Iowa State Mandatory Child and Dependant Adult Abuse Education

NYSNA Continuing Education

This course meets the Iowa State mandatory training on abuse identification and reporting. This curriculum is approved by the Abuse Education Review Panel and was assigned approval number 856 on January 4, 2005. This course includes updates through 2007.

The New York State Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This course has been awarded 3 contact hours.

All American Nurses Credentialing Center (ANCC) accredited organizations' contact hours are recognized by all other ANCC accredited organizations. Most states with mandatory continuing education requirements recognize the ANCC accreditation/approval system. Questions about the acceptance of ANCC contact hours to meet mandatory regulations should be directed to the Professional licensing board within that state.

NYSNA has been granted provider status by the Florida State Board of Nursing as a provider of continuing education in nursing (Provider number 50-1437).

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How to Take This Course

Please take a look at the steps below; these will help you to progress through the course material, complete the course examination and receive your certificate of completion.

1. **REVIEW THE OBJECTIVES**

   The objectives provide an overview of the entire course and identify what information will be focused on. Objectives are stated in terms of what you, the learner, will know or be able to do upon successful completion of the course. They let you know what you should expect to learn by taking a particular course and can help focus your study.

2. **STUDY EACH SECTION IN ORDER**

   Keep your learning "programmed" by reviewing the materials in order. This will help you understand the sections that follow.

3. **COMPLETE THE COURSE EXAM**

   After studying the course, click on the "Course Exam" option located on the course navigation toolbar. Answer each question by clicking on the button corresponding to the correct answer. All questions must be answered before the test can be graded; there is only one correct answer per question. You may refer back to the course material by minimizing the course exam window.

4. **GRADE THE TEST**

   Next, click on "Submit Test." You will know immediately whether you passed or failed. If you do not successfully complete the exam on the first attempt, you may take the exam again. If you do not pass the exam on your second attempt, you will need to purchase the course again.

5. **FILL OUT THE EVALUATION FORM**

   Upon passing the course exam you will be prompted to complete a course evaluation. You will have access to the certificate of completion **after you complete the evaluation**. At this point, you should print the certificate and keep it for your records.

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Objectives:

Upon completion of this course, the learner will be able to:

- Describe the role of mandatory reporters of child abuse and dependent adult abuse in Iowa.
- Discuss the nine kinds of child abuse that are identified in Iowa State Code.
- Discuss the categories of dependent adult abuse identified in Iowa State Code.
- Describe physical, behavioral and environmental indicators of abuse in children and dependent adults.
- Identify characteristics of perpetrators of child abuse and dependent adult abuse.
- Describe the reporting requirements for child abuse and dependent adult abuse.
- Explain what happens during an assessment/evaluation of child abuse or dependent adult abuse.
- Identify the legal ramifications of not reporting child abuse or dependent adult abuse.

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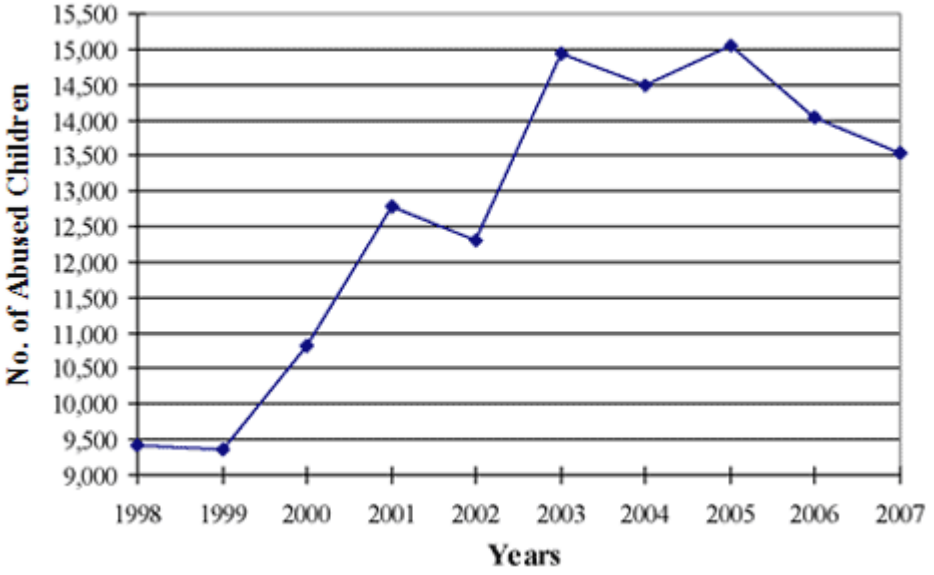
Introduction

Children are dependent on adult caretakers to have their needs met. This dependency puts them in a vulnerable position. According to Iowa's Department of Human Services, in 2006 and 2007, there was a notable decline in the abuse suffered by children in Iowa. Despite the decline from 2005, the abuse numbers had climbed from 10,822 abused children in 2000 to 15,060 children in 2005 and 13,529 in 2007. Figure 1 clearly illustrates these figures. Too many children in Iowa are suffering abuse (Prevent Child Abuse, Iowa, [PCAI], 2007).

Figure 1: Rate of Child Abuse, 1998-2007



Source: PCAI, 2007

Dependent adults, 18 or older, who because of diminished cognitive and/or physical abilities are unable to meet their own needs, are also dependent on adult caregivers and are also therefore vulnerable. While we would all like to believe that abuse of these vulnerable populations doesn't occur, in fact, it occurs with alarming frequency. In the state of Iowa, the law clearly identifies that certain professionals are required to report any evidence of such abuse.

Although child abuse reporting laws have been in effect in Iowa since 1978, the 2001 Iowa Acts, established a panel for "review and approval of mandatory reporter training curricula for those persons who work in a position classification that under law makes the persons mandatory reporters of child or dependent adult abuse and the position classification does not have a mandatory reporter training curriculum approved by a licensing or examining board". The director of the department of public health convened an expert panel to satisfy the mandates of the legislation.

Mandatory report training curricula must be approved by the Abuse Education Review Panel to satisfy the Iowa Code mandated training requirement. Licensed professionals are required to complete training that is required and approved by their respective licensing and examining boards or approved by the Abuse Education Review Panel (Iowa Department Public Health [IDPH], n.d.).

According to the Iowa Board for Nursing, a licensee who regularly examines, attends, counsels or treats children or adults in Iowa is required to complete training related to the identification and reporting of child/dependent adult abuse. The licensee is required to complete at least *two hours of training every five years*. The board of nursing must require the licensee, to document

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completion of the training requirements at the time of renewal (Iowa Board of Nursing, n.d.). This course has been approved by the Iowa Board for Nursing.

This course is divided into two parts. Part I addresses the identification and reporting of child abuse and Part II addresses the identification and reporting of dependant adult abuse.

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About the Author

Silvia Y. Beaupre, NPP, APRN, BC

Ms. Beaupre is an Associate Director, Nursing Education for the New York State Nurses Association and a board certified psychiatric nurse practitioner in private practice. Ms. Beaupre has worked in a variety of clinical settings, treating a range of psychiatric illness, from the chronically and persistently mentally ill in inpatient settings to treating adult patients in private out-patient settings. Her specialty area of focus is mood disorders in women. She has been an educator in the classroom and in the clinical setting for nursing students at associate degree, baccalaureate degree and master's degree levels. She also has extensive experience in staff development and clinical supervision.

Ms. Beaupre received a baccalaureate in nursing from DePaul University in Chicago, a master's degree in Psychiatric-Community Mental Health Nursing from the University of Illinois at Chicago and a Post Master's Certificate in Nursing, Psychiatric Nurse Practitioner from The Sage Colleges in Troy, NY. Ms. Beaupre has many years of clinical experience as a psychiatric clinical nurse specialist and psychiatric nurse practitioner, functioning as an educator, administrator, therapist, consultant and psychopharmacologist.

This course was updated in August 2008 by **Ann L. Purchase, MS, RN**, Associate Director for the Education, Practice & Research Program of the New York State Nurses Association. Ms. Purchase has extensive teaching experience in academic nursing programs and staff development. She recently taught the mandatory Child Abuse course for an academic nursing program and also taught the content for elder abuse. Her specialty focus is medical/surgical and oncology.

Ms. Purchase received her bachelor's degree from Hartwick College in Oneonta, NY, and her master's in nursing education from The Sage Colleges in Troy, NY.

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Part I. The Identification and Reporting of Child Abuse

Source: Corporate Graphics Resource, Albany, NY

It shouldn't hurt to be a child. Child abuse and maltreatment is a widespread international, national, state, local, community, and family violence issue. It is seen in many areas of clinical practice. It is important when examining the information that professionals realize that the indicators of child abuse, maltreatment and neglect can be applied to all practice settings in which professionals interact with children and their families/caregivers. As child abuse is not limited to one setting, neither is its identification or reporting.

National Statistics

In 2006, the United States Department of Health and Human Services reported in the publication *Child Maltreatment*, that nationally, there were an estimated 3.3 million reports of child abuse and neglect involving approximately 6.0 million children; 62% of the cases were accepted for investigation. In those reported cases, 30% were determined to be actual abuse, resulting in approximately 905,000 children who were victims of abuse or neglect (U.S. Department of Health and Human Services, Child Maltreatment, [USDHHS-ACF], 2006). Inclusion in the national estimates means that the child is being counted each time they are identified as a subject of a maltreatment investigation. The age group zero to three years old represented the highest rate of victimization. The following pie chart from The National Child Abuse and Neglect Data System (NCANDS) illustrates the magnitude of the maltreatment in this age range.

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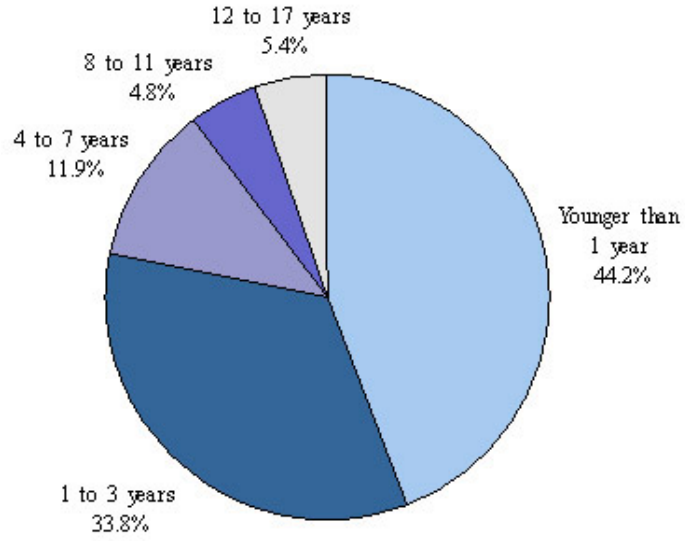
Figure 2: Child and Neglect Fatality Victims by Age, 2006



Source: Child Welfare Information Gateway, 2008

Disturbingly, only about one third of children who are actually maltreated are reported. This means that it is likely that more than 2.7 million children are abused every year. That number is staggering. Child abuse is beginning to be recognized as a component of family violence. In homes where there is intimate partner abuse, previously called domestic violence, it is not only women who are abused. When domestic violence between adults is present, child abuse is 15 times more likely to occur (USDHHS-ACF, 2006).

Iowa Statistics

In 2007, the Department of Human Services (DHS) determined that there were 9,257 confirmed cases of abuse in Iowa which represents 37% of the 24,789 accepted reports of child abuse. There were 13,529 victims named in the confirmed reports indicating that some of the children suffered more than one occurrence of maltreatment or multiple types of abuse (PCAI, 2007).

In Iowa, the first child abuse reporting law (Iowa Code sections 232.67 through 232.75) was enacted in 1978, although it has been amended multiple times since. The intent of the reporting law is to identify children who are victims of abuse, provide a professional assessment to the victims to determine if abuse has occurred and provide protective services to treat and prevent additional maltreatment.

Historical Factors Related to Child Abuse and Maltreatment

Accounts of the abuse and maltreatment of children have strong historical roots. Children were considered to be the property of the parents or caregivers. Indeed, childhood itself is a relatively new concept. Until approximately the 18th century, children were seen as small adults. Children, as property of their parents or caregivers, did not have rights. The old saying, “Spare the rod and spoil the child’ gives an indication of the prevailing perspective, the thought was that in order to flourish, children needed to be punished. Begging, mutilation, and infanticide were not uncommon. Indeed in many parts of the world today these actions persist to impact the lives of children. Home imprisonment throughout history was not uncommon; child labor has long been a problem (and remains so in many parts of the world), and the industrial revolution in the Western countries only created yet another means for children to be in servitude.

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The Society for Prevention of Cruelty to Children (SPCC) was founded in New York City in 1875. To a significant degree it was the case of Mary Ellen McCormack that spurred its creation. In 1873, Mary Ellen McCormack, a nine year old orphan, lived in New York City with Francis and Mary Connolly. She was physically abused almost daily by Mrs. Connolly, who often used a raw-hide whip. Mary Ellen had few clothes, no bed, and was not allowed to leave the house. A social worker, Etta Wheeler, learned of the child's horrible situation; she saw the conditions under which the child lived and she saw Mary Ellen herself, an undernourished and uncared for child whose body bore the marks of repeated beatings. Despite efforts to intervene on her behalf, Ms. Wheeler found that the laws, as well as charitable institutions, were unable to protect the girl. Finally, it was the Society for the Prevention of Cruelty to Animals who intervened to protect Mary Ellen as an abused member of the animal kingdom. On April 9, 1874, Mary Ellen McCormack, a fresh gash on her face, was brought into a New York courtroom to tell her story to the Judge Abraham Lawrence. This was the beginning of the children's rights movement (New York Society for the Prevention of Cruelty to Children [NYSPCC], n.d.).

Nearly a century later, in 1961, after several journal articles about the frequent injuries children suffered at the hands of those responsible for their care, the American Academy of Pediatrics held a conference on "The Battered Child Syndrome". The classic text *The Battered Child Syndrome* by Dr. C. Henry Kempe was an outgrowth of that conference.

Although the abuse of children has strong historical roots, and in our current society it is abhorred, it still occurs with epidemic prevalence.

Who are Mandatory Reporters of Child Abuse?

Iowa law defines categories of persons who must make a report of child abuse within 24 hours when they reasonably believe a child has suffered abuse. These "mandatory reporters" are professionals who have frequent contact with children, generally in one of six disciplines:

- Health
- Education
- Child care
- Mental health
- Law enforcement
- Social work

As outlined in Iowa Code, the following are mandatory reporters when they examine, attend, counsel, or treat a child in the scope of professional practice or in their employment responsibilities:

- All licensed physicians and surgeons
- Physician assistants
- Dentists
- Licensed dental hygienists
- Optometrists
- Podiatrists
- Chiropractors
- Residents or interns in any of the professions listed above
- Registered nurses
- Licensed practical nurses
- Basic and advanced emergency medical care providers
- Social workers
- An employee or operator of a public or private healthcare facility as defined in Iowa Code
- Certified psychologists

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- Licensed school employees, certified paraeducators, or holders of a coaching authorization
- Employees or operators of a licensed child care center, registered child care home, Head Start program, Family Development and Self-Sufficiency Grant program under Iowa Code, or Healthy Opportunities for Parents to Experience Success – Healthy Families Iowa program under Iowa Code
- Employees or operators of a licensed substance abuse program or facility licensed under Iowa Code
- Employees of an institution operated by the Department of Human Services (DHS) listed in Iowa Code
- Employees or operators of a juvenile detention or juvenile shelter care facility approved under Iowa Code
- Employees or operators of a foster care facility licensed or approved under Iowa Code
- Employees or operators of a mental health center
- Peace officers
- Counselors or mental health professionals
- An employee or operator of a provider of services to children funded under a federally approved Medicaid home- and community-based services waiver

The law also specifies that the employer or supervisor of a person who is a mandatory reporter cannot make a policy that would interfere with the person making a report of child abuse.

Clergy members are not considered to be mandatory reporters unless they are functioning as social workers, counselors, or another role described as a mandatory reporter. If a member of clergy provides counseling services to a child, and the child discloses an abuse allegation, then the clergy member is mandated to report as a counselor. (The counseling is provided to a child during the scope of the reporter's profession as a counselor, not as clergy.) (Iowa Department of Human Services, Child Abuse [IDHS, Child Abuse], 2007).

Health Service Professionals

Health service professionals play many roles in the recognition and treatment of child abuse, including the recognition of the abuse, reporting the suspected abuse, crisis intervention, and long-term treatment. Health services personnel are often the first line of defense in the early detection of child abuse. Most health professionals who treat children are required to be mandatory reporters of child abuse.

Healthcare professionals are often called upon to work collaboratively with many other disciplines, including social work, education, law enforcement, and the courts to ensure a multi-disciplinary approach to the recognition and treatment of child abuse.

A healthcare practitioner may, if medically indicated, take or cause to be taken, a radiological examination, physical examination, or other medical test of the child or take photographs which would provide medical indications for the child abuse assessment.

A physician has the authority to keep a child in custody without a court order and without the consent of a parent, guardian, or custodian, provided that the child is in a circumstance or condition that presents an imminent danger to the child's life or health. However, the physician must orally notify the court within 24 hours. The ability to take or keep a child in custody is unique to physicians and peace officers (IDHS, Child Abuse, 2007, p. 6).

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Educators

Educators play an important role in the mandatory reporting process. They may actually spend more time each day with the child than their families. All licensed school employees, including teachers, coaches and paraeducators are mandatory reporters.

Federal standards and regulations, as well as state laws, policies and procedures mandate the involvement of educators in the reporting of child abuse. At each of these levels of government, the process for reporting and the actual obligations of the educators is spelled out.

The primary authority at the federal level is the Federal Family Education Rights and Privacy Act (FERPA) of 1974. FERPA, which governs the release of information from school records, does not bar the reporting of suspected child abuse by educators. In most cases, educators will be relying not on school records, but on their own personal knowledge and observations when reporting child abuse. Since no school records are involved in these cases, FERPA does not apply.

Exceptions to the law may apply in cases of child abuse. For example, under normal situations, parental consent is required to consult school records, but in a small number of cases, it may be necessary to consult school records to determine whether a report of child abuse should be made.

Some local school systems and boards of education have enacted school policies and procedures regarding child abuse reporting. The policies and procedures support state law with regard to reporting and often provide internal mechanisms to be followed when a report of child abuse is made.

Local school policy may specify that parents be notified when the school makes a report of child abuse. If so, notify the Iowa Department of Human Services (IDHS) of that local policy when making the report of child abuse. Sometimes local procedure may require that administrative staff be notified when a report of child abuse is made and a copy of the written report be filed (IDHS, Child Abuse, 2007, p. 7).

Child Care Providers

Child care providers are also vitally important in keeping children safe. It is very important for them to report when they suspect child abuse. Child care providers include:

- child care staff;
- foster parents; and
- residential care personnel.

All of these individuals are mandatory reporters. A child care provider who suspects that a child has been abused should report that to the DHS and to the licensing worker (IDHS, Child Abuse, 2007, p. 8).

Mental Health Care Professionals

The role of mental health professionals is another that is critical when reporting child abuse. Mental health professionals are often trusted with intimate information about children and families. All counseling providers, even those who are self-employed, are mandatory reporters of child abuse in regard to the child they counsel (IDHS, Child Abuse, 2007, p. 8).

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Law Enforcement Officers

Law enforcement officers play a very important role in protecting our children from child abuse. The officers are seen as a symbol of public safety. They are in an excellent position to raise community awareness about child abuse.

