



Final Voluntary Consensus Guidelines for
State Adult Protective Services Systems
September, 2016

Administration for Community Living
U.S. Department of Health and Human Services
Washington, D.C. 20201

Voluntary Consensus Guidelines for State Adult Protective Services Systems

Table of Contents

PREFACE.....	II
EXECUTIVE SUMMARY	III
INTRODUCTION.....	1
BACKGROUND	2
DEVELOPMENT OF VOLUNTARY CONSENSUS GUIDELINES.....	5
NEXT STEPS	14
FINAL VOLUNTARY CONSENSUS GUIDELINES FOR STATE ADULT PROTECTIVE SERVICES SYSTEMS	16
APPENDIX 1: RESEARCH QUESTIONS, SUMMARY OF LITERATURE REVIEW FINDINGS, AND BIBLIOGRAPHY	A1-1
APPENDIX 2: APS ADMINISTRATIVE SYSTEM PRACTICES COMPARISON.....	A2-1
APPENDIX 3: FEDERAL INVOLVEMENT IN CHILD WELFARE.....	A3-1
APPENDIX 4: STAKEHOLDER ENGAGEMENT PROCESS.....	A4-1
APPENDIX 5. APS GUIDELINES PUBLIC COMMENTS DATA ANALYSIS	A5-1
APPENDIX 6. TEXTUAL CHANGES SUGGESTED BY PUBLIC COMMENT.....	A6-1
APPENDIX 7. LISTING OF CONTRIBUTORS	A7-1
ENDNOTES.....	E-1

PREFACE

The Administration for Community Living (ACL) is providing these *Voluntary Consensus Guidelines for State Adult Protective Services* systems to promote an effective adult protective services (APS) response across the country so that all older adults and adults with disabilities, regardless of the state or jurisdiction in which they live, have similar protections and service delivery from APS systems. These guidelines were developed by subject matter experts in the field of APS and abuse, neglect, and exploitation of older adults and adults with disabilities. These guidelines are informational in content and are intended to assist states in developing efficient and effective APS systems.

The Final “Voluntary Consensus Guidelines” do not constitute a standard nor regulation, and do not create any new legal obligations, nor impose any mandates or requirements. They do not create nor confer any rights for, or on, any person.

A listing of Contributors can be found in Appendix 7.

EXECUTIVE SUMMARY

The Administration for Community Living (ACL) envisions a comprehensive, multidisciplinary system that effectively supports older adults and adults with disabilities so they can exercise their right to live where they choose, with the people they choose and fully participate in their communities without threat of abuse, neglect, self-neglect, or financial exploitation.¹

Adult protective services (APS) agencies are a critically important component of this comprehensive system to address abuse, neglect, self-neglect or financial exploitation of older adults and adults with disabilities (hereinafter referred to as “adult maltreatment”). APS is a social services program provided by state and local government nationwide serving older adults and adults with disabilities who are in need of assistance because of adult maltreatment. In all states, APS is charged with receiving and responding to reports of maltreatment and working closely with clients and a wide variety of allied professionals to maximize clients’ safety and independence.

Historically, there has been no federal “home” for APS nor a designated federal appropriation for this critically important service. Instead, states and local agencies have developed a wide variety of APS practices, resulting in significant variations. For example, APS systems differ in the populations served, settings in which services are available, timeliness of responses, types of services provided, and relationships with other service providers and the justice system.

Strong federal leadership in addressing maltreatment of older adults and adults with disabilities must include a commitment to bolstering and assisting the APS system in responding to victims in the most effective way possible.² ACL believes that several building blocks are needed in order to develop an effective network of APS systems across the nation, among these are:

- a national Office of Elder Justice and Adult Protective Services housed at ACL,
- support for effective APS practice through a National Adult Protective Services Resource Center,
- a national APS data collection system which will help inform research on appropriate interventions for older adults and adults with disabilities, and
- National Voluntary Consensus Guidelines for State APS Systems.

ACL is uniquely qualified to spearhead these efforts because of its mission to maximize the independence, well-being, and health of older adults, adults with disabilities, and their families and caregivers. In addition, ACL has a long history of leadership in the area of adult maltreatment, and good working relationships with the national aging, disability and APS networks.

DEVELOPMENT AND SUBSTANCE OF THE GUIDELINES

ACL engaged in the development of National Voluntary Consensus Guidelines for State APS Systems (hereinafter “the Guidelines”) by first performing an environmental scan of available literature and research produced by scholars. There was a paucity of peer-reviewed research found on APS practice. Consequently, the environmental scan was broadened to included a

review of a national survey of APS practices, a review of minimum practice standards promulgated by an APS membership organization, as well as a review of practices of analogous systems (e.g., Child Welfare System). The environmental scan resulted in a list of preliminary topics for consideration. After that, ACL convened the first of two expert working groups; each one consisted of various professionals and experts from the field of protective services, and related fields (e.g., disability rights). The first expert working used the previously identified topics as an evidence base to ultimately create the draft guidelines. They based the initial draft guidelines on their identification of seven domains related to efficient and effective APS practice. These seven domains included:

1. Program administration
2. Time frames
3. Receiving reports of maltreatment
4. Conducting the investigation
5. Service Planning and Intervention
6. Training
7. Evaluation/Program Performance

In order to increase stakeholder outreach and input, ACL shared the draft guidelines to the public through a notice-and-comment period. The comments submitted during this Stakeholder Engagement period showed a great diversity of viewpoints, interests, and concerns. Based on both a qualitative and quantitative data analysis of the comments received, the overriding principle of the majority of themes was the desire for more specificity and more guidance. To resolve this, a second expert working group was convened to revise the text of the draft guidelines. In addition to these revisions, the second expert working group also decided to add four new elements under Domain 1 to the Guidelines. These new topics cover issues surrounding worker safety, community emergencies, outreach and engagement, and research.

Overall, the Guidelines were designed to provide State APS Administrators with recommendations from the field about quality APS practice. There are several ways that states may choose to utilize the Guidelines. For instance, some states can use the Guidelines as a model of comparison to existing APS systems offered, to identify new areas of interest, or to identify areas for improvement in their state statutes or policies. No matter how the Guidelines are used, all states are encouraged to suggest any revisions to ACL, as the agency plans on performing biennial reviews.

It is important to note that the Guidelines do not constitute a standard nor regulation, and do not create any new legal obligations, nor impose any mandates or requirements. They do not create nor confer any rights for, or on, any person. They should be viewed more as sub-regulatory recommendations concerning efficient APS practices than requirements for states to follow.

INTRODUCTION

PROJECT RATIONALE

The Administration for Community Living's (ACL's) goal was to facilitate the development of field-driven and consensus-informed national guidelines in order to provide a core set of principles and common expectations to encourage consistency in the policies and practices of adult protective services (APS) across the country. Through the National Voluntary Consensus Guidelines for APS Systems (hereinafter "the Guidelines"), ACL seeks to help ensure that older adults and adults with disabilities are afforded similar protections and service delivery, regardless of which state or jurisdiction they are in. This consistent approach will also be beneficial to supporting interdisciplinary and interagency coordination,³ as partners from other agencies and disciplines better understand both APS' responsibilities and its limitations. The goals of this consistent approach are for the enhancement of partnerships and effective, efficient, and culturally competent delivery both of services to victims and responses to perpetrators. Most importantly, a consistent approach for APS systems displays the value this nation places on its older adults and adults with disabilities as contributing members of society.

Development of the Guidelines officially began in 2014, but was based on previous research performed by APS agencies and affiliated organizations. Overall, the process involved:

1. an environmental scan,
2. convening the first expert working group to draft an initial set of guidelines,
3. a stakeholder engagement process through a public notice-and-comment period,
4. a quantitative and qualitative data analysis of the public comments, and
5. convening a second expert working group to refine and build consensus around the Guidelines based on the comments received.

While each component of the process is important and expressed in greater detail below, some historical background material is given in the next section concerning the history of adult maltreatment and APS' role in responding to it. The section after that goes into more detail on the development of the Guidelines, and gives some suggestions on ways in which the Guidelines may be used by state systems. Finally, the Guidelines in their entirety are provided and broken down by domain and element. For each individual element, a quick background is provided followed by the text of the recommended guideline. Finally, several appendices at the end of the document provide additional details related to the sections mentioned above.

BACKGROUND

PROBLEM OF ADULT MALTREATMENT*

Governments have long recognized the principle of individual dignity and rights. These basic rights are found in both national and international human rights doctrines, advocating the values of self-determination in decision making, equal access to resources, full participation in all aspects of society, and the value of a dignified quality of life.⁴ Abuse, neglect, and exploitation of older adults and of adults with disabilities violate these inherent rights.

Adult maltreatment is a significant public health and human rights problem. The most recent data available on the prevalence of adult maltreatment suggests that at least 10% of older Americans—approximately 5 million persons—experienced emotional, physical, or sexual abuse, financial exploitation and neglect each year, and many of them experience it in multiple forms.⁵ Adults with disabilities are 4 to 10 times more likely to become a victim of maltreatment than persons without disabilities.⁶ In 2010, the age-adjusted, serious violent crime (e.g. rape, robbery, assault) victimization rate for persons with disabilities was three times the rate of adults without disabilities.⁷

In addition, data from state APS agencies show an increasing trend in reports of adult maltreatment.⁸ These increases are concerning as other research estimates that as few as 1 in 23 cases of elder abuse,⁹ and 1 in 44 cases of financial exploitation,¹⁰ ever come to the attention of authorities.

Legal definitions of adult maltreatment vary from state to state, and there is no consistently used definition by researchers, nor across federal agencies. Some states and federal statutes also include the concepts of abandonment of an elder or an adult with a disability by a person who has assumed a duty to care, isolation, and self-neglect.¹¹ The Elder Justice Act defines the following terms¹²:

- Abuse: “the knowing infliction of physical or psychological harm or the knowing deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm.”
- Exploitation: “the fraudulent or otherwise illegal, unauthorized, or improper act or process of an individual, including a caregiver or fiduciary, that uses the resources of an elder for monetary or personal benefit, profit, or gain, or that results in depriving an elder of rightful access to, or use of, benefits, resources, belongings, or assets.”
- Neglect: “(A) the failure of a caregiver or fiduciary to provide the goods or services that are necessary to maintain the health or safety of an elder; or “(B) self-neglect.”

* Throughout this document, the term “adult maltreatment” will be used, and should be understood to encompass, all types of abuse, neglect, self-neglect, and financial exploitation of older adults and of adults with disabilities.

- Self-neglect: “an adult’s inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including— (A) obtaining essential food, clothing, shelter, and medical care; (B) obtaining goods and services necessary to maintain physical health, mental health, or general safety; or (C) managing one’s own financial affairs.”

There are significant and serious health consequences of experiencing adult maltreatment. Older adults who experience even modest forms have dramatically higher (300%) morbidity and mortality rates than those who have not experienced maltreatment.¹³ Victims of elder abuse are four times more likely to be admitted to a nursing home¹⁴ and three times more likely to be admitted to a hospital.¹⁵ Older adults who are victims of violence have more health care problems than other older adults, including increased bone or joint problems, digestive problems, depression or anxiety, chronic pain, high blood pressure, and heart problems.^{16,17,18,19,20,21} Victims of maltreatment have significantly higher levels of psychological distress and lower perceived self-efficacy than older adults who have not been victimized.²² For older victims of sexual violence the negative health impacts of abuse are even more pronounced.²³

As with older adults, research shows that maltreatment of adults with disabilities increases the risk and rates of depression, anxiety, and other emotional and psychological problems, in addition to increased medical problems.²⁴ It is important to note that many of these conditions are already prevalent in adults with disabilities, thereby making it more likely that the abuse will go unnoticed, untreated, and unaddressed.²⁵ In fact, for those with mental illness, exposure to interpersonal violence decreases psychosocial functioning and is correlated with more frequent hospitalizations, longer hospital stays, and more emergency room visits.²⁶

Adult maltreatment takes a sizeable toll on the health and well-being of our nation’s economy as well. It is estimated that older adults throughout the U.S. lose a minimum of \$2.6 billion annually due to elder financial abuse and exploitation.²⁷ The actual losses are likely higher, as that estimate does not account for the resources lost by adults with disabilities age 18–64. In a 2012 report, the Agency for Healthcare Research and Quality estimated from the most recent available data that \$1.9 trillion, or 16% of the U.S. gross domestic product, was spent on health care. Of all conditions, trauma ranked as the second most expensive in terms of total health care spending.²⁸

There is a personal cost as well, and that must not be forgotten. Adult maltreatment threatens a person’s independence, undermines one’s dignity, and imperils physical and financial safety. Considering these factors together—the threat to human dignity and safety, higher rates of chronic conditions for victims of abuse, and higher costs of trauma associated with adult maltreatment—we are faced with a human rights, public health, and economic imperative to prevent and intervene in these cases.

