VITA

Nancy K. Repetz was born in Philadelphia, Pennsylvania on December 5, 1961. She received her Bachelor's Degree from the University of Virginia in 1983 and worked for one year with handicapped adults in Silver Spring, Maryland. She then obtained a Master's degree at the University of Bridgeport in 1987 and did internship at the West Haven Veterans Administration Medical Center in Connecticut. Ms. Repetz attended graduate studies in Clinical Psychology at Indiana State University from 1987 to 1992 and completed her internship at Temple University Hospital in Philadelphia, Pennsylvania. She was awarded a Doctor of Psychology degree in August, 1992.
INDIANA LAWS AFFECTING HEALTH CARE PROVIDERS IN PSYCHOLOGY: ABUSE OF CHILDREN AND ENDANGERED ADULTS

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Nancy K. Repetz
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APPROVAL SHEET

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Judy A. Murphy
Committee Chairperson

Date: July 23, 1992

N. Anderson
Committee Member

Date: 8/5/92

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ABSTRACT

This project discusses Indiana law addressing child abuse and abuse of endangered adults as it relates to the practice of psychology. Intended as a resource for psychologists, this paper reviews important issues in the areas of child abuse and abuse of endangered adults, offers understandable explanations of the laws and procedures utilized in the application of these laws in Indiana, discusses ethical concerns related to confidentiality, and offers suppositions for public policy and advocacy by the profession. In addition, selected text of the Indiana Code is presented for future reference.
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Chapter 1

INTRODUCTION

This project constitutes a section of a larger effort to compile and annotate Indiana statutes and Administrative Codes which are applicable to the practice of psychology. The purpose of this compilation is to serve as a guide and resource tool for psychologists in Indiana. It is anticipated that this document will serve as a comprehensive reference text regarding state statutes and their relevance to the professional practice of psychology. It will also offer an analysis of the issues related to the area and provide a basis for recommending public policy positions and directing advocacy by the profession. Other areas previously addressed in this endeavor include Family Law, Hospitalization of the Mentally Ill, Incompetency and Guardianship, Criminal Law, Confidentiality and Records (Schockmel, 1987), Malpractice Law, and Regulation of Professional Psychologist (Urban, 1989). The present paper will include statutes relevant to abuse of children and endangered adults.

Consistent with these previous efforts, the text of statutes is presented and commentary is offered in an
attempt to define terminology which may be foreign to the practitioner. In addition, the implications of the statutes for the health care practitioner are discussed, and procedures employed in the actual implementation of the laws are presented. Legislation and history of the legal concepts are also discussed, as well as future trends where applicable. In addition, relevant issues are analyzed, and suggestions for public policy and advocacy by the profession are offered. Finally, the reader is provided with a comprehensive list of references which may be explored for more extensive study of any particular statute or issue.

While the training received by professional psychologists prepares them well to conduct treatment, assessment, and consultation, few have been even introduced to the many legal and managerial issues which have direct bearing on the competency with which they practice (Stromberg et al., 1988). Some of these areas with which psychologists should be fully acquainted include liability, reimbursement, taxes, advertising, and ethical violations. For years, the practice of mental health providers has been directly affected by the laws of licensure and certification, third party reimbursement and professional incorporation. Yet despite this pervasive influence, most professionals are not aware of, much less comprehend, most of the laws which influence their practice, the services they provide, and the clients with whom they work (Miller and Sales, 1986). In addition, the practice of psychology
has become increasingly complex, and so too have the laws that regulate it (Grisso and Sales, 1978). Therefore, the psychologist must be familiar with a greater number of statutes in all of their complexities.

Understanding the legal aspects of psychology practice and the maintenance of this knowledge is critical for several reasons. First, the American Psychological Association mandates that psychologists must be aware of statutes affecting the practice of psychology and must remain abreast of current legal developments. For example, Principle 3 of the Ethical Principles of Psychologists (APA, 1990) requires that psychologists stay abreast of federal and state law in order to ensure that psychologists do not engage in "... any action that will violate or diminish the legal and civil rights of clients or of others who may be affected by their actions ... " (p. 391). In addition, Standards 2.2.2 and 2.2.4 of the General Guidelines for Providers of Psychological Services (APA, 1987) and of the Specialty Guidelines for the Delivery of Services by Clinical Psychologists (APA Committee on Professional Standards, 1981) also address the necessity of psychologists to remain informed and up-to-date concerning laws which affect their practice. Specifically, Standard 2.2.4 states that "... providers of psychological services seek to conform to relevant statutes established by federal, state, and local governments ... " (p. 716).

Aside from professional standards, there are other
important reasons why psychologists need to remain informed of relevant laws. One obvious reason is to ensure that one's practice is maintained within the bounds of the law in order to avoid the consequences imposed by the state. In this regard, violation of the law can result in sanctions ranging from a fine, to loss of licensure or certification, to a prison term. In addition, laws can affect psychologists' scope of practice and so professionals need to keep abreast of laws which impinge on them. Lastly, laws may also afford psychologists with important benefits (Sales, 1983). Such benefits include freedom of choice legislation, and licensure and certification laws which have generally benefitted the psychologist in the marketplace.

Although there is consensus that psychologists must remain informed and current concerning the statutes that regulate and influence the profession, there are no systematic ways in which this information is made available to the practitioner. While there has been a recent proliferation of law/psychology books and journals, and Division 41 (Law and Psychology) has been established within the American Psychological Association, these sources do not directly specify the laws relevant to practice at a state level. Standard 2.2.4 of the Specialty Guidelines for the Delivery of Services by Clinical Psychologists (APA, 1981) vaguely addresses this issue in that it states that "... it is the responsibility of the American Psychological Association to maintain current files of those federal
policies, statutes, and regulations...and to assist its members in obtaining them ... " (p. 645). In terms of state statutes, " ... the state psychological associations and the state licensing boards periodically publish and distribute appropriate state statutes and regulations ... " (p. 645).

While some state organizations such as the Illinois Psychological Association have followed this recommendation (Foster, 1988), the Indiana Psychological Association has yet to offer this to its constituents. Although relevant statutes may be forwarded to the professional from various agencies such as the Indiana State Psychology Board, which provides applicants with a copy of the legislation governing certification, no comprehensive compilation of relevant legislation exists at this time. Therefore, this project, in conjunction with similar efforts (Schockmel, 1987; Urban, 1989), is intended to provide the foundation for such a publication at the state level in Indiana.

The first area to be addressed is child abuse. Although estimates of the incidence of child abuse vary widely, typical figures suggest that approximately two million children are abused annually and that there are approximately 700,000 new cases of sexual abuse each year (Straus, Gelles, and Steinmetz, 1980). Simply due to these staggering numbers, psychologists encounter many cases of child abuse through their practice. Furthermore, research shows that histories of family violence occur in disproportionate amounts among those who are suffering from
a large variety of mental health problems. For example, 29% of hospitalized psychiatric patients reported a history of family violence (Carmen, Rieker, & Mills, 1984) and members of the general population who had a history of child sexual abuse were over twice as likely to have sought mental health treatment (Bagley and Ramsey, 1986). Therefore, it is likely that as much as one-third of a psychologist's practice could involve cases of either previous or current abuse.

The second area to be addressed is abuse of endangered adults, which includes the elderly and handicapped. While this issue is of more recent concern and therefore has much less research, some preliminary work has been done in the area of elder abuse. Pillemer and Finkelhor (1988) estimate that there are approximately one million abused elderly in the United States. In addition, the rapid growth of the 75 and older population in the U.S. has alarming implications since this cohort is the most vulnerable to the physical, mental, and financial crises which result in their inability to care for themselves (Mowbray, 1989). With increasing public awareness of abuse of endangered adults, most states, including Indiana, have passed mandatory reporting laws as well as other statutes related to elder abuse. The practitioner must be aware of these statutes in order to practice competently in today's society.

Each chapter begins with a brief overview of the statutes and important related issues. This will be
followed by definitions of legal terminology, as well as historical information concerning the legislation and related legal issues. An understandable explanation of the current Indiana abuse statutes is then presented, along with details concerning the actual procedures utilized in the application of these laws. The focus is on the current role of the mental health service provider in such proceedings, analysis of the issues involved, and the implications for public policy and advocacy by the profession. Because this paper is intended to be a comprehensive reference text, it will not be feasible to discuss all of the relevant literature regarding each statute. Rather, an extensive reference section is provided for the reader to facilitate more intense exploration of specific topics. The section will conclude with a listing of the relevant state statutes as they appear in Burns' Annotated Indiana Code (Burns, 1988).

As was previously mentioned, this text is intended as a comprehensive resource for the professional psychologist. However, it is not designed to offer legal advice or expert assistance in handling legal matters. This text will in no way serve as a substitute for sound legal counsel, and the reader is encouraged to seek such counsel in appropriate instances. Rather, this text is designed to help psychologists anticipate the legal implications of issues or choices in practice so that problems can be avoided, to assist psychologists in formulating the right questions to
ask a lawyer, and to aid in understanding the answers.

In addition, the reader should bear in mind that changes in state law are frequent, especially in the areas of abuse of the children and endangered adults which are currently receiving increased public attention. Therefore, continuing education is the only method by which the professional can remain abreast of legislative initiative, new legislation, revisions, and relevant court decisions which will impact upon the practice of psychology in this state.

Lastly, understanding legal documentation will facilitate understanding of the cited codes and administrative documents. Indiana statutes are identified with the initials IC which stand for Indiana Code. This is followed by the Title, Article, Chapter and Section number. Thus, IC 31-6-11-3 refers to Title 31, "Family Law," Article 6, "Juvenile Law," Chapter 11, "Child Abuse," Section 3, "Duty to Report."
Chapter 2

CHILD ABUSE

The abuse of children is not a recent phenomenon. Exploitation, harsh discipline, infanticide, ritual sacrifice and abandonment of children have existed for as long as history has been recorded and have been rationalized by religious beliefs, the need for birth control, and the need for forceful teaching methods. Over time, however, there has been an increasing recognition of the rights of children and the need for state intervention to protect these rights. Although they were only enforced in extreme cases, many of the thirteen American colonies had laws against certain forms of child maltreatment (Besharov, 1983). In 1875 the New York Society for the Prevention of Cruelty to Children was established and was the first agency with the specific purpose of discovering and assisting abused and neglected children. Early neglect statutes began to be adopted by state legislatures around 1825, and by 1920 most states had passed specific laws against child abuse and had juvenile court systems (Thomas, 1987). Finally, near the end of the 1930s most states had rudimentary systems of child welfare agencies (Besharov, 1983).
It was not until the 1960s, however, that child abuse was brought to public awareness and attempts were made to monitor it comprehensively. A small group of physicians, led by Dr. C. Henry Kempe, sponsored a symposium on child abuse in 1961 and proposed the concept of "the battered child syndrome," which spawned considerable public interest. This group went on to advocate that specified professions should be required by law to report cases of child abuse. In 1963, the U.S. Children's Bureau was persuaded to draft a model law that mandated physicians to report physical child abuse, and the states' rapid response was startling: within four short years, all fifty states had passed some sort of child abuse reporting statute (Thomas, 1987). Since that time, the reporting laws have been broadened to include different types of abuse and increased numbers of professionals required to report.

Mandatory reporting statutes have had a significant impact on the number of cases of child abuse or neglect that have been brought to the attention of authorities. The number of child abuse case reports in the United States jumped from about 7,000 in 1967 (Gil, 1970, cited in "Indiana Statutory Protection," 1974) to at least 652,000 in 1979 (United States Department of Health and Human Services, 1981). In Indiana, reports of abuse increased from 106 in 1967 (Gil, 1970, cited in "Indiana Statutory Protection," 1974), to 745 in 1973 (Indiana State Department of Public Welfare, 1973, cited in "Indiana Statutory Protection,"
1974), 29,344 in 1987, and 50,093 in 1990 (State of Indiana Office of the Governor, 1990). Of those cases reported in Indiana during 1990, 55.2% were substantiated or indicated, and there were 54 fatalities (State of Indiana Office of the Governor, 1990). It is unclear whether these numbers simply reflect an increase in the proportion of abuse cases which are reported or an increase in the actual incidence of abuse.

Because of the number of instances in which child maltreatment occurs in the population, mental health practitioners encounter this issue in a significant portion of their cases. This is particularly true when victims who seek treatment as adults are considered. In addition, the state has "recruited" mental health practitioners to become actively and officially involved in child abuse and neglect through the passage of mandatory reporting laws (Guyer, 1982). Despite these mandatory reporting statutes, studies suggest that a large proportion of practitioners are either unaware of the law or knowingly violate it. Swoboda, Elkwork, Sales, & Levine (1978) found that 17% of social workers, psychologists and psychiatrists combined were unfamiliar with the mandatory reporting law and 63% of those who were aware of the child abuse reporting law chose to break it anyway.

Similarly, the National Study of the Incidence and Severity of Child Abuse and Neglect (1981) found that professionals failed to report more than half of the
mistreated children that they encounter. Reasons cited for the lack of compliance with the mandatory reporting law include: ignorance of the law, fear of legal involvement, fear of retaliation from the client, and a belief that interfering with the therapeutic relationship to report abuse is more damaging than it is helpful.

Mental health professionals have become involved in the legal process through reporting suspected cases of child abuse, assessing the need for services for members of abusive families, and providing treatment services. The role of the mental health practitioner has been further expanded to include the gathering of evidence and the provision of testimony concerning whether abuse occurred (Melton and Limber, 1989). These diverse roles confront professionals with a variety of ethical, legal, and professional difficulties including determining what must be reported, concern about the impact of reporting on confidentiality and the therapeutic alliance, dealing with the issue of predicting future behavior, and maintaining the best interest of the client.

This chapter is intended to provide the practitioner with a rudimentary understanding of the many complex issues related to child abuse and how they affect the practice of psychology. The discussion begins with clarification of definitions of child abuse and the exploration of controversial issues in this area. This is followed by delineation of the current Indiana statutes concerning child
Definitions of Abuse

One of the most important but difficult issues in child abuse legislation involves the definition of abuse. Although there are many proposed definitions, they typically suffer from vagueness and ambiguity. The Child Abuse Prevention and Treatment Act of 1974, which established the National Center on Child Abuse and Neglect and required states to develop child protective systems in order to qualify for grants, also required state reporting laws to mandate the reporting of all forms of child maltreatment. Specifically, the Act defined abuse as:

The physical or mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of 18 by a person who is responsible for the child’s health and welfare under the circumstances which
While this definition appears to accurately reflect the concept of abuse, it is much too broad to be practically applied. As is evident in this definition, abuse is not a single phenomena but, rather, consists of a broad array of acts that range from emotional neglect to the infliction of fatal physical injury. The concept is typically divided into acts of commission, such as physical abuse, and acts of omission, such as negligence.

More specifically, child abuse has been categorized into the following types, although the explanations given for each should not be taken as broadly accepted definitions because there is still considerable disagreement in this area (ten Bensel, 1984; Wald, 1982; Watkins & Bradbard, 1982):

1) **Physical Abuse**: Infliction of nonaccidental physical injury to the child by a caretaker, irrespective of the likelihood of long-term harm, which is outside the realm of customary discipline procedures and which is not explained in a manner consistent with the child's history.

2) **Sexual Abuse**: Rape, molestation, incest, prostitution, or exposure of children to sexual contact or sexually exploiting situations by an adult, where the child's health or welfare is harmed or threatened.

3) **Physical Neglect**: Failure to provide a home environment that supplies the basic necessities of life, such as food, clothing, shelter, supervision, and protection from harm, to the extent that the child's physical well-being is endangered.

4) **Medical Neglect**: A caretaker's failure or unwillingness to provide medical treatment which would cure, alleviate, or prevent their child from suffering serious physical injury or emotional damage.
5) Abandonment: Failure of a caretaker to make provisions for the continued sustenance of the child.

6) Emotional Abuse: The active rejection of a child through constant statements and actions which communicate criticism, disrespect, and the denial of worth which thwarts the healthy personal and social development of a child.

7) Emotional Neglect: Failure of a caretaker to provide normal experiences which promote feelings of being loved, wanted, secure, and worthy, or failure to seek treatment for a child's symptoms of serious emotional damage which may or may not have been caused by the caretaker.

8) Educational Neglect: Failure of a caretaker to provide or enforce a child's opportunity to learn.

9) Contributing to Delinquent Behavior: Pressure to commit, guidance concerning, or approval of delinquent acts by a caretaker.

Given the range of behaviors and difficulties inherent in specifying what acts constitute abuse, it follows that the states vary in their definitions of abuse in terms of specificity, inclusion of emotional abuse, differentiation of reasonable corporal punishment from abuse, exclusion of spiritual treatment or nontreatment for religious reasons from the definition of medical neglect, inclusion of threatened harm, and restriction of the identity of the abuser (Meriwether, 1986).

As stated previously, a storm of controversy surrounds the definition of abuse. In addition, this is a critical issue because it is necessary for reporting statutes to adequately define abuse and neglect so as to clearly delineate what constitutes a reportable condition. While a substantial body of literature has been devoted to this topic, a full discussion is beyond the scope of this chapter and only the main points will be addressed here. The
interested reader is referred to Meriwether (1988) or Wald (1982) for comprehensive reviews of the complicated issues involved in the definitions of abuse and neglect.

A key issue which has been extensively debated is whether the definition of abuse should be broad or limited in scope. The argument focuses on whether protection should be provided to all children at risk or whether state intrusion into the family's privacy should be minimized. A broad definition facilitates the early identification and provision of services, yet may cause over-reporting. Indeed, approximately 50-60% of reports are found to be unsubstantiated (National Study on Child Neglect and Abuse Reporting, 1978; State of Indiana Office of the Governor, 1990) and some argue that intervention by the state is often harmful in and of itself (Goldstein, Freud, & Solnit, 1979). A practical dilemma exists between the potential squandering of already scarce resources on unsubstantiated reports and the possibility of early detection and, therefore, less drastic and less expensive intervention (Meriwether, 1986).

A second source of debate in the definition of child abuse is whether the focus should be on the behavior of the caregiver or on the harm to the child. Most state laws focus on parental behavior in their definition of child abuse. This approach recognizes the importance of the intentions of the perpetrator, the influence of chance factors, the need to identify potential harm, and the chance that some children may not immediately display readily
identifiable behavioral indices when they are the victims of sexual or emotional abuse (Meriwether, 1988). However, there are some authors, such as Wald (1982), who advocate the use of harm to the child as the focus of definitions of child abuse. He argues that limiting the definition of abuse to cases where specific harm to the child has occurred or is likely to occur reduces the risks inherent in predicting the effects of parental behavior and reduces the potential harm incurred by the intervention itself. Wald (1982) also points out that it is possible to be more specific about harm done to the child than it is to delineate potential problematic parental behavior. Meriwether (1988) proposes a compromise between the two positions, advocating the use of criteria based on harm to the child in reporting abuse and the addition of information concerning parental behavior in the investigation and remediation of cases.

In addition to these two major points, there are several other key issues concerning the definition of abuse. Many authors agree that definitions should include specific guidelines in order to assist reporters in accurately assessing whether a case is reportable in that state (Wald, 1982; Meriwether, 1988). It is also commonly agreed that the potential for harm should be included in definitions of abuse although some advocate the need to limit this to substantial risk of serious injury (Wald, 1982). Lastly, the great majority of families identified in neglect cases
are at or below the poverty level and many of their
difficulties are due to their financial problems (United
Considering this finding, many commentators suggest that
neglect should be defined in a manner which includes minimal
standards, such as failure to provide adequate food,
clothing, shelter, and medical care, in order to avoid
subjective judgments based on cultural biases of what
constitutes "adequate" parenting (Meriwether, 1988; Wald,
1982).

Indiana Statutes on Child Abuse

The State of Indiana provides protection for abused
children primarily through four types of statutes: statutes
governing the reporting and investigation of suspected cases
of child abuse, criminal laws which apply to the punishment
of the perpetrator of abuse, provisions under juvenile law
which allow abused children to be placed under protective
supervision or removed from the abusive home, and statutes
which provide a program of child welfare services for abused
and neglected children ("Indiana's Statutory Protection,"
1974). The statutes dealing with the reporting of child
abuse and neglect have the most implications for the mental
health practitioner, and it is these statutes which will be
presented and discussed. These statutes fall under Title 31
- Family Law, Article 6 - Juvenile Law, Chapter 11 - Child
Abuse. Therefore, the statute numbers will begin with 31-6-
11.
Definitions

An initial statute which is of primary concern to the practitioner is IC 31-6-11-2.1, Definitions. These definitions, however, are not self-contained in that they refer to other areas of family law and sex-related crimes. In the interest of clarity, these definitions will be consolidated to facilitate understanding, and the related statutes will be cited for the interested reader. The statute reads: "'Child abuse or neglect' refers to a child who is alleged to be (A) a child in need of services (as defined by IC 31-6-4-3(a)(1) through IC 31-4-3(a)(5))." It should be noted that situations which are considered abusive constitute only a subset of "children in need of services," and so a child can be "in need of services" without necessarily being considered abused. However, any child who is considered abused or neglected is also "in need of services."