Law enforcement officers often encounter situations that involve child abuse. For example, on domestic calls or during drug arrests the officer may learn of information that constitutes an allegation of child abuse. Situations in which children are residing in homes where methamphetamine is being manufactured or where precursors are present, constitutes an allegation of child abuse as well as possible criminal charges. Law enforcement is mandated to report to DHS. Law enforcement officers who suspect child abuse in the line of duty are required to report that abuse to the Department of Human Services (DHS) as soon as they suspect it. Law enforcement officers need to follow the same procedures as all mandatory reporters in reporting child abuse.

Law enforcement and child protective services may need to work together. Sometimes child protective service workers must visit isolated, dangerous locations and deal with unstable, violent or substance abusing individuals. Generally, child protective service workers do not have on-site communications (radio, car phone, etc.), weapons, or special training in self-protection. It is often necessary for law enforcement personnel to accompany child protective workers to conduct their assessment. Failure to have proper backup may have unfortunate consequences to both the child protection worker and the child that may have been abused.

Law enforcement has the power to arrest and to enforce any standing orders of the court. When it is necessary to remove a child from the child's home, law enforcement officers are often called upon for assistance. Law enforcement has the general authority to take custody of children. Law enforcement is often able to react to emergency situations faster than child protective service. Law enforcement is also available 24 hours a day, while the child protection worker after hour response is limited in some communities (IDHS, Child Abuse, 2007, p. 8).

Others Required to Report

Some employers may have specific policies that require certain training and reporting procedures regarding child abuse for their staff, even when they are not by law considered mandatory reporters. Reporters who by law are not considered mandatory reporters will be considered permissive reporters regardless of the employer's requirements.

Iowa Administrative Code mandates certified adoption investigators and DHS income maintenance workers to report suspected abuse. Income maintenance workers and certified adoption investigators are "mandated," not mandatory reporters. As such, they are not required to make a written report, although they may do so if they wish.

They receive the same information and notices as permissive reporters. They are not entitled to written notification that the assessment has been completed nor to a copy of information placed on the Registry (IDHS, Child Abuse, 2007, p. 9).

Definitions: How Does Iowa Law Define Child Abuse?

The Iowa Department of Human Services (DHS) has the legal authority to conduct an assessment of child abuse when it is alleged that:

1. The victim is a child.
2. The child is subjected to one or more of the nine categories of child abuse defined in Iowa Code section 232.68:

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- Physical Abuse
- Mental Injury
- Sexual Abuse
- Denial of critical care
- Child prostitution
- Presence of illegal drugs
- Manufacturing or possession of a dangerous substance
- Bestiality in the presence of a child
- Cohabits with a registered sex offender

(IDHS, Child Abuse, 2007, p. 15)

Definition of "Child"

A child is defined in Iowa Code as any person under the age of 18 years.

The victim of child abuse is a person under the age of 18 who has suffered one or more of the categories of child abuse as defined in Iowa law physical abuse, mental injury, sexual abuse, denial of critical care, child prostitution, presence of illegal drugs, manufacturing or possession of a dangerous substance, bestiality in the presence of a minor or cohabits with a registered sex offender (IDHS Child Abuse, 2007, p. 15).

Caretaker/Perpetrator

A perpetrator of child abuse must be a person responsible for the care of a child. A **person responsible for the care of a child** is defined in Iowa Code:

- Parent, guardian, or foster parent.
- A relative or any other person with whom the child resides and who assumes care or supervision of the child, without reference to the length of time or continuity of such residence.
- An employee or agent of any public or private facility providing care for a child, including an institution, hospital, healthcare facility, group home, mental health center, residential treatment center, shelter care facility, detention center, or child care facility.
- Any person providing care for a child, but with whom the child does not reside, without reference to the duration of the care.

A person who assumes responsibility for the care or supervision of the child may assume such responsibility through verbal or written agreement, or implicitly through the willing assumption of the care-taking role (IDHS, Child Abuse, 2007, p. 16).

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Child Abuse: What are the indicators?

There may be physical and/or behavioral indicators of child abuse that should be considered prior to filing a report. Evaluation of these indicators is always warranted because the presence of one or more of these symptoms may not prove that abuse has occurred. The lists provided are not all inclusive, but may be suggestive of abuse.

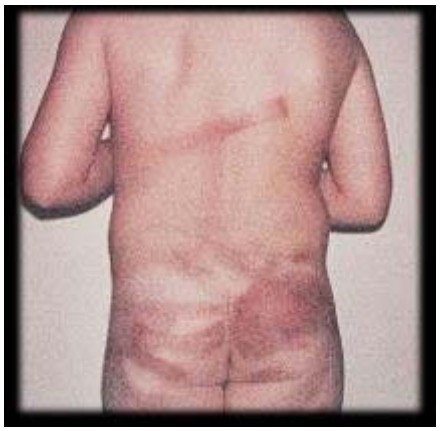
Physical Indicators

Physical abuse is any non-accidental physical injury, or injury which is at variance with the history given of it, suffered by a child as the result of the acts or omissions of a person responsible for the care of the child (IDHS, Child Abuse, 2007, p. 18).

Special attention should be paid to injuries that are unexplained or are inconsistent with the parent(s)/caregiver's explanation and/or the developmental stage of the child. This section will describe physical and behavioral signs that could indicate abuse.

Bruises, welts, and bite marks, all of which may be in various stages of healing:

- On face, lips, mouth, neck, wrists, and ankles
- On torso, back, buttocks, and thighs



Source: Corporate Graphics Resource, Albany, NY

- Both eyes or cheeks - always of suspicious origin because only one side of the face is usually injured as the result of an accident.

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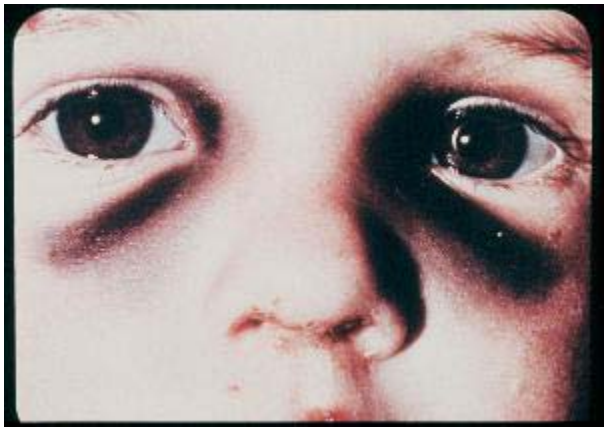

Source: Corporate Graphics Resource, Albany, NY

- Clustered, forming regular or unusual patterns reflecting the shape of article used to inflict injury, such as an electric cord, belt buckle, etc.
- Grab marks, on arms or shoulders

Source: Corporate Graphics Resource, Albany, NY

- On several different surface areas
- Evidence of human bite - human bite compresses the flesh, animal bite tears flesh and has narrower teeth imprint
- Regularly appear after absence, weekend, or vacation

Lacerations or abrasions:

- To mouth, lips, gums, eyes
- To external genitalia
- On backs or arms, legs or torso

Burns:

- Cigar, cigarette burns, especially on soles, palms, back, or buttocks
- Immersion burns by scalding water (sock-like, glove-like, doughnut-shaped on buttocks or genitalia - "dunking syndrome")

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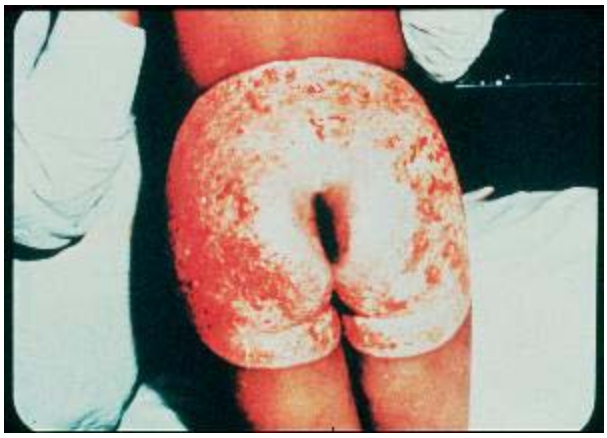

Source: Corporate Graphics Resource, Albany, NY

- Patterned burn, for example electric burner, iron, etc.

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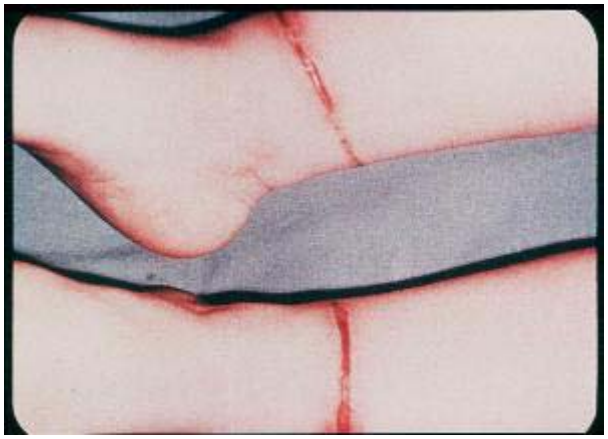
- Rope burns on arms, legs, neck, or torso



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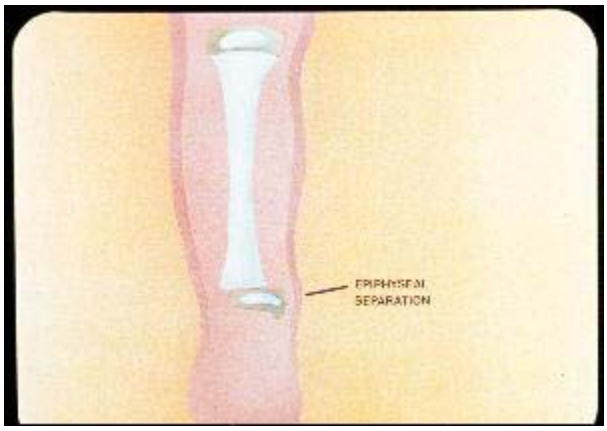
Fractures:

- To skull, nose, facial structure
- Skeletal trauma accompanied by other injuries, such as dislocations



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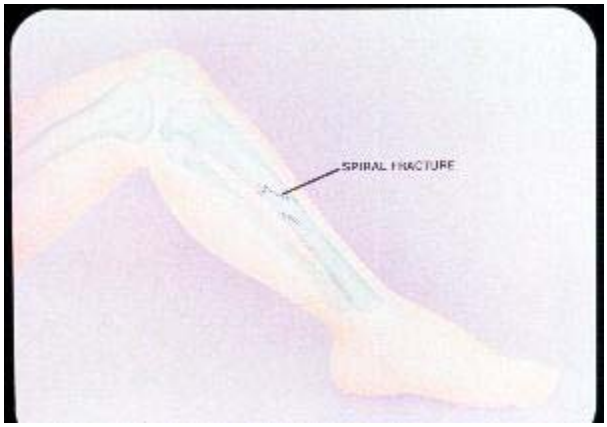
- Multiple or spiral fractures



Source: Corporate Graphics Resource, Albany, NY

- Fractures in various stages of healing
- Fracture "accidentally" discovered in the course of a physical exam

Head Injuries

- Absence of hair and/or hemorrhaging beneath the scalp due to vigorous hair pulling
- Subdural hematoma (a hemorrhage beneath the outer covering of the brain, due to severe hitting or shaking)

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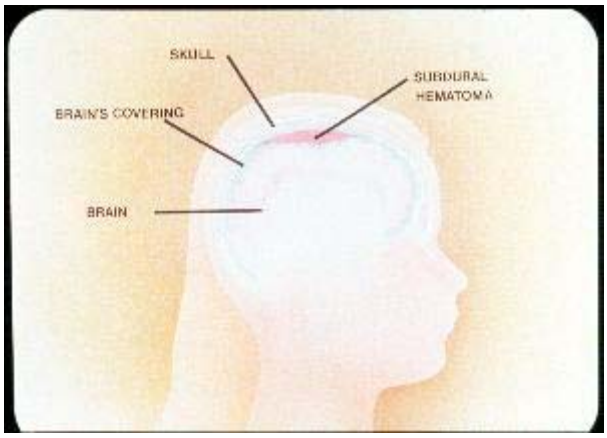

Source: Corporate Graphics Resource, Albany, NY

- Retinal hemorrhage or detachment, due to shaking
- Shaken baby syndrome/Whiplash shaken infant syndrome

Source: Corporate Graphics Resource, Albany, NY

- Eye injury
- Jaw and nasal fracture
- Tooth or frenulum injury

Symptoms suggestive of parentally - induced or fabricated illnesses:

- Sometimes know as Munchausen Syndrome by Proxy (MSP) - an example might be repeatedly causing a child to ingest quantities of laxatives sufficient to cause diarrhea, dehydration, and hospitalization

Behavioral, Psychological and Environmental Indicators

Some indicators of child abuse are not visible on the child's body. Many times there are no physical indicators of abuse. A child's behavior can change as a result of abuse. Health services personnel need to be alert to possible behavioral indicators of abuse and if they believe those to be present, they are required to make a report. Behavioral indicators include behaviors such as:

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- Wary of contact with other adults
- Apprehensive when other children cry
- Exhibits behavioral extremes:
    - Aggressiveness
    - Destructiveness
    - Withdrawal
    - Emotionless behavior
    - Extreme mood changes
- Is afraid to go home, has repeated incidents of running away
- Suggestions that may show problems at home, saying, “I’d like to live with you”
- Fear of parents
- Seductive behaviors or promiscuity
- Being uncomfortable with physical contact or closeness
- Reports injury by parents
    - Sometimes blames self, e.g. "I was bad and I was punished"
- Has habit disorders
    - Self-injurious behaviors
    - Psychological reactions (obsessions, phobias, compulsions, hypochondria)
- May wear long sleeves or other concealing clothing to hide physical indicators of abuse
    - Often inappropriate for season
- Alcohol or drug abuse
- Manifests low self-esteem
- Attempts suicide
- Begging, stealing or hoarding food
- Extended stays at school – arrives early and/or stays late

What is a Mental Injury?

Mental injury is defined as any mental injury to a child’s intellectual or psychological capacity as evidenced by an observable and substantial impairment in the child’s ability to function within the child’s normal range of performance and behavior as the result of the acts or omissions of a person responsible for the care of the child, if the impairment is diagnosed and confirmed by a licensed physician or qualified mental health professional as defined in Iowa Code.

Examples of mental injury may include:

- **Ignoring** the child and failing to provide necessary stimulation, responsiveness, and validation of the child’s worth in normal family routine.

- **Rejecting** the child’s value, needs, and request for adult validation and nurturance.

- **Isolating** the child from the family and community; denying the child normal human contact.

- **Terrorizing** the child with continual verbal assaults, creating a climate of fear, hostility, and anxiety, thus preventing the child from gaining feelings of safety and security.

- **Corrupting** the child by encouraging and reinforcing destructive, antisocial behavior until the child is so impaired in socio-emotional development that interaction in normal social environments is not possible.

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- **Verbally assaulting** the child with constant, excessive name-calling, harsh threats, and sarcastic put downs that continually "beat down" the child's self-esteem with humiliation.

- **Over pressuring** the child with subtle but consistent pressure to grow up fast and to achieve too early in the areas of academics, physical or motor skills, or social interaction leaves the child feeling that he or she is never quite good enough.

(IDHS, Child Abuse, 2007, p. 18)

What is Sexual Abuse?

Sexual abuse is defined as a sexual offense with or to a child as a result of the acts or omissions of the person responsible for the care of the child.

The commission of a sexual offense includes any sexual offense with or to a person under the age of 18 years.

Several sub-categories of sexual abuse exist, including:

- First degree sexual abuse
- Second degree sexual abuse
- Third degree sexual abuse
- Detention in a brothel
- Lascivious acts with a child
- Indecent exposure
- Assault with intent to commit sexual abuse
- Indecent contact with a child
- Lascivious conduct with a minor
- Incest
- Sexual exploitation by a counselor or therapist
- Sexual exploitation of a minor
- Sexual misconduct with offenders and juveniles
- Invasion of privacy-nudity

(IDHS, Child Abuse, 2007, p. 19)

Sexual abuse cases may not have overtly apparent physical evidence and the makes identification and recognition very difficult. The problem of detection and identification is further compounded because of the many legitimate fears which child victims of sexual abuse experience. It makes it extremely difficult for them to report the abuse, even to a very trusted adult or friend since their trust has been so violated.

The vast majority of child molesters are family members or friends of the child or his/her family and this fact makes disclosure of the abuse very difficult for the child. Victims of child sexual abuse experience the fear of betraying a loved one and possibly losing affections forever if they disclose the abuse. Child victims fear the overwhelming shame and guilt that such disclosure may cause, and they fear that family members and other significant people in their lives will blame them for the abuse. They also fear the common threats of being hurt or even killed if they disclose the abuse. Even after disclosing sexual abuse, a child may retract the disclosure as the family system may begin to place pressure. For these and other reasons, sexually abused children often decide to live in quiet and devastating isolation with their "secret" rather than risk the realization of their fears.

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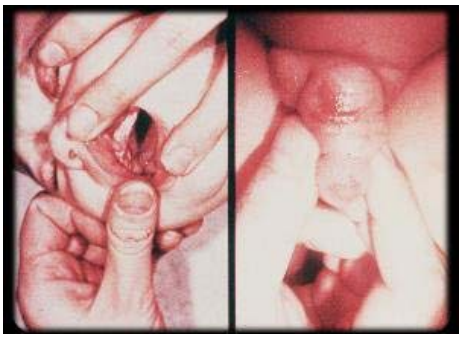
It is very important to keep in mind that the overwhelming majority of child sexual abuse occurs within the child's immediate or extended family. Most perpetrators of child sexual abuse are known to the child before the abuse. They are usually trusted family members who have easy physical access to their child victims, not the stereotypical strangers in raincoats who wait for children on street corners with lures of candy or money. Child sexual abuse is not a problem uniquely found in only certain geographic areas or among people of certain economic conditions, races, or occupations. There is absolutely no profile of a child molester or of the typical victim. Do not assume that because an alleged offender has an unparalleled reputation for good works in the community or holds a certain job, he or she could not also be a child molester.

Physical indicators of sexual abuse may include:

- Difficulty in walking, sitting
- Torn, stained, bloody clothing or underwear
- Genital pain, itching
- Bruises, bleeding, or any injury in genital, vaginal or anal areas
- Bruising, injury to the hard or soft palate



Source: Corporate Graphics Resource, Albany, NY

- Sexually transmitted diseases, especially in preteens, including venereal oral infections
- Pregnancy, especially in early adolescent years
- Painful urination or urinary tract infections
- Presence of foreign bodies in vagina or rectum

Remember, the lack of physical evidence makes identification and recognition difficult. Since the vast majority of child molesters are family members or friends, admitting the abuse is very difficult for the child.

Behavioral indicators may include:

- Low self esteem
- Refusal to participate in/or change for gym
- Infantile behavior
- Withdrawn/elaborate fantasy life
- Sexually suggestive, inappropriate, or promiscuous behavior or verbalization
- Expressing age-inappropriate knowledge of sexual relations
- Sexual victimization of other children
- Prostitution
- Extreme fear of being touched
- Poor peer relationships
- Delinquent, truancy, running away
- Self-injurious activities/suicide

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There are specific physical examination procedures used in child abuse. For instance, in the evaluation of sexual abuse, the colposcope provides for a taped copy of that examination. That copy alleviates the need then for the child to be subjected to further examinations.

Denial of Critical Care

Denial of critical care is defined as the failure on the part of a person responsible for the care of a child to provide for the adequate food, shelter, clothing or other care necessary for the child's health and welfare when financially able to do so or when offered financial or other reasonable means to do so. What most people think of as an issue of "neglect" is covered under the child abuse category of "denial of critical care".