RESPONDING TO MALTREATMENT: STATE ADULT PROTECTIVE SERVICES SYSTEMS

States respond to the problem of adult maltreatment with a variety of systems and programs, including law enforcement, Protection and Advocacy systems, Long-term Care Ombudsman programs, and APS. For many, if not most, older adults and adults with disabilities who live in the community, APS will be the first to respond to reports of suspected maltreatment.

APS was recognized by federal law in 1975 under Title XX of the Social Security Act via the Social Services Block Grant (SSBG). SSBG provides states with funding to support social service programs, as well as flexibility in deciding how to spend the SSBG funding.²⁹ Since then, all 50 states and the District of Columbia have developed APS programs in accordance with local needs, structures, and laws. Today, SSBG remains the only federally appropriated funding available for state APS operations.

As the APS system is presently configured, APS programs are often the gateway for adult maltreatment victims who need additional community, social, health, behavioral health, and legal services to maintain independence in the settings in which they prefer to live, as well as the avenue through which their maltreatment is reported to police or other agencies of the criminal justice system. APS receives and responds to reports of adult maltreatment, and works closely with clients and a wide variety of allied professionals to maximize safety and independence. APS programs provide a range of services to the people they serve, including:

- receiving and investigating reports of adult maltreatment;
- case planning, monitoring, evaluation, and other case work and services; and
- providing, arranging for, or facilitating the provision of medical, social service, economic, legal, housing, law enforcement, or other protective, emergency, or support services.

As state-established, administered, and primarily funded programs, state and local APS systems and interventions reflect the unique parameters of each state's legislation and cultural history. At the state level, APS typically resides administratively within a state's Department of Aging or Department of Human/Social Services. States and local agencies have developed a wide variety of APS practices, resulting in significant variations. For example, state APS systems differ in the populations served, settings in which services are available, types of services provided, relationships with other service providers and the justice system, and timeliness of responses.

Because the APS system is designed and administered at the state or local level, as a national system it is fragmented and unequal, both within and across states. This uneven access especially affects services to racial and ethnic minorities, and those with limited English-speaking skills.³⁰ Fragmentation hinders cross-jurisdictional cooperation, information sharing, and investigation.³¹ There exists a lack of standardized service provision across states and localities, contributing to the absence of critical supports for victims (e.g., reporting hotlines, shelters, and counseling) and the system at large.³² Moreover, there are significant research and

data gaps on the causes and effective, evidence-based prevention and intervention strategies for adult maltreatment. These conditions perpetuate the absence of uniform approaches, guidance, and training across the allied industries working to prevent and address adult maltreatment, resulting in APS investigations that are difficult to conduct; such as complicated processes for securing needed services and supports and the reduced likelihood that cases referred to the criminal justice system will be prosecuted.

DEVELOPMENT OF VOLUNTARY CONSENSUS GUIDELINES

Voluntary consensus guidelines are encouraged by the Office of Management and Budget and are characterized by a development process that includes openness, balance, due process and general agreement.³³ Standardization is a process of constructing uniformities across time and space through the generation of agreed-upon understandings. The general goal of guidelines, rules or standards is to foster consistent coordination in a way that would be difficult to achieve without their existence, and they are created, almost always, by groups using a collective process.³⁴ Guidelines do not encourage consistency just for consistency's sake, but should lead to improvement in outcomes.

The process for developing the Guidelines involved multiple steps, with each one using and building onto the previous step's work. These included: (1) an in-depth environmental scan on related literature and research; (2) convening the first expert working group to draft the initial set of guidelines; (3) an expanded stakeholder engagement process and review of the draft guidelines; (4) a comprehensive data analysis of the public comments received from stakeholders; and finally (5) convening a second expert working group to refine the draft guidelines and build consensus around the Guidelines.

These steps are detailed below and in the attached appendices.

ENVIRONMENTAL SCAN

ACL began by identifying an initial list of topics to explore for inclusion in a set of national APS system guidelines. These topics were drawn from analogous state programs with similar characteristics, such as child protective services and the Long-Term Care Ombudsman program, as well as those needs identified by APS systems in nationwide surveys.

List of topics covered in the literature and research review:

- General program administration
- Standardized, "minimum" threshold definitions of abuse, neglect, self-neglect, and financial exploitation
- Mandated reporting requirements
- Assessment and intake protocol
- Investigation and case planning response times
- Case closure protocol

- Staffing/caseload ratios
- Case worker education levels
- Case worker training

For each of the nine topics, two activities were conducted. First, the available empirical research was reviewed related to the impact of current regulations, guidelines and practices on outcomes at the program and individual levels. Documents that inform current practice in the field of APS and other analogous fields were also reviewed. These included: (1) the 2012 survey of state APS system conducted by the National Adult Protective Services Association (NAPSA) and the National Association of States United for Aging and Disabilities survey; (2) the NAPSA Minimum Recommended Program Standards for APS systems; and (3) laws and regulations governing children’s protective services practices.

The information obtained from these steps was synthesized to create an evidence base that informed the initial draft for national guidelines for state APS systems.

LITERATURE REVIEW

The literature from 2004 through March 2014, related to the administration of APS systems and systems for all adults served in this system was reviewed. In addition, the literature in similar systems—child protective services, Long-Term Care Ombudsman programs, and supportive services for older adults—was reviewed.

ACL staff worked with staff from the Department of Justice and its librarians to identify a list of research questions related to administrative practices. The National Criminal Justice Reference Service Library Services (NCJRS) at the Department of Justice conducted a search of 12 databases for articles appearing in 2004 through March 2014.³⁵ NCJRS conducted a keyword search of the databases including search terms such as abuse, fraud, exploitation, maltreatment, adult protective service, elder, disabled, and outcomes.

The search resulted in 219 abstracts: 107 in APS and elder abuse, 29 from the Long-Term Care Ombudsman program, 20 from the literature on supportive services for older adults in the community, and 63 related to child protective services. We reviewed the abstract of each article to determine whether it contained research related to the questions. This process yielded 31 articles: 14 in APS and elder abuse, six from Long-Term Care Ombudsman programs, two on supportive services for older adults in the community, and nine from child protective services.

The 31 articles were reviewed and included in the literature review only if they contained quantitative data analysis or involved a systematic literature review. Using these basic criteria, eight articles from the APS literature, two from the Long-Term Care Ombudsman program, and six from child protective services were included. The 17 articles that remained were then summarized. These summaries provide the basis for the information in the research results. The articles’ summaries are available on request from ACL. Please see Appendix 1 for the articles’ citations and brief summaries of their findings.

RESEARCH RESULTS

From the available literature, the evidence base included a few quasi-experimental studies; however, most of the studies relied on surveys of staff or states. These studies generally were not rigorous scientific projects and they shed little light on most of the research questions that were around APS administrative practice; however they offered valuable insights into training, team structure, and police and forensic involvement, resources and reporting requirements. The text below reports only results that are statistically significant. These results are also shown in Appendix 1.

- *Education and Training*

More educational preparation and longer training could lead to more staff effectiveness. Studies measured effectiveness using several types of indicators—investigation and substantiation of allegations and staff’s self-perceived effectiveness. The studies conclude that training improves staff knowledge, confidence and self-perceived skills, as well as increases their rates of investigation and substantiation of abuse reports.³⁶

- *Staffing Resources*

Results of studies of team composition were mixed. In two studies, having a social work background affected performance in different ways. One study indicates that asking one staff person to investigate both child and adult abuse cases lowers staff effectiveness.³⁷ Comprehensive evaluation of supervisors can improve their effectiveness with the staff who report to them.³⁸

- *Practice*

Involvement of police and forensic centers can improve investigative work and increase substantiation of abuse allegations.³⁹ Standardized forms and checklists can increase investigations and documentation of incidents.⁴⁰ Oddly, additional programmatic resources did not always lead to more staff effectiveness.⁴¹ The mixed results are likely due to differences among the states’ systems.

While these results indicate future directions for improving APS systems, many questions about how to improve administrative effectiveness remain. Future research and, perhaps, more importantly, rigorous evaluation can help drive the field forward in terms of preventing and addressing adult maltreatment.

COMPARATIVE PROTECTIVE SERVICES SYSTEMS

In addition to the research, ACL sought to understand current protective services practices, as well as current thinking on protective services system standards across various fields. Several sources were reviewed. Appendices 2 and 3 include charts cataloguing the information reviewed, as identified below:

- *APS Survey of States 2012 (APS Survey)*:
ACL reviewed the survey “Adult Protective Services in 2012: Increasingly Vulnerable⁴²” to determine what practices states have in place regarding each of the nine research topics. A chart was developed that catalogued the data found.
- *NAPSA Recommended Minimum Program Standards (NAPSA Minimum Standards)⁴³*:
The NAPSA Standards were reviewed to identify which of ACL’s research topics were also components of the standards. This information was included in the comparison chart.
- *Catalogue of Federal Involvement in Child Welfare:⁴⁴*
Existing federal law, regulations, and guidelines for Child Welfare in the nine identified research topics was catalogued and included in the comparison chart. This information was included to demonstrate in what areas, and to what extent, the federal government has provided guidelines to states related to protective services.

Below appears a brief summary of the available findings from the review of current practices:

1. *Definitions of Maltreatment*

State laws define abuse differently, including who is eligible for APS services, etc. The federal government establishes a definition of what constitutes child abuse and who is eligible for services under various Child Welfare provisions.⁴⁵

2. *Mandatory Reporting*

49 states have mandatory reporting of suspected elder abuse for some professionals, with 37 states reporting that their APS system investigates abuse for people aged 18+ years. State laws regarding who is a mandated reporter vary widely, with 15 states indicating that all persons are required to report. Federal guidelines governing child protective services addresses mandatory reporting and the professionals that should do so.⁴⁶

3. *Assessment*

31 states responded that they conduct some type of risk assessment, though the tools described generally addressed the assessment of cognitive impairment, rather than risk of maltreatment. NAPSA Minimum Standards recommend that APS systems have a systematic approach to completing a needs/risk assessment. Federal requirements of CPS are that systems have a differential response to various types of allegations in their screening and assessment procedures.⁴⁷

4. *Intake*

The APS Survey revealed that 26 states have a centralized intake for APS reports, 41 states have a toll free number to report maltreatment, and 38 accept reports 24 hours a day. NAPSA Minimum Standards say that systems should have a systematic means of receiving and screening abuse maltreatment reports. The Child Welfare 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 2003.⁴⁸

5. Investigation and Case Planning

The APS Survey shows that 21 states respond to cases 24 hours a day and 42 states say that they tie investigation response time frames to the type of allegation. Only eight states responded that they do not have timeframes for closure of investigations. Of those that do, the range was from 30 to 90 days. 18 states responded that they do not have regular contact with the client. Of those states that require regular contact, the most frequent interval reported was monthly. Services provided to the client vary greatly based on client needs and APS resources. The most commonly provided services are 1) advocacy with other systems, 2) in-home services, and 3) developing a case plan. NAPSA Minimum Standards suggest systematic examination of all aspects of reported maltreatment to determine the appropriate response. The standards list key aspects of this examination and response. Federal CPS standards address minimum frequencies for visits, and establish maximum time limits on home visit reports and identification of differential responses for screening and assessment related to the types of cases reported.⁴⁹

6. Case Closure

Twenty states do not have time limits for case closures. The NAPSA Minimum Standards address this topic and list commonly accepted reasons for closing cases. Federal CPS requirements have minimum timeframes for case closure and guidelines for processing case closure.

7. Staffing Ratios

The APS Survey indicates that APS worker caseload varied 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 CPS requirements recommend that states establish ratios, but do not say what those ratios should be.

8. Caseworker Education

The literature review indicates that higher education requirements for workers lead to higher substantiation of allegations. Requiring a social work education background led to higher investigation and substantiation rates.⁵⁰ Investigation rates were significantly higher when the state required that staff have a social work degree, but substantiation ratios were significantly lower in these same states.⁵¹ The APS Survey shows that at least 35 states report that supervisors and caseworkers must have a college degree. NAPSA Minimum Standards say only that staff should be qualified by training and experience to do their jobs. Federal CPS requirements say that states must establish minimum qualifications for staff.

