



National Voluntary Consensus Guidelines for
State Adult Protective Services Systems

Proposed Updated Guidelines

All Content

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Purpose

This document provides proposed updated content for the 2016 National Voluntary Consensus Guidelines for State Adult Protective Services (APS) Systems (Guidelines). The Guidelines were first released by the Administration for Community Living (ACL) in 2016 to provide the APS field with guidance for effective practices. The Guidelines were based on findings from published studies as well as experiences from the field.

This year, ACL is updating the Guidelines to incorporate new research findings and new areas of interest in APS practices and policies. To identify new findings, a literature search of peer-reviewed journal articles, published between April 1, 2014 and November 30, 2018, was conducted. A final group of 24 articles met the inclusion criteria and were used to draft proposed updates to the Guidelines, based on the authors' findings and recommendations. The Guidelines including the proposed updated are provided below. To see a summary of the proposed updates only, please see the document titled 'Proposed Updates to the APS Guidelines_Extracted Updates'.

1. PROGRAM ADMINISTRATION

1A. ETHICAL FOUNDATION OF APS PRACTICE

Background:

A code of ethics provides a conceptual framework and practical guidance that workers can use when they are challenged by conflicting ethical duties and obligations. Most professions have developed their own codes of ethics, including social work (National Association of Social Workers, 2015) and Adult Protective Services (APS) (National Adult Protective Services Association, 2015). APS practice is rife with situations that require workers to navigate complicated ethical situations. Key concepts in the ethical foundation for APS practice include, but are not limited to:

- *Least restrictive alternative:*
Least restrictive alternative means a setting, a program, or a course of action that puts as few limits as possible on a person's rights and individual freedoms while, at the same time, meeting the person's care and support needs.
- *Person-centered service:*
Person-centered service refers to an orientation to the delivery of services that consider an adult's needs, goals, preferences, cultural traditions, family situation, and values. Services and supports are delivered from the perspective of the individual receiving the care, and, when appropriate, his or her family.
- *Trauma-informed approach:*
A trauma-informed approach seeks to do the following:

- 1) realize the widespread impact of trauma and understand potential paths for recovery;
- 2) recognize the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
- 3) respond by fully integrating knowledge about trauma into policies, procedures, and practices; and
- 4) actively resist re-traumatization.

A trauma-informed approach can be implemented in any type of service setting or organization and is distinct from trauma-specific interventions or treatments that are designed specifically to address the consequences of trauma and to facilitate healing. Trauma-specific intervention programs generally recognize the:

- survivor's need to be respected, informed, connected, and hopeful regarding their own recovery;
 - interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety; and
 - need to work in a collaborative way with survivors, family and friends of the survivor, and other human services agencies in a manner that will empower survivors and consumers (SAMHSA, n.d.).
- *Supported decision-making:*
Supported decision-making is a series of relationships, practices, arrangements, and agreements, of more or less formality and intensity, designed to assist an individual with a disability to make, and communicate to others, decisions about the individual's life (Dinerstein, 2012).

Guideline:

It is recommended that APS systems establish and adopt a set of ethical principles and codify these in their policies and program manuals. It is recommended that APS systems require all employees to sign a Code of Ethics that includes, at a minimum, those key concepts described above (i.e., least restrictive alternative, person-centered service, trauma-informed approach, and supported decision-making). The system's Code of Ethics would be signed at the time of employment with APS. In addition, it is recommended that training on ethics be covered during pre-service training and ongoing staff education.

1B. DEFINITIONS OF MALTREATMENT

Background:

The APS Survey reveals that the vast majority of APS systems respond to reports of physical, emotional, and sexual abuse; financial exploitation; neglect; and self-neglect. A 2016 study revealed that differing interpretations of definitions of confirmed, inconclusive, and unfounded case findings may lead to variability of APS findings regardless of type of maltreatment (Mosqueda, 2016).

The Child Welfare System, also known as the Child Protective Services (CPS) system, specifies a minimum federal definition of what constitutes child abuse and who is eligible for services under various Child Welfare provisions (Children’s Bureau, n.d.; a).

Guideline:

It is recommended that APS systems define and respond to, at a minimum, reports of the following categories of maltreatment: physical, emotional, and sexual abuse; financial exploitation; neglect; and self-neglect.

1C. POPULATION SERVED

Background:

The APS Survey reveals that the vast majority of APS systems serve adults (18+ years) who are the subject of an APS report and who also meet the state’s eligibility criteria for being vulnerable or at risk (terms and definitions vary from state to state). Most elders and adults with disabilities successfully manage their own lives and are capable of providing for their own care without assistance. They are not automatically defined as “vulnerable adults” simply because of age or disability. Many states also serve the older adult population (usually starting at either 60 or 65 years) without requiring an additional finding of vulnerability.

Guideline:

It is recommended that APS systems develop criteria for determining the eligibility for APS services of adults (18+ years) who are vulnerable and who are the alleged victims of maltreatment. It is recommended that APS serve those who are eligible for their services regardless of their settings.

1D. MANDATORY REPORTERS

Background:

According to the APS Survey, 49 states currently have mandatory reporting statutes. Some states require all citizens to report suspected adult maltreatment. Most identify professionals required by law to report. The federal system provides guidance and examples on establishing mandated reporting, as well as the role of various professions as mandated reporters (Children’s Bureau, n.d.; b). In addition, states are required to identify in a state plan laws identifying categories of mandated reporters (Children’s Bureau, n.d.; c).

Researchers in Massachusetts found that reports made by mandated reporters to APS were more likely to be substantiated and less likely to result in service refusal than reports made by non-mandated reporters. The findings highlight that those with the legal responsibility to report are more likely to report situations that are truly mistreatment (i.e., are substantiated through APS investigation) and that will result in victims receiving some type of intervention aimed at alleviating their risk. (Lees, K, 2018). Another study that examined the impact of a new mandated

reporting law for child sexual abuse (CSA) in Australia, determined that the mandatory reporting law for CSA is associated with a substantial and sustained increase in identification of cases of CSA (Mathews, 2016).

Guideline:

It is recommended that states require mandatory reporting to APS by members of certain professions and industries who, because of the nature of their roles, are more likely to be aware of maltreatment. It is recommended that employees, contractors, para-professionals and volunteers be mandated to report. It is recommended that states mandate reporting from the following groups, including, but not limited to:

- a) County, state and federal law enforcement
- b) First responders
- c) Medical, behavioral health services and social service providers
- d) Educational organizations
- e) Disability organizations
- f) Victim services providers
- g) Long-term care providers, including home health providers
- h) Financial services providers
- i) Aging services
- j) Anyone engaged in the care of a vulnerable adult.

Clear guidelines and mechanisms for taking reports from both mandatory and non-mandatory reporters should be established. Exemptions to mandatory reporting requirements should be consistent with professional licensing requirements and state and federal laws.

It is further recommended that mandated reporters be immune from liability when reports of suspected adult maltreatment are made in good faith, unless the reporter is later determined to be the perpetrator.

It is recommended that APS be mandated to report suspected crimes related to adult maltreatment to law enforcement.

1E. COORDINATION WITH OTHER ENTITIES

Background:

According to the NAPSA Minimum Standards, APS systems should:

work with other agencies and community partners.... The goal of these intentional and specific collaborations is to provide comprehensive services to alleged victims by building on the strengths, and compensating for the weaknesses, of the service delivery system available in the community, and by avoiding working at cross-purposes (National Adult Protective Services Association, 2013).

Formal multidisciplinary teams (MDTs)¹ have been shown to increase effectiveness, satisfaction of workers, rates of prosecution, and be associated with a reduction in future mistreatment risk (Navarro et al., 2013; Rizzo et al., 2015; Wiglesworth, 2006). Specifically, assessing the impact of an elder abuse forensic center on collaboration of staff from multiple agencies the authors found that staff believed they were more efficient and effective when they collaborated with the forensic center (Wiglesworth et al., 2006). Assessing the involvement of an elder abuse forensic center in financial exploitation case, compared to cases engaged in usual practice, Navarro et al. (2013) found that the center's cases were more often submitted to the District Attorney, more often resulted in filing of charges, and increased the odds of establishing a perpetrator's guilt. Findings from Rizzo et al., (2015) showed a significant reduction in future mistreatment risk for clients who received services through an MDT model consisting of social workers and lawyers under the same room, compared to clients receiving social work services only. Additional research has that another MDT model – the Elder Abuse Forensic Center model – is an effective approach for determining whether cases should be referred to a public guardian or if conservatorship should be established, to ultimately ensure the safety of victims who require the highest level of protection (Gassoumis et al., 2015). Similarly, Wilber et al. (2014) have shown that MDT/Forensic Centers significantly increase prosecution rates and conservatorships for cognitively impaired older adults, and reduce the rate at which cases re-enter the APS system.

Research focusing on coordination with other entities, including mental health and substance use services, have also shown positive outcomes. For instance, Sirey et al. (2015) have shown that APS clients with mental health needs are often willing to accept an offer of additional mental health services at the same time that they are receiving mistreatment resolution services, supporting the potential for elder abuse service providers to work in tandem with mental health clinicians. He and Phillips (2017) found that more intense collaboration (i.e., having an MOU and co-location of staffs) with child welfare and drug and alcohol services on service delivery, resulted in greater availability of substance use disorder (SUD)-related resources. These findings provide support for improving collaboration between child welfare and SUD providers. The results also highlight the potential benefit for collaboration between APS and SUD providers since recent referrals of older adults to APS show an increase in substance abuse among clients (Susman et al., 2015).

