Recognizing and Reporting Maltreatment and Abuse

Division of Developmental Disabilities

Department of Economic Security
Your Partner For A Stronger Arizona

Participant Guide
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Defining and Recognizing Maltreatment and Abuse

OBJECTIVES

- Define maltreatment
- Recognize maltreatment
- List common characteristics of perpetrators
According to the National Survey on Abuse Against People with Disabilities _______ of people with developmental disabilities have or will be victims of abuse in their lives.
Abuse and Neglect Case Outcomes

Out of 100 cases of abuse against people with developmental disabilities:

Reported  Investigated  Arrested  Prosecuted

2012 National Survey on Abuse Against People with Disabilities Findings Spectrum Institute National Disability and Abuse Project
COURSE OBJECTIVES

1. Defining and Recognizing Maltreatment and Abuse

2. Risk Factors for People with Developmental Disabilities

3. Ethics of Touch

4. Reporting Maltreatment and Abuse
DEFINING MALTREATMENT

As a group, brainstorm what these terms mean to you.

Abuse

Neglect

Exploitation
Division of Developmental Disabilities Definition

*DDD Operations Manual 6002-G*

Intentional infliction of pain or injury to a member

- Intentional infliction of physical harm
- Injury caused by negligent acts or omissions
- Unreasonable confinement or unlawful imprisonment
- Sexual abuse or sexual assault

Includes hitting, kicking, pinching, slapping, pulling hair, sexual abuse

Ridiculing or demeaning an individual, making derogatory remarks, or cursing at an individual

Violations of Article 9 such as using a restricted technique without a Division approved Behavior Treatment Plan or using a prohibited technique
Division of Developmental Disabilities Definition

DDD Operations Manual 6002-G

A pattern of conduct without the person’s informed consent resulting in deprivation of food, water, medication, medical services, shelter, cooling, heating or other services necessary to maintain minimum physical or mental health.

_______________ is an act you intentionally do resulting in harm to another person.

_______________ is an act you intentionally do not do resulting in harm to another person.

_______________ includes:

- Intentional lack of attention
- Intentional failure to report maltreatment
- Lack of supervision
- Intentional failure to carry out a prescribed treatment
- Sleeping on duty
- Abandoning shift
Division of Developmental Disabilities Definition

*DDD Operations Manual 6002-G*

Illegal or improper use of a vulnerable adult or his resources for another’s profit or advantage.

*Examples:*
- Misusing a vulnerable person’s checks, credit cards, bank accounts
- Stealing cash, social security checks, household goods

Department of Child Safety Definition

Use of a child by a parent, guardian or custodian for material gain which may include forcing the child to panhandle, steal or perform other illegal activities.

Photographs of a resident without written consent are forbidden. Staff are prohibited from taking pictures with cameras of any kind; this includes, but is not limited to, smartphones, a personal camera, a camera phone or tablet.

Taking photographs of a resident without written consent is considered a form of abuse; it is considered demeaning to the resident, exploitive and humiliating.

**Role of Social Media**
RECOGNIZING ABUSE AND NEGLECT

Any time an individual displays one or more of the following injuries, abuse must be suspected. Special attention needs to be given to the number of past injuries the individual has as well as the explanation of how the current injury occurred.

It is not your job to investigate or prove abuse and neglect. If you reasonable suspicion of abuse or neglect, report it.

When in doubt – report!
Physical Indicators

Non - Accidental Bruises

Non-accidental or suspicious bruising usually looks like the object with which the person was hit. Bruises are also more suspicious when they are discovered on the fleshy parts of the body such as the buttocks, lower back, upper arms, and/or thighs.