9. Caseworker Training

The literature indicates that training can increase a worker's knowledge, self-confidence, and lessen stress. Longer training systems led to higher substantiation rates and increased detection of child abuse. The APS Survey showed that 18 states required less than one week of training, 10 states had one week or more, and four states had no training. All but nine states required training for supervisors. NAPSA Minimum Standards identify core activities critical to the mission of APS, recommend that staff training address related activities, and provide information about a curriculum that covers them. Federal CPS requirements govern types of training that CPS workers should have.

10. Quality Assurance

The APS Survey shows that over 70% of states have case review systems and in three-quarters of those states, every case is reviewed, mostly by a supervisor or administrator. More than one-quarter of states report no quality assurance. NAPSA Minimum Standards recommend a standard case review system. Federal requirements of CPS relate to outcomes measures and the federal government provides resources on these and other topics.

As expected, a great deal of variation was found in APS practices across the states. Most notably, caseload to worker ratios ranged from less than 25 per worker to over 100. There also were wide variations in required contact between workers and clients. Due to APS being a primarily state-administered program, it also was not surprising to find that the NAPSA Minimum Standards set very broad guidelines for practice, in contrast to the specific standards for CPS systems set by the federal government.

ENVIRONMENTAL SCAN CONCLUSION

APS practices vary a great deal across the United States. Information is available for most of the nine topics that were reviewed; however, the evidence base was very rudimentary and limited in scope. While the evidence indicates future directions for improving APS systems, many questions remain about how to improve administrative practices. Future research and, perhaps, more importantly, rigorous evaluation can help drive the field forward in terms of protecting adults against maltreatment.

FIRST EXPERT WORKING GROUP

The Formulation Phase of the APS Guidelines began in February 2015, when ACL engaged the input of a small group of experts selected from APS, Long-Term Care Ombudsman, and Disability Rights communities based on their breadth and depth of knowledge and experience in the field. The engagement of this group of experts was critical in defining the scope, structure, and breadth of the Guidelines document. This first expert working group received the full results from the environmental scan, as outlined above, and used these materials to inform discussions held weekly via conference calls. From February–March 2015, the expert working group discussed and refined each of the guidelines’ domains and elements. The result of this work was a list of seven domains and multiple elements on which to provide guidance for in the draft guidelines:

Table 1. List of Domains and Elements

1. Program Administration
 - 1a. Ethical Foundation Of APS Practice
 - 1b. Definitions Of Maltreatment
 - 1c. Population Served
 - 1d. Mandatory Reporters

- 1e. Coordination With Other Entities
 - 1f. Program Authority, Cooperation, Confidentiality And Immunity
 - 1g. Protecting Program Integrity
 - 1h. Staffing Resources
 - 1i. Access To Expert Resources
 - 1j. Case Review-Supervisory Process
 - 1k. Worker Safety and Well-being[†]
 - 1l. Responding During Community Emergencies
 - 1m. Community Outreach and Engagement
 - 1n. Participating in Research
2. Time Frames
- 2a. Responding To The Report
 - 2b. Completing The Investigation
 - 2c. Closing The Case
3. Receiving Reports Of Maltreatment
- 3a. Intake
 - 3b. Screening, Triaging, And Assignment Of Screened In Reports
4. Conducting The Investigation
- 4a. Determining If Maltreatment Has Occurred
 - 4b. Conducting A Psycho-Social Assessment
 - 4c. Investigations In Congregate Care Settings
 - 4d. Completion Of Investigation And Substantiation Decision
5. Service Planning And Intervention
- 5a. Voluntary Intervention
 - 5b. Involuntary Intervention
 - 5c. Closing The Case
6. Training
- 6a. Case Worker And Supervisor Minimum Educational Requirements
 - 6b. Case Worker Initial And Ongoing Training
 - 6c. Supervisor Initial And Ongoing Training
7. Evaluation/Program Performance

STAKEHOLDER ENGAGEMENT PROCESS

To refine the guidelines developed by the first expert working group, ACL launched a stakeholder engagement and outreach strategy. The goal of the outreach was to hear from all stakeholders about their experiences with APS, ensure all stakeholders understood why and

[†] Items 1k-1m were added to the guidelines after the Public Comment period.

how ACL was leading the development of guidelines for APS, and provide interested parties an opportunity to give input into the process and content of the guidelines. Throughout the process, ACL's stakeholder engagement and outreach endeavored to:

- respect people's history and experience with APS, and their other life experiences;
- empower the public and stakeholders to contribute to the development of national APS guidelines in a meaningful way;
- understand the public's vision for APS and for ACL's role in APS;
- build consensus on proposed guidelines by including representatives from materially affected and interested parties, to the extent possible; and
- incorporate a civil rights/personal rights perspective in developing the system guidelines.

ACL conducted the stakeholder engagement and outreach strategy from July 2015–February 2016. During this period, ACL utilized several means to actively solicit, receive, and record input from stakeholders. This section of the report provides a summary of the phases of the engagement and outreach strategy, and the methods ACL employed for soliciting public comments, and Appendix 4 includes a more detailed discussion.

PRESENTATION PHASE

During August 2015, ACL Administrator and Assistant Secretary for Aging, Kathy Greenlee, held six meetings with small groups of stakeholders to present information about ACL's current and proposed work related to strengthening the APS system and to solicit feedback on that work, including the creation of the Guidelines. The small groups included representatives from disability rights advocates, mental health advocates, long-term care advocates, aging advocates, APS, and representatives of other federal offices that conduct elder justice work, and provided an opportunity for ACL and the stakeholder groups to discuss ways to encourage and increase involvement in the APS Guidelines Project public comment period.

FEEDBACK PHASE

Between August–November 13, 2015, and again from January 25, 2016–February 8, 2016, . ACL utilized four (4) strategies to actively solicit, receive, and record input from stakeholders. The four methods are listed below, and discussed in detail in Appendix 4:

- One-hour, teleconference listening sessions with stakeholders from both targeted professional groups and the general public;
- Teleconference listening sessions with Regional Administrators and the State Unit on Aging Directors in each of ACL's regional offices;

- Presentations at professional conferences, and
- Collection of written comments via an on-line submission form on the ACL website.

DATA ANALYSIS

Upon the completion of the stakeholder engagement process, ACL conducted two different analyses of the information received throughout the stakeholder engagement process. First, ACL performed a preliminary quantitative data analysis to understand the types of comments that were received. Due to the complexity and number of comments received, ACL engaged a team of Health and Aging Policy Fellows⁵² to perform a qualitative data analysis of all of the public comments received by ACL. Below is a brief summary of the analyses performed. The full Data Analysis Report is included in Appendix 5.

QUANTITATIVE ANALYSIS

ACL received over 700 pages of narrative content in the form of transcripts from the listening sessions and written public comments via email or the on-line comment form. ACL conducted a preliminary review of the comments and identified over 550 comments submitted by 113 discrete commenters. When a comment was identified, it was inserted into a table and tagged by: (1) the date received; (2) stakeholder group represented; (3) section of the Guidelines being addressed by the comment (e.g., 1a, 4b); and (4) state of commenter’s residence. A [table of public comments received](#) is available on-line. More information is available in Appendix 5, Data Analysis Report.

QUALITATIVE DATA ANALYSIS

ACL engaged the Health and Aging Policy Fellows (HAPF) team to perform a qualitative data analysis of all of the public comments received. Because the Guidelines are meant to reflect consensus and feedback from APS and other stakeholders, the HAPF team used the following questions as a foundation for the analysis:

1. What are stakeholder reactions to the released draft guidelines as revealed through the open comment period and listening sessions?
2. What topics and themes arise?
3. How do these topics and themes align with the domains of the draft guidelines?

Data analysis was then conducted using “Atlas.ti” to identify emerging and cross-cutting themes. Factors in considering whether a theme existed included, but were not limited to: quantity of

remarks regarding a specific issue, number of different stakeholder groups commenting on that issue within the code, and the significance of the issue. The themes and trends that emerged from the analysis were designed to inform the second expert working group in its recommendations for changes to the original Guidelines. The analysis highlighted stakeholder concerns and feedback and identified 17 prominent themes found across comments. The overriding principle of the majority of themes is the desire for more specificity and more guidance. The comments also confirm though that the draft guidelines were generally a step in the right direction, and would prove useful to regional and local APS agencies as they move forward.

SECOND EXPERT WORKING GROUP

Upon receipt of the Qualitative Data Report from the Health and Aging Policy Fellows, ACL convened a second expert working group. The second expert working group was comprised of 18 experts in APS systems. The goal of the second expert working group was to review the qualitative data analysis report, to review the public comments received, and to make recommendations to ACL about what changes should be made to the draft guidelines.

The second expert working group was randomly divided into three small working groups, which were each assigned themes from the Qualitative Data Analysis Report. Each small group met five times in July and August of 2016, and made edits and amendments to portions of the original guidelines. At the end of this process, the entire group of 18 members met again twice to review all of the small groups' work and make final edits to the revised guidelines.

The second expert working group also formulated new guidance on topics not covered in the original guidelines. The four new topics covered are: (1) Worker Safety; (2) Responding to Community Emergencies; (3) Community Outreach and Engagement; and (4) Participating in Research. These new items were integrated into Domain 1: Program Administration.

NEXT STEPS

The Guidelines do not constitute a standard nor regulations, do not create any new legal obligations, nor impose any mandates or requirements. They will do create nor confer any rights for, or on, any person.

The guidelines are designed to provide State APS Administrators with recommendations from the field about quality APS practice. There are several ways that states may choose to use the guidelines, such as:

- States may choose to review the guidelines against current policy and practice in the state and identify where current practice is congruent with the national guidelines and where it is different.

- States may choose to use the guidelines to identify areas that could benefit from study and research in their area (e.g., impact of caseload ratios or the efficacy of training). ACL encourages this kind of local research and supports the sharing of information so that other APS programs may benefit.
- States may choose to use the guidelines to identify needed changes in state policies or laws to enhance APS programs (e.g., authorizing APS to participate in multi-disciplinary teams).

ACL plans to perform biennial reviews of these guidelines to incorporate additional knowledge into the guidelines as the APS evidence base grows. ACL continually seeks to gain insights from demonstration projects, practice evaluations, additional research findings, stakeholders, and other sources in order to build the evidence base that will inform future versions of these guidelines. Because the guidelines are fluid and subject to change, states should feel free to suggest needed revisions for future consideration based upon their own related research or experience.

FINAL VOLUNTARY CONSENSUS GUIDELINES FOR STATE ADULT PROTECTIVE SERVICES SYSTEMS

Following is the full set of national consensus guidelines for state APS systems. A background section outlining the information which informed the development of each of the guidelines precedes each element. Here is a full list of the domains and elements:

Table 3 - List of Domains

1. PROGRAM ADMINISTRATION	17
1A. ETHICAL FOUNDATION OF APS PRACTICE.....	17
1B. DEFINITIONS OF MALTREATMENT	18
1C. POPULATION SERVED.....	19
D. MANDATORY REPORTERS	19
1E. COORDINATION WITH OTHER ENTITIES	20
1F. PROGRAM AUTHORITY, COOPERATION, CONFIDENTIALITY AND IMMUNITY	21
1G. PROTECTING PROGRAM INTEGRITY.....	22
1H. STAFFING RESOURCES	23
1I. ACCESS TO EXPERT RESOURCES	24
1J. CASE REVIEW-SUPERVISORY PROCESS	25
1K. WORKER SAFETY AND WELL-BEING.....	26
1L. RESPONDING DURING COMMUNITY EMERGENCIES.....	26
1M. COMMUNITY OUTREACH AND ENGAGEMENT	27
1N. PARTICIPATION IN RESEARCH	28
2. TIME FRAMES.....	28
2A. RESPONDING TO THE REPORT/INITIATING THE INVESTIGATION	28
2B. COMPLETING THE INVESTIGATION	29
2C. CLOSING THE CASE.....	30
3. RECEIVING REPORTS OF MALTREATMENT.....	30
3A. INTAKE.....	30
3B. SCREENING, PRIORITIZING, AND ASSIGNMENT OF SCREENED IN REPORTS.....	31
4. CONDUCTING THE INVESTIGATION.....	32
4A. DETERMINING IF MALTREATMENT HAS OCCURRED.....	32
4B. CONDUCTING AN APS CLIENT ASSESSMENT	34
4C. INVESTIGATIONS IN CONGREGATE CARE SETTINGS	35
4D. COMPLETION OF INVESTIGATION AND SUBSTANTIATION DECISION.....	35
5. SERVICE PLANNING AND INTERVENTION	36
5A. VOLUNTARY INTERVENTION.....	36
5B. INVOLUNTARY INTERVENTION.....	37
5C. CLOSING THE CASE.....	39

6. TRAINING	39
6A. CASE WORKER AND SUPERVISOR MINIMUM EDUCATIONAL REQUIREMENTS	39
6B. CASE WORKER INITIAL AND ONGOING TRAINING.....	40
6C. SUPERVISOR INITIAL AND ONGOING TRAINING.....	43
7. EVALUATION/PROGRAM PERFORMANCE.....	44

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 work⁵³ and Adult Protective Services (APS).⁵⁴ 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.⁵⁵

- *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.⁵⁶

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. 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.⁵⁷

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.⁵⁸ In addition, states are required to identify in a state plan laws identifying categories of mandated reporters.⁵⁹

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.⁶⁰

Formal multidisciplinary teams have been shown to increase effectiveness, satisfaction of workers and rates of prosecution. Navarro⁶¹ studied the involvement of an elder abuse forensic center in financial exploitation cases. The team compared cases that involved the center with those engaged in usual practice. 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. Wiglesworth⁶² studied the impact of an elder abuse forensic center on collaboration of staff from multiple agencies in Orange County, California. Using surveys of agency staff, the team found staff believed they were more efficient and effective when they collaborated with the forensic center.