Children are considered abused or neglected in the State of Indiana if they are under the age of 18 and their physical or mental condition is seriously impaired or endangered as a result of the inability, refusal, or neglect of their parent, guardian, or custodian to supply them with necessary food, clothing, shelter, medical care, education, or supervision. Children are also considered abused or neglected if their physical or mental health is seriously endangered due to injury by the act or omission of their parent, guardian, or custodian.
Children are also considered abused or neglected if they are the victim of the following sexual offenses: rape, criminal deviate conduct (which includes forced sexual acts other than intercourse), child molestation (which includes sexual intercourse, deviate sexual conduct, or the fondling or touching of the buttocks, genitals, or female breasts with a child under 12 years of age, or by a person 16 years of age or older with a person who is between the ages of 12 and 15), child exploitation (which includes the involvement with material which depicts or describes sexual conduct by a child under 16 years of age), child seduction (which includes sexual intercourse or deviate sexual conduct with a child who is either 16 or 17 years of age by the guardian, adoptive parent or grandparent, custodian or stepparent), incest (which includes sexual intercourse or deviate sexual conduct by an individual who is at least 18 years of age with a biologically related parent, child, grandparent, grandchild, sibling, aunt, uncle, niece, or nephew), public indecency, or prostitution. (IC 35-42-4-1, IC 35-42-4-2, IC 35-42-4-3, IC 35-45-4-4, IC 35-42-4-7, IC 35-45-4-1, IC 35-45-4-2, IC 35-46-1-3). Lastly, children are considered abused or neglected if the child's parent, guardian, or custodian allows the child to participate in an obscene performance (as defined by IC 35-49-2-2 or IC 35-49-3-2) or allows the child to commit public indecency, prostitution, patronizing a prostitute, promoting prostitution, or voyeurism (IC 35-45-4).
Other important issues related to child abuse and neglect are addressed in the statutes but are not actually considered abuse or neglect. These situations result in children being deemed to be "in need of services" but not considered abused or neglected. One situation which constitutes a "child in need of services" but is not considered child abuse or neglect in the State of Indiana is the failure to provide nutrition or medical treatment to a handicapped child if that intervention is generally provided to similarly situated handicapped or nonhandicapped children. There is also a section which specifically states that there is nothing in this chapter which limits the right of a parent, guardian, or custodian to use reasonable corporal punishment when disciplining a child. However, "reasonable corporal punishment" is in no way defined.

The issue of not providing specific medical treatment to children because of religious beliefs is also addressed in the statutes. It is stated that in this situation a child is not considered to be in need of services. However, when the life or health of a child is in serious danger the child can be considered a child in need of services and a juvenile court can order medical services when the health of the child requires such action. It appears, then, that there is a great deal of room for the discretion of the court in applying this statute, although the law does allow for state intervention if it is deemed necessary.

As can be seen by the delineation of what constitutes
abuse, the definition is fairly broad and there is a primary focus on the behavior of the parents. More specifically, the definition is aimed mainly at parental acts of commission or omission which result in physical abuse or neglect, sexual abuse, educational neglect, and medical neglect. Although there is reference to emotional harm to the child, there are no specifications for parental behaviors which would directly cause this harm, so it appears that emotional harm would occur indirectly as a result of the other types of abuse. Indeed, the State Department of Welfare is currently working on a definition of emotional abuse in an attempt to delineate a working clarification of "emotional harm," but this has not yet been completed or adopted.

The definitions for various types of sexual abuse are much more specific than those for other types of abuse and, therefore, this type of abuse is easier to categorize as a reportable condition. It is still difficult to gain knowledge of this type of sexual activity, however, but at least the law is clear in terms of what does and what does not constitute sexual abuse. For other types of abuse, though, the focus on parental behavior in the definitions makes it difficult for a professional to identify a reportable condition because their contact is typically with the child rather than the parent. In addition, "seriously impaired or endangered physical or mental condition" is rather vague and requires a great deal of subjective
evaluation except in extreme cases. This last point is especially true considering the intangibility of the concept of "mental condition."

While many authors advocate increased specificity in the definitions of abuse (Besharov, 1988; Meriwether, 1988; Wald, 1982), and this would make it much easier to identify abusive situations, this increased specificity has proved elusive. The best attempt was made by Besharov (1988) who produced a list of specific types of abuse much like that offered earlier in this discussion. In addition, he, like Wald (1982), focuses on "seriously harmful behavior" and realistically posits that minor assaults and marginally unfit child care should not be considered child abuse. Besharov (1988) points out that although everyone is eager to protect all children from all forms of maltreatment, society must begin to accept the fact that some children cannot be protected from abuse and neglect no matter what laws or procedures are adopted. In practice, too, unless there is evidence of the occurrence or the potential for serious harm to the child, the case is considered unsubstantiated. The Indiana statutes are consistent with these observations and include only "seriously" impaired or endangered conditions to be considered abusive. However, determining the degree of impairment or endangerment requires a great deal of discretion.

Mandated Reporting - Who and What Must Be Reported

The duty to report abuse is the next statute of
interest and it requires any individual who has reason to believe that a child is a victim of child abuse or neglect, as defined above in IC 31-6-4-3(a)(1) through IC 31-6-4-3(a)(5), to make a report (IC 31-6-11-3). A "child" is defined as anyone under the age of 18, so anyone less than 18 years of age who is suspected to be the victim of abuse or neglect must be reported as long as the perpetrator can be identified - whether the abuse occurred recently or 17 years ago. However, the law does not state whether there is a duty to report long past abuse of an adult patient (Stromberg et al., 1988).

While practitioners frequently learn of adult patients' childhood abuse, they are often unsure of whether they are required to report this to Child Protective Services. Since the law in Indiana does not address this issue directly, a practitioner would not be required to report past abuse of an individual who is over 18 years of age. However, if the perpetrator can be identified and there is a risk that the perpetrator could abuse or neglect other children, a practitioner may want to report in order to avoid any further abuse. The issues of liability for damages and the applicability of immunity in these cases is still unclear and has not been defined by case law. Therefore, practitioners should be cautious in these cases and seek legal counsel before reporting.

The relationship of the perpetrator to the child is also of importance in determining whether or not abuse or
neglect has occurred. In cases of suspected physical, emotional, medical or educational abuse or neglect, the perpetrator must be a parent, guardian, custodian or any person responsible for the child's welfare who is employed by a public or private residential school or foster care facility in order for the actions to be considered abusive. If any other person commits physically abusive actions it is considered battery and the case is handled by the police. However, in cases of suspected sexual abuse or rape any individual who commits a sexual offense against a child is considered to have committed sexual abuse and should be reported.

The degree of proof necessary to make a report is stated as "reason to believe," which means that the individual has evidence which would cause individuals of similar background and training to believe that a child was abused or neglected. Therefore, even if a practitioner does not have clear proof that abuse or neglect has occurred, he or she is still required to report the suspected abuse or neglect. In short, it is the job of Child Protective Services to investigate reports and attempt to prove whether abuse or neglect occurred, and mental health professionals are simply required to report suspected cases. Although many reports upon investigation are unfounded, the law clearly prefers false positives to false negatives (Stromberg et al., 1988). In addition to any individual being required to make a report, if a person is a member of
the staff of a medical or other public or private institution, school, facility, or agency, he or she has an additional duty to notify the individual in charge of the institution, school, facility or agency, who then also becomes responsible to report. Statute IC 31-6-11-4 specifies that this report should consist of an oral report to the local child protection service or law enforcement agency. Within the State of Indiana, most of the counties have a local Child Protection Service within the Department of Public Welfare which receives reports of abuse and implements Chapter 11 (IC 31-6-11-10). The local Child Protection Service receives complaints on a 24-hour hotline, and the phone number is listed in the white pages under "C" as Child Protection Service.

In addition to the initial oral report, any person required to report cases of known or suspected child abuse or neglect who is also a health care provider (which includes mental health professionals and social workers, in addition to various medical personal, and any persons working under the direction of these practitioners) or person in charge of a hospital or similar medical institution treating the child, is also mandated to have photographs taken of the areas of trauma which are visible on the child. If medically indicated, a physician may also do a medical examination or have a radiological examination performed. All photographs and examination results should be forwarded to the local Child Protection Service as soon
as possible, preferably within forty-eight hours, and the cost of the above procedures are reimbursable by the State Department of Public Welfare (IC 31-6-11-6).

Abrogation of Evidentiary Privileges

The mandatory reporting law poses special problems for the practitioner because it is directly contradictory to privilege laws which protect certain professionals from being forced to reveal any confidential communications in court. Privilege laws are basically an exception to an important principle of law which holds that the courts are presumptively "entitled to every man's evidence" (Weisburg & Wald, 1984). Privileged communication typically applies to the lawyer-client, physician-patient, husband-wife, and psychotherapist-client relationships based on the logic that certain relationships which are dependent on mutual trust are crucial for the welfare of society, and, therefore, should be protected. The mandatory reporting law also conflicts with the related concept of confidentiality which is an ethical standard that obliges a professional not to disclose information about a client to anyone (APA, 1990).

This conflict between the mandatory reporting law and privileged communication is addressed in IC 31-6-11-8, "Privilege Communications; Abrogation" which was recently amended in 1988. This statute holds that the privileged communication between a husband and wife, health care provider and patient (which includes mental health practitioners and social workers), or a school counselor and
student is not a ground for failure to report child abuse or neglect. In addition, it states that privilege is not a ground for excluding evidence in any judicial proceeding resulting from, or relating to, a report of abuse or neglect. Although the law directly addresses this issue, its application is not clear and many ethical issues still plague the mental health practitioner who is considering making a report. A fuller discussion of these ethical dilemmas will be included in a later section of this paper.

**Immunity for Reporters**

The law is clear in stating that any person, other than a person accused of child abuse or neglect, who makes a report of suspected abuse, detains a child for the taking of photographs or medical examinations, or participates in any proceedings resulting from the report is immune from any civil or criminal liability that might otherwise be imposed because of such actions. A person making a report of abuse or neglect is presumed to have acted in good faith, but if a person has acted maliciously or in bad faith immunity does not apply (IC 31-6-11-7). Therefore, a health care practitioner in psychology who reports child abuse is protected from being sued for a breach of confidentiality or harm caused by the report.

However, mental health practitioners need to be aware that this immunity holds only for the report of suspected abuse or neglect to child protective services or the police and does not apply to collateral communications. In other
words, a practitioner would not be able to tell other individuals or clients of the potential danger of getting involved with a suspected perpetrator—whether the case was substantiated or not (Stromberg et al., 1988).

Sanctions for Failure to Report

In the State of Indiana, any person who knowingly fails to make a report of suspected child abuse or neglect commits a Class B misdemeanor. In addition to the above requirement, any person who is a member of the staff of a medical or other public or private institution, school, facility, or agency who knowingly fails to report the suspected abuse to the individual in charge of the facility commits an additional Class B misdemeanor. Similarly, if the individual in charge of such a facility fails to make a report of suspected abuse after receiving such information, he or she also commits an additional Class B misdemeanor (IC 31-6-11-20). Basically, then, most mental health professionals who fail to make a report of suspected abuse or neglect commit two counts of a Class B misdemeanor. By doubling the potential sanctions for professionals who fail to report abuse, the state is attempting to ensure that professionals assume responsibility in order to increase the likelihood that a child who is being abused or neglected will be identified.

In addition to sanctions for failure to report abuse, any individual who knowingly falsifies child abuse or neglect information or records also commits a Class B
misdemeanor (IC 31-6-11-21). Therefore, information given concerning a suspected case of child abuse must be true to the best of the reporter's knowledge. The penalty for a Class B misdemeanor in the state of Indiana is imprisonment for a fixed term of not more than 180 days. In addition, a fine of not more than $1,000 may be assessed (IC 35-50-3-3).

While criminal prosecution for failure to report is quite unlikely and virtually only occurs in extreme cases or fatalities, it serves to encourage reporting and may be used as a justification for the report ("Indiana's Statutory Protection," 1974; Smith & Meyer, 1984).

The practitioner should also be aware that in addition to legal requirements, Standard 2.2.4 of the General Guidelines for Providers of Psychological Services (APA, 1987) states that providers of psychological services should conform to relevant statutes and Principle 3d of the Ethical Principles of Psychologists (APA, 1990) requires psychologists to adhere to relevant governmental laws unless the laws are in conflict with Association standards and guidelines. Therefore, failure to report could be considered an ethical violation and could result in disciplinary action by the Indiana Psychology Board as well. Although it is unlikely that a psychologist would be charged with an ethical violation for failure to report suspected child abuse or neglect, the knowledge that it actually does constitute an ethical violation may encourage more psychologists to report.
Lastly, a health service provider in psychology who fails to report a suspected case of child abuse or neglect may become the target of a civil suit. The practitioner might be found liable for damages that resulted from the failure to report, and liability would be based on malpractice, negligent or otherwise (Schockmel, 1987). A benchmark case which occurred in the state of California (Landeros v. Flood, 1976) set the precedent that failure to report may leave the practitioner civilly liable if there are repeated incidents of abuse subsequent to the unreported incident (Heymann, 1986).

**Child Protective Services Procedures**

The procedures which the Child Protective Service must follow in receiving, investigating, and intervening in cases of reported child abuse and neglect are set forth in IC 31-6-11-11. Although these guidelines cover general regulations of the investigations and handling of child abuse and neglect cases, each county Department of Public Welfare drafts its own local plan for the provision of child protection services which is submitted for approval to the administrator of the State Department of Public Welfare (IC 31-6-11-10(f)). So, although the procedures described below are generally applicable, there may be some variation from county to county, and the mental health practitioner is urged to inquire about the local policies in his or her area.

Basically, upon receipt of an oral report, the Child
Protective Service is required to begin an investigation of all cases of suspected child abuse within 24 hours, unless there is immediate danger to the child's safety or well-being, in which case the investigation is begun at once. Investigations of cases of suspected neglect must begin "within a reasonably prompt time," which is within 15 days in District 6. Anonymous reports are accepted and investigated, but the professional might prefer to be named in order to prove that the obligation to report was fulfilled.

A written report of a child who is suspected to be the victim of abuse or neglect is required of the Child Protective Service within 48 hours of the receipt of the oral report. In addition to identifying information, such reports must include the following information, if it is known: evidence of prior injuries, abuse or neglect of the child or siblings; the name of the alleged perpetrator; the source of the report and how to reach him or her; the actions taken by the reporter such as the taking of photographs or x-rays, removal or keeping of the child, or notifying the coroner; and any other information which is felt to be necessary or which is offered by the reporter. A copy of this report is immediately made available to the appropriate law enforcement agency, the prosecutor, and, if necessary, the coroner.

After the oral report is received, the Child Protective Service is required to have color photographs taken of the
areas of trauma visible on a child and, if medically indicated, to have a radiological examination performed if these steps have not been taken by the reporter. A thorough investigation is then completed which includes, to the extent that is reasonably possible: the nature, extent, and cause of the abuse or neglect; the identity of the perpetrator; the names and conditions of other children in the home; an evaluation of the person responsible for the care of the child; the home environment and the relationship of the child to the person responsible for the child's care; and any other pertinent information. The investigation may include a visit to the child's home, an interview with the child, and a physical, psychological, or psychiatric examination of any child in that home. The Child Protective Service is then required to make a written report of the investigation which includes their recommendations. These reports are made available to the court, the prosecutor, or the police.

If during the investigation it is decided that immediate removal of the child from the home is necessary to protect the child from further abuse or neglect, the juvenile court may issue an order for such removal. If there is no threat of immediate danger, however, there are several different ways for the Child Protective Service to proceed depending on the degree of cooperation offered by the family or perpetrator. If the family voluntarily consents to participate in services and there is no grave
danger, an "informal adjustment" is made in which the child remains in the home and the family signs an agreement to participate with services and to guarantee the child's safety. Services offered by Child Protective Services include homemakers, parent training, intensive case management, and family therapy. During the informal adjustment the family or guardian retains legal custody which means that Child Protective Services would have to file for wardship in order to later remove the child from the home.

If it is determined that there is a higher risk of the recurrence of abuse or neglect than in cases which can be informally adjusted, Child Protective Service files for wardship through the juvenile court. Upon the granting of wardship, a predispositional report is filed which delineates what treatment is needed for the care and rehabilitation of the child and what participation is expected of the parent or guardian. There are many stipulations within the law to allow the parent or guardian additional chances to comply with treatment in order to preserve the family and reduce the number of children who are removed from their natural homes. There are two types of wardship, the first of which is supervisory. Supervisory wardship is similar to an informal adjustment in that the child remains in the home, but the Department of Welfare has legal custody and can remove the child from the home quickly if necessary. The second type of wardship is called regular
wardship and consists of foster placement.

Child Protective Service reviews each case in six months and, if at the end of 18 months the case still cannot be closed, termination of parental rights is seriously considered. Termination of parental rights can be voluntarily sought by the parents or may be sought against their will, but only a small percentage of cases actually get to this stage due to the court's preference for keeping the family intact and the stringent requirements that must be met (IC 31-6-5). In order for parental rights to be terminated it must be proven by the Child Protective Service that: the child has been removed from the parent for at least six months under a dispositional decree; there is a reasonable probability that the conditions that resulted in the child's removal will not be remedied or that the continuation of the parent-child relationship poses a threat to the well-being of the child (which can be assumed if the parent or guardian is convicted of such crimes as murder, battery, or sexual offenses against a child under the age of 16); termination is in the best interests of the child; and there is a satisfactory plan for the care and treatment of the child.

All of the above proceedings are classified as civil actions and are typically heard in the Juvenile Court. However, Child Protective Service may also determine that action in the criminal court is required and refer the case to the prosecutor for criminal prosecution. However, it is
widely recognized that criminal prosecution of perpetrators of child abuse is not an effective deterrent, and criminal prosecution typically only occurs in severe cases ("Indiana's Statutory Protection," 1974). Perpetrators of child abuse or neglect in Indiana can be prosecuted under general criminal law provisions for homicide (IC 35-42-1), battery (IC 35-42-2), and sex crimes (IC 35-42-4), or under a set of statutes dealing with offenses against the family which includes neglect of a dependent, contributing to the delinquency of a minor, and exploitation of a dependent (IC 35-46-1).

Whenever the Child Protective Service receives a report of suspected child abuse or neglect from a hospital, community mental health center, physician, or a school, the Child Protective Service sends a report to the administrator of the facility or to the referring physician within 30 days. Another report is sent out within 90 days after the receipt of the report including any additional information which had not been covered in the first report. The report must include demographic information, the status of the case, the placement of the child, whether wardship was established, whether criminal action is pending, any casework plan which has been developed, and a caseworker's name and telephone number.

Record-Keeping and Confidentiality of Records

There are no provisions in the law of the State of Indiana for the collection of all reports of abuse or
neglect in a central registry. This is unfortunate because central registries are useful in assisting child protective service workers in assessing how much danger a child is in by quickly accessing previous reports on the same child or his or her siblings. Patterns of suspicious injuries are highly indicative of abuse, and only through a central indexing of reports can this information be readily accessible. Abusive families typically utilize many different medical resources and may move frequently to avoid getting caught, and a central registry is an invaluable tool in tracking these families and previous reports against them. In addition, central registries can be used to monitor cases and assist in assuring that investigations and reports are properly conducted in a timely manner. Central registries are also helpful in conducting research concerning abuse and its treatment (Fontana & Besharov, 1977). Although there is no central registry, IC 31-6-11-18(b) does allow disclosure of information of a general nature or case histories of child abuse and neglect to qualified individuals who are engaged in good faith research projects.

Despite the lack of a central registry in Indiana, the law does address the expungement of child abuse or neglect information if it is determined to be unfounded after an investigation by the child protection service or a court proceeding (IC 31-6-11-5(b)). Indiana also has confidentiality provisions to protect information, reports,
or photographs in the possession of the Child Protection Service concerning child abuse or neglect cases (IC 31-6-11-18). Specifically, these records are considered confidential and the statute explicitly lists various individuals and agencies which may have access to them. Generally, these are people who are either investigating a suspected case of abuse or neglect, treating a child or family involved in a case, or are responsible for the welfare of a child who is a victim of abuse or neglect.

Of interest are the stipulations that allow alleged victims and the parents, guardians, or custodians of a child named in a report or record to have access to the reports. This is important for practitioners in that their reports may be read by their clients - both the child and the parents - and so the working relationship could be severely affected. However, there is also a stipulation that when the parents, guardians, or custodians of a child named in a record are given access to the record the identity of the reporters and other appropriate individuals will be protected (IC 31-6-11-18(a)(7)).