A parent or guardian legitimately practicing religious beliefs who does not provide specified medical treatment for a child for that reason alone shall not be considered abusing the child. However, this does not preclude a court from ordering that medical service be provided to the child where the child's health requires it.

Denial of critical care includes the following eight sub-categories:

- **Failure to provide adequate food and nutrition** to such an extent that there is danger of the child suffering injury or death.
- **Failure to provide adequate shelter** to such an extent that there is danger of the child suffering injury or death.
- **Failure to provide adequate clothing** to such an extent that there is danger of the child suffering injury or death.
- **Failure to provide adequate healthcare** to such an extent that there is danger of the child suffering serious injury or death.
- **Failure to provide the mental healthcare** necessary to adequately treat an observable and substantial impairment in the child's ability to function.
- **Gross failure to meet the emotional** needs of the child necessary for normal development evidenced by the presence of an observable and substantial impairment in the child's ability to function within the normal range of performance and behavior.
- **Failure to provide proper supervision** of a child which a reasonable and prudent person would exercise under similar facts and circumstances, to such an extent that there is danger of the child suffering injury or death.

This definition includes cruel and undue confinement of a child and the dangerous operation of a motor vehicle when the person responsible for the care of the child is driving recklessly or driving while intoxicated with the child in the vehicle (IDHS, Child Abuse, 2007, p. 20).

When is it safe to leave a child home alone?

The Iowa Department of Human Services receives many inquiries each year regarding when a child can be left home alone safely. Iowa law does not define an age that is appropriate for a child to be left alone. Each situation is unique. Examples of questions to help determine whether there are safety concerns for the child include:

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- Does the child have any physical disabilities?
- Could the child get out of the house in an emergency?
- Does the child have a phone and know how to use it?
- Does the child know how to reach the caretaker?
- How long will the child be left home alone?
- Is the child afraid to be left home alone?
- Does the child know how to respond to an emergency such as fire or injury?

Failure to respond to the infant's life-threatening conditions by failing to provide treatment which in the treating physician's judgment will be most likely to be effective in ameliorating or correcting all conditions. This subcategory or the denial of critical care abuse type is also known as withholding of medically indicated treatment. The types of treatments included are appropriate nutrition, hydration and medication. The term does not include the failure to provide treatment other than appropriate nutrition, hydration and medication to an infant when in the treating physician's medical judgment. Any of the following circumstances apply:

- The infant is chronically and irreversibly comatose.

- The provision of treatment would merely prolong dying, not be effective in ameliorating or correcting all of the infant's life-threatening conditions, or otherwise be futile in terms of the survival of the infant.

- The provision of the treatment would be virtually futile in terms of the survival of the infant and the treatment itself under the circumstances would be inhumane.

(IDHS, Child Abuse, 2007, p. 21)

Professionals should be alert for and aware of physical and behavioral signs of possible denial of critical care. Professionals should look for patterns, clues, or a combination of indicators.

Physical indicators may include:

- Obvious malnourishment
- Failure to thrive (physically or emotionally)
- Drug withdrawal symptoms in newborns
- Lags in physical development
- Poor hygiene/inappropriate seasonal dress, consistent hunger
- Speech disorders
- Chronic lack of supervision, especially in dangerous activities or for long periods
- Unattended physical problems/medical needs
- Untreated need for glasses, dental care
- Chronic truancy
- Abandonment

Behavioral indicators may include:

- Begging for, or stealing food
- Extended stays at school (early arrival or late departure)
- Constant fatigue/listlessness
- Alcohol or drug use/abuse
- Delinquency (e.g. thefts)
- Runaway behavior

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- Habit disorders (sucking, biting, rocking, head banging)
- Conduct disorders (antisocial, destructive)
- Neurotic traits (sleep disorders, inhibited play)
- Psychological reactions (hysteria, phobias, hypochondria)
- Behavioral extremes (compliant, passive, aggressive, demanding)
- Lags in mental and/or emotional development
- Suicide attempts

Child Prostitution

Child prostitution is defined as the acts or omissions of a person responsible for the care of a child which allow, permit, or encourage the child to engage in acts prohibited pursuant to Iowa Code, with or to a person under the age of 18 years.

Prostitution is defined as a person who sells or offers for sale the person's services as a partner in a sex act, or who purchases or offers to purchase such services (IDHS, Child Abuse, 2007, p. 22).

Presence of Illegal Drugs

Presence of illegal drugs is defined as occurring when an illegal drug is present in a child's body as a direct and foreseeable consequence of the acts or omissions of the person responsible for the care of the child.

Illegal drugs are defined as cocaine, heroin, amphetamine, methamphetamine, other illegal drugs (including marijuana), or combinations or derivatives of illegal drugs which were not prescribed by a health practitioner.

Manufacturing or Possession of a Dangerous Substance

Manufacturing or possession of a dangerous substance as defined in Iowa Code, occurs when the person responsible for the care of a child:

- Has manufactured a dangerous substance in the presence of the child; or
- Possesses a product containing ephedrine, its salts, optical isomers, salts of optical isomers, or pseudoephedrine, its salts, optical isomers, salts of optical isomers, with the intent to use the product as a precursor or an intermediary to a dangerous substance in the presence of the child.

For the purposes of this definition, **in the presence of a child** means the manufacture or possession occurred:

- In the physical presence of a child; or
- In a child's home, on the premises, or in a motor vehicle located on the premises; or
- Under other circumstances in which a reasonably prudent person would know that the manufacture or possession may be seen, smelled, or heard by a child.

For the purpose of this definition, **dangerous substance** means any of the following:

- Amphetamine, its salts, isomers, or salts of its isomers.
- Methamphetamine, its salts, isomers, or salts of its isomers.

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- A chemical or combination of chemicals that poses a reasonable risk of causing an explosion, fire, or other danger to the life or health of people who are in the vicinity while the chemical or combination of chemicals is used or is intended to be used in any of the following:

    - The process of manufacturing an illegal or controlled substance.
    - As a precursor in the manufacturing of an illegal or controlled substance.
    - As an intermediary in the manufacturing of an illegal or controlled substance

(IDHS, Child Abuse, 2007, p. 23)

Bestiality in the Presence of a Minor

- "Bestiality in the presence of a minor is defined as the commission of a sex act with an animal in the presence of a minor as defined in 717C.1 by a person who resides in a home with a child, as the result of the acts or omissions of a person responsible for the care of the child.

Cohabits with a Registered Sex Offender

- When a caretaker knowingly cohabits with a person who is a registered sex offender or who lives with someone who is required to register as a sex offender, the caretaker is committing child abuse. There are exceptions to this which include:

    - The sex offender is the caretaker's spouse
    - The sex offender is the parent of the alleged child victim
    - The sex offender is a minor child of the caretaker

    Note: The Iowa Department of Human Services must report this allegation to a law enforcement agency since this is representative of a criminal act" (IDHS, Child Abuse, 2007, p. 24).

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The Extent of the Problem: The Startling Statistics

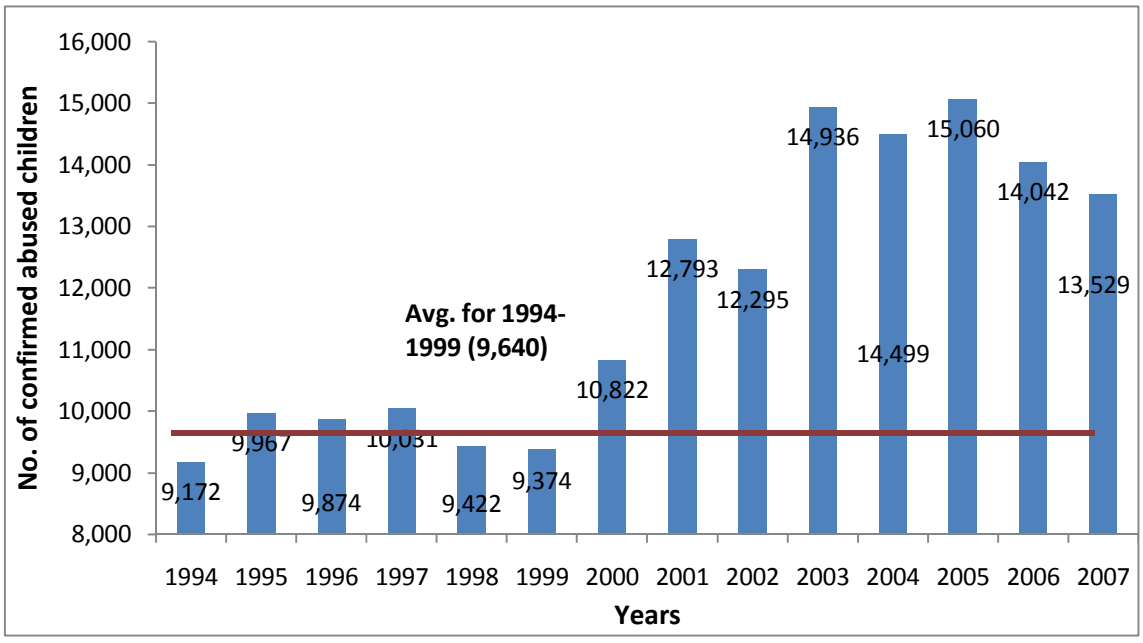
National Rates of Child Abuse

The rate of child abuse nationally and in Iowa had been on divergent paths. While the overall national rate had been decreasing, the overall rate of child abuse in Iowa was increasing. The Iowa statistics in 2006 and 2007 demonstrate a substantial change and one that, according to the Iowa Department of Human Services (DHS), is the most significant in the last twenty years. The decrease in the rate should be looked at cautiously, said DHS, because some of the risk factors associated with child abuse remain high. Such factors as child poverty rates, lack of health insurance, illegal use of drugs and single parenting are still present and until these risk factors decline, child abuse rates may remain high.

Iowa Rates of Child Abuse

In 2006, the rate of child abuse may have declined by about seven percent from 2005, but in 2005, the figures were at a record high of 15,060. The steep climb from 2000 to 2005 and the changes now showing the decrease are shown in Figure 3. In 2007, the numbers declined by about 500 (PCAI, 2007).

Figure 3: Confirmed Abused Children in Iowa



Source: Prevent Child Abuse Iowa (PCAI), 2008

Categories of Child Abuse

Table 1 identifies the types of abuse that DHS found in 2007. Most child abuse in Iowa (73.7%), involved the *denial of critical care*, commonly called *neglect*. In 2007, DHS determined that there were 10,741 confirmed instances of denial of critical care. DHS also confirmed 1,751 cases of *physical injury* (12% of abuse) and 672 reports of *sexual abuse* (4.6% of abuse) (PCAI, 2007). The 2007 sexual abuse numbers are the lowest in more than twenty years!

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The 2007 DHS figures reveal the disturbing risks to children from the use and manufacturing of illegal drugs. A total of 1,173 cases of abuse (8% of all confirmed abuse) involved the *presence of illegal drugs* in a child's body as a result of the actions of a parent or other caretaker. In the past, this type of abuse usually resulted from prenatal illegal drug use by the infant's mother (PCAI, 2007).

A category of abuse was added in 2007 and is identified as the parent or caretaker cohabiting with a sex offender. This accounted for a total of 165 cases (1.1%). Mental injury was represented by 24 cases (0.2%) (see Table 1).

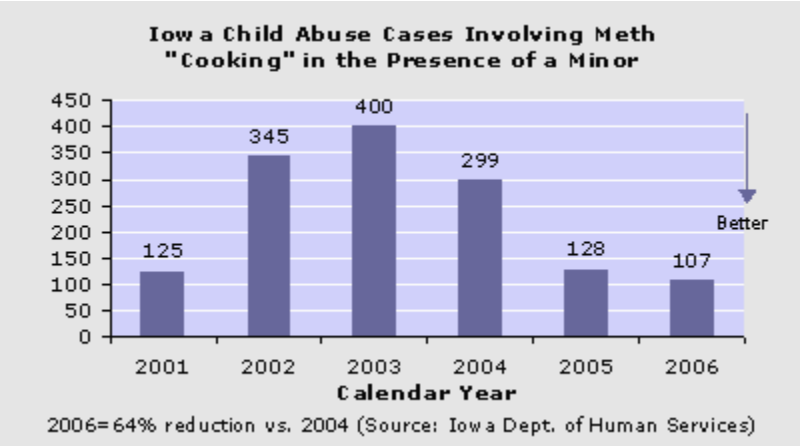
Table 1: Number and Types of Child Abuse, 2007

Types	Number	Percent
Denial of critical care	10,741	73.7%
Physical injury	1,751	12.0%
Presence of illegal drugs in a child's body	1,173	8.0%
Sexual abuse	672	4.6%
Cohabiting with a sex offender	165	1.1%
Manufacturing a dangerous drug in a child's presence	56	0.4%
Mental injury	24	0.2%

Source: PCAI, 2007

Children in Iowa also face risks from the manufacturing of dangerous drugs, specifically methamphetamine (meth). In 2001, the Iowa Legislature was the first in the nation to add a new category of child abuse to include cases where a child's parent or other caretaker was involved in manufacturing this drug in the child's presence. In all, DHS confirmed that 107 children were present while their parents or other caretakers were involved in manufacturing meth. Since the reporting began, this figure represents the lowest reported number of cases (see Figure 4) and is less than one percent of all confirmed cases of child abuse in 2007.

Figure 4: Child Abuse Involving Meth "Cooking" in Presence of a Minor



Source: Iowa Department of Human Services, 2007

Two categories of abuse, those for denial of critical care and the presence of an illegal drug in a child's body, represented significant increases.

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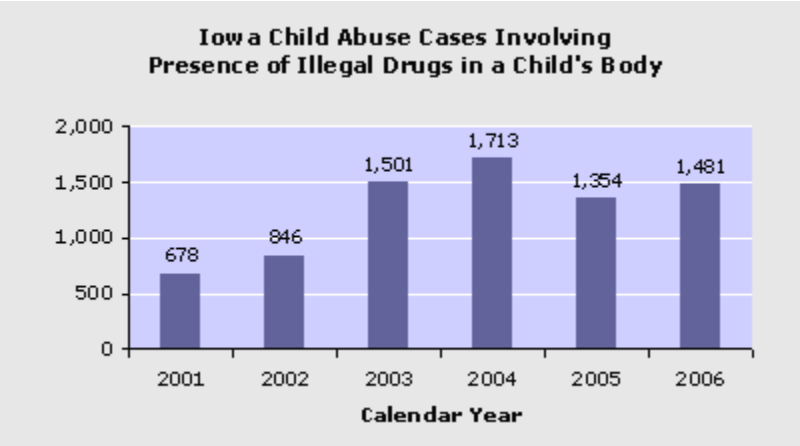
Figure 5: Presence of Illegal Drugs in a Child's Body



Source: Iowa Department of Human Services, 2007

The denial of critical care numbers increased by almost 5,000 cases between the years 2001 to 2006, which is almost a 44 percent increase. Authorities confirmed the presence of an illegal drug in a child's body more than doubled in the same time period, increasing from 678 cases in 2001 to 1,481 cases in 2006. Contrasting with these increases in numbers, confirmed cases of physical injury dropped by more than one-third from 2001 to 2006, and cases of sexual abuse decreased.

Rates of Abuse by Iowa County

The rate of child abuse (i.e., the number of children confirmed abused per 1,000 children) varies widely by county (PCAI, 2007).

According to information compiled by Prevent Child Abuse Iowa (2007), the rates of child abuse in 2007 in Wapello County, for example, was more than 10 times the rate for Taylor County.

A simple answer for this variation does not exist. Although many of the counties with higher proportions of unemployment, child poverty, and single-parent households have higher child abuse rates, this is not true for all counties. It is unclear as to why these differences occur (PCAI, 2007).

Child Abuse Rates: Iowa Compared to the National Rates

Figure 6 compares the national and Iowa rates of child abuse from 1999 through 2003. It is important to remember when comparing rates of abuse in Iowa and other states legal definitions of what constitutes child abuse vary from state to state. Although there is some similarity in the four main categories of abuse: neglect, physical injury, sexual abuse, and mental injury, there is variation in the definition of abuse and how abuse is determined to have occurred. Less than a dozen states include drug-affected children as a category of abuse, and even fewer track the number of children who are exposed to the manufacturing of dangerous drugs (PCAI, 2004).

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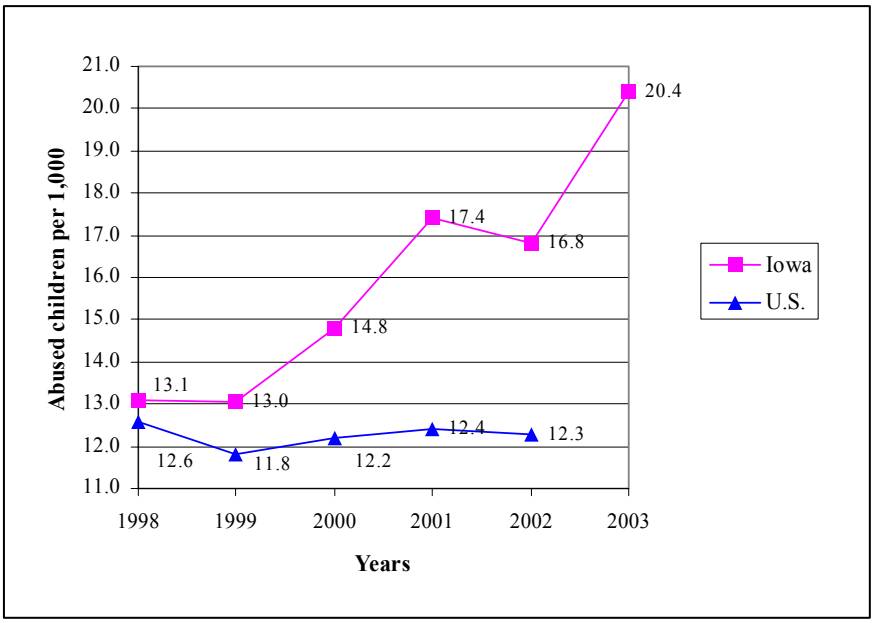
Figure 6: The Rates of Child Abuse in Iowa and the U.S., 1998-2003



Source: Prevent Child Abuse Iowa, 2004

National Rates of Child Abuse

Nationally, for calendar year 2006, referrals to the state and local Child Protective Services (CPS) included more than 3.6 million children, and of those, approximately 905,000 children were determined to be victims of child abuse or neglect by the CPS agencies (USDHHS-ACF, 2006).

CPS agencies respond to the needs of children who are alleged to have been maltreated and ensure that they remain safe. An estimated 905,000 children were found to be victims, which was approximately 25.2% of all children who received an investigation or assessment. The national rate of victimization was 12.1 per 1,000 children (USDHHSACF, 2006). The five-year state-specific trends illustrate that 28 states decreased their rate from 2002-2006, while the other 22 states increased their rate.

Neglect is the most common form of child maltreatment in Iowa. Neglect is more recently identified under the category of denial of critical care.

Characteristics of Child Victims

Nationally in 2006, 48.2 percent of child victims were boys, and 51.5 percent of the victims were girls. The youngest children had the highest rate of victimization (USDHHS-ACF, 2006).