The APS Survey revealed that most APS systems participate in multidisciplinary teams. 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 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:

- a) County, state and federal law enforcement

- b) Medical, behavioral service and social service providers
- c) Disability organizations
- d) Domestic violence, sexual assault and victim services providers
- e) Financial services providers
- f) Aging services
- g) Animal welfare organizations
- h) 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.”⁶³ 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.⁶⁴ Research in Child Welfare also points to supportive supervision as a critical factor in reducing turnover.⁶⁵

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.⁶⁶

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).

II. 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.

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

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.

GUIDELINE:

It is recommended that APS systems create policies and protocols, and provide adequate resources related to worker safety. These provision 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 is still lacking. APS programs should play a role in educating the public about adult maltreatment and the goals and services of the APS program.

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](#).

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.⁶⁷

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% of 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.⁶⁸

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.

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 2003.⁶⁹

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.⁷⁰

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.⁷¹

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. 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.

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.⁷²

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 to insure that:

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. 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.
3. Other vulnerable adults that are affected by the alleged maltreatment or appear to be victims of possible maltreatment are identified, and reported to APS.
4. While the investigation may continue, the client has the right not to participate in the investigation.
5. 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.
6. Immediate attention has been given to clients in crisis, imminent risk, or in an emergency situation.
7. APS programs are encouraged to utilize standardized and validated screening tools.
8. 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).
9. 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.

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

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:

Some APS systems handle only alleged and confirmed maltreatment cases that occur in community settings while others also handle cases that occur in congregate care settings (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.⁷³

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 and state licensing and regulatory bodies that also play a role in safeguarding the health and welfare of their residents. Memoranda of Understanding and other formal documents can help to facilitate local and state-level coordination.

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 other entities that also play a role in safeguarding the health and welfare of these residents in order to facilitate local and state-level coordination.

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.⁷⁴

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.⁷⁵

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.⁷⁶

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.⁷⁷

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.

GUIDELINE:

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. 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.⁷⁸

The NAPSA 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.”⁷⁹ The NAPSA 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.⁸⁰ 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.⁸¹ 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.⁸²

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.

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.”

The Child Welfare System provides guidelines on the process for closing cases.⁸³

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 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.⁸⁴ 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.⁸⁵

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.⁸⁶ 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.⁸⁷

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. Research 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 and self-perceived skills, as well as increases rates of investigation and substantiation of maltreatment reports.⁸⁸

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.⁸⁹ 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.⁹⁰ In the federal Child Welfare System, states are required to provide certain types of training for CPS workers.⁹¹ Federal Child Welfare guidelines promote ongoing training and certification of caseworkers to maintain competency.⁹²

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, and online courses. 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 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 signs and symptoms;
- e) the case documentation process;

- 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 whether or not maltreatment has occurred;
- h) serving clients with disabilities;
- i) the importance of culturally competent service; and
- j) how to implement person-centered planning into service planning and interventions.

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) Mental Health Issues
- f) Substance Abuse
- g) Dynamics of Abusive Relationships
- h) Professional Communication Skills (Written and Verbal)
- i) Self-Neglect
- j) Caregiver Neglect
- k) Financial Exploitation
- l) Physical Abuse
- m) Sexual Abuse
- n) Emotional/Psychological Abuse
- o) APS Case Documentation/Report Writing
- p) Initial Investigation and Worker Safety
- q) Assessing Decision-making capacity
- r) Supported Decision-making models
- s) Risk Assessment
- t) Public benefits eligibility (e.g., Medicare, Medicaid, Social Security)
- u) Voluntary Case Planning/Intervention Process
- v) Involuntary Case Planning/Intervention Process
- w) Collaboration & Resources (including working in multi-disciplinary teams)
- x) Laws related to APS work (e.g., guardianship/conservatorship, mental health commitments, domestic violence)

- y) Working with the Criminal Justice System
- z) 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.

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) 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 multidisciplinary team.

7. EVALUATION/PROGRAM PERFORMANCE

BACKGROUND:

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.⁹³ In addition, the Child Welfare System requires states to implement Child Welfare Improvement Policies.⁹⁴

GUIDELINE:

It is recommended that APS systems develop performance measures, including client outcomes, and collect and analyze data related to those measures on an annual basis. It is recommended that the data collected 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.

APPENDIX 1: RESEARCH QUESTIONS, SUMMARY OF LITERATURE REVIEW FINDINGS, AND BIBLIOGRAPHY

A. RESEARCH QUESTIONS

1. General program administration
 - a. What impact does oversight have on client outcomes?
 - b. What evaluation measures have been implemented to monitor the performance of programs?
 - c. What impact do sanctions have on compliance with program administration and protocols?
2. Standardized, “minimum” threshold definitions of maltreatment
 - a. Do definitions of abuse, neglect, and financial exploitation affect client outcomes? If so, how?
3. Mandatory Abuse Reporting Requirements
 - a. Do mandatory reporting requirements influence reporting, substantiation, or closure rates?
4. Assessment and intake protocol
 - a. Do standardized assessment and intake tools impact individual’s outcomes?
 - b. Do standardized assessment and intake tools improve staff ability to assist clients more effectively?
5. Investigation and planning response times
 - a. Do contact and investigation response timeframe requirements affect client outcomes? If so, how?
 - b. Does the frequency of contact with a client affect outcomes? If so, how?
 - c. Does cross-jurisdictional coordination affect client outcomes?
 - d. Does the ability to disclose confidential information across providers to secure client services affect client outcomes?
6. Case closure protocol
 - a. Do time limits regarding the length of time a case may remain open affect client outcomes? If so, how?
7. Staffing/caseload ratios
 - a. Do caseload levels have an impact on client outcomes? If so, how?
 - b. Is there evidence of ideal staff ratios? If so, what is the basis for those ratios, i.e., are they based on demographics or functional status?
8. Case worker education levels
 - a. Do minimum case worker education level requirements affect client outcomes? If so, how?

- b. Do different degree/field requirements (i.e. social worker, law enforcement, none) affect client outcomes? If so, how?
9. Case worker training
 - a. Does staff training influence client outcomes? If so, how?

B. LITERATURE REVIEW FINDINGS

B.1. REPORTING REQUIREMENTS

- Jogerst (2005) studied the impact of criminal penalties for elder abuse on the number of reports of abuse, investigations, and substantiations. The team found that states with felony fines had higher rates substantiation of abuse reports. Those with misdemeanor penalties had lower substantiation rates. Those with both felony and misdemeanor penalties had less substantiation.
- Bae (2010) studied the effects of Florida CPS factors on reporting of child abuse. The team found that substantiated reports of child abuse were predominantly from non-mandatory reporters of abuse. Families where there were recurring reports of child abuse received more frequent contact from CPS staff over longer periods of time.

B.2. TEAM STRUCTURE AND PROCESS

- Este (2007) evaluated an overhaul of Texas' APS system in 2004. Through an employee survey the program evaluator found that involving employees in change, hiring a dedicated performance management team, leadership investment in change and additional resources led to an increase in face-to-face meetings with clients within deadline, and no changes in quality of cases staff chose to review.
- Ernst (2012) studied the differences in outcomes between a team of a geriatric nurse and social worker, versus a social worker working alone on APS cases in Maryland. The team found, in this natural quasi-experimental study, that lone social workers were significantly more likely to "confirm" physical abuse, financial exploitation, and neglect. The nurse and social worker teams were significantly more likely to reduce risks for neglect, and risks in social and physical environments.
- Jogerst (2004) studied the impact of various APS system characteristics on reports of abuse, investigations, and substantiated elder abuse. Data came from a survey of states. Investigators who handle reports of abuse of children and adults had lower investigation and substantiation rates than those who handled one or the other type of abuse report.
- Kelly (2007) studied the impact of "360 evaluation" on clinical skill of CPS supervisors. The average scores of these "first-line supervisors" related to communication, leadership, facilitation and professionalism improved during the first year of the new evaluation process where feedback was gathered from the supervisors' colleagues at all levels.

- Hughes (2013) reviewed the literature on the impact of two levels of response to child abuse allegations, where one level is less intense than traditional responses. The team found insufficient data to confirm the safety of children experiencing less intense responses to abuse allegations. The less intense interventions vary and resources become allocated to children undergoing less intense responses.

B.3. POLICE AND FORENSIC INVOLVEMENT

- Navarro (2013) studied the involvement of an elder abuse forensic center in financial exploitation cases. The team compared cases that involved the center with those using usual practice. 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.
- Wiglesworth (2006) studied the impact of an elder abuse forensic center on collaboration of staff from multiple agencies in Orange County, California. Using surveys of agency staff, the team found participants believed they were more efficient and effective when they collaborated with the forensic center.
- Cross (2005) studied the impact of police involvement in CPS and found that their involvement increased findings of credible abuse allegations, provision of service provision or referrals for services.

B.4. TRAINING

- Turcotte (2009) tested staff knowledge before and after a training program related to recognizing and dealing with child abuse in Quebec, Canada. The team found that immediately after the 6 day training program the participants reported increased knowledge, self-confidence, and less stress.
- Connell-Carrick (2008) studied the impact of training on APS workers' perceptions of the training and their own skills shortly after their training finished. The training lasted 3 months and involved class room and field experience. Staff reported positive experiences with training and gains in knowledge and skills. They were most confident in their ability to assess physical abuse and self-neglect, and least confident of assessing sexual abuse and financial exploitation.
- Jogerst (2004) studied the impact of various APS system characteristics on reports of abuse, investigations, and substantiated elder abuse. Data came from a survey of states. Longer training programs for workers led to higher substantiation rates. Higher education requirements for workers led to higher substantiation of allegations. Requiring a social work education background led to higher investigation and substantiation rates.

- Daly (2005) studied state regulatory requirements for elder abuse workers' education to determine the requirements' relationship with rates of reporting, investigating, and substantiating cases. Investigation rates were significantly higher when the state required that staff have a social work degree, but substantiation ratios were significantly lower in these same states.
- Baker (2013) studied the impact of training ombudsmen to use a clinical toolkit about geriatric diagnosis. Seventeen ombudsmen filled out a survey after using the toolkit for one month. The team found that the more experience an ombudsman had the more they found the toolkit to be useful.
- Carter (2006) did a systematic literature review of training and procedural interventions in CPS. The team found that structured forms and checklists are useful in investigations and improved documentation of incidents. After training, clinical staff were more vigilant about possible abuse and neglect. Training increased detection of child abuse, and improved staff rating of their own effectiveness, knowledge, and satisfaction.