Examples

- Hands and fingers including pinch marks
- Paddles
- Belt (rectangular bruise often covering a curved body surface).
- Lash (narrow, straight edged bruises usually caused by a tree branch or switch).
- Loop marks (usually caused by a doubled over electrical cord or rope, often leaves loop-shaped scar).
# Head and Facial Injuries

<table>
<thead>
<tr>
<th>Head</th>
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</table>
| Eye  | • Acute hyphema (blood in the interior chamber of the eye)  
     | • Black eye  
     | • Dislocated lens  
     | • Retinal hemorrhage, dislocated lens, detached retina (shaken baby syndrome)  |
| Nose | • Broken nose  
     | • Nose bites  |
| Mouth| • Loosened or missing teeth  
     | • Jaw fractures  
     | • Upper lips and frenulum bruising, lacerations  |
| Ear  | • Injuries to the lobe (pinching or twisting)  
     | • “Cauliflower Ear” (may be result of repeated blows)  
     | • Rupture of the tympanic membrane  |
| Head | • Fractured skull  
     | • Subdural hematoma injuries  |
Burns

- Scalding burns display as deep burns at site of initial impact with less severely burned areas surrounding them. Non–accidental burns often involve the buttocks, perineum and legs.

- Immersion burns are characterized by “stocking” burns on the arms or legs or “doughnut-like” burns on the buttocks and genitalia.

- Lighter burns are most commonly found on palms, soles, and the buttocks.

- Dry contact burns often leave clear imprints of the burning object: e.g. iron, heating grate.

- Rope burns
## Bodily Injuries

<table>
<thead>
<tr>
<th>Binding marks</th>
<th>Indicate choking or restraining such as with cord or rope</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bite marks</strong></td>
<td></td>
</tr>
<tr>
<td>• Human bites: usually superficial abrasions or bruises and are oval shaped</td>
<td></td>
</tr>
<tr>
<td>• Dog bites: deep punctures</td>
<td></td>
</tr>
<tr>
<td><strong>Skeletal injuries</strong></td>
<td></td>
</tr>
<tr>
<td>• Broken neck</td>
<td></td>
</tr>
<tr>
<td>• Rib fractures: in cases of abuse, rib fractures are often multiple and may be in various stages of healing.</td>
<td></td>
</tr>
<tr>
<td>• Other broken bones</td>
<td></td>
</tr>
<tr>
<td><strong>Abdominal injuries</strong></td>
<td></td>
</tr>
<tr>
<td>• Ruptured liver or spleen (most common abdominal injury)</td>
<td></td>
</tr>
<tr>
<td>• Intestinal perforation</td>
<td></td>
</tr>
<tr>
<td>• Ruptured blood vessel</td>
<td></td>
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<tr>
<td>• Pancreatic injury</td>
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<tr>
<td>• Kidney or bladder injury</td>
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</table>
## Indicators of Abuse and Neglect

### Behavioral Indicators

The following is a list of common behavioral characteristics of individuals who have been abused or maltreated. No single one of these behaviors or combination of these behaviors necessarily means maltreatment. They may reflect distress for a variety of reasons.

<table>
<thead>
<tr>
<th>Withdrawal from friends or usual activities</th>
<th>Developmental regression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hostility</td>
<td>Low self-esteem and lack of friends</td>
</tr>
<tr>
<td>Anger /Hyperactivity</td>
<td>Indirect hints, allusions to problems at home</td>
</tr>
<tr>
<td>Changes in school performance</td>
<td>Use of alcohol and/or other drugs</td>
</tr>
<tr>
<td>Frequent absences from school</td>
<td>Compulsive behavior such as constant washing</td>
</tr>
<tr>
<td>Running away from home</td>
<td>Sleep disturbances, e.g., bed wetting, nightmares</td>
</tr>
<tr>
<td>Defiance</td>
<td>Over-compliance, extreme docility</td>
</tr>
<tr>
<td>Suicide attempts</td>
<td>Denial of a problem with a marked lack of expression</td>
</tr>
<tr>
<td>Change in appetite</td>
<td>Appearing to have overwhelming responsibilities</td>
</tr>
<tr>
<td>Reluctance to go home after school, or constant early arrival</td>
<td>Reluctance to go to a particular place or to be with a particular person</td>
</tr>
</tbody>
</table>

### Environmental Indicators

<table>
<thead>
<tr>
<th>Environmental odors</th>
<th>Filthy and cluttered environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infestations</td>
<td>Individual left unsupervised</td>
</tr>
</tbody>
</table>
INDICATORS OF SEXUAL ABUSE