The APS Survey revealed that most APS systems participate in MDTs. About 50% of the states that do so have formal agreements to facilitate interagency cooperation.

Guideline:

To improve communities' response to adult maltreatment, it is recommended that APS systems create policies and protocols, including the development of Memoranda of Understanding, cross-training, and co-location of staffs, to promote their collaboration with other entities, as needed, during investigations and interventions to benefit clients. It is recommended that APS collaborate with the following categories of organizations or agencies, including, but not limited to:

¹ A multidisciplinary team is a model that brings together the distinct client systems (e.g., health, social, and protective services) with the justice systems (e.g., law enforcement, attorneys, and victim advocates) (Gassoumic et al., 2015).

- a) County, state and federal law enforcement
- b) Medical providers
- c) Behavioral service/Mental health providers
- d) Social service providers
- e) Disability organizations
- f) Alcohol and drug abuse service providers
- g) Domestic violence, sexual assault and victim services providers
- h) Financial services providers
- i) Legal service providers
- j) Aging services
- k) Animal welfare organizations
- l) Universities and other research institutions.

It is further recommended that states establish policies and protocols to facilitate APS participation in formal interdisciplinary adult maltreatment teams, while protecting client confidentiality and other rights.

Additionally, it is recommended that APS systems develop policies and protocols that allow them to share information with APS and law enforcement systems in other states and jurisdictions, including tribes, in order to detect, prevent, and remedy adult maltreatment.

1F. PROGRAM AUTHORITY, COOPERATION, CONFIDENTIALITY AND IMMUNITY

Background:

APS systems regularly deal with legal issues such as its authority, confidentiality of its records, and immunity of its workers. APS systems require the services of legal counsel to provide guidance on these issues. The APS Survey shows that many APS systems receive legal counsel from their county or state's attorney, though some have attorneys on staff.

Guideline:

It is recommended that APS systems have access to legal counsel with expertise in the legal issues the APS systems may face. In addition, it is recommended that states provide APS systems with the following authority:

- *Access to victims:*
It is recommended that APS systems be given the authority to access alleged victims of maltreatment and the authority to prevent another's interference in an APS case. That access includes the authority to conduct a private, face-to-face interview with the alleged victim.
- *Access to information:*
It is recommended that APS systems be given the authority to access certain documents in a timely manner from individuals, agencies, or institutions, including federal and other public benefit programs, for the purposes of investigating alleged maltreatment and for the

protection of the alleged victim. This includes the ability of APS to access records, by subpoena if necessary, for the investigation of the alleged maltreatment and for the protection of the alleged victim.

- *Communication and cooperation:*

In order to detect, prevent, and remedy adult maltreatment, it is recommended that APS systems be given the authority to cooperate with and share information related to an APS case with:

- 1) other APS and/or law enforcement programs outside of the jurisdiction in which the report was made; and
- 2) non-APS members of multi-disciplinary teams convened within the jurisdiction in which the report was received, provided that all members of the MDT have agreed to keep the information confidential.

Further, it is recommended that APS be given the authority to provide the reporter of the alleged maltreatment with the following information, at a minimum:

- 1) whether APS has or has not opened an investigation as a result of the report,
- 2) that APS has not opened an investigation as a result of the report, and
- 3) whether an APS investigation has been closed.

- *Immunity:*

It is recommended that legal protections from liability be created for APS staff who are acting in good faith and within the scope of their employment.

- *Confidentiality:*

It is recommended that the confidentiality of APS records and exceptions to confidentiality be delineated, including what shall be the APS system's response to subpoenas seeking those records.

1G. PROTECTING PROGRAM INTEGRITY

Background:

Policies related to program integrity help ensure compliance with laws and regulations, increase accountability within APS systems, and foster the public's trust in the program's actions.

Guideline:

It is recommended that APS systems create and implement policies to ensure that the APS program is held to high standards of integrity. Policies are needed to address the issues below:

- *Conflicts of interest:*

APS programs should have a process for handling the APS case investigation when the APS

program itself, its contractors, staff members, or those with whom they have a close relationship have a conflict or the potential for perceived conflict of interest.

- *Dual relationships:*
The National Association of Social Workers (NASW) defines dual relationships as: “when professionals assume two or more roles at the same time or sequentially with a client, such as: assuming more than one professional role or blending of professional and nonprofessional relationship.” (National Association of Social Workers, n.d.). In instances when dual relationships are unavoidable, APS workers should make the client’s protection their priority. The worker, not the client, is responsible for setting clear, appropriate and culturally sensitive boundaries.
- *Receiving and handling complaints:*
APS programs should have a process for addressing complaints made about case findings or actions of APS employees.
- *Screening APS Personnel:*
APS programs should have a process for screening potential APS employees for suitability.
- *Consistency of practice:*
APS programs should establish policy and standards regarding the process for handling a case from the point of intake through case closure. This should include APS workers as well as those with supervisory responsibilities (e.g., receiving, screening, and prioritizing maltreatment reports; investigation procedures to be implemented; determining the validity of reports; definitions of findings; providing services to maltreated adults; and casework supervision provided) with the goal of consistent casework practice within the program.
- *Client rights:*
At the time of the initial interview with that person, APS programs should provide an explanation of APS program and goals, and the client’s rights, in terms that are reasonably understandable to the adult who is the subject of the investigation.

1H. STAFFING RESOURCES

Background:

The APS Survey indicates that APS worker caseloads vary from 0-25 per worker (13 states) to 100+ per worker (4 states). In the majority of states (21) the caseload per worker was 26-50. The ratio of supervisor to investigators varied from 1:1 to 1:14. NAPSA Minimum Standards and federal Child Welfare guidelines recommend that states establish ratios, but do not specify those ratios.

The Child Welfare System has dealt with the issue of staffing for decades and lessons from that

system may inform the creation of caseload studies for APS. For example, in a nationwide survey, state Child Welfare System administrators identified reducing caseloads, workloads, and supervisory ratios as the most important action for Child Welfare agencies to take to retain qualified frontline staff (Cyphers, 2001). Research in Child Welfare also points to supportive supervision as a critical factor in reducing turnover (Zlotnick et al., 2005).

Research shows that investigators who handle reports of alleged abuse of children and vulnerable adults had lower investigation and substantiation rates than those who handled one or the other type of abuse report (Jogerst et al., 2004).

Guideline:

It is recommended that APS systems be provided with sufficient resources to ensure that staffing is adequate to serve the target population and fulfill mandates. To reach that goal, it is recommended that APS systems conduct caseload studies to determine and implement manageable ratios. In determining ratios, APS systems are encouraged to consider the following:

1. *Ratio of supervisor to direct APS service personnel.*

Consideration should be given to the important role of the supervisor in reviewing cases during critical supervisory junctures, and the differences in the amount of time needed to supervise complex cases. Further, programs should consider the challenge to supervisors of simultaneously supervising workers from different programs (e.g., APS, Child Protective Services, In Home Support Services, aging services). Among the roles and functions of APS supervisors, programs should articulate the role of supervisor as trainer, especially for new workers; as mentor and advisor to workers; in community engagement; and in participation on multi-disciplinary teams. Finally, it is recommended that there be a limit on the number of workers supervised by each supervisor.

2. *Ratio of APS worker to cases*

There should be a limit on the number of cases assigned to each worker in order to insure delivery of comprehensive APS services. Failure to implement a limit on the number of cases assigned to each worker may result in serious risks to the APS system's efficiency and efficacy.

Furthermore, research shows that when workers are responsible for handling both adult and child protective cases, client outcomes suffer. APS programs should develop a target and/or cap for the number of cases per APS worker. In developing this ratio, consideration should be given to:

- historical trends and experience needed regarding the types and complexities of cases in the state;
- differences in geographical areas;
- differences in time required to manage cases at various phases in the casework process (e.g., ongoing casework vs. investigation); and
- differences in complexity of allegations (e.g., many financial exploitation cases and self-neglect cases take significant time and expertise).

1I. ACCESS TO EXPERT RESOURCES

Background:

Often it is helpful or necessary to consult with content or clinical experts when handling APS cases. Nearly every state APS system reported in the APS Survey that they had some access to legal consultation. Over half of the states surveyed reported that they have access to physicians, while over 60% indicated that they had access to mental health professionals as well as nurses and physician assistants. The APS Survey also noted that, while financial exploitation is one of the top areas in APS, access to forensic specialists and accountants were not available in over 60% of the states. Several states, but not all, indicated that they could consult with law enforcement, faith-based groups, the attorney general's office, and domestic violence agencies.

To address the scarcity of expert resources for APS client assessment, especially in rural areas, Burnett et al. (2018) created a Forensic Assessment Center Network that uses a web-based portal and low-cost videophone technology to connect an APS agency and its clients to a centralized geriatric and elder mistreatment expert medical team for virtual in-home assessments. The authors suggest it can serve as a model for fostering state protective agencies and medical professional collaborations. The authors highlight that the technology makes it easier to gather data, access records, complete evaluations, and transmit reports, which facilitates timely provision of assessments. In addition, it streamlines communication, makes the process quicker, and helps prevent unexpected process delays, such as reports being lost in the mail. The authors note that virtual assessments also increase timeliness and efficiency by dissolving geographic barriers that limit expert availability and increase assessor travel time, and offers a way to enhance collaborations.