B.5. RESOURCES

- Estes (2010) studied the self-reported effectiveness of ombudsmen in California and New York using ombudsman survey data and data from the National Ombudsman reporting system. The team found mixed results. In New York, an increased number of facilities and beds was associated with more community education, monitoring of laws and regulations, and policy advocacy. Increased volunteers, staff and resources were also associated with increases in these activities in New York. Quality training had beneficial impacts on these activities in both states.
- Hollister (2013) studied ombudsman program effectiveness and program resources in California, Georgia, and New York. Data came from a survey of ombudsmen in these states and data from the National Ombudsman reporting system. Ombudsmen in Georgia and New York generally rated their effectiveness in carrying out various ombudsmen duties more highly when they had more volunteers and paid staff. In California, higher staffing generally was associated with lower effectiveness ratings. Results were similar for budgetary resources. In Georgia and New York higher budgets were generally associated with higher program effectiveness. In California, the opposite was generally true.

C. ENVIRONMENTAL SCAN BIBLIOGRAPHY

C.1. ADULT PROTECTIVE SERVICES

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

- 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.
- Ernst, J. S., & Smith, C. A. (2012). Assessment in Adult Protective Services: Do multidisciplinary teams make a difference?. *Journal of Gerontological Social Work*, 55(1), 21-38.
- Este, S. (2007). The challenges of accountability in the human services: Performance management in the adult protective services program of Texas. Retrieved from: <https://digital.library.txstate.edu/bitstream/handle/10877/3527/fulltext.pdf>
- Jogerst, G. J., J. M. Daly, et al. (2004). APS investigative systems associated with county reported domestic elder abuse. *Journal of Elder Abuse & Neglect* 16(3): 1-17.
- Jogerst, G. J., Daly, J. M., Brinig, M. F., & Bibas, S. (2005). The association between statutory penalties and domestic elder abuse investigations. *Journal of Crime and Justice*, 28(2), 51-69.
- 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.
- Wiglesworth, A., Mosqueda, L., Burnight, K., Younglove, T., & Jeske, D. (2006). Findings from an elder abuse forensic center. *The Gerontologist*, 46(2), 277-283.

C.2. LONG-TERM CARE OMBUDSMAN

- Baker, N. R., Jablonski, R. A., & Moss, J. A. (2013). A nurse developed toolkit for long-term care ombudsmen. *Geriatric Nursing*.
- Estes, C. L., Lohrer, S. P., Goldberg, S., Grossman, B. R., Nelson, M., Koren, M. J., & Hollister, B. (2010). Factors associated with perceived effectiveness of local long-term care ombudsman programs in New York and California. *Journal of Aging and Health*, 22(6), 772-803.
- Hollister, B. A., & Estes, C. L. (2013). Local long-term care ombudsman program effectiveness and the measurement of program resources. *Journal of Applied Gerontology*, 32(6), 708-728.

C.3. CHILD PROTECTIVE SERVICES

- Bae, H. O., Solomon, P. L., Gelles, R. J., & White, T. (2010). Effect of Child Protective Services system factors on child maltreatment rereporting. *Child Welfare*, 89(3).
- Carter, Y. H., Bannon, M. J., Limbert, C., Docherty, A., & Barlow, J. (2006). Improving child protection: A systematic review of training and procedural interventions. *Archives of Disease in Childhood*, 91(9), 740-743.
- Cross, T. P., Finkelhor, D., & Ormrod, R. (2005). Police involvement in Child Protective Services investigations: Literature review and secondary data analysis. *Child Maltreatment*, 10(3), 224-244.
- Hughes, R. C., & Rycusa, J. S. (2013). Issues in Differential Response. *Research on Social Work Practice*, accessed online at <http://rsw.sagepub.com/content/23/5/493> .

Kelly, M. J., & Sundet, P. (2007). Using 360 degree evaluation to improve clinical skill development by first line Child Protective Services supervisors. *Journal of Evidence-Based Social Work*, 4(3-4), 145-161.

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.

APPENDIX 2: APS ADMINISTRATIVE SYSTEM PRACTICES COMPARISON

The table below synthesizes information from three sources: the NAPSA Survey of States 2012⁹⁵; the NAPSA Recommended Minimum Practice Standards⁹⁶; and a set of research questions about APS systems formulated by ACL staff⁹⁷. The purpose of this table is to identify and present in an easy-to-read format what information about APS systems is available in the NAPSA Survey of States and the NAPSA Practice Standards.

Description of table:

- Column One identifies several global topics of interest to the Administration for Community Living regarding the organization and administration of state Adult Protective Services programs (e.g., Staff, Training Requirements).
- Column Two lists the research questions that ACL staff formulated for their environmental scan of current APS systems (e.g., Do caseload levels have an impact on client outcomes?).
- Column Three extracts text from the NAPSA Minimum Practices Standards as it relates to the topics in Columns One and Two.
- Column Four describes or includes verbatim, questions from the NAPSA Survey of States that pertain to the topics covered in Columns One and Two.
- Finally, Column Five presents selected findings from the NAPSA Survey of States which amplify the information provided in Column Four (e.g., 18 states provide less than one week of training to new workers).

1. TOPICS	2. Included in Research/Lit Review	3. NAPSA Minimum Practice Standards	4. NAPSA Survey 2012 ⁹⁸	5. Data Points from NAPSA Survey
Mandatory Reporting	Do mandatory reporting requirements influence reporting, substantiation, or closure rates	Not covered	Does your state law mandate reporting of suspected adult abuse to APS? What populations is reporting mandated for (e.g., 18+, 65+, etc.) If yes, in your state, who is a mandated reporter?	Mandatory reporting of suspected elder abuse by some professionals to APS is the law in 49 states.
Assessment	Do standardized assessment tools impact individual’s outcomes? Do standardized assessment tools improve staff ability to	APS programs have in place a systematic screening method, means, and ability to conduct and complete a needs/risk assessment including clients’ strengths and weaknesses...	Please check all assessment tools used: (check all that apply). Examples include MMSE, SLUMS, GDS.	31 states responded that they conduct some type of risk assessment. ⁹⁹

1. TOPICS	2. Included in Research/Lit Review	3. NAPSA Minimum Practice Standards	4. NAPSA Survey 2012 ⁹⁸	5. Data Points from NAPSA Survey
Intake	<p>assist clients more effectively?</p> <p>Do standardized intake tools impact individual's outcomes?</p> <p>Do standardized intake tools improve staff ability to assist clients more effectively?</p>	<p>APS programs have a systematic method, means, and ability to promptly receive and screen reports of abuse, neglect, self-neglect, and/or financial exploitation...</p>	<p>Is your intake centralized?</p> <p>Is the APS intake line combined with another program's intake (such as CBS or aging services)?</p> <p>Do you have a toll free number?</p> <p>Do you accept reports 24 hours a day?</p>	<p>25 states have a centralized intake for APS reports. 22 states report that their intake is combined with another program's intake line. 41 states have a toll free number and 38 accept reports 24 hours a day, though only 26 of those lines are staffed by a live person 24 hours a day.</p>
Definitions of maltreatment	<p>Do uniform, national definitions of abuse, neglect, and exploitation affect client outcomes across states? If so, how?</p>	<p>Not covered</p>	<p>Not covered</p>	<p>State laws define elder abuse differently, including who is an elder, who is eligible for APS services, etc.</p>
Education and Training	<p>Do minimum case worker education level requirements affect client outcomes? If so, how?</p> <p>Do different degree/field requirements (i.e., social worker, law enforcement, none) affect client outcomes? If so, how?</p>	<p>Training: NAPSA has identified a number of Core activities that are critical to the mission of any and all state and local government APS programs. Description of the 23-session core curriculum developed by San Diego State University's School of Social Welfare.</p> <p>Under Staff: The established training curricula minimally include the APS core competencies or equivalencies as identified by NAPSA</p> <p>APS supervisors are qualified by training and experience to provide supervision.</p> <p>The established training curricula for supervisors minimally includes APS supervisor core competencies or</p>	<p>More than 30 questions related to training of staff at all levels, including questions about specific content offered (e.g., legal information, communication skills, disability information)</p> <p>How much pre-service (new worker) APS-specific training is provided for investigators/caseworkers?</p> <p>How much in-service (existing staff) training is provided for investigators/caseworkers per year?</p> <p>Does your program provide training for APS supervisors?</p> <p>How is the majority of your APS training provided? If more than</p>	<p>Only one state indicated that a Master's degree is required for employment as an APS caseworker (specifically an MSW).</p> <p>37 states require caseworkers to have a Bachelor's degree; 5 specify that the degree shall be in social work.</p> <p>The remaining states (12) require either no higher education or did not answer the question.</p> <p>Regarding annual hours of in-service training for casework investigators, programs responded with the following information about training hours provided:</p>

1. TOPICS	2. Included in Research/Lit Review	3. NAPSA Minimum Practice Standards	4. NAPSA Survey 2012 ⁹⁸	5. Data Points from NAPSA Survey
		<p>equivalencies as identified by NAPSA</p>	<p>one method is used to train, please check all the methods that apply (e.g. classroom and online)</p>	<ul style="list-style-type: none"> • Less than one week = 18 • 1 week= 6 • More than one week = 4 • None = 4 • Several programs responded “Other.” <p>Regarding training for APS Supervisors, programs responded with the following information about training hours provided:</p> <ul style="list-style-type: none"> • No training = 9 • Training, but not specific to APS = 20 • Training specific to APS = 23 <p>Training takes place mostly on the job, but some states partner with academic institutions for in-person or on-line classes (34%).</p>
<p>Staffing/caseload ratios</p>	<p>Do caseload levels have an impact on client outcomes? If so, how?</p> <p>Is there evidence of ideal staff ratios? If so, what is the basis for those ratios, i.e., are they based on demographics or functional status?</p>	<p>Staff: The number of staff is sufficient to serve the target population and fulfill state mandates.</p> <p>A recommended ratio of supervisor to direct service personal is established and regulated.</p> <ul style="list-style-type: none"> • APS direct service personnel are qualified by training and experience to deliver adult protective services 	<p>How many full-time state positions are in the APS program as Supervisors?</p> <p>How many full-time state positions are in the APS program as Investigators/Caseworkers?</p> <p>How many full-time state positions are in the APS program: intake positions</p> <p>Additional questions about other kinds of APS staff (e.g., legal, IT)</p>	

1. TOPICS	2. Included in Research/Lit Review	3. NAPSA Minimum Practice Standards	4. NAPSA Survey 2012 ⁹⁸	5. Data Points from NAPSA Survey
			Does your APS program track annual staff turnover rates?	
Investigation	<p>Do mandatory contact and investigation response timeframes affect client outcomes? If so, how?</p> <p>Does the frequency of contact with a client affect client outcomes? If so, how?</p> <p>Does cross-jurisdictional coordination affect client outcomes?</p> <p>Does the ability to disclose confidential information across providers to secure client services affect client outcomes?</p>	<p>Investigation is a systematic, methodical, and detailed inquiry and examination of all components, circumstances, and relationships pertaining to a reported situation. APS programs have a systematic method, means, and ability to conduct and complete an investigation in a timely and efficient manner, to determine if the reported abuse has occurred, and to determine if services are needed to reduce or eliminate the risk of abuse, neglect, self-neglect or exploitation of a vulnerable adult.</p> <p>The APS Investigation Protocols include:</p> <ul style="list-style-type: none"> • An assessment of information received... • An assessment of danger to the worker... • Preparation for a home visit... • Interviews with the parties • Review of relevant documents... • Coordination: APS programs work with other agencies and community partners, including, but not limited to, courts and law enforcement agencies, mental and physical health providers, domestic violence... <p>The goal of these intentional and specific collaborations is to provide comprehensive services to vulnerable adults in need of</p>	<p>Do you respond (go out on) cases 24 hours a day?</p> <p>Are investigation time frames triaged depending on allegations?</p> <p>Must APS complete investigations within a certain timeframe? What about closing cases?</p> <p>Is there required regular contact with the victim of an open case?</p> <p>Developing a case plan: What services does APS provide to victims (e.g., money management, counseling)?</p> <p>Are cases, upon being reported to APS, cross-reported to law enforcement? Under what conditions? (e.g., if crime is suspected, all substantiated cases, etc.)</p>	<p>21 states indicated that they respond to cases 24 hours a day.</p> <p>Six states responded that they do not tie investigation time frames to allegations.</p> <p>Only 8 states responded that they do not have timeframes for closure of <i>investigations</i>. Of those that do, the range was from 30 to 90 days.</p> <p>18 states responded that they are not required to have regular contact with the client. Of those that are required to have contact, the most frequent interval reported was monthly either in person or by telephone.</p> <p>Services provided to the client vary greatly based on their needs. The most commonly provided services are 1) advocacy with other systems, 2) in-home services, and 3) developing a case plan.</p>