Behavioral Indicators

In addition to the behavioral indicators listed above, the following is a list of behavioral characteristics more specific to individuals who have been sexually abused or maltreated.

| Unusual interest in and/or knowledge of sexual acts | Abrupt change in behavior in response to personal safety lesson in the classroom |
| Seductive behavior with classmates, teachers, other adults | Reluctance to undress for physical education / avoidance of P.E. class |
| Excessive masturbation | Continual avoidance of bathrooms |
| Attempts to touch people’s or animals’ genitals | Wearing multiple layers of clothing |
| Wearing tight and/or revealing clothing | |

Physical Indicators

| Evidence of trauma to the mouth of genitals | Genital bruises |
| Changes in bowel or bladder habits | Recurrent urinary tract infections |
| Significant weight loss or gain | Difficulty walking or sitting |
| Psychosomatic complaints | Unusual or offensive odors |
| Pain or discomfort in the genital area | Torn or blood-stained clothing |

Key Physical Indicators

In many cases, there are no visible signs of sexual abuse. Sexual abuse should be immediately suspected if any of these conditions present in a child or non-sexually active vulnerable adult.
Failure to Thrive can be the result of neglect and/or abuse. However, it can be caused by many things including medical problems and factors in the child's environment or a combination of medical and environmental factors. Many times, the cause cannot be determined. Not treating Failure to Thrive constitutes neglect by the child's caregiver(s).

Failure to Thrive refers to children whose current weight or rate of weight gain is much lower than that of other children of similar age and gender. Children who fail to thrive do not grow and develop normally as compared to children of the same age. Height, weight, and head circumference do not match standard growth charts. Other names for Failure to Thrive include: Growth Failure, Feeding Disorder; and Poor Feeding.

Babies who fail to gain weight or develop often lack interest in feeding or have a problem receiving the proper amount of nutrition. The following are the most common symptoms of failure to thrive:

- Delayed or slow development of physical skills such as rolling over, sitting, standing and walking
- Delayed or slow development of cognitive and social skills
- Delayed secondary sexual characteristics
- Lack of interest in feeding or a problem receiving the proper amount of nutrition
- Constipation
- Excessive crying
- Excessive sleepiness (lethargy)
- Irritability

Depending on the length of time a child fails to thrive, permanent mental, emotional, or physical delays can occur.
## Possible Causes of Failure to Thrive

<table>
<thead>
<tr>
<th>Physical</th>
<th>Environmental</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organ problems</td>
<td>Loss of emotional bond between parent and child</td>
</tr>
<tr>
<td>Hormone problems</td>
<td>Poverty</td>
</tr>
<tr>
<td>Damage to the brain or central nervous system, which may cause feeding difficulties in an infant</td>
<td>Problems with child-caregiver relationship</td>
</tr>
<tr>
<td>Heart or lung problems, which can affect how nutrients move through the body</td>
<td>Parents not understanding diet needs for their child</td>
</tr>
<tr>
<td>Anemia or other blood disorders</td>
<td>Exposure to infections, parasites, or toxins</td>
</tr>
<tr>
<td>Gastrointestinal problems that make it hard to absorb nutrients or cause a lack of digestive enzymes</td>
<td>Poor eating habits, such as eating in front of the television and not having formal meal times</td>
</tr>
<tr>
<td>Long-term (chronic) infections</td>
<td></td>
</tr>
<tr>
<td>Metabolism problems</td>
<td></td>
</tr>
<tr>
<td>Problems during pregnancy or low birth weight</td>
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</table>

Abuse / neglect

CONDITIONS/PRACTICES MISTAKEN FOR ABUSE

Mongolian Spots

These are blue, blue gray, blue black, or deep brown irregularly shaped birthmarks. Infants may be born with one or more of these spots. They usually disappear by age five and almost always by puberty.

Cupping

Cupping is a type of alternative medicine in which a flammable substance such as alcohol, herbs, or paper is placed in a cup and set it on fire. As the fire goes out, the cup is placed upside down on the skin. As the cup cools down, suction is created. It is used to relieve pain, increase blood flow, and is a type of deep tissue massage.