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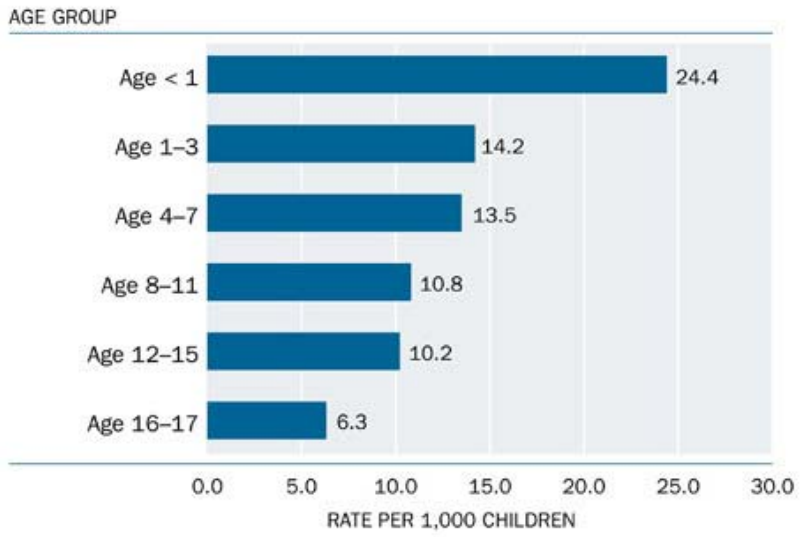
Figure 7: Victimization Rates by Age Group, 2006

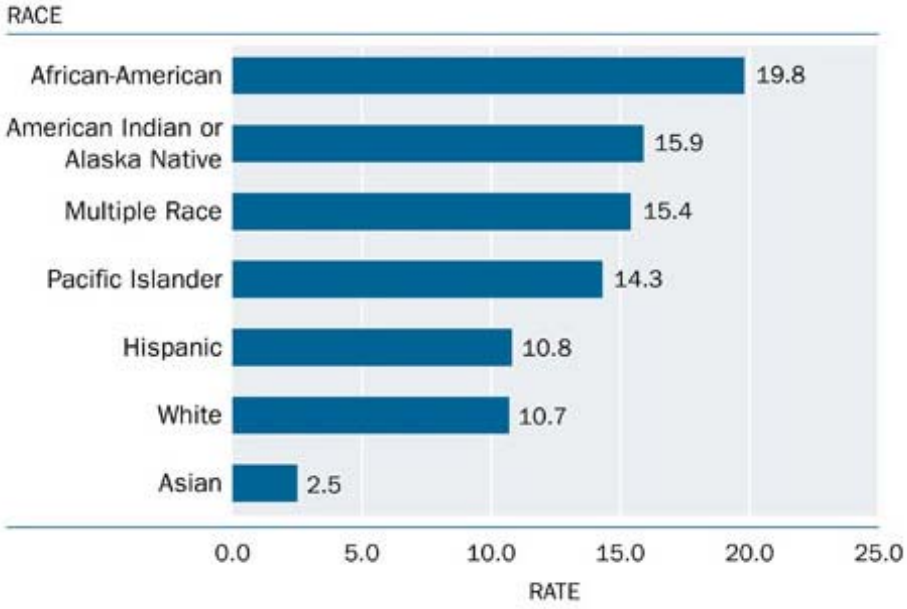


Source: USDHHS-ACF, 2006

Overall, the rate of victimization was inversely related to the age of the child. The youngest children accounted for the largest percentage of victims (USDHHS-ACF, 2006).

American Indian or Alaska Native children and African-American children had the highest rates of victimization. Asian-Pacific Islander children had the lowest rate of 2.5 per 1,000 children of the same race or ethnicity (USDHHS-ACF, 2006).

Figure 8: Race and Ethnicity of Victims, 2006



Source: USDHHS-ACF, 2006

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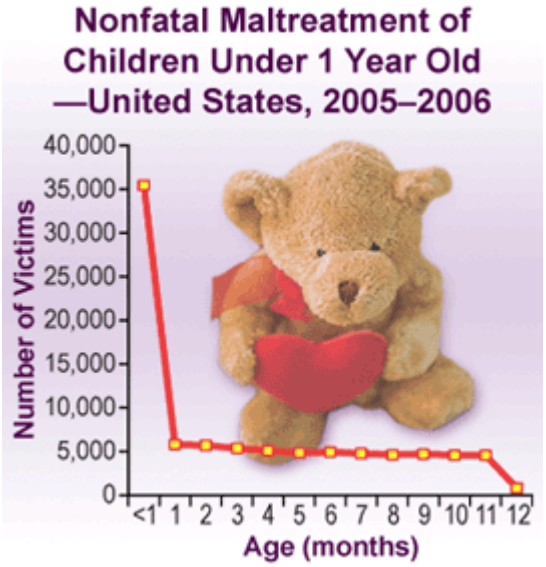
One-half of all victims were White (54.2%); one-quarter (26.1%) were African-American; and one-tenth (11.0%) were Hispanic. American Indians or Alaska Natives accounted for 1.8 percent of victims, and Asian-Pacific Islanders accounted for 0.9 percent of victims (USDHHS-ACF, 2006).

Nationally, from October 2005 through September 2006, more than 91,000 unique victims less than 12 months of age were victims of maltreatment! Thirty-nine percent occurred in the first 30 days from the child's birth and nearly ninety percent occurred during their first week of life. These alarming statistics are illustrated in Figure 9.

Figure 9



Source: USDHHS-ACF, 2006

Fatalities

Child fatalities are the most tragic consequence of abuse. The National Child Abuse and Neglect Data System (NCANDS) reported an **estimated 1,530 child fatalities in 2006**. NCANDS defines "child fatality" as the death of a child caused by an injury resulting from abuse or neglect, or where abuse or neglect were contributing factors (USDHHS, 2006).

Research indicates very young children (ages three and younger) are the most frequent victims of child fatalities. NCANDS data for 2006 demonstrated children younger than four years accounted for 78 percent of fatalities. This population of children is the most vulnerable for many reasons, including their dependency, small size, and inability to defend themselves (USDHHS, 2002; USDHHS, 2006).

Infant boys (younger than one year old) had the highest rate of fatalities with nearly 19 deaths per 100,000. Infant girls (younger than one year old) had a rate of 14.7 deaths per 100,000. The three main categories of maltreatment related to fatalities were neglect, combinations of maltreatments and physical abuse (USDHHS, 2006).

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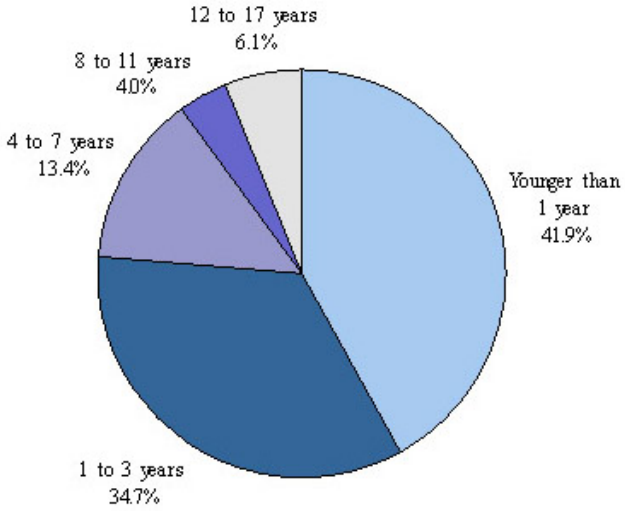
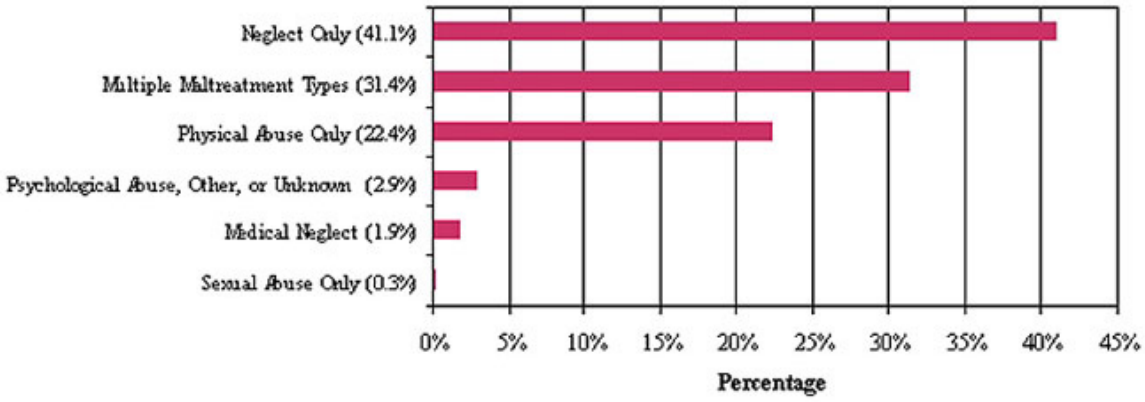
Figure 10: Child Abuse and Neglect Fatality Victims by Age, 2005



Source: Child Welfare Information Gateway, 2008

What are the primary causes of these deaths nationally?

Figure 11: Child Abuse and Neglect Fatalities by Maltreatment Type, 2006



Source: Child Welfare Information Gateway, 2008

Many researchers and practitioners believe child fatalities due to abuse and neglect are underreported. States' definitions of key terms such as "child homicide," "abuse," and "neglect" vary (therefore, so do the numbers and types of child fatalities they report). In addition, some deaths officially labeled as accidents, child homicides, and/or Sudden Infant Death Syndrome (SIDS) might be attributed to child abuse or neglect if more comprehensive investigations were conducted or if there was more consensus in the coding of abuse on death certificates (USDHHS, 2004).

Recent studies in Colorado and North Carolina have estimated as many as **50 to 60 percent** of deaths resulting from abuse or neglect are not recorded (Crume, DiGuiseppi, Byers, Sirotnak, Garrett, 2002; Herman-Giddens, Brown, Verbiest, Carlson, Hooten, et al., 1999). These studies indicate that neglect is the most underrecorded form of fatal maltreatment (HHS, 2004).

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Who abuses children?

Perpetrators of child abuse come from all walks of life, races, religions, and nationalities. They come from all professions and represent all levels of intelligence and standards of living. There are no single social stratums free from incidents of child abuse (IDHS, Child Abuse, 2007).

Characteristics of abusive parents or caregivers can be identified by careful assessment that includes:

- Parent/Caregivers History
- Parent/Child History
- Environmental Factors

It is important to remember that child abuse and neglect is a family problem. It is a disease of parenting; it is deviant parenting. Child abuse should receive the same logical, step-wise diagnostic work-up, treatment, and management as any other serious condition. The challenge is to recognize the potential for child abuse early and to intervene on a primary, rather than secondary, level.

American culture, on the whole, accepts and condones the use of physical discipline as normal practice in the adult-child relationship. There is definitely room for learning in parenting styles. However, the message from the caregiver to the child must be “it is safe, you can trust me, come out, experiment, and you will not be destroyed.”

An abusive/neglecting parent does not fit a simple mold. Child abuse/neglect covers a broad continuum of behaviors. Abuse/neglect can run the gamut from an isolated explosive episode to psychotic behavior. However, most abusive parents are not psychotic; they are frequently adults who were abused/maltreated children. Their parenting model was an abusive one. They know no other way of acting. We all essentially parent the way we were parented. Each of us has the potential to abuse. We are saved by our coping mechanisms, our own positive experiences as children and as adults, our own thoughtful examination of and response to parenting and/or our intact social supports such as spouses, family and friends.

Abusive parents show disregard for the child’s own needs, limited abilities, and feelings. Many abusive parents believe that children exist to satisfy parental needs and that the child’s needs are unimportant. Children who don’t satisfy the parent’s needs may become victims of child abuse (IDHS, Child Abuse, 2007).

It should be noted that these indicators are clues but not conclusive proof. They may exist in situations where a child is not suspected to be abused or maltreated. However, they are useful to remember when dealing with the parent/caregiver or child. Clues rarely appear as single entities. Typically, several clues will appear regarding the child and his/her family. Except for the obvious, single clues should be treated as "flags" which indicate that the professional needs to look further, more closely, and methodically.

Items in the personal history of the parent/caregiver that should be seen as “red flags” include:

- Parent was abused or neglected as a child
- Lack of friendships or emotional support
    - Isolated from supports such as friends, relatives, neighbors, community groups
    - Lack of self-esteem, feelings of worthlessness
- Marital problems of the parents (and grandparents)
    - May include intimate partner violence
- Physical or mental health problems or irrational behavior
- Life crisis
    - Financial debt

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    - Unemployment/underemployment
    - Housing problems
    - Other significant life stressors
- Alcohol/substance abuse of parents or grandparents
- Adolescent parents

There are also aspects of the parent-child history that warrant examination:

- Parents have unrealistic expectations of child's physical and emotional needs
    - Mentally/developmentally disabled children are particularly vulnerable
- Parent's unrealistic expectations for child to meet parent's emotional needs
    - Role reversal
    - Children viewed as "miniature adults"
- Absence of nurturing child-rearing skills
    - Violence/corporal punishment is accepted as unquestioned child-rearing practice within the parent's culture
    - Violence is accepted as a normal means of personal interaction
- Delay or failure in seeking healthcare for child's injury, illness, routine checkups, immunizations, etc.
- Parent views child as bad, evil, different, etc.

Environmental factors that should be considered:

- Lack of social support
    - Note: there may be an inability to ask for and receive the kind of help and support parents need for themselves and their children
- Homelessness

Behaviors of parents/caregivers of abused children that should send up a “red flag”:

- Contradictory histories
- Cannot explain the child's injury or condition
- Reluctant to give information
- Blame the child's injury on siblings or others
- Hospital "shop", delay in getting care
- Refuse to give consent for diagnostic workup
- Exhibit loss of control
- Overreact or under react to child's condition
- Complain about issues unrelated to child's condition
- Have unrealistic expectations of the child
- Cannot be located
- Present a history of family discord

Both the abusing and non-abusing parent are ultimately responsible for the abuse.

Nationally, in 2006, by far, the largest percentage of perpetrators (almost 80%), were parents, including birth parents, adoptive parents, and stepparents. Other relatives represented a small percentage as did unmarried partners of parents (USDHHS-ACF, 2006).

Also in 2006, almost 60% of the perpetrators were women and a little more than 40% were men. Female perpetrators were typically younger than male perpetrators. The median age of perpetrators was 31 years for women and 34 years for men. More than 40 percent of women who were perpetrators were younger than 30 years of age compared to one-third of the men who were younger than 30 years (USDHHS-ACF, 2006).

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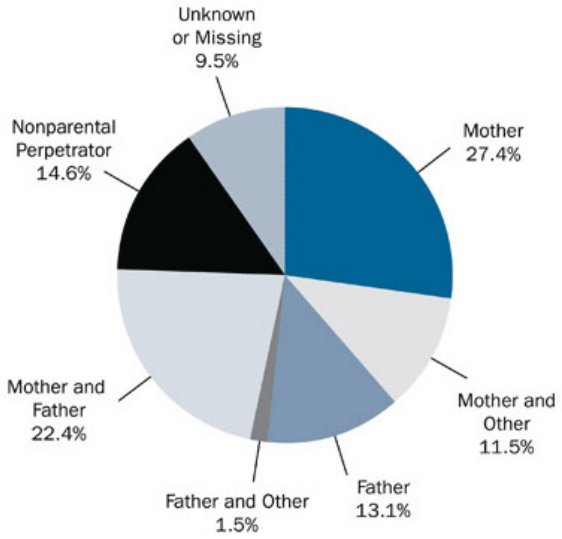
More than one-half (60.4%) of all perpetrators were found to have neglected children. Slightly more than 10% of perpetrators physically abused children, and 7% sexually abused children (USDHHS-ACF, 2006).

Sexual abusers may have deviant personality traits and behaviors that can result in sexual contact with a child. Sexual abuse perpetrators sometimes use threats, bribery, and coercion or force to engage a child in sexual activity. They violate the trust that a child inherently places in them for care and protection, and exploit the power and authority of their position as a trusted caretaker in order to sexually misuse a child. Often the child is threatened or warned "not to tell," creating a conspiracy of silence about the abuse.

There is no single profile of a perpetrator of fatal child abuse, although certain characteristics reappear in many studies. Frequently the perpetrator is a young adult in his or her mid-20s without a high school diploma, living at or below the poverty level, depressed, and who may have difficulty coping with stressful situations. In many instances, the perpetrator has experienced violence first-hand. Most fatalities from *physical abuse* are caused by fathers and other male caretakers. Mothers are most often responsible for deaths resulting from *child neglect* (USDHHS-ACF, 2007).

Figure 12 illustrates the types of perpetrators and their relationship to the child fatalities.

Figure 12: Perpetrator Relationships of Child Fatalities, 2006



Source: USDHHS-ACF, 2006

Who reports child maltreatment?

During the fiscal year of 2006, an estimated total of 3.3 million referrals concerning the welfare of approximately six million children were made to CPS agencies throughout the United States. Of these, approximately two-thirds were accepted for investigation or assessment (USDHHS-ACF, 2006).

Professionals submitted more than one-half of the reports. "Professional" indicates that the report source came into contact with the alleged victim as part of the reporter's occupation. State laws require most professionals to notify CPS agencies of suspected maltreatment. The categories of professionals include educators, legal and law enforcement personnel, social services personnel, medical personnel, mental health personnel, child daycare providers, and

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foster care providers. The three most common sources of reports in 200 were from professionals— teachers, legal or law enforcement personnel and social services personnel (USDHHS-ACF, 2006).

Nonprofessional report sources submitted the remaining percent of reports. These included parents, other relatives, friends and neighbors, alleged victims, alleged perpetrators, anonymous callers, and "other" sources. Anonymous "other" sources and other relatives accounted for the largest groups of nonprofessional reporters (USDHHS-ACF, 2006).

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The Cost of Child Abuse to Society

In 2001, a study reported in the National Institute of Justice that general delinquency is linked with childhood maltreatment, physical and sexual, and that children who are neglected are also at risk. Key findings demonstrated that maltreated children were more likely to be arrested as juveniles and adults and that physically abused and neglected children were more likely to be arrested for violent crime. The research also found that female children were also at increased risk for violence as juveniles and adults.

In 2008, according to a report by Prevent Child Abuse America, $103.8 billion is spent annually responding to child abuse (Mass, Herrenkohl, & Sousa, 2008). The long term costs and the indirect costs of child abuse include such problems as mental and physical health care, juvenile delinquency, lost productivity, special education and adult criminality. Because of the abuse they suffered as children, some adults become involved in criminal activity, and a National Institute of Justice study estimated that 13% of all adult violence can be linked to maltreatment of children. The costs to society are not only in numbers, but in human suffering and cannot be ignored. Prevent Child Abuse Iowa, recognizing the critical nature of child abuse in their state, is working diligently to coordinate efforts toward prevention.

The cost of child maltreatment on long term health can cause stress that is harmful to the development of the nervous and immune systems of children. As a recent CDC factsheet demonstrates, the resulting stress from maltreatment places the children at higher risk for problems such as alcoholism, depression, eating disorders, drug abuse, obesity, sexual promiscuity, smoking and suicide. The costs to society are immense.

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Safe Haven for Newborns

Iowa is among 30 other states creating safe havens for infants. The Safe Haven Act is a law that allows parents (or another person who has the parent's authorization) to leave an infant up to 14 days old at a hospital or healthcare facility without fear of prosecution for abandonment.

Safe havens are institutional health facilities, such as a hospital or healthcare facility. According to the law, an **institutional health facility** means:

- A **hospital** as defined in Iowa Code, including a facility providing medical or health services that is open 24 hours per day, seven days per week and is a hospital emergency room; or

- A **healthcare facility** as defined in Iowa Code means a residential care facility, a nursing facility, an intermediate care facility for persons with mental illness, or an intermediate care facility for persons with mental retardation.

