm occurs when the parent, guardian, or other person responsible for the child's welfare:

- Inflicts or allows to be inflicted upon the child physical or mental injury or engages in acts or omissions that present a substantial risk of physical or mental injury to the child, including injuries sustained as a result of excessive corporal punishment
- Abandons the child
- Encourages, condones, or approves the commission of delinquent acts by the child and the commission of the acts are shown to be the result of the encouragement or approval
- Has committed abuse or neglect as described above such that a child who subsequently becomes part of the person's household is at substantial risk of one of those forms of abuse or neglect

Physical injury means death or permanent or temporary disfigurement or impairment of any bodily organ or function.

- **Neglect**

Citation: Ann. Code § 63-7-20

Child abuse or neglect or harm occurs when the parent, guardian, or other person responsible for the child's welfare fails to supply the child with adequate food, clothing, shelter, education as required by law; supervision appropriate to the child's age and development; or health care even though financially able to do so or offered financial or other reasonable means to do so and the failure to do so has caused or presents a substantial risk of causing physical or mental injury.

- **Sexual Abuse/Exploitation**

Citation: Ann. Code § 63-7-20

Child abuse or neglect or harm occurs when the parent, guardian, or other person responsible for the child's welfare commits or allows to be committed against the child a sexual offense as defined by the laws of this State or engages in acts or omissions that present a substantial risk that a sexual offense as defined in the laws of this State would be committed against the child.

- **Emotional Abuse**

Citation: Ann. Code § 63-7-20

Mental injury means an injury to the intellectual, emotional, or psychological capacity or functioning of a child as evidenced by a discernible and substantial impairment of the

child's ability to function when the existence of that impairment is supported by the opinion of a mental health professional or medical professional.

- **Abandonment**

Citation: Ann. Code § 63-7-20

Abandonment of a child means a parent or guardian willfully deserts a child or willfully surrenders physical possession of a child without making adequate arrangements for the child's needs or the continuing care of the child.

- **Standards for Reporting**

Citation: Ann. Code § 63-7-310

A report is required when there is reason to believe that a child has been abused or neglected.

- **Persons Responsible for the Child**

Citation: Ann. Code § 63-7-20

Person responsible for a child's welfare includes:

- The child's parent, guardian, or foster parent
- An operator, employee, or caregiver, as defined by § 63-13-20, of a public or private residential home, institution, agency, or child care facility
- An adult who has assumed the role or responsibility of a parent or guardian for the child, but who does not necessarily have legal custody of the child

A person whose only role is as a caregiver and whose contact is only incidental with a child, such as a babysitter or a person who has only incidental contact but may not be a caregiver, has not assumed the role or responsibility of a parent or guardian.

- **Exceptions**

Citation: Ann. Code § 63-7-20

The term child abuse or neglect excludes corporal punishment or physical discipline that:

- Is administered by a parent or person *in loco parentis*
- Is perpetrated for the sole purpose of restraining or correcting the child
- Is reasonable in manner and moderate in degree
- Has not brought about permanent or lasting damage to the child
- Is not reckless or grossly negligent behavior by the parents

A child's absences from school may not be considered abuse or neglect unless the school has made efforts to bring about the child's attendance, and those efforts were unsuccessful because of the parents' refusal to cooperate.

Chapter 3

Children¹

Child Maltreatment 2007

Each State bases its own definitions of child abuse and neglect based on the standards set by Federal and State laws. The child protective services (CPS) units within each State respond to the safety needs of children who are alleged to have been maltreated based on those State definitions. The *Federal Child Abuse Prevention and Treatment Act (CAPTA)*, (42 U.S.C.A. §5106g), as amended by the *Keeping Children and Families Safe Act of 2003*, defines child abuse and neglect as:

- Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or
- An act or failure to act which presents an imminent risk of serious harm.

National child maltreatment estimates for Federal fiscal year (FFY) 2007 are based on child populations for the 50 States, the District of Columbia, and the Commonwealth of Puerto Rico. During FFY 2007:

- An estimated 794,000 children were victims of maltreatment;
- The rate of victimization was 10.6 per 1,000 children in the population; and
- More than 3.5 million children received CPS investigations or assessments.

This chapter provides in-depth information about the characteristics of children found to be abused or neglected during FFY 2007. This chapter also discusses the 5-year trend of children who received investigations or assessments and the 5-year trend of victimization rates.