Access to trained forensic personnel remains a challenge for state APS systems. Brink et al. (2015) studied the differences in child welfare case determinations between cases that went to a multi-disciplinary team and cases that went to Child Protective Services (CPS). The authors suggest that the results highlight the importance of the forensic interview in CPS decisions of child sexual abuse, and the potential role for child advocacy centers in providing trained professionals to conduct a high-quality interview during the initial assessment. The findings may also support the use of forensic interviewing in APS cases.

Guideline:

It is recommended that APS systems dedicate sufficient resources and develop systems and protocols to allow for expert consultation from outside professionals in the fields identified as most needed by APS workers, including, but not limited to:

- Civil and criminal law
- Medicine
- Forensic science
- Mental/behavioral health
- Finance/accounting/real estate

- Domestic violence/sexual assault

It is also recommended that states test the use of technology to bring needed resources to clients who might not otherwise be able to access experts in their physical locations.

1J. CASE REVIEW-SUPERVISORY PROCESS

Background:

The APS Supervisor provides both clinical and administrative oversight, approves key casework decisions, and guides the caseworker in overall case planning and management.

The APS survey revealed that over 70% of states have case review systems and about 75% of those states review every case. Cases are mostly reviewed by a supervisor and/or an administrator. Five states had specialized quality control staff to review cases and over a quarter reported that their cases were not reviewed. The NAPSA Minimum Standards suggest that “[a] case review process [be] standardized and consistently applied

Guideline:

It is recommended that APS systems create policies and protocols for supervisory consultation and case review at critical case junctures (i.e., decisions that are likely to have a significant impact on the welfare of the client). These include at a minimum, but are not limited to:

- Intake and case assignment
- Investigation planning
- Determining the investigation findings
- Service provision planning
- If legal action is being considered (especially involuntary interventions or actions)
- At case closure

For APS systems where cases may be open for periods longer than six months, a supervisory consultation and case review should be conducted at least every six months (e.g., for re-determination of eligibility or ongoing service provision).

1K. WORKER SAFETY AND WELL-BEING

Background:

APS work can involve personal risk to the worker. This problem can have a marked impact on the ability of APS systems to provide services to the adults who need them most.

In a survey of 321 APS workers and supervisors to assess their responses to APS work environments, 92.8% of respondents reported exposure to at least one hazard in their APS careers and 71% reported exposure to one or more hazards in the past month. In the past month, respondents reported an average of 3.42 different hazard exposures, with the most common exposures being dangerously cluttered living spaces, garbage or spoiled food, insect infestations,

and being yelled at, cursed at, or belittled by a client or client's family. The authors note that the findings highlight the importance of building a positive and supportive work environment for APS workers, and that results can help inform management strategies for the prevention of burnout among APS workers. In addition, based on previous studies in child welfare, the authors suggest that if work stressors identified in this study were addressed effectively, work turnover in APS might decrease (Ghesquiere, et al., 2018).

Guideline:

It is recommended that APS systems create policies and protocols, and provide adequate resources related to worker safety. These provisions should include at a minimum, but are not limited to, the following:

1. APS programs should have systems in place to know where their workers are when conducting investigations in the field.
2. When worker safety concerns are identified, workers should have real-time access to consultation with supervisors to review safety assessments and to determine appropriate responses.
3. Workers should have access to resources to protect them from biological hazards that may be encountered during home visits (e.g., gowns, masks).
4. Workers should have access to resources to protect them from safety hazards, including access to information related to criminal and civil legal proceedings, the ability to request law enforcement accompaniment for home visits, and worker safety training.
5. Workers should be provided with work/agency cell phones.
6. Workers should be provided with the means to keep their personal information confidential, including using a business card that has only the name of the agency; using agency vehicles or other means to keep their personal car license confidential
7. Workers should never be required to respond to a situation that would put the worker at risk without adequate safety supports available.
8. Workers should have available and access to supportive, professional counseling for job-related trauma and stress.

1L. RESPONDING DURING COMMUNITY EMERGENCIES

Background:

APS plays a role in insuring the safety and well-being of their clients and other vulnerable adults during community emergencies.

Guidelines:

It is recommended that APS systems create policies and protocols that clearly outline the role of APS supervisors and workers in the event of emergencies in the community, such as natural disasters (e.g., hurricanes, flooding, earthquakes, severe storms), violent attacks, or other states of emergency. It is recommended that these policies address the following phases:

1. *Planning for Emergencies Before They Occur:*

- through multi-agency planning and coordination, understanding the role of APS as well as the potential resources and limitations of partnering agencies;
- by establishing data systems capable of adequately tracking clients who may be affected by emergencies;
- by establishing a clear chain of command, base of operations, and means to communicate with workers;
- by creating clear lines of communication and responsibility with first responders, Neighborhood Emergency Response Teams, Red Cross, etc. before the emergency has occurred; and
- by training workers on emergency preparedness for when in the office and when out in the field.

2. *Responding During the Emergency:*

- workers shall not be required to respond to a situation that would put the worker or his/her family at risk;
- workers shall understand the changing nature of emergencies and demonstrate flexibility of attitude and approach;
- workers should be clear what their role is and is not during emergencies; and
- by providing all APS personnel with emergency personal protection (e.g., filtering masks, gloves) and emergency equipment (e.g., flashlights, two-way radios), as needed, to safely carry out their assigned duties.

1M. COMMUNITY OUTREACH AND ENGAGEMENT

Background:

Although the public's awareness of adult maltreatment is rising, the awareness of how to respond to suspicions of that maltreatment and how to reduce repeat visits is still lacking. Recent research sheds light on the kinds of maltreatment cases that are not reported to APS (i.e., 90%

of financial maltreatment perpetrated by family and friends and 85% of emotional maltreatment regardless of relationship to perpetrator goes unreported) (Acierno, 2018). APS programs should play a role in educating the public about adult maltreatment, how and where to report it, and the goals and services of the APS program. Recent research also indicates that lack of awareness and miscommunication may be amenable for education interventions for professionals, families and communities to help reduce repeat visits (Susman et al., 2015).

Guideline:

It is recommended that state APS programs devote resources for engaging their communities through public awareness and/or educational sessions. These sessions should minimally include:

- a) defining adult maltreatment,
- b) when and how to report, and
- c) APS authority and limitations.

1N. PARTICIPATION IN RESEARCH

Background:

Research on adult maltreatment is needed to answer important fundamental questions that exist related to adult maltreatment risk factors, forensic markers, and the efficacy of APS and other interventions, etc. APS programs can play an important role in this research. It is in the best interest of adult maltreatment victims that services, including APS services, are based on sound research and data. It is important that APS programs develop protocols to allow participation in research, and allocate resources for research. The NAPSA/NCPEA Research Committee has provided information on how APS programs may participate in research. See <http://www.preventelderabuse.org/about/research.html>.

Guideline:

While abiding by all applicable regulations related to privacy and confidentiality, it is recommended that State APS programs:

- support collaborative research between and among APS programs and researchers from academic institutions, research organizations, and consultants at the local, state, national and international level;
- support research-based evaluation of APS programs, initiatives, policy and practice;
- conduct analyses of APS program client outcomes;
- participate in national APS data collection efforts; and
- disseminate findings from research to other state and county APS programs, policymakers and other researchers.

2. TIME FRAMES

2A. RESPONDING TO THE REPORT/INITIATING THE INVESTIGATION

Background:

According to the APS Survey, most APS systems prioritize reports into either emergency or non-emergency situations and have time frames for responding in either a few hours or a few days, as deemed appropriate. In over 35% of the states, staff must initiate an investigation within the first 24 hours; but in 45% of the states, it must be initiated in a shorter time period than the first 24 hours. The federal Child Welfare System provides guidelines for determining the needed response time (DePanfilis and Salus, 2003).

Guideline:

It is recommended that APS systems develop and implement a consistent protocol for initiating the APS investigation in response to the receipt of a report. The purpose of the investigation is to collect information about the allegations of maltreatment, assess the risk of the situation, determine if the client is eligible for APS services, and make a finding as to the presence or absence of maltreatment.

Initiating the investigation typically includes:

- contacting the alleged victim, the alleged victim's service providers (if any), the reporter, and other individuals with knowledge of the alleged victim and his/her situation;
- conducting a social service database search to identify all department records pertaining to the adult;
- reviewing all appropriate department records including records that are not in the APS case management database; and
- searching the APS case management database for previous reports.

It is recommended that APS see the alleged victim face-to-face, regardless of the response time set. The two levels of response are:

- 1) Immediate response for cases that involve risk of death, irreparable harm, or significant loss of assets and/or property. An immediate response should occur in person within the first 24 hours after receiving the report, or sooner.
- 2) Less immediate response for less imminent and less severe risk. A less immediate response should occur between one to five business days after the report is received, or sooner.

2B. COMPLETING THE INVESTIGATION

Background:

The timeframe in which APS systems must complete the investigation varies greatly. The APS Survey reveals that 31% of programs must complete the investigation within 30 days. 42% states allow the investigation to be completed in more than 30 days. Eight states have no timeline for completing the investigation.

Guideline:

It is recommended that APS systems create policy establishing the timeframe for completion of investigations. It is suggested that this policy:

- provide structure for the worker related to caseload and time management;
- encourage consistent practice;
- keep cases progressing through the system; and
- allow for extensions for good cause.