Another limitation in the statutes which protects the practitioner who is involved in cases of child abuse or neglect is IC 31-6-11-18(a)(8) which states that although courts have access to records, the access is limited to in camera inspection unless public disclosure is absolutely necessary. The translation of this statute into practice in most counties is that when the report of a mental health
professional is entered into evidence at any stage of the judicial proceedings, except the termination of parental rights, typically only the attorneys and judge have access to it. The parents do not see the report in order to protect the potential benefits of the therapeutic relationship. However, there is always the possibility that public disclosure of the report may be required, and, even if the report is limited to in camera inspection, the practitioner may be called upon to testify.

The Role of the Mental Health Practitioner

Until recently, the role of the practitioner was limited to the beginning and end of the legal process in cases of child abuse and neglect. A mental health professional may have initiated a report of abuse but was not involved in the investigation itself. After a report was substantiated, a practitioner was typically called in to assess the child and family's need for services or, quite often, to implement the court's decision that treatment was indicated (Melton & Limber, 1989). While these types of involvement in cases of child abuse and neglect continue, practitioners are increasingly being asked to become involved in the investigatory process by interviewing the child and assisting in gathering evidence. Mental health professionals are also involved at the adjudication phase of child maltreatment cases in order to assist in determining whether abuse occurred (Melton & Limber, 1989). Opinions concerning the potential of the perpetrator to benefit from
treatment and recommendations for the placement of the child may also be requested from practitioners. In addition, mental health professionals may be called upon to assist the courts in determining what constitutes "emotional harm or abuse" since this category of abuse is particularly poorly delineated in the statutes (Guyer & Ash, 1985).

Basically, there appear to be primarily two different roles of the practitioner in cases of child maltreatment: required, potentially reluctant, involvement and voluntary service provision. In the first case, the practitioner is initially involved in a therapeutic relationship with the child or family but is required to report or testify as to direct evidence of suspected maltreatment. The practitioner does not want to breach confidentiality more than is required by law and is ethically and legally bound not to, and will typically offer only information which is directly related to evidence of abuse or neglect. A mental health professional who is called in to cases of maltreatment after the report has been made, however, is in a different position. This practitioner is really working for the court, and while this position needs to be clarified to the client and is difficult to navigate, confidentiality does not apply because the court will require periodic reports. Therefore, in these cases the professional can potentially provide the court with a broad range of information which Weisburg and Wald (1984) refer to as indirect evidence.

The indirect evidence that mental health practitioners
can provide to the courts includes knowledge concerning conditions of the parent or guardian, such as substance dependence, which may influence their ability to adequately care for the child. In addition, a practitioner who has worked with a parent or guardian may be able to advise the court on their receptivity to treatment or their past violent behavior which is unrelated to the child. Also, a parent or guardian may have made statements which would assist in determining whether abuse occurred or whether a dispositional plan is realistic (Weisburg & Wald, 1984).

**Scope of the Mandatory Reporting Law**

Although the types of information which a mental health professional may provide have been divided here into required direct evidence and voluntary, direct or indirect evidence, the distinction is very crude. In fact, the exact scope of the mandatory reporting law is quite unclear. The law states that "any individual who has reason to believe that a child is a victim of child abuse or neglect shall make a report" (IC 31-6-11-3) and that privileged communication is not grounds for failure to report or for "excluding evidence in any judicial proceeding resulting from a report" (IC 31-6-11-8). What exactly constitutes "evidence" has not been clarified.

In order to address the question of exactly what needs to be reported, the laws concerning confidentiality and release of mental health records must be considered. Although these issues are very complex, the ways in which
these issues impact on reporting requirements and child abuse proceedings will be briefly discussed. The law obviously requires mental health professionals to report suspected cases of child abuse. After a report is made, however, the record is sealed and can only be released with signed consent or following a hearing which results in a court order to disclose the record. A subpoena is not sufficient to compel a practitioner to release the record and, unless an emergency exists in which a child is alleged to be a child in need of services, proceedings for access to a patient's mental health record are subject to the Indiana Rules of Trial Procedure.

If an emergency does exist, and the county Department of Public Welfare seeks access to the mental health records of the parent, guardian, or custodian of the child, the department may file a verified petition which sets forth the facts which allegedly constitute an emergency to request an emergency hearing. Under these circumstances, the court may order the release of the mental health records if the court finds, by a preponderance of the evidence, that there are no other reasonable methods of obtaining the information and that the need for disclosure outweighs the potential harm to the patient caused by a necessary disclosure. In weighing the potential harm to the patient, the court must consider the impact of disclosure on the provider-patient relationship and the patient's rehabilitative process (IC 16-4-8-3.2(h)).
Therefore, the laws and procedures discussed above reveal that while practitioners are clearly required to report suspected cases of child abuse or neglect, they can only be required to provide additional information after extended legal proceedings. In addition, mental health professionals would be wise to only offer information after receiving a court order, because immunity applies only to information which is required.

**Expert Witness Testimony**

Mental health professionals can be involved in informal communications with the child protective service, may write reports for the court, or they may need to testify at hearings or judicial proceedings. While a full discussion of expert witness testimony is beyond the scope of this paper, some of the issues concerning testimony which bear specifically on child maltreatment cases will be reviewed briefly.

In formal proceedings, practitioners may be called upon to provide testimony concerning their credentials in order to qualify as an expert. Once established as an expert, the witness may testify concerning opinions or conclusions in his or her areas of expertise rather than being restricted to matters of fact as is an ordinary witness (Guyer & Ash, 1985). Several different sorts of opinions may be requested of the expert witness during the adjudication phase of child abuse and neglect cases, and the admissibility of many of these opinions is controversial. It seems to be widely
accepted, however, that testimony concerning the characteristics of abusers which is intended to infer similarity of the defendant to people who have abused children is inadmissible unless the defendant enters such evidence first (Melton & Limber, 1989).

Slightly more controversial is testimony concerning the characteristics of abused children. Testimony of this type intended to clarify aspects of the child victim's behavior which appears confusing, such as delay in reporting or retraction of an accusation, has typically been admitted when the child victim's credibility has been challenged. Testimony concerning abuse syndromes which is offered to demonstrate that a child fits the profile of an abuse victim has also tended to be admitted as long as the expert witness does not go so far as to state an opinion concerning the credibility of a specific child (Melton & Limber, 1989).

Ethically, this type of testimony is acceptable as long as the expert witness communicates the limits of knowledge such as the utilization of base rates and the validity of the findings (APA, 1990; Melton & Limber, 1989).

Another type of testimony, that concerning whether a specific child has been abused or has told the truth, has been unanimously determined to be inadmissible. Legally, an expert witness is determined to possess expertise in areas of mental health and is not qualified to render opinions on the ultimate issue - whether or not the defendant is guilty (Melton et al., 1987). Ethically, this type of testimony
would constitute a violation because it misrepresents a legal and moral decision as a scientific or clinical judgment. Therefore, the opinion of an expert witness concerning whether a particular child has told the truth or has been abused should not be sought by lawyers, should not be admitted by judges, nor should it be offered by mental health professionals in the form of testimony or a report to the court (Melton & Limber, 1989).

Similarly, mental health professionals may be asked whether abuse is likely to recur. While the practitioner may make statements concerning a parent’s progress or potential to benefit from treatment, the ability of mental health professionals to predict future behavior – especially future violent behavior – is notoriously dubious (Monahan, 1984). Therefore, a practitioner would be overstepping the bounds of competence to make absolute statements concerning whether or not abuse will recur.

Legal, Ethical and Procedural Difficulties

The relatively new mandatory reporting laws and accompanying legislation have far-reaching implications and touch on beliefs concerning the privacy of the family, cultural differences in what constitutes adequate parenting, and the rights of children to be protected from harm (Guyer, 1982). In addition to these philosophical concerns, the issues surrounding child abuse arouse strong emotional reactions in the public, the legislature, and within mental health practitioners themselves (Melton & Limber, 1989).
Amid this social and emotional backdrop practitioners are faced with numerous ethical dilemmas concerning how they can comply with the law, thereby protecting children, but do so within a therapeutic framework which is consistent with their clinical judgment. This "minefield of ethical problems" (Melton & Limber, 1989, p. 1226) is especially troublesome for practitioners who provide psychotherapy for clients who seek treatment voluntarily, because the law requires an intrusion into the privacy of the therapist-patient relationship and results in a breach of confidentiality (Guyer, 1982).

Added to these ethical concerns, the child abuse statutes are insufficiently detailed and have not yet been clarified through case law, leaving the mental health practitioner with new legal risks and responsibilities but giving little guidance as to how these responsibilities are to be carried out. In addition, the mandatory reporting laws take an all-or-none approach which ignores many issues and situations that are inherently part of the real-life reporting which practitioners face in their professional practice. For example, one issue which is not addressed in the statutes is when and under what circumstances the suspected abuse or neglect occurred. As Heymann (1986) points out, cases differ in terms of whether the abuse is current, whether the abuse was ongoing or an isolated incident, and whether the perpetrator is voluntarily seeking treatment. Certainly this variety among cases should lead
to differences in treatment and cannot be ignored.

Another dilemma stemming from reporting statutes is whether the law serves the best interests of the client. The law requires mental health professionals to make immediate reports of suspected abuse without regards to the appropriateness of doing so or the consequences of the report (Heymann, 1986). Will the report actually protect the child from further harm, what will the report do to the therapeutic alliance with the child or the family, and will the intervention of child protective services be beneficial to the child?

These questions represent serious moral and clinical concerns which are typically not addressed by the law but which confront the practitioner who is faced with a reportable situation of suspected child abuse. As Heymann (1986) points out, by reporting these situations we set into motion a series of events which are completely beyond our control. Legally, there are no provisions which require that mental health practitioners be included in the resolution of the investigation, nor are child protective service agencies required to consider or follow any recommendations made by professionals. Therefore, it is difficult to predict what will happen after a report is made and whether these results will be beneficial or potentially harmful to the child.

The discussion will now turn to a full examination of the difficulties concerning confidentiality in cases of
child abuse and neglect. In addition, other procedural and ethical concerns will be examined and specific suggestions will be offered concerning how practitioners can address or avoid some of these difficulties. This will be followed by a discussion of some of the consequences of intervention by child protective services, including evaluations of foster care placements, which is intended to assist practitioners in weighing different treatment approaches.

Confidentiality

As has been stated previously, one of the most difficult conflicts for mental health practitioners in cases of suspected child abuse and neglect is that between the legal requirement to report and the ethical and clinical needs to maintain confidentiality. This conflict is most problematic when a therapist learns that an ongoing patient is currently engaging in child abuse, but it can also be a dilemma when a therapist becomes aware during the course of psychotherapy that a child-patient is being abused. If the suspicion is reported, the necessary trust could be broken and the therapeutic relationship with either the parent or child could be destroyed. On the other hand, if the professional fails to report, he or she could be held liable for any resulting damages and may be found guilty of criminal charges (Guyer, 1982).

The law is clear in stating that the practitioner must report any suspected cases of child abuse or neglect. However, the social role of mental health professionals is
to assist people with their personal problems within a trusting and private relationship. This role and the accompanying expectation of confidentiality have been passed down over the ages from priest to physician to therapist, and are legally sanctioned by privilege laws (Heymann, 1986). However, if within this trusting relationship the client reveals child abuse, the therapist is transformed into a police agent. As Heymann (1986) states, "[t]he client is still the same person, but there has been a sudden and drastic switch in social roles, whereby the therapist exits and the informer bursts in at the door" (p. 152).

While mental health professionals are not comfortable with this exception to the privacy typically afforded their services, society has apparently determined that the prevention of child abuse is of higher priority. Therefore, until the law changes, practitioners must focus on how to best manage their reporting obligations within the present system.

In order to prepare for cases where during the course of therapy the therapist becomes aware of abuse or neglect, the practitioner should inform the client of confidentiality and its limits prior to the onset of treatment. While this practice is wise in light of the mandatory reporting laws, it is also an ethical obligation as stated in Principle 5 of the Ethical Principles of Psychologists: "[w]here appropriate, psychologists inform their clients of the legal limits of confidentiality" (APA, 1990). Clients should be
informed that a practitioner is required to report abuse but that the release of further information can only be compelled after a great deal of effort and proof of necessity. Therefore, the chances of the record being disclosed are relatively small. Although informing the client of this slight risk regarding breach of confidentiality may inhibit their disclosures within therapy, this is certainly less detrimental than blatantly betraying a client's trust without prior warning.

Apprising a client of the limits of confidentiality is not the same as telling a client not to reveal information concerning abuse because the practitioner does not want to have to report it. In addition, if a mental health professional begins to suspect abuse during the course of treatment, after an explanation of the limits of confidentiality was given at the outset of therapy, that suspicion must be reported whether or not additional details are gained. An additional warning not to reveal information concerning abuse at this stage will not avoid the need to report the suspected abuse, nor is it in line with sound clinical judgment. Treating an individual who is either abusing or being abused while ignoring the abuse and the related issues cannot be especially beneficial regardless of the clinical utility of reporting abuse.

In cases where the mental health professional is called in to perform an assessment, assist in gathering information, or to provide treatment, confidentiality is
much more limited. When clients are voluntarily receiving services the practitioner needs to inform them that their records may be requested by a court order and that confidentiality cannot be assured. In cases where clients are court-ordered to receive services, the court will be receiving records and periodic updates concerning treatment progress, and so clients must be fully informed of the absence of any privilege or confidentiality. In addition, clients should be advised that the information which they share may be used in a manner adverse to their interests and that they do not have to participate or respond to questions if they do not wish to do so. Only when this information is provided to clients can they give "informed consent" to treatment, and it might be beneficial for the practitioner to obtain this consent in written form.

How can the mental health practitioner inform a client about a lack of confidentiality and still develop a therapeutic alliance? The waiver of confidentiality must be handled skillfully and tactfully so that the client is not frightened away from the therapeutic relationship. Basically, the practitioner can assist the parent in understanding that working with the therapist is an important part of evaluating their ability to change and benefit from treatment, and that this ability needs to be demonstrated in order to regain custody of their child. The practitioner must attempt to ally with the parent's desire to improve, and demonstrate ways in which he or she can
assist the parent regardless of the lack of confidentiality (Guyer & Ash, 1985). In addition, labeling and blaming need to be avoided, individual rights must be respected, and sides within the family should not be taken by the practitioner.

Requiring mental health professionals to report suspected abuse to local authorities runs contrary to their typical role of advocacy and support. Because of these conflicting roles and the multitude of ways in which practitioners become involved in cases of child abuse and neglect, the nature of their involvement becomes clouded not only for the professionals themselves but for the families, child protective service agencies, and courts as well. Therefore, in order not to misrepresent themselves, it is always necessary for mental health professionals to assess their function and the legal requirements of the situation, and to clearly define their role to all parties involved at the outset (APA, 1989; Melton & Limber, 1989; Guyer & Ash, 1985). A practitioner needs to determine whether they are functioning as an evaluator, an investigator, or a therapist, and to clarify who the client is - the child, parent, court or child protective services. In addition, the accompanying limits of confidentiality must be realistically apprised and communicated to the client, and the matter of fees for services should be expressly addressed at the outset.

In order to decrease the likelihood of
misunderstandings concerning roles or expectations, it is prudent for the mental health practitioner to limit his or her involvement in cases of child abuse and neglect to one role - be it investigative, evaluative, or therapeutic (Melton & Limber, 1989). Clearly, using one's therapeutic role to foster trust from a parent in order to gain additional information which will be used to terminate parental rights is a mixture of roles and a misrepresentation, and constitutes an ethical, and perhaps a legal, violation. In addition, the practitioner needs to maintain his or her chosen role in order to remain objective. The mental health professional must conduct assessments and make recommendations independent of pressures from the child protective services and must avoid getting carried away in unwarranted enthusiasm for the return of a child to a home of questionable safety.

Consequences of Intervention

An accusation of child maltreatment and the involvement of the child protective service in itself can have deleterious effects on the family. No matter how tactfully or delicately the investigation is handled, the essential message given to the parents is that they have failed as parents. And, for many adults, the role of parent is central to their identity. The response of a parent to an investigation of child abuse may include anger at the investigator or reporting source, fear of losing their children, feelings of helplessness or hopelessness, or self-
doubt (Faller, 1985). In addition, the investigation itself can further increase the stress level in the home which leaves the child at greater risk than before.

Beyond the negative consequences of the investigation itself, the efficacy of various interventions is crucial in treatment planning. Unfortunately, however, there is very little reliable data concerning the interventions which are typically used. The literature consists mainly of theoretical works and clinical studies, and there is basically no longitudinal research concerning the impact of different interventions (Faller, 1985). In addition, what research there is tends to be conflicting and inconclusive.

As reporting increased and the existing treatment programs were unable to meet the demands posed by severely disturbed parents, the use and duration of foster care increased to an estimated 300,000 children in foster care at any one time (Besharov, 1983). While it intuitively would seem to be desirable to rescue maltreated children from a poor environment through foster placement, it has become widely recognized in recent years that foster care is not stable nor typically therapeutic (Besharov, 1983; Brown & Riley, 1984; Goldstein, Freud, & Solnit, 1979; Wald, 1982). Theoretical works and clinical findings indicate that children are typically strongly attached to their parents— even bad parents—and that interference with these bonds can damage a child (Wald, 1982). In addition, children are often moved through a series of foster homes, the quality of
which varies widely, and their emotional needs are typically
not met. Finally, while foster care is supposed to be a
short-term remedy to protect children from harm while their
parents undergo treatment, it is often a long-term placement
due to a lack of other alternatives and an unwillingness on
the part of child protective service to pursue the
termination of parental rights. Therefore, while some
children do benefit from foster care placement, there is
enough evidence concerning the potential negative
consequences to merit a cautious policy concerning its use.

The reliance on foster care is partly due to the scant
resources of child protective service agencies. Due to high
caseloads, workers typically are only able to investigate
reports and loosely monitor families. Very few communities
have more intensive treatment programs or are even able to
provide intensive supervision (Faller, 1985). Families may
be referred to other agencies for treatment, but such
agencies typically take a traditional approach to treatment
which is not well-suited to the majority of protective
service population. "Talking therapy" which takes place in
an office and which typically does not address concrete
problems is difficult for this clientele to identify with
and participate in. These parents tend to be overwhelmed by
their current situations and typically lack the motivation,
capacity for insight, and verbal skills necessary to form
therapeutic alliances with professionals who use a
traditional therapeutic approach (Faller, 1985). Rather, a
"hands on" approach in which the practitioner goes out to the families' homes and addresses concrete problems such as unemployment, inadequate housing, and parenting skills would appear to be more useful (Faller, 1985).

Conclusions

It is apparent, then, that the area of child abuse and neglect presents the mental health practitioner with a mass of difficulties and dilemmas. The scope of the reporting law and the boundary between reporting and maintaining confidentiality are vaguely addressed in the statutes and have not been delineated through case law. While these issues remain "... in a kind of legal limbo" (Heymann, 1986, p. 147), the mental health practitioner is left pretty much on his or her own when faced with the duty to report child abuse or neglect. In addition, the question of how to best intervene in cases of abuse or neglect has yet to be adequately answered. None of the interventions currently used have been found to be broadly effective, nor have determinations been made concerning which families may respond to what treatment (Faller, 1985).

However, there are steps which practitioners can take to better deal with cases of child abuse and neglect. First, knowing the reporting laws, the procedures of the child protective service agencies, and how to identify abuse and neglect will allow the professional to make informed decisions. In addition, the practitioner can prepare for
the potential of having to report a suspicion of abuse by
advising clients of the limits of confidentiality at the
outset of treatment. A professional can also be more
flexible in the treatment of protective service cases by
using a more "hands-on" approach which addresses concrete
issues and in-home parenting skills training. Lastly, a
mental health practitioner who is uncomfortable with the
lack of confidentiality inherent in the treatment of
protective service families can refuse the courts' requests
to provide services in substantiated cases.

Although the difficulties in the area of child abuse
and neglect may seem overwhelming and the option of
decaying involvement in these cases may be tempting, the
continued avoidance of this issue by mental health
practitioners will not make it go away. And while the
efforts of legislators, the police, and the public are
certainly well-intentioned, who is better suited to make
judgments concerning the best approach to the treatment of
abusive families than mental health professionals?
Therefore, practitioners need to get involved in issues
concerning abuse and neglect, and need to communicate their
concerns and opinions to legislators and the public.
Specifically, professionals need to push for more detailed
definitions of abuse in the statutes, more clearly
delineated boundaries of the reporting law, less reliance on
foster care, and more emphasis on intensive case-management
and parent skills training. In addition, mental health
professionals need to make the extensive deleterious effects of child abuse clear to legislators in an effort to gain the support and funding which is necessary to provide the needed services.
Chapter 3

ABUSE OF ENDANGERED ADULTS

The oldest laws intended to protect vulnerable adults are those related to guardianships and conservatorships. These laws stem from English laws which granted kings the authority to make decision regarding adults within the kingdom who were less than capable of managing their own affairs. The idea behind these laws has developed into the doctrine of parens patriae, which holds that society is responsible for the care of individuals who are unable to care for themselves (Quinn, 1985). While the doctrine of parens patriae has existed for a long time, it did not develop into official adult protective services until 1935, when the Social Security Act was passed and public welfare departments and private agencies began providing services to the aged poor.