1. TOPICS	2. Included in Research/Lit Review	3. NAPSA Minimum Practice Standards	4. NAPSA Survey 2012 ⁹⁸	5. Data Points from NAPSA Survey
<p>Case Closure</p>	<p>Do time limits regarding the length of time a case may remain open affect client outcomes? If so, how?</p>	<p>protection...</p> <p>APS programs have in place a systematic method to complete a Case Closure.</p> <p>The goals of intervention of APS is to reduce or eliminate risk of abuse, neglect, or exploitation of a vulnerable adult. Once that goal is met, the case is closed.</p> <p>Case Closure follows the law and policy of each jurisdiction.</p> <p>Goes on to list commonly accepted reasons for case closure (e.g., unable to locate, client refused services, risk ameliorated)</p>	<p>Must APS complete investigations within a certain timeframe?</p> <p>Must APS close cases within a specific time frame?</p>	<p>20 states responded that they do not have timeframes for closing <i>cases</i>.</p>

APPENDIX 3: FEDERAL INVOLVEMENT IN CHILD WELFARE

CATEGORY	PROVISION
I. Federal Leadership	<p>Child Abuse Protection Act of 1974 designed to provide <i>Federal Leadership</i> in child welfare services, in response to congressional hearings in 1973 highlighting following problems:</p> <ul style="list-style-type: none"> • differences in the definitions of child abuse and neglect among States, which made collecting information difficult; • incomplete identification and reporting; • inadequate resources for conducting investigations and providing treatment services; • understaffed child protective services units and undertrained workers; • limited prevention efforts; and • a lack of coordination of child protective agencies.¹⁰⁰
A. Data Collection System	<p><i>Federal Requirement:</i></p> <ul style="list-style-type: none"> • Requires a national data collection system on services, individuals served, and outcomes¹⁰¹ • Requires State data reports to include <u>specific data elements</u>¹⁰² • HHS to designate <u>standard data elements</u> for any category of information required to be reported¹⁰³ • States required to have a programs for <u>technology to track CPS reports</u> from intake through final disposition¹⁰⁴ • Authorized the Secretary to impose specified <u>penalties</u> against a State for failure to provide necessary data¹⁰⁵ <p><i>Federal Guidelines:</i></p> <ul style="list-style-type: none"> • Provides guidance on best practices for case documentation¹⁰⁶
B. Public Awareness	<p><i>Federal Requirement:</i></p> <ul style="list-style-type: none"> • Requires national public awareness campaign¹⁰⁷
II. Core Program Components	
A. Definitions	<p><i>Federal Requirement:</i></p> <ul style="list-style-type: none"> • Minimum Federal definition of what constitutes abuse and who is eligible for services under various child welfare provisions¹⁰⁸
B. Case Worker Education Levels	<p><i>Federal Requirement:</i></p> <ul style="list-style-type: none"> • Requires states to establish a minimum education and qualifications of CPS workers¹⁰⁹ <p><i>Federal Guidelines:</i></p> <ul style="list-style-type: none"> • Promotes the recruitment of, including the direction of federal funds towards, individuals with higher educational attainment and backgrounds in social work education¹¹⁰

CATEGORY	PROVISION
<p>C. Case Worker Training</p>	<p><i>Federal Requirement:</i></p> <ul style="list-style-type: none"> • Requires reservation of proportion of funds to be used for <u>improving performance and quality of services</u>.¹¹¹ • States required to provide certain types of <u>training</u> for CPS workers and other service providers¹¹² • Requires HHS to develop regulations for the <u>provision of training and technical assistance</u> for carrying out CW programs¹¹³ <p><i>Federal Guidelines:</i></p> <ul style="list-style-type: none"> • Promotes ongoing training and certification of caseworkers to maintain competency¹¹⁴
<p>D. Staffing/Caseload Ratios</p>	<p><i>Federal Requirement:</i></p> <ul style="list-style-type: none"> • Requires states to establish caseload requirements¹¹⁵ <p><i>Federal Guidelines:</i></p> <ul style="list-style-type: none"> • Provides guidance on developing ratios¹¹⁶
<p>E. Investigation and Case Planning Response Times</p>	<p><i>Federal Requirement:</i></p> <ul style="list-style-type: none"> • Establishes federal <u>minimum frequencies for visits</u>¹¹⁷; • Requires states to make a certain <u>number of visits</u> to children in a caseload based on a federal established formula¹¹⁸; • Establishes <u>maximum time limits</u> on interstate home visit reports¹¹⁹ • States required to identify in a state plan laws, policies, or programs for <u>differential response</u> in screening and assessment procedures¹²⁰ <p><i>Federal Guidelines:</i></p> <ul style="list-style-type: none"> • Provides guidelines for determining the needed response time.¹²¹
<p>F. Case Closure</p>	<p><i>Federal Requirement:</i></p> <ul style="list-style-type: none"> • Requires a minimum timeframe for ongoing case review, as well as maximum time limit for determinations of case status.¹²² <p><i>Federal Guidelines:</i></p> <ul style="list-style-type: none"> • Provides guidelines for process of closing cases¹²³
<p>G. Mandated Reporting Requirements</p>	<p><i>Federal Requirement:</i></p> <ul style="list-style-type: none"> • States required to identify in a state plan laws identifying categories of <u>mandated reporters</u>¹²⁴ • Requires states to create provisions for <u>disclosing confidential information</u> to Federal, State, or local governments with a need for such information¹²⁵ <p><i>Federal Guidelines:</i></p> <ul style="list-style-type: none"> • Provides guidance and examples on establishing mandated reporting, as well as the role of various professions as mandated reporters¹²⁶

CATEGORY	PROVISION
<p>H. Assessment and Intake</p>	<p><i>Federal Requirement:</i></p> <ul style="list-style-type: none"> • States required to identify in a state plan laws, policies, or programs for differential response in screening and assessment procedures¹²⁷ <p><i>Federal Guidelines:</i></p> <ul style="list-style-type: none"> • Provides guidance and examples on assessment and screening tools and protocols¹²⁸
<p>I. Program Administration</p>	<p><i>Federal Requirement:</i></p> <ul style="list-style-type: none"> • Defines <u>services to be provided</u> by the States, including supportive services and prevention¹²⁹ • Requires States to engage in a <u>comprehensive planning process</u> and collaboration across multiple agencies and sectors¹³⁰ • Graduated <u>financial penalties</u> for States that do not comply with the State Plan requirements¹³¹ • Sets forth <u>child welfare improvement policies</u> that states must implement¹³² • Requires HHS to establish <u>outcome measures to monitor and improve</u> State performance¹³³ <p><i>Federal Guidelines:</i></p> <ul style="list-style-type: none"> • Provides multiple user manuals and guidance for case handling, supervision of case workers, and program/system structure and development¹³⁴
<p>III. Criminal Justice System</p>	<p><i>Federal Requirement:</i></p> <ul style="list-style-type: none"> • Establishes within the criminal justice system a court program for child welfare cases¹³⁵ <p><i>Federal Guidelines:</i></p> <ul style="list-style-type: none"> • Provides multiple resources and best practices on enhancing the role of the court system in child welfare cases¹³⁶

APPENDIX 4: STAKEHOLDER ENGAGEMENT PROCESS

To refine the guidelines developed by the first expert working group, ACL launched a stakeholder engagement and outreach strategy. The goal of the outreach was to hear from all stakeholders about their experiences with APS, ensure all stakeholders understood why and how ACL was leading the development of guidelines for APS, and provide interested parties an opportunity to give input into the process and content of the guidelines. Throughout the process, ACL's stakeholder engagement and outreach endeavored to:

- respect people's history and experience with APS, and their other life experiences;
- empower the public and stakeholders to contribute to the development of national APS guidelines in a meaningful way;
- understand the public's vision for APS and for ACL's role in APS;
- build consensus on proposed guidelines by including representatives from materially affected and interested parties, to the extent possible; and
- incorporate a civil rights/personal rights perspective in developing the system guidelines.

ACL conducted the stakeholder engagement and outreach strategy from July 2015–February 2016. During this period, ACL utilized several means to actively solicit, receive, and record input from stakeholders. This Appendix provides a detailed discussion of the phases of the engagement and outreach strategy, and the methods ACL employed for soliciting public comments.

PRESENTATION PHASE

The Presentation Phase occurred during August 2015. During that period, ACL Administrator and Assistant Secretary for Aging, Kathy Greenlee, held six meetings with small groups of stakeholders. The goal of these meetings was to present information about ACL's current and proposed work related to strengthening the APS system and to solicit feedback on that work, including the creation of the Guidelines. The small groups included representatives from disability rights advocates, mental health advocates, long-term care advocates, aging advocates, APS, and representatives of other federal offices that conduct elder justice work. Additionally, these meetings provided an opportunity for ACL and the various stakeholder groups to discuss ways to encourage and increase involvement of their members in the APS Guidelines Project public comment period.

FEEDBACK PHASE

The Feedback Phase took place between August–November 13, 2015, and again from January 25, 2016–February 8, 2016. During that period, ACL utilized four (4) strategies to actively solicit, receive, and record input from stakeholders (described in more detail below): listening sessions held via teleconference calls, teleconference calls with each of ACL’s Regional Offices, participation in professional conferences, and the collection of written comments.

CONFERENCE CALL LISTENING SESSIONS

From August–November 2015, ACL hosted 15 one-hour listening sessions via conference calls with stakeholders from both targeted professional groups and the general public. Though some listening sessions targeted certain professional groups, ACL advertised that every call was open to anyone who wanted to participate. Listening sessions were publicized via several means, including emails from ACL to its listserv, postings to the National Center on Elder Abuse listserv, and postings to ACL’s Twitter and Facebook accounts. In addition, ACL added several pages on the Guidelines project to its website, including a page showing the calendar of all of the public listening sessions. In some instances, ACL staff reached out to colleagues in other agencies or operating divisions within the Department of Health and Human Services (HHS) (e.g., Minority Health), and to other federal government Departments (e.g., Department of Justice), to assist with outreach to their constituencies and encourage attendance. Registration was handled via the [EventBrite platform](#) (maximum of 150 participants per call).

ACL received a total of 1,201 registrations to participate in one of the public listening sessions. Due to technology limitations, ACL was not able to determine if people participated in multiple listening sessions, nor the final count of participants for each listening session. Below in Table 2 is the schedule of public listening sessions:

Table 2. Schedule of Public Comment Listening Sessions

Target Audience	Date	Number Registered
1. General Public	Aug 26, 2015	75
2. Aging Network	September 9, 2015	74
3. APS Network	September 14, 2015	79
4. APS Network	September 16, 2015	120
5. Tribal	September 17, 2015	83
6. Disability Rights Network	September 29, 2015	115
7. Long-term Care Network	October 7, 2015	150
8. General Public	October 13, 2015	85
9. General Public	October 21, 2015	115
10. Minority Aging Network	October 22, 2015	54
11. Disability Rights Network	October 26, 2015	85
12. Law Enforcement	November 2, 2015	19
13. Legal Services Network	November 10, 2015	34
14. Domestic Violence, Sexual Assault, and Victim	November 12, 2015	70

Target Audience	Date	Number Registered
Services Network		
15. APS Network	November 13, 2015	43

ACL also facilitated two additional conference call listening sessions. First, ACL facilitated a listening session and discussion with APS State Administrators via teleconference, convened by NAPSA (August 27, 2015). On September 17, 2015, project staff facilitated a listening session with representatives of Native American Tribes who were attending an annual meeting at ACL headquarters in Washington, D.C.

ACL REGIONAL CALLS

In addition to the public listening sessions, ACL convened listening sessions with its Regional Administrators and the State Unit on Aging Directors in ACL’s Regional Support Centers. Regional Support Centers serve as the focal point for the development, coordination, and administration of ACL’s programs and activities within designated HHS regions. To see a complete list of the states within each region, please visit the [Regional Support Center page](#) on the ACL website.

- HHS Regions I and II, September 15, 2015
- HHS Regions VI and VIII, September 19, 2015
- HHS Regions IX and X, September 24, 2015
- HHS Regions V and VII, October 20, 2015

PRESENTATIONS AT PROFESSIONAL CONFERENCES

Between July 1, 2015–September 30, 2015, ACL staff made presentations at three (3) national conferences on the APS Guidelines project. ACL staff took notes during these sessions in order to capture comments and questions from attendees:

- National Area Agency on Aging conference, Philadelphia
- Home and Community-based Services conference, Washington, DC;
- NAPSA conference, Orlando, FL.