Coining (Coin Rubbing)

Coining, or cao gio, is a common Southeast Asian alternative medical treatment. It is used for minor illnesses such as cold, flu, headache, fever, pain, cough, or low energy.

The practice of coining involves rubbing heated oil on the skin, most commonly the chest, back, or shoulders, and then strongly rubbing a coin over the area in a linear fashion until a red mark appears.

Allergic black Eye

Bleeding disorders/Hemophilia
LONG TERM EFFECTS OF MALTREATMENT

PTSD

Death

Substance abuse

Anxiety

Aggression

Depression

Repeated abuse
**Abuse Characteristics**

Abuse is widespread and not confined to any one cultural, regional or economic group.

Most abuse is perpetrated by those known to the victim, usually those in a caregiving or support role.
PROFILE OF AN ABUSER

An abuser can look like anyone or be anyone. However, there are some personality characteristics that are common among abusers.

- Displaced aggression
- Impulsive
- History of exposure to abuse
- Need to control
- Authoritarian
- Lacks attachment to victim
- Devalues victim
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OBJECTIVES

- Identify factors that increase vulnerability of people with developmental disabilities to maltreatment
- List common case characteristics of maltreatment against people with developmental disabilities
RISK FACTORS

Myths and Stereotypes

Myths and stereotypes about individuals with disabilities contribute to increased vulnerability of abuse and neglect.

Sometimes these myths and stereotypes are positive— that the child is one of God’s little angels, always good, which is patronizing.
More often they’re negative.
What are some of the Myths/Stereotypes you have heard about people with developmental disabilities?

What are some myths and stereotypes you have heard about people with developmental disabilities?
Respect and Maltreatment

Myths and stereotypes contribute to a lack of respect for people with developmental disabilities. Those that are not respected are devalued and have a lower status in their family and community. People who are devalued are a greater risk of abuse and neglect.
Lack of Reporting

Only 33% of abuse to people with developmental disabilities is reported. There are many reasons for this.

How does not reporting abuse increase risk of maltreatment of people with developmental disabilities?
Risk Factors Activity

Features of disability that increase vulnerability


Environmental Risk Factors


Congregant Care Characteristics


Cultural influences that increase vulnerability


OBJECTIVES

- Discuss issues regarding privacy and touch
- List guidelines for personal touch when providing care
Privacy is a mental health and quality of life issue.

Activity

Instructions
Write one private item from your own life on each slip of paper. These can be:

- Objects
- Information
- Activities
- Places

These will not be shared with anyone else in the class.

As you write one item on each piece of paper, fold the paper in half with the information on the inside.

Do not share what you have written with anyone.
Personal Bubble Theory

The size of personal space we need is determined by culture, sensory physiology, and preference. Its size may vary from culture to culture, but it is almost never less than 18 inches (or about the length of a forearm). This space gives us room to maneuver in risky situations and allows time for preparing for “fight or flight”.

Depending on how a person assesses the threat level, they may actually back away and go into what we call a defensive stance which is like a shape of an “L”.

PERSONAL SPACE
Personal Space Issues

We often don’t allow people with developmental disabilities to have a “bubble of safety” or personal space. Their personal space is so often violated and disrespected that they “lose” their sense of personal space.

The “bubble of safety” is a critical feature for our own protection. Caregivers may not consider the personal space of people they support. They often feel that a member’s personal bubble doesn’t apply when providing care. After all, they were hired to provide support.

If someone we support is moving back or away from you, back off! Give them their space. We need to be aware of all body language as indicators that person feels uncomfortable or unsafe. The people we support may not be able to physically move away but they may communicate their discomfort by other means.

Living in group homes and sharing all “spaces” makes the concept of privacy change its meaning. Having to rely on another person, often times a new staff member who hasn’t spent any time with you, to assist with your most intimate tasks, can change the way you measure your personal boundaries, your personal space, and privacy.

An average group home can have up to 10 staff working in a week (weekends, shift changes, and managers). Those people can completely change every few months due to turnover rates. This means that in a 5 year period there can be as many as 80 people or more that have seen this person naked and touched them intimately. The lesson learned by someone who has these care needs is, “My body is a public place.” And “There is no such thing as strangers, just staff I have not met yet.”
You may not develop a sense of personal space which may increase your risk for being violated and for violating others’ personal space.