Despite this initial acknowledgement of the vulnerability of elders, it has not been until recently that public awareness has grown and been extended to include the abuse and neglect inflicted on some elderly by their own caretakers. This type of maltreatment has been compared to other forms of domestic violence, and the legislative
response has been largely based on child abuse laws. In the 1960s, child abuse was a central focus of societal concern and it was during that decade that the majority of child abuse laws were developed and enacted. Similarly, spousal abuse garnered significant attention in the 1970s. It was not until the late 1970s and the 1980s, however, that abuse of endangered adults received considerable social recognition and legislative attention (Ambrogi & London, 1985).


Since that time, essentially every state has developed some form of adult protective service agency and has provided for adult protection in their statutes (Hunzeker, 1990). Mandatory reporting, enhanced penalties for crimes committed against endangered adults, and special statutes protecting elders from consumer fraud constitute various
legal responses which have been developed in some states to better protect endangered adults. However, the definitions of elder abuse, specifications concerning the setting in which abuse occurs, who must report, the presence of enhanced penalties for crimes against the elderly, and the specification of penalties for abuse or for the failure to report suspected abuse vary considerably from state to state.

Although the 1981 U.S. House Select Committee on Aging report stated that elder abuse occurs with almost the same frequency and rate as child abuse, the incidence of abuse of endangered adults is significantly lower than that for child abuse. Data on the national incidence of abuse and neglect of the elderly are sparse, however, and the first methodologically sound prevalence study was conducted in the Boston metropolitan area in 1990 (Pillemer & Finkelhor, 1990). This study sampled 2020 elderly people who lived in domestic settings and found that 32 of every 1000 elderly experienced physical violence, verbal aggression, or neglect. By applying this rate to the entire U.S. elder population, the authors estimated that there are between 700,000 and 1.1 million abused elders in the country. According to this study, only 1 in 14 cases is reported. A study of reported cases of domestic elder abuse found that 140,000 cases of elder abuse were reported in the U.S. in 1988 (Hunzeker, 1990). If the rate of reporting from the Boston prevalence study are applied to these figures, it
would suggest that 2 million cases of elder abuse occurred in 1988. In Indiana, there were 742 reports of suspected abuse of endangered adults in 1985, 4601 in 1989, and 7956 in 1991 (Indiana Department of Human Services, 1990; Indiana Family and Social Services Administration, 1992).

The relatively lower incidence of elder abuse suggests that mental health practitioners encounter cases of elder abuse less frequently than cases of child abuse. In addition, the under-utilization of mental health services by the elderly has been well documented (Kramer, Taube & Redick, 1973; Lewinsohn, Teri & Hautzinger, 1984). It had been suggested that just a decade ago 70% of practicing psychologists did not work clinically with the aged, and that only 2.7% of the health services provided by psychologists were received by the elderly (VandenBos, Stapp & Kilberg, 1981).

Nevertheless, the incidence of elder abuse will likely increase considering the rapid growth of the elderly population in the United States. The 75-and-older age group is currently the fastest growing segment of the population, going from 895,000 in 1900 to 9,967,000 in 1990. This age group constituted 5% of the population in 1982, but conservative estimates suggest that this group will increase to 10% of the population by 2030 (U.S. Senate Special Committee on Aging, 1984). In addition, there has been increased focus on gearing mental health services toward the elderly and training mental health practitioners to work
competently with an older population (Lewinsohn, Teri & Hautozinger, 1984). Therefore, it is likely that mental health practitioners will be more frequently encountering the issue of elder abuse in their clerical work and will need to be cognizant of the practical legal and ethical issues involved.

Although there are no studies which have specifically addressed mental health practitioners' awareness or response to the abuse of endangered adults, there have been some investigations of this issue with physicians who, as a group, are more likely to encounter elder abuse in their work. Overall, physicians have been found to be frequently uninformed about abuse and about state laws concerning elder maltreatment (Daniels, Baumhover, & Clark-Daniels, 1989; O'Brien, 1987). In one study, 80% of physicians knew that they had a legal responsibility to report elder abuse, but 60% reported that they were unclear as to how to report cases, 73% were unaware of any penalties for failure to report, and 80% were unsure or did not believe that prompt action would be taken if a report were made (Daniels, Baumhover, & Clark-Daniels, 1989). It is likely that mental health practitioners are similarly lacking in knowledge of the abuse of endangered adults and their responsibilities concerning such abuse.

Mental health practitioners have become involved in the legal process through reporting suspected cases of abuse of endangered adults which have been encountered in their
clinical practice. While psychologists have not yet become directly involved in a widespread basis in the gathering of evidence or the provision of testimony concerning whether abuse occurred or whether an individual is determined to be an "endangered adult," their role may be expanded as it has been in the area of child abuse. This diversification of roles is likely to increase as the elderly population and their use of mental health services continues to grow. As with child abuse, these various roles confront mental health professionals with numerous ethical, legal, and practical difficulties including determining what must be reported, assessing the impact of reporting on confidentiality and the therapeutic alliance, determining whether an adult is incapable or endangered, and maintaining the best interest of the client.

This chapter is intended to provide the practitioner with a basic understanding of the laws concerning the abuse of endangered adults and the related issues which affect clinical practice. The chapter begins with a discussion of definitions of abuse and neglect of endangered adults and the exploration of controversial issues in this area. This is followed by a delineation of the current Indiana statutes concerning abuse of endangered adults including definitions, reporting laws, and sanctions for failure to report. The procedures of investigation and provision of services for the Adult Protective Services Unit are discussed next. This is followed by the delineation of federal legislation which
impacts primarily on abuse within nursing homes and services for the elderly who have mental illness. Ethical dilemmas posed by the involvement of mental health practitioners in cases involving the abuse of endangered adults are then discussed. Finally, specific suggestions are made for advocacy by the profession concerning public policy issues and the need for funding for the provision of services to the elderly.

Definitions of Abuse of Endangered Adults

Since the beginnings of scientific investigation and legislative action in the area of abuse of endangered adults, definitions have been problematic and controversial. Because of this lack of agreement as to what constitutes abuse, definitions have varied considerably from one state to another and from one research project to the next. As a result, it has been difficult, if not impossible, to compare data across studies and to aggregate statistics from the state reporting systems. This definitional problem obviously impedes the expansion of the knowledge base in the area of elder abuse and impairs the gathering of accurate incidence and prevalence data (Wolf, 1988). In addition, Johnson (1986) suggests that without a "standard definition of elder abuse, causal theory cannot be explored" (p. 168).

The Elder Abuse Prevention, Identification and Treatment Act [HR 1674] which was introduced in 1985 attempted to clarify and standardize the language relating to mistreatment of the elderly (Cited in Jones, Dougherty,
Schelble & Cunningham, 1988). Specifically, the following definitions were provided:

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abuse</td>
<td>Willful infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical harm, pain, or mental anguish; or the willful deprivation by a caretaker of goods or services that are necessary to avoid physical harm, mental anguish, or mental illness.</td>
</tr>
<tr>
<td>Physical Harm</td>
<td>Bodily pain, injury, impairment, or disease.</td>
</tr>
<tr>
<td>Exploitation</td>
<td>Illegal or improper act of a caretaker using the resources of an elder for monetary or personal benefit, profit, or gain.</td>
</tr>
<tr>
<td>Neglect</td>
<td>Failure of a caretaker to provide the goods or services that are necessary to avoid physical harm, mental anguish, or mental illness.</td>
</tr>
</tbody>
</table>

While these definitions may assist in standardizing the language used in the area of elder abuse, they do not fully delineate the various conditions which constitute abuse or neglect, nor do they provide measurable criteria which can be practically applied. Therefore, several general categories which are typically agreed to constitute abuse will be outlined. Although there is consensus as to what the broad categories are, there is less consistency concerning what the categories represent, and so the clarification of each type of abuse should not be regarded as a widely held definition as there is still considerable controversy in this area (Wolf, 1988).

Physical abuse is the most widely recognized form of elder abuse and is commonly labeled as an act of commission which can range from scratches and bruises to death.
Physical abuse may also take the form of sexual attack or rape (Hunzeker, 1990). Neglect, typically considered to be an act of omission, occurs when a designated caretaker fails to meet the needs of an elder (Pillemer & Finkelhor, 1988). Neglect of the elderly has frequently been divided into two types based on the intent of the caretaker. When the caregiver intentionally fails to meet the elder's needs it is considered active neglect and when the failure is unintentional it is considered passive neglect. Neglect may consist of the deprivation of medical services or assistive devices and can result in dehydration, malnutrition, bedsores, or irreparable physical harm (Quinn & Tomita, 1986).

Another type of abuse of the elderly is psychological or emotional abuse, although its definition is particularly difficult and controversial. Psychological abuse is typically thought to consist of acts which are intended to inflict emotional pain on another person, such as threats or insult (Pillemer & Moore, 1989). Financial exploitation is also a form of abuse of the elderly and can include misappropriation of funds, misuse of the guardianship function, theft, or consumer fraud (Hunzeker, 1990). Violation of rights is another area of elder abuse which can consist of denying a person his or her right to open one's personal mail or the right to privacy. The elderly also have the right to due process of law in competency hearings and, unfortunately, this right is sometimes denied by
professionals or relatives intervening ostensibly in the elder's best interest. The final type of abuse is termed "self-abuse," and refers to the failure of an individual to provide oneself with the necessities of life. It can include poor nutrition and hygiene, inadequate medical care, or unreasonable management of finances (Quinn & Tomita, 1986).

Aside from the lack of consistency, the other major issue in the definition of elder abuse is whether the focus should be on the intent of the caretaker or on the effects of the act. O'Malley, Everett, O'Malley, and Campion (1983) have suggested that the focus should be on the unmet needs of the elder, or the effects of abuse, because the terms abuse and neglect are accusatory and result in decreased cooperation on the part of the caretaker. In addition, they suggest that intervention should consist of attempts to resolve the elder's unmet needs whatever the cause. Taking this line of thinking a step further, Quinn & Tomita (1986) suggested that the intent of the caretaker may never be established and that the elder is injured in some way regardless of the intent of the caregiver. They further posit that while the effects on the elder are central in the identification of abuse, the intent of the caregiver is crucial in terms of intervention. For example, respite care may be indicated for an elder who was struck once by a fatigued caretaker while a very different intervention would be necessary for an elder who was repeatedly beaten by an
alcoholic caretaker.

Johnson (1986) also addressed this issue and suggested that the act must be distinguished from the cause of elder abuse. Specifically, it was argued that the act must be the focus in identifying cases of elder abuse and that the intention of the caregiver should be the focus in delineating intervention. Johnson (1986) suggests that "...combining identification and intent in the same definition confounds both detection and treatment" (p. 179). She then offers a definition with several parts: an intrinsic definition, an extrinsic definition with behavioral manifestations, an operation definition, and a causal definition.

Indiana Statutes on Elder Abuse

Legislation concerning the maltreatment of the elderly typically follow one of three models: child abuse statutes, domestic violence statutes, or advocacy statutes (Brewer et al., 1989). Laws following the child abuse model focus on the helplessness and incompetency of elders and may allow protective services to be forced on an elder who competently chooses to remain in an abusive setting. Domestic violence laws can also be applied to elder abuse if the abuser is a spouse or family member. These laws center on protective orders and the use of crisis intervention techniques. In order to use these statutes, elders must be willing and able to go to court and aggressively defend their rights. Unfortunately, elders who are abused are typically not able
to actively follow these procedures. In addition, the domestic violence laws do not address neglect in any manner.

The third model for elder abuse legislation is advocacy law which was developed as a response to the needs of developmentally delayed adults. Advocacy statutes typically focus on the establishment of a service agency to provide advocacy and flexible intervention, and to attempt to allow individuals as much independence as possible. The statutes in Indiana which address elder abuse are modeled on, and combined with, advocacy laws, and this is reflected in the term "endangered adults," which will be defined below.

The State of Indiana provides protection for abused elders primarily through three types of statutes: statutes governing Adult Protective Services which include the reporting and investigation of suspected cases of elder abuse, criminal laws which address home improvement fraud (one type of crime to which the elderly are especially vulnerable) and include enhanced penalties when these crimes are committed against elders, and criminal laws which define abuse and determine the punishment for perpetrators of abuse and those who fail to report suspected abuse. The statutes which cover Adult Protective Services and the reporting of elder abuse are the most pertinent to the practice of mental health professionals and these statutes fall under Title 12 - Administration, Article 9 - Division of Aging and Rehabilitative Service, Chapter 3 - Adult Protective Services. Therefore, the statutes concerning Adult
Protective Services will begin with 12-9-3. Other statute numbers will be clarified as they are presented. Please refer to Table 2 for a complete listing of the statutes.

What Constitutes Abuse?

In Indiana, abuse of the elderly or endangered adults is addressed in Adult Protective Service law as well as Criminal Law. The first statute of concern to mental health practitioners is IC 12-9-3-2 in which "endangered adult" is defined. As stated above, advocacy laws are combined with elder abuse laws in Indiana, and so an endangered adult is defined as an individual of at least 18 years of age who is incapable of managing his or her property or providing self-care due to insanity, mental illness, mental retardation, senility, habitual drunkenness, excessive use of drugs, old age, infirmity, or other incapacity. In addition, and individual must be harmed or threatened with harm as a result of neglect, battery or exploitation, in order to be considered an endangered adult.

Unfortunately, the terms used in this definition are not clear and do not offer much guidance for the mental health practitioner. For example, how severe would these conditions need to be for the individual to be considered incapable, and what exactly does "incapable" mean? What constitutes harm, neglect, battery and exploitation?

Some of these issues are addressed in Title 35 - Criminal Law, Article 46 - Miscellaneous Offenses, Chapter 1 - Offenses Against the Family. In IC 35-46-1-4, neglect of
a dependent (a person of any age who is mentally or physically disabled - IC 35-46-1-1) is defined as the placement of a dependent in a situation which may endanger his life or health, abandonment or cruel confinement, or the deprivation of necessary support (food, clothing, shelter, or medical care - IC 35-46-1-1). Here again, however, the terms are not clarified. What constitutes disability, what qualifies as endangerment, and what determines necessity?

Exploitation is defined in IC 35-46-1-12 as reckless, knowing, or intentional unauthorized used of the personal services of property of an endangered adult or adult dependent for one's own advantage, or for the profit or advantage of another. Lastly, battery is addressed in Title 35 - Criminal Law, Article 42 - Offenses Against the Person, Chapter 2 - Battery and Related Offenses. Battery is defined as the knowing or intentional touching of another person in a rude, insolent, or angry manner. In addition, there is an enhanced penalty (Class D felony) if the battery results in bodily injury to an endangered adult (IC 35-42-2-1).

While sexual abuse is not directly included in the definition of endangered adults, it is addressed in criminal law. It is considered rape with a person intentionally has sexual intercourse with a member of the opposite sex when the other person is compelled by force or imminent threat of force. In addition, it is also considered rape when the other person is unaware that the sexual intercourse is
occuring or is so mentally disabled or deficient that consent to sexual intercourse cannot be given (IC 35-46-4-1). Similarly, unlawful deviate conduct (intentionally causing another person to perform or submit to deviate sexual conduct or to cause penetration of the sex organ or anus or another person) and sexual battery (touching another person with the intent to arouse or satisfy the person's own sexual desires) are committed when the other person is compelled by force or imminent threat of force, is unaware that the conduct is occurring, or is so mentally disabled or deficient that consent to the conduct cannot be given (IC 35-42-4-2); 35-42-4-8). There is no enhanced penalty for committing these sexual offenses against an endangered adult.

In addition to the above conditions which constitute abuse, it is also considered illegal for a person to intentionally fail to provide support to a spouse "when the spouse needs support" (IC 35-46-1-6). Similarly, it is considered illegal to intentionally fail to provide support to a parent, when the parent is unable to support himself, unless the individual was not supported as a child by the parent (IC 35-46-1-7). These two statutes have important implications because they not only delineate another facet of what is considered abuse or neglect but they also designate who is responsible for an incapacitated adult.

So, for example, if an elderly woman is found to be unable to manage her own self care, her adult children are legally
bound to provide support if they are so able.

The last area of state law which addresses exploitation of the elderly is Title 35 - Criminal Law, Article 43 - Offenses Against Property, Chapter 6 - Home Improvement Fraud. The details of what constitutes home improvement fraud are beyond the scope of this paper and the complete chapter of this law is included in Table 2 for the interested reader. However, this statute is important because the legislation addresses the fact that the elderly are frequently victims of this type of crime by inserting enhanced penalties when consumer fraud is committed against individuals who are at least 60 years of age (IC 35-43-6-13). In Indiana, home improvement fraud and battery are the only crimes which carry enhanced penalties.

In reviewing the statutes pertinent to the mistreatment of elders, it seems that the mental health professional must use considerable judgment in interpreting the law when determining whether an individual is an endangered adult. First, the professional must determine whether an adult is disabled or incapable of managing his or her financial affairs or self-care. Then, a judgment must be made as to whether the adult is harmed or threatened with harm due to neglect, exploitation (including home improvement fraud), or battery. Finally, a decision needs to be made concerning whether the adult is the victim of a sexual crime. It appears that the law is broad and quite inclusive, and that practically any situation which is harmful or potentially
harmful could be considered abusive. While these definitions are likely to maximally protect vulnerable adults, they may be so broad as to generate many unsubstantiated reports as has been the case with child abuse laws.

**Mandatory Reporting**

Any individual who believes or has reason to believe that another individual is an endangered adult is required to make a report to the Adult Protective Services Unit, a law enforcement agency, or the Division of Aging and Rehabilitative Services through the statewide toll free telephone number, 1-800-922-6978 (IC 12-9-3-9; IC 12-9-3-10; IC 12-9-3-12). An individual has "reason to believe" that an adult is endangered if the individual has been presented with evidenced that, if presented to an individual of similar background and training, would cause the individual to believe that the adult is an endangered adult. In addition, if an individual is a member of the staff of a medical or other public or private institution, school, hospital, facility, or agency, then the individual must notify the person in charge of the facility, who also becomes responsible to report or cause a report to be made (IC 12-9-3-9). Notifying the individual in charge, however, does not relieve an individual of the obligation to report unless a report has already been made to the best of the individual's belief.

Reports are required to include as much of the
following information as is known: the name, age, and address of the endangered adult; the names and addresses of family members or other persons financially responsible for the endangered adult's care; the apparent nature and extent of the alleged neglect, battery, or exploitation and the endangered adult's physical and mental condition; the name, address, and telephone number of the reporter and the basis of the reporter's knowledge; and other relevant information regarding the circumstances of the endangered adult (IC 12-9-3-10(c)). Reports may also be anonymous.

Unlike the mandatory reporting law for the child abuse, psychologists in particular are not specified as a group that are required to report suspected abuse of endangered adults. Rather, the law is quite broad, stating that "any individual" who suspects abuse is required to report. Regardless, the law obviously includes mental health practitioners and indirectly refers to any member of the staff of agencies which typically employ and are run by mental health professionals. Failure to report the facts supporting a belief that an endangered adult is the victim of battery, neglect, or exploitation constitutes a Class A infraction which may render a judgment of up to $10,000 (IC-36-46-1-13; IC 34-4-32-4). In addition, any individual who discharges, reduces work privileges, or retaliates against an individual who in good faith makes a report also commits a Class A infraction.

Immunity for Reporters
Any person, other than a person against whom a complaint concerning an endangered adult has been made, who in good faith reports suspected abuse of an endangered adult, is immune from both civil and criminal liability. Any person who testifies or participates in an investigation or proceeding relevant to the report, makes photographs or x-rays of an endangered adult, or discusses the report with the Division of Aging and Rehabilitative Services, the Adult Protective Services Unit, or a law enforcement agency, is also immune from liability (IC 12-9-3-11(a)).

Privileged Communication

The bottom line concerning privileged communication in cases of abuse of endangered adults is that mental health practitioners may not use privilege as grounds for failure to testify regarding such cases. The issue of whether privilege can be grounds for failing to report suspected cases of endangered adults is not directly addressed in the law concerning Adult Protective Services. The law does state that an individual may not be excused from testifying before a court or grand jury concerning a report of abuse of an endangered adult on the basis that the testimony is privileged information unless the individual is an attorney, a physician, a clergyman, a husband or a wife (IC 12-9-3-11(b)). In other words, the above-mentioned relationships are covered by privilege and can be grounds for failure to testify in cases of maltreatment of endangered adults. This is directly opposed to the child abuse statutes which state
that privilege does not apply to the report or testimony related to suspected child abuse.

Another important point, however, is that mental health practitioners, including psychologists, who are not working under direct supervision of a physician, are not covered by privilege under this section (IC 34-1-14-5; Whitehead vs. State, 1987). Therefore, mental health practitioners cannot use privileged communication as a grounds for failure to testify concerning a report of abuse of an endangered adult, just as in cases of child abuse.

