Child Abuse Identification and Reporting:

Iowa Training for Mandatory Reporters

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Answer Sheet: **Child Abuse Identification and Reporting:**

Iowa Training for Mandatory Reporters

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Objectives

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

- Discuss the scope of the problem of child abuse.
- Identify the legal definitions of categories of child abuse in Iowa.
- Describe possible indicators, physical and behavioral, of the categories of child abuse.
- Describe the perpetrators of child abuse and maltreatment/neglect.
- Evaluate situations to determine if a report of child abuse should be made.
- State the criteria for reporting the categories of child abuse.
- Describe the reporting procedure.
- Discuss the process that the Department of Human Services uses to evaluation whether or not child abuse occurred.
- Explore possible outcomes and services for cases of child abuse.
- State how the Iowa Safe Haven for Newborns law impacts mandated reports.

Introduction

In the United States, one of the most educated and affluent countries in the world, in 2006, an estimated 905,000 children were determined to be victims of child abuse neglect/maltreatment, an increase of over 6,000 children from 2005. These maltreated children were identified based on 3.6 million referrals alleging child abuse or neglect that were accepted by state and local child protective services (CPS) agencies for investigation. That means about 12 out of every 1,000 children up to age 18 in the United States were found to be victims of maltreatment in 2006 (USDHHS, 2008). Nationally, 1,530 children died as a result of this victimization, also an increase from 2005, when there were 1,460 child fatalities (USDHHS-ACF, 2008).

In Iowa, in 2006, the child population was 710,194. Of those children 14,589 were determined to have been abused or neglected/maltreated. In 2006, 6 children died in Iowa as a result of abuse or neglect/maltreatment, a decrease from 2005 when there were 9 child fatalities (USDHHS-ACF, 2008).

The suffering of children continues despite laws identifying mandatory reporters. In Iowa, all mandatory reporters are required to complete two hours of approved training relating to the identification and reporting of child abuse within six months of initial employment or self-employment. All mandatory reporters are also required to complete at least two hours of additional child abuse identification and reporting training every five years. The Iowa Department of Public Health, Abuse Education Review Panel has approved this course to meet that requirement.

Note: National statistics are based on reports from each individual state. However, each state, through its laws defines child abuse, neglect, maltreatment, etc. differently. For example, some states use the term “neglect” which in Iowa is considered “denial of critical care”; some states specifically identify “medical neglect”, while in other states, “medical neglect” is considered part of “neglect”. Additionally, some authors of the references used in this course define these terms differently. For the purpose of this course the terms “abuse and neglect/maltreatment” or “maltreatment” will be used to

identify the entire spectrum of reportable mistreatment of children. When a specific type of mistreatment is addressed, it will be identified as such.

Ken Hammond, USDA.

Who Are the Mandatory Reporters?

Mandatory reporters of child abuse are identified in Iowa law. The purpose of this law is to provide protection to children by encouraging the reporting of abuse. The law defines categories of people 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 (IDHS, 2005):

- Health,
- Education,
- Child care,
- Mental health,
- Law enforcement, and
- Social workers.

As outlined in Iowa Code section 232.69, the following categories of people are mandatory reporters when they examine, attend, counsel, or treat a child in the scope of professional practice or in their employment responsibilities (IDHS, 2005):

- 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.
- Employees or operators of a public or private health care facility as defined in Iowa Code section 135C.1.
- Certified psychologists.
- Licensed school employees, certified paraeducators, or holders of coaching authorizations issued under Iowa Code section 272.31.
- 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 section 217.12, or Healthy Opportunities for Parents to Experience Success – Healthy Families Iowa program under Iowa Code section 135.106.
- Employees or operators of a licensed substance abuse program or facility licensed under
  Iowa Code Chapter 125.
- Employees of an institution operated by DHS listed in Iowa Code section 218.1.
- Employees or operators of a juvenile detention or juvenile shelter care facility approved
  under Iowa Code section 232.142.
- Employees or operators of a foster care facility licensed or approved under Iowa Code
  Chapter 237.
- Employees or operators of a mental health center.
- Peace officers.
- Counselors or mental health professionals.
- Employees or operators of a provider of services to children funded under a federally
  approved Medicaid home- and community-based services waiver.

The employer or supervisor of a person who is a mandatory reporter **cannot** institute any policies, work rules, or other requirements that 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 the 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 clergy (IDHS, 2005).

Why Professionals Do Not Report

Despite laws regarding the mandatory reporting of child abuse by select professionals, often they do not report. The New York State Office of Children and Family Services (NYS-OCFS) (NYS-OCFS, 2005), reporting on two separate studies, a National Incidence Study conducted during the 1980s, and a 1999 University of Rochester study, found that professionals only reported about half of all maltreatment incidents that they knew about. Some of the reasons for not reporting were:

- Confusion or misunderstanding about reporting laws and procedures;
- Lack of knowledge or awareness of warning signs/clues.
- Lack of clarity about abuse/neglect as defined in State Law; and
- Influence of professional beliefs, values and experiences.

Confidentiality

Issues of **confidentiality** and privileged communication are often areas of concern for some mandatory reporters, particularly those in mental health and healthcare providers. Rules around confidentiality and privileged communication are waived during the child abuse assessment process (once a report of child abuse becomes a case). Indeed, Iowa Code section 232.71B indicates that the DHS 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 DHS (IDHS, 2005).

Iowa law states that the DHS shall not reveal the identity of the reporter of child abuse in the written notification to parents or otherwise. Only the court may require DHS to release the reporter's name. The reporter's name could be released during juvenile, civil or criminal court actions. The information on the Child Abuse Registry is confidential and can be accessed by authorized entities, agencies or individuals specified in law (IDHS, 2005).

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 (IDHS, 2005):

- making a report, photographs, or x-rays;
- 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. As used in this section and section 232.77, "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 (IDHS, 2005).

Failure to Report

Iowa Code section 232.75 provides for civil and criminal sanctions for **failing to report child abuse.** Any person, official, agency, or institution required by this chapter 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 section 232.69 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 of section 232.70, is **civilly liable** for the damages proximately caused by such failure or interference (IDHS, 2005).

False Reporting

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 section 232.75, subsection 3. If DHS receives a fourth report which identifies the same child as a victim of child abuse and the same person as the alleged abuser or which is from the same person, and DHS determined that the three earlier reports were entirely false or without merit, DHS may (IDHS, 2005):

- 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.

Ken Hammond, USDA

Abuse and Neglect/Maltreatment Have Many Presentations

Case #1: Corey

Corey is an 8 year old boy who was brought into the emergency department where you work, by emergency medical services (EMS) personnel after he was hit by a softball during physical education class at school. Corey lost consciousness for several minutes. During the physical exam, you note that he has bilateral bruises to his shoulders, arms and abdomen. Crying, Corey reports that he was "beaten up" by classmates. When his father arrives at the ED, Corey becomes visibly fearful and stops crying. The father is clearly angry; he begins to shout at Corey about having to leave work early during an important business meeting; he was shouting at Corey about not paying attention to the game, about being a lousy ball player and acting like a baby. As the physician in the ED, you note the dad's behavior and how Corey is responding to it.

Case #2: Juanita

You are a family nurse practitioner working in a primary care office. Juanita's mother comes to the office in follow-up to the hypertension noted at the last visit. She brings 9-year old Juanita with her to the appointment, as she usually does. Today you note that Juanita is withdrawn and has bruises on her face and arms. She looks like she's been crying. Juanita is typically a chatty girl who usually engages you in talking about her love of dancing, often showing off her latest moves for the staff. Her mother appears irritable and distracted. You ask her what's wrong and she says she's fine. You mention that Juanita is so quiet and looks upset today, to which she replies that Juanita has been "bad". What would you do if you were the nurse practitioner this situation?

Case #3: Sam

Twelve year old Sam comes to school wearing only a short sleeved t-shirt and jeans on days when the temperature is in the 30s. Sam is a quiet, slender young man. He often seems nervous; he is easily startled. Sam is a C student. He never seems to be paying much attention during class; he looks preoccupied. Sam doesn't make much eye contact. He spends most of his time alone; he doesn't really have any friends at school. Indeed, often Sam is the focus of harassment and teasing from his classmates. About 2 weeks ago Sam came to class limping. He said he sprained his left ankle. The ankle didn't get better after a week, so you sent a note home to have Sam's family get medical attention for Sam. That was last week and there has been no change. As the teacher in this 7th grade classroom you wonder if Sam might be really injured.

Case #4: Alicia and Martin

The visiting nurse comes to the home to follow-up on 10 week old Alicia. The baby was born to a 19 year old mother with a history of cocaine addiction. Alicia weighed 6 lbs. 2 oz. at birth and was not drug addicted. Today, the first day you have been able to get into the home since the referral was made 6 weeks ago, you note that Alicia weighs 4 lbs. 6 oz. The mom tells the nurse that she ran out of formula yesterday and hasn't had a chance to get to the store yet today. Alicia is fretful, but does not cry. Also, during the home visits the nurse notes that 3 year old Martin has circular burn marks on his arms and legs. He is a lethargic child who cries frequently and is very shy and fearful of adults. The nurse examines Martin and finds that he also has a patterned bruise on his back which looks much like a wooden spoon.

Case #5:Tisha

5 year old Tisha has been to see her primary care provider almost weekly for the past month. Each week Tisha has complained to her mother that her stomach hurts, so her mother brings her in to be examined. Tisha's only symptom is abdominal pain. She has no nausea, vomiting or diarrhea. She is well nourished and developmentally appropriate for her age; she clearly has been well cared for. Multiple diagnostic tests have been run over the past month. As the family nurse practitioner in this practice, you must inform Tisha's mother that Tisha has tested positive for syphyllis.

Case #6: Marcus, Amber and Isaiah

Sometimes, the Shaw children come to school appearing to be hungry. You are the school nurse who comes to this school most afternoons, usually getting to the school at lunchtime. You note that the Shaw children often don't have any lunch. When they do bring a lunch, it is often not enough food. Other than this, the children seem well-groomed and well-behaved. The children are generally quiet, rather private. As the nurse, you begin talking to them and learn that their father does seasonal work and is often between jobs. How would you handle this if you were the school nurse?

Case #7: Tim

At a residential treatment center for boys age 13-16, recently some of the boys have alleged that they were sexually abused by staff. The internal investigations at the facility have never supported these claims. One of the registered nurses, Jean, suspects that what she is being told by the boys is correct; she has noted how some of the aides, mostly males, treat the boys so roughly on the one hand and then at other times are often way too familiar. She has often felt uncomfortable with their behavior. 15 year old Tim showed Jean his bloody underwear. He also told Jean that one of the aides, Joe, was forcing him to have sexual relations with some of the other aides and that Joe was recording these sessions and making money by selling the DVDs. Jean complains to the facility administration about these allegations, but was told that an internal investigation has occurred and there is no evidence that these allegations are based in fact.

Ken Hammond, USDA

These situations are real, or at least they could be real; several are based on real situations. If you were faced with these situations, what would you do? Do you know what child abuse looks like? Would you recognize child abuse if signs and symptoms were presented to you? Would you know what to do ethically if you suspect child abuse? Do you know what you must do legally if you suspect child abuse? What if you are not sure? Do you know what you might face legally if you did not report your suspicions? Would you face repercussions if you did report? How should you proceed?

The Disturbing Statistics

The National Child Abuse and Neglect Data System (NCANDS) is a federally sponsored effort that collects and analyzes annual data on child abuse and neglect. The data are submitted voluntarily by the States, the District of Columbia and the Commonwealth of Puerto Rico. State laws determine what is considered abuse, maltreatment or neglect in each state and these laws can vary from state to state. The information that is collected in each state also varies.

The reader is requested to remember that the data presented here are provided voluntarily by each state and compiled by NCANDS. The first report

from NCANDS was based on data for 1990; the most recent report, *Child Maltreatment 2006*, published in 2008, reports on data collected from October 1, 2005 through September 30, 2006. Most of the statistics in this course come from the US Department of Health and Human Services, Administration for Children and Families' *Child Maltreatment 2006* (USDHHS-ACF, 2008).

The National Picture

For Federal fiscal year 2006, an estimated 3.6 million referrals alleging child abuse or neglect were made to State and local child protective services (CPS) agencies for investigation or assessment. Of the children who received an investigation, approximately one-quarter (25.2%) were determined to have been abused or neglected. In 2006, 905,000 children were determined to have been victims of child abuse or maltreatment in the US (USDHHS-ACF, 2008).