2C. CLOSING THE CASE

Background:

APS systems are generally designed to provide emergency and short-term response to urgent situations. The length of time that cases remain open for APS to provide services varies. According to the APS Survey, as of 2012, 40% of programs reported no specific timeframe for closing cases, and eight required closure within 90 days. Others allowed cases to remain open longer. In the states that had timelines, there were provisions for extensions when required. The federal Child Welfare System requires a minimum timeframe for ongoing case review, as well as a maximum time limit for determinations of case status (Children’s Bureau, n.d.; c).

A 2015 study (Mariam, et al.) assessed the effectiveness of an elder abuse intervention and prevention program, for building alliances between elders with suspected abuse and trained outreach specialists, and for helping elders overcome ambivalence regarding making difficult life changes. In this program, outreach specialists met with elders in person and used different strategies, including motivational interviewing, to build an alliance and connect elders to resources in the community based on their readiness to change, preferences, and needs. Results showed that risk factors of elder abuse decreased over the course of the intervention. In addition, nearly 75% of participants made progress on their treatment goals and 43% moved into the stages of action and maintenance regarding their goal. The authors note that, for other agencies serving at-risk elders, the project’s findings suggest that a longer-term, relationship-based intervention for entrenched elders who are reluctant to receive services may be effective and therefore worth considering.

Guideline:

It is recommended that APS systems establish case closure criteria and the frequency with which open cases should be reviewed. A procedure for closing cases is also recommended. The criteria for case closure should include, but are not limited to:

- a) the service plan is completed,
- b) the client’s situation is stabilized,

- c) safety issues have been resolved or mitigated,
- d) the client was referred to another APS agency,
- e) the client has moved out of the APS jurisdiction,
- f) the client having capacity to consent refuses continued services, and
- g) should allow for extensions for good cause.

In addition, APS systems should consider trying longer-term, relationship-based interventions for elders who are reluctant to receive services.

3. RECEIVING REPORTS OF MALTREATMENT

3A. INTAKE

Background

The intake process must be easy and fully accessible to those needing to make a report and must include collection of essential data to facilitate an appropriate, timely, and helpful response to the alleged victim. The APS Survey revealed that 75% of states had intake lines for reporting alleged adult maltreatment 24 hours a day, 68% of which were staffed. Other 24-hour intake lines used contracted call centers, a message service, or online services during non-business hours. In states without a 24-hour intake line, callers were urged to contact law enforcement to report maltreatment.

The Council on Accreditation recommends that a child abuse report intake system be available 24 hours a day. The majority of Child Welfare Systems addressed this recommendation in policy and met this guideline as of 2003 (Office of the Assistance Secretary for Planning and Evaluation, 2003).

Guideline:

It is recommended that APS systems have a systematic method, means, and ability to promptly receive reports of alleged maltreatment. It is recommended that APS systems establish multiple methods for receiving reports of alleged maltreatment 24 hours a day, seven days a week (e.g., toll-free telephone hotline, TTY, fax, web-based). It is recommended that mechanisms be easily accessible and free to the reporter. The hotline or other service should be fully accessible (e.g., using augmentative communication devices) and it is recommended that programs utilize translation services, including American Sign Language, for reporters who require them.

Intake systems should have an APS staff person on duty to receive and respond to reports. The system should notify APS of all reports taken. The system should have the capacity to respond to emergencies with trained APS personnel.

The system should ensure the protection of the reporter's identity, unless otherwise ordered by a court. Additionally, the system should explain to the reporter the role of APS.

When receiving reports, the system should have a standardized process for eliciting and documenting the content of the report, including, but not limited to, information about:

- the alleged victim and his or her circumstances;
- the location of the victim;
- the alleged type(s) of maltreatment;
- the alleged perpetrator, if any;
- the level of response needed to be made by APS due to the victim's situation (e.g., immediate); and
- risks that may be encountered by an APS worker in responding to this report (e.g., presence of animals, weapons in the home).

3B. SCREENING, PRIORITIZING, AND ASSIGNMENT OF SCREENED IN REPORTS

Background:

Screening is a process of carefully reviewing the intake information to determine if the report should be screened in for investigation, screened out, or referred to a service or program other than APS. Risk factors are identified to determine the urgency for commencing investigation of screened reports. Nearly all states reported prioritizing reports screened in for investigation and having required timeframes for APS response associated with identified risk levels.

The NAPSA Minimum Standards suggest that APS systems have the following four (4) elements, among others:

- 1) a prompt process to screen and investigate reports;
- 2) a review of safety and risk factors using a consistently-applied screening tool;
- 3) agency decision-making criteria to review and assign cases, report to other authorities and initiate court action when required; and
- 4) a process by which reports are reviewed and assigned for investigation, referred to other providers, or screened out as soon as possible, but no later than 24 hours after receipt (National Adult Protective Services Association, 2013).

The federal Child Welfare System provides significant guidance and examples to the States on assessment tools, screening tools and protocols for children suspected of being victims of child abuse and neglect (Children's Bureau, n.d.; d).

Guideline:

It is recommended that APS systems develop standardized screening, triaging, and case assignment protocols that include, at a minimum, those elements outlined above in the background section.

4. CONDUCTING THE INVESTIGATION

4A. DETERMINING IF MALTREATMENT HAS OCCURRED

Background:

APS's response to a report of maltreatment is complicated and involves numerous interrelated tasks that typically happen concurrently. For the purposes of providing guidance, in this document we have separated the process of gathering information relevant to determining if the maltreatment occurred (determining a finding) and the process of gathering information as part of a client assessment. This section focuses on the process undertaken by APS systems to determine if maltreatment has or has not occurred.

Information is gathered to determine if maltreatment has occurred through interviews with the client, alleged perpetrator, other involved parties, and review of relevant documents and records. Evidence typically gathered during investigation includes:

- Client statements
- Direct observations
- Physical evidence (e.g., injuries, cluttered home, no utility service)
- Corroborating evidence (e.g., witness statements, physician records, documents)
- Circumstantial evidence
- Unobserved/third-party suspicions
- Client history

Some programs use a structured decision-making tool to standardize the collection of information and guide the investigator in evaluating collected evidence through an objective and more detailed approach. For instance, substantiation rates have shown to be higher with the use of the technology-based Elder Abuse Decision Support System (EADSS) full interview guide and short-form, compared to and APS protocols (Beach et al., 2017; Conrad et al., 2017). However, standardized tools should not preclude staff from approaching clients creatively and exploring ways to reduce the risk of harms the client faces and engaging clients who say they do not want services.

A 2016 study on variability of APS findings in California concluded that differing interpretations of definitions of confirmed, inconclusive, and unfounded case findings, along with differences in worker expertise and practices, were the major contributors to variation in elder abuse data. They highlight that more rigorous means of detecting elder abuse are needed to obtain accurate prevalence data and to inform policy decisions. Specifically, the authors suggest establishing clear definitions and training to standardize the assignment of findings for elder abuse/neglect cases, and developing a statewide policy on how to address the issue of autonomy (Mosqueda, 2016).

As noted elsewhere, the federal Child Welfare System provides significant guidance and examples to the States on assessment tools, screening tools and protocols for children suspected of being victims of child abuse and neglect (Children's Bureau, n.d.; d). In addition, studies examining differences in child abuse and neglect determinations have shown that an MDT approach, including a forensic interview, is an effective approach for conducting the initial assessment (Brink et al., 2015). Similar findings have been published in the area of elder abuse, showing that MDT/Forensic Centers significantly increase prosecution rates and

conservatorships for cognitively impaired older adults, and reduce the rate at which cases re-enter the APS system (Wilber et al., 2014).

Guideline:

It is recommended that APS systems establish standardized practices to collect and analyze information when determining whether or not maltreatment has occurred. It is recommended that the following elements, at a minimum, be considered:

1. The following issues are explored before deciding whether or not to notify the alleged victim of the initial visit:
 - Preservation of individual rights
 - Preservation of evidence
 - Maximum engagement potential with client
 - Victim safety
 - Worker safety
2. APS programs are encouraged to use MDTs to support decision-making during the initial assessment.
3. All of the types of maltreatment alleged in the report are investigated. Any additional type of maltreatment discovered during the course of the investigation is noted and investigated.
4. Other vulnerable adults that are affected by the alleged maltreatment or appear to be victims of possible maltreatment are identified, and reported to APS.
5. While the investigation may continue, the client has the right not to participate in the investigation.
6. Law enforcement has been notified if there is cause to believe that the alleged victim has been maltreated by another person in a manner that constitutes a crime.
7. Immediate attention has been given to clients in crisis, imminent risk, or in an emergency situation.
8. APS programs are encouraged to utilize standardized and validated decision-making tools and screening tools for determining whether mistreatment has occurred.
9. APS workers are trained on and have a clear understanding of the definitions of case findings (for example, “confirmed” or “unfounded”).
10. Acceptance of APS services is voluntary (except in cases where there has been a determination of extreme risk and the client lacks capacity or cannot consent to services. See Section 5b, Involuntary Intervention, below).

11. The worker has been trained and is competent to investigate the particular set of circumstances described in the report (e.g., he/she has received training on working with nonverbal clients, with clients with intellectual disabilities, with clients with mental health issues, with residents of institutions, or with minority populations).

4B. CONDUCTING AN APS CLIENT ASSESSMENT

Background:

The APS assessment is key in collecting information about the vulnerable adult's overall situation. The purpose of the assessment is to determine the services or actions needed for the vulnerable adult to be safe and remain as independent as possible.