Children Who Were Subjects of a Report

Based on data from 50 States, the rate of children who were subjects of a screened-in referral (a report) and who subsequently received an investigation or assessment was 47.2 per 1,000 children.² State rates ranged from 8.4 to 127.4 per 1,000 children.

When applied to the national population for all 52 States, an estimated 3.5 million children received an investigation or assessment.³ The national rate of children who received an investigation or assessment rose from 46.3 during FFY 2003 to 48.3 in FFY 2005, but has been

declining since 2005.⁴ The FFY 2006 rate was 47.9 and the FFY 2007 rate was 47.2 per 1,000 children (figure 3–1). The national estimate of children who received an investigation or assessment has declined from 3.6 million during 2006 to 3.5 million during 2007.

Child Victims

Based on data from 50 States, nearly one-quarter (22.5%) of children who received an investigation or assessment were found to have been maltreated.⁵ This compares to 25.2 percent of children who were found to have been maltreated during FFY 2006. The number of reported victims of maltreatment from the 50 States was 753,357.⁶ The victimization rate for FFY 2007 was 10.6 per 1,000 in the population.⁷ State rates of victimization ranged from 1.5 to 26.3 per 1,000 children. Based on the victimization rate of 10.6 per 1,000 in the population, an estimated 794,000 children were victims of maltreatment during FFY 2007.⁸

Between FFY 2003 and FFY 2006, the rate of victimization fluctuated between 12.2 and 12.0 per 1,000 children. Between FFY 2006 and FFY 2007, the rate of victimization dropped from 12.1 to 10.6 per 1,000 children, which is a change of 12 percent. This decrease can be attributed to several factors including the increase in children who received an “other” disposition, the decrease in the percentage of children who received a substantiated or indicated disposition, and the decrease in the number of children who received an investigation or assessment. It is not possible to tell whether this year’s decrease indicates a trend until more data are collected.

First-Time Victims

Approximately three-quarters of victims (75.4%) had no history of prior victimization.⁹ Information regarding first-time victims is a Program Assessment Rating Tool (PART) measure. The Community-Based Child Abuse Prevention Program (CBCAP) reports this PART measure to the Office of Management and Budget (OMB) each year as an average of all States. Individual State data are not reported to OMB.

Age and Sex of Victims

Nearly 32 percent (31.9%) of all victims of maltreatment were younger than 4 years old (figure 3–2). An additional 23.8 percent were

in the age group 4–7 years and 19.0 percent were in the age group 8–11 years.¹⁰ Victimization was split almost evenly between the sexes; 48.2 percent of victims were boys and 51.5 percent of the victims were girls. The sex of 0.3 percent of child victims was unknown.

The youngest children had the highest rate of victimization. The rate of child victimization for boys in the age group of birth to 1 year was 22.2 per 1,000 male children of the same age group (figure 3–3). The child victimization rate for girls in the age group of birth to 1 year was 21.5 per 1,000 female children of the same age group. The victimization rate for children in the age group of 4–7 years was 11.4 per 1,000 for boys and 11.6 per 1,000 for girls. The victimization rate for children in the age group of 16–17 was 5.4 per 1,000 children in the same age group. Overall, the victimization rates decreased for older age groups.

Race and Ethnicity of Victims

African-American children, American Indian or Alaska Native children, and children of multiple races had the highest rates of victimization at 16.7, 14.2, and 14.0 per 1,000 children of the same race or ethnicity, respectively. Hispanic children and White children had rates of 10.3 and 9.1 per 1,000 children of the same race or ethnicity, respectively. Asian children had the lowest rate of 2.4 per 1,000 children of the same race or ethnicity.¹¹ Nearly one-half of all victims were White (46.1%), one-fifth (21.7%) were African-American, and one-fifth (20.8%) were Hispanic.

Types of Maltreatment

During FFY 2007, 59.0 percent of victims experienced neglect, 10.8 percent were physically abused, 7.6 percent were sexually abused, 4.2 percent were psychologically maltreated, less than 1 percent were medically neglected, and 13.1 percent were victims of multiple maltreatments (figure 3–4).¹² In addition, 4.2 percent of victims experienced such "other" types of maltreatment as "abandonment," "threats of harm to the child," or "congenital drug addiction." States may code any condition that does not fall into one of the main categories—physical abuse, neglect, medical neglect, sexual abuse, and psychological or emotional maltreatment—as "other."