The rate of all children who received a disposition increased from 43.8 per 1,000 children in 2002 to 47.8 per 1,000 children in 2006. The national estimates are based upon counting a child each time he or she was the subject of a CPS investigation. While almost a million children were determined to be victims of child maltreatment, the rate of victimization has decreased slightly since 1990. The rate of victimization per 1,000 children in the national population has dropped from 13.4 children in 1990 to 12.3 per 1,000 children in 2002 to 12.1 per 1,000 children in 2006 (USDHHS-ACF, 2008).

During 2006, 64.1 percent of victims experienced neglect, 16.0 percent were physically abused, 8.8 percent were sexually abused, 6.6 percent were psychologically maltreated, and 2.2 percent were medically neglected. In addition, 15.1 percent of victims experienced such "other" types of maltreatment as "abandonment," "threats of harm to the child," or "congenital drug addiction." States may code any condition that does not fall into one of the main categories-physical abuse, neglect, medical neglect, sexual abuse, and psychological or emotional maltreatment-as "other." These maltreatment type percentages total more than 100 percent because children who were victims of more than one type of maltreatment were counted for each maltreatment (USDHHS-ACYF, 2008).

Child fatalities are the most tragic consequence of maltreatment. For 2006, an estimated 1,530 children died due to child abuse or neglect (USDHHS-ACF, 2008). This is a 4.8 percent increase from the 1,460 fatalities that occurred the previous year (PCA-NY, n.d.). The overall rate of child fatalities was 2.04 deaths per 100,000 children. The rate of 2.04 is an increase from the rate for 2005 of 1.96 per 100,000 children. This increase can be attributed to better reporting practices and is not necessarily an increase in the number of fatalities (USDHHS-ACF, 2008). Neglect was the cause in 41.1% of fatalities; combinations of maltreatments accounted for 31.4%, and physical abuse was the cause in 22.4% of cases. Medical neglect accounted for 1.9% of fatalities (USDHHS-ACF, 2008).

Ken Howard, USDA

Characteristics of Child Victims

Generally, the rate of victimization was inversely related to the age group of the child; the youngest children had the highest rate of victimization. Children younger than 4 years are the most vulnerable for many reasons, including their dependency, small size, and inability to defend themselves (USDHHS-ACF, 2005). The rate of child victimization for the age group of birth to 1 year was 24.4 per 1,000 children of the same age group. The victimization rate for children in the age group of 1-3 years was 14.2 per 1,000 children in the same age group. The victimization rate for children in the age group of 4-7 years was 13.5 per 1,000 children in the same age group (USDHHS-ACF, 2008).

Nearly three-quarters of child victims (72.2%) ages birth to 1 year and age group of 1-3 (72.9%) were neglected compared with 55.0 percent of victims ages 16 years and older. For victims in the age group of 4-7 years 15.3 percent were physically abused and 8.2 percent were sexually abused, compared with 20.1 percent and 16.5 percent, respectively, for victims in the age group of 12-15 years old (USDHHS-ACF, 2008).

More than three-quarters (78.0%) of children who were killed were younger than 4 years of age, 11.9 percent were 4-7 years of age, 4.8 percent were 8-11 years of age, and 5.4 percent were 12-17 years of age (USDHHS-ACF, 2008).

In 2006, girls were more likely than boys to be maltreated; 48.2 percent of child victims were boys, and 51.5 percent of the victims were girls (USDHHS-ACF, 2008). However, infant boys (younger than 1 year old) had the highest rate of fatalities, 18.5 deaths per 100,000 boys of the same age in the national population. Infant girls had a rate of 14.7 deaths per 100,000 girls of the same age (USDDHS-ACF, 2008).

Of the children maltreated in 2006, almost one-half of all victims were White (48.8%); almost one-quarter (22.8%) were African-American; and 18.4 percent were Hispanic. For all racial categories, the largest percentage of victims suffered from neglect (USDDH-ACF, 2008).

African-American children, American Indian or Alaska Native children, and Pacific Islander children had the highest rates of victimization at 19.8, 15.9,

and 15.4 per 1,000 children of the same race or ethnicity, respectively. White children and Hispanic children had rates of approximately 10.7 and 10.8 per 1,000 children of the same race or ethnicity, respectively. Asian children had the lowest rate of 2.5 per 1,000 children of the same race or ethnicity (USDDH-ACF, 2008).

Child victims who were reported with a disability accounted for 7.7 percent of all victims. Children with the following risk factors were considered as having a disability: mental retardation, emotional disturbance, visual impairment, learning disability, physical disability, behavioral problems, or another medical problem. In general, children with such conditions are undercounted as not every child receives a clinical diagnostic assessment by CPS. Three percent of victims had behavior problems; 1.9 percent of victims were emotionally disturbed. A victim could have been reported with more than one type of disability (USDHHS-ACF, 2008).

Reporters of Child Maltreatment

Professionals submitted more than one-half (56.3%) of the reports. "Professional" indicates that the person encountered the alleged victim as part of the report source's occupation. State laws require most professionals to notify CPS agencies of suspected maltreatment. The categories of professionals include teachers, legal staff or police officers, social services staff, medical staff, mental health workers, child daycare workers, and foster care providers. The three most common sources of reports in 2006 were from professionals-teachers (16.5%), lawyers or police officers (15.8%), and social services staff (10.0%) (USDHHS-ACF, 2008).

Non-professionals submitted almost 44% of reports. These reports were made by parents, relatives, friends and neighbors, alleged victims, alleged perpetrators, anonymous callers, and "other" sources (which may include clergy members, sports coaches, camp counselors, bystanders, volunteers, and foster siblings). The three largest groups of nonprofessional reporters were anonymous (8.2%), "other" (8.0%) and other relatives (7.8%) (USDHHS-ACF, 2008).

The data for victims of specific types of maltreatment were analyzed in terms of the report sources. Of victims of physical abuse, 24.2 percent were reported by teachers, 23.1 percent were reported by police officers or lawyers, and 12.1 percent were reported by medical staff. In physical abuse cases, 74.9 percent were reported by professionals and 25.1 percent were reported by nonprofessionals. The patterns of reporting of neglect and sexual abuse victims were similar-police officers or lawyers accounted for the largest report source percentage of neglect victims (27.1%) and the largest percentage of sexual abuse victims (28.1%) (USDHHS-ACF, 2008).

<u>In the State of Iowa</u>

The same NCANDS data that provided information for Child Maltreatment 2006 also provided state-specific information related to certain categories of

information. Much of the following information has been obtained for Iowa from the same document.

In 2006, 14,589 Iowa children were abused or neglected (USDHHS-ACF, 2008). There were 42,457 reports of child abuse or neglect in 2006. Of the 25,029 reports that were accepted, involving 38,767 children, 15,619 reports were unsubstantiated as situations of child abuse, while 9,410 reports were substantiated. Those reports of substantiated abuse involved 14,589 children. There are more victims than reports because some reports involve more than one child. The rate of child victimization in Iowa in 2006 was 20.5, while the national rate was 12.1, indicating that Iowa has a higher rate of child abuse than the national rate. Additionally, Iowa's rate of victimization has been rising since 2002, when the victimization rate was 16.9; in 2003, the rate increased to 18.6; in 2004 it increased to 19.4; in 2005 the victimization rate was 19.7. It is not clear why the rate is increasing. It may be due to an increase in actual victimization, however it may also be related to better reporting and investigation.

In Iowa, of the 14,589 children who were maltreated in 2006 (USDHHS-ACF, 2008):

- 11,581 children, or 79.4% were neglected;
- 1,888 children, or 12.9% were physically abused;
- 146 children, or 1% were medically neglected;
- 789 children, or 5.4% were sexually abused;
- 97 children, or 0.7% were psychologically abused;
- 1,524 children, or 10.4 endured other types of maltreatment.

The "other" types of maltreatment include, for example, abandonment, threats of harm, or congenital drug addiction. Totals are more than 100% because a child may be the victim of more than one type of maltreatment. In Iowa in 2006, 6 children died as a result of abuse or neglect, a fatality rate of 0.84 per 100,000 children. This is a decrease from 2005 when 9 children died in Iowa as a result of maltreatment (USDHHS-ACF, 2008).

Legal Definitions Related to Child Maltreatment

Federal Definitions

The Child Abuse Prevention and Treatment Act (CAPTA) is the Federal legislation that provides minimum standards for the definition of child abuse and neglect that States must incorporate in their statutory definitions (CWIG, 2007).

Under CAPTA, child abuse and neglect means, at a minimum:

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

serious harm.

The term sexual abuse includes:

The employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or the rape, and in cases of caretaker or interfamilial relationships, statutory rape, molestation, prostitution or other form of sexual exploitation of children, or incest with children.

Ken Hammond, USDA

Iowa State Law Definitions

While the Federal CAPTA law provides for the minimum standards needed for State laws, it is important to know the specific legal definitions in the States in which you practice, in particular, it is important to know how Iowa laws define who is a child, what is considered to be abuse, maltreatment and neglect and who is the subject of the report of abuse. Indeed, the law that mandates certain professionals in Iowa to take this coursework that you are now reading, requires that you receive this training regarding the specific laws in Iowa.

In Iowa, a **child** is defined, per Iowa Code section 232.68, as any person under the age of 18 years.

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 section 232.68 as:

- 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, health care 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 caretaking role.

The victim of **child abuse** is a person under the age of 18 who has suffered one or more of the nine categories of child abuse as defined in Iowa law (IDHS, 2005):

- **Physical Abuse** is defined as 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.

- **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 section 622.10.

- **Sexual Abuse** is defined as the commission of a sexual offense with or to a child pursuant to Iowa Code Chapter 709, Iowa Code section 726.2, or Iowa Code section 728.12, subsection 1, as a result of the acts or omissions of the person responsible for the care of the child. Notwithstanding Iowa Code section 702.5, the commission of a sexual offense under this paragraph includes any sexual offense referred to in this paragraph with or to a person under the age of 18 years. There are several sub-categories of sexual abuse: 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.

- **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. Denial of critical care is the category of abuse in Iowa law that is relevant to what most consider to be "neglect". This does not apply to a parent or guardian legitimately practicing religious beliefs who do 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:
  - F**ailure to provide adequate food and nutrition;**

- **Failure to provide adequate shelter;**
- **Failure to provide adequate clothing;**
- **Failure to provide adequate health care;**
- **Failure to provide mental health care;**
- **Gross failure to meet the emotional needs of the child;**
- **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. Other items in this subcategory includes legal drug usage by the caretaker (some drugs cause more impairment than others); children home alone (Iowa law does not define an age that is appropriate for a child left alone, however, each situation is unique; some questions that may be asked are, "Does the child have a phone and know how to use it? Could the child get out of the house in an emergency? How long a period of time will the child be alone? Etc.; and lice and truancy (while often reported as an abuse allegation, other conditions must be present, or the situation must pose a risk to the child's health and welfare); and
- **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. It is also known as "withholding of medically indicated treatment." The type of treatments included are appropriate nutrition, hydration, and medication.

- **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 section 725.1. Notwithstanding Iowa Code section 702.5, acts or omissions under this paragraph include an act or omission referred to in this paragraph 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.

- **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. Iowa Code section 232.77 states that, "If a health practitioner discovers in a child physical or behavioral symptoms of the effect of exposure to cocaine, heroin, amphetamine, methamphetamine, or other illegal drugs or combination or derivatives thereof, which examination of the natural mother of the child that the child was were not prescribed by a health practitioner, or if the health practitioner has determined through exposed in utero, the health practitioner may perform or cause to be performed a medically relevant test as defined section 232.73, on the child. The practitioner shall report any positive results of such a test on the child to the department. The department shall begin an assessment pursuant to section 232.71B upon receipt of such a report." **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** is defined in Iowa Code section 232.2, subsection 6, paragraph p, as occurring when the person responsible for the care of a child:
    - Has manufactured or knowingly allows the manufacture of a dangerous substance by another person in the presence of a child;
    - 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; 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.
    - Iowa Code section 232.2, subsection 6, paragraph p, defines "dangerous substance" as: Amphetamine, its salts, isomers, or salts of its isomers; methamphetamine, its salts, isomers, or salts of its isomers; 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.
    - **DHS must report this type of allegation to law enforcement, as this is a criminal act.**

- **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 Iowa Code section 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. **DHS must report this type of allegation to law enforcement, as this is a criminal act.**

- **Cohabits with a Registered Sex Offender**
  A caretaker who knowingly cohabits with person who is a registered sex offender or with a person who is required to register commits child abuse. The exceptions are if the sex offender is the caretaker' spouse; or the sex offender is the parent of the alleged victim child, or the sex offender is a minor child of the caretaker. **DHS must report this type of allegation to law enforcement, as this is a criminal act.**

Ken Hammond, USDA

Recognizing Child Abuse

The first step in helping abused or neglected children is learning to recognize the signs of child abuse and neglect. The presence of a single sign does not prove child abuse is occurring; however, when these signs appear with significant injury, or they occur repeatedly or in combination, the professional must take a closer look at the situation and consider the possibility of child abuse (CWIG, 2006). Special attention should be paid to injuries that are unexplained or are inconsistent with the parent or caretaker's explanation and/or the child's developmental age (PCA-NY, nd).