**Adult Protective Service Procedures**

In the State of Indiana, the Division of Aging and Rehabilitative Services contracts in each county for the provision of adult protective services. In most counties, the prosecuting attorney's office houses the Adult Protective Services Unit and hires their own investigators. Other governmental agencies typically collaborate with the Adult Protective Services Unit to provide the necessary services to endangered adults.

As stated previously, reports of suspected abuse of endangered adults are made to either the Adult Protective Services Unit, a law enforcement agency, or the Division of Aging and Rehabilitative Services. Unless the immediate health or safety of an endangered adult is threatened, in which case an investigation is made immediately referral to the appropriate Adult Protective Services Unit must be made within five working days after the receipt of a report (IC
12-9-3-18). Upon receipt of a report, the Adult Protective Services Unit investigates the complaint or causes the complaint to be investigated, and makes a determination as to whether the individual reported is an endangered adult (IC 12-9-3-8).

If the Adult Protective Services Unit receives a report alleging that an individual who is a resident of a nursing home or long-term health care facility is an endangered adult, the report must be immediately communicated to the State Department of Health. A health facility in this case is defined as any building intended for the accommodation, treatment, board or care of more than four individuals, extending for more than 24 hours, for reason of physical or mental impairment. Private homes, hospitals and psychiatric hospitals are not considered to be health facilities under this section (IC 12-10-4-14). In the case where a report is made concerning a resident of a health facility, the Adult Protective Services Unit will not become further involved unless requested to do so by the Department of Health (IC 12-9-3-17).

If an individual who is not a resident of a nursing home is found to be an endangered adult, the Adult Protective Services Unit initiates procedures to provide the least restrictive protective services necessary to protect the endangered adult. These services are provided in accordance with a plan developed in cooperation with the endangered adult, and are then monitored to determine their
effectiveness (IC 12-9-3-8). If an endangered adult gives consent to receive protective services and another person interferes with the delivery of the services, the unit may petition the court for an order to enjoin the interference with the delivery of the services and to implement the provision of the services (IC 12-9-3-20).

If an endangered adult does not or is unable to consent to the receipt of protective services, the Adult Protective Services Unit may petition the court to require the endangered adult to receive protective services (IC 12-9-3-21). The endangered adult is entitled to be represented by counsel during this hearing. The court may require an individual to receive protective services, and issue a protective services order, only if the court finds that the individual is an endangered adult, is in need of protective services, and lacks the ability to make an informed decision concerning their own need for protective services (IC 12-9-3-23). A protective services order must stipulate the least restrictive protective services necessary, note the duration of the order, and arrange for the provision of the services outlined. The protective services order must be reviewed at least every six months, and can be modified or terminated earlier if necessary (IC 12-9-3-24; IC 12-9-3-26).

The adult Protective Services Unit may petition the court for an emergency protective order if the endangered adult is involved in a life threatening emergency. The petition must include evidence that immediate and
irreparable injury will result if there is a delay in the provision of services. In addition, a description of the emergency protective services to be provided must also be included. If the court determines that the individual is an endangered adult, that a life threatening emergency exists, and that the endangered adult is in need of the proposed emergency protective services, then the court may issue an emergency protective order. An emergency protective order may not remain in effect for longer than ten days or thirty days if the Adult Protective Services Unit shows that an extraordinary need exists. If at the expiration of an order the Adult Protective Services Unit determines that the endangered adult is in need of further protective services and that the endangered adult does not consent to the receipt of the services, a petition for a protective service order may be filed as discussed previously (IC 12-9-3-28).

In terms of record keeping, the Division of Aging and Rehabilitative Services maintains records on individuals who have been determined to be endangered adults and the protective services needed. In addition, records are kept of agencies, individuals, or institutions that were determined to have permitted neglect, battery, or exploitation of endangered adults. Lastly, nonidentifying statistical records are maintained concerning unsubstantiated reports of endangered adults. All of these records are to be used solely for statistical purposes and must be available to governmental agencies and employees who
have a legitimate interest in the welfare of individuals who may be endangered adults (IC 12-9-3-13). In addition, a person who is named in the report, the subject of the report, or the guardian or attorney of these individuals may also have access to the records. Otherwise, reports or photographs in the records are confidential (IC 12-9-3-15). Identifying information is destroyed in reports which are determined to be unsubstantiated (IC 12-9-3-15).

Federal Legislation

Federal interest in the area of elder abuse, as evidenced by legislative activity, has existed for almost fifteen years. The paucity of national incidence data and a lack of consensus regarding the most appropriate federal response to elder abuse, however, have resulted in relatively little federal law regarding elder abuse and no special elder abuse social-service programs. Specifically, there has been an ongoing debate among Congress members as to whether a domestic violence model or a child abuse model should be used to prevent and treat elder abuse (Rinkle, 1989). Increased support for the advocacy model developed in 1985 when the Department of Health and Human Services supported local voluntary and community-based service programs to address the problem of elder abuse (U.S. House of Representatives, 1985). Although some researchers promote allowing state and local agencies discretion in utilizing existing aging programs to combat elder abuse rather than developing federal programs aimed specifically
at elder abuse, local agencies are struggling to garner the financial resources to expand established aging and family violence programs (Rinkel, 1989). This shortage of resources and funding will be addressed in more detail in a later section of this paper, but it is sufficient for the present discussion to note the lack of federal financial support.

The attention of federal legislators has recently been directed towards the improved quality of care in nursing homes and in catastrophic health care (Rinkel, 1989). The Nursing Home Reform Amendments in the Omnibus Budget Reconciliation Act of 1987 (OBRA) mandated broad-ranging changes in nursing home and survey agency practices as of October, 1990 (Frank, 1992). The Amendments stipulated requirements to improve and ensure the quality of care, personal rights, and the quality of life for nursing home residents. In addition, enforcement of the standards were outlined, as were pre-admission screening and review requirements (PASARR).

Of the many issues addressed in The Nursing Home Reform Amendments, only those most pertinent to abuse of endangered adults and the practice of mental health professionals will be reviewed here. Interested reader should refer to An Ombudsman's Guide to the Nursing Home Reform Amendments of OBRA '87 (Frank, 1992) for a complete delineation of the law. In terms of abuse, the amendments state that the facility must not abuse residents by verbal, mental, sexual
or physical abuse, corporal punishment, or involuntary seclusion. Any allegations of such abuse must be reported, corrective action must be taken, and residents must be informed how to file a complaint and obtain supportive services. In addition the facility may not employ individuals who have been found guilty of abuse, neglect, or mistreatment of individuals by a court of law or who have had an incident of abuse, neglect, or mistreatment of residents or misappropriation of residents' property listed in the State nurse aide registry.

The amendments also address the use of restraints with nursing home residents. Physical restraints are to be used only to ensure the physical safety of the resident or other residents, and only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used. Prior to the use of physical restraints, less restrictive methods should be attempted, occupational or physical therapists should be consulted, and the resident and family should receive a full explanation. In terms of chemical restraints, the amendments state that residents must be free from unnecessary drugs and not be given antipsychotic drugs unless for treating a specific condition. Gradual dose reductions and behavioral interventions should also be employed in an effort to reduce or discontinue medications. In addition, an independent consultant must be obtained to monitor all psychopharmacologic drugs.
The Amendments also provide regulations regarding Pre-Admission Screening and Annual Resident Review (PASARK). The screening and review process is intended to prevent mentally retarded and mentally ill individuals who are in need of intensive mental health treatment from living in nursing homes, assuming that they can receive more appropriate services in a different setting. Nursing homes typically do not offer mental health services or have mental health expertise on staff, and individuals with primary mental health needs frequently would be better served in group homes or mental health settings. The Pre-Admission Screening is conducted prior to an individual's being admitted to a nursing facility, and the Annual Resident Review is conducted annually after admission.

There are two levels involved in the screening, the first of which is typically conducted by the nursing home staff. If the individual is found to have a diagnosis or recent history of mental illness or mental retardation, have been prescribed a major tranquilizer or psychotropic medication, to be presenting evidence of mental illness or retardation, or to have been referred or received services from an agency that serves persons with mental retardation, then he or she is determined to be in need of a more in-depth Level II evaluation.

A level II evaluation must be conducted by an independent agent with whom the state contracts, and must be co-signed by a physician. Mental health practitioners are
frequently involved in Level II evaluations, especially for individuals determined to be mentally retarded. In these cases a psychologist must make the determination of need for active treatment. In a Level II evaluation, an individual is considered to be mentally ill if he or she has a primary diagnosis of schizophrenia, paranoia, major affective disorder, schizoaffective disorder, or atypical psychosis. An individual is not considered to be mentally ill if he or she has dementia or a secondary Axis I diagnosis. If an individual is found to be mentally ill or mentally retarded, then it must be determined as to whether there is a need for nursing home care or active treatment.

Basically, the Nursing Home Reform Amendments stipulate that nursing homes may not admit any person with serious mental illness or mental retardation unless he or she has been evaluated by the state and determined to need nursing home services. Residents of nursing home who, in an Annual Resident Review, are found not to be in need of nursing home or specialized services (highly specialized 24 hour care for mental health needs) must be discharged. Those residents who, in an Annual Resident Review, are found to need specialized services but not nursing home care, and who have been in the nursing facility for less than 30 months, must be discharged to another setting. If the individual has resided in the nursing facility for 30 months or more, he or she may elect to stay or to go to another setting. In either case the state supposedly must assure that they
receive specialized services, but the resources are frequently not available to provide these services.

Conclusions

In reviewing Indiana law regarding the abuse of endangered adults it becomes apparent that the ethical, legal, and practical dilemmas which confront the mental health professional in these cases are similar to those related to cases of child abuse. The interested reader is referred to Chapter 2 for a complete discussion of these ethical concerns, but the main points will be briefly reviewed. To begin with, the definitions of abuse are not clearly delineated, making it difficult to determine exactly what must be reported. In addition, the mandatory reporting law conflicts directly with confidentiality which is central to the psychologist-client relationship and which mental health practitioners have been trained to aggressively protect. Lastly, it is often unclear as to whether the best interests of the client are being served by reporting suspected cases of abuse, largely because of the lack of financial support for needed services and the resultant reliance on institutionalization as an intervention.

By far, the most cited problem with the current mandatory reporting legislation is the lack of commitment of resources to investigation and service delivery. In 1985 it was estimated that while the states spend an average of $22 per child for child abuse, they only spend an average of $2.91 per elder on protective services (Sub-Committee on
Health and Long Term Care of the Select Committee on Aging, 1985). In Indiana, as in most other states, the statutes support case discovery and protective services without requiring the disbursement of adequate funding. The Indiana legislature set a budget of $58,000 for the funding of Adult Protective Services in 1985 but has not increased this amount in the last seven years despite the jump in reported cases from 742 in 1985 to 7956 in 1991.

This lack of funding results in an unrealistic burden being placed on social service agencies. In addition, the limited availability of in-home services frequently leaves institutionalization as the only intervention— an option which is often undesirable and not in keeping with the principle of least-restrictive intervention. The biggest need is for long-term and residential treatment for the mentally ill and mentally retarded endangered adults. Nursing homes are reluctant to accept these individuals and although the state is required by The Nursing Home Reform Amendments (1987) to provide appropriate services to the mentally ill or mentally retarded population, these resources are scarce.

At present, mental health professionals as a group lack sufficient training in working with the elderly. In addition, it is estimated that by the year 2020 the elderly population in the United States will grow to a total of 72 million. Broad-based coursework and practical training regarding the elderly should be required in the training of
mental health professionals so that they are better prepared to meet the needs of the increasing elderly population. Research investigating the needs of the elderly and the efficacy of various interventions is also sorely needed. In addition, practitioners have a responsibility to educate the public and members of the legislature regarding the needs of the elderly in an attempt to secure much-needed resources.

Pressuring the legislature to pass additional inadequately funded laws which overburden the social service agencies is not the answer to the growing needs of endangered adults. Rather, what is needed is the procurement of necessary funding to provide endangered adults with mental health services, residential facilities, respite care, and home-based services. In addition, practitioners must receive more specialized training in working with the elderly population. The long-term care of the elderly is not only a problem of the poor. Practically every middle class family will be affected by the need for long-term care of the elderly, and garnering the financial resources to address this problem will be the challenge of the years ahead.
REFERENCES


Indiana Family and Social Service Administration Adult Protective Services (1992). *Adult protective service reports by unit.*


APPENDIX A

Selected Indiana Statutes: Child Abuse
SELECTED INDIANA STATUTES

CHILD ABUSE

Title 31  Family Law
Article 6  Juvenile Law

Chapter 11  REPORTING AND INVESTIGATION OF CHILD ABUSE OR NEGLECT

31-6-11-1  Purpose
It is the purpose of the of this chapter to encourage effective reporting of suspected or known incidents of child abuse or neglect, to provide in each county an effective child protection service to quickly investigate reports of child abuse or neglect, to provide protection for such a child from further abuse or neglect, and to provide rehabilitative services for such a child and his parent, guardian, or custodian. As added by Acts 1979, P.L. 276, SEC. 55.

31-6-11-2.1  Definitions
As used in this chapter:
(1) "Administrator" means the administrator of the state department of public welfare.
(2) "Child abuse or neglect" refers to a child who is alleged to be a child in need of services (as defined by IC 31-6-4-3(a)(1) through IC 31-6-4-3(a)(5).
However, the term does not include a child who is alleged to be a victim of a sexual offense under IC 35-42-4-3(d) unless the alleged offense under IC 35-42-4-3(d) involves the fondling or touching of the buttocks, genitals, or female breasts.
(3) "Health care provider" means:
   (A) a licensed physician, intern, or resident;
   (B) an osteopath;
   (C) a chiropractor;
   (D) a dentist;
   (E) a podiatrist;
   (F) a registered nurse or other licensed nurse;
   (G) a mental health professional;
   (H) a paramedic or emergency medical technician;
   (I) a social worker, x-ray technician, or laboratory technician employed by a hospital; or
(J) a person working under the direction of any of the practitioners listed in clauses (A) through (I).

(4) "Reason to believe" means evidence that, if presented to individuals of similar background and training would cause those individuals to believe that a child was abused or neglected.

5) "State department" means the state department of public welfare.

6) "Victim of child abuse or neglect" refers to a child in need of services (as defined by IC 31-6-4-3(a)(1) through IC 31-6-4-3(a)(5) and IC 31-6-4-3.1). However, the term does not include a child who is alleged to be a child in need of services if that child is alleged to be a victim of a sexual offense under IC 35-42-4-3 (d) unless the alleged offense under IC 35-42-4-3 (d) involves the fondling or touching of the buttocks, genitals, or female breast.

31-6-11-3 Report of victim of child abuse; requirement; notice to individual in charge

(a) In addition to any other duty to report arising under other sections contained in this chapter, any individual who has reason to believe that a child is a victim of child abuse or neglect shall make a report as required by this chapter.

(b) If an individual is required to make a report under this chapter in his capacity as a member of the staff of a medical or other public or private institution, school, facility, or agency, or his designated agent, who also becomes responsible to report or cause a report to be made. Nothing in this section is intended to relieve individuals of their obligation to report on their own behalf, unless a report has already been made to the best of the individual's belief. As added by Acts 1979, P.L. 276, Sec. 55.

31-6-11-4 Immediate oral report to local child protection service or law enforcement agency

A person who has a duty to report that a child may be a victim of child abuse or neglect under Section 3 of this chapter shall immediately make an oral report to the local child protection service or law enforcement agency. As added by Acts 1979, P.L. 6, SEC. 55.

31-6-11-5 Report by child protection service; distribution; expungement of information

(a) A written report of a child who may be a victim of child abuse or neglect shall be made by the child protection service within forty-eight (48) hours of its receipt of the oral report required of individuals by section 4 of this chapter. Written reports shall be made on forms supplied by the administrator. Such reports must include, if known,
the following information:

(1) the names and addresses of the child and his parents, guardian, custodian, or other person responsible for his care;
(2) the child's age and sex;
(3) the nature and apparent extent of the child's injuries, abuse, or neglect, including any evidence of prior injuries of the child or abuse or neglect of the child or his siblings;
(4) the name of the person allegedly responsible for causing the injury, abuse, or neglect;
(5) the source of the report;
(6) the person making the report and where he can be reached;
(7) the actions taken by the reporting source, including the taking of photographs and x-rays, removal or keeping of the child, or notifying the coroner; and
(8) any other information that the administrator may, by regulation, require, or the person making the report believes might be helpful.

A copy of the written report of the child protection service shall immediately be made available to the appropriate law enforcement agency, the prosecutor, and, in a case involving death, to the coroner for his consideration whereupon the coroner shall accept the report for investigation and shall report his findings to the appropriate law enforcement agency, the prosecutor, the local child protection service, and, if the institution making the report is a hospital, the hospital.

(b) Child abuse or neglect information may be expunged under IC 31-6-8-2 if the probative value of the information is so doubtful as to outweigh its validity. Child abuse or neglect information shall be expunged if it is determined to be unfounded after;
(1) an investigation of a report of a child who may be a victim of child abuse or neglect by the child protection service; or
(2) a court proceeding.


31-6-11-6  Health care provider or person in charge of medical institution; photographs, x-rays or physical medical examination reports of trauma, availability; reimbursement of costs

(a) Any person required to report cases of known or suspected child abuse or neglect who is also a health care provider, or person in charge of a hospital or similar medical institution treating the child, shall cause photographs to be taken of the areas of
trauma visible on the child who is the subject of a report. If medically indicated, a physician may cause a radiological examination or a physical medical examination, or both, of the child to be performed.

(b) The reasonable cost of photographs, x-rays, or physical medical examinations made under this section shall be reimbursed by the state department.

(c) All photographs taken and a summary of x-rays and other medical care shall be sent to the local child protection service at the time the written report is sent, or as soon thereafter as possible. Notice of the existence and location of photographs, x-rays, and physical medical examination reports shall be given by the child protection service to the prosecutor and the appropriate law enforcement agency. Photographs, x-rays, or physical medical examination reports shall be made available to the county department, prosecutor, guardian ad litem, or court appointed special advocate appointed by the juvenile court for use in any judicial proceeding relating to the subject matter of a report made under this chapter and, to the extent permissible under the Indiana rules of trial procedure, to the adverse party in any proceeding or proceedings arising under this chapter. As added by Acts 1979, P.L. 276, SEC. 55. Amended by P.L. 153-1984, SEC. 7; P.L. 287-1985, SEC. 2.

31-6-11-7 Immunity from civil or criminal liability; presumption of acting in good faith

A person, other than a person accused of child abuse or neglect, who:

(1) makes or causes to be made a report of a child who may be a victim of child abuse or neglect;

(2) is a health care provider and detains a child for purposes of causing photographs, x-rays, or a physical medical examination to be made under section 6 of this chapter;

(3) makes any other report of a child who may be a victim of child abuse and neglect; or

(4) participates in any judicial proceeding or other proceedings resulting from a report that a child may be a victim of child abuse or neglect, or relating to the subject matter of such report.

is immune from any civil or criminal liability that might otherwise be imposed because of such actions. However, immunity does not attach for any person who has acted maliciously or in bad faith. A person making a report that a child may be a victim of child abuse or neglect or assisting in any requirement of this chapter is presumed to have acted in good faith. As added by Acts 1979, P.L. 276, SEC. 55. Amended by P.L. 287-1985, SEC. 3.
31-6-11-8 Privileged communications; abrogation
The privileged communication between a husband and wife, between a health care provider and that health care provider's patient, or between a school counselor and a student.

(1) excluding evidence in any judicial proceeding resulting from a report of a child who may be a victim of child abuse or neglect, or relating to the subject matter of such a report; or

(2) failing to report as required by this chapter.

31-6-11-9 Guardian ad litem, special advocate
(a) In every judicial proceeding under this chapter the court may appoint for the child a guardian ad litem or a court appointed special advocate, or both, under IC 31-6-3-4.

(b) The guardian ad litem or the court appointed special advocate, or both, shall be given access under IC 31-6-3 to all reports relevant to the case and to any reports of examinations of the child's parents or other person responsible for the child's welfare. The agency shall be destroyed when the child reaches eighteen (18) years of age. As added by P.L. 49-1989, SEC. 16.

31-6-11-10 Local child protection service; establishment by counties; powers and duties; local plan; certification
(a) Each county department of public welfare shall establish within itself a local child protection service to carry out the provisions of this chapter. In counties with populations greater than one hundred thousand (100,000), the child protection service shall be a separate organizational unit administered and supervised by a person reporting directly to the county department of public welfare. The local child protection service shall have sufficient qualified and trained staff to fulfill the purpose of this chapter and shall be organized to maximize the continuity of responsibility, are, and service of individual case-workers toward individual children and families.