- **Immunity 2001 Iowa Acts, SF 355**, provides immunity from prosecution for abandonment for a parent (or a person acting with the parent's authorization) who leaves an infant at a hospital or healthcare facility. **The Safe Haven Act** provides immunity from civil or criminal liability for hospitals, healthcare facilities, and persons employed by those facilities that perform reasonable acts necessary to protect the physical health and safety of the infant.

For more information on the Safe Haven Act, go to:
http://www.dhs.iowa.gov/Consumers/Safety_and_Protection/Safe_Haven.html.

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Reporting Suspected Child Abuse

Mandatory reporters (according to Iowa Code) of child abuse who suspect a child has been abused, must report the suspicion to the Department of Human Services orally within 24 hours of becoming aware of the situation. A written report must follow the oral report within 48 hours.

Mandatory reporters are also required to make an **oral report to law enforcement** if there is reason to believe that immediate protection of the child is necessary. The law requires the reporting of suspected child abuse by mandatory reporters. It is not required that reporters have proof that abuse has occurred; the reporter has no role in validating the abuse. In addition the law specifies that reports of child abuse must be made when the person reporting "reasonably believes a child has suffered abuse". Reporting allows for the assessment and determination process determining whether abuse has occurred. It is important to maintain the focus on the child's possible condition, rather than in relation to an accusation against the parents or other caretakers. It allows for the potential for helping by halting the abuse and therefore the suffering of the child and facilitating the services needed for the healing process.

Reporting child abuse may be difficult. Professionals may have doubts about whether the circumstances merit a report; there may be concerns about how the parents will react, what the outcome will be, and whether or not the report will put the child at greater risk. The best way to minimize the difficulty of reporting is to:

- Be knowledgeable about the reporting requirements; and
- Be aware of the Department's intake criteria and the response that is initiated by making a report.

Within 24 hours of receiving a report, the reporter will be orally notified whether or not the report has been accepted or rejected. Within five working days, form 470-3789, *Notice of Intake Decision*, will be sent, indicating whether the report of child abuse was accepted or rejected.

<u>Reporting Procedures</u>

If a child is in imminent danger, immediately contact law enforcement in order to provide immediate assistance to the child. Law enforcement is the only profession that can take a child into custody in that situation. After you have notified law enforcement, then call DHS.

To report a suspected case of child abuse:

- Call your county DHS office during regular business hours.
- Outside of regular business hours, call 1-800-362-2178.
- Then, follow up by making a written report within 48 hours of the oral report.

Oral and written reports should contain the following information, if it is known:

- The names and home address of the child and the child's parents or other persons believed to be responsible for the child's care.
- The child's present whereabouts.
- The child's age.
- The nature and extent of the child's injuries, including any evidence of previous injuries.
- The name, age, and condition of other children in the same household.
- Any other information that you believe may be helpful in establishing the cause of the abuse or neglect to the child.
- The identity of the person or persons responsible for the abuse or neglect to the child.
- Your name and address.

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A sample copy of form 470-0665, *Report of Suspected Child Abuse*, is located in Appendix A of this course or from the DHS website at www.dhs.state.ia.us. This specific form is not required, but you may use it as a guide in making a report of child abuse.

If you suspect sexual abuse of a child under the age of 12 by a non-caretaker, you are required by law to make a report of child abuse to DHS. If the child is aged 12 or older, you may report the sexual abuse by a non-caretaker but you are not required by law to do so. DHS must report all sexual abuse allegations to law enforcement within 72 hours.

Legal Issues

Waiver of Confidentiality

The issues of confidentiality and privileged communication are often areas of concern for mental health and health service professionals. Rules around confidentiality and privileged communication are waived during the child abuse assessment process (once a report of child abuse becomes a case).

Iowa Code indicates that the Department may request information from any person believed to have knowledge of a child abuse case. County attorneys, law enforcement officers, social services agencies, and all mandatory reporters (whether or not they made the report of suspected abuse) are obligated to cooperate and assist with the child abuse assessment upon the request of the Department.

Confidentiality is waived in Iowa Code section 232.74, which reads:

> "Sections 622.9 (on communication between husband and wife) and 622.10 (on communication in professional confidence) and any statute or rule of evidence which excludes or makes privileged the testimony of health practitioners or mental health professionals as to confidential communications do not apply to evidence regarding a child's injuries or the cause of the injuries in any judicial proceeding, civil or criminal, resulting from a report of child abuse."

Physician privilege is waived in cases of suspected child abuse. Physicians are allowed to share whatever information is necessary with the Department of Human Services to facilitate a thorough assessment. It is a good idea to let your clients know your status as a child abuse reporter at the onset of treatment. This will help establish an open relationship and minimize the client's feelings of betrayal if a report needs to be made. Making a child abuse referral does not necessarily mean that your relationship with the child and family will end, especially when you are able to support the family during the assessment process. When possible, discuss the need to make a child abuse report with the family. However, be aware that there are certain situations where if the family is warned about the assessment process, the child may be at risk for further abuse, or the family may leave with the child.

In situations where you are not required to make a child abuse report, ethically you need to address these concerns in a therapeutic setting. Refer to your Professional Code of Ethics for further clarification on issues surrounding child abuse.

The Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, also addresses confidentiality. However, the privacy provisions contained in this regulation do not affect the responsibilities of mandated reporters. Information concerning the provisions of HIPAA may be found at www.hhs.gov/ocr/hipaa.

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Immunity from Liability

Iowa Code section 232.73 provides immunity from any civil or criminal liability which might otherwise be incurred when a person participates in good faith in:

- Making a report, photographs, or x-rays; or
- Performing a medically relevant test; or
- Assisting in an assessment of a child abuse report.

A person has the same immunity with respect to participation in good faith in any judicial proceeding resulting from the report or relating to the subject matter of the report. A "medically relevant test" means a test that produces reliable results of exposure to cocaine, heroin, amphetamine, methamphetamine, or other illegal drugs, or their combinations or derivatives, including a drug urine screen test.

Sanctions for Failure to Report Child Abuse

Iowa Code provides for civil and criminal sanctions for failing to report child abuse. Any person, official, agency, or institution required to report a suspected case of child abuse who knowingly and willfully fails to do so is guilty of a simple misdemeanor. Any person, official, agency, or institution required by Iowa Code to report a suspected case of child abuse who knowingly fails to do so, or who knowingly interferes with the making of such a report in violation and is civilly liable for the damages caused by such failure or interference.

Sanctions for Reporting False Information

The act of reporting false information regarding an alleged act of child abuse to DHS or causing false information to be reported, knowing that the information is false or that the act did not occur, is classified as simple misdemeanor under Iowa Code.

If DHS receives a fourth report identifying the same child as a victim of child abuse and the same person as the alleged abuser, and DHS determined that the three earlier reports were entirely false or without merit, DHS may:

- Determine that the report is again false or without merit due to the report's spurious or frivolous nature.
- Terminate its assessment of the report.
- Provide information concerning the reports to the county attorney for consideration of criminal charges.

<u>What Happens After a Report is Made</u>

The Iowa Department of Human Services Employee Manual, Title 16, Chapter E, *Child Protective Assessments* (2001) states that the DHS has the responsibility to accept and investigate allegations of child abuse from mandatory reporters. There is an assessment process that is followed. The primary purpose of the assessment is to take action to protect and safeguard the child when necessary by evaluating the safety of and risk to the child named in the report and any other children in the same home as the parents or other person responsible for their care.

The assessment process does allow for a differential response to reports of child abuse, taking into account:

- The allegation of abuse.
- The safety of and risk to the child.
- The functioning of the family.
- The family's history of child abuse, substance abuse, or domestic violence.

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- The resources available within the child's and family's community.

According to Iowa Code, child abuse assessment consists of the following processes (DHS, 2001):

- **Intake** - the purpose of intake is to obtain information to ensure that reports of child abuse meeting the criteria for assessment are accepted and that reports that do not meet the legal requirements are appropriately rejected.

  Written notification of whether or not a report of suspected child abuse from a mandatory reporter has been accepted by the Department of Human Services can be obtained within five working days of the receipt of the report. It is Form 470-3789, *Notice of Intake Decision*.

- **Case assignment** - once a case has been assigned, the waiver of confidentiality goes into effect. A child who is considered to be at high risk must be assigned a caseworker within 12 hours of the report.

- **Evaluation of the alleged abuse**, including evaluating the safety of and risk to the child. This includes observing the alleged child victim; interviewing the alleged victim, subjects of the report and other sources; gathering of physical and documentary evidence; evaluating the safety of and risk to the child; determining the credibility of the information.

- **Determination of abuse**, including determining placement on the Registry and recommendations for juvenile and district court action. This determination is based on a preponderance of credible evidence. Each category or subcategory requires that specific criteria be met in order to conclude that abuse occurred.

- **Preparation of forms and reports**, including the *Child Protective Assessment Summary*, as well as an assessment of the family's strengths and needs.

A plan of action is jointly developed with the family. It should address the family's needs. The plan of action should include resources such as informal supports, community services and services provided by Department of Human Services (IDHS, Child Abuse, 2007).

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Conclusion of Part I

Child abuse continues to plague our nation and our world; every day children are suffering, and as mandatory reporters of child abuse, nurses must learn to identify it and to intervene and to participate in the efforts aimed at prevention.

If you suspect a child under the age of 18 is being abused or maltreated, call the following numbers:

- Telephone a **DHS Local Office** (Map of County Office locations can be accessed at http://www.dhs.state.ia.us/Consumers/Find_Help/MapLocations.html)
  8:00 AM – 4:30 PM, Monday-Friday

  Or

- Telephone **Iowa's Child Abuse/Dependent Adult Abuse Hotline**
  1-800-362-2178, 24 hours per day, 7 days per week.

  Please be ready to provide identifying information and the whereabouts of the child or dependent adult.

- **If you believe the child is in imminent danger, call 911 immediately.**
  DO NOT e-mail a report – CALL!!!!!!!

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Part II. The Identification and Reporting of Dependent Adult Abuse

Introduction

First, what is a dependent adult? Dependent adults may be elderly or may have diminished physical or mental capacities that prevent them from meeting their own needs adequately. Dependent adult abuse allegations involve people who are aged 18 or over and are incapable of adequate self care due to physical or mental conditions and require assistance from other people.

Iowa Code requires that a mandatory reporter whose work involves the examination, attending, counseling, or treatment of adults on a regular basis shall:

- Obtain a statement of the abuse reporting requirements from the person's employer (or from DHS, if self-employed) within one month of initial employment or self-employment.
- Complete **two** hours of training relating to the identification and reporting of dependent adult abuse within six months of initial employment (or self-employment).
- Complete at least two hours of additional dependent adult abuse identification and reporting training every five years.

(Iowa Department of Human Services [IDHS], 2008)

Note: These requirements do not apply to a physician whose professional practice does not regularly involve providing primary healthcare to adults.

If the person is an employee of a hospital or similar public or private facility, the employer is responsible for providing the training. To the extent that the employer provides approved training on the employer's premises, the hours of training completed by employees shall be included in the calculation of nursing or service hours required to be provided to a patient or resident per day.

If the person is self-employed, employed in a licensed or certified profession, or employed by a facility or program that is subject to licensure, regulation, or approval by a state agency, the person shall obtain the training as part of:

- A continuing education program required under Iowa Code and approved by the applicable licensing board.
- A training board using a curriculum approved by the abuse education review panel established by the Director of Public Health, or a training program using such an approved curriculum offered by the Department of Human Services, the Department of Elder Affairs, the Department of Inspection and Appeals, the Iowa Law Enforcement Academy, or a similar public agency.

A person required to complete both child abuse and dependent adult abuse mandatory reporter training may complete the training through a program which combines child abuse and dependent adult abuse curricula and thereby meet both training requirements simultaneously. The person may satisfy the combined requirements through completion of a *two-hour training program*, if the training curriculum is approved by the appropriate licensing or examining board or the abuse education review panel established by the Department of Public Health.

Who Are the Mandatory Reporters?

Iowa Code requires all of the following people to report suspected dependent adult abuse to the DHS:

- A person who in the course of employment examines, attends, counsels, or treats a dependent adult and reasonably believes the dependent adult has suffered abuse, including: a member of the staff of a community mental health center or hospital, a

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member of the staff or employee of a public or private healthcare facility, and a peace officer;
- An in-home homemaker-home health aide;
- A person employed as an outreach person;
- A health practitioner, as defined in Iowa Code;
- A member of the staff or an employee of a community supervised apartment living arrangement, sheltered workshop, or work activity center;
- A social worker;
- A certified psychologist;
- A person who performs inspections of elder group homes for the Department of Elder Affairs;
- A care review committee member assigned to an elder group home pursuant to Iowa Code; and
- A member of the staff or employee of an elder group home, an assisted living program, or an adult day services program.

(IDHS, 2008, p. 3)

Note: Any other person who believes that a dependent adult has suffered abuse **may** make a report of the suspected abuse to DHS. Mandatory reporters may also report suspected abuse **outside** the scope of their professional practice, as **permissive** reporters. An employee of a financial institution may report suspected financial exploitation of a dependent adult.

Historical Overview

There is not a clear picture of the prevalence of elder abuse in the United States. In order for social policy to be created that will impact treatment and prevention, the incidence and prevalence of elder abuse needs to be illuminated (Wood, 2006). According to the National Center for Victims of Crime (NCVC) 2001, literary references to elder abuse can be traced throughout Greek mythology, the writings of Shakespeare and modern literature. However, it has only been since the 1960s that serious attention has been given to family violence and elder abuse.

In 1978, the Congressional sub-committee on domestic violence heard testimony regarding the abuse of the elderly. This prompted the House Select Committee on Aging to further investigate the mistreatment of the elderly. The term “elder abuse” was derived from this committee (NCVC, 2001).

The National Center for the Prevention of Elder Abuse has been collecting data regarding the abuse of elders since 1986. In 1987 federal definitions of elder abuse, neglect and exploitation first appeared in amendments to the Older American Act. Currently the various forms of elder abuse or maltreatment are defined in state law; these definitions vary from state to state. However, elder abuse is generally divided into three broad categories: domestic abuse, institutional abuse and self-abuse and neglect.

Unfortunately, the variations in definitions of abuse, mistreatment, neglect, and maltreatment contribute to the difficulty in obtaining accurate national statistics on prevalence of elder abuse. Also contributing to the difficulty in understanding elder abuse is that research with limited funding has occurred in this area.

The oldest of the baby boom generation will soon be reaching the age of 65, with millions more to follow. This growing number of elderly can be attributed to the large percentage of the population in that developmental stage of life, as well as the advances in healthcare, which allow for longer life expectancies. In the year 1900, only 4% of older adults lived to be over the age of 65 (Fulmer, 1999). In 1999, there were 34.5 million persons over the age of 65, constituting 13% of the U.S. population; by the year 2025, that number is expected to increase to 20%. That is one in five persons!

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Persons living past 85 years of age numbered three million in 1994, or 1% of the population. By the year 2050, it is expected that this segment of the population will increase to 19 million, or 24% of the elderly population and 5% of the total population of the US (Greenberg et. al., 1999).

Along with the growth in the numbers of elderly, comes growth in the numbers of abused, neglected or maltreated elderly. Defining the various terms related to elder abuse has been difficult.

Researchers estimate that only one in 14 incidents of elder abuse actually come to the attention of law enforcement or human service agencies. Elder abuse is one of the most under-recognized and under-reported social problems in the United States. It is far less likely to be reported than child abuse because of the lack of public awareness. Nationally, it is estimated that over 55% of elder abuse is due to self-neglect. Such abuse can happen anywhere, in private homes, at healthcare facilities and in the community at large.

Iowa has an increasing proportion of people who are aged 60 and over. The group that is 80 and over is increasing more rapidly than any age group. Iowa's proportion of older adults in the population exceeds that of the United States as a whole. Nationwide, Iowa ranks:

- 2nd in percentage of persons over age 85
- 2nd in percentage of persons over age 75
- 3rd in percentage of persons over age 65
- 4th in percentage of persons over age 60

(IDHS, 2008 p. 1)

In 1993 the Department of Elder Affairs at the Iowa State University and area agencies on aging conducted a statewide needs assessment of non-institutionalized Iowans aged 60 - 104. Overall, older people in Iowa seem to be doing fairly well, but there are also large numbers who are vulnerable and at risk.

About half of the people in the study lived alone, a trend that is likely to continue into the next century. A high percentage of these individuals are older women with lower incomes. The older a woman becomes in our society, the more likely she is to live alone. Independent living, for many older adults can be problematic due to health problems. In addition to the assistance and support of family and friends, the elderly also rely on services by healthcare providers and from professionals.

Dependent adults also include those who have diminished physical or mental capacity. People who have a diminished ability to protect themselves and are dependent on others for basic needs are particularly vulnerable to mistreatment, physical violence, threats of assault, verbal abuse, financial exploitation, physical or emotional neglect, and sexual abuse. Iowa has a sizable population of adults who are dependent but are not elderly.

In 1999, a study done by the University of Iowa found that 190,005 reports of domestic elder abuse were made by 17 states. States that require mandatory reporting and tracking had higher rates of investigation.

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Incidence and Prevalence of Elder Abuse/Maltreatment

Like other forms of abuse such as intimate partner violence and child abuse, elder abuse occurs in all socioeconomic groups and cultures. The victims of abuse have a common characteristic of being vulnerable. Reports of the numbers of elderly being maltreated vary; however, a commonly used estimate in the past was one in 20. Because this is a crime of secrecy, accurate numbers are difficult to identify. Despite the estimate, in 1990 experts testifying at the Hearing Before the Subcommittee on Health and Long-Term Care of the House Select Committee on Aging suggested that only one in eight abusive events are reported. More recently, the US Department of Justice (2001) estimates that only one in 14 abusive events is reported.

In domestic settings, the number of reported cases of elder abuse was 117,000 in 1986 (when records were first collected by the National Center on Elder Abuse). The best national estimate is that a total of 449,924 elderly persons, aged 60 and over, experienced abuse and/or neglect in domestic settings in 1996 (the date of the landmark National Center on Elder Abuse study) (Administration on Aging, 1998). Of this total, 115,110 (21%) were reported to and substantiated by Adult Protective Service (APS) agencies, with the remaining 435,901 (79%) not being reported to APS agencies. One can conclude from these figures that almost four times (3.8) as many new incidents of elder abuse, neglect, and/or self-neglect were unreported versus those that were reported to and substantiated by APS agencies in 1996. The standard error suggests that nationwide as many as 787,027 elders or as few as 314,995 elders could have been abused, neglected, and/or self-neglecting in domestic settings in 1996. This range indicates that between 1.4 and 6.2 times as many elders were abused, neglected, and/or self-neglecting and not reported to APS as were reported to and substantiated by APS agencies (Administration on Aging, 1998).

The 1996, National Elder Abuse Incidence Study, the landmark research conducted by the Administration on Aging:

- More than 550,000 persons, aged 60 and over, experienced abuse, neglect, and/or self-neglect in a one-year period;
- Almost four times as many new incidents of abuse, neglect, and/or self-neglect were not reported as those that were reported to and substantiated by adult protective services agencies;
- Persons, aged 80 years and older, suffered abuse and neglect two to three times their proportion of the older population; and
- Among known perpetrators of elder abuse and neglect, the perpetrator was a family member in 90 percent of cases. Two-thirds of the perpetrators were adult children or spouses.

Neglect was the most common form of elder abuse/maltreatment, from 47% of reported cases in 1990, to 55% in 1996 (NCEA, 1999).

Victims of maltreatment were most often female. In 1990, 68.3% of reports involved female victims; in 1996 the percentage decreased slightly to 67.3%. The median age of maltreatment victims was 77.9 years in 1996. In that same year 66.4% of the victims of domestic elder maltreatment were Caucasian, 18.7% were African-American; 10.4% were Hispanic and less than 1% each were Native Americans and Asians (NCEA, 1999).