The following are some signs often associated with particular types of child abuse/maltreatment: physical abuse, neglect, sexual abuse, and emotional abuse. It is important to note, however, these types of abuse are more typically found in combination than alone. A physically abused child, for example, is often emotionally abused as well, and a sexually abused child also may be neglected (CWIG, 2006).

The list that follows contains some common indicators of abuse or neglect/maltreatment. This list is not all-inclusive, and some abused or neglected/maltreated children may not show any of these signs and symptoms.

Physical Abuse

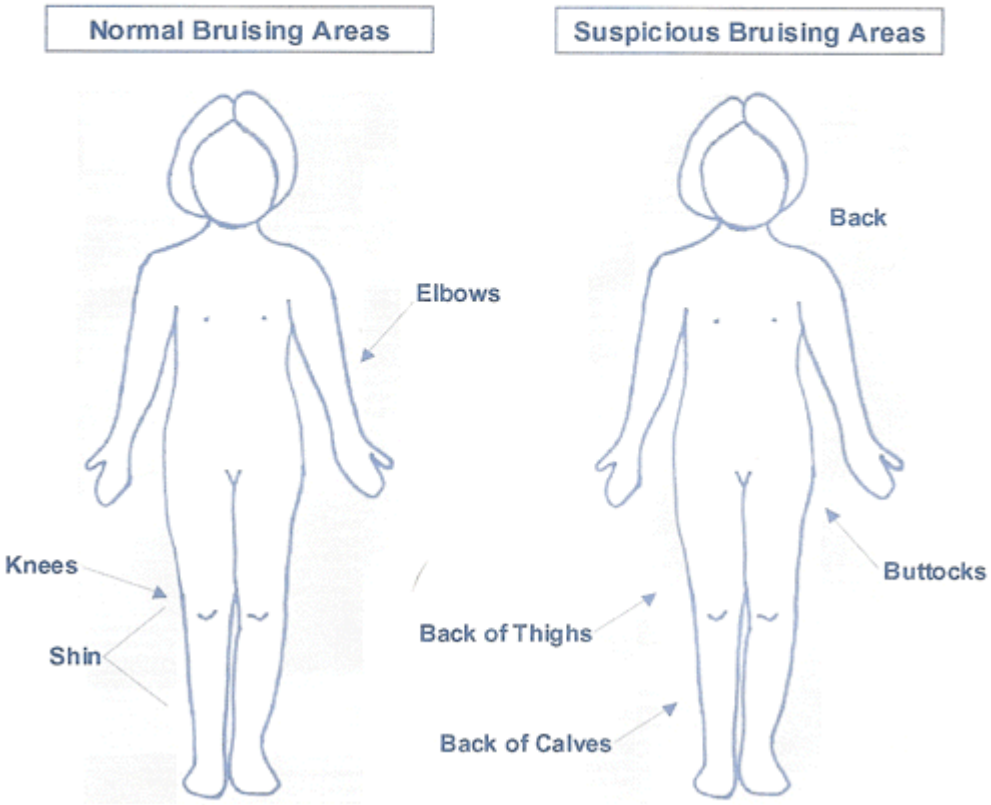
Physical Indicators

Physical abuse is often the most obvious form of abuse. It is any non-accidental injury to a child by a parent or caretaker. The mandatory professional should pay close attention to any frequent injuries that are "accidental" or "unexplained", or that are developmentally unlikely or any explanation that seems unlikely.

Physical abuse may present as (NYCACS, 2008; CDC, 2007; CWIG, 2005; PCA-NY, nd; NYS-OCFS, 2005; IDHS, 2005):

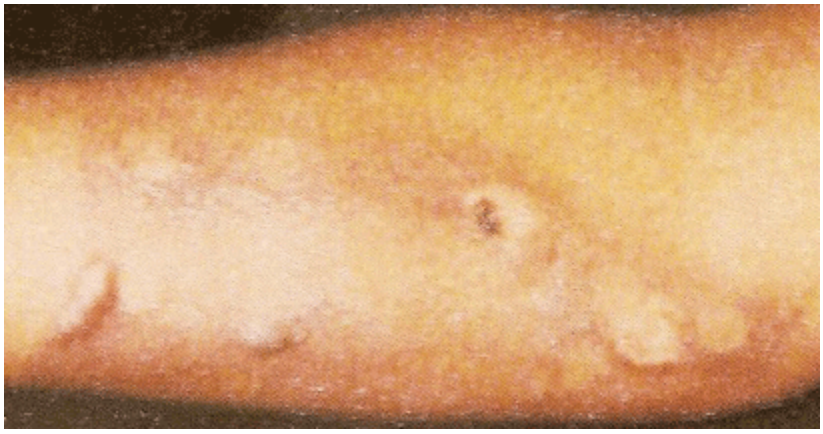
- Frequent and unexplained bruises
    - On face, lips or mouth;
    - On torso, back, buttocks, thighs or calves (typically children would be bruised on the shins, knees and elbows during normal play activities);
    - May be in various stages of healing;
    - On several different surface areas of the body;
    - May appear in distinctive patterns reflecting the shape of the article used such as grab marks or human bite marks, electric cord, belt buckle, etc.;
    - Fading bruises or other marks noticeable after an absence, weekend or vacation from school or day care.

Normal and Suspicious Bruising Areas

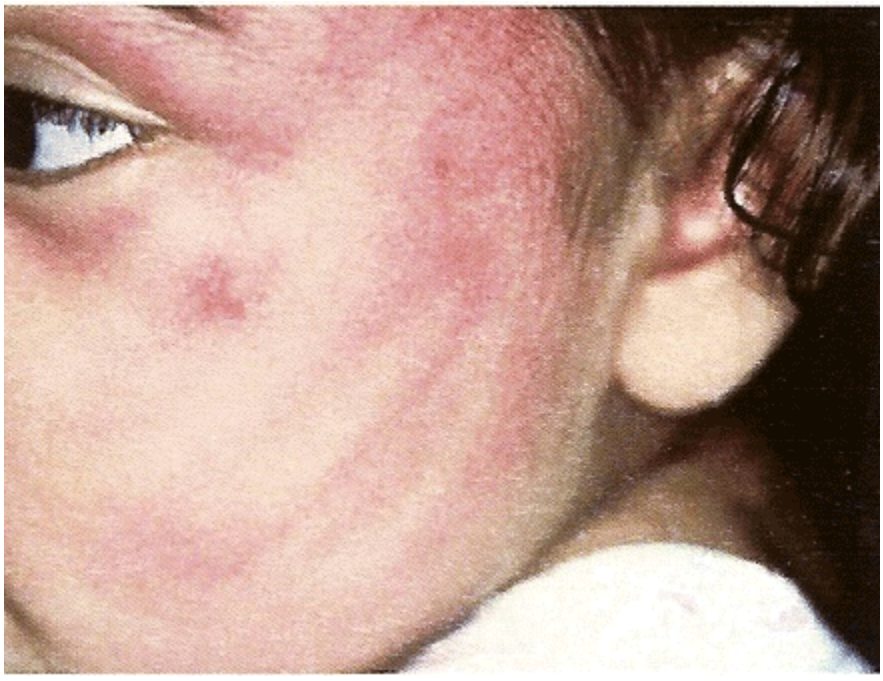


- Burns
    - Cigar or cigarette burns, especially on the soles, palms, back and buttocks;
    - Immersion burns (sock-like, glove-like, or doughnut shaped on buttocks or genitalia from having feet, hand, buttocks/genitals immersed in scalding water);
    - Distinctive patterned burn impressions from appliances or instruments such as steam irons, curling irons, etc.;
    - Rope burns on arms, legs, neck or torso.

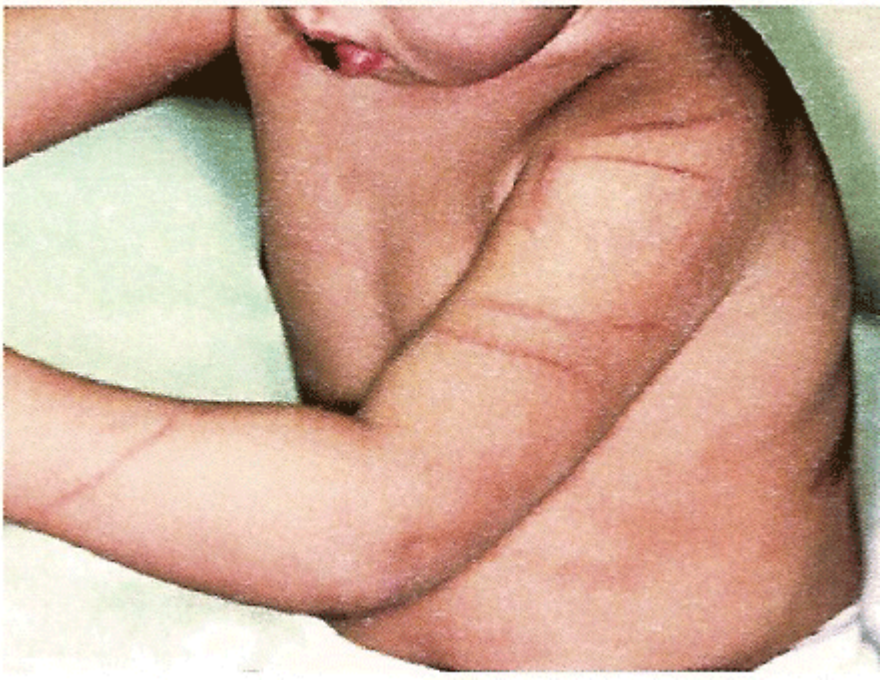
Steam Iron Injury



Handprint Injury



Looped Cord Injury



- Cuts;
- Welts;
- Swelling;
- Sprains;
- Fractures
    - To skull, nose, facial structures;
    - In various stages of healing;
    - Multiple or spiral fractures
    - Swollen or tender limbs.

- Lacerations or abrasions
    - To mouth, lips, gums, eyes;
    - To external genitalia;
    - On backs of arms, legs or torso;
    - Human bite marks.

- Injuries to the eyes or both sides of the head or body (accidental injuries typically only affect one side of the body).

Child's Behavior - Possible Indicators of Physical Abuse

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. Healthcare providers 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. The following behavioral signs do not necessarily mean that a child is abused or neglected/maltreated, but should be considered in light of other indicators. These behavioral indicators are often general, potentially pointing to a problem that may or

may not relate to abuse/maltreatment (NYCACS, 2008; CDC, 2007; CWIG, 2005; PCA-NY, nd; NYS-OCFS, 2005; IDHS, 2005):

- Wary of adult contacts; may shrink at the approach of adults;
- Apprehensive when other children cry;
- May be overly afraid of the parent's reaction to misbehavior;
- Shows sudden changes in behavior or school performance;
- Has not received help for physical or medical problems brought to the parents' attention;
- Has learning problems (or difficulty concentrating) that cannot be attributed to specific physical or psychological causes;
- Is always watchful, vigilant, as though preparing for something bad to happen;
- Lacks adult supervision;
- Is overly compliant, passive, withdrawn or emotionless behavior;
- Destructive, aggressive or disruptive behavior;
- Behavior extremes, such as appearing overly compliant and passive or very demanding and aggressive or withdrawn;
- Comes to school or other activities early, stays late, and does not want to go home;
- Uncomfortable with physical contact;
- Low self esteem;
- Lags in physical, emotional, or intellectual development;
- Seems frightened of the parents and protests or cries when it is time to go home;
- Is either inappropriately adult (parenting other children, for example) or inappropriately infantile (frequently rocking or head-banging, for example);
- Has attempted suicide;
- Reports a lack of attachment to the parent;
- Reports injury by parent;
- Wears long sleeved or similar clothing to hide injuries;
- Seeks affection from any adult.

Parent's Behavior - Possible Indicators of Physical Abuse

- Shows little concern for the child;
- Denies the existence of-or blames the child for-the child's problems in school or at home;
- Takes an unusual amount of time to obtain medical care for the child;
- Attempts to conceal the child's injury;
- Takes the child to a different healthcare provider or hospital for each injury;
- Offers an inadequate or inappropriate explanation for the child's injury;
- Offers conflicting, unconvincing, or no explanation for the child's injury;
- Disciplines the child too harshly considering the child's age or what s/he has done wrong
- Asks teachers or other caretakers to use harsh physical discipline if the child misbehaves;
- Sees the child as entirely bad, worthless, or burdensome;
- Demands a level of physical or academic performance the child cannot achieve;
- Looks primarily to the child for care, attention, and satisfaction of emotional needs;

- Describes the child as "evil," or in some other very negative way;
- Has a history of abuse as a child;
- Is unduly protective of the child or severely limits the child's contact with other children especially of the opposite sex;
- Is secretive and isolated;
- Is jealous or controlling with family members;
- Constantly blames, belittles, or berates the child;
- Is unconcerned about the child and refuses to consider offers of help for the child's problems;
- Overtly rejects the child;
- Appears to be indifferent to the child;
- Seems apathetic or depressed;
- Behaves irrationally or in a bizarre manner;
- Has poor impulse control;
- Is abusing alcohol or other drugs.