(b) Except in cases involving a child who may be a victim of institutional abuse or cases in which police investigation also appears appropriate, the child protection service shall be the primary public agency responsible for receiving, investigating or arranging for investigation, and coordinating the investigation of all reports of a child who may be a victim of known or suspected child abuse or neglect. In accordance with the local plan for the child pro-
tection services, it shall, by juvenile court order, provide protective services to prevent cases where a child may be a victim of further child abuse or neglect and provide for or arrange for an coordinate and monitor the provision of those services necessary to insure the safety of children. Reasonable efforts must be made to provide family services designed to prevent a child’s removal from his parent, guardian, or custodian.

(c) The child protection service shall cooperate with and shall seek and receive the cooperation of appropriate public and private agencies, including law enforcement agencies, the courts, and organizations, groups, and programs providing or concerned with services related to the prevention, identification, or treatment of a child who may be a victim of child abuse or neglect. The child protection service shall also cooperate with public and private agencies, organizations, and groups that provide family services designed to prevent a child's removal from his home. Such cooperation and involvement may include consultation services, planning, case management, public education and information services, and utilization of each other's facilities, staff, and other training.

(d) County departments of public welfare situated in adjacent counties may establish a joint or multicounty child protection service to carry out the provisions of this chapter. Any county department of public welfare may contract with the county department of public welfare of an adjacent county to provide child protection services in fulfillment of this chapter.

(e) Any other provision of law notwithstanding, the child protection service may purchase and utilize the services of any public or private agency if adequate provision is made for continuity of care and accountability between the local protection service and the agency. If the local child protection service purchases services under this chapter, the expenses, to the extent allowed by state and federal laws, rules, and regulations, shall be reimbursed by the state to the locality or agency in the same manner and to the same extent as if the services were provided directly by the local child protection service.

(f) Before February 2 of each odd-numbered year, each county department of public welfare, after a public hearing, shall prepare a local plan for the provision of child protection services and shall submit the plan to:

(1) the administrator, after consultation with local law enforcement agencies;
(2) a juvenile court;
(3) the child protection team, as provided for in section 14 of this chapter; and

(4) appropriate public or voluntary agencies, including organizations for the prevention of child abuse or neglect.

(g) The plan must describe the county department of public welfare implementation of this chapter, including the organization, staffing, mode of operations, and financing of the child protection services, as well as the provisions made for the purchase of service and interagency relations. Within sixty (60) days, the administrator shall certify whether the local plan fulfills the purposes of and meets the requirements set forth in this chapter. If he certifies that the local plan does not do so, he shall state the reasons for his decision, and he may withhold state reimbursement for any part of the county department of public welfare activities relating to the provisions of this chapter.

(h) The decisions of the administrator under this section are judicially reviewable under IC 4-21.5-5.


3-6-11-11 Arrangement for receipt of reports; investigations; reports and recommendations; offer of social services; referral to juvenile court; rehabilitative services; coordination, provision and arrangement

(a) The local child protection service shall arrange for receipt, on a twenty-four (24) hour, seven (7) day week basis, of all reports of suspected child abuse or neglect under this chapter. Each local child protection service shall cause to be inserted in each local phone directory in the county a listing of its number under the name "Child Protection Service".

(b) The local child protection service shall initiate an appropriately thorough child protection investigation of every report of known or suspected child abuse or neglect it receives, whether in accordance with the chapter or otherwise. Where the report alleges a child may be a victim of child abuse, the investigation shall be initiated with twenty-four (24) hours of the receipt of the report. Where other reports of child neglect are receive, the investigation shall be initiated within a reasonably prompt time, with the primary consideration being the well-being of the child who is the subject of the report. However, if the immediate safety or well-being of a child appears to be endangered or the facts otherwise warrant, the child protection investigation shall be initiated immediately, regardless of the time of day.

(c) The local child protection service shall cause color photographs to be taken of the areas of trauma
visible on a child who is subject to a report and, if medically indicated, cause a radiological examination of the child to be performed. The expenses of the photographs and x-rays shall be reimbursed by the state department of public welfare.

(d) The local child protection service shall give telephone notice and forward immediately a copy of reports made under this chapter which involve the death of a child to the appropriate prosecutor. A copy of all reports made under this chapter shall be forwarded immediately by the child protection service to the appropriate prosecutor if a prior request in writing for such copies has been made to the service by the prosecutor.

(e) The local child protection service shall promptly make a thorough investigation upon either the oral or written report. The primary purpose of such an investigation is the protection of the child. The investigation, to the extent that is reasonably possible, shall include:

(1) the nature, extent, and cause of the known or suspected child abuse or neglect;
(2) the identity of the person allegedly responsible for the child abuse or neglect;
(3) the names and conditions of other children in the home;
(4) an evaluation of the parent, guardian, custodian, or person responsible for the care of the child;
(5) the home environment and the relationship of the child to the parent, guardian, or custodian, or other persons responsible for his care; and
(6) all other data considered pertinent.

The investigation may include a visit to the child's home, an interview with the subject child, and a physical, psychological, or psychiatric examination of any child in that home. If the admission to the home, school, or any other place that the child may be, or if permission of the parent, guardian, custodian, or other persons responsible for the child, for the physical, psychological, or psychiatric examination cannot be obtained, then the juvenile court, upon good cause shown shall follow the procedures under IC 31-6-7-12. If, before the examination is complete, the opinion of the investigators is that immediate removal is necessary to protect the child from further abuse or neglect, the juvenile court may issue an order under IC 31-6-7-14. The child protection service shall make a complete written report of the investigation, together with its recommendations. These reports shall be made available to the appropriate court, the prosecutor, or the appropriate law enforcement agency upon request. If the investigation substantiates a finding of child abuse or neglect as determined by the child protection service, a
report shall be sent to the coordinator of the community child protection team, under section 15 of this chapter.

(f) Based on the investigation and evaluation conducted under this chapter, the local child protection service shall offer to the family or any child believed to be suffering from child abuse or neglect, the family or rehabilitative services, or both types of services, that appear appropriate for either the child or the family. However, before offering these services to a family, the local child protection service shall explain that it has no legal authority to compel the family to receive the social services but may inform the family of the obligations and authority of the child protection service to petition a juvenile court for a proceeding alleging that the child may be a victim of child abuse or neglect.

(g) If the child protection service determines that the best interests of the child require action in the juvenile or criminal court, the child protection service shall refer the case to the juvenile court, under IC 31-6-4-8, or make a referral to the prosecutor, if criminal prosecution is desired.

(h) The local child protection service shall assist the juvenile court or the court having criminal jurisdiction during all stages of the proceedings in accordance with the purposes of this chapter.

(i) The local child protection service shall coordinate, provide or arrange for, and monitor, as authorized by this chapter and IC 12, family or rehabilitative services, or both types of services, for a child and his family on a voluntary basis or under an order of the court, subject to IC 31-6-4-14 and IC 31-6-4-15. As added by Acts 1979, P.L. 276, SEC. 55. Amended by P.L. 154-1984, SEC. 11.

31-6-11-12 Receipt of report by law enforcement agency; communication to local child protection service; investigation

When a law enforcement agency receives a report that a child may be a victim of child abuse or neglect, it shall immediately communicate the report to the local child protection service. If the law enforcement agency has reason to believe there exists an imminent danger to the child's health or welfare, it shall initiate an immediate investigation of a report, or act as prearranged in the local plan of child protection. However, in all instances the law enforcement agency shall forward any information, including copies of which a child may be a victim of child abuse or neglect, whether obtained under this chapter or not, to the local child protection agency, and to the juvenile court under IC 31-6-4-8. As added by Acts 1979, P.L. 276, SEC. 55.
31-6-11-13 Review by juvenile court of status of child removed from family

The juvenile court shall review the status of every child removed from his family under this chapter according to IC 31-6-4-19. As added by Act. 1979, P.L. 276, SEC. 55.

31-6-11-14 Community child protection team; members

The director of the county department of public welfare shall appoint and convene a community-wide, multidisciplinary child protection team to be known as the "community child protection team". The team must include the director of the local child protection service or his representative and the juvenile court judge or his representative. The team may include:

(1) a representative of the local law enforcement agency;
(2) a representative of a local school system;
(3) a physician, nurse, attorney, social worker, individual trained in mental health, representative of a community mental health center, individual trained in mental retardation, representative of a community mental retardation or other developmental disabilities center, or representative of a local child abuse and neglect group; and
(4) one (1) or more lay representatives of the community.

The team shall consist of no less than five (5) and no more than eleven (11) members who shall elect a team coordinator from their own membership. As added by Acts 1979, P.L. 276, SEC. 55. Amended by P.L. 28-1085, SEC. 54.

31-6-11-15 Meetings; diagnostic and prognostic services

(a) The team coordinator shall supply the community child protection team with copies of reports of child abuse or neglect under section 11 of this chapter.

(b) The coordinator shall also supply the team with any other information or reports he considers essential to its deliberations.

(c) The child protection team may meet at least once a month or at such times as its services are needed by the child protection service. Meetings shall be called by the team coordinator, who shall determine the agenda; however, a majority of the membership of the team may call a meeting upon giving forty-eight (48) hour notice to all the members. Notwithstanding IC 5-14-1.5, meetings are open only to those persons authorized to receive information under this chapter.

(d) The child protection team shall provide diagnostic and prognostic service for the local child protection service or the juvenile court, and may recommend to the local child protection service that a
petition be filed in the juvenile court on behalf of the subject child if it believes this would best serve the interests of the child. As added by Acts 1979, P.L. 276, SEC. 55.

31-6-11-16 Public or private agencies to investigate reports; designation; written protocol or agreement

(a) Through a written protocol or agreement, the state department shall designate the public or private agencies primarily responsible for investigation reports involving a case of a child who may be a victim of child abuse or neglect and who is under the care of a public or private institution. The designated agency must be different from and separately administered from the one involved in the alleged acts or omissions; subject to this limitation, the agency may be the state department, the local child protection service, or a law enforcement agency, but may not include the office of the prosecuting attorney.

(b) The protocol or agreement must describe the specific terms or conditions of the designation, including the manner in which reports of a child who may be a victim of child abuse or neglect and who is under the care of a public or private institution will be received, the manner in which such reports will be investigated, the remedial action which will be taken, and the manner in which the state department will be kept fully informed on the progress, findings, and disposition of the investigation.

(c) To fulfill the purposes of this section, the state department may purchase the services of the public or private agency designated to investigate reports of child abuse or neglect. As added by Acts 1979, P.L. 276, SEC. 55.

31-6-11-17 Repealed
(Repealed by P.L. 155-1984, SEC. 1).

31-6-11-18 Confidentiality of reports and information; disclosure; rules and regulations

(a) Reports made under this chapter, and any other information obtained, reports written, or photographs taken concerning such reports in the possession of the department, the county department of public welfare, or the local child protection service are confidential and shall be made available only to those persons authorized by this chapter and to:

(1) a legally mandated, public or private child protection agency investigating a report of child abuse or neglect or treating a child or family which is the subject of a report or record;

(2) a police or other law enforcement agency, prosecutor, or coroner in the case of the
death of a child, investigating a report of a child who may be a victim of child abuse or neglect;

(3) a physician who has before him a child whom he reasonably suspects may be a victim of child abuse or neglect;

(4) an individual legally authorized to place a child in protective custody if that individual has before him a child whom he reasonably suspects may be a victim of abuse or neglect and that individual requires the information in the report or record in order to determine whether to place the child in protective custody;

(5) an agency having the legal responsibility or authorization to care for, treat, or supervise a child who is the subject of a report or record, or a parent, guardian, custodian, or other person who is responsible for the child's welfare;

(6) any individual named in the report or record who is alleged to be abused or neglected, or if the individual named in the report is a child or is otherwise incompetent, his guardian ad litem or his court appointed special advocate, or both;

(7) a parent, guardian, custodian, or other person responsible for the welfare of a child named in a report or record, with protection for the identity of reports and other appropriate individuals;

(8) a court, upon its finding that access to the records may be necessary for determination of an issue before the court, but access is limited to in camera inspection, unless the court determines that public disclosure of the information contained in the records is necessary for the resolution of an issue then pending before it;

(9) a grand jury upon it determination that access to the records is necessary in the conduct of its official business; or

(10) any appropriate state or local official responsible for the child protective service or legislation carrying out his official functions.

(b) Nothing contained in subsection (a) prevents the county department of public welfare or the local child protection service from disclosing to any qualified individual engaged in a good faith research project, either:

(1) information of a general nature, including the incidents of reported child abuse or neglect or other statistical or social data used in connection with studies, reports, or surveys, and information related to their function and
(2) information relating to case histories of child abuse or neglect if the information disclosed does not identify or reasonably tend to identify those involved, and if the information is not a subject of pending litigation.

To implement this subsection, the state department shall adopt, under IC 4-22-2, rules to govern the dissemination of information to qualifying researchers. As added by Acts 1979, P.L. 276, SEC. 55. Amended by P.L. 153-1984, SEC. 9.

31-6-11-19 Costs of services; payment
The costs of any services ordered by the court for any child or his parent, guardian, or custodian shall be paid according to IC 31-6-4-18. As added by Acts 1979, P.L. 276, SEC. 55.

31-6-11-20 Failure to make reports; offenses
(a) A person who knowingly fails to make a report required by section 3(a) of this chapter commits a Class B misdemeanor.
(b) A person who knowingly fails to make a report required by section 3(b) of this chapter commits a Class B misdemeanor. This penalty is in addition to the penalty imposed by subsection (a). As added by Acts 1979, P.L. 276, SEC. 55.

31-6-11-21 Wrongful requesting, obtaining information or records, or falsification thereof; offense
An individual who knowingly requests, obtains, or seeks to obtain child abuse or neglect information under false pretenses, or any individual who knowingly falsifies child abuse or neglect information or records, commits a Class B misdemeanor. As added by Acts 1979, P.L. 276, SEC. 55.

31-6-11-22 Reports; contents; confidentiality
Whenever the child protection service receives a report of suspected child abuse or neglect from a hospital, community mental health center, referring physician, or a school, the child protection service shall send a report to the administrator of the hospital, community mental health center, referring physician, or the principal of the school. Within thirty (3) days after the date the child protection service receives the report of suspected child abuse or neglect, a report shall be sent, containing such items listed in this section as are known at the time the report is sent. With ninety (90) days after the date the service receives the report of suspected child abuse or neglect, a report shall be sent, containing any additional items listed in this section not covered in the prior report, if then available. The administrator, director, referring physician, or principal may appoint a designee to receive the report. The report must contain the following information:
(1) The name of the alleged victim of child abuse or neglect.
(2) The name of the alleged perpetrator and that person's relationship to the alleged victim.
(3) Whether the case is closed.
(4) Whether information concerning the case has been expunged.
(5) The name of any agency to which the alleged victim has been referred.
(6) Whether the child protection service has made an investigation of the case and has not taken any further action.
(7) Whether a substantiated case of child abuse or neglect was informally adjusted.
(8) Whether the alleged victim was referred to the juvenile court as a child in need of services.
(9) Whether the alleged victim was returned to his home.
(10) Whether the alleged victim was placed in residential care outside his home.
(11) Whether a wardship was established for the alleged victim.
(12) Whether criminal action is pending or has been brought against the alleged perpetrator.
(13) A brief description of any casework plan that has been developed by the child protection service.
(14) The caseworker's name and telephone number.
(15) The date the report is prepared.
(16) Such other information as the department of public welfare may prescribe.

A report made under this section is confidential and may be made available only to the agencies named in this section and the persons and agencies listed in section 18 (a) of this chapter. As added by P.L. 159-1984, SEC. 1.

Title 31  Family Law
Article 6  Juvenile Law
Chapter 4  SEX CRIMES

31-6-4-3  Child in need of services
(a) A child is a child in need of services if before the child's eighteenth birthday:
(1) the child's physical or mental condition is seriously impaired or seriously endangered as a result of the inability, refusal, or neglect of the child's parent, guardian, or custodian to supply the child with necessary food, clothing, shelter, medical care, education or supervision;
(2) the child's physical or mental health is seriously endangered due to injury by the act or omission of the child's parent, guardian, or custodian;

(3) the child is the victim of a sex offense under IC 35-42-4-1, IC 35-42-4-2, IC 35-42-4-3, IC 35-42-4-4, IC 35-42-4-7, IC 35-45-4-1, IC 35-45-4-2, or IC 35-46-1-3;

(4) the child's parent, guardian, or custodian allows the child to participate in an obscene performance (as defined by IC 35-49-2-2 or IC 35-49-3-2);

(5) the child's parent, guardian, or custodian allows the child to commit a sex offense prohibited by IC 35-45-4;

(6) the child substantially endangers the child's own health or the health of another;

(7) the child's parent, guardian, or custodian fails to participate in a disciplinary proceeding in connection with the student's improper behavior, as provided for by IC 20-8.1-5-7, where the behavior of the student has been repeatedly disruptive in the school;

(8) the child is a missing child (as defined in IC 10-1-7-2);

and needs care, treatment, or rehabilitation that the child is not receiving, and that is unlikely to be provided or accepted without the coercive intervention of the court.

(b) An omission under subdivision (a)(2) is an occurrence in which the parent, guardian, or custodian allowed that person's child to receive any injury that the parent, guardian, or custodian had a reasonable opportunity to prevent or mitigate.

(c) A custodian under subsection (a) includes any person responsible for the child's welfare who is employed by a public or private residential school or foster care facility.

(d) When a parent, guardian, or custodian fails to provide specific medical treatment for a child because of the legitimate and genuine practice of the parent's, guardian's, or custodian's religious beliefs, a rebuttable presumption arises that the child is not a child in need of services because of such failure. However, this presumption does not prevent a juvenile court from ordering, when the health of a child requires, medical services from a physician licensed to practice medicine in Indiana. This presumption does not apply to situations in which the life or health of a child is in serious danger.

(e) Nothing in this chapter limits the right of a person to use reasonable corporal punishment when disciplining a child if the person is the parent, guardian, or custodian of the child. In addition, nothing in this chapter limits the lawful practice of
teaching of religious beliefs.

(f) A child in need of services under subsection (a) includes a handicapped child who is deprived of nutrition that is necessary sustain life, or who is deprived of medical or surgical intervention that is necessary to remedy or ameliorate a life threatening medical condition, if the nutrition or medical or surgical intervention is generally provided to similarly situated handicapped or nonhandicapped children.


31-6-4.3-1 Child in need of services; alcohol, controlled substance or legend drugs

A child is a child in need of services if:

1. the child is born with:
   A. fetal alcohol syndrome; or
   B. an addiction to a controlled substance or a legend drug; or

2. the child:
   A. has an injury;
   B. has abnormal psychological development; or
   C. is at a substantial risk of a life threatening condition;

that arises or is substantially aggravated because the child's mother used alcohol, a controlled substance, or a legend drug during pregnancy; and needs care, treatment, or rehabilitation that the child is not receiving, or that is unlikely to be provided or accepted without the coercive intervention of the court. As added by P.L. 294-1987, SEC.3. Amended by P.L. 155-1990, SEC. 21.

31-6-4-4 Taking child into custody; circumstances

(a) A child may be taken into custody by a law enforcement officer under an order of the court.

(b) A child may be taken into custody a law enforcement officer acting with probable cause to believe that the child has committed a delinquent act.

(c) A child may be taken into custody by a law enforcement officer, probation officer, or caseworker acting with probable cause to believe the child is a child in need of services if:

1. it appears that the child's physical or
mental condition will be seriously endangered if the child is not immediately taken into custody; 
(2) there is no reasonable opportunity to obtain an order of the court; and 
(3) consideration for the safety of the child precludes the immediate use of family services to prevent removal of the child.

However, a probation officer or caseworker may take a child into custody only if the circumstances make it impracticable to obtain assistance from a law enforcement officer.
(d) A child may be taken into custody by a:
(1) law enforcement officer;
(2) discharge the child or the child's parent, guardian, or custodian.


31-6-4-19.5 Report; availability to special advocate
In addition to the requirements of section 19(e) of this chapter, any report prepared by the state for the juvenile court's review shall also be made available to any court appointed special advocate within the same time period and in the same manner as required in the case of a parent under section 19(e) of this chapter. However, if under section 19(e) of this chapter the court determines on the record that the report contains information that should not be released to the parent, the court shall still provide a copy of such a report to any court appointed special advocate.

Chapter 5 TERMINATION OF THE PARENT CHILD RELATIONSHIP

31-6-5-1 Law governing proceedings
Proceedings under this chapter are governed by the procedures prescribed by IC 31-6-4 and IC 31-6-7 but are distinct from proceedings under IC 31-6-4. As added by Acts 1978, P.L. 136, SEC. 1.

31-6-5-2 Petition for voluntary termination of parental rights; notice of hearings; consent to termination; default judgment
(a) The county department, or a licensed child placing agency may sign and file a verified petition with the juvenile or probate court for the voluntary termination of parent-child relationship if requested by the parents. The probate court has concurrent original jurisdiction with the juvenile court in proceedings in the petition. The petition shall be entitled "In the Matter of the Termination of the Parent-Child Relationship of __________, a child, and
allege that:

(1) the parents are the child's natural or adoptive parents;
(2) the parents, including the alleged or adjudicated father if the child was born out of wedlock, knowingly and voluntarily consent to the termination of the parent-child relationship;
(3) termination is in the child's best interest; and
(4) the petitioner has developed a satisfactory plan of care and treatment for the child.