The data for victims of specific types of maltreatment were analyzed in terms of report sources, race, and age group. Of victims of physical abuse, 25.4 percent were reported by teachers, 23.9 percent were reported by police officers or lawyers, and 13.3 percent were reported

by medical staff.¹³ Police officers or lawyers accounted for the largest report source percentage of neglect victims (28.1%) and sexual abuse victims (29.4%). "Other" and unknown reporters are not classified as either professional or nonprofessional reporters. They were responsible for 11.5 percent of all reports. Overall, 67.5 percent of victims were reported by professionals and 20.9 percent were reported by nonprofessionals.

When looking at the maltreatment types by race, some disproportionality issues become apparent. Of the victims of all maltreatments, 45.4 percent were White, but only 36.4 percent of medical neglect victims were White. African-Americans comprised 21.4 percent of all victims, but 35.3 percent of medical neglect victims.¹⁴ Of the sexual abuse victims, more than one-half (51.5%) were White, compared with 45.4 percent of all victims who were White.

Analyzing the data by age groups reveals that of the victims who were medically neglected, 20.4 percent were younger than 1 year old (figure 3–5). Victims who were younger than 1 year old comprised 12.0 percent of all maltreatment victims.

Of the victims who were sexually abused, 35.2 percent were in the age group 12–15 years, 23.8 percent were in the age group 8–11 years, and 23.3 percent were in the age group 4–7 years.¹⁵

Living Arrangement of Victims

Data are incomplete for the living arrangement of victims. Some States that reported data were excluded from the analysis if the State reported more than 50 percent of the data as unknown or missing. Less than one-half of the States (22) reported usable data for this field. It is hoped that the reporting of this data element will improve in the coming years.¹⁶

In the 22 States that reported living arrangement data, approximately 26 percent (25.5%) of victims were living with a single mother. Nearly 20 percent (19.1%) of victims were living with married parents, while approximately 21 percent of victims (20.9%) were living with both parents, but the marital status was unknown.

Risk Factors

Children who were reported with any of the following risk factors were considered as having a disability: Mental retardation, emotional

disturbance, visual or hearing impairment, learning disability, physical disability, behavioral problems, or another medical problem. In general, children with such risk factors are undercounted, as not every child receives a clinical diagnostic assessment from CPS agency staff. Slightly more than 8 percent (8.1%) of victims had a reported disability. Approximately 3 percent (3.1%) of victims had behavior problems, another 3.1 percent had some other medical condition, and 1.9 percent of victims were emotionally disturbed. A victim could have been reported with more than one type of disability.¹⁷

The data were examined to determine if the child had a caregiver risk factor of domestic violence, meaning the caregiver perpetrated or was the victim of domestic violence in the child's home environment. For the 34 States that reported this data element, 14.9 percent of victims and 2.6 percent of nonvictims had a caregiver risk factor of domestic violence.¹⁸

Perpetrator Relationship

Victim data were analyzed by relationship to their perpetrators. Nearly 39 percent (38.7%) of victims were maltreated by their mother acting alone (figure 3–6). Nearly 18 percent (17.9%) of victims were maltreated by their father acting alone. Nearly 17 percent (16.8%) were maltreated by both parents.¹⁹

The Impact of Maltreatment on the Developing Child

Dana M. Hagele, MD, MPH

Overview

Childhood, from infancy to adolescence, is a time of enormous neurological growth and development. Child maltreatment—including physical, sexual, and emotional abuse; neglect; and exposure to domestic violence—represents an *extreme traumatic insult* to the developing child. Specifically, maltreatment results in disruption of the bond between child and caregiver, and it causes up-regulation of the biological stress response system. Chronic traumatic exposure may then lead to persistent changes in brain structure and chemistry. Current research suggests that these biological alterations contribute to long-term physical, emotional, behavioral, developmental, social, and cognitive dysfunction seen in adults who have experienced childhood maltreatment. As described by DeBellis, the “psychobiological sequelae of child maltreatment may be regarded as an environmentally induced, complex developmental disorder.”¹

Child Maltreatment: Biological Pathways to Adverse Outcomes

Immediate Alterations in Brain Chemistry

The psychological trauma of maltreatment triggers the complex neurochemical and hormonal systems involved in the stress response and in emotional regulation. When a child experiences an abusive insult, in their glucocorticoid, noradrenergic, and vasopressin-oxytocin systems² are activated; this highly adaptive response allows for survival in a dangerous environment. Chronic activation, however, may result in permanent changes in

brain chemistry, structure, and function. Over time, maltreated children are at risk for the development of an exaggerated response to relatively minor stress. Compounding this insult, maltreated children are forced to respond to environmental threats (family violence), rather than engaging in activities necessary for the development of complex emotional, behavioral, and cognitive functioning.