Maltreatment/Neglect

Maltreatment/neglect includes a parent or caretaker's failure to give the child food, clothing, hygiene, shelter, medical care and supervision. Maltreatment/Neglect may be difficult to identify correctly. What appears as maltreatment/neglect may be the result of poor parental or caretaker judgment. Or it may be the result of poverty rather than neglect.

Maltreatment/neglect is a term used to encompass many situations. What they all have in common is that maltreatment/neglect is often determined by a lack of action-an act of omission-regarding a child's needs. Most commonly, maltreatment/neglect is related to a failure to meet a child's physical needs (including food, clothing, shelter, supervision, and medical needs), but it also can refer to a failure to meet a child's educational and emotional needs. Maltreatment/neglect can range from a caregiver's momentary inattention to willful deprivation. Single incidents can have no harmful effects or, in some cases, they can result in death. Chronic patterns of maltreatment/neglect may result in severe developmental delays or severe emotional disabilities.

Physical Indicators of Maltreatment/Neglect

- Consistent hunger;
- Obvious malnourishment, listlessness or fatigue;
- Poor hygiene; is consistently dirty or malodorous;
- Lacks sufficient clothing; inappropriate dress for age or season;
- Consistent lack of supervision, especially in dangerous activities or long periods;
- Abandonment;
- Child may frequently go to neighbors saying parents told them to stay away;
- Unattended physical problems or medical or dental needs, immunizations or glasses;
- Delayed physical development;
- Abuses alcohol or other drugs.

Child's Behavior - Possible Indicators of Maltreatment/Neglect

- Begging or stealing food or money;
- Extended stays in school (early arrival and late departure);
- Frequent tardiness to school; " Infrequent school attendance;
- Constant fatigue, falling asleep in class;
- Alcohol and drug abuse;
- States there is no caretaker.

Parent's Behavior - Possible Indicators of Maltreatment/Neglect

- Misuses alcohol or other drugs;
- Has disorganized, chaotic or upsetting home life;
- Is apathetic, feels nothing will change;
- Is isolated from friends, relatives and neighbors;
- Has long-term chronic illness;
- Cannot be found;
- Has history of neglect as a child;
- Exposes child to unsafe living conditions;
- Evidences limited intellectual capacity.

Emotional Abuse

Physical Indicators of Emotional Abuse

- Conduct disorders (fighting in school, anti-social behavior, destructive, etc.);
- Habit disorders (rocking, biting, sucking fingers, pulling out hair, etc.);
- Anxiety disorders, speech disorders, sleep problems, inhibition of play; phobias, hysterical reactions, compulsions, hypochondria;
- Lags in physical development;
- Failure to thrive.

Child's Behavior - Possible Indicators of Emotional Abuse

- Overly adaptive behavior, such as inappropriately adult or inappropriately infantile;
- Developmental delays (mental and emotional);
- Extremes of behavior (compliant, passive, aggressive, demanding);
- Self-mutilation;
- Suicide attempts or gestures.

Parent's Behavior - Possible Indicators of Emotional Abuse

- Treats children in the family unequally;
- Ignores the child, failing to provide necessary stimulation, responsiveness and validation of the child’s worth in normal family routine;
- Doesn't seem to care much about the child's problems;
- Blames or belittles the child;
- Is cold and rejecting;
- Inconsistent behavior toward child;

- Verbally terrorizes 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.
- Continually and severely criticizes the child;
- Failure to express any affection or nurturing;
- Humiliation;
- Engages in actions intended to produce fear or extreme guilt in a child;
- Rejects the child's value, needs, and request for adult validation and nurturance;
- Isolates the child from the family and community; denying the child normal human contact;
- Corrupts the child by encouraging and reinforcing destructive, antisocial behavior until the child is so impaired in socioemotional development that interaction in normal social environments is not possible;
- Overpressures 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, which leaves the child feeling that he or she is never quite good enough.

Sexual Abuse

Sexual abuse can include promoting prostitution, fondling, intercourse, or using the child for pornographic materials. Consider the possibility of sexual abuse when the **child** exhibits some of the following (CWIG,2006a; IDHS, 2005):

Physical Indicators – Possible sexual abuse

Physical indicators of sexual abuse can include:

- Has difficulty walking or sitting;
- Reports nightmares or bedwetting;
- Experiences a sudden change in appetite; or complains frequently of abdominal discomfort of pain;
- Becomes pregnant, particularly in early adolescent years;
- Contracts a sexually transmitted disease, including venereal oral infections in pr-adolescent age group;
- Has sudden, unusual difficulty with toilet habits;
- Experiences pain or itching, bruises or bleeding in the genital area;
- Has torn, stained, or bloody clothing.

Child's Behavior - Possible Indicators of Sexual Abuse

The child's **behavior** can also be possible indicators of sexual abuse:

- Suddenly refuses to change for gym or to participate in physical activities;
- Demonstrates bizarre, sophisticated, or unusual sexual knowledge or behavior, particularly given the child's age;
- Sexual victimization of other children;
- Exhibits withdrawal, fantasy or infantile behaviors;
- Poor peer relationships;

- Aggressive or disruptive behavior, delinquency, running away or school truancy;
- Any sudden change in behavior;
- Self-injurious behaviors;
- Suicide attempts;
- Reports sexual abuse by caretaker;
- Exaggerated fear of closeness or physical contact.

Parent's Behavior - Possible Indicators of Sexual Abuse

- Very protective or jealous of child;
- Encourages or forces child to engage in prostitution;
- Encourages or forces sexual acts in the presence of caretaker;
- Misuses alcohol or other drugs;
- Is geographically isolated and/or lacking in social and emotional contacts outside the family;
- Has low self-esteem.

Child Prostitution

Child prostitution may be identified by similar physical and behavioral indicators as the child who is sexually abused. Children are recruited into prostitution through forced abduction, pressure from parents, or through deceptive agreements between parents and traffickers (USDOJ, 2007). The majority of American victims of commercial sexual exploitation tend to be runaway or thrown away youth who live on the streets who become victims of prostitution. These children generally come from homes where they have been abused, or from families that have abandoned them and often become involved in prostitution as a way to support themselves financially or to get the things they want or need (USDOJ, 2007).

Manufacturing or Possession of a Dangerous Substance In the Presence of a Child

Manufacturing or possession of a dangerous substance in the presence of a child is defined in Iowa law as child abuse. If the person responsible for the child's care engages in the following, a report of child abuse should be made:

- Has manufactured a dangerous substance in the presence of the child, or
- Knowingly allows the manufacture of a dangerous substance by another person in the presence of a 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.

Presence of Illegal drugs in Newborn

Presence of illegal drugs in a newborn infant as determined by laboratory testing due to the illegal drug usage by the mother before the baby's birth; a three-year-old child tests positive for illegal drugs due to exposure to the illegal drugs when the child's caretakers used illegal drugs in the child's home (IDHS, 2005).

Case #1: Corey

Corey is an 8 year old boy who was brought into the emergency department where you work, by EMS personnel after he was hit by a softball during physical education class at school. Corey lost consciousness for several minutes. During the physical exam, you note that he has **bilateral bruises to his shoulders, arms and abdomen**. Crying, **Corey reports that he was "beaten up" by classmates. When his father arrives at the ED, Corey becomes visibly fearful and stops crying. The father is clearly angry; he begins to shout at Corey about having to leave work early during an important business meeting; he was shouting at Corey about not paying attention to the game, about being a lousy ball player and acting like a baby**. As the physician in the ED, you note the dad's behavior and how Corey is responding to it.

- Corey has bilateral bruises on his shoulders and arms. Accidental injuries tend to occur on one side or another, not usually on both shoulders or both arms.
- Corey's explanation that he was "beaten up" by classmates is not consistent with what EMS personnel describe about the injury during physical education class.
- Corey is fearful when his father appears.
- Corey stops crying when his father appears.
- Corey's father is angry and not concerned about his son's injury.
- Corey's father belittles Corey about his ability to play softball; Corey feels that he is never good enough.

Corey's father uses humiliation (ie. "acting like a baby") because Corey had been crying.

Case #2: Juanita

You are a family nurse practitioner working in a primary care office. Juanita's mother comes to the office in follow-up to the hypertension noted at the last visit. She brings 9-year old Juanita with her to the appointment, as she usually does. Today you note that **Juanita is withdrawn and has bruises on her face and arms. She looks like she's been crying. Juanita is typically a chatty girl who usually engages you in talking about her love of dancing, often showing off her latest moves for the staff**. Her mother appears irritable and distracted. You ask her what's wrong and she says she's fine. You mention that Juanita is so quiet and looks upset today, to which **she replies that Juanita has been "bad"**. What would you do if you were the nurse practitioner this situation?

- She has bruises on her face and arms.
- Juanita has had a change in behavior, from outgoing and engaging to withdrawn and tearful.

Ms. Flores says Juanita has been "bad".

Case #3: **Sam**

Twelve year old **Sam comes to school wearing only a short sleeved t-shirt and jeans on days when the temperature is in the 30s. Sam is a quiet, slender young man. He often seems nervous; he is easily startled**. Sam is a C student. **He never seems to be paying much attention during class; he looks preoccupied. Sam doesn't make much eye contact. He spends most of his time alone; he doesn't really have any friends at school. Indeed, often Sam is the focus of harassment and teasing from his classmates. About 2 weeks ago Sam came to class limping. He said he sprained his left ankle. The ankle didn't get better after a week, so you sent a note home to have Sam's family get medical attention for Sam. That was last week and there has been no change.** As the teacher in this 7th grade classroom you wonder if Sam might be really injured.

- Sam wears a short-sleeved t-shirt even during cold weather; this is inappropriate attire for the season.
- Sam's family did not seek the medical attention that you, as the teacher, suggested because of Sam's limping and apparent injury to his left ankle.
- Sam seems nervous and is easily started.
- Sam is preoccupied during class and doesn't pay much attention to the class work.
- Sam doesn't make eye contact and is isolated at school; he has no friends and is often teased and bullied at school.

Case #4: Alicia and Martin

The visiting nurse comes to the home to follow-up on 10 week old Alicia. The baby was born to a 19 year old mother with a history of cocaine addiction. Alicia weighed 6 lbs. 2 oz. at birth and **was not drug addicted**. Today, the first day you have been able to get into the home since the referral was made 6 weeks ago, you note that Alicia weighs 4 lbs. 6 oz. **The mom tells the nurse that she ran out of formula yesterday and hasn't had a chance to get to the store yet today**. Alicia is fretful, but does not cry. Also, during the home visits the nurse notes that 3 year old Martin has circular burn marks on his arms and legs. **He is a lethargic child who cries frequently and is very shy and fearful of adults**. The nurse examines Martin and finds that he also has a patterned bruise on his back which looks much like a wooden spoon.

- Alicia has lost significant weight since birth. Although some weight loss is not uncommon, by 10 weeks, she should have gained more weight.
- Alicia is fretful.
- The home is lacking formula for Alicia.
- Martin has circular burn marks on his arms and legs; the nurse notes that they look like cigarette burns.
- Martin has a patterned bruise on his back which looks like a wooden spoon.

Martin is lethargic, cries frequently and seems fearful of adults.

Case #5: Tisha

5 year old Tisha has been to see her primary care provider almost weekly for the past month. **Each week Tisha has complained to her mother that her stomach hurts, so her mother brings her in to be examined**. Tisha's only symptom is abdominal pain. She has no nausea, vomiting or diarrhea. She is well nourished and developmentally appropriate for her age; she has clearly has been well cared for. Multiple diagnostic tests have been run over the past month. As the family nurse practitioner in this practice, you must inform Tisha's mother that **Tisha has tested positive for syphyllis**.

- Tisha has frequent complaints about abdominal pain; these complaints often happen on Mondays, after spending the weekend with her father.

Five year old Tisha has tested positive for a sexually transmitted disease.