Victims of elder maltreatment most commonly live with a relative and are physically disabled or cognitively impaired. They tend to be socially isolated and have low self-esteem. They are dependent on their caretakers, and have a poor relationship with the perpetrators. Many have been prior victims of abuse and have used alcohol (Hogstel & Curry, 1999).

The latest performance outcome reports, coming from information generated by Iowa's Elder Abuse Initiative, compare the categories of referrals received in fiscal years 2005 to 2007 and are in similar to national statistics which indicate that denial of self critical care and denial of critical care are the most prevalent categories of abuse.

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Characteristics of Perpetrators

Family members are the most likely perpetrators of elder abuse. Adult children are the perpetrators most often. Males more often physically abuse; females more commonly neglect (Hogstel & Curry, 1999).

Other characteristics of those who mistreat elders:

- has a mental illness or other disturbed psychological state (CNSNA, 2002);
- abuses substances;
- has high levels of hostility;
- is between 40 to 60 years old;
- is under high stress;
- was abused as a child;
- is dependent on the victim financially.

Caregivers in Domestic Elder Abuse

Caregivers are those individuals who routinely provide assistance to another with a chronic or debilitating condition. Generally, a primary caregiver is identified, often the spouse, or an adult child. Others who assist in care are called secondary caregivers. Which family members become caregivers and what type of care they provide are influenced by cultural factors.

Although providing care to an aged relative can be emotionally gratifying, there can be negative consequences for some caregivers. The stress involved in providing care can be physically and emotionally intense, although this varies among caretakers. The level of stress experienced by caretakers is influenced significantly, by their feelings about their care giving responsibilities as well as how they feel about the person to whom they are providing care (Nerenberg, 2002).

Higher stress levels are reported by those who feel overwhelmed, guilty, constantly in demand or who feel out of control. Perceived feelings of inadequate support from other family members, social networks or public entities have also been reported to contribute to higher levels of stress. Elders who are perceived by the caregiver to be manipulative, unappreciative or unreasonable also contribute to higher stress levels.

Depression and anxiety are a significant problem for all caregivers (Nerenberg, 2002). The rate of depression for caregivers of elders who do not have dementia is 35%; among dementia caregivers, the rate of depression is as high as 46%.

Common physical complaints of caregivers include lack of sleep and inadequate exercise and nutrition. Caregivers who experienced the greatest levels of stress were 63% more likely to die within the next four years than non-caregivers (Nerenberg, 2002).

Others who may perpetrate abuse or maltreatment are: paid caregivers in the home; neighbors; volunteers in the home; institutional caregivers such as staff in hospitals, nursing facilities, personal care homes and assisted living facilities; healthcare providers such as physicians, nurses, social workers, technicians; and businesses such as telemarketers (Hogstel & Curry, 1999).

Contributing Factors/Risk Factors for the Occurrence of Dependent Adult Abuse

Explanations for the etiology of elder abuse/maltreatment, as in other forms of domestic or intimate partner violence, are difficult to identify. There is no single causal factor, rather it is likely the interplay of multiple factors.

Violence is prevalent throughout our society. Countless news stories of violence occur daily, from sensational school shootings to intimate partner violence, child abuse and neglect, drive by shootings, sexual exploitation, etc. As a society, we have long used violence as means of solving problems: from child rearing to dispute resolution, violence is everywhere. Social Learning Theory gives rise to the position that violence is a learned behavior, learned through experience

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or by witnessing the violence. Some families are more prone to violence than others and they have historically utilized these behaviors as “normal” responses to conflicts or tension. This learned violence tends to be multigenerational and intergenerational (CNSNA, 2002).

One obvious contributing factor to the incidence of elder abuse is intimate partner abuse in an aging couple. In relationships wherein one partner has utilized power and control through physical violence or threats and intimidation, or other acts of abuse, while the couple was younger, there is a likelihood that such behavior will continue into old age.

Ongoing problems in the relationship between the caregiver and the elderly person may also be a factor, as are personality conflicts among family members. Parents and children may be at odds as well as siblings disagreeing with each other. Women, who may have been abused by their intimate partners, may now become the abuser, when the partner becomes ill or infirm. Grown children who themselves were abused as children, by the very parents they may now be caring for, may struggle with the unconscious feelings their own experiences have produced; retribution may be a possibility, even if unconscious. Adult children who are abusers may have a higher incidence of personal problems than do those who are not abusers, including mental disorders, alcoholism, drug addiction and financial difficulty.

Caregiver stress is often cited as a contributing factor. Caring for the frail elderly is a difficult, complex set of tasks. Caregiving becomes more difficult when the elder is mentally or physically impaired or if the caregiver is not well prepared for the task, or if resources are lacking. Caregivers may be resentful of the demands the care of the elderly person places on them such as fatigue, lack of socialization, time constraints, etc.

Cognitive impairment, as occurs in Alzheimer’s disease and other dementias is considered to contribute to the occurrence of elder abuse (CNSNA, 2002). A number of research studies have indicated that those with dementia are more likely to be victims of abuse. Complicating this picture is that some persons with dementia exhibit disruptive, aggressive behavior as a result of cognitive impairment. Some of the research indicates that caregiver abuse of an individual with dementia is related to the violence from the care recipient (CNSNA, 2002).

Financial factors may contribute to maltreatment, as inadequate resources place stress on the caregivers, either because the care of the elder is costly, or the time required to care for the elder interferes with employment.

Social isolation of the family, when the elder and caretakers live in the same household, is considered to be a contributing factor (CNSNA, 2002). Families with poor social supports have a higher occurrence of elder abuse.

Ageism may also contribute to maltreatment. Older people are not as valued in our culture. This also points to the influence of culture in the abuse of elders. Cultural beliefs, values, traditions, responsibilities and roles clearly affect family life. How members of families relate to one another is also culturally impacted. Additionally, culture plays a role in how families manage stress and conflict. Some culturally sensitive questions to consider and to ask of families and elders, in the assessment and intervention process can include (NCEA, 2003):

- What role do seniors play in the family? In the community?
- Who, within the family, is expected to provide care to frail members? What happens when they fail to do so?
- Who makes decisions about how family resources are expended? About other aspects of family life?
- Who, within the family, do members turn to in times of conflict or strife?
- What conduct is considered abusive? Is it considered abusive to use an elder's resources for the benefit of other family members? To ignore a family member?
- (With immigrant seniors), when did they come to the U.S. and under what circumstances? Did they come alone or with family members? Did other family members sponsor them and, if so, what resources did those family members agree to provide? What is their legal status?

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- What religious beliefs, past experiences, attitudes about social service agencies or law enforcement, or social stigmas may affect community members' decisions to accept or refuse help from outsiders?
- Under what circumstances will families seek help from outsiders? To whom will they turn for help (e.g. members of the extended family, respected members of the community, religious leaders, physicians)?
- What are the trusted sources of information in the community? What television and radio stations, shows, and personalities are considered reliable? What newspapers and magazines do people read?
- How do persons with limited English speaking or reading skills get their information about resources?

Ageism may also play a role in why funding for research on elder abuse has been lacking (CNSNA, 2002).

The abuse of elders is not uniquely a phenomenon in the United States. According to the National Committee for the Prevention of Elder Abuse (2002), the issue of elder abuse is an international issue and was addressed by the United Nations Second World Assembly on Ageing, held in Madrid, Spain in April, 2002. The Valencia Forum, also held in April, 2002 in Valencia, Spain, which brought together the world's leading researchers, educators and practitioners in aging, and the World NGO (Non-Governmental Organization) Forum on Ageing. These organizations addressed abuse, violence and ill-treatment of elders at the local, national and international levels.

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Iowa's Response

The Dependent Adult Abuse Law, Iowa Code Section 235B, was initially enacted effective January 1, 1983 and has been amended yearly since then. This legislation authorizes the Department of Human Services (DHS) to accept reports of suspected dependent adult abuse, evaluate reports, complete an assessment of needed services, make appropriate referrals for services, and maintain a central registry. Additionally, dependent adult abuse may be a crime. Frequently the DHS worker and law enforcement work together. Criminal laws provide for the prosecution of alleged perpetrators in cases where a criminal act has been committed. Other laws provide other means of protection for dependent adults, including guardianships and conservatorships, and, when necessary, the involuntary commitment of adults for substance abuse or mental health reasons (IDHS, 2008).

In 2008 Iowa Acts, the Department of Inspections and Appeals (DIA) is responsible to accept reports of suspected dependent adult abuse in the following facilities that are defined as such in the Iowa Code:

- Healthcare facilities
    - Hospitals;
    - Elder group homes;
    - Assisted living programs *certified* in Iowa Code; and
    - Adult day services programs.

DHS has legal authority to conduct evaluations and assessments of alleged dependent adult abuse that occurs in the community when it is alleged that:

- The victim meets the definition of being a dependent adult;
- The victim suffers one or more of the four categories of abuse or neglect; and
- The abuse or neglect occurred as a result of the acts or omissions of a responsible caretaker or of the dependent adult.

DHS conducts approximately 1,600 such evaluations annually. Dependent adult abuse that occurs in a health-related facility is evaluated by the Department of Inspections and Appeals, while suspected dependent abuse occurring in the community is evaluated by the Department of Human Services. The two departments may work together on an abuse evaluation.

Services can be provided for dependent adults. However all adults have a right to self-determination. This means that the dependent adult can refuse services unless a court determines that the person is not competent to make decisions or is threatening his or her own life or that of others.

Iowa Code also creates a central registry in DHS to provide a single source for the statewide collection, maintenance, and dissemination of dependent adult abuse information. The Central Abuse Registry includes report data, investigative data, and disposition data relating to reports of dependent adult abuse.

The purpose of the Registry is to:

- Facilitate the identification of victims or potential victims of dependent adult abuse by making available a single, statewide source of dependent adult data;
- Facilitate research on dependent adult abuse by making available a single, statewide source of dependent adult abuse data; and
- Provide maximum safeguards against the unwarranted invasions of privacy which such a registry might otherwise entail.

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(IDHS, 2008, p. 2)

Definitions: What Is Dependent Adult Abuse Under Iowa Law?

There are two Iowa laws for dependent adult abuse, one for dependent adults living in the community, and new in 2008, Iowa Acts, House File 2591 for dependent adults who live in healthcare facilities (IDHS, 2008, p. 9).

As defined in Iowa Code section 235B.2, "dependent adult abuse" includes the following five categories of abuse as the result of the willful or negligent acts or omissions of a caretaker:

- Physical abuse (including unreasonable confinement or punishment and assault)
- Sexual abuse
- Financial exploitation
- Denial of critical care (including denial of critical care by the dependent adult)
- Sexual exploitation by a caretaker

Victim

To be accepted for evaluation, a report must concern a **dependent adult**. Iowa Code defines "dependent adult" as a person 18 years of age or older who:

- Is unable to protect the person's own interests or unable to adequately perform or obtain services necessary to meet essential human needs.
- As a result of a physical or mental condition requires assistance from another.

Dependent adult abuse does **not** include allegations involving:

- Domestic abuse in a situation where the victim is not "dependent."
- People who are legally incarcerated in a penal setting, either in a local jail or in the custody of the Department of Corrections.

(IDHS, 2008, p. 9)

Person Responsible for Abuse

Iowa Code section 235B.2 defines **caretaker** as a related or nonrelated person who has the responsibility for the protection, care, or custody of a dependent adult as a result of assuming the responsibility voluntarily, by contract, through employment, or by the order of the court.

Physical Abuse

Physical abuse means one of the following, as a result of the willful or negligent acts or omissions of a caretaker. Note that there does not have to be an injury to constitute physical abuse.

- Physical injury to a dependent adult
- Injury to a dependent adult which is at a variance with the history given of the injury
- Unreasonable confinement of a dependent adult
- Unreasonable punishment of a dependent adult
- Assault of a dependent adult

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(IDHS, 2008, p. 10)

Case Example:

Arnold is 75 years old and lives with his 50 year old son Roger who was recently divorced after a number or years. Roger has assumed management of the household and has responsibility for Arnold's Social Security checks which is all Arnold has. Roger has become very controlling and refuses to let Arnold out of his sight. He locks Arnold in his room and prevents him from social functions like his monthly poker game which he had enjoyed for many years. Though Arnold's friends suspect there is abuse in the home they were very reluctant to do anything that might make Arnold's life more difficult. Finally, a neighbor called the abuse hotline and reported her concerns and an investigation ensued.

Which agency should the neighbor call?

Should she call the Department of Human Services or the Department of Inspections and Appeals (DIA)?

Answer: The Department of Human Services should be called. The DIA accepts reports for suspected abuse occurring in a health-related facility.

Sexual Abuse

Sexual abuse means the commission of a sexual offense under Iowa Code with or against a dependent adult as a result of the willful or negligent acts or omissions of a caretaker. This includes the following sub-categories:

- First degree sexual abuse
- Second degree sexual abuse
- Third degree sexual abuse
- Detention in a brothel
- Indecent exposure
- Assault with intent to commit sexual abuse and incest
- Sexual exploitation by a counselor or therapist
- Sexual exploitation by a caretaker, which means that it is consensual or nonconsensual sexual conduct for the purpose of arousing the sexual desires of the caretaker or the dependent adult
- Invasion of privacy, nudity
- Incest

(IDHS, 2008, p. 11)

Financial Exploitation

Financial exploitation means the act or process of:

- Taking unfair advantage of a dependent adult or the adult's physical or financial resources for one's own personal or pecuniary profit without the informed consent of the dependent adult, including theft.
- By the use of undue influence, harassment, duress, deception, false representation, or false pretenses.
- As a result of the willful or negligent acts or omissions of a caretaker (IDHS, 2008, p. 11).

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Case Example:

Sarah is an 89 year old woman with a significant cardiac history. She has lived in the same home her entire life and doesn't want to move into senior housing or assisted living. Her great granddaughter Mary agrees to move into her home to provide care in exchange for free rent. At Mary's insistence, Sarah adds Mary's name to her checking and savings accounts so that she can also manage the bills. Sarah's bank account balance diminishes quickly. A teller at the bank notices irregular payment requests and provides a report to APS. Sarah is upset by the investigation because she does not want her great-granddaughter arrested. She is embarrassed by the situation.

Denial of Critical Care

Denial of critical care means the deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, or other care necessary to maintain a dependent adult's life or health, as a result of the willful or negligent acts or omissions of a caretaker.

This includes the following sub-categories:

- Denial of or failure to provide adequate food
- Denial of or failure to provide adequate shelter
- Denial of or failure to provide adequate clothing
- Denial of or failure to provide adequate medical care
- Denial of or failure to provide adequate mental health care
- Denial of or failure to meet emotional needs necessary for normal functioning
- Denial of or failure to provide proper supervision
- Denial of or failure to provide adequate physical care

Note: Denial of critical care may also be the deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, and other care necessary to maintain a dependent adult's life or health as a result of the acts or omissions of the dependent adult (IDHS, 2008, p. 12).

Case Study:

Jane is an 80 year old woman who lives with her daughter Susan. Jane had a stroke last year and is left unable to walk without the use of a walker. Jane attends meetings regularly at the local senior center where she engages in various activities. Lately she is having difficulty seeing the cards when playing bridge, and she appears disheveled and unkempt. Jane tells her friends that Susan has been too busy with her job to take her to the eye doctor and just doesn't have time to do her laundry. When Jane comes to the center one day complaining of pain in her hip from a fall the previous day, her friends call in a report to APS because they feel Jane isn't being cared for at home.

Dependent adult abuse does **not** include the following circumstances:

- The dependent adult declines medical treatment because the dependent adult holds a belief or is an adherent of a religion whose tenets and practices call for reliance on spiritual means in place of reliance on medical treatment.
- The dependent adult's caretaker declines such treatment acting in accordance with the dependent adult's stated or implied consent.
- The dependent adult or the dependent adult's next of kin or guardian requests withholding or withdrawal of health care from a dependent adult who is terminally ill, in

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the opinion of a licensed physician, pursuant to the applicable procedures under Iowa Code.

(IDHS, 2008, p. 12)

In 2008, a new House File was enacted and gave DIA authority to evaluate reports of abuse in:

- Healthcare facilities, including:
    - Hospitals
    - Assisted living programs
    - Elder group homes, and
    - Adult day services programs

The House File defines “dependent adult abuse to include physical and sexual abuse, financial and sexual exploitation and neglect” (IDHS, 2008 p. 13).

Although the categories of abuse remain the same for the community or for healthcare facilities, for purposes reporting to either the Department of Human Services or the Department of Inspections and Appeals, here are some of the differences.

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Reports of Suspected Dependent Adult Abuse Distinctions in the laws relating to the 2008 changes	
In the Community	In a Health-related Facility
Reports made to Department of Human Services	Reports sent to Department of Inspections and Appeals
Five categories of abuse	Same five categories of abuse
Caretaker – related or nonrelated individual	Caretaker – a staff member of a facility or program
Sexual exploitation – as previously discussed	Sexual transmission **also includes** transmission, display, or taking of electronic images of the unclothed breast, groin, buttock, anus, or pubes not related to treatment or diagnosis
Denial of critical care means the deprivation of food, shelter, clothing, supervision, physical or mental health care or necessary to maintain physical and mental health **as the result of willful or negligent acts or omissions of a caretaker.**	Referred to as **Neglect** in a health-related facility and means the deprivation of food, shelter, clothing, supervision, physical or mental health care required to maintain physical or mental health
Physical abuse **also includes** an assault without justification such as pointing a firearm toward another	Same five categories – as previously discussed
Three outcomes in abuse evaluation: founded (abuse has occurred), **except when self-denial of critical care**, unfounded, and confirmed, not registered	Three outcomes in abuse evaluation: founded (abuse has occurred), unfounded and confirmed, not registered (minor, isolated and unlikely to reoccur
Source: Adapted from Iowa Department of Human Services Dependent Adult Abuse: a Guide for Mandatory Reporters (IDHS), 2008, p. 9-15	

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Indicators of Possible Dependent Adult Abuse

The following physical, behavioral, and environmental indicators are listed as signs of possible dependent adult abuse for you to consider in making your report. These lists are examples and are not all-inclusive.

Environmental Indicators

- No food in the house or rotted, infested food
- Lack of proper food storage
- Special dietary foods not available
- Inadequate cooking facilities or equipment
- Clothes extremely dirty or uncared for
- Not dressed appropriately for the weather
- Inadequate or ill fitting clothing, not dressing
- Wearing all of one's clothing at once
- Structure dilapidated or in poor repair
- Fallen steps, high grass, rotted porch, leaking roof
- Utilities cut off or lack of heat in winter
- Doors or windows made out of cardboard
- Unvented gas heaters, chimney in poor repair
- No fuel for heating or fuel stored dangerously
- Lack of water or contaminated water
- Gross accumulation of garbage, papers, and clutter
- Lack of access to essential rooms
- Lack of access to community resources
- Lives on the street
- Large number of pets with no apparent means of care
- No income, unpaid bills
- Out of money by second week of the month
- Income does not meet monthly expenditures
- Signs checks over to others
- Sudden change in money management habits
- Sudden withdrawals or closing out of bank accounts
- No TV, radio, telephone, newspapers, magazines
- No friends or family visits
- No means of transportation
- Not physically able to get out and shop, pay bills, etc.