“Recent neuroimaging studies demonstrate that neuroanatomy is significantly altered among individuals who have experienced childhood maltreatment and abuse-related Posttraumatic Stress Disorder.”

Persistent Alterations in Brain Structure and Function

Recent neuroimaging studies demonstrate that neuroanatomy is significantly altered among individuals who have experienced childhood maltreatment and abuse-related Posttraumatic Stress Disorder (PTSD).³ For example, children diagnosed with maltreatment-related PTSD have reduced cerebral volume

(prefrontal white matter, right temporal lobe, and mid-section of the corpus callosum), and associated enlargement of the ventricular system.⁴ This finding indicates significant neuronal loss, and therefore, lost potential for child growth, development, and functioning. Studies have shown alterations in the pituitary⁵ and hippocampus⁶ of children with PTSD; this demonstrates a possible link between the trauma of child abuse, resultant changes in brain anatomy, and adverse effects on learning and memory.⁷

Chronic or extreme maltreatment may result in altered neurophysiology and neuroanatomy through persistent activation of the hypothalamic-pituitary-adrenal axis (HPA) and the catecholamine stress system. For example, women with a history of childhood sexual abuse exhibit HPA-axis abnormalities (cortisol suppression following dexamethasone challenge) comparable to that of adults with combat-related PTSD.⁸ Similarly,

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children with a history of sexual abuse show evidence of higher catecholamine functional activity, which manifests as physiological agitation.⁹ Finally, children with a history of maltreatment-associated PTSD demonstrate characteristic changes in cerebral blood flow patterns,¹⁰ as well as characteristic alterations in regional activation of the brain.¹¹ These findings offer a neurophysiological explanation for the behavioral and emotional changes seen in children with histories of abuse.¹²

Child Maltreatment: Intermediate and Long-Term Outcomes

Impact on Child, Family, Community, and Society

Child maltreatment, and the associated disruption of secure parent-child attachment, represents a severe traumatic exposure comparable to that of military combat. The initial physiological and behavioral response to abuse may be appropriate and adaptive. However, if the trauma is severe or chronic, persistent changes in neuroanatomy and neurophysiology may occur, often leading to the development of psychiatric disturbance, particularly depression and PTSD. Ultimately, maltreatment and its associated morbidities predict adverse short- and long-term outcomes across physical, developmental, cognitive, emotional, behavioral, and social functional domains.

General Medical Problems and High-Risk Health Behaviors

Adults and adolescents with a history of childhood abuse, neglect, or domestic violence exposure, demonstrate nearly twice the number of serious health problems as children without these experiences.¹³ Documented medical problems associated with childhood maltreatment include: chronic fatigue;¹⁴ altered thyroid function;¹⁵ altered immune function;¹⁶ eating disorders and obesity;¹⁵ asthma;¹⁶ hypertension,¹⁷ and peptic ulcer disease.¹⁸ Similarly, these exposures increase the likelihood of high-risk health behaviors among men and women, including: a higher number of lifetime sexual partners;¹⁹ increased male involvement in teen pregnancies;²⁰ higher incidence of unprotected sex with partners of unknown HIV status;²¹ younger age at first voluntary intercourse;²³ diminished birth control efficacy;²² younger age at the birth of the first child;²² and greater likelihood of becoming a teen mother.²² Similarly, childhood maltreatment is predictive of significantly higher levels of alcohol and substance abuse disorders.²³⁻²⁷

Developmental Dysfunction and Mental Health Disorders

Children with a history of maltreatment frequently demonstrate significant deficits across developmental and cognitive domains, ultimately affecting educational performance. Specifically, maltreated children demonstrate deficits in attention, abstract reasoning, impulse control, and long-term memory for

verbal information.¹² Similarly, traumatic exposure is associated with significant decrease in IQ.²⁸ Due to overlapping cognitive, behavioral, and emotional symptomatology, childhood PTSD may resemble Attention-Deficit Hyperactivity Disorder (ADHD) or other learning disabilities in the classroom.