Case #6: Marcus, Amber and Isaiah

Sometimes, **the Shaw children come to school appearing to be hungry**. You are the school nurse who comes to this school most afternoons, usually getting to the school at lunchtime. You note that **the Shaw children often don't have any lunch. When they do bring a lunch, it is often not enough food**. Other than this, the children seem well-groomed and well-behaved. The children are generally quiet, rather private. As the nurse, you begin talking to them and **learn that their father does seasonal work and is often between jobs**. How would you handle this if you were the school nurse?

- The children appear to be hungry when they come to school.
- The children often don't have any lunch, or if they bring lunch it is not enough.

The Shaw children, normally quiet and private, when they speak with the nurse provide information about their father's underemployment/unemployment.

Case #7: Tim

At a residential treatment center for boys age 13-16, recently **some of the boys have alleged that they were sexually abused by staff**. The internal investigations at the facility have never supported these claims. One of the registered nurses, Jean, suspects that what she is being told by the boys is correct; **she has noted how some of the aides, mostly males, treat the boys so roughly on the one hand and then at other times are often way too familiar. 15 year old Tim showed Jean his bloody underwear. He also told Jean that one of the aides, Joe, was forcing him to have sexual relations with some of the other aides and that Joe was recording these sessions and selling the DVDs.**. Jean complains to the facility administration about these allegations, but was told that an internal investigation has occurred and there is

no evidence that these allegations are based in fact.

- Some of the boys at the residential treatment center have reported that they have been sexually abused by staff members.
- Tim showed his bloody underwear to the nurse, Jean.
- Jean felt uncomfortable with the way some male staff interacted with the boys, either to rough or too familiar.

Tim told Jean that an aide, Joe, was forcing him to have sex and that Joe was recording the sexual activity and then selling the DVDs.

Ken Hammond, USDA

Risk Factors Contributing to Child Abuse and Maltreatment

All of the causes of child abuse are not known, but a significant amount of research points to a number of factors that put children at risk for abuse. Generally, risk factors can be divided into 4 categories: the child, the family, the community and the society. It is important to understand that the child is not responsible for the abuse, however there are some child characteristics that put the child at greater risk for maltreatment. It is important to note that this is not an all-inclusive or exhaustive list and these factors do not imply causality and should not be interpreted as such (CDC, 2007; CDC, 2007a; CWIG, 2006; PCA-NY, 2003):

Child Risk Factors

- Premature birth
- Birth anomalies
- Low birth weight
- Exposure to toxins in utero
- Temperament: difficult or slow to warm up
- Physical/cognitive/emotional disability, chronic or serious illness

- Childhood trauma
- Anti-social peer group
- Age
- Child aggression, behavior problems, attention deficits

Parental/Family Risk Factors

- Poverty
- Parental substance abuse
- Parental impulsivity
- Parental low self-esteem
- A lack of social support for the family.
- Parental immaturity
- Parents' unrealistic expectations
- Unmet emotional needs
- The stress of caring for children
- Economic crisis
- Domestic/intimate partner violence
- Lack of parenting knowledge/skills
- Lack of communication skills
- Inaccurate knowledge and expectations about child development
- Difficulty in managing relationships
- Depression, anxiety or other mental health problems
- Personality factors
- External locus of control
- Low tolerance for frustration
- Feelings of insecurity
- Lack of trust
- Insecure attachment with own parents
- Childhood history of abuse
- Family structure - single parent with lack of support, high number of children in household
- Social isolation, lack of support
- Separation/divorce, especially high conflict divorce
- High general stress level
- Poor parent-child interaction, negative attitudes and attributions about child's behavior

Community Risk Factors

- Low socioeconomic status
- Stressful life events
- Social isolation/lack of social support
- Dangerous/violent neighborhood
- Community violence
- Poverty
- Lack of access to medical care, health insurance, adequate child care, and social services

Societal Risk Factors

- Homelessness
- Exposure to racism/discrimination
- Poor schools
- Exposure to environmental toxins
- Narrow legal definitions of child maltreatment
- Social acceptance of violence (as evidenced by music lyrics, television, film and video games)
- Political and religious views that value noninterference in families

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Protective Factors for Child Abuse and Neglect/Maltreatment

Child Protective Factors

Resilience is a concept that has been identified as an important protective factor among children who have been abused or maltreated. Research has identified that resilience was found to be related to personal characteristics that included a child's ability to: recognize danger and adapt, distance oneself from intense feelings, create relationships that are crucial for support, and project oneself into a time and place in the future in which the perpetrator is no longer present.

Additional protective factors include (CWIG, 2007; CDC, 2007a):

- Good health, history of adequate development
- Above-average intelligence
- Hobbies and interests
- Good peer relationships

- Personality factors such as an easy-going temperament
- Positive disposition
- Active coping style
- Positive self-esteem
- Good social skills
- Internal locus of control
- A balance between help seeking and autonomy

Parental/Family Protective Factors

- Secure attachment with children; positive and warm parent-child relationship
- Supportive family environment
- Parents have come to terms with own history of abuse
- Household rules/structure; parental monitoring of child
- Extended family support and involvement, including caregiving help
- Stable relationship with parents
- Parents have a model of competence and good coping skills
- Family expectations of pro-social behavior
- High parental education

Community Protective Factors

- Mid to high socioeconomic status
- Access to health care and social services
- Consistent parental employment
- Adequate housing
- Family religious faith participation
- Good schools
- Supportive adults outside of family who serve as role models/mentors to child

Societal Protective Factors

- Families with two married parents encounter more stable home environments, fewer years in poverty, and diminished material hardship
- Supportive institutions in the society such as good child care and healthcare

The Consequences of Child Abuse

An estimated 905,000 children in the US were victims of child abuse or maltreatment in 2006 (USDHHS-ACF, 2008). While physical injuries may or may not be immediately visible, abuse and neglect can have consequences for children, families, and society that last lifetimes, if not generations.

The impact of child abuse and neglect is often discussed in terms of physical, psychological, behavioral, and societal consequences. In reality, however, it is impossible to separate them completely. Physical consequences (such as damage to a child's growing brain) can have psychological implications (cognitive delays or emotional difficulties, for example). Psychological problems often manifest as high-risk behaviors. Depression and anxiety, for example, may make a person more likely to smoke, abuse alcohol or illicit drugs, or overeat. High-risk behaviors, in turn, can lead to long-term

physical health problems such as sexually transmitted diseases, cancer, and obesity. In additional to the human consequences, all of these consequences also have an economic impact on a society.

Not all abused and neglected children will experience long-term consequences. Outcomes of individual cases vary widely and are affected by a combination of factors, including (CDC, 2007a, CDC, 2007b):

- The child's age and developmental status when the abuse or neglect occurred
- The type of abuse (physical abuse, neglect, sexual abuse, etc.)
- Frequency, duration, and severity of abuse
- Relationship between the child victim and the abuser.

Physical Health Consequences

The immediate physical effects of abuse or neglect can vary greatly; the effects may be relatively minor (bruises or cuts) or severe (broken bones, hemorrhage, or even death). In some cases the physical effects are temporary; however, the pain and suffering they cause a child should never be discounted. The long-term impact of child abuse and neglect on physical health is just beginning to be explored. Below are some outcomes researchers have identified (USDHHS-ACF, 2007):

- **Shaken baby syndrome**. The immediate effects of shaking a baby (a common form of child abuse in infants) can include vomiting, concussion, respiratory distress, seizures, and death. Long-term consequences can include blindness, learning disabilities, mental retardation, cerebral palsy, or paralysis.

- **Impaired brain development**. Child abuse and neglect have been shown, in some cases, to cause important regions of the brain to fail to form properly, resulting in impaired physical, mental, and emotional development. In other cases, the stress of chronic abuse causes a "hyperarousal" response by certain areas of the brain, which may result in hyperactivity, sleep disturbances, and anxiety, as well as increased vulnerability to post-traumatic stress disorder, attention deficit/hyperactivity disorder, conduct disorder, and learning and memory difficulties.

- **Poor physical health**. A study of 700 children who had been in foster care for 1 year found more than one-quarter of the children had some kind of recurring physical or mental health problem (National Survey of Child and Adolescent Well-Being). A study of 9,500 HMO participants showed a relationship between various forms of household dysfunction (including childhood abuse) and long-term health problems such as sexually transmitted diseases, heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease.

- **Death**

Psychological Consequences

The immediate emotional effects of abuse and neglect-isolation, fear, and an inability to trust-can translate into lifelong consequences including low self-esteem, depression,

and relationship difficulties. Researchers have identified links between child abuse and neglect and the following (USDHHS-ACF, 2007):

- **Poor mental and emotional health**. In one long-term study, as many as 80 percent of young adults who had been abused met the diagnostic criteria for at least one psychiatric disorder at age 21. These young adults exhibited many problems, including depression, anxiety, eating disorders, and suicide attempts. Other psychological and emotional conditions associated with abuse and neglect include panic disorder, dissociative disorders, attention-deficit/hyperactivity disorder, post-traumatic stress disorder, and reactive attachment disorder.

- **Cognitive difficulties**. The National Survey of Child and Adolescent Well-Being recently found children placed in out-of-home care due to abuse or neglect tended to score lower than the general population on measures of cognitive capacity, language development, and academic achievement.

- **Social difficulties**. Children who are abused and neglected by caretakers often do not form secure attachments to them. These early attachment difficulties can lead to later difficulties in relationships with other adults as well as with peers.

Behavioral Consequences

Not all victims of child abuse and neglect will experience behavioral consequences; however, child abuse and neglect appear to make the following more likely (USDHHS-ACF, 2007):

- **Difficulties during adolescence**. Studies have found abused and neglected children to be at least 25 percent more likely to experience problems such as delinquency, teen pregnancy, low academic achievement, drug use, and mental health problems.
- **Juvenile delinquency and adult criminality**. A National Institute of Justice study indicated being abused or neglected as a child increased the likelihood of arrest as a juvenile by 59 percent. Abuse and neglect increased the likelihood of adult criminal behavior by 28 percent and violent crime by 30 percent.
- **Alcohol and other drug abuse**. Research consistently reflects an increased likelihood that abused and neglected children will smoke cigarettes, abuse alcohol, or take illicit drugs. According to the National Institute on Drug Abuse, as many as two-thirds of people in drug treatment programs reported being abused as children (2000).
- **Abusive behavior**. Abusive parents often have experienced abuse during their own childhoods. It is estimated approximately one-third of abused and neglected children will eventually victimize their own children (PCA-NY, 2001).

Societal Consequences

While child abuse and neglect almost always occur within the family, the impact does not end there. Society as a whole pays a price for child abuse and neglect, in terms of both direct and indirect costs (USDHHS-ACYF, 2007).

- **Direct costs**. Direct costs include those associated with maintaining a child welfare system to investigate allegations of child abuse and neglect, as well as

expenditures by the judicial, law enforcement, health, and mental health systems to respond to and treat abused children and their families. A 2001 report by Prevent Child Abuse America estimates these costs at $24 billion per year.

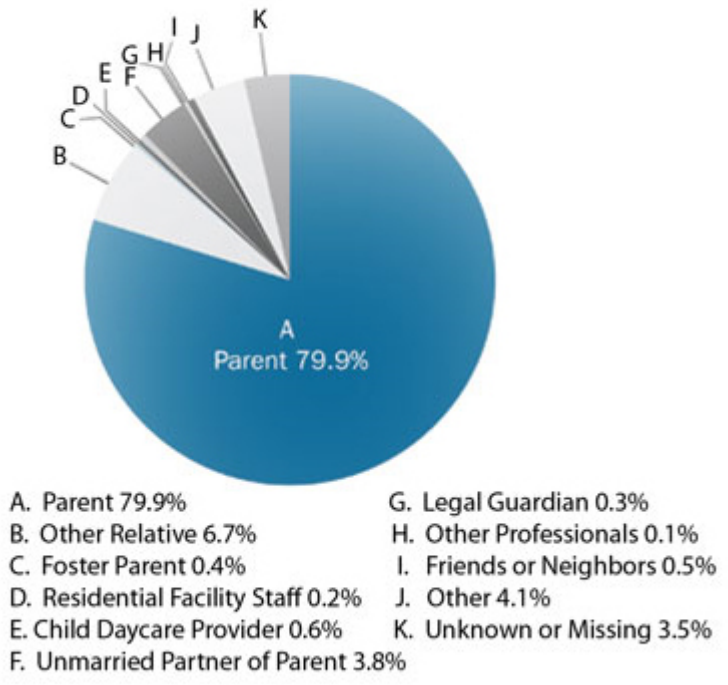
- **Indirect costs**. Indirect costs represent the long-term economic consequences of child abuse and neglect. These include juvenile and adult criminal activity, mental illness, substance abuse, and domestic violence. They can also include loss of productivity due to unemployment and underemployment, the cost of special education services, and increased use of the health care system. Prevent Child Abuse America recently estimated these costs at more than $69 billion per year (2001).