(b) The parents shall be notified of the hearing in accord with IC 31-6-7-5.

(c) The parents must give their consent in open court unless the court makes findings of fact upon the record that:

(1) the parents gave their consent in writing before a person authorized by law to take acknowledgements;
(2) they were notified of their constitutional and other legal rights and of the consequences of their actions under section 3 of this chapter; and
(3) they failed to appear.

Before the court may enter a termination order, it must inquire about the reasons for the parents' absence, and may require an investigation by a probation officer to determine whether there is any evidence of fraud or duress and to establish that the parents were competent to give their consent. The investigation must be entered on the record under oath by the person responsible for making it. If there is any competent evidence of probative value that fraud or duress was present when the written consent was given, or that a parent was incompetent, the court shall dismiss the petition or continue the proceeding. The court may issue any appropriate order for the care of the child pending the outcome of the case.

(d) Before consent may be given in court, the court must advise the parents of their constitutional and other legal rights and of the consequences of their actions under section 3 of this chapter.

(e) A parent who is incompetent may give consent to termination only with the approval of the court of the parent's guardian. A person under eighteen (18) years of age who is a parent may give the person's consent without such approval if the person is competent except for the person's age.

(f) if:

(1) the court determines that the allegations in the petition described in subsection (a) are true; and
(2) the other requirements of this chapter
are met; the court shall terminate the parent-child relationship. Otherwise, except as provided in subsection (g), the court shall dismiss the petition.

(g) If the court makes findings of fact upon the record that:

(1) one parent has made a valid consent to the termination of the parent-child relationship;
(2) the other parent cannot be located, after a good faith effort has been made to do so;
(3) the other parent has been served with notice of the proceedings in the most effective means under the circumstances; and
(4) the investigation that may be required under subsection (c) has been completed and entered on the record;


31-6-5-3 Advice to parents
For purposes of section 2 of this chapter, the parents must be advised that:

(1) their consent is permanent and cannot be revoked or set aside unless it was obtained by fraud or duress, or unless the parent is incompetent;
(2) when the court terminates the parent-child relationship, all rights, powers, privileges, immunities, duties, and obligations (including any rights to custody, control, visitation, or support) pertaining to that relationship are permanently terminated, and their consent to the child’s adoption is not required;
(3) they have a right to the care, custody, and control of their child as long as they fulfill their parental obligations;
(4) they have a right to a judicial determination of any alleged failure to fulfill their parental obligations in a proceeding to adjudicate their child a delinquent child or a child in need of services;
(5) they have a right to assistance in fulfilling their parental obligations after a court has determined that they are not doing so;
(6) proceedings to terminate the parent-child relationship against their will can be initiated only after:

(A) the child has been adjudicated a delinquent child or a child in need of services and the child has been removed from
their custody following that adjudication; or 
(B) a parent has been convicted and 
imprisoned for an offense listed in section 
4.2(a) of this chapter, the child has been 
removed from that parent's custody under a 
dispositional decree, and the child has been 
removed from that parent's custody for six 
(6) months under a court order. 
(7) they are entitled to representation by 
counsel, provided by the state if necessary 
throughout any proceedings to terminate the 
parent-child relationship against their will; and 
(8) they will receive notice of the hearing 
at which the court will decide if their consent 
was voluntary, and that they may appear at the 
hearing and allege that it was not voluntary. 
1979, P.L. 276, SEC. 33; Acts 1982, P.L. 183, SEC. 3; P.L. 
1-1990, SEC. 282.

31-6-5-4 Petition for termination of rights; delinquent 
child or child in need of services; hearing; 
objections 
(a) A verified petition to terminate the parent-
child relationship involving a delinquent child or a 
child in need of services may be signed and filed with 
the juvenile or probate court by: 
(1) the attorney for the county department; 
(2) the prosecutor; 
(3) the child's court appointed special 
advocate; or 
(4) the child's guardian ad litem. 
(b) Upon the filing of a petition under this 
section, the attorney for the court department or 
the prosecutor shall represent the interests of 
the state in all subsequent proceedings on the 
petition. The probate court has concurrent 
original jurisdiction with the juvenile court in 
proceedings on the petition. The personal filing 
the petition may request the court to set the 
petition for a hearing. 
(c) The petition shall be entitled "In the Matter of 
Termination of the Parent-Child Relationship of 
__________, a child, and ____________, the 
parent (or parents)" and must allege that: 
(1) the child has been removed from the 
parent for at least six (6) months under a 
dispositional decree; 
(2) there is a reasonable probability that: 
(A) the conditions that resulted in 
the child's removal will not be remedied; or 
(B) the continuation of the parent-
child relationship poses a threat to the 
well-being of the child
(3) termination is in the best interests of the child; and
(4) there is a satisfactory plan for the care and treatment of the child.

31-6-5-4.2 Termination of parent-child relationship; petition; hearing (later effective date)

(a) If an individual is convicted of the offense of:

(1) murder (IC 35-42-1-1);
(2) causing suicide (IC 35-42-1-2);
(3) voluntary manslaughter (IC 35-42-1-3);
(4) involuntary manslaughter (IC 35-42-1-4);
(5) rape (IC 35-42-4-1);
(6) criminal deviate conduct (IC 35-42-4-2);
(7) child molesting (IC 35-42-4-3);
(8) child exploitation (IC 35-42-4-4); or
(9) incest (IC 35-4-1-3);

and the victim of that offense was under sixteen (16) years of age at the time of the offense and is that individual's biological or adoptive child, or is the child of a spouse of the individual who has committed the offense, the prosecuting attorney, the attorney for the county department, or the child's guardian ad litem or court appointed special advocate may file a petition with the juvenile or probate court to terminate the parent-child relationship of the individual who has committed the offense with the victim of the offense, the victim's siblings, or any biological or adoptive child of that individual. The probate court has concurrent original jurisdiction with the juvenile court in proceedings on the petition. The person filing the petition shall represent the interests of the state in all subsequent proceedings on the petition. Upon the filing of a petition under this section, the attorney for the county department or the persecutor shall represent the interests of the state in all subsequent proceedings. The person filing the petition may request that the court set the petition for a hearing.

(b) The verified petition filed under subsection (a) shall be entitled "In the matter of the _________, a child, and _________, the parent (or parents)" and must allege that:

(1) the victim of an offense listed in subsection (a) is:
(A) the subject of the petition;
(B) the biological or adoptive sibling of the subject of the petition; or
(C) the child of a spouse of the individual whose parent-child relationship is sought to be terminated under this chapter;
(2) the individual whose parent-child relationship is sought to be terminated under this chapter was convicted;
(3) the child has been removed from the parent under a dispositional decree, and the child has been removed from the parent's custody for at least six (6) months under a court order;
(4) there is a reasonable probability that the conditions that resulted in the child's removal will not be remedied or that continuation of the parent-child relationship poses a threat to the well-being of the child;
(5) termination is in the best interests of the child; and
(6) there is a satisfactory plan for the care and treatment of the child.
(C) A showing that an individual has been convicted of an offense described in subsection (a) is prima facie evidence that there is a reasonable probability that:
(1) the conditions that resulted in the removal of the child from the parent under a court order will not be remedied; or
(2) continuation of the parent-child relationship poses a threat to the well-being of the child.


31-6-5-4.3 Termination of parent-child relationship; dismissal of petition

If the court finds that the allegations in a petition described in section 4 or 4.2 of this chapter are true, the court shall terminate the parent-child relationship. Otherwise the court shall dismiss the petition. As added by P.L. 3-1989, SEC. 182. Amended by P.L. 1-1990, SEC. 285.

31-6-5-5 Disposition upon termination of parental rights

When the juvenile or probate court terminates the parent-child relationship, it may:
(1) refer the matter to the court having probate jurisdiction for adoption proceedings; or
(2) order any dispositional alternative specified by IC 3-16-4-15.4.


31-6-5-6 Rights, privileges and obligations of parent and child upon termination of relationship

(a) When the juvenile or probate court terminates the parent-child relationship, all rights, powers,
privileges, immunities, duties, and obligations (including any rights to custody, control, visitation, or support) pertaining to that relationship are permanently terminated, and the parent's consent to the child's adoption is not required.

(b) Any support obligations that accrued before the termination are not affected except that the support payments shall be made under the juvenile or probate court's order. As added by Acts 1978, P.L. 136, SEC. 1. Amended by Acts 1979, P.L. 276, SEC. 34; Acts 1982, P.L. 183, SEC. 7.

Title 35    Criminal Law
Article 42   Offenses Against The Person
Chapter 12    SEX CRIMES

35-42-4-1   Rape
A person who knowingly or intentionally has sexual intercourse with a member of the opposite sex when:

(1) the other person is compelled by force of imminent threat of force;
(2) the other person is unaware that the sexual intercourse is occurring; or
(3) the other person is so mentally disabled or deficient that consent to sexual intercourse cannot be given;

commits rape, a Class B felony. However, the offense is a Class A felony if it is committed by using or threatening the use of deadly force or it is committed while armed with a deadly weapon, or if it results in serious bodily injury to a person other than a defendant. As added by Acts 1976, P.L. 148, Sec.2. Amended by Acts 1977, P.L. 340, SEC. 36; P.L. 320-1983, SEC. 23, P.L. 16-1984, SEC. 19; P.L. 297-1989, SEC. 1.

35-42-4-2 Criminal deviate conduct
A person who knowingly or intentionally causes another person to perform or submit to deviate sexual conduct when:

(1) the other person is compelled by force or imminent threat of force;
(2) the other person is unaware that the conduct is occurring; or
(3) the other person is so mentally disabled or deficient that consent to the conduct cannot be given;

commits criminal deviate conduct, a Class B felony. However, the offense is a Class A felony if it is committed by using or threatening the use of deadly force, if it is committed while armed with a deadly weapon or if it results serious bodily injury to any person other than a defendant. As added by Acts 1976, P.L. 148, SEC. 2. Amended by Acts 1977, P.L. 340, SEC. 37; P.L. 320-1093, SEC. 24; P.L. 183-
1984, SEC. 3.

35-42-4-3 Child molesting
(a) A person who, with a child under twelve (12) years of age, performs or submits to sexual intercourse or deviate sexual conduct commits child molesting, a Class B felony. However, the offense is a Class A felony if it is committed by using or threatening the use of deadly force, or while armed with a deadly weapon, or if it results in serious bodily injury.
(b) A person who, with a child under twelve (12) years of age, performs or submits to any fondling or touching, of either the child or the older person, with intent to arouse or to satisfy the sexual desires of either the child or the older person, commits child molesting, a Class C felony. However, the offense is a Class A felony if it is committed by using or threatening the use of deadly force, or while armed with a deadly weapon.
(c) A person sixteen (16) years of age or older who, with a child of twelve (12) years of age or older but under sixteen (16) years of age, performs or submits to sexual intercourse or deviate sexual conduct commits child molesting, a Class C felony. However, the offense is a Class A felony if it is committed by using or threatening the use of deadly force, or while armed with a deadly weapon.
(d) A person sixteen (16) years of age, or older who, with a child twelve (12) years of age or older but under sixteen (16) years of age, performs or submits to any fondling or touching, of either the child or the older person, with intent to arouse or to satisfy the sexual desires of either the child or the older person, commits child molesting, a Class D felony. However, the offense is a Class B felony if it is committed by using or threatening the use of deadly force, or while armed with a deadly weapon.
(e) It is a defense that the accused person reasonably believed that the child was sixteen (16) years of age or older at the time of the conduct.

35-42-4-4 Child exploitation; child pornography; exceptions
(a) As used in this section:
"disseminate" means to transfer possessions for free or for a consideration.
"Matter" has the same meaning as in IC 35-49-1-3.
"Performance" has the same meaning as in IC 35-49-1-7.
"Sexual conduct" means sexual intercourse, deviate
sexual conduct, exhibition of the uncovered genitals intended to satisfy or arouse the sexual desires of any person, sado-masochistic abuse, sexual intercourse or deviate sexual conduct with an animal, or any fondling or touching of a child by another person or of another person by a child intended to arouse or satisfy the sexual desires of either the child or the other person.

(b) A person who knowingly or intentionally:

(1) manages, produces, sponsors, presents, exhibits, photographs, films, or videotapes any performance or incident that includes sexual conduct by a child under sixteen (16) years of age; or

(2) disseminates, exhibits to another person, offers to disseminate or exhibit to another person, or sends or brings into Indiana for dissemination or exhibition matter that depicts or describes sexual conduct by a child under sixteen (16) years of age;

commits child exploitation, a Class D felony.

(c) A person who knowingly or intentionally possesses:

(1) a picture;

(2) a drawing;

(3) a photograph;

(4) a negative image;

(5) undeveloped film;

(6) a motion picture;

(7) a videotape; or

(8) any pictorial representation;

that depicts or describes sexual conduct by a child who is, or appears to be, less than sixteen (16) years of age and that lacks serious literary, artistic, political or scientific value commits possession of child pornography, a Class A misdemeanor.

This section does not apply to a bona fide school, museum, or public library that qualifies for certain property tax exemptions under IC 6-1.1-10, or to an employee of such a school, museum, or public library acting within the scope of the employee's employment when the possession of the listed materials are for legitimate scientific or educational purposes. As added by Acts 1978, P.L. 148, SEC. 5. Amended by P.L. 325-1983, SEC. 1; P.L. 206-1986, SEC. 1; P.L. 37-1990, SEC. 25.

35-42-4-5 Vicarious sexual gratification

(a) A person eighteen (18) years of age or older who knowingly or intentionally directs, aids, induces, or causes a child under the age of sixteen (16) to touch or fondle himself or another child under the age of sixteen (16) with intent to arouse or satisfy the sexual desires of a child or the older person commits vicarious sexual gratification, a Class D felony.
However, the offense is a Class C felony if a child involved in the offense is under the age of twelve (12), and it is a Class B felony if the offense is committed by using or threatening the use of deadly force, or while armed with a deadly weapon, and a Class A felony if it results in serious bodily injury.

(b) A person eighteen (18) years of age or older who knowingly or intentionally directs, aids, induces, or causes a child under the age of sixteen (16) to:
   (1) engage in sexual intercourse with another child under sixteen (16) years of age;
   (2) engage in sexual conduct with an animal other than a human being;
   (3) engage in deviate sexual conduct with another person;

with intent to arouse or satisfy the sexual desires of a child or the older person commits vicarious sexual gratification, a Class C felony. However, the offense is a Class B felony if any child involved in the offense is less than twelve (12) years of age, and it is a Class A felony if the offense is committed by using or threatening the use of deadly force, or while armed with a deadly weapon, or if it results in serious bodily injury. As added by P.L. 183-1984, SEC. 4.

35-42-4-6 Child solicitation
A person eighteen (18) years of age or older who knowingly or intentionally solicits a child under twelve (12) years of age to engage in:
   (1) sexual intercourse;
   (2) deviate sexual conduct; or
   (3) any fondling or touching intended to arouse or satisfy the sexual desires of either the child or the older person;

commits child solicitation, a Class A misdemeanor. As added by P.L. 183-1984, SEC. 5.

35-42-4-7 Child seduction
(a) As used in this section, "adoptive parent" has the meaning set forth in IC 31-3-4-3.

(b) As used in this section, "adoptive grandparent" means the parent of an adoptive parent.

(c) As used in this section, "custodian" includes any person responsible for a child's welfare who is employed by a public or private residential school or foster care facility.

(d) As used in this section, "stepparent" means an individual who is married to a child's custodial or noncustodial parent and is not the child's adoptive parent.

(e) If a person who is:
   (1) at least eighteen (18) years of age; and
   (2) the guardian, adoptive parent, adoptive grandparent, custodian, or stepparent of a child
at least sixteen (16) years of age but less than eighteen (18) years of age;
engages in sexual intercourse or deviate sexual conduct with
the child, the person commits child seduction, a Class D

35-42-4-8 Sexual battery
A person who, with intent to arouse or satisfy the person's
own sexual desires or the sexual desires of another person,
touches another person when that person is:
(1) compelled to submit to the touching by
force or the imminent threat of force; or
(2) so mentally disabled or deficient that
consent to the touching cannot be given;
commits sexual battery, a Class D felony. However, the
offense is a Class C felony if it is committed by using or
threatening the use of deadly force or while armed with a
deadly weapon. As added by P.L. 322-1987, Sec. 2.

Title 35 Criminal Law
Article 46 Miscellaneous Offenses

Chapter 1 OFFENSES AGAINST THE FAMILY

35-46-1-1 Definitions
As used in this chapter:
"Dependent" means:
(1) an unemancipated person who is under
eighteen (18) years of age; or
(2) a person of any age who is mentally or
physically disabled.
"Endangered adult" has the meaning set forth in IC
4-28-5-2.
"Support" means food, clothing, shelter, or
Amended by Acts 1977, P.L. 340, SEC. 84; P.L. 185-1984,
SEC. 2; P.L. 208-1986, SEC. 1; P.L. 41-1987, SEC. 19.

35-46-1-2 "Tobacco" defined
As used in this chapter, "tobacco" includes:
(1) chewing tobacco;
(2) cigars, cigarettes, and snuff that
contain tobacco; and
(3) pipe tobacco.
As added by P.L. 318-1987, SEC. 2.

35-46-1-2 Bigamy
(a) A person who, being married and knowing that
his spouse is alive, marries again commits bigamy, a
Class D felony.
(b) It is a defense that the accused person
reasonably believed that he was eligible to remarry.
As added by Acts 1976, P.L. 148, SEC. 6. Amended by

35-46-1-3 **Incest**
(a) A person eighteen (18) years of age or older who engages in sexual intercourse or deviate sexual conduct with another person, when the person knows that the other person is related to the person biologically as a parent, child, grandparent, grandchild, sibling, aunt, uncle, niece, or nephew, commits incest, a Class D felony.
(b) It is a defense that the accused person's otherwise incestuous relation with the other person was based on their marriage, if it was valid where entered into. As added by Acts 1976, P.L. 148, SEC. 6. Amended by Acts 1977, P.L. 340, SEC. 86; P.L. 158-1987, SEC. 5.

35-46-1-4 **Neglect of a dependent; child selling**
(a) A person having the care of a dependent, whether assumed voluntarily or because of a legal obligation, who knowingly or intentionally:
(1) places the dependent in a situation that may endanger his life or health;
(2) abandons or cruelly confines the dependent;
(3) deprives the dependent of necessary support; or
(4) deprives the dependent of education as required by law;
commits neglect of a dependent, a Class D felony. However, except for a violation of clause (4), the offense is a Class B felony if it results in serious bodily injury. It is a defense that the accused person, in the legitimate practice of his religious belief, provided treatment by spiritual means through prayer, in lieu of medical care, to his dependent.
(b) Except for property transferred or received:
(1) under a court order made in connection with a proceeding under IC 31-1-11.5 or IC 31-6-5; or
(2) under IC 35-46-1-9(b);
a person who transfers or receives any property in consideration for the termination of the are, custody, or control of a person's dependent child commits child selling, a Class D felony. As added by Acts 1976, P.L. 148, SEC. 6.


35-46-1-5 **Nonsupport of a dependent child**
(a) A person who knowingly or intentionally fails to provide support to his dependent child commits nonsupport of a child, a Class D felony.
(b) It is a defense that the child had abandoned the home of his family without the consent of his parent or on the order of a court, but it is not a defense that the child abandoned the home of his family if the cause of the child's leaving was the fault of his parent.

(c) It is a defense that the accused person, in the legitimate practice of his religious belief, provided treatment by spiritual means through prayer, in lieu of medical care, to his dependent child.

(d) It is a defense that the accused person was unable to provide support. As added by Acts 1976, P.L. 148, SEC. 6. Amended by Acts 1977, P.L. 340, SEC. 88; Acts 1978, P.L. 144, SEC. 9.

35-46-1-6 Non-support of a spouse

(a) A person who knowingly or intentionally fails to provide support to his spouse, when the spouse needs support, commits non-support of a spouse, a Class D felony.

(b) It is a defense that the accused person was unable to provide support. As added by Acts 1976, P.L. 148, Sec. 6. Amended by Acts 1977, P.L. 340, SEC. 89; Acts 1978, P.L. 144, SEC. 10.

35-46-1-7 Non-support of a parent

(a) A person who knowingly or intentionally fails to provide support to his parent, when the parent is unable to support himself, commits non-support of a parent, a Class A misdemeanor.

(b) It is a defense that the accused person had not been supported by the parent during the time he was a dependent child under eighteen (18) years of age, unless the parent was unable to provide support.

(c) It is a defense that the accused person was unable to provide support. As added by Acts 1976, P.L. 148, SEC. 6. Amended by Acts 1977, P.L. 340, SEC. 90; Acts 1978, P.L. 144, SEC. 11.