Child abuse and neglect are independently associated with the development of adolescent and adult mental health disorders. This effect is mediated, in part, through persistent stimulation of biological stress systems, as well as through the development of PTSD. Mood and anxiety disorders are most prevalent among this population;^{29,30} between one-third and one-half of all abused children meet the Diagnostic and Statistical Manual of Mental Disorders³ criteria for PTSD.³¹⁻³³ In addition to the development of mental health disorders, maltreatment is associated with the development of co-morbid personality disorders.³⁵ Overall, child maltreatment and associated co-morbidities are independent risk factors for suicidal thoughts and behavior.^{35,36} By eight years of age, approximately 10% of maltreated children experience suicidal ideation.³⁷

Re-victimization and Dysfunctional Parenting

A childhood history of maltreatment is associated with dysfunctional interpersonal relations in adulthood. Compared to individuals who have not been abused, adults with a childhood history of abuse and neglect report twice as many subsequent sexual assaults, higher rates of domestic violence, and four times the incidence of self-harm.^{38,39} Chronic, severe maltreatment is independently associated with re-victimization, including later involvement in intimate partner violence.³⁹ This outcome may be mediated through the development of cognitive distortions, learned in the context of child maltreatment.⁴⁰ Similarly, child maltreatment independently predicts later dysfunction in parenting, including the perpetration of severe physical maltreatment⁴¹ and inappropriate maternal dependence on children for emotional fulfillment.⁴² These findings may contribute to the intergenerational transmission of maltreatment.

Adverse Societal Effects

Child maltreatment and associated morbidities independently predict child and familial dysfunction across physical, developmental, emotional, behavioral, cognitive, and social domains. Thus, maltreatment—both directly and indirectly—has a profound, adverse effect on societal health and functioning. Specifically, child abuse and neglect are correlated with increased prevalence of public health problems, including community and domestic violence, delinquency, mental health disorders, alcohol and illicit substance use, obesity, suicide, and teen pregnancy. These outcomes, in turn, correlate with increased utilization of public and private resources. For example, individuals with childhood histories of maltreatment participate in more emergency room and general medical evaluations.⁴³ They also demonstrate higher utilization rates with regard to

a “The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition™ (DSM IV) is the manual physicians, psychiatrists, psychologists, therapists, and social workers use to diagnose mental illness.

inpatient and outpatient psychiatric services, as well as surgical hospitalizations.⁴⁴⁻⁴⁶ In addition to direct healthcare costs, maltreatment and its sequelae result in incalculable expenditures across the child welfare, public and private mental health, early intervention and education, juvenile delinquency and criminal justice, public welfare, and public health systems.

Adverse Affect of Maltreatment on the Developing Child: Public Health Implications

Physiological and psychological response to stress, including maltreatment, is often adaptive, allowing for the preservation of

individual safety and integrity. With chronic or extreme traumatic exposure, this response may become highly maladaptive, resulting in further child and family dysfunction. Ultimately, child and family dysfunction impacts community and societal well-being. Thus, the optimal public health response to child maltreatment necessitates policies and practices supportive of evidence-based primary prevention efforts, early detection through screening and evaluation, prompt stabilization of child and family safety and well-being, and initiation of appropriate intervention and therapy. **NCMedJ**

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This is an example of local state information. As previously noted, the instructor will need to tailor materials to the state in which the class is being conducted (or the variety of states the students represent).

South Carolina

Child Abuse and Neglect

Making and Screening Reports of Child Abuse and Neglect

To better understand this issue and to view it across States, download the [PDF](#) (619 KB) of this publication.

- **Reporting Procedures**
 - **Individual Responsibility**

Citation: Ann. Code § 63-7-310

 - A mandated reporter shall report to the Department of Social Services or a law enforcement agency when the reporter has reason to believe that a child may have been abused or neglected.
 - The report is made to a law enforcement agency when abuse is committed by someone other than a person responsible for the child's welfare.
 - Reports may be made orally by telephone or otherwise to the county Department of Social Services or to a law enforcement agency in the county where the child resides or is found.
 - **Content of Reports**

Citation: Ann. Code § 63-7-310

 - Reports must include the identity of the reporter, which is kept confidential.
- **Special Reporting Procedures**
 - **Suspicious Deaths**