According to Prevent Child Abuse America (2007), the economic cost of child abuse was estimated to be 103.8 billion dollars in 2007. This estimation is considered to be conservative, as it focuses only on the direct costs of hospitalized abused children. There are many costs associated with child abuse and many children's victimization did not result in hospitalization. Additionally, the vast amount of pain and suffering and other intangible costs have not been factored into the above dollar amount (PCA-A, et al., 2007).

Perpetrators of Child Abuse

It is a myth that strangers most often abuse children. By far the vast majority of maltreated children are victimized by those who are familiar to the child and who have ready access to the child. Relatives of the child are most often the perpetrators of child abuse. In particular, parents make up the majority of child abuse perpetrators. Approximately 80% (79.9%) of perpetrators were parents. Of the parents who were perpetrators, more than 90% (91.5%) were biological parents, 4.2% were stepparents, and 0.7 percent were adoptive parents. Other relatives accounted for an additional 6.7%; unmarried partners of parents accounted for 3.8% (USDHHS-ACF, 2008).

Figure 1. Child Maltreatment Perpetrators by Relationship to Victim, 2006



Courtesy of the Children's Bureau, Administration for Children and Families, US Department of Health and Human Services (2008)

Female perpetrators, mostly mothers, were typically younger than male perpetrators, who were mostly fathers. The median age for women perpetrators was 31 years; for men, it was 34 years. Women also comprised a larger percentage of all perpetrators than men, 57.9% compared to 42.1% (USDHHS-ACF, 2008). Nearly 76 percent of all perpetrators of sexual abuse were friends or neighbors and 30 percent were other relatives. Less than 3 percent of parental perpetrators were associated with sexual abuse (USDHHS-ACF, 2008).

The racial distribution of perpetrators was similar to the race of their victims. During 2006, more than one-half (53.7%) of perpetrators were White and one-fifth (20.7 %) were African-American. Approximately 20% (19.5%) of perpetrators were Hispanic (USDHHS-ACF, 2008).

More than one-half (60.4%) of all perpetrators were found to have neglected children. Slightly more than 10 percent (10.3%) of perpetrators physically abused children, and 7.0% sexually abused children. Almost 12% (11.5%) of all perpetrators were associated with more than one type of maltreatment (USDHHS-ACF, 2008).

In Iowa in 2006 there were 19,695 substantiated perpetrators of child maltreatment, of these 14,355 were the parents of the child(USDHHS-ACF, 2008).

Dos and Don'ts Regarding Talking with Children about Possible Abuse or Maltreatment

Do:

- Find a private place to talk.
- Remain calm.
- Be honest, open and up front with the child.
- Use age-appropriate language.
- Remain supportive to the child.
- Listen to the child.
- Stress that it is ***NOT*** the child's fault.
- Report the situation immediately.

Don't:

- Overreact.
- Make judgments
- Make promises
- Interrogate the child or try to investigate. This is especially important in sexual abuse cases.

Reporting Child Abuse and Maltreatment

Overview

As previously stated, mandated reporters fail to report child abuse and maltreatment because they feel they cannot identify abuse correctly and they feel they do not know the correct procedure for reporting. Additionally, people sometimes fear that reporting child abuse or maltreatment will destroy a family. The truth, however, is that reporting should lead to getting help for the family by protecting the child from further suffering and harm and by assisting the family in facing and overcoming its problems. Professionals can all help end child abuse by their efforts to become more aware of the signs of child abuse and maltreatment and reporting suspected cases (PCA-NY, n.d.; NYCACS, 2008).

As mentioned previously, more than one-half (56.3%) of all reports made to Child Protective Services agencies came from professionals who came in contact with the child as part of their professional responsibilities. In 2006, the three most common sources of reports were from professionals-teachers (16.5%), lawyers or police officers (15.8%), and social services staff (10.0%) (USDHHS-ACF, 2008). Many people in these professions are required by law to report suspected abuse or neglect.

Non-professionals submitted almost 44% of reports. These reports were made by parents, relatives, friends and neighbors, alleged victims, alleged perpetrators, anonymous callers, and "other" sources (which may include clergy members, sports coaches, camp counselors, bystanders, volunteers, and foster siblings). The three largest groups of nonprofessional reporters were anonymous (8.2%), "other" (8.0%) and other relatives (7.8%) (USDHHS-ACF, 2008). It is important for everyone to know the signs that may indicate maltreatment and how to report it. We all share a responsibility

to help keep children safe as we take steps to prevent abuse from occurring in the first place (CWIG, 2006a).

Case #1: Corey

Does the emergency department physician have reasonable cause to suspect that Corey has been abused? Should a report be made?

The emergency department physician was given conflicting information about how Corey was injured (the EMS personnel reported that Corey had been hit with a softball during practice; Corey reports he was "beat up"). However, Corey also has multiple bilateral bruises in various stages of healing. These differing accounts of Corey's injuries are noted by the physician. Corey seems so distressed by his father's presence and the father is very angry at Corey and humiliates him, despite the boy's injury and pain. Corey's father seems to have particular anger towards what he perceives as Corey's shortcomings. As the emergency department physician you report Corey to the Child Abuse hotline.

Case #2: Juanita

As the family nurse practitioner, who knows this family well, you decide to ask mother and daughter about what happened that upset them both so much. Mom does not respond, but Juanita blurts out that she stole some nail polish and lipstick from the drug store and her mother found out once they got home. Mom uses corporal punishment in dealing with Juanita and she slapped the girl across the face as well as grabbed her arm rather roughly. She ordered Juanita to take the items back to the store and to apologize to the clerk at the store. Juanita, although initially minimizing her actions, began to feel guilt and remorse for her actions. She was still recovering from the incident that had occurred earlier today.

After Juanita confessed her crime to the nurse practitioner, Mom confirmed the story and talked about how upset she was that her daughter had stolen from the store. She was angry because she is a religious woman who lives by a strict moral code and feels betrayed by her daughter for not also living by the values she thought she had instilled in her daughter. As the nurse practitioner, you believe the explanation that the mother and daughter provide you and you encourage them to continue to talk about the incident with each other. You decide this is not a case of potential abuse and you do not report this to the Child Abuse Hotline.

Case #3: **Sam**

As the teacher, you recognize that Sam's clothing, wearing a short-sleeved t-shirt and jeans despite the 30 degree temperature, is inappropriate attire for the season. His family has neglected to seek medical attention for Sam, despite his ongoing difficulty walking, despite your request to have him receive medical attention. Although an adequate student, Sam has poor social skills with his peers; he is even bullied by them. His behavior, including poor eye contact, nervousness and significant startle reflex leads you to think that Sam is likely experiencing, at the very least, neglect from his parents, and possibly also physical abuse. You call the Child Abuse Hotline.

Case #4 Alicia and Martin

As the visiting nurse you recognize the obvious signs of neglect in the Alicia and the signs of abuse and neglect in Martin. You call the Child Abuse Hotline and discuss the immediacy of the need for safety and services (ie. This is the first time you have been in the house in 6 weeks; there is a history of cocaine use; Alicia has lost a significant amount of weight and there is no formula or food in the house; Martin has been abused multiple times and is fearful of adults). You request that immediate action be taken; it is your belief that the children are not safe in the home at this time. You also call law enforcement to take the children into protective custody.

Case #5: Tisha

As the family nurse practitioner in the primary care practice, you must report Tisha to the Child Abuse Hotline. In a child as young as Tisha, only 5 years old, a positive lab test for syphyllis is a strong indication that the child is being sexually abused. You report the positive result to Tisha's mother, who becomes tearful and angry and agrees to cooperate with the report, because she fears that Tisha has been sexually abused and is very upset that she has not been able to keep her daughter safe. She wants to find out how this could have happened.

Case #6: Marcus, Amber and Isaiah

The school nurse meets with the teachers of the Shaw children, requesting their perspectives on whether or not the Shaw children are neglected. She learns that they rarely miss school. Amber and Isaiah are average students, but Marcus is in gifted classes. There has never been any suspicion on the part of the teachers that there may be any abuse in the family. Given what the Shaw children have told the nurse, as well as the teachers' reports, the nurse decides to refer the Shaw children for the school breakfast and lunch programs, seeing this as a financial issue, not a case of denial of care. The nurse does not report the Shaw children to the Child Abuse Hotline, but refers them and their family to the social service office for other potential entitlements.

Case #7: Tim

As the nurse for this residential treatment center and a mandatory reporter, Jean knows that she has a legal obligation report her suspicions of child abuse. This legal requirement overrides any loyalty she may feel towards her employer. She also recognizes that reporting may put her job in jeopardy, since the employer has "investigated" and does not believe the allegations of abuse. Given what Tim has told her, the bloody underwear, and her own discomfort/suspicions when observing staff/client interactions, Jean knows that she has a legal responsibility to report. Ethically and professionally, she also recognizes that she must report, despite whatever ramifications there may be from her employer.

Despite the internal investigation that was conducted by the employer, Jean still has a legal responsibility to report her suspicion of sexual abuse to the Child Abuse Hotline.

How to Report

According to Iowa Code section 232.70, mandatory reporters of child abuse must report any suspicion of child abuse to the Department of Human Services (DHS). An oral report of suspected child abuse must be reported to DHS within 24 hours of becoming aware of the situation. A written report must follow the oral report to DHS within 48 hours. The employer or supervisor of the mandatory or permissive reporter may not apply any policy, work rule, or other requirement that interferes with the person making a report of child abuse (IDHS, 2005).

If a child is in **imminent danger**, as a mandatory reporter, an **oral report to law enforcement** must be immediately made. Law enforcement is the only profession that can take a child into custody in that situation (IDHS, 2005).

The law requires the reporting of **suspected** child abuse; one does not need to be certain that abuse is occurring. It is not the reporter's role to validate the abuse. The law does not require you to have proof that the abuse occurred before reporting. The law clearly specifies that reports of child abuse must be made when the person reporting "**reasonably believes a child has suffered abuse."** Reports are made in terms of the child's possible condition, not in terms of an accusation against parents. A report of child abuse is not an accusation, but a request to determine whether child abuse exists and begin the helping process (IDHS, 2005).

Within 24 hours of receiving the report, the mandatory 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*, indicating whether the report of child abuse was accepted or rejected, will be sent (IDHS, 2005).

To report a suspected case of child abuse (IDHS, 2005):

- Or call the CALL a DHS Local Office. A link to these offices can be found in our online course or by emailing the Iowa Dept Human Services Offices at **contactdhs@dhs.state.ia.us**
  8:00 AM - 4:30 PM Monday-Friday, ***or***
- Call **Iowa's Child Abuse Hotline 1-800-362-2178**

  Please be ready to provide identifying information and the whereabouts of the child. You may remain anonymous.

- If you believe the child is in imminent danger, call 911 immediately.
- Follow up with a written report within 48 hours.

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.
- The reporter's name and address.

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		City	State
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. 10/06)

Form 470-0665, *Report of Suspected Child Abuse,* can be retrieved from the DHS website http://www.dhs.state.ia.us/policyanalysis/PolicyManualPages/Manual_Documents/Forms/470-0665.pdf.

This specific form is not required, but may be used as a guide in making a report of child abuse. Mail the form to the local office of the Department of Human Services (see Resource section of this course) or to the:

Central Abuse Registry
Iowa Department of Human Services
1305 E. Walnut
Des Moines, IA 50319

If sexual abuse of a child under the age of 12 by a non-caretaker is suspected, mandatory reporters are required by law to make a report of child abuse to DHS. If the child is aged 12 or older, a report of sexual abuse by a non-caretaker may be made, although it is not required by law. DHS must report all sexual abuse allegations to law enforcement within 72 hours.

Reporting Abuse/Neglect Outside of Iowa or Nationally

If you suspect that a child is being abused or maltreated/neglected, you should call your local Child Protective Services (CPS) agency or the CPS agency in the State in which the abuse occurred. As you identify the appropriate agency for making a report, remember the following:

- Not every State has a toll free hotline, or the hotline may not operate on a 24 hour basis.
- If a toll free (800 or 888) number is available, it may be accessible only from within that State.

Federal agencies have no authority to intervene in individual child abuse and neglect cases.

Each state has its own procedure for reporting child abuse. A listing of phone numbers for the states that have them is available at http://www.childwelfare.gov/pubs/reslist/rl_dsp.cfm?rs_id=5&rate_chno=11-11172. If a number is not listed, or if you need to report suspected abuse in a State other than your own, please call:

Childhelp® USA National Child Abuse Hotline
1-800-4-A-CHILD® (1-800-422-4453)
TDD: 1-800-2-A-CHILD

Childhelp® USA is a non-profit agency which can provide reporting numbers, and has Hotline counselors who can provide referrals.