35-46-1-8 Contributing to the delinquency of a minor

A person eighteen (18) years of age or older who knowingly or intentionally encourages, aids, induces, or causes a person under eighteen (18) years of age to commit an act of delinquency as defined by IC 31-6-4-1 commits contributing to delinquency, a Class A misdemeanor. As added by Acts 1976, P.L. 148, SEC. 6. Amended by Acts 1977, P.L. 340, SEC. 91; Acts 1978, P.L. 144, SEC. 12; Acts 1979, P.L. 276, SEC. 58.

35-46-1-9 Profiting from an adoption

(a) Except as provided in subsection (b), a person who, with respect to an adoption, transfers or receives any property in connection with the waiver of parental rights, the termination of parental rights,
the consent to adoption, or the petition for adoption commits profiting from an adoption, a Class D felony.
(b) This section does not apply to the transfer or receipt of:
1. reasonable attorney's fees;
2. hospital and medical expenses concerning childbirth and pregnancy incurred by the adopted person's natural mother;
3. reasonable charges and fees levied by a child placing agency licensed under IC 12-3-2 or by a county department of public welfare; or
4. other charges and fees approved by the court supervising the adoption.

35-46-1-10 Sale or distribution of tobacco to certain minors; defenses; "distribute" defined
(a) A person who knowingly sells or distributes tobacco to a person less than eighteen (18) years of age commits a Class C infraction.
(b) It is not a defense that the person to whom the tobacco was sold or distributed did not smoke, chew, or otherwise consume the tobacco.
(c) It is a defense that the accused person reasonably believed that the buyer or taker was at least eighteen (18) years of age.
(d) It is a defense that the accused person sold or delivered the tobacco to a person who acted in the ordinary course of employment or a business concerning tobacco:
1. agriculture;
2. processing;
3. transporting;
4. wholesaling; or
5. retailing.
(e) As used in this section, "distribute" means to give tobacco to another person as a means of promoting, advertising, or marketing the tobacco to the general public. As added by Acts 1980, P.L. 209, SEC. 1. Amended by P.L. 330-1983, SEC. 1; P.L. 318-1987, SEC. 3; P.L. 125-1988, SEC. 4.

35-46-1-10.5 Purchase or acceptance of tobacco by minors
A person less than eighteen (18) years of age who:
1. purchases tobacco; or
2. accepts tobacco for personal use;
commits a Class C infraction. As added by P.L. 125-1988, SEC. 5.

35-46-1-11 Retail sale of tobacco; warning notices to minors required, failure to post, offenses
(a) A tobacco vending machine that is located in a public place must bear a conspicuous notice reading as follows, with the capitalization indicated: "If you
are under 18 years of age, YOUR ARE FORBIDDEN by Indiana law to buy tobacco from this machine.
(b) A person who owns or has control over a tobacco vending machine in a public place and who:
   (1) fails to post the notice required by subsection (a) on his vending machine; or
   (2) fails to replace the notice within one month after it is removed or defaced;
commits a Class C infraction.
(c) An establishment selling tobacco at retail shall post and maintain in a conspicuous place a sign, printed in letters at least one-half (1/2) inch high, reading as follows: "The sale of tobacco to persons under 18 years of age is forbidden by Indiana law."
(d) A person who:
   (1) owns or has control over an establishment selling tobacco at retail; and
   (2) fails to post and maintain the sign required by subsection (c);

35-46-1-12 Exploitation of a dependent or an endangered adult
A person who recklessly, knowingly, or intentionally exerts unauthorized use of the personal services or the property of:
   (1) an endangered adult; or
   (2) a dependent eighteen (18) years of age or older;
for one's own profit or advantage, or for the profit or advantage of another, commits exploitation of a dependent or endangered adult, a Class A misdemeanor. As added by Acts 1981, P.L. 299, SEC. 3. Amended by P.L. 185-1984, SEC. 3.

35-46-1-13 Battery, neglect or exploitation of endangered adult; failure to report; unlawful disclosure; referrals; retaliation
(a) A person who:
   (1) believes or has reason to believe that an endangered adult is the victim of battery, neglect, or exploitation as prohibited by this chapter, IC 35-42-2-1(2)(C), or IC 35-42-2-1(2)(E); and
   (2) fails to report the facts supporting that belief to the department of human services, the adult protective services unit designated under IC 4-28-5, or a law enforcement agency having jurisdiction over battery, neglect, or exploitation of an endangered adult;
commits a Class A infraction.
(b) An officer or employee of the department or adult protective services unit who unlawfully discloses information contained in the records of the department
of human services under IC 4-28-5-9 commits a Class C infraction.

(c) A law enforcement agency that receives a report that an endangered adult is or may be a victim of battery, neglect, or exploitation as prohibited by this chapter, IC 35-42-2-1(2)(C), or IC 35-42-2-1(2)(E) shall immediately communicate the report to the adult protective services unit designated under IC 4-28-5.


35-46-1-14 Reporting or documenting battery, neglect or exploitation; immunity from civil or criminal liability

Any person acting in good faith who:

(1) makes or causes to be made a report of neglect, battery, or exploitation under this chapter, IC 35-42-2-1(2)(C), or IC 35-42-2-1(2)(E);

(2) makes or causes to be made photographs or X-rays of a victim of suspected neglect or battery of an endangered adult or a dependent eighteen (18) years of age or older; or

(3) participates in any official proceeding or a proceeding resulting from a report of neglect, battery, or exploitation of an endangered adult or a dependent eighteen (18) years of age or older relating to the subject matter of that report;

is immune from any civil or criminal liability that might otherwise be imposed because of these actions. However, this section does not apply to a person accused of neglect, battery, or exploitation of an endangered adult or a dependent eighteen (18) years of age or older. As added by Acts 1981, P.L. 299, SEC. 5. Amended by P.L. 185-1984, SEC. 5.
APPENDIX B

Selected Indiana Statutes: Abuse of Endangered Adults
SELECTED INDIANA STATUTES

ABUSE OF ENDANGERED ADULTS

Title 12 Administration
Article 9 Division of Aging and Rehabilitative Services

Chapter 3 ADULT PROTECTIVE SERVICES

12-9-3-1 "Adult protective services unit" defined
As used in this chapter, "adult protective services unit" refers to the entity with which the division has contracted to:

(1) investigate or coordinate the investigation of reports concerning an endangered adult; and
(2) assist in obtaining protective services for an endangered adult.

12-9-3-2 "Endangered adult" defined
As used in this chapter, "endangered adult" means an individual who is:

(1) at least eighteen (18) years of age;
(2) incapable by reason of insanity, mental illness, mental retardation, senility, habitual drunkenness, excessive use of drugs, old age, infirmity, or other incapacity, of either managing the individual's property or providing self-care, or both; and
(3) harmed or threatened with harm as a result of:
(A) neglect;
(B) battery; or
(C) exploitation of the individual's personal services or property.

12-9-3-3 "Government entity" defined
As used in this chapter, "governmental entity" means an office or a department that is under the direct supervision of a local elected official or a county department.

12-9-3-4 "Life threatening emergency" defined
As used in this chapter, "life threatening emergency" means a situation in which:

(1) a severe threat to the life or health of an endangered adult exists;
(2) immediate care or treatment is required to alleviate that threat; and
(3) the endangered adult is unable to provide or obtain the necessary care or treatment.

12-9-3-5 "Protective services" defined
As used in this chapter, "protective services" refers to available medical, psychiatric, residential, and social services that are necessary to protect the health or safety of an endangered adult.

12-9-3-6 "Reason to believe" defined
For the purpose of this chapter, an individual has "reason to believe" that a particular adult is an endangered adult if the individual has been presented with evidence that, if presented to an individual of similar background and training, would cause the individual to believe that the adult is an endangered adult.

12-9-3-7 Contracts for required services
The division shall contract for the services required in each county under this chapter with:

(1) the prosecuting attorney in each judicial circuit;

(2) the prosecuting attorney to perform part of the services and a governmental entity qualified to perform the remainder of the services required; or

(3) if the prosecuting attorney decides not to enter into a contract, a governmental entity qualified to provide the services required.

12-9-3-8 Endangered adults; duties of adult protective services unit
If the adult protective services unit has reason to believe that an individual is an endangered adult, the adult protective services unit shall do the following:

(1) Investigate the complaint or cause the complaint to be investigated by a law enforcement or other agency and make a determination as to whether the individual reported is an endangered adult.

(2) Upon a determination that an individual is an endangered adult under this chapter, do the following:

(A) Initiate procedures that the adult protective services unit determines are necessary, based on an evaluation of the needs of the endangered adult, to protect the endangered adult.

(B) Coordinate and cooperate with the division or other appropriate person to obtain protective services for the endangered adult, including the development of a plan in cooperation with the endangered adult, whereby the least restrictive protective
services necessary to protect the endangered adult will be made available to the endangered adult.

(C) Monitor the protective services provided the endangered adult to determine the effectiveness of the services.

12-9-3-9  

Endangered adult reports; duty of individuals and institutions

(a) An individual who believes or has reason to believe that another individual is an endangered adult shall make a report under this chapter.

(b) If an individual is required to make a report under this chapter in the individual's capacity as a member of the staff of a medical or other public or private institution, school, hospital, facility, or agency, the individual shall immediately notify the individual in charge of the institution, school, hospital, facility, or agency, or the individual's designated agent, who also becomes responsible to report or cause a report to be made.

(c) This section does not relieve an individual of the obligation to report on the individual's own behalf, unless a report has already been made to the best of the individual's belief.

12-9-3-10  

Endangered adult reports; communication; notice to department; contents

(a) Each endangered adult report made under this chapter shall be communicated immediately to at least one (1) of the following:

(1) The adult protective services unit.
(2) A law enforcement agency.
(3) the division by telephone on the statewide toll free telephone number established under section 12 of this chapter.

(b) A law enforcement agency that receives an endangered adult report shall immediately communicate the report to the adult protective services unit and the unit shall notify the division of the report.

(c) Reports must include as much of the following information as is known:

(1) The name, age, and address of the endangered adult.
(2) The names and addresses of family members or other persons financially responsible for the endangered adult's care or other individuals who may be able to provide relevant information.
(3) The apparent nature and extent of the alleged neglect, battery, or exploitation and the endangered adult's physical and mental condition.
(4) The name, address, and telephone number
of the reported and the basis of the reporter's knowledge.

(5) Any other relevant information regarding the circumstances of the endangered adult.

12-9-3-11 Immunity from liability; privileged information; actions of employer

(a) A person, other than a person against whom a complaint concerning an endangered adult has been made, who in good faith:

(1) makes or causes to be made a report required to be made under this chapter;

(2) testifies or participates in any investigation or administrative or judicial proceeding on matters arising from the report;

(3) makes or causes to be made photographs or x-rays of an endangered adult; or

(4) discusses a report required to be made under this chapter with the division, the adult protective services unit, a law enforcement agency, or other appropriate agency;

is immune from both civil and criminal liability arising from those actions.

(b) An individual may not be excused from testifying before a court or grand jury concerning a report made under this chapter on the basis that the testimony is privileged information, unless the individual is an attorney, a physician, a clergyman, a husband, or a wife who is not a competent witness under IC 34-1-14-5.

(c) An employer may not discharge, demote, transfer, prepare a negative work performance evaluation, or reduce benefits, pay, or work privileges, or take any other action to retaliate against an employee who in good faith files a report under this chapter.

12-9-3-12 Statewide toll free telephone line
The division shall establish a statewide toll free telephone line continuously open to receive reports of suspected neglect, battery, or exploitation.

12-9-3-13 Department records
The division shall maintain the following:

(1) Records on individuals that the division and adult protective services units have determined to be endangered adults and the protective services needed.

(2) Records of agencies, persons, or institutions who are determined to have permitted neglect, battery, or exploitation of endangered adults.

(3) Nonidentifying statistical records concerning unsubstantiated reports about
endangered adults.
The information maintained under this section shall be used solely for statistical purposes and must be available to law enforcement officials, state licensing agencies, and other officials and employees of municipal, county, and state government having a legitimate interest in the welfare of individuals who may be endangered adults or who have a legitimate interest in the operation of agencies or institutions providing care to individuals served under this chapter.

12-9-3-14 Reports
The division shall refer reports of neglect, battery, or exploitation to appropriate adult protective services units.

12-9-3-15 Confidentiality of reports
Reports made under this chapter and any other information obtained, reports written, or photographs taken concerning the reports are confidential and may be made available only to the following:

(1) Those persons authorized by section 13 of this chapter.
(2) A person who is the subject of the report.
(3) A person named in the report.
(4) The guardian or attorney of the persons described in subdivision (2) or (3).

12-9-3-16 Expungement of unsubstantiated reports
If the adult protective services unit determines that a report concerning an endangered adult is unsubstantiated, the adult protective services unit and the division shall destroy any identifying records the unit and division possess concerning the report.

12-9-3-17 Report to state board of health; request for assistance
If an adult protective services unit receives a report alleging that an individual who is a resident of a facility licensed under IC 16-10-4 is an endangered adult, the adult protective services unit shall immediately communicate the report to the state department of health under IC 16-10-4-14. The division or the adult protective services unit shall perform the other responsibilities concerning endangered adults under section 8 of this chapter only if the state department of health requests the assistance of the division or the adult protective services unit.

12-9-3-18 Referrals
If it appears that the immediate health or safety of an endangered adult is in danger, the division or adult protective services unit shall immediately refer the matter to the appropriate law enforcement agency and shall assist the law enforcement agency as requested by that agency. In
all other cases, referral to the appropriate adult protective services unit shall be made within five (5) working days after the receipt of a report.

12-9-3-19  **Jurisdiction**
The circuit and superior courts with jurisdiction in the county in which the alleged endangered adult resides have original and concurrent jurisdiction over a matter filed under this chapter.

12-9-3-20  **Consent to receive services**
If an endangered adult gives consent to receive protective services arranged by the division or adult protective services unit and another person interferes with the delivery of the services, the division or adult protective services unit may, through the prosecuting attorney's office of the county in which the endangered adult resides, petition the circuit or superior court for an order to do the following:

1. Enjoin the interference with the delivery of the services.
2. Implement the delivery of services the endangered adult has consented to receive.

12-9-3-21  **Petitions**
If an alleged endangered adult does not or is unable to consent to the receipt of protective services arranged by the division or the adult protective services unit or withdraws consent previously given, the adult protective services unit, or any person upon consent of the adult protective services unit, may petition the court to require the alleged endangered adult to receive protective services. The petition must be under oath or affirmation and must include the following:

1. The name, age, and residence of the alleged endangered adult who is to receive protective services.
2. The nature of the problem or reason for the filing of the petition for protective order.
3. The name and address of the petitioner and the name and address of the person or organization that may be required to complete the court ordered protective services. If the petitioner is an organization, the petition must contain information concerning the title and authority of the individual filing on behalf of that organization.
4. Certification that notice of the petition has been given to the alleged endangered adult, the alleged endangered adult's attorney, if any, or the alleged endangered adult's next of kin or guardian, if any. If notice has not been given, a description of the attempts to give
notice shall be given.

(5) The name and address of the individuals most closely related by blood or marriage to the alleged endangered adult, if known.

(6) A description of the proposed protective services to be provided.

(7) A statement that the adult protective services unit has been notified and consented to the petition if the petitioner is not the adult protective services unit.

12-9-3-22 **Hearings**
At a hearing at which a court determines whether an endangered adult should be required to receive protective services, the endangered adult is entitled to the following:

(1) To be represented by counsel.

(2) To have the court appoint counsel for the endangered adult if the court determines the endangered adult is indigent.

12-9-3-23 **Requirements for orders**
The court may require an individual to receive protective services only if the court finds, after a hearing, that the individual:

(1) is an endangered adult;

(2) is in need of protective services; and

(3) lacks the ability to make an informed decision concerning the endangered adult's need for protective services.

12-9-3-24 **Orders**
If, after a hearing, the court determines that an endangered adult should be required to receive protective services, the court shall issue a protective services order. The order must stipulate the following:

(1) The objectives of the protective services order.

(2) The least restrictive protective services necessary to attain the objectives of the protective services order that the endangered adult much receive.

(3) The duration during which the endangered adult much receive the protective services.

(4) That the adult protective services unit or other person designated by the court shall do the following:

(A) Provide or arrange for the provision of the protective services ordered by the court.

(B) Petition the court to modify or terminate the protective services order if:

(1) the protective services ordered by the court have not been
effective in attaining the objectives of the protective services order;
(ii) the physical or mental health of the endangered adult is no longer in danger and the termination of the protective services order will be likely to place the endangered adult's physical or mental health in danger; or
(iii) the endangered adult has consented to receive the protective services ordered by the court.

12-9-3-25 Termination of orders
The court may modify or terminate a protective services order upon its own motion or upon the motion of any of the following:

(1) The endangered adult.
(2) The endangered adult's guardian, custodian, or guardian ad litem.
(3) The adult protective services unit.
(4) Any person providing services to the endangered adult under the protective services order.

12-9-3-26 Continuing jurisdiction
Every six (6) months after the date of the original protective services order or more often if ordered by the court, the adult protective services unit shall petition the court to hold a hearing on the question of continuing jurisdiction. For jurisdiction to continue, the court must find one (1) of the following:

(1) That the objectives of the order have not been attained, but that there is a reasonable probability that the objectives will be attained if the order is continued with or without modifications.
(2) That the objectives of the order have been attained, but that termination of the order will likely place the endangered adult's physical or mental health in danger.

12-9-3-27 Orders to enjoin interference
The court may issue an order to enjoin a person from interference with the delivery of a protective service ordered under section 24 of this chapter.

12-9-3-28 Emergency protective services; petitions; hearings; orders
(a) If:
   (1) an alleged endangered adult does not or is unable to consent to the receipt of protective services arranged by the division or the adult protective services unit or withdraws consent previously given; and
(2) the endangered adult is involved in a
life threatening emergency;
the adult protective services unit may petition the
superior or circuit court in the county where the
alleged endangered adult resides for an emergency
protective order.
(b) A petition for an emergency protective order
must be under oath or affirmation and must include the
following:

(1) The name, age, and residence of the
endangered adult who is to receive emergency
protective services.

(2) The nature of the problem and an
allegation that a life threatening emergency
exists.

(3) Evidence that immediate and irreparable
injury will result if there is a delay in the
provision of services.

(4) The name and address of the petitioner
who is filing the petition and the name and
address of the person or organization that may be
required to complete the court ordered emergency
protective services.

(5) Certification that notice has been given
to the alleged endangered adult, the alleged
endangered adult's attorney, if any or the alleged
endangered adult's next of kin, if any. If notice
has not been given, a description of the attempts
to give notice shall be given.

(6) A description of the emergency
protective services to be provided.

(c) If, after the hearing of the petition, the
court determines that the endangered adult should be
required to receive emergency protective services, the
court shall issue an emergency protective order if the
court finds the following:

(1) The individual is an endangered adult.

(2) A life threatening emergency exists.

(3) The endangered adult is in need of the
proposed emergency protective services.

The court may issue the order ex parte.

(d) An emergency protective order must stipulate
the following:

(1) The objectives of the emergency
protective order.

(2) The least restrictive emergency
protective services necessary to attain the
objectives of the emergency protective order that
the endangered adult must receive.

(3) The duration during which the endangered
adult must receive the emergency protective
services.

(4) That the emergency protective services
unit or other person designated by the court shall
do the following:
   (A) Provide or arrange for the provision of the emergency protective services ordered by the court.

   (B) Petition the court to modify or terminate the emergency protective order if:
       (i) the emergency protective services ordered by the court have not been effective in attaining the objectives of the emergency protective order.
       (ii) the physical or mental health of endangered adult is no longer in danger and the termination of the emergency protective order will not be likely to place the endangered adult's physical or mental health in danger; or
       (iii) the endangered adult has consented to receive the emergency protective services ordered by the court.

   (e) The court may issue an order to enjoin a person from interfering with the delivery of services ordered by an emergency protective order issued under this section.

   (f) An emergency protective order issued under this section may not remain in effect for longer than:
       (1) ten (10) days; or
       (2) thirty (30) days if the adult protective services unit show the court that an extraordinary need exists that requires the order to remain in effect for not more than thirty (30) days.

   (g) If at the expiration of an order the adult protective services unit determines that the endangered adult is in need of further protective services and that the endangered adult does not consent to the receipt of the services, a petition may be filed under section 21 of this chapter.

12-9-3-29 Immunity from liability
An officer, agency, or employee of the division or adult protective services unit who performs duties in good faith under this chapter in rendering care to an endangered adult is immune from both civil and criminal liability arising from acts or omissions in rendering the service or care to the endangered adult.

12-9-3-30 Report to general assembly
The division shall report to the general assembly before December 1 of each year concerning the division's activities under this chapter during the preceding fiscal year. The report must include the recommendations of the division relating to the need for continuing care of endangered adults under this chapter.