Citation: Ann. Code § 63-7-310

 - A mandated reporter who has reason to believe that a child has died as a result of abuse or neglect shall report the information to the appropriate medical examiner or coroner.
 - The medical examiner or coroner shall accept the report for investigation and shall report his or her findings to the appropriate law enforcement agency, circuit solicitor's office, the county Department of Social Services, and if the institution making a report is a hospital, to the hospital.
 - **Substance-Exposed Infants**
 - Not addressed in statutes reviewed.
- **Screening Reports**

Citation: Ann. Code §§ 63-7-340; 63-7-350; 63-7-910; 63-7-920; 63-7-930

 - When a report is referred to the department for an investigation, the department must determine whether previous reports have been made regarding the same child or the same subject of the report.
 - If the department does not conduct an investigation, the department must make a record of the report and classify the record as a Category IV unfounded report. The department and law enforcement are authorized to use information from the report for purposes of assessing risk and safety if additional contacts are made concerning the child, the family, or the subject of the report.

- The department may maintain a toll-free number available to persons throughout the State for the reporting of known or suspected cases of child abuse or neglect.
- Within 24 hours of the receipt of a report of suspected child abuse or neglect, the department must begin an appropriate and thorough investigation to determine whether a report of suspected child abuse or neglect is "indicated" or "unfounded." The finding must be made no later than 45 days from the receipt of the report.
- The department must furnish to parents or guardians on a standardized form the following information as soon as reasonably possible after commencing the investigation:
 - The allegations being investigated
 - Whether the person's name has been recorded by the department as a suspected perpetrator of abuse or neglect
 - How information provided by the parent or guardian may be used
 - The possible outcomes of the investigation
- Reports of child abuse and neglect must be classified in the department's data system and records in one of three categories: suspected, unfounded, or indicated. All initial reports must be considered suspected. Reports must be maintained in the category of suspected for no more than 60 days after the report was received. By the end of the 60-day time period, suspected reports must be classified as either unfounded or indicated based on the investigation.

Mandatory Reporters of Child Abuse and Neglect

To better understand this issue and to view it across States, download the [PDF](#) (380 KB) of this publication.

- **Professionals Required to Report**

Citation: Ann. Code § 63-7-310

- The following professionals are required to report:
 - Physicians, nurses, dentists, optometrists, medical examiners, coroners
 - Any other medical, emergency medical services, or allied health professionals
 - Teachers, school counselors, principals, or assistant principals
 - Child care workers in any child care 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, undertakers, or funeral home directors or employees
 - Persons responsible for processing films or computer technicians

- **Reporting by Other Persons**

Citation: Ann. Code § 63-7-310

- 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**

- **Citation: Ann. Code § 63-7-310**

- A report is required when a reporter, in his or her professional capacity, receives information that gives him or her reason to believe that a child has been or may be abused or neglected.

- **Privileged Communications**

- **Citation: Ann. Code § 63-7-420**

- 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 a Christian Science practitioner or religious healer, and penitent, does not constitute grounds for failure to report. However, a clergy member, including a Christian Science practitioner or religious healer, must report in accordance with this subarticle except when information is received from the alleged perpetrator of the abuse and neglect during a communication that is protected by the clergy and penitent privilege as provided for in § 19-11-90.

- **Inclusion of Reporter's Name in Report**

- Not addressed in statutes reviewed.

- **Disclosure of Reporter Identity**

- **Citation: Ann. Code § 63-7-330**

- 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, except as specifically provided for in statute.

Year of Training: _____

CHILD VICTIMIZATION PRE-SEMINAR EVALUATION

1. Out of the cases reported to Child Protective Services, what percentage of children were identified as victims of physical abuse:
 - a. 5-10%
 - b. 15-20%
 - c. 40-50%
 - d. 65-80%
 - e. None of the above

2. What percentage of perpetrators are known to their victims?
 - a. Less than 10%
 - b. 25%
 - c. 50%
 - d. over 70%

3. Which of the following behaviors does *not* qualify as child physical abuse:
 - a. Failure to provide food
 - b. Kicking
 - c. Shaking
 - d. Biting
 - e. None of the above

4. _____ **True or False:** While many cases of abuse are not reported to authorities due to lack of child's disclosure, most cases of abuse detected by professionals are reported to the proper authorities.

5. _____ **True or False:** In addition to Posttraumatic Stress Disorder, other consequences of child maltreatment include cognitive difficulties, occupational problems, and negative health outcomes (e.g. heart disease, liver disease, increased smoking).