What Happens After a Report is Made

The assessment process that DHS utilizes for reports of child abuse consists of (IDHS, 2005):

Intake

The purpose of intake is to obtain information to ensure that reports of child abuse meeting the criteria for assessment are accepted and reports that do not meet the legal requirements are appropriately rejected. DHS policy is to accept a report when there is insufficient information to reject it.
The DHS decision on whether to accept or reject a report of child abuse is to be made within a **1-hour or 12-hour** time frame from receipt of the report, depending on the information which is provided and the level of risk to the child. When a report indicates that the child has suffered a "**high-risk**" injury or there is an **immediate threat** to the

child, the Department acts immediately to address the child's safety. The decision to accept the report of child abuse is made within **one hour** from receipt of the report. When a report indicates that the child has been abused, but it is not considered a "high risk" injury or there is **no immediate threat** to the child, DHS still acts promptly. The decision to accept the report of child abuse and supervisory approval on that decision are made within **12 hours** from receipt of the report. When the report **does not meet the criteria** to be accepted, such as the person alleged responsible is not a caretaker, and the report alleges the child is not considered to be at "high risk," a supervisor reviews and approves the decision to reject the report of child abuse within **12 hours** from receipt of the report.

Case Assignment

The primary purpose of the assessment is to take action to protect and safeguard the child 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. When a report indicates that the child has suffered a "high risk" injury or there is an immediate threat to the child, DHS must act immediately to address the child's safety. The case must be assigned **immediately**. When a report indicates that the child has been abused but it is not considered a "high risk" injury or there is no immediate threat to the child, DHS must still act promptly. The case must be assigned within **12 hours from receipt of the report**.

Evaluation of the Alleged Abuse

During the evaluation process, DHS gathers information about the allegations of child abuse, as well as the strengths and needs of the family, through:

- Observing the alleged child victim;
- Interviewing subjects of the report and other sources;
- Gathering documentation; and
- Evaluating the safety of and risk to the child.

Determining if Abuse Occurred

After gathering necessary information from observations, interviews and documentation, and after assessing the credibility of subjects of the report, collateral contacts and information, DHS must determine whether or not abuse occurred. Each category or subcategory of child abuse requires that specific criteria be met in order to conclude that abuse occurred. This determination is based on a "preponderance" of credible evidence, defined as greater than 50% of the credible evidence gathered.

The child protective worker must make one of the following conclusions regarding a report of child abuse:

- **Not confirmed:** Based on the credible evidence gathered, DHS determines that there is not a preponderance of available credible evidence that abuse did occur.

- **Confirmed** (but not placed on the Central Child Abuse Registry): Based on a preponderance of all of the credible evidence available to DHS, the allegation of abuse is confirmed; however, the abuse will not be placed on the Central Child Abuse Registry.

- **Founded:** Based on a preponderance of credible evidence available to DHS, the
allegation of abuse is confirmed and it is the type of abuse that requires placement on the Central Child Abuse Registry.

Only two types of abuse may be confirmed but not placed on the Central Child Abuse Registry. This includes physical abuse where the injury was nonaccidental and minor, isolated, and unlikely to reoccur and denial of critical care (lack of proper supervision or lack of adequate clothing) where the risk to the child's health and welfare was minor, isolated and is unlikely to reoccur. If the abuse was minor, isolated, and unlikely to reoccur, the abuse may not be placed on the Registry.

Placing a Report on the Central Child Abuse Registry

The Central Child Abuse Registry was established by Iowa law and is maintained by the Department of Human Services. The Central Child Abuse Registry serves several functions. It gathers information about child abuse cases in Iowa, records repeat occurrences of child abuse, records dissemination of child abuse, collects information for appeals, and provides background checks for certain professionals.

After a decision is made that a report of child abuse is confirmed, DHS makes a determination about whether the report must be placed on the Central Child Abuse Registry. When a report of child abuse is placed on the Central Child Abuse Registry, the child's name, the names of the child's parents, and the name of the perpetrator of the abuse are all entered into the Registry. Placing the name of a person responsible for the abuse of a child on the Registry may affect employment, registration, and licensure opportunities for that person. "Founded" reports must be placed on the Central Child Abuse Registry. A report that is not confirmed cannot be placed on the Registry.

Assessment of Family Strengths and Needs

The assessment process requires an evaluation of the family's functioning, strengths, and needs. The family's participation is essential. Information is gathered from family members to identify strengths, possible rehabilitation needs of the child and family, and develop the plan of action. The process usually includes a visit to the home. As part of the evaluation of the family functioning, the Department gathers information on: Home environment; parent or caretaker characteristics; child characteristics; domestic violence and substance abuse; and social and environmental characteristics.

Preparing Forms and Reports

Multiple reports and forms that provide notification and other relevant information include*: Notice of Intake Decision, Parental Notification, Child Protective Services Assessment Summary, Notice of Child Abuse Assessment.*

Mandatory reporters can expect to receive *Notice of Intake Decision* within 24 hours of making the report, written notification of intake decision sent within 5 working days, outcome notification of assessment is to be sent within 20 working days, and a copy of the founded abuse report if requested.

Custodial and non-custodial parents receive *Parental Notification* that a child abuse assessment is being conducted within 5 working days of the report. DHS is required by Iowa law to notify parents.

The *Child Protective Services Assessment Summary* provides documentation of efforts to assess the abuse allegations and to assess the child and family functioning. The *Child Protective Services Assessment Summary* is available to the mandatory reporter who made the report, upon request. The custodial and noncustodial parents are provided a copy of the summary at the completion of the assessment. The safety and risk assessment can be released only with the permission of the subjects.
The *Summary* includes report and disposition information divided in several sections:

- Abuse reported;
- Assessment of child safety;
- Summary of contacts;
- Determination if the abuse occurred;
- Rationale for placement or non-placement on the Central Child Abuse Registry;
- Recommendations for juvenile court action;
- Recommendations for criminal court action.

The *Notice of Child Abuse Assessment* indicates:

- Indicates that the assessment process is concluded and whether the allegations of abuse were
  founded, confirmed or not confirmed.
- Lists the recommendation for services and juvenile or criminal court.
- Provides information regarding confidentiality provisions related to child abuse assessment information and how to request an appeal hearing.
- Provides information on how to obtain copies of the *Child Protective Assessment Services Summary*. Mandatory reporters may use the notice form to request a copy of the written summary of the assessment of their allegations of abuse.

<u>Law Enforcement Involvement</u>

Law enforcement may become involved in a child abuse assessment at any time. Cases of child prostitution, homicide, sexual abuse and severe trauma require a joint assessment by law enforcement personnel and the DHS.

Protective Custody of a Child

Iowa laws provide for a child to be placed in protective custody in various situations. DHS
does not have a statutory authority to simply “remove” a child from a parent or other caretaker. The procedures for a child to be placed in protective custody are outlined in Iowa Code sections 272.78 through 232.79A.

Assessment workers do not have the legal authority to remove children from their home without a court order or parental consent. Only a peace officer or a physician treating a child may remove a child without a court order if the child’s immediate removal is necessary to avoid imminent danger to the child’s life or health. There are four legal procedures for the emergency temporary removal of a child:

- Emergency removal by an ex parte court order
- Emergency removal of the child by a peace officer
- Emergency removal of the child by a physician
- With parent’s consent

After the Assessment Process

By the close of the child protective assessment process, a determination of the family’s eligibility and need for services is made. The eligibility for services is based on age of the child, the risk of abuse or reabuse, and the finding of child abuse assessment. DHS provides protective services to abused and neglected children and their families without regard to income when there is a founded child abuse report or with a court order. Community resources provide rehabilitative services for the prevention and treatment of child abuse to children and
families.

During, or at the conclusion of, a child abuse assessment, DHS may recommend information, information and referral, community care referral, or services provided by the department. If it is believed that treatment services are necessary for the protection of the abused child or other children in the home, juvenile court intervention shall be sought.

Information or Information and Referral - Families with children of any age that have confirmed or not confirmed abuse and low risk of abuse shall be provided either information and referral or information when:

- No service needs are identified, and the worker recommends no service; or
- Service needs are identified, and the worker recommends new or continuing services to the family to be provided through informal supports; or
- Service needs are identified, and the worker recommends new or continuing services to the family to be provided through community agencies.

Community Care Referral – This includes child and family-focused services and supports provided to families referred from DHS. Services are geared toward keeping the children in the family safe from abuse and neglect; keeping the family intact; preventing the need for further intervention by the department, including removal of the child from the home; and building ongoing linkages to community-based resources that improve the safety, health, stability, and well-being of families served.

With the exception of families of children with an open department service case, court action pending, or abuse in an out-of-home setting, a referral to community care is offered to:

- Families with children whose abuse is not confirmed that have moderate to high risk of abuse when service needs are identified and the worker recommends community care.
- Families with children that have confirmed but not founded abuse and moderate or high risk of abuse when service needs are identified and the worker recommends community care.
- Families with children with founded abuse, a victim child six years of age or older, and a low risk of repeat abuse when service needs are identified and the worker recommends community care.

Referral for Department Services - Families with children that have founded abuse and moderate to high risk of abuse and families with victim children under age six that have founded abuse and low risk of abuse shall be offered department services on a voluntary basis.

- The worker recommends new or continuing treatment services to the family to be provided by the department, either directly or through contracted agencies.
- Families refusing voluntary services shall be referred for a child in need of assistance action through juvenile court.

DHS services such as homemaker services, parenting classes, respite child care, foster care,
financial assistance, psychological and psychiatric services, and sexual abuse treatment
may be provided and may be provided without court involvement if the parent consents to
services. Other interventions can be ordered by a court.

Juvenile Court Intervention - Juvenile court intervention may be sought in order to intervene on an emergency basis to place the child in protective custody by removing the child from the home or by seeking adjudication of the child to place the child under the protective supervision of the juvenile court with the child remaining in the care and custody of the parent.

Juvenile court hearings are held when children are removed from their parent's custody or when treatment or DHS supervision of abused or neglected children is necessary because the parents are unwilling or unable to provide such treatment or supervision.

The court ensures that the parent's and the children's rights will be protected. An attorney is appointed to represent the child's best interest. The attorney representing the child is called the guardian ad litem. The court may also appoint a court appointed special advocate (CASA) to assist in informing the court regarding child's progress and recommendations. The parents have a right to legal counsel. If they cannot afford an attorney, the court will appoint one.

Child Abuse Prevention Services

The Iowa Department of Human Services has multiple services to keep children safe. See the "Resource" section of this course for a complete listing of the local county offices of the DHS, or go to http://www.dhs.state.ia.us/Consumers/Find_Help/MapLocations.html.

Iowa Child Abuse Prevention Programs, authorized by the legislature, provides services through local Child Abuse Prevention Councils. These Councils provide services based on the communities' needs. Some of the services provided include: crises nursery, parent education, respite care, sexual abuse prevention, and young parent support (PCA-I, 2007).

According to the Department of Human Services (n.d.a.), Community Partnerships for Protecting Children (CPPC) is an approach that recognizes "keeping children safe is everybody's business." Community Partnerships for Protecting Children is an approach that neighborhoods, towns, cities, and states can adopt to improve how children are protected from maltreatment.

- It aims to blend the work and expertise of professionals and community members to bolster supports for vulnerable families and children.
- Community partnerships is not a "program" - rather, it is a way of working with families that helps services be more inviting, needs-based, accessible, and relevant.
- It incorporates prevention strategies as well as those needed to address maltreatment, once identified.

For more information on CPPC, go to http://www.dhs.state.ia.us/cppc/what_cppc/index.html.

Community Based Child Abuse Prevention (CBCAPP) programs designed to support networks of resources/services/activities to strengthen and support families in order to reduce the likelihood of child abuse and neglect. Services provided may include (PCAI, 2007):

- offering assistance;
- providing early, comprehensive support for parents;
- promoting the development of parenting skills, especially in young parents and parents with very young children;
- increasing family stability;
- improving family access to other resources within communities;
- support the additional needs of families with children with disabilities through respite care and other services;
- demonstrate a commitment to meaningful parent leadership, including among parents of children with disabilities, parents with disabilities, racial and ethnic minorities, and members of underrepresented and underserved groups;
- provide referrals to early health and development services.