Physical Indicators

- Lack of medical care
- Lack of personal cleanliness and grooming, body odors
- Swollen eyes or ankles, decayed teeth or no teeth
- Bites, fleas, sores, lesions, lacerations
- Multiple, repeated or untreated injuries
- Injuries incompatible with explanation
- Bruises, broken bones or burns
- Untreated pressure sores
- Signs of confinement (tied to furniture, locked in a room, etc.)
- Obesity, malnourishment or dehydration
- Tremors
- Difficulty in communication

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- Broken glasses, frames or lenses
- Drunk, overly medicated
- Lying in urine, feces, old food
- No use of limbs, lack of mobility

Behavioral/Psychological Indicators

- Intentional physical self-abuse, suicidal statements
- Persistent liar
- Does not follow medication directions
- Refuses needed medical attention
- Refuses to accept services offered by others
- Threatens or attacks others physically or verbally
- Refuses to accept presence of visitor
- Refuses to open door
- In total darkness
- Denies obvious problems (medical conditions, etc.)
- Increased depression, anxiety or hostility
- Withdrawn, reclusive, suspicious, timid, unresponsive
- Refuses to discuss the situation
- Lack of trust in family as well as in others
- Refuses to take medication
- Denies any wrong-doing, medically or otherwise
- Unjustified pride in self-sufficiency
- Procrastination
- Turns off hearing aid
- Hallucinations, confusion or delusions
- Disorientation as to place and time
- Forgetfulness, losing things, not shutting stove off
- Loneliness, anger, or fearfulness
- Diminished mental capacity
- Vague health complaints
- Longing for death

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Reporting Dependent Adult Abuse

According to Iowa Code, and 2008 Iowa Acts, House File 2591, mandatory reporters of dependent adult abuse, who suspect a dependent adult has been abused, must report it to DHS or the DIA. The 2008 Iowa Acts require that if the suspected abuse occurred in a healthcare facility, a report should be made to the DIA. Make the report to DHS by telephone at 1-800-362-2178, 24-hours per day, seven days per week. Make the report to the DIA at 1-877-686-0027. Both the DHS Central Abuse Registry and DHS local offices accept reports from mandatory reporters or any other person who believes dependent adult abuse has occurred.

Any person may use the above number to report cases of suspected dependent adult abuse. All authorized persons may also use this number for obtaining dependent adult abuse information.

If there is reason to believe that immediate protection for the dependent adult is advisable, an oral report to the appropriate law enforcement agency must also be made. A county attorney or law enforcement agency that receives a report of dependent adult abuse must refer it to DHS.

The oral report must be followed in writing within **48 hours**. You may use DHS form 470-2441, *Suspected Dependent Adult Abuse Reporting Form* (Appendix B), or a format you develop that meets the requirements listed below, based on 441 Iowa Administrative Code.

Staff members or employees of agencies, must also immediately notify the person in charge or the person's designated agent. The employer or supervisor of a mandatory abuse reporter shall not apply any policy, work rule, or other requirement that interferes with the person making a report of dependent adult abuse or that result in failure of another person to make the report.

If you are an employee of a health-related facility that is licensed or certified by the DIA, the person in charge or their designee must be notified who then makes the report to the DIA **within 24 hours**, unless the person you report to is the suspected abuser of the dependent adult.

Report Requirements

The report should contain the following information, or as much of it as can be furnished:

- The names and home addresses of the dependent adult, relatives, caretakers, and other people believed to be responsible for the care of the dependent adult.
- The dependent adult's present whereabouts, if not the same as the address given.
- The reason the adult is believed to be dependent.
- The dependent adult's age.
- The nature and extent of the adult abuse, including evidence of previous adult abuse. (The existence of alleged adult abuse is the second criterion DHS considers before beginning an evaluation.)
- Information concerning the suspected adult abuse of other dependent adults in the same residence.
- Other information which you believe might be helpful in establishing the cause of the abuse or the identity of the people responsible for the abuse or helpful in assisting the dependent adult.
- Your name and address.

A report that meets the criteria will be accepted whether or not it contains all of the information listed (IDHS, 2008, p. 6).

Confidentiality and Immunity from Liability

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Iowa Code section 235B.3:

> The department shall inform the appropriate county attorneys of any reports of dependent adult abuse. The department may request information from any person believed to have knowledge of a case of dependent adult abuse. The person, including but not limited to a county attorney, a law enforcement agency, a multidisciplinary team, or a social services agency in the state shall cooperate and assist in the evaluation upon the request of the department…County attorneys and appropriate law enforcement agencies shall also take any other lawful action necessary or advisable for the protection of the dependent adult.
>
> A person participating in good faith in reporting or cooperating with or assisting the department in evaluating a case of dependent adult abuse has immunity from liability, civil or criminal, which might otherwise be incurred or imposed based upon the act of making the report or giving the assistance. The person has the same immunity with respect to participating in good faith in a judicial proceeding resulting from the report or cooperation or assistance or relating to the subject matter of the report, cooperation, or assistance.
>
> It shall be unlawful for any person or employer to discharge, suspend, or otherwise discipline a person required to report for voluntarily reporting, an instance of suspected dependent adult abuse pursuant to subsection 2 or 4, or cooperating with, or assisting the department of human services in evaluating a case of dependent adult abuse, or participating in judicial proceedings relating to the reporting or cooperation or assistance based solely upon the person's reporting or assistance relative to the instance of dependent adult abuse.
>
> A person required by this section to report a suspected case of dependent adult abuse who knowingly and willfully fails to do so commits a simple misdemeanor. A person required by this section to report a suspected case of dependent adult abuse who knowingly fails to do so or who knowingly interferes with the making of a dependent adult abuse report or applies a requirement that results in a failure to make a report, is civilly liable for the damages proximately caused by the failure (IDHS, 2008, p. 7).

How Does DHS Respond?

Immediately upon receipt of a report of dependent adult abuse, DHS shall:

- Make an oral report to the Central Abuse Registry.
- Forward a copy of the report to the Registry.
- Notify the appropriate county attorney of the receipt of the report.
- Commence an appropriate evaluation or assessment.

Note: The state Department of Inspections and Appeals is responsible for the evaluation and disposition of a case of adult abuse in a healthcare facility, including health-related facilities such as hospitals. DHS forwards all information concerning adult abuse in a healthcare facility to the Department of Inspections and Appeals on the first working day following submission of the report. The Department of Inspections and Appeals informs the Registry of all actions taken or contemplated concerning a reported case of adult abuse in a healthcare facility.

Upon receipt of a report of suspected dependent adult abuse, the Central Abuse Registry searches its records. If Registry records reveal any previous report of dependent adult abuse

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involving the same adult or any other pertinent information with respect to the same adult, the Registry immediately notifies the appropriate DHS office or law enforcement agency of that fact. The primary purpose of the evaluation or assessment is the protection of the dependent adult named in the report. The evaluation or assessment shall include all of the following:

- Identification of the nature, extent, and cause of the adult abuse, if any, to the dependent adult named in the report.
- The identification of the person(s) responsible for the adult abuse.
- A determination of whether other dependent adults in the same residence have been subjected to adult abuse.
- A critical examination of the residential environment of the dependent adult named in the report, and the dependent adult's relationship with caretakers and other adults in the same residence.
- A critical explanation of all other pertinent matters.

The DHS process of evaluating reports of dependent adult abuse is as follows:

- Intake
- Appropriate evaluation or assessment
- Contact with the dependent adult at the person's residence or at a care or training program
- Interview with the alleged perpetrator
- Obtaining information from subjects of the report and other relevant parties
- Documentation of evaluative conclusions and recommendations for services or court action
- Documentation of evaluation through completion of reports
- Completion of required correspondence to subjects and mandatory reporters

(IDHS, 2008, p. 16)

Evaluation/Assessment

DHS may request information from any person believed to have knowledge of a case of dependent adult abuse. This includes but is not limited to a county attorney, a law enforcement agency, a multidisciplinary team, a social services agency in the state, or any person who is required to report dependent adult abuse, whether or not the person made the specific dependent adult abuse report. The person **shall cooperate and assist** in the evaluation upon the request of DHS.

County attorneys, law enforcement agencies, multidisciplinary teams, and social services agencies in the state shall cooperate and assist in the evaluation or assessment upon the request of DHS. County attorneys and law enforcement agencies shall also take any other lawful action necessary or advisable for the protection of the dependent adult.

With the consent of the dependent adult or caretaker, the evaluation or assessment may, when appropriate, include a visit to the residence of the dependent adult named in the report and an examination of the dependent adult.

If permission to enter the residence and to examine the dependent adult is refused, the district court may authorize DHS to enter the dependent adult's residence and to examine the dependent adult to make an evaluation or assessment, upon a showing of probable cause that the dependent adult has been abused. Upon a showing of probable cause that the dependent adult has been financially exploited, a court may authorize DHS to gain access to the financial records of the dependent adult.

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DHS transmits a copy of its preliminary report, including actions taken or contemplated, to the Registry within 20 regular working days after it receives the adult abuse report, unless the Registry grants an extension of time for good cause. Upon completion of the report, **all subjects and mandatory reporters are notified in writing** of the conclusions of the evaluation/assessment report (IDHS, 2008, p.17).

Report Conclusions

The conclusion of the investigation is based on an evaluation of all of the information gathered during the investigation. Beginning July 1, 2007, a new category of "confirmed, not registered has been added. This new category applies **only** to reports of physical abuse, including both assault and denial of critical care. However, the category does not apply to self-denial or critical care when there is no caretaker; does not apply to the sexual abuse category or exploitation including sexual exploitation of a dependent adult who resides in a healthcare facility; there are now four possible outcomes in a dependent adult evaluation/assessment:

- **Founded:** It has been determined by a preponderance of evidence (more than 50%) that abuse has occurred. Information on founded reports is maintained on the Central Abuse Registry for ten years and then sealed.

- **Exception:** When the dependent adult is responsible for self-denial of critical care, DHS keeps the report in the county office, not on the Central Registry. These are called "assessments" rather than "evaluations."

- **Unfounded:** It has been determined by a preponderance of evidence (more than 50%) that abuse has not occurred. Information on unfounded reports is destroyed one year from the date they were unfounded.

- **Confirmed, not registered:** It has been determined by a preponderance of evidence (over 50%) that physical abuse of denial of critical care has occurred, but it is determined to be minor in nature, isolated and unlikely to occur again. The reports will be kept in the local DHS office for five years and then will be expunged, unless there is another report involving the same caregiver. If these reports are changed to the "founded" category, they will be maintained on the Central Abuse Registry.

Another revision to the Administrative Code on March 1, 2007, provides that DHS supervisors have the sole authority to approve extension of time for completing Dependent Adult Abuse reports. They also have the sole authority to rescind the rules regarding access to dependent adult abuse information; and they clarified when DHS could withhold the name of the person who made the report of the dependent adult abuse (IDHS, 2008, p.18).

<u>What Happens after the Evaluation?</u>

Based on the evaluation, DHS completes an assessment of services needed by a dependent adult believed to be the victim of abuse, the dependent adult's family, or a caretaker. In some situations there are treatment services that are available and may be offered to assist the dependent adult.

DHS does not have independent legal authority to compel the acceptance of protective services. Adults have constitutional rights which guarantee certain freedoms. DHS strives to balance a person's right to personal freedom with the need to protect dependent adults who are unable to protect themselves. Adults have a right to self-determination and have the right to voluntarily accept such services or to decline or refuse them.

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Upon voluntary acceptance of the offer of services, DHS makes referrals or may provide necessary protective services to eligible dependent adults, their family members, and caretakers. The following services may be offered and provided without regard to income: dependent adult protection, social casework, adult day care, adult support, transportation, and family planning.

Law Enforcement Intervention

Iowa Code gives the following responsibilities to law enforcement officers.

If a peace officer has reason to believe that dependent adult abuse, which is criminal in nature, has occurred, the officer shall use all reasonable means to prevent further abuse, including but not limited to any of the following:

1. If requested, remaining on the scene as long as there is a danger to the dependent adult's physical safety without the presence of a peace officer, including but not limited to staying in the dwelling unit, or if unable to remain at the scene, assisting the dependent adult in leaving the residence and securing support services or emergency shelter services.

2. Assisting the dependent adult in obtaining medical treatment necessitated by the dependent adult abuse, including providing assistance to the dependent adult in obtaining transportation to the emergency room of the nearest hospital.

3. Providing a dependent adult with immediate and adequate notice of the dependent adult's rights. The notice shall consist of handing the dependent adult a copy of the following written statement, requesting the dependent adult to read the card and asking the dependent adult whether the dependent adult understands the rights:

    a. You have the right to ask the court for the following help on a temporary basis:

        - Keeping the alleged perpetrator away from you, your home, and your place of work.
        - The right to stay at your home without interference from the alleged, perpetrator.
        - Professional counseling for you, your family, or household members, and the alleged perpetrator of the dependent adult abuse.

    b. If you are in need of medical treatment, you have the right to request that the peace officer present assist you in obtaining transportation to the nearest hospital or otherwise assist you.

    c. If you believe that police protection is needed for your physical safety, you have the right to request that the peace officer present remain at the scene until you and other affected parties can leave or safety is otherwise ensured. The notice shall also contain the telephone number of the local emergency shelter services, support services, or crisis lines operating in the area.

(IDHS, 2008, p. 18)

Court Action

DHS transmits a copy of the report of its evaluation or assessment to the appropriate county attorney. The county attorney notifies the DHS county office of any actions or contemplated actions with respect to a suspected case of adult abuse.

When a dependent adult is the victim of a criminal act by the caretaker, the caretaker may be criminally charged for maltreatment of the dependent adult. Some examples are:

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- Neglect or abandonment of a dependent person
- Wanton neglect of a dependent adult
- Nonsupport of a dependent adult Assault (various forms)
- Sexual abuse (various forms)
- Incest
- Dependent adult abuse (various forms)

All of these examples are cited in Iowa Code.

When there is no way to protect a dependent adult adequately with voluntary services, the district court may be petitioned to intervene on behalf of the dependent adult. The district court can be petitioned to do any of the following:

- Authorize the provision of protective services to a dependent adult in need of such services, but who lacks the capacity to consent to receipt of such services.
- Enjoin a caretaker from interfering with the provision of protective services to a dependent adult in need of such services to a dependent adult who consents to the receipt of such services.
- Order the provision of the following services to a dependent adult who has been the victim of dependent adult abuse, and who is in immediate threat to health and safety of the dependent adult, and the dependent adult lacks the capacity to consent to the receipt of such services:

    - Removal of the dependent adult to safer surroundings
    - Provision of medical services to the dependent adult
    - Provision of other needed services to the dependent adult

(IDHS, 2008, p. 19)

When DHS determines that the best interests of the dependent adult require court action, DHS may initiate action for:

- The appointment of a guardian or conservator, or
- The admission or commitment to an appropriate institution or facility, pursuant to the applicable procedures under Iowa Code.

The county attorney shall assist DHS in the preparation of the necessary papers to initiate the action, and shall appear and represent DHS at all district court proceedings.

DHS assists the district court during all stages of court proceedings involving a suspected case of adult abuse.

In every case involving adult abuse substantiated by DHS which results in a judicial proceeding on behalf of the dependent adult, legal counsel shall be appointed by the court, to represent the dependent adult in the proceedings. The court may also appoint a guardian to represent the dependent adult when necessary to protect the dependent adult's best interests. The same attorney may be appointed to serve both as legal counsel and as guardian.

Before legal counsel or a guardian is appointed pursuant to 1983 Iowa Acts the court shall require the dependent adult to complete under oath a detailed financial statement. If, on the basis of that financial statement, the court deems that the dependent adult or the legally responsible person is able to bear all or a portion of the cost of the legal counsel or guardian, the court shall so order. When the dependent adult or the legally responsible person is unable to bear the cost of the legal counsel or guardian, the expense shall be paid out of the court expense fund (IDHS, 2008, p. 21).

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Substance Abuse Commitment

Proceedings for the involuntary commitment of a substance abuser to a facility under Iowa Code may be commenced by the county attorney or an interested person. Proceedings begin with the filing of a verified application with the clerk of the district court of the county where the respondent is presently located or which is the respondent's place of residence. The application must:

- State that the applicant believes that the respondent is a chronic substance abuser
- State other pertinent facts
- Be accompanied by one or more or the following:
    - A written statement of support by a physician
    - One or more supporting affidavits
    - Other corroborative information

An attorney is appointed to represent the respondent. The court orders a hearing and an examination. The court may issue an order for immediate custody if the respondent is believed to be a danger to self or others.

A commitment hearing is held. The respondent's welfare is paramount. If the evidence is clear and convincing, a complete evaluation is ordered. The evaluating facility must report to the court whether the respondent:

- Does not require further treatment, or
- Requires full-time (inpatient) treatment, or
- Requires out-patient treatment, or
- Needs treatment but is not responding to the treatment provided

Further hearings can order continued treatment if warranted (IDHS, 2008, p. 21).

Mental Health Commitment

Proceedings for the involuntary hospitalization of a person under Iowa Code may be commenced by any interested person. Proceedings are begun by filing a verified application with the clerk of the district court of the county where the respondent is presently located, or which is the respondent's place of residence. The application must:

- State that the applicant believes that the respondent is seriously mentally impaired
- State other pertinent facts
- Be accompanied by one or more of the following:
    - A written statement of support by a physician
    - One or more supporting affidavits
    - Other corroborative information

An attorney is appointed to represent the respondent. The court orders a hearing and an examination. The court may issue an order for immediate custody if the respondent is believed to be a danger to self or others.

A commitment hearing is held. The respondent's welfare is paramount. If the evidence is clear and convincing, a complete evaluation is ordered. The evaluating facility must report to the court whether the respondent:

- Does not require further treatment, or
- Requires full-time (inpatient) treatment, or

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- Requires out-patient treatment, or
- Needs treatment but is not responding to the treatment provided

Further hearings can order continued treatment if warranted (IDHS, 2008, p. 22).

Conservatorship

A **conservatorship** is a court-authorized relationship under Iowa Code sections 633.566 - 633.667 whereby one person assumes the responsibility for the custody and control of the property of another. The person to whom custody of the property is awarded is called a "conservator." The person over whose property custody is granted is called a "ward." The appointment of a conservator means that the ward is either under legal age or by reason of mental, physical, or other incapacity is unable to make or carry out important decisions concerning the ward's **financial** affairs. It does not mean that the ward is of unsound mind.

A petition for the appointment of a conservator of the property of a dependent adult may be sought to protect the property of the dependent adult if the protective concern is based on an imminent danger to that person's property. In the absence of legal action, no person has the right to manage the property of an adult contrary to the adult's consent.

A conservator must do all of the following:

- Take possession of the ward's property and protect and preserve it, invest it prudently and account for it.
- Maintain a complete list of all receipts and disbursements.
- Within 60 days of appointment, file an initial report and inventory of the property of the ward in the conservator's possession or of which the conservator has knowledge.
- File the following reports with the court containing full itemized accounting and a list of all assets:
    - An annual report within 30 days of the anniversary date of the appointment.
    - A final report at the termination of the conservatorship.

Failure in getting the required report filed is a breach of the conservator's duty to the ward and to the court. If the wards will come into the conservator's hands, it must be delivered to the court for safekeeping.

A conservator has these general powers:

- Collect, receive and receipt for any property or income of the ward, including Social Security or Veterans Benefits.
- Sell or transfer perishable personal property or personal property having an established market value.
- Receive additional property from any source.
- Make payments to the ward or to others for the benefit of the ward.
- After obtaining a court order the conservator may:
    - Invest and reinvest the funds of the ward.
    - Sell lease or mortgage real estate.
    - Do any other thing the Court determines to be in the best interest of the ward.

(IDHS, 2008, p. 23)

Guardianship

When the concern is for the dependent adult's life, rather than the adult's property, a person may seek guardianship appointment to provide for the legal sanction of moving the adult or protecting

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the adult. In the absence of such legal action, no one has the right to physically relocate an adult against the adult's will. The appointment of a guardian, authorized under Iowa Code sections 633.552 - 633.565, does not constitute an adjudication that the ward is of unsound mind.