6. Who of the following is considered a mandated reporter?
 - a. Clergy
 - b. Computer technician
 - c. Teacher's Aid
 - d. Emergency Medical Technician
 - e. All of the above

7. _____ **True or False:** If you only suspect abuse, you should not make a report.

8. _____ **True or False:** Minority populations are at greatest risk for experiencing short and long-term effects of traumatic events since typically used treatments are not helpful to them.

9. Which of the following statements is **NOT** true:
 - a. It is very rare for a child to make a false report of abuse.
 - b. If a child who has been victimized refuses to talk, it is better to not talk about the abuse and just let the child forget what happened.
 - c. Not all children will exhibit significant long-term problems as a result of abuse.
 - d. Children are often unaware that an abusive situation is not "normal."
 - e. All of the above statements are true.

10. _____ **True or False:** The definitions of what types of abuse are reportable vary by state.

EVALUATION FORM

To improve the quality of the seminar, we would like your feedback. The confidentiality of the information you provide is guaranteed. Please circle the answer that corresponds to your level of agreement with the following statements. Feel free to include specific.

| Child Victimization Seminar | Strongly Disagree | Disagree | Neither Agree nor Disagree | Agree | Strongly Agree | Not Applicable |
|--|-------------------|----------|----------------------------|-------|----------------|----------------|
| FACULTY PRESENTERS: | | | | | | |
| 1. Material was presented clearly and logically. | 1 | 2 | 3 | 4 | 5 | N/A |
| 2. Presenter(s) demonstrated an expert knowledge of the subject. | 1 | 2 | 3 | 4 | 5 | N/A |
| 3. Presenter(s) answered participant questions effectively. | 1 | 2 | 3 | 4 | 5 | N/A |
| 4. Discussion was encouraged and facilitated effectively. | 1 | 2 | 3 | 4 | 5 | N/A |
| Feedback on Faculty: | | | | | | |
| | | | | | | |
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| Feedback on Faculty: | | | | | | |
| | | | | | | |
| SESSION: | | | | | | |
| 5. Session was relevant to my professional needs. | 1 | 2 | 3 | 4 | 5 | N/A |
| 6. Session was interactive. | 1 | 2 | 3 | 4 | 5 | N/A |
| 7. Session was well organized, clear and comprehensive. | 1 | 2 | 3 | 4 | 5 | N/A |
| 8. Session addressed the critical issues affecting this topic. | 1 | 2 | 3 | 4 | 5 | N/A |
| 9. Session contained the right amount of background information. | 1 | 2 | 3 | 4 | 5 | N/A |
| 10. Session contained the right amount of practical information. | 1 | 2 | 3 | 4 | 5 | N/A |
| 11. Readings were helpful in learning subject matter. | 1 | 2 | 3 | 4 | 5 | N/A |
| 12. I will be able to use the information covered in this session in the future. | 1 | 2 | 3 | 4 | 5 | N/A |
| 13. Time allocated to topic was adequate. | 1 | 2 | 3 | 4 | 5 | N/A |
| Feedback on Sessions: | | | | | | |
| | | | | | | |

Answer the following questions about this seminar on the reverse side of the form. Please use examples where possible.

1. What did you like most about this seminar?

2. What did you like least about this seminar? How would you suggest changing/improving this seminar?

3. What information was missing from this seminar? What additional information would you have liked included?

4. Any additional comments?

Thank you for taking the time to complete this evaluation form.

Year of Training: _____

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Sample Create Child Victim Resources Card

MUSC

Medical University of South Carolina Child Victim Resources

| | |
|---------------------------------|--------------|
| Charleston County DDS | 843-953-9422 |
| Berkeley County DDS | 843-761-8044 |
| Dorchester County DDC | 843-873-5111 |
| City of Charleston Police Dept. | 843-577-7434 |
| North Charleston Police Dept. | 843-207-0666 |
| Charleston Co. Sheriff's Office | 843-202-1700 |

| | |
|---------------------------------|----------------------------|
| Dorchester Co. Sheriff's Office | 843-832-0300 |
| Berkeley Co. Sheriff's Office | 843-567-3186 |
| Moncks Corner Police Dept. | 843-719-7930 |
| Goose Creek Police Dept. | 843-572-4300 |
| Summerville Police Dept. | 843-871-2463 |
| Lowcountry Children's Center | 843-723-3600 |
| My Sister's House | 843-744-3242 |
| 211 Hotline | 211 or 843-744-HELP (4357) |
| People Against Rape | 843-745-0144 |