Innovative approaches have shown that technology can be effective for conducting virtual in-home assessments, including mental health assessments, telephone-based protective service planning during interdisciplinary team meetings, and consultations services (see the Texas Elder Abuse and Mistreatment Institute Forensic Assessment Center Network [TEAM-FACN]) (Burnett et al., 2018). Virtual assessment strategies like these may be especially useful for remote areas where services are limited and lengthy travel may be required.

Guideline:

It is recommended that APS systems create and apply systematic assessment methods to conduct and complete a needs/risk assessment including the vulnerable adult's strengths and weaknesses. The purpose of the assessment is to determine the services or actions needed for the vulnerable adult to be safe and remain as independent as possible.

APS programs are encouraged to utilize standardized and validated assessment tools.

The needs/risk assessment needs to include criticality or safety of the client in all the significant domains listed below:

- Nature of the maltreatment (e.g., origins, duration, frequency, etc.)
- Physical health
- Functional ability (to perform Activities of Daily Living, etc.)
- Mental health status
- Decision-making capacity and ability to direct his or her own care
- Support system (formal and informal)
- Care needs
- Behavioral issues
- Interpersonal dynamics
- Environmental conditions—including presence of abused, dangerous or hoarded animals in the home
- Financial means and capacity

APS programs are encouraged to use innovative strategies, such as videophone technology to conduct virtual in-home assessment that can increase timeliness and efficiency by overcoming geographic barriers and limited expert availability, and offers a way to enhance collaborations.

Unless specifically qualified or authorized by state law, an APS worker does not carry out clinical health or capacity assessments, but rather screens for indications of impairment, and, as needed, refers the client on to qualified professionals (physicians, neuropsychologists, etc.) to administer thorough evaluations.

It is recommended that State APS systems create policies for APS workers who are nurses to do non-invasive screenings to include: blood sugars, vital signs, pulse oximetry, etc. and that those policies allow the results of these screens to be referred to qualified professionals including physicians, psychologists, and psychiatrists.

It is also recommended that an assessment of the alleged perpetrator and/or caregiver be conducted to ascertain the risk to the safety and independence of a vulnerable adult victim.

4C. INVESTIGATIONS IN CONGREGATE CARE SETTINGS

Background:

Approximately 50% of APS programs conduct investigations in congregate care facilities (i.e., facilities or institutions). APS systems that are responsible for investigating and intervening in cases of maltreatment in congregate care settings carry the burden of ensuring that their staff are trained and are receiving supervision and consultation on the specific issues that can arise in these cases. These issues include clinical, forensic, and legal considerations, such as the possibility that multiple residents have been harmed when an abusive employee, resident, or visitor has had access to vulnerable residents. Special skills and approaches are often required in congregate care cases, including exercising caution to avoid escalating danger to those involved (Ramsey-Klawnsnik and Teaster, 2012).

Whether or not the APS system investigates reports of maltreatment in congregate care settings, it is critically important that APS systems coordinate with agencies such as the Long-Term Care Ombudsman (LTCO), state regulatory agencies, law enforcement, and others that also play a role in safeguarding the health and welfare of congregate care residents. Memoranda of Understanding and other formal documents can help to facilitate local and state-level coordination.

In 2015, the Code of Federal Regulation was amended to include regulations governing states' Long-Term Care Ombudsman programs (45 CFR Part 1324). The regulations include the following requirement:

Through adoption of memoranda of understanding and other means, the [State Long- Term Care] Ombudsman shall lead state-level coordination, and support appropriate local Ombudsman entity coordination, between the Ombudsman program and other entities with

responsibilities relevant to the health, safety, well-being or rights of residents of long-term care facilities including, but not limited to: Adult Protective Services.”

45 CFR Section 1327.13(h)

Guideline:

It is recommended that APS systems responsible for responding to alleged and confirmed maltreatment of vulnerable adults residing in congregate care settings provide training, supervision, and consultation to their staff on the special and complex issues that can be involved in those maltreatment cases.

It is also recommended that APS systems, whether or not they investigate allegations of maltreatment in congregate care settings, develop formal agreements and protocols with the entities that play a role in safeguarding the health and welfare of these residents in order to facilitate local and state-level coordination, in particular, the Long-term Care Ombudsman program, state licensing, other regulatory bodies, and law enforcement.

4D. COMPLETION OF INVESTIGATION AND SUBSTANTIATION DECISION

Background:

The NAPSA Minimum Standards state that:

APS programs have in place a systematic method to make a case determination and record the case findings. A determination must be made as to whether the abuse, neglect, self-neglect, and/or financial exploitation has occurred. The decision to substantiate the allegation is based on a careful evaluation of all information gathered during the Intake, Investigation, and Needs and Risk Assessment phases (National Adult Protective Services Association, 2013).

In addition, the NAPSA Minimum Standards also recommend protocols that establish a standard of evidence to be applied when investigation conclusions are reached. Typically, APS systems apply the “preponderance of evidence” standard requiring that at least slightly more than half of the evidence supports an allegation to substantiate it. This standard is very different from the “clear and convincing” and “beyond a reasonable doubt” standards typically applied in criminal situations (Ramsey-Klasnik, 2015).

Guideline:

It is recommended that APS systems create and implement a systematic method to make a case determination and record case findings, including protocols for the standards of evidence applied as shown in the background section above.

5. SERVICE PLANNING AND INTERVENTION

5A. VOLUNTARY INTERVENTION

Background:

After APS has completed the investigation and the client assessment, in many states a service plan is created with the client. The goal of the service plan is to improve client safety, prevent maltreatment from occurring, and improve the client's quality of life. Service plans are monitored and changes can be made, with the client's involvement, to facilitate services to address any identified shortfalls or newly identified needs and risks. The service plan will include the arrangement of essential services as defined in statute or policy (Note: programs may use various terms to refer to the plan, e.g., case plan, service plan, action plan, etc.).

The NAPSA Minimum Standards state that the Guiding Principles for APS Person-centered Practice be followed when developing service plans, as excerpted below:

- respect the integrity and authority of victims to make their own life choices;
- hold perpetrators, not victims, accountable for the maltreatment and for stopping their behavior. Avoid victim blaming questions and statements;
- take into consideration victims' concepts of what safety and quality of life mean;
- recognize resilience and honor the strategies that victims have used in the past to protect themselves; and
- redefine success—success is defined by the victim; not what professionals think is right or safe (National Adult Protective Services Association, 2013).

In addition, the NAPSA Minimum Standards for development of the voluntary service plan include the following four recommendations:

- identify with the victim the factors that influence intervention risk and needs;
- engage the victim and caregiver as appropriate in an ethical manner with useful strategies to develop mutual goals to decrease risk of maltreatment;
- determine with the victim and other reliable sources (such as family members, friends and community partners) the appropriate interventions that may decrease risk of maltreatment; and
- in some cases, the use of a proper Domestic Violence Safety Planning tool is warranted.” (National Adult Protective Services Association, 2013).

Research indicates that interventions tailored to meet the unique characteristics associated with each type of mistreatment may lead to greater victim safety (Jackson & Hafemeister, 2014). In addition, specific services or supports, such as social support and participation in supportive community social outlets, may be effective for mitigating against negative outcomes of elder

mistreatment, such as depression, generalized anxiety, and poor health (Acierno et al, 2017) as well as future risk of mistreatment (Burnes et al., 2014). It has also been shown that APS clients with mental health needs are often willing to accept an offer of additional mental health services at the same time that they are receiving mistreatment resolution services (Sirey et al., 2015). Research on mental health highlights the importance of also addressing mental health issues, such as depression, and it affects an individual's perception of their need for care and their motivation, initiative, and energy to seek help and engage in services (DiMatteo et al., 2000; Sirey et al., 2005).

The APS Survey reveals that once a case is initiated through APS, 63% of the programs report that they have a requirement to have regular communication with the victim either by phone or in person. Close to 90% of the states stated that, once a month, an in-person visit is required while a case is open, although most also indicated that ongoing investigations may require more frequent contact. Once a month phone calls are required in 64% of the states. Research indicates that longer-term, relationship-based interventions, may be effective for entrenched elders who are reluctant to receive services (Mariam et al., 2015).

Guideline:

It is recommended that programs intervene in elder mistreatment cases as early as possible and develop targeted safety planning for clients experiencing different forms of abuse and/or neglect. For clients who may be reluctant to receive services, APS should consider providing longer-term interventions focused on building a working alliance with the client and applying motivational interviewing techniques (e.g., see Eliciting Change in At-Risk Elders intervention).

It is recommended that APS systems develop the client's APS voluntary service plan using person-centered planning principles and monitor that plan until the APS case is closed. Services and supports should entail those that have been shown to be effective in protecting against negative outcomes, such as social support and programs that promote participation in community social outlets (e.g., senior centers). Programs that facilitate bidirectional support in the form of education, volunteerism, or socialization may be most effective (e.g., Experience Corps, congregate meal program) (Anetzberger, 2018). In addition, APS systems should consider working in tandem with mental health clinicians to offer mental health services, if needed, at the same time as APS are provided (see **Providing Options To Elderly Clients Together [PROTECT]** intervention).

It is recommended that APS systems establish clear guidelines related to APS service delivery which incorporate the elements listed above in the background section.

5B. INVOLUNTARY INTERVENTION

Background:

APS systems are sometimes called on to provide services in cases where there has been a determination of extreme risk and the client lacks capacity or cannot consent to services. The NAPSA Minimum Standards suggest the following:

In order to provide an involuntary intervention, APS obtains legal standing, either by going to court with legal counsel or by involving another agency that has legal jurisdiction. Any and all such court action(s) is well documented in the case....