According to *Prevent Child Abuse Iowa* (2007) the following services are offered at these specific county locations:

- **Crisis Child Care -** Adams, Adair, Bremer, Butler, Cerro Gordo, Dallas, Franklin, Grundy, Hancock, Union, Winnebago and Worth counties;
- **Group and Home-Based Parent Education -** Adams, Adair, Benton, Black Hawk, Boone, Buchanan, Buena Vista, Calhoun, Cass, Cerro Gordo, Cherokee, Chickasaw, Clay, Delaware,
  Dickinson, Fayette, Floyd, Hancock, Henry, Iowa, Jackson, Jasper, Jefferson, Keokuk, Marshall, Mills, Mitchell, Monona, Montgomery, Muscatine, Worth, Winnebago, Osceola, O'Brien, Shelby, Harrison, Poweshiek, Tama, Washington, Van Buren, Polk, Lyon, Plymouth, Union, Webster and Pocahontas
- **Parent Support Groups -** Benton, Black Hawk, Boone, Hamilton, Humboldt, Ida, Iowa, Linn, Polk, and Sioux
- **Respite Child Care -** Allamakee, Audubon, Bremer, Butler, Carroll, Clayton, Dubuque, Franklin, Greene, Grundy, Guthrie, Johnson, Howard and Winneshiek
- **Child Abuse Prevention Awareness Activities -** conducted by all CPPC sites

Prevent Child Abuse Iowa also subcontracts with *Iowa Respite and Crisis Care Coalition* to offer respite care to families with children with disabilities and crisis care to families in need of emergency child care.

Safe Haven for Newborns--Overview of the Safe Haven Act

What is the Safe Haven Act?

The State of Iowa has joined 30 other states in creating Safe Havens for infants (IDHS, n.d.).

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 health care facility without fear of prosecution for abandonment.

Who is a Safe Haven?

A Safe Haven is an institutional health facility - such as a hospital or health care facility. According to the law - an "institutional health facility" means:

- A "hospital" as defined in Iowa Code section 135B.1, including a facility providing medical or health services that is open twenty-four hours per day, seven days per week and is a hospital emergency room, or
- A "health care facility" as defined in Iowa Code section 135C.1 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.

Requirements for Safe Haven Facilities

Hospitals and health care facilities are encouraged to prominently display the Safe Haven logo.

Hospitals or health care facilities:

May	**Must**
Ask for, but cannot require: • The name of the parent or parents. • Medical history of the infant. • Medical history of the infant's parents.	Notify the Iowa Department of Human Services (DHS) as soon as possible by calling 1-800-362-2178 that physical custody of an infant has been taken under the Safe Haven Act. DHS will make the necessary court and legal contacts and assume care, control and custody of the child.
Perform reasonable acts to protect the physical health and safety of the infant with immunity from criminal or civil liability or omissions made in good faith.	Submit the certificate of birth report as required in Iowa Code section 144.14.
Testify at any court hearing held concerning the infant.	Keep confidential any information received or recorded in connection with a good faith effort to voluntarily release an infant under the Safe Haven Act except as outlined in 2001 Iowa Acts, SF 355. Failure to keep information confidential is a serious misdemeanor.

Requirements for Parents

A parent - or another person authorized by the parent to relinquish physical custody of an infant:

May	Cannot
Directly relinquish custody of an infant to an individual on duty at: • A hospital, • 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.	Be required to provide identifying information.
Leave the infant at a hospital or health care facility and immediately contact the facility or call a 911 service to be sure that: • An individual on duty is aware of the location of the infant, AND • The facility knows an infant has been left there under provisions of the Safe Haven Act.	Be charged with abandonment.

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 health care facility.

The Safe Haven Act provides immunity from civil or criminal liability for hospitals, health care facilities, and persons employed by those facilities that perform reasonable acts necessary to protect the physical health and safety of the infant.

Information Resources

For more information about the Safe Haven Act, go to http://www.dhs.state.ia.us/Consumers/Safety_and_Protection/Safe_Haven.html.

The following printable information is available:

Publication Links	Recomended Use
Safe Haven Logo [MSWord 123KB]	For hospitals and health care facilities to: • Print in color and laminate if possible. • Prominently display in public areas.
Information for Hospitals and Health Care Facilities [MSWord 36KB]	For hospitals and health care facilities to: • Print and place in a prominent location for employee access. • Include in procedure manuals.
Information for Parents [MSWord 38.5KB]	For hospitals and health care facilities to: • Print and give to a parent or authorized person leaving an infant at a Safe Haven. • Include in procedure manuals. • For Iowa Department of Human Services offices to: • Include in procedure manuals.
Department of Human Services Responsibilities [MSWord 35.5KB]	For Iowa Department of Human Services offices to: • Print and place in a prominent location for employee access. • Include in procedure manuals.

Conclusion

Because mandatory reporters work in professional capacities in many occupations that interface with children, the residents of Iowa are counting on you to recognize child abuse and maltreatment/neglect, in all its forms, when you see it. Once identified, Iowans are counting on mandatory reporters to report their suspicions to the Department of Health. It is critical that all mandatory reporters understand their legal responsibility to report, as well as take on the professional and ethical responsibility to stop the abuse and maltreatment/neglect and end the suffering of children.

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Resources

Iowa Department of Human Services
http://www.dhs.state.ia.us/index.html
contactdhs@dhs.state.ia.us

ChildHelp USA
Hotline 800.422.4453

Prevent Child Abuse Iowa
505 Fifth Avenue, Suite 900
Des Moines, Iowa 50309
Phone: 515-244-2200
Toll Free: 800-237-1815
Fax: 515-280-7835
Email: pcaia@pcaiowa.org
http://www.pcaiowa.org/index.html

The National Clearinghouse on Child Abuse and Neglect Information (NCCAN)
800.FYI.3366

Prevent Child Abuse America
PCA America National Office:
500 North Michigan Avenue
Suite 200
Chicago, IL 60611.3703
Phone: 312.663.3520
Fax: 312.939.8962
E-mail: mailbox@preventchildabuse.org
http://www.preventchildabuse.org/index.shtml

ChildFind (Registry for missing and Exploited Children)
800.222.1464

Child Welfare Information Gateway
Multiple Resources available
http://www.childwelfare.gov/admin/find_help.cfm

Domestic Violence
Hotline 800.799.7253

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Course Test

1. What is the purpose of the Iowa Child Abuse reporting law?

    A. To encourage state agencies to add additional duties to their employees.
    B. To provide protection to children by encouraging the reporting of suspected abuse.
    C. To require mandatory reporters to accuse parents of misdemeanor charges.
    D. None of the above.

2. The most common form of child maltreatment, in the US is:

    A. Physical abuse.
    B. Sexual abuse.
    C. Neglect.
    D. Emotional abuse.

3. In Iowa, a mandatory reporter need not be absolutely certain that an injury or condition was caused by abuse or maltreatment/neglect; the reporter should only reasonably believe a child has suffered abuse. The mandatory reporter does not have to prove the abuse or maltreatment. A report is not an accusation, rather it is a request to determine whether child abuse exists and a beginning to the helping process.

    A. True.
    B. False.

4. Mandatory reporters of child abuse and maltreatment/neglect in Iowa:

    A. Have immunity from prosecution if they reported in good faith.
    B. Can be charged with a simple misdemeanor for failing to report.
    C. May be civilly liable for any damages caused by failure to report.
    D. All of the above.

5. Who are people “responsible for the care of a child”?

    A. A 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.
    B. An employee or agent of any public or private facility providing care for a child, including an institution, hospital, health care facility, group home, mental health center, residential treatment center, shelter care facility, detention center, or child care facility.
    C. Any person providing care for a child, but with whom the child does not reside, without reference to the duration of the care. The person who assumes responsibility for the care or supervision of the child may do so through verbal or written agreement, or implicitly through the willing assumption of the caretaking role.
    D. All of the above.

6. In 2006, more than half of the reports of child abuse and maltreatment/neglect (55.8%) were made by professionals who are required to report their suspicions of abuse or maltreatment/neglect.

    A. True.
    B. False.

7. The rate of child abuse in Iowa has been increasing since 2002. However, in 2006 child fatalities decreased.

    A. True.
    B. False.

8. Examples of mental injury can be any of the following **EXCEPT**:

    A. Ignoring, isolating and/or rejecting the child, so that the child does not get basic emotional needs met.
    B. Cigarette burns on the soles of the feet.
    C. Terrorizing or verbally assaulting the child, so that the child lives in a climate of fear or humiliation.
    D. Corrupting or overpressuring the child, so that the child's destructive behavior is reinforced or the child never feels good enough.

9. What are the subcategories of "denial of critical care", often thought of as "neglect"?

    1. Failure to provide adequate food and nutrition.
    2. Failure to provide adequate shelter.
    3. Failure to provide adequate clothing.
    4. Failure to provide adequate health care.
    5. Failure to provide mental health care.
    6. Gross failure to meet emotional needs.
    7. Failure to provide proper supervision.
    8. Failure to respond to an infant's life-threatening condition.

    .

    A. 1, 2, 3, and 6.
    B. "Denial of Critical Care" is not a legal definition of child abuse in Iowa.
    C. None of the above.
    D. All of the above.

10. Physical abuse should be considered if:

    A. The caretaker explanation for the injury does not fit the physical evidence.
    B. The explanation for the injury is not possible based on the child's developmental stage.
    C. There are repeated or patterned injuries.
    D. All of the above.

The following case relates to questions 11-15.

10 year old Michael was always a talkative, rambunctious and social boy with many friends. Last year his mother married a man who Michael liked very much. For approximately the last 6 months, Michael has been moody, sometimes being withdrawn and socially isolated and at other times, getting into fights at school. He's also been failing exams and his grades have fallen. You see Michael for complaints of a sore throat in the primary care office in Polk County, accompanied by his step-father. Michael and his step-father hardly speak to one another; Michael avoids interacting with him. Prior to the exam, Michael tells you that he "hates" his step-father and that Michael's mother works the evening shift part-time, which is why his mother is not available for today's urgent visit. When you attempt to examine Michael, he flinches at your touch. A throat culture reveals gonorrhea.

11. **Behavioral indicators** of possible abuse include all the following **EXCEPT**:

    A. Lab results indicating gonorrhea.
    B. Sudden change in behavior, and school performance.
    C. Behavioral extremes.
    D. Avoidance of touch.

12. **Physical indicators** of possible abuse include:

    A. Sore throat and lab results indicating gonorrhea.
    B. Avoidance of his step-father.
    C. Avoidance of touch during the exam.
    D. Change in behavior.

13. During the office visit, you are aware that you need to be careful in talking with Michael, so that he feels comfortable telling you about his situation. You make sure you are able to do all the following **EXCEPT**:

    A. Remain calm, be open and honest with Michael.
    B. Listen carefully and remain supportive, stressing that it is NOT Michael's fault.
    C. Interrogate Michael in an attempt to investigate what is really happening in his life.
    D. Report the situation to the Child Abuse Hotline.

14. You know that gonorrhea in a child of Michael's age is often a sign of child sexual abuse, and you note his behavioral changes and what he has told you. As a mandatory reporter, you do which of the following?

    A. Call the Polk County Department of Human Services office or call the 24 hrs/day child abuse/dependent abuse hotline number at 800.362.2178.
    B. Call law enforcement, as Michael remains in imminent danger.
    C. Both A and B.
    D. Neither A or B.

15. After you orally report your suspicion of sexual abuse of Michael, you have what amount of time before you are required to follow up with a written report?

    A. 24 hours.
    B. 48 hours.
    C. 72 hours.
    D. A written report must immediately follow the oral report.

16. During the child abuse assessment, conducted by the DHS, who is likely to be interviewed?

    A. The alleged child victim.
    B. The parents and other adults in the household, as well as the alleged perpetrator.
    C. Collateral sources, witnesses, or other parties with information.
    D. All of the above.

17. The most frequent perpetrators of child abuse and maltreatment/neglect are

    A. Strangers.
    B. Caretakers who are not family members.
    C. Parents.
    D. Family members other than parents.

18. Information that should be included in oral and written reports of child abuse made by mandatory reporters are:

    A. The names and addresses of the child, the child's parents or others responsible for the child's care, as well as the child's current whereabouts and the child's age.
    B. The nature and extent of the child's injuries, including any evidence of previous injuries, as well as the names, ages and condition of any other children in the same household.
    C. The identity of the person(s) responsible for the abuse or neglect/maltreatment; any other information that is relevant, as well as the reporter's name and address.
    D. All of the above.

19. All of the following are possible conclusions that a child protective worker may reach at the completion of the assessment **EXCEPT**:

    A. Abuse is not confirmed.
    B. Abuse is confirmed (but not placed on the Central Child Abuse Registry).
    C. Abuse is founded but not confirmed.
    D. Abuse is founded (confirmed AND placed on the Central Child Abuse Registry).

20. Which of the following are training requirements for mandatory reporters of child abuse in Iowa?

A. All mandatory reporters are required to complete two hours of approved training related to the identification and reporting of child abuse within six months of initial employment or self-employment.
B. All mandatory reporters are required to complete at least two hours of additional child abuse identification and reporting training every five years.
C. Both A and B.
D. Neither A or B.