If you are violating others’ personal space you may be viewed by others as rude, aggressive, offensive, and forward.

As a caregiver, we have the right to have our personal space respected. If the person we support is violating our personal bubble, we have a right and responsibility to say “this is making me uncomfortable” or create space between you and the person.
**Touch**

**Professional Relationships**

There are some major cultural differences as it relates to touch. We want to make sure that we are clear about standards we should use in our professional lives. We may have learned things in our lives culturally that may not match with our professional life.

Some people grew up in a home where everyone hugged. In some families hugs were reserved for immediate family only. Some of you grew up in an environment that upon meeting someone for the first time a hug and a kiss on a cheek was customary. We need to consider all of those differences when we are working with people professionally.

When you are working with people professionally, you should always take the most conservative approach.

You are not friends or family. This means your relationship with the people you support is framed by different rules. The one exception to that is the ADH/CDH home. These living arrangements are designed to be “surrogate” families.

Paid caregivers might take liberties with people whom they barely know in physically demonstrative ways. Staff often hug, pat, caress or hold hands with the persons they serve. If these actions were taken on another staff member or colleague, it could be considered sexual harassment.
Caregiver Boundaries

If you walk into a room (like a program) and someone attending the program comes running and gives you a big bear hug, you have the right and responsibility to say no.

Do not allow the member to hug you. We need to establish and maintain a professional boundaries with the members we support. If your doctor walked in your office and gave you a bear hug or you gave the doctor a bear hug. That would be entirely inappropriate. The same is true for the caregiver and a member’s relationship. This is a professional relationship. The people we support need to be treated like you would treat anyone else with whom you have a professional relationship.

Just as if a member violates your personal space, this is an opportunity to teach rules of touch in your relationship.

How might you use this situation as a teachable moment?

This is not to say that paid support givers should not show they care about the people that we support. Every person, disability or not, needs some level of physical touch.

How can you someone you care without physically touching them?
As caregivers, it is vital that we educate the people we support about appropriate touch. We need to teach that every part of the body is private. Too often people are taught their private areas are the "privacy triangle" (genitals, bottom, breasts). However, we need to teach that touching another person anywhere is off limits without that person’s consent. We need to be vigilant in the way we teach the people we support. If they are taught the wrong rules they might be set up for failure.

As an example:

A young member of the division commutes to his group supported employment using public transportation. While riding to work on the bus one day, a young lady sat next to him. They smiled at each other and struck up a conversation. Then he reached over and placed his hand on her thigh.

She screamed, the bus pulled over, and the police were called. Fortunately, the bus driver knew the man and where he worked so he called the program. Program staff arrived at the scene.

The young man was so upset when the staff got there and was convinced he didn’t do anything wrong because he “didn’t touch her in her privates”.

We set him up.

We gave him the wrong message.

The message should be that every part of the body is private unless you are given permission.

Even the palm of the hand! In order to shake someone’s hand what do we have to do? We have to offer our own and the other person has to accept.
There are times when touch is necessary to provide assistance with personal care; however, there are vast differences between using this touch in ways that are forceful, uninformed, and disrespectful; and ways that are gentle, informed, aware and respectful.

This requires that we follow certain guidelines around when and how we use touch with an individual. When using touch to provide care it is critical to explain, ask permission, and inform the person.
BODY INTEGRITY STEPS

1. Explain Task
   - 
   - 
   - 
   - 

2. Ask Permission
   - 
   - 
   - 
   - 

3. Wait for Response
   - 
   - 
   - 
   - 
Behavior to Language Dictionary for _______________________________

<table>
<thead>
<tr>
<th>When he/she does:</th>
<th>During this situation:</th>
<th>We think it means:</th>
<th>And we should:</th>
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BODY INTEGRITY STEPS, CONTINUED

If Yes, Proceed

Explain

Fade Assistance
OBJECTIVES

- List methods of reporting maltreatment and abuse to protective agencies
- Identify key differences between Department of Child Safety and Adult Protective Services
- Recognize situations requiring a report to a protective service agency
Mandatory reporting laws are listed in Arizona Revised Statutes.