APS programs follow the particular laws and policies in their jurisdiction regarding involuntary services to vulnerable adults who lack the capacity to protect themselves from maltreatment (National Adult Protective Services Association, 2013).

The NAPS program standards recognize that “lack of capacity may also limit the victim’s ability to engage in the decisions surrounding the identification of risk and needs, as well as goals and intervention strategies to be protected from further harm.” (National Adult Protective Services Association, 2013). The NAPS standards go on to emphasize that, although involuntary service planning may involve a victim who lacks capacity in some areas, principles of supportive decision-making should be utilized (National Adult Protective Services Association, 2013). The law has traditionally responded to cognitive disability by authorizing surrogate decision-makers to make decisions on behalf of individuals with cognitive disabilities. However, supported decision-making, an alternative paradigm for addressing cognitive disability, is rapidly gaining support. According to its proponents, supported decision-making empowers individuals with cognitive challenges by ensuring that they are the ultimate decision-maker but are provided support from one or more others, giving them the assistance they need to make decisions for themselves (Kohn et al., 2013). Working with the individual requires the recognition that the individual also has strengths and may be able contribute to the decision-making process.

After an assessment indicates that a client may lack capacity, a service plan is developed that addresses the risks and needs identified in the assessments, and a formal process should be in place to:

- determine when involuntary intervention may be indicated;
- identify those situations where the client’s immediate safety takes precedence over the client’s right to self-determination;
- explore the ethical issues in the decision to use involuntary intervention;
- document information needed to justify the use of involuntary intervention;
- identify the appropriate resources needed to be able to implement an involuntary case plan;
- develop and defend an involuntary intervention plan; and
- have in place a systematic method to continue to provide protective services to those clients who are being provided involuntary protective services (National Adult Protective Services Association, 2013).

Research has shown that the Elder Abuse Forensic Center model is an effective approach for determining whether cases should be referred to a public guardian or if guardianship should be established, to ultimately ensure the safety of victims who require the highest level of protection (Gassoumis et al., 2015).

Guideline:

It is recommended that State APS systems create policies and protocols to respond to situations where there has been a determination of extreme risk and the client lacks capacity or cannot consent to services. The decision to take involuntary action is not to be taken lightly. It is recommended that APS systems establish clear guidelines related to APS involuntary intervention, which incorporate the elements listed above in the background section.

It is recommended that APS systems adopt promising models, such as the Forensic Center model, which draws on multidisciplinary experts to help make the difficult determination as to whether a public guardian and guardianship is needed.

5C. CLOSING THE CASE

Background:

The NAPSA Minimum Standards state: “The goal of intervention in APS is to reduce or eliminate risk of maltreatment of a vulnerable adult. In most APS programs, once that goal is met, the case is closed.” However, safety goals should be balanced with the right, preferences and self-determination of the client, making case resolution an intrinsically subjective and multilayered outcome. Thus, goals toward case closure should be specific to each client and should be contingent on clients’ attainment of their specific goals (Burnes et al, 2018).

The Child Welfare System provides guidelines on the process for closing cases (DePanfilis and Salus, 2003).

Guideline:

It is recommended that APS systems create a systematic method to complete a case closure. The criteria for case closure should include, but are not limited to:

- the goals of the client have been attained;
- the service plan is completed;
- the client’s situation is stabilized;
- safety issues have been resolved or mitigated;
- the client was referred to another APS agency;
- the client has moved out of the APS jurisdiction; and
- the client having capacity to consent refuses continued services.

The case record should contain documentation of APS’ interventions and services delivered, their outcomes, an assessment of their efficacy, and the reason for the decision to close the case. If the resources needed to reduce the risk are not available, this information should also be

documented in the case file.

6. TRAINING

6A. CASE WORKER AND SUPERVISOR MINIMUM EDUCATIONAL REQUIREMENTS

Background:

Research indicates that higher education requirements for workers lead to higher substantiation of allegations. In one study, requiring a social work education background led to higher investigation and substantiation rates (Jogerst et al., 2004). Investigation rates were significantly higher when the state required that staff have a social work degree; however, substantiation ratios were significantly lower in these same states (Daly et al, 2005).

The APS Survey shows that at least 35 states report that supervisors and caseworkers must have a college degree.

The federal Child Welfare system requires states to establish minimum education and qualification requirements of CPS workers (CAPTA Reauthorization Act, 2010). Child Welfare guidelines promote the recruitment of, including the direction of federal funds towards, individuals with higher educational attainment and backgrounds in social work education (DePanfilis and Salus, 2003).

Guideline:

It is recommended that APS' direct service personnel and supervisors are qualified by training and experience to deliver adult protective services. It is recommended that states institute minimum qualifications for APS workers and supervisors.

- At a minimum, APS workers should have an undergraduate college degree.
- Preference should be given to supervisors who have an undergraduate college degree and a minimum of two years of experience in APS.
- Preference should be given to those with a Master's degree in social work, gerontology, public health or other related fields.
- In states that employ nurses in their APS program, it is recommended that preference be given to those with a Bachelor's Degree in Nursing (BSN).

6B. CASE WORKER INITIAL AND ONGOING TRAINING

Background:

It is in the best interest of clients that APS caseworkers receive initial and on-the-job training in the core competencies of their challenging job. For instance, research has shown that differing

interpretations of definitions of confirmed, inconclusive, and unfounded case findings, along with differences in worker skill, expertise and training, may contribute to variability in APS case decisions on allegations and findings (Mosqueda et al., 2016).

However, research also indicates that more educational preparation and longer training sessions lead to more staff effectiveness. Studies measured effectiveness of training using several types of indicators—investigation and substantiation of allegations and staff’s self-perceived effectiveness. The studies indicate that training improves staff knowledge, confidence, self-perceived skills, and perceived competence in delivering APS, leads to change in practice (DuMont et al, 2017; Pickering et al., 2018; Storey et al., 2018), as well as increased rates of investigation and substantiation of maltreatment reports (Connell-Patrick and Scannapieco, 2008; Jogerst et al., 2004; Turcotte et al., 2009). Importantly, these improvements have shown to be significant when comparing outcomes for APS workers who did and did not complete trainings (Storey et al., 2018).

In the Child Welfare System, research shows that well-trained staff is able to complete tasks accurately and in a timely manner. In addition, studies suggest that educational programs provide workers with both competencies and increased commitment to their jobs, which are associated with retention (Zlotnick et al., 2005). Child Welfare agencies deliver a variety of training initiatives to build competencies and align skills with new practice models. Some states have formed university–agency partnerships that provide training and, in some cases, funding for Child Welfare staff to pursue graduate social work degrees (The Social Security Act, Title IV-E). In the federal Child Welfare System, states are required to provide certain types of training for CPS workers (Children’s Bureau, n.d.; e). Federal Child Welfare guidelines promote ongoing training and certification of caseworkers to maintain competency (DePanfilis and Salus, 2003).

The APS Survey revealed that 18 APS systems provided less than one week of training, 10 one week or more, and four states provided no training to new case workers. The NAPSA Minimum Standards identify core activities critical to the mission of APS and recommend that staff receive training on how to carry out these core activities skillfully.

Guideline:

Training plays a role in APS worker satisfaction and worker retention and enables staff to continue their development. Structured, comprehensive, and consistent training promotes skillful, culturally competent, and consistent APS practice. Training curricula should address the various education levels, experience, years of service, and training needs of both new workers and more experienced workers.

It is recommended that an APS worker training process have four important components or phases: (1) orientation to the job, (2) supervised fieldwork, (3) core competency training, and (4) advanced or specialized training.

The complex roles performed by APS workers require both formal content delivery and guided fieldwork to affect the transfer of learning from the classroom to practice. Subject content may

be delivered in a variety of modalities, including, but not limited to classroom workshops, reading, work book exercises, case conferences, shadowing experienced workers, online courses, and virtual-reality-/simulation-based trainings for experiential learning. APS systems are encouraged to be creative in content delivery.

Trainers should be qualified and proficient by academic degree, expertise, and/or work experience to provide training on the topic offered. When possible, APS programs are encouraged to bring in trainers from outside of the APS program.

1. Orientation to the Job

The purpose of the orientation is for workers to (1) acquire knowledge and skills in key areas and (2) understand when they need to seek guidance from their supervisor. It is recommended that APS systems develop and provide orientation for all new workers. If possible, key elements of that orientation need to be completed and workers need to demonstrate competence in these key areas before they are assigned cases. It is recommended that, at a minimum, the following areas be addressed in the orientation:

- a) concepts articulated in the APS System's Code of Ethics, including the principles of autonomy, least restrictive alternatives, person-centered service, trauma-informed practice, and supported decision-making;
- b) the role of APS and how the program fits into the larger long-term services and support network;
- c) common legal issues with which APS is involved, including confidentiality, conflict of interest, and guardianship/conservatorship (including alternatives to guardianship and conservatorship);
- d) the types of maltreatment covered by their state's statute, including their definition, signs, and symptoms;
- e) the case documentation process, including tracking and documenting attainment of client goals;
- f) the goals and process for conducting an APS investigation, including both the determination of maltreatment and the client assessment;
- g) the process for determining capacity;
- h) the process for determining whether or not maltreatment has occurred, including clear definitions of confirmed, inconclusive, and unfounded case finding determinations;

- i) serving clients with disabilities;
- j) the importance of culturally competent service;
- k) how to implement person-centered planning into service planning and interventions; and
- l) criteria for closing the case and applying a standardized process to determine if client goals were attained.