COLLECTION OF WRITTEN COMMENTS

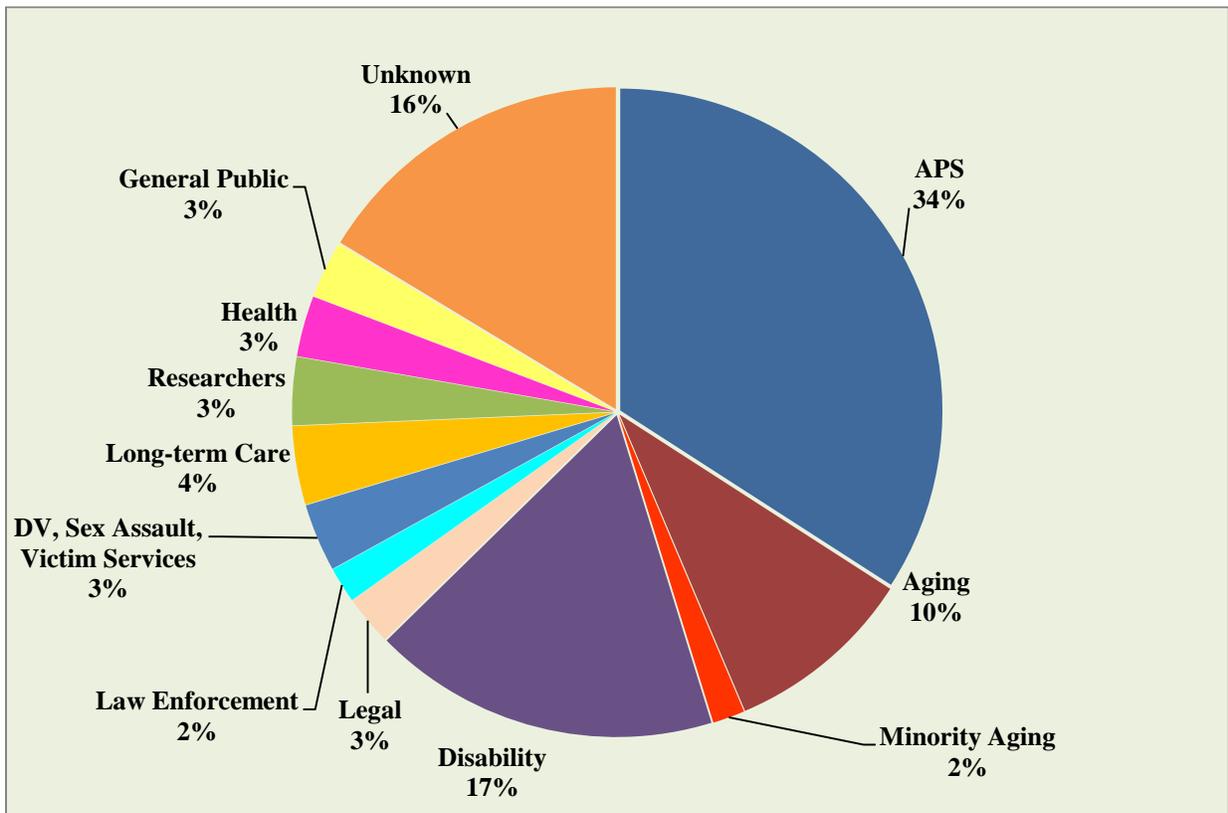
Starting in July–November 13, 2015, and again from January 25, 2016–February 8, 2016, ACL provided a mechanism for the public to submit written comments to ACL about the draft guidelines. In July 2015, ACL added to its website an on-line comment form to collect written input from stakeholders and the public. Comments that exceeded the web platform’s 5,000 character limit could also be submitted via email to ACL staff.

APPENDIX 5. APS GUIDELINES PUBLIC COMMENTS DATA ANALYSIS

QUANTITATIVE DATA ANALYSIS

The professional categories of the commenters include those shown in Figure 1, below. APS professionals submitted the largest number of comments, followed by Disability advocates, and then persons who did not identify from which sector they were commenting. Commenters on both the web-based platform and on the listening session conference calls were encouraged to identify themselves, but were permitted to provide comments anonymously.

Figure 1. Percentages of Stakeholder Groups Providing Comments



ACL was able to identify that comments came from individuals or organizations within at least 36 states and two U.S. territories. In addition, at least 15 national groups provided comment, including the Alzheimer's Association, AARP, the Consumer Voice for Quality Long-term Care, the National Council on Independent Living, the National Disability Rights Network, and the Geriatric Society of America. The largest number of comments came from national groups, followed by commenters from the states of California and New York.

Almost half of all comments collected related to the Guidelines' first domain, Administration of APS Programs, which, with 10 sub-sections, covers the largest number of topics. Issues related to Domain Four, Conducting the Investigation, and Domain Six, Training, also garnered a high number of comments. In addition, dozens of comments were received that suggested amendments to the Background section of the document. Finally, many additional comments offered new items for integration into the Guidelines.

Figure 2. . Percentages of Domains Receiving Comments

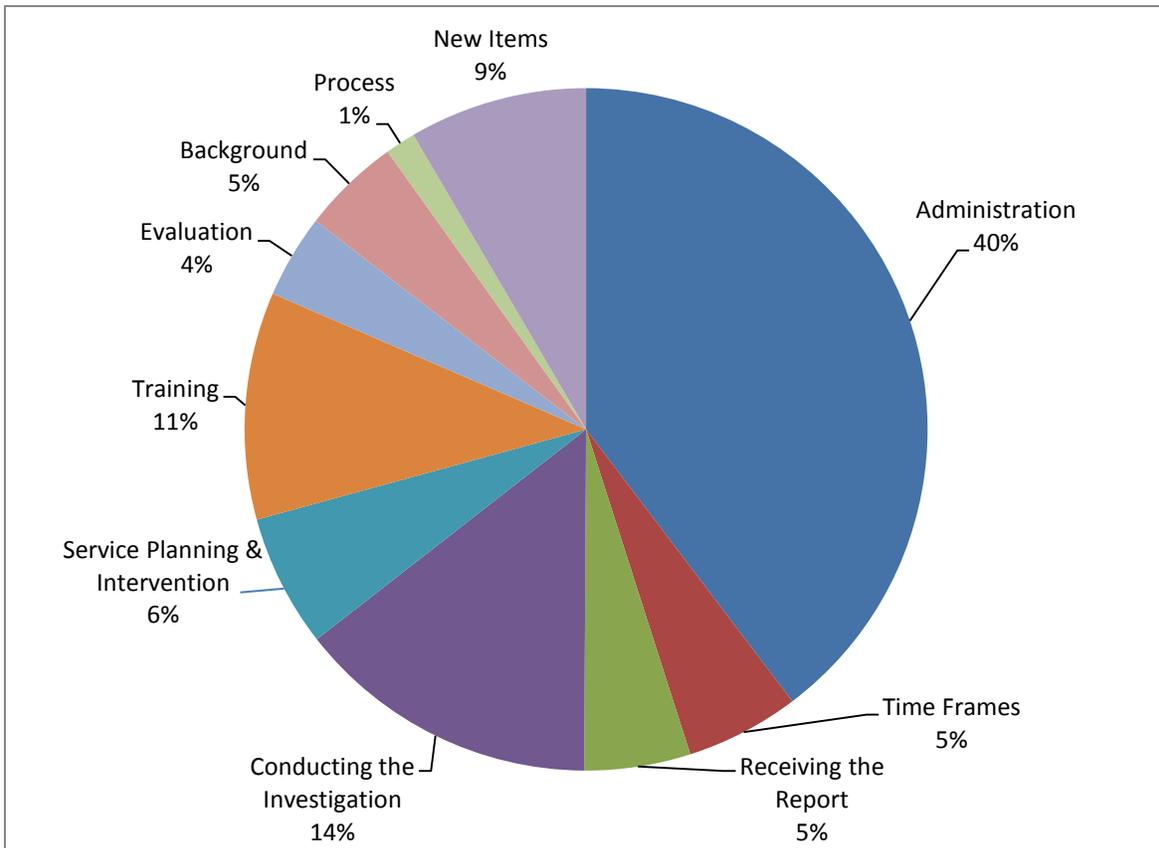


Table 1 below displays the number of comments received for all sections of the draft guidelines. These areas with the highest number of comments informed the next step of the process, the qualitative data analysis.

Table 1. Number of Comments Received by Sub-Section

Domain	Number of Comments Received
1e Coordination with other entities	47
6b Caseworker initial and ongoing training	41
4a Determining if maltreatment has occurred	39
1c Population served	28
1f Program authority, cooperation, confidentiality and immunity	25

Domain	Number of Comments Received
1h Staffing resources	25
4b Conducting a psycho-social assessment	23
1b Definitions of maltreatment	22
7 Evaluation/program performance	22
1a Ethical Foundation of APS Practice	21
3a Intake	19
1d Mandatory reporters	18
1g Protecting program integrity	15
6a Caseworker and supervisor minimum educational requirements	15
5a Voluntary interventions	14
1i Access to expert resources	12
2c Closing the case	12
4c Investigations in congregate care settings	12
5b Involuntary interventions	11
2a Responding to the report	10
3b Screening, triaging, and assignment of screened in reports	9
5c Closing the case	9
1j Case review-supervisory process	8
2b Completing the investigation	8
Comments related to the process ACL used or should use to create the Guidelines	8
4d Completion of investigation and substantiation decision	6
6c Supervisor initial and ongoing training	4
5 Service planning and intervention	1

QUALITATIVE DATA ANALYSIS

Qualitative data analysis was conducted using *Atlas.ti* to identify emerging and cross-cutting themes from the various codes. Queries to analyze the codes were run using the *Atlas.ti* Query tool and the Co-occurrence Table. These tools allowed the researchers to look at all the comments made using a specific code, as well as to look at codes by specific stakeholder groups. Object Crawler was also used to look for common words and/or themes that emerged from the data across codes and stakeholder groups. After reviewing all the comments within a specific code, the researchers then individually noted any theme or themes emerging from that code. Factors in considering whether a theme existed included, but are not limited to: quantity of remarks regarding a specific issue, number of different stakeholder groups commenting on that issue within the code, and the significance of the issue. After each individual researcher had listed themes by code, the researchers discussed the themes that had emerged. In some instances, more than one theme emerged from a code, or conversely, several codes collapsed into one crosscutting theme. Triangulation was used to establish agreement between the researchers in

order to confirm the credibility of the emerging themes. As with codes, themes were only considered if an agreement was reached among all of the researchers that the theme was present and significant.

RESULTS

The following themes are arranged according to their corresponding domains within the Guidelines document: Program Administration, Timeframes, Receiving Reports of Maltreatment, Conducting the Investigation, Service Planning and Intervention, Training, and Evaluation/Program Performance. Additionally, any crosscutting themes that arose from the data will be presented and discussed at the end.

DOMAIN 1: PROGRAM ADMINISTRATION

Stakeholders made more comments regarding domain one than any other domain; more than one-third of the comments were regarding the subjects within this domain.

1B. DEFINITIONS OF MALTREATMENT

Comments regarding this section of domain 1 showed diversity with how stakeholders felt regarding the definition of maltreatment, particularly self-neglect.

Stakeholders had differing opinions about how to address self-neglect.

Some stakeholders felt that self-neglect should be discussed separately from abuse and discussed how differently those cases are handled from abuse cases, including a domestic violence stakeholder who noted that the both the terms “maltreatment” and “abuse” imply an offender is involved. Other stakeholders applauded the inclusion of self-neglect within the definition of maltreatment. Additionally, some stakeholders noted complicating factors such as self-neglect when the person has decision-making capacity or assessing whether a person may not be able to perform self-care but can still direct that care. In general, commenters acknowledged the complexity of self-neglect and requested it be addressed more substantially.

—

“Definition of Maltreatment: include self-neglect; include incidents of competent individuals who choose to neglect self (reference Person Centered Planning).”

—

“We agree with a number of comments that self-neglect should not be treated/defined as abuse or maltreatment and needs special consideration. Data appears to indicate that over half of the reports to APS are for self-neglect, and these cases consume a tremendous amount of time and resources. Also, because there is no real perpetrator in these cases, and many such cases call for long-term casework rather than crisis intervention, we suggest that the role of APS be addressed separately.”

—

“Why [is] self-neglect almost invisible in this document?”

—

“We commend ACL for including self-neglect as a type of adult maltreatment, especially since self-neglect comprises much of APS workers’ caseloads.”