Children: A.R.S § 46-454
Vulnerable adults: A.R.S § 13-3623

If a mandated reporter has a reasonable basis to suspect that abuse, neglect, or exploitation of the individual’s property has occurred, they are required to report such information immediately to a police officer or a protective services worker.

Mandated Reporters

People having responsibility for the care of a child, an incapacitated or vulnerable adult are mandated reporters.

- Medical Professionals
- Social Services Staff (Support Coordinators and others)
- Educators
- Legal and Law Enforcement

Reasonable Belief

- A person discloses information to you indicating abuse or neglect
- A person has unexplained (non-accidental) injuries or an explanation that is inconsistent with the injuries
- Someone provides reliable information about a person that has been abused or neglected
Department of Child Safety (DCS)

Report to DCS when there is a reasonable basis to suspect:

- A child is a victim
- Suspected current or past abuse
- Non-accidental physical injury, abuse and/or neglect

Directions: During the presentation, focus on the following questions.

1. Am I required to report?

2. When and what should a person report? Whom should I report to?

3. What are situations that are outside of the Department of Child Safety’s authority?

4. When should I report to Adult Protective Services and when to Department of Child Safety?

6. Can I report online?
7. What can I expect after submitting a report online?

8. What type of questions will the hotline representative ask?

9. Will I have to give my name or can I stay anonymous?

Report Child Abuse

https://dcs.az.gov/services/suspect-abuse-report-it-now

Child Abuse Hotline: 1-888-SOS-CHILD (1-888-SOS-CHILD)
**ADULT PROTECTIVE SERVICES (APS)**

**Directions:** During the presentation, focus on the following questions.

1. Who is considered a “vulnerable adult”?

2. Does APS have any limitations?

3. Who is eligible for APS services?

4. Who is considered a “mandated reporter”?

6. Can I report online?

7. Will I have to give my name or can I stay anonymous?
## Differences between APS and DCS

<table>
<thead>
<tr>
<th>Department of Adult Protection Services</th>
<th>Department of Child Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do not have authority to remove adult from residence.</td>
<td>Do have the authority remove a child from their residence.</td>
</tr>
<tr>
<td>Client has the right to refuse all services.</td>
<td>Client cannot refuse all services without potentially losing children.</td>
</tr>
<tr>
<td>Generally requires less court-mandated activity.</td>
<td>Generally requires significant judicial involvement.</td>
</tr>
<tr>
<td>State cannot take custody of an adult.</td>
<td>State can take custody of a child.</td>
</tr>
</tbody>
</table>
TO REPORT OR NOT TO REPORT?

**Directions:** In each scenario respond to the questions below:

1. Should you report the situation? (Yes/No)
2. Should you report the situation to a protective agency?

**Scenario 1**

Sally 75, a person with a disability is yelling loudly, cussing at staff and is upset. A staff member, John, walks over to her and tells her to shut up or he will give her something to yell about.

1. ____________________________
2. ____________________________

**Scenario 2**

David 42, an individual with a disability is upset and hits Larry. Larry, group home manager, yells at David ordering him to never hit him again, then walks away and will not talk to him.

1. ____________________________
2. ____________________________
Directions: In each scenario respond to the questions below.

1. Should you report the situation? (Yes/No)
2. Should you report the situation to a protective agency?

Scenario 3

A staff member is assisting Maria, an adult with disabilities, with her bath. A person outside the bathroom hears Maria crying. The person then hears a loud sound that sounds like a slap, and Maria starts crying louder. When the person enters the bathroom, Maria is sitting on a chair rubbing the back of her head with her hands.

1. ______________________________________________________
2. ______________________________________________________

Scenario 4

Jasmine 68, a person who uses a wheelchair, is being assisted by Carlos to transfer. Carlos tells Jasmine that he is putting on the breaks and he guides her hand to the rail so she can help pull herself up, then he lifts her. Jasmine flinches when he lifts her. He says he is sorry, he forgot to tell her that he was going to use the gait belt to help steady her.

1. ______________________________________________________
2. ______________________________________________________