2. *Supervised Fieldwork:*

It is recommended that the orientation phase be followed by a period of close supervision of the new worker by a mentor or supervisor for a period of no less than 12 months. The ultimate goal of this supervised fieldwork phase is the “transfer of learning” (i.e., the direct application of knowledge and skills to work with clients).

3. *Core Competency Training:*

It is recommended that APS systems provide ongoing training to workers on a regular basis. It is suggested that the following Core Competencies for APS workers be provided within the worker’s first 24 months:

- a) APS Ethical Issues and Dilemmas
- b) APS Philosophy, Values and Cultural Competence
- c) The Aging Process
- d) Serving Clients with Physical & Intellectual Disabilities
- e) Interviews with Older Adults and Caregivers
- f) Mental Health Issues
- g) Substance Abuse
- h) Dynamics of Abusive Relationships
- i) Professional Communication Skills (Written and Verbal)
- j) Self-Neglect
- k) Caregiver Neglect
- l) Financial Exploitation
- m) Physical Abuse
- n) Sexual Abuse
- o) Emotional/Psychological Abuse
- p) APS Case Documentation/Report Writing
- q) Initial Investigation and Worker Safety
- r) Assessing Decision-making capacity
- s) Supported Decision-making models
- t) Risk Assessment
- u) Public benefits eligibility (e.g., Medicare, Medicaid, Social Security)
- v) Voluntary Case Planning/Intervention Process
- w) Involuntary Case Planning/Intervention Process

- x) Collaboration & Resources (including working in multi-disciplinary teams)
- y) Laws related to APS work (e.g., guardianship/conservatorship, mental health commitments, domestic violence)
- z) Working with the Criminal Justice System
- aa) Case Closure & Termination

Nurses working within the APS program should receive ongoing education related to medical, physical, emotional and social needs of older adults and adults with disabilities.

4. Advanced or Specialized Training:

It is recommended that programs provide advanced or specialized training for workers. For example, if the APS agency serves Native American, Hispanic, or other ethnicities, workers should have access to training specific to those populations. The training should go beyond a mere “overview” and provide in-depth training on the specific needs of those populations to be served.

Certification process: It is recommended that workers be supported in their goal of achieving state or national certification, if desired.

6C. SUPERVISOR INITIAL AND ONGOING TRAINING

Background:

The APS supervisor provides a combination of case oversight, approval of key decisions, case direction, problem-solving, and support and encouragement to the worker. According to the APS Survey, all but nine states require training for supervisors.

Given the potential hazardous work environment and negative impact on job satisfaction, work stress, and health outcomes (physical and mental) for APS workers, it is essential that supervisors have the tools to build positive and supportive work environments. These tools may include management strategies for the prevention of burnout and secondary traumatic stress (Ghesquiere et al., 2018).

Guideline:

It is recommended that APS supervisors be qualified by training and experience to deliver Adult Protective Services. It is recommended that all APS supervisors receive initial and ongoing training specific to their job responsibilities and the complex needs of APS clients and managing APS workers. It is recommended that new supervisors be trained on basic supervisory skills within the first year of assuming supervisory responsibilities, including, but not limited to:

- a) Mentoring
- b) Phases of APS Supervision
- c) The Supervisor as Trainer
- d) Managing the Investigative Process
- e) Supporting APS Workers (on how to deal with client environmental hazards and how to

- care for themselves)
f) Human Resources/Legal Issues for Supervisors

In addition, it is recommended that supervisors refresh their skills with ongoing annual training on higher level topics, such as training processes, worker development, and effective adult learning.

Nurses on the APS team should have their performance monitored and overseen by a supervisory nurse. The APS nurse should have access to consultation with a senior nurse and other members of a medical MDT.

7. EVALUATION/PROGRAM PERFORMANCE

Background:

Assessing program performance and client outcomes in social service programs is key for continuous quality improvement and for establishing best practices. For APS programs, research has shown clients to be overall satisfied with their APS experience, but additional work may be needed to determine whether services meet clients' specific needs (Booker et al., 2018), whether safety planning is targeted to different forms of mistreatment (Burnes et al, 2014), and at what point cases may be safe to close (Susman et al., 2015). In addition, programs may need to determine and implement policies for retaining APS records from substantiated cases to ensure the availability of longitudinal data (Susman et al., 2015).

The APS Survey reveals that 43 states have developed benchmarks and metrics for program evaluation. Generally, however, annual evaluations are not a standard tool in each state's program. Only 17 states reported publishing an annual APS report, with the details of each report varying greatly. The NAPSA Minimum Standards suggest that "APS program data is collected, analyzed, and reported" and that "[d]ata is utilized for program improvements such as budgeting, resource management, program planning, legislative initiatives and community awareness, and to improve knowledge about clients, perpetrators and the services and interventions provided to them."

The federal Child Welfare System requires the Department of Health and Human Services to establish outcome measures to monitor and improve state performance (Adoption and Safe Families Act, 1997). In addition, the Child Welfare System requires states to implement Child Welfare Improvement Policies (Child and Family Services Improvement and Innovation Act, 2011).

Guideline:

It is recommended that APS systems develop performance measures, and collect and analyze data related to those measures on an annual basis. Performance measures should assess (1) programmatic aspects and service areas to determine whether interventions were implemented timely and services met clients' needs; and (2) client-centered outcomes to determine whether

clients were satisfied with the services and whether goals specific to the clients were attained. Innovative measurement strategies that allow for client variability and that are capable of tracking change on an individualized set of outcome indicators, such as goal attainment scaling (Burnes et al., 2018), may be effective to assess client-centered APS intervention outcomes.

It is recommended that the data collected also be congruent with the National Adult Maltreatment Reporting System. It is recommended that APS systems compile a written report of those performance measures and make that report available to state and federal bodies and the public on a regular basis.

It is recommended that APS systems determine and implement policies for retaining APS records from substantiated cases to ensure the availability of longitudinal data. Programs may consider keeping records for approximately 10-15 years, but should consider their quality assurance needs when determining the most appropriate timeframe for retaining their APS records.

REFERENCES

- Acierno, R. (2018). National Elder Mistreatment Survey: 5 Year Follow-up of Victims and Matched Non-Victims. National Institute of Justice (NIJ). Retrieved from: <https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=274251>
- Acierno, R., Hernandez-Tejada, M. A., Anetzberger, G. J., Loew, D., & Muzzy, W. (2017). The national elder mistreatment study: An 8-year longitudinal study of outcomes. *Journal of Elder Abuse & Neglect*, 29(4), 254-269.
- Anetzberger, G. A. (2018). Community-Based Services. In Ronder, B. R., & Bello-Hass, V. D. (4th Edition), *Functional Performance of Older Adults* (437-452). Philadelphia, F. A. Davis Company.
- Adoption and Safe Families Act of 1997.
- Beach, S. R., Liu, P.-J., DeLiema, M., Iris, M., Howe, M. J. K., & Conrad, K. J. (2017). Development of short-form measures to assess four types of elder mistreatment: Findings from an evidence-based study of APS elder abuse substantiation decisions. *Journal of Elder Abuse and Neglect*, 29(4), 229-253.
- Booker, J. G., Breaux, M., Abada, S., Xia, R., & Burnett, J. (2018). Assessment of older adults' satisfaction with Adult Protective Services investigation and assistance. *Journal of Elder Abuse & Neglect*, 30(1), 64-74.
- Brink, F. W., Thackeray, J. D., Bridge, J. A., Letson, M. M., & Scribano, P. V. (2015). Child advocacy center multidisciplinary team decision and its association to child protective services outcomes. *Child Abuse & Neglect*, 46, 174-181.
- Burnes, D., Connolly, M. T., Hamilton, R., Lachs, M. S. (2018). The feasibility of goal attainment scaling to measure case resolution in elder abuse and neglect adult protective services intervention. *Journal of Elder Abuse and Neglect*, 30(3), 209-222.
- Burnes, D. P. R, Rizzo, V. M., & Courtney, E. (2014). Elder Abuse and Neglect Risk Alleviation in Protective Services. *Journal of Interpersonal Violence*, 29(11), 2091-2113.
- Burnett, J., Dyer, C. B., Clark, L. E., & Halphen, J. M. (2018). A Statewide Elder Mistreatment Virtual Assessment Program: Preliminary Data. *Journal of The American Geriatrics Society*. doi: 10.1111/jgs.15565. [Epub ahead of print]
- CAPTA Reauthorization Act of 2010.

Child and Family Services Improvement and Innovation Act of 2011.

Children's Bureau. (n.d.; a). Administration for Children and Families. U.S. Department of Health and Human Services. *Fostering Connections to Success and Increasing Adoptions Act of 2008; Child Abuse Prevention and Treatment Amendments of 1996; Family Preservation and Support Services Program Act of 1993; Adoption Assistance and Child Welfare Act of 1980*. Retrieved from: <https://www.childwelfare.gov/topics/systemwide/laws-policies/federal/search/>.

Children's Bureau. (n.d.; b). Administration for Children and Families. U.S. Department of Health and Human Services. *Mandatory Reporters of Child Abuse and Neglect*. Retrieved from: <https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/mandat/>.

Children's Bureau. (n.d.; c). Administration for Children and Families. U.S. Department of Health and Human Services. *Adoption Assistance and Child Welfare Act of 1980; Child and Family Services Improvement and Innovation Act; Adoption and Safe Families Act of 1997*. Retrieved from: <https://www.childwelfare.gov/topics/systemwide/laws-policies/federal/search/>.