—

“Addressing the definition of Self-neglect): ‘...to perform essential self-care tasks.’ For many people with disabilities, they have lived their lives directing their services through personal care attendants. The question then becomes not whether the person can perform their self-care tasks independently, but whether they can successfully direct the services for their care. In the case of people with some types of disabilities, not being able to perform the tasks should not be the measure of self - neglect or be used to categorize that person as a vulnerable adult if they have the capacity to direct their own care.”

1C. POPULATION SERVED

The issue of age and vulnerability defining eligibility was an overarching theme across all stakeholder groups. In particular, disability and long-term care advocates voiced the most comments.

Stakeholders requested further guidance on what should make an individual eligible for APS services.

Generally, comments focused on requesting more clarity in defining the population served by APS. While most commenters voiced support for including all adults age 18 and over, one stakeholder expressed concern with the feasibility of APS serving such a broad population well, and whether the focus on older adults would be diluted. Further, there were some comments related to whether or not all older adults or individuals with disabilities should be served by APS, or only those categorized as vulnerable, and then exactly how vulnerability should be defined.

“I strongly support the recommendation to have APS serve clients age 18+ and determine vulnerability/risk criteria that would make someone eligible for APS services. I also think that a vulnerability/risk based eligibility criteria rather than an age criteria takes away some of the ethical quandary for healthcare providers in having to be mandated reporters.”

—

“Recommended that states use age plus some level of vulnerability as an eligibility factor since age as a proxy for vulnerability is ageist.”

—

“Many states also serve the older adult population (either 60 or 65) without requiring and [sic] additional finding of vulnerability’- This can be very

problematic. There is no way that some states could accommodate such policy due to the numbers. Maybe the states that have this, (what many believe is an outdated law), are experiencing very high caseloads. The truly vulnerable may be placed at higher risk if we are covering this non vulnerable population. ACL should strongly look at this issue. Many consider it an insult if you are 60 years old and considered an APS client. By the way - many of our senior staff are over 60 and they are, by far, not vulnerable and should not fall under APS purview. Given the improved technology for adults with disabilities, and improving health care practices for older adults who are living longer and healthier, ACL should update and revise the definition of elders and adults with disabilities, by pointing out older adults are not at risk simply due to age.”

In addition to concerns regarding eligibility by age and vulnerability, many stakeholders recommend that care settings, and in particular residence in a nursing facility, should not exclude someone from APS jurisdiction. Currently as written, the guidelines note that states vary in whether adults in institutional care settings are eligible for APS services and section 4c of the Guidelines gives some guidance for states where APS does currently have jurisdiction in institutional settings; however, the Guidelines do not explicitly state whether adults in institutional settings should be included.

Stakeholders believe there should be more of an emphasis on including individuals in various institutional settings as a population served.

“Consumer Voice recommends that the Guidelines clarify that all vulnerable adults be eligible recipients of services from APS, regardless of whether they live in an institutional setting or in a community based setting. There currently is lack of clarity, as well as wide inconsistency, within and among states, as to the population to be served by APS.”

—

“...Investigate no matter where the mistreatment occurs. No setting should be exempt from APS investigation.”

—

“Population Served by APS. NASOP recommends that any vulnerable adult, not just those who live in the community, should be eligible recipients of services from APS.”

—

“Although we understand that ‘[l]egal definitions of adult maltreatment vary from state to state,’ this definition must include institutional abuse.”

ID. MANDATORY REPORTERS

Mandatory Reporting was one of the few sections that garnered comments from every stakeholder group, although more comments came from the aging network, domestic violence advocates, and uncategorized commenters than other stakeholders. Many of the comments received indicated a concern with various aspects of the Guidelines' recommendation regarding mandatory reporting. The Guidelines note that 49 states require some type of mandatory reporting currently, and some stakeholders questioned the underlying assumption in the Guidelines that mandatory reporting is the best practice. While some expressed strong concerns with the evidence for mandatory reporting, other stakeholders accepted this assumption regarding this long standing, widespread APS practice without question and instead focused on who should be mandatory reporters. Domestic violence advocates in particular expressed concerns about specifically which professionals are to be mandatory reporters. Still other stakeholders voiced strong support for mandatory reporting.

Some stakeholders questioned the value of and evidence for mandatory reporting.

There was nearly an even split in comments in support of and opposed to mandatory reporting, and multiple comments noting the need for more research in this area.

“Mandatory Reporting: As many have noted, there are concerns about the recommendation for mandatory reporting in all states. As they note, there is not sufficient data to support whether or not it is effective in identifying and supporting the individuals it is intended to serve. It may have significant unintended consequences including it may deter people from seeking help and services they need if they think the professional whose help they seek may be required to violate confidentiality and file a report with APS. We strongly agree with ACL in focusing on the overriding principles of person-centered-planning and supported-decision making throughout most of the Guidelines, however we would go further and suggest that those principles should be applied in considering the pros and cons of mandatory reporting. Historically, when states started adopting Elder Abuse/APS laws in the early 1980s, nearly all patterned their laws on the child abuse model without sufficient consideration of the differences between the decision-making rights of children vs. those of adults. Unlike children, unless a court has determined otherwise, adults are presumed to have capacity to make their own decisions; we believe that mandatory reporting is not consistent with that right. Further, we suggest that mandatory reporting be considered within the context of the intervention it triggers.”

—

“Mandatory Reporters – Our team felt that the document requires greater research and clarification regarding the success, or lack of success, in mandated reporting states. As New York State is currently considered the only state in the United States that does not have mandated reporting our Elder Justice Committee has

attempted to do research on the various formats of mandated reporting with little or no success in determining what types have worked and what have not. Are those states that make everyone a mandated reporter more successful in dealing with the issue than those states that have no mandated reports or only a few designated reporters? What is the most successful method and how do we know this?”

—

“However, we have some key concerns related to the recommendation for mandatory reporting in all states. There is insufficient data to support whether or not mandatory reporting is effective in identifying and supporting victims. In fact, there may be significant unintended consequences in requiring mandatory reporting including deterring help-seeking and violations of confidentiality and privacy. For victims of domestic violence, including elder abuse, confidentiality is often essential in helping to protect against further harm by an abuser. Federal laws governing domestic violence and sexual assault service providers, such as the Violence Against Women Act and the Family Violence Prevention and Services Act, explicitly include requirements that personally identifying information about adult victims not be disclosed without informed, time-limited consent. We are concerned that requiring mandatory reporting of elder abuse is in conflict both with these legal mandates around confidentiality and with the broader purpose and intent behind safeguarding victims’ privacy. Furthermore, we know that for many victims, the possibility of mandatory reporting often dissuades them from accessing the help and services that are critical to their safety and physical and emotional well-being. Many victims do not wish to engage with systems like Adult Protective Services and perceive, often correctly, that APS may cause more harm and disruption in their lives. We also know that particularly for victims from marginalized communities, such as communities of color and LGBTQ communities, there is frequently even greater reluctance to engage with systems like APS and the criminal legal system. If mandatory reporting were required in all states, ACL risks deterring and preventing many victims from accessing needed services. At a minimum, we recommend that domestic violence and sexual assault service providers be exempt from any mandatory reporting requirements, in order to ensure that elder abuse victims have a safe and confidential place to seek help.”

—

“I believe that we lack any data to support Item 1d. Despite the proliferation of state reporting laws, we haven’t the slightest clue whether they redound to the benefit of the people they’re intended to help. This issue has been the subject of review by the NCEA policy committee; the GAO; NCALL; elder abuse experts in NYC; and legal scholar Nina Kohn. There are important arguments going both ways, and many anecdotal examples of both the benefits and perils of mandatory

reporting. We simply don't know; thus it's premature to endorse mandatory reporting in this document."

—

"Mandatory reporting should be required by all with the exception of those that may have a professional privileged [sic]. Reporters should be encouraged to identify but in cases in which a reporter is unwilling, states should allow for the report to be made anonymously."

—

"We strongly agree with the recommendation that 'states require mandatory reporting of known and suspected vulnerable adult maltreatment by certain professionals.'"

While some stakeholders had concerns about the value of mandatory reporters in general, others focused on the need for more explicit guidance in this section of the Guidelines.

Stakeholders requested more specificity or examples of which professionals should be mandatory reporters, and which ones should be exempt.

The Guidelines currently recommend that states require "certain professionals" to be mandatory reporters.

"Provide a specific list of professionals who, at a minimum, should be mandatory reporters. Provide guidelines to recommend mandatory reporting of all APS populations served and that reporting be made to either APS or law enforcement."

—

"Why not have a guideline that suggests specifically which 'certain professionals' at a minimum should be mandated reporters? This particular guideline gives no guidance. I understand that it varies from state to state which professionals by law are mandated reporters, but it wouldn't hurt to give a list of suggested professionals, to give APS an idea what they should be advocating for."

—

"Though states determine which professionals are mandatory reporters, ACL's guideline as written is vague. ACL should offer examples of 'certain professionals' (e.g., health care providers), as well as additional explanation of 'mandatory' and 'non-mandatory' reporters. ACL should also provide examples of exemptions."

“Mandatory Reporters: The guideline should include an exception for attorneys and advocates working for attorneys when a mandatory reporting requirement would violate the attorney-client relationship or otherwise conflict with the ethical and confidentiality requirements of an attorney or anyone employed by a law firm, whether public or privately funded.”

1E. COORDINATION WITH OTHER ENTITIES

Several different but related themes emerged from the comments on this section, with the overarching theme being that stakeholders desire to see more written in the Guidelines about forming formalized partnerships between APS agencies and various entities. This broad theme of the need for collaboration was crosscutting through all stakeholders with close to seventy comments. The disability and APS stakeholder groups had the highest frequency of comments endorsing collaboration.

Stakeholders requested explicit direction regarding entities with whom APS should formally collaborate.

Stakeholders requested more specificity than the initial Guidelines provided, and often suggested particular entities that should be included. Minority aging groups in particular requested more emphasis on formalized partnerships, especially between tribal groups and APS.

“Pursuant to the recommendation in section one of the guidelines to collaborate with other organizations, we urge that the guidelines require coordination between the APS program and the state P&A and DD council.”

“Include language that speaks to relationships that states form with APS and law enforcement as well as Regulatory and Enforcement Agencies as well as the Bureau of Medi-Cal Fraud.”

“APS programs should develop partnerships with local research institutions to assist them to refine and develop performance and evidence based outcome measures.”

“Recommends development of policies/procedures that include the ombudsman program when appropriate.”

“Tribal Aging Departments, Tribal Social Services, and relevant tribal departments or agencies need a formal agreement with County APS, a formal relationship that allows for the sharing of information to better serve abuse

victims, increase prosecution, etc. - Develop or include in these standards (from the point of intake to the point of case closure) a way for County APS workers to include Tribes, Tribal Aging Units, and other relevant tribal departments or agencies in the process when handling cases involving Tribal Members.”

—

“Add “Tribes” specifically, to the list of cross-Jurisdictional and inter-disciplinary cooperation.”

Within this theme, disability advocates and APS staff were the most frequent commenters noting a need for cross-jurisdictional agreements.

Stakeholders requested that the Guidelines explicitly suggest policies for coordination across states, jurisdictions, and agencies.

While the Guidelines already encourage collaboration in general, the topic of interstate coordination in particular is currently unaddressed in the Guidelines.

“Policies and protocols should accommodate coordination with out-of-state entities, as many means of exploitation occur across state lines.”

—

“The delineation of the APS system’s authority to work with other jurisdictions to investigate alleged maltreatment or to serve victims of maltreatment should include Protection and Advocacy (P&A) agencies within each state. P&A agencies frequently conduct their own investigations and coordination with APS systems can be a crucial part of the fact finding process.”

—

“We would like to see an interstate MOU that affords the ability to communicate with and help other states. Information on other jurisdictions should be easily accessible.”

The final theme related to collaboration was stakeholders requesting some practical assistance from ACL for APS agencies, to make their formal relationships more effective.

Stakeholders requested more guidance on effective agreements and sample MOUs.

“One of the issues that we have is that they can guide us through something, give advice but since there’s no agreement on the reservation they can’t like come to court or, you know, kind of support that way. So I’m kind of thinking that is there something that you’re going to put together like a sample resolution or MOUs that we can present to our Tribal Council and get this so it will be okay?”

“Just in my little section that I manage ... I need a higher level of somebody coming in to say, you know, this is how you work with