The following conditions must be verified before filing a guardianship petition:

- The dependent adult is incompetent to make decisions regarding the adult's person.
- A qualified professional has written a document clearly stating that the dependent adult is incompetent to make decisions regarding the adult's person and the reasons for this.
- A qualified person has agreed to act as the guardian if appointed.

A guardian may be granted the following powers and duties, which may be exercised without prior court approval:

- Providing for the care, comfort and maintenance of the ward, including the appropriate training and education to maximize the ward's potential.
- Taking reasonable care of the ward's clothing, furniture, vehicle and other personal effects.
- Assisting the ward in developing maximum self-reliance and independence.
- Ensuring the ward receives necessary emergency medical services.
- Ensuring the ward receives professional care, counseling, treatment or services as necessary.
- Any other powers or duties the court may specify.

A guardian may be granted the following powers, which may be exercised only upon court approval:

- Changing the ward's permanent residence at the guardian's request, if the proposed new residence is more restrictive of the ward's liberties than the current residence.
- Arranging the provisions of major elective surgery or any other non-emergency major medical procedure.
- Consent to the withholding or withdrawal of life-sustaining procedures in accordance with Iowa Code.

The court may take into account all available information concerning the capabilities of the ward and any additional evaluation deemed necessary. The court may direct that the guardian has only a specially limited responsibility for the ward. If so, the court shall state those areas of responsibility which shall be supervised by the guardian; all others shall be retained by the ward. The court may alter the respective responsibilities of the guardian and the ward after notice to the ward and an opportunity to be heard.

A guardian must file the following reports with the Court:

- An initial report within 60 days of appointment.
- An annual report within 30 days of the anniversary date of the appointment.
- A final report within 30 days of the event causing termination.

(IDHS, 2008, p. 24)

How Is Dependent Adult Abuse Information Handled?

Confidentiality of dependent adult information shall be maintained, except as specifically authorized. DHS must withhold the name of the person who made the report of suspected

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dependent adult abuse. Only the court or the central registry may allow the release of that person's name (IDHS, 2008, p. 25).

Access to Information

Access to "founded," or "unfounded" dependent adult abuse information is authorized to:

- "Subjects" of a report (the adult victim, the guardian or legal custodian of the adult victim, and the alleged perpetrator) or the attorney for any subject.
- An employee or agent of DHS responsible for investigating an abuse report.
- DHS personnel when necessary for the performance of their official duties.
- The mandatory reporter who reported the abuse.
- The long-term care resident's advocate.
- Multidisciplinary teams.

Access to "founded" dependent adult abuse information (not to "unfounded' information) is also authorized to:

- People involved in an investigation of dependent care, including a health practitioner or mental health professional, a law enforcement officer, a multidisciplinary team.
- Individuals, agencies, or facilities providing care to a dependent adult named in a report under some circumstances. This includes a facility licensing authority, a person or agency responsible for the care of a dependent adult victim or perpetrator, a DHS registration or licensing employee, or a person providing care to an adult who is regulated by DHS, and the legally authorized protection and advocacy agency.
- Judicial and administrative proceedings, under some circumstances. This may include district court, a court or administrative agency hearing an appeal for correction of dependent adult abuse information, and an expert witness at any stage of an appeal hearing.
- A person conducting bona fide dependent adult abuse research.
- DHS personnel, a person or agency under contract with DHS to carry out the duties of the Registry, or the attorney for DHS.
- The Department of Justice.
- A legally constituted adult protection agency from another state for investigative or treatment purposes.
- A healthcare facility administrator or designee.

To request dependent adult abuse information, complete form 470-0612, *Request for Dependent Adult Abuse Registry Information*. Send this form to the county DHS office or to the Central Abuse Registry at the following address: DHS Central Abuse Registry, 1305 E Walnut St, 5th Floor, Des Moines, Iowa 50319-0114 (IDHS, 2008, p. 26).

Request for Correction or Expungement of Dependent Adult Abuse Information

A subject of a dependent adult abuse report who feels there is incorrect or erroneous information contained in the report, or who disagrees with the conclusions of the report, may request correction of the report.

To request a correction of a report, a person must file a written statement to the effect that the information referring to the person is in whole or in part erroneous with DHS within six months of the date of the notice of the results of the evaluation. Submit to: DHS Appeals Section, 1305 E Walnut St, 5th Floor, Des Moines, Iowa 50319-0114.

The local office social worker or the social worker's supervisor may wish to review the report, along with any additional information the requester provides. They may uphold, modify or

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overturn the original funding. A requester not satisfied with the local office review may request an administrative appeal hearing. The administrative law judge may uphold, modify or overturn the finding. DHS may defer the hearing until the conclusion of a court case relating to the information or findings.

If the requester is not satisfied with the decision of the administrative law judge, the matter may be appealed to the district court. The decision resulting from the hearing may be appealed to the Court of Polk County or to the court of the district in which the person resides (IDHS, 2008, p.27).

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Conclusion of Part II

Like child abuse, dependent adult abuse involves the abuse of vulnerable populations. Mandatory reporters have a legal as well as moral obligation to identify and report dependent adult abuse. Part II of this mandatory training has addressed the identification and reporting of dependent adult abuse.

If you suspect a dependent adult is being abused or maltreated, call the following numbers:

- Telephone a **DHS Local Office** (Map of County Office locations can be accessed at http://www.dhs.state.ia.us/Consumers/Find_Help/MapLocations.html)
  8:00 AM – 4:30 PM Monday-Friday

  Or

- In the Community or in a Health-related facility, telephone **Iowa's Child Abuse/Dependent Adult Abuse Hotline** 1-800-362-2178, 24 hours per day, seven days per week. All reports are accepted here no matter where the suspected abuse has occurred.

- In a Health-related facility, contact the Department of Inspections and Appeals at 1-877-686-0027.

  Please be ready to provide identifying information and the whereabouts of the child or dependent adult.

- **If you believe the child or dependent adult is in imminent danger, call 911 immediately. DO NOT e-mail a report – CALL!!!!!!!**

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Conclusion of the Course

Vulnerable persons such as children and dependent adults rely on caretakers to have their needs met. Some caretakers clearly do not meet their needs and contribute to the suffering of these vulnerable populations. Mandatory reporters, such as nurses, physicians, social workers and other healthcare practitioners must be able to identify and intervene in the abuse of these individuals. This includes intervening to stop the suffering and intervening to put in place the services needed to keep vulnerable populations safe.

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Appendix A

Iowa Department of Human Services

REPORT OF SUSPECTED CHILD ABUSE

This form may be used as the written report which the law requires all mandated reporters to file with the Department of Human Services following an oral report of suspected child abuse. If your agency has a report form or letter format which includes all of the information requested on this form, you may use the agency format in place of this form.

Fill in as much information under each category as is known. Submit the completed form to the local office of the Department of Human Services within 48 hours of oral report.

FAMILY INFORMATION

Name of child	Age	Date of birth
Address		
Phone	School	Grade level
Name of parent or guardian		Phone *(if different from child's)*
Address (if different from child's)		

OTHER CHILDREN IN THE HOME

NAME	BIRTH DATE	CONDITION

INFORMATION ABOUT SUSPECTED ABUSE

In this section, indicate the date of suspected abuse; the nature, extent and cause of the suspected abuse; the persons thought to be responsible for the suspected abuse; evidence of previous abuse; and other pertinent information needed to conduct the assessment. Use the back of this form if necessary to complete the information requested above and to identify individuals who have been informed of the child abuse report, such as building administrator, supervisor, etc.

REPORTER INFORMATION

Name and title or position	
Office address	
Phone	Relationship to child
Names of other mandatory reporters who have knowledge of the abuse	
Signature of reporter	Date

470-0665 (Rev. 7/04)

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Appendix B

Iowa Department of Human Services

SUSPECTED DEPENDENT ADULT ABUSE REPORT

This form may be used as the written report that mandatory reporters file with the Department of Human Services following an oral report of suspected dependent adult abuse. See page 2 for instructions.

There are three criteria for a dependent adult abuse referral:

(1) A dependent adult. (2) Abuse as defined in Iowa Code 235B. (3) A caretaker, if applicable.

REPORT INFORMATION

Name of Dependent	Phone ( )	Birth Date	
Street	City	State	Zip Code
1. Person is a dependent adult because:			
2. Type of abuse noted: ❑ Physical injury ❑ Financial exploitation ❑ Denial of care by dependent adult him/herself ❑ Sexual offense ❑ Unreasonable punishment ❑ Denial of care by caretaker ❑ Unreasonable confinement			
Information about suspected abuse: (Incidents, previous abuse, person responsible for abuse, name and address of guardian, etc.)			
3. Caretaker: (Omit if deprivation is by the dependent adult.)			
Name		Phone ( )	
Street	City	State	Zip Code
Person is a caretaker because:			

REPORTER INFORMATION

Name	Position	Relationship to Adult
Office Address		Phone ( )
Names of other mandatory reporters who have knowledge of the abuse		
Signature of Reporter		Date

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Iowa Resources

The Iowa Department of Human Services
Hoover State Office Building
Des Moines, IA 50319

Iowa's Toll-Free **Child Abuse Hotline**
1-800-362-2178
For general information call: 1-800-972-2017
E-mail: fdhs@dhs.state.ia.us

For a listing of **Iowa Department of Human Services, county offices** go to
http://www.dhs.state.ia.us/Consumers/Find_Help/MapLocations.html

Prevent Child Abuse Iowa
431 E. Locust, Suite 202
Des Moines, Iowa 50309
Phone: 515-244-2200
Toll Free: 800-237-1815
Fax: 515-280-7835
E-mail: pcaia@pcaiowa.org

Children and Families of Iowa
1111 University Ave.
Des Moines, IA 50314
(515) 288-1981
(515) 288-9109
contactus@cfiowa.org

National Resources

American Humane Association
Children's Division
63 Inverness Dr. East
Englewood, CO 80112-5117
(303) 792-9900
http://www.americanhumane.org/

This is a national center promoting responsive child protection services in every community through program planning, training, education, and consultation. It operates the National Resource Center on Child Abuse and Neglect. Please contact for free general information.

C. Henry Kempe National Center for the Prevention & Treatment of Child Abuse & Neglect
1825 Marion St.
Denver, CO 80218
(303) 864-5320
http://naccchildlaw.org

The center emphasizes the development of treatment programs for abused children, conducts training and consultation programs, and offers technical assistance. A catalog of materials and services is available upon request.

Center for the Prevention of Sexual and Domestic Violence
936 North 34th St.
Suite 200
Seattle, WA 98103
(206) 634-1903
www.cpsdv.org

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This educational and training center is designed to train clergy and lay leaders about family violence and concerns that arise for both the victims and offenders.

Child Welfare League of America (CWLA)
440 First St. NW
Suite 310
Washington, DC 20001
(202) 638-2952
www.cwla.org

This organization is comprised of public and private direct service agencies throughout the United States and Canada. CWLA offers a variety of publications and audiovisual materials for professionals.

Children's Defense Fund (CDF)
25 E. St. NW
Washington, DC 20001
(202) 628-8787
www.childrensdefense.org

This national advocacy organization focuses on the education, care, welfare, and health of children, and on federal legislation affecting children and families. CDF offers numerous publications on important issues in child health and family welfare.

Children of the Night
14530 Sylvan St.
Van Nuys, CA 91411
(818) 908-4474
www.childrenofthenight.org

Provide protection and support for street children, usually runaways, ages 11 – 17 who are involved in pornography or prostitution. Provides shelter, a 24-hour hotline, and a street outreach program.

Family Support America
20 North Wacker Dr.
Suite 1100
Chicago, IL 60606
(312) 338-0900
http://www.familysupportamerica.org/

This membership organization is comprised of social services, agencies concerned with family issues and preventive programs. FSA maintains a clearinghouse of information on family resource programs throughout the United States and Canada.

National Center for Missing and Exploited Children
699 Prince St.
Arlington, VA 22314
(703) 235-3900
www.missingkids.com

This nonprofit corporation operates a national resource and technical assistance center to deal with child abduction and exploitation.

National Clearinghouse on Child Abuse and Neglect (NCCAN)
U.S. Dept. of Health and Human Services
P.O. Box 1182
Washington, DC 20013
1-800-FYI-3366
http://www.childwelfare.gov/

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The NCCAN was established by the Child Abuse Prevention and Treatment Act in 1974. Its activities include conducting research, collecting and analyzing information, and providing assistance to states and communities for activities on the prevention of child abuse and neglect.

National Coalition Against Domestic Violence (for members)
119 Constitution Ave. NE
Washington, DC 20002
(202) 544-7358
www.ncadv.org

The coalition is a national organization that works to end violence in the lives of battered women and their children. The coalition provides information, technical assistance, publications, newsletters, and resource materials. Call or write for membership information.

National Network For Youth
1319 F St. NW.
Suite 401
Washington, DC 20004
(202) 783-7949
www.nn4youth.org

Works to ensure that young people can be safe and grow up to lead healthy and productive lives. Provides Community Youth Development (CYD) services to members and communities. CYD is an approach that models the best practice in youth work and focuses on lifelong learning in which youth develop skills and competencies.

Prevent Child Abuse America
200 South Michigan Ave. 17th Floor
Chicago, IL 60604
(312) 663-3520
www.preventchildabuse.org

This organization is committed to the reduction of child abuse and neglect through public awareness, education, research and advocacy. PCAA coordinates chapters at the state level and is a primary resource for local child abuse and neglect prevention efforts. A number of publications on the prevention of child abuse and neglect are produced by PCAA.

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Iowa State Mandatory Child and Dependant Adult Abuse Education
Course Exam

After studying the downloaded course and completing the course exam, you need to enter your answers online. **Answers cannot be graded from this downloadable version of the course.** To enter your answers online, go to e-leaRN's Web site, www.elearnonline.net and click on the Login/My Account button. As a returning student, login using the username and password you created, click on the "Go to Course" link, and proceed to the course exam.

1. In Iowa, the Board for Nursing requires that nurses receive, at a minimum, 2 hours of continuing education on the topic of child abuse and dependent adult abuse identification and reporting.

    A. True
    B. False

2. Iowa laws define child abuse to include all the following categories **EXCEPT**:

    A. Physical and sexual abuse and child prostitution.
    B. Mental injury and denial of critical care.
    C. Neglect.
    D. Presence of illegal drugs and the manufacturing or possession of a dangerous substance.

3. Physical signs that almost always indicate child abuse are:

    A. Bruises.
    B. Lacerations.
    C. Persistent diaper rash.
    D. Injuries to both eyes or both cheeks.

4. A burn that should be considered a physical indicator of child abuse is one that

    A. Occurs during the night.
    B. Has a patterned design.
    C. Affects one limb only.
    D. Is nearly healed on first presentation.

5. Special attention should be paid to a child's injuries when they are

    A. Easily explained by parent/caretaker.
    B. Consistent with the explanations given.
    C. Inconsistent with the child's developmental stage.
    D. Explained with a great deal of emotion by parent/caretaker.

6. You are the nurse in an outpatient office and you notice a nine year old child and his parents in the waiting room. You overhear the parents repeatedly telling the child that he is stupid and so different from his siblings because of his inability to read. The child sits passively as the parents continue to berate the child. This may be an example of:

    A. Physical abuse
    B. Denial of critical care
    C. Mental injury
    D. Neglect

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7. You work in the emergency room of a community hospital. A 12 year old child is brought into the emergency room with a tibial fracture that occurred 2 weeks ago when the child fell off his bicycle. The parents report they knew the child was in pain after the fall, but did not respond because they felt that the child was behaving “like a baby”. Today the child is brought to the emergency room after the child’s teacher intervened for treatment. This situation may be examples of:

    A. Denial of critical care and mental injury.
    B. Neglect and denial of critical care.
    C. Physical abuse and neglect.
    D. None of the above.

8. You are a nurse in a pediatric office. A 4 year old patient’s lab work just came back positive for gonorrhea. As a mandatory reporter you make the call to the Central Abuse Registry hotline to report this case of suspected:

    A. Physical abuse.
    B. Sexual abuse.
    C. Mental injury.
    D. All of the above.

9. Children are ***most*** often physically abused by:

    A. Strangers.
    B. Older children.
    C. Their teachers.
    D. Their parents.

10. When a mandatory reporter makes a verbal telephone report of child abuse, a written report must be filed within:

    A. 24 hours
    B. 48 hours
    C. 3 days
    D. 7 days

11. If the nurse suspects that a child is in imminent danger, the following action is also required by law:

    A. Immediately notifying your supervisor of the report.
    B. Contacting the parents within 24 hours to notify them of the report.
    C. Immediately notifying law enforcement.
    D. All of the above.

12. In Iowa if a nurse does not report a suspected case of child abuse, it is considered

    A. A felony.
    B. Assault and battery.
    C. A simple misdemeanor.
    D. Professional misconduct.

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13. In Iowa a dependent adult is a person who is age 18 or over who may be elderly and who is incapable of adequate self care due to:

    A. Diminished physical capacities that prevent him or her from meeting his or her own needs adequately.
    B. Diminished mental capacities that prevent him or her from meeting his or her own needs adequately.
    C. Neither A nor B
    D. Both A and B

14. The incidence of elder abuse has declined since 1986.

    A. True
    B. False

15. In Iowa, dependent adult abuse is considered to be all the following **EXCEPT**:

    A. Physical and sexual abuse.
    B. Denial of critical care.
    C. Financial exploitation.
    D. Presence of illegal drugs.

16. Denial of critical care means the deprivation of the minimum food, shelter, clothing, supervision, physical or mental healthcare, or other care necessary to maintain a dependent adult's life or health, as a result of the willful or negligent acts or omissions of a caretaker.

    A. True
    B. False

17. In Iowa financial exploitation means the act or process of:

    A. Taking unfair advantage of a dependent adult or the adult's physical or financial resources for one's own personal or pecuniary profit without the informed consent of the dependent adult, including theft.
    B. The use of undue influence, harassment, duress, deception, false representation, or false pretenses.
    C. These acts are a result of the willful or negligent acts or omissions of a caretaker.
    D. All of the above.

18. An oral report of dependent adult abuse is made to the same number as the child abuse hotline.

    A. True
    B. False

19. An oral report of dependent adult abuse must be followed up with a written report in:

    A. 24 hours
    B. 48 hours
    C. 72 hours
    D. A written report is not necessary.

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20. Some actions provided to dependent adults after DHS evaluation can include:

    A. Substance abuse or mental health treatment commitment
    B. Conservatorship
    C. Guardianship
    D. All of the above

21. A nurse who, in good faith, reports or cooperates with or assists DHS evaluating a case of dependent adult abuse has immunity from liability, civil or criminal, which might otherwise be incurred or imposed based upon the act of making the report or giving the assistance.

    A. True
    B. False

22. DHS may respond with which of the following actions after receiving a report of dependent adult abuse?

    A. Make an oral report to the Central Abuse Registry followed by a copy of the written report.
    B. Notification of the appropriate county attorney of receipt of the report.
    C. Begin an appropriate evaluation/assessment.
    D. All of the above.

23. DHS responds to all reports of child abuse and dependent adult abuse, except for cases of adult abuse in healthcare facilities. It is the State Department of Inspections and Appeals that is responsible for the evaluation and disposition of cases of adult abuse in a healthcare facility.

    A. True
    B. False

24. As a nurse with an Iowa license, having taken this course, you have met the training requirement for a period of:

    A. 1 year
    B. 2 years
    C. 5 years
    D. It is only a one-time requirement.

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