Children's Bureau. (n.d.; d). Administration for Children and Families. U.S. Department of Health and Human Services. *Screening and Intake*. Retrieved from: <https://www.childwelfare.gov/topics/responding/ia/screening/?hasBeenRedirected=1>.

Children's Bureau. (n.d.; e). Administration for Children and Families. U.S. Department of Health and Human Services. *CAPTA Reauthorization Act of 2010; Keeping Children and Families Safe Act of 2003; Fostering Connections to Success and Increasing Adoptions Act of 2008; Child and Family Services Improvement Act of 2006; Deficit Reduction Act of 2005; Child Abuse Amendments of 1984*. Retrieved from: <https://www.childwelfare.gov/topics/systemwide/laws-policies/federal/search/>.

Connell-Carrick, K., & Scannapieco, M. (2008). Adult Protective Services: State of the workforce and worker development. *Gerontology & Geriatrics Education, 29*(2), 189-206.

Conrad, K. J., Iris, M., & Liu, P.-J. (2017). Elder Abuse Decision Support System: Field test outcomes, abuse measure validation, and lessons learned. *Journal of Elder Abuse and Neglect, 29*(2-3), 134-156

Cyphers, G. (2001). *Report from the child welfare workforce survey: State and county data*

and findings.

Washington, DC: American Public Human Services Association.

Daly, J. M., Jogerst, G. J., Haigh, K. M., Leeney, J. L., & Dawson, J. D. (2005). APS workers job requirements associated with elder abuse rates. *Social Work in Health Care, 40*(3), 89-102.

DePanfilis, D., & Salus, M. K. (2003). *Child Protective Services: A Guide for Caseworkers*. Office on Child Abuse and Neglect, Administration for Children and Families. Washington, DC: National Clearinghouse on Child Abuse and Neglect Information. Retrieved from: <https://www.childwelfare.gov/pubPDFs/cps.pdf>.

DiMatteo M. R., Lepper, H. S., & Croghan, T. W. (2000). Depression is a risk factor for noncompliance with medical treatment: Meta-analysis of the effects of anxiety and depression on patient adherence. *Archives of Internal Medicine, 160*, 2101–2107.

Dinerstein, R. (2012). Implementing Legal Capacity Under Article 12 of the UN Convention on the Rights of Persons with Disabilities: The Difficult Road from Guardianship to Supported Decision Making. *Human Rights Brief, 19*(2), 8-12.

Du Mont, J., Kosa, D., Yang, R., Solomon, S., & Macdonald, S. (2017). Determining the effectiveness of an Elder Abuse Nurse Examiner Curriculum: A pilot study. *Nurse Education Today, 55*, 71-76.

Gassoumis, Z. D., Navarro, A., & Wilber, K. H. (2015). Protecting victims of elder financial exploitation: the role of an Elder Abuse Forensic Center in referring victims for conservatorship. *Aging & Mental Health, 19*(9), 790-798.

Ghesquiere A., Plichta, S. B., McAfee, C., & Rogers, G. (2018). Professional quality of life of adult protective service workers. *Journal of Elder Abuse and Neglect, 30*(1), 1-19.

He, A. S., & Phillips, J. (2017). Interagency collaboration: Strengthening substance abuse resources in child welfare. *Child Abuse & Neglect, 64*, 101-108

Jackson, S. L., & Hafemeister, T. L. (2014). How Case Characteristics Differ Across Four Types of Elder Maltreatment: Implications for Tailoring Interventions to Increase Victim Safety. *Journal of Applied Gerontology, 33*(8), 982-997.

Jogerst, G. J. J., Daly, J. M., Dawson, J. D., Brinig, M. F., Schmuch, G. A., & Peek-Asa, C. (2004). APS Investigative Systems Associated with County Reported Domestic Elder Abuse. *Journal of Elder Abuse & Neglect, 16*(3), 1-17. Turcotte, D., Lamonde, G., & Beaudoin, A. (2009).

- Kohn, N., Blumenthal, J., & Campbell, A. (2013). Supported Decision-Making: A Viable Alternative to Guardianship? *Penn State Law Review*, 117 (4), 1111-1157.
- Lees, K. (2018). *Elder Mistreatment: An examination of formal and informal responses to a growing public health concern* (Doctoral dissertation). Retrieved from <https://repository.library.northeastern.edu/files/neu:cj82r9210>
- Mariam, L. M., McClure, R., Robinson, J. B., & Yang, J. A. (2015). Eliciting Change in At-Risk Elders (ECARE): Evaluation of an Elder Abuse Intervention Program. *Journal of Elder Abuse & Neglect*, 27, 19-33.
- Mathews, B., Lee, X. J., & Norman, R. E. (2016). Impact of a new mandatory reporting law on reporting and identification of child sexual abuse: A seven year time trend analysis. *Child Abuse & Neglect*, 56, 62-79.
- Mosqueda, L., Wigglesworth, A., Moore A. A., Nguyen, A., Gironde, M., Gibbs, L. (2016). Variability in Findings from Adult Protective Services Investigations of Elder Abuse in California. *Journal of Evidence-Informed Social Work*, 13(1), 34-44.
- National Adult Protective Services Association (2013). *Adult Protective Services Recommended Minimum Program Standards*. Retrieved from <http://www.napsa-now.org/wp-content/uploads/2014/04/Recommended-Program-Standards.pdf>.
- National Adult Protective Services Association. (n.d.). NAPSAs (or APS) Code of Ethics. Retrieved from <http://www.napsa-now.org/about-napsa/code-of-ethics/>.
- National Association of Social Workers. (n.d.). Read the Code of Ethics. Retrieved from <https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English>.
- Navarro, A. E., Gassoumis, Z. D., & Wilber, K. H. (2013). Holding abusers accountable: An elder abuse forensic center increases criminal prosecution of financial exploitation. *The Gerontologist*, 53(2), 303-312.
- Office of the Assistant Secretary for Planning and Evaluation. U.S. Department of Health and Human Services (2003). *National Study of Child Protective Services Systems and Reform Efforts: Review of State CPS Policy*. Retrieved from: <http://aspe.hhs.gov/hsp/cps-status03/state-policy03/>
- Pickering, C. E. Z., Ridenour, K., Salaysay, Z., Reyes-Gastelum, D., & Pierce, S. J. (2018). EATI Island – A virtual-reality-based elder abuse and neglect educational intervention. *Gerontology & Geriatrics Education*, 39(4), 445-463.

- Ramsey-Klawnsnik, H. (2015). *Investigation Protocols*. NAPSRC Technical Assistance Brief. Retrieved from <http://www.napsa-now.org/wp-content/uploads/2015/03/TA-Brief-Invesitgation-Protocols.pdf>
- Ramsey-Klawnsnick, H., & Teaster, P. (2012). Sexual Abuse Happens in Healthcare Facilities—What Can Be Done To Prevent It? *Generations*, 36(3), 53-59.
- Rizzo, V. M., Burnes, D., & Chalfy, A. (2015). A Systematic Evaluation of a Multidisciplinary Social Work–Lawyer Elder Mistreatment Intervention Model. *Journal of Elder Abuse & Neglect*, 27(1), 1-18.
- Sirey, J. A., Berman, J., Depasquale, A., Halkett, A., Raeifar, E., Banerjee, S., Bruc, M. L., Raue, P. J. (2015). Feasibility of Integrating Mental Health Screening and Services Into Routine Elder Abuse Practice to Improve Client Outcomes. *Journal of Elder Abuse & Neglect*, 27, 254-269.
- Sirey, J. A., Bruce, M.L., & Alexopoulos, G. S. (2005). The Treatment Initiation Program: An intervention to improve depression outcomes in older adults. *The American Journal of Psychiatry*, 162, 184–186.
- Social Security Act, Title IV-E.
- Storey, J. E., & Prashad, A. A. (2018). Recognizing, reporting, and responding to abuse, neglect, and self-neglect of vulnerable adults: an evaluation of the re:act adult protection worker basic curriculum. *Journal of Elder Abuse & Neglect*, 30(1), 42-63.
- Substance Abuse and Mental Health Services Administration. (n.d.). U.S. Department of Health and Human Services. Trauma-Informed Approach and Trauma-Specific Interventions. Retrieved from <https://www.samhsa.gov/nctic/trauma-interventions>.
- Susman, A., Lees, K. E., & Fulmer, T. (2015). Understanding repeated visits to adult protective services. *The Journal of Adult Protection*, 17(6), 391-399.
- Turcotte, D., Lamonde, G., & Beaudoin, A. (2009). Evaluation of an in-service training program for child welfare practitioners. *Research on Social Work Practice*, 19(1), 31-41.
- Wiglesworth, A., Mosqueda, L., Burnight, K., Younglove, T., & Jeske, D. (2006). Findings from an elder abuse forensic center. *The Gerontologist*, 46(2), 277-283.
- Wilber, K. H., Navarro, A. E., Gassoumis, Z. D. (2014). Evaluation the Elder Abuse Forensic

Center Model. Retrieved from <https://www.ncjrs.gov/>

Zlotnick, J., DePanfilis, D., Daining, C., & Lane, M. M. (2005). Professional Education for Child Welfare Practice: Improving Retention in Public Child Welfare Agencies. *Child Welfare Workforce Series*. IASWR Research Brief 2. Retrieved from <http://www.socialworkpolicy.org/wp-content/uploads/2007/06/7-CW-SRR-Brief2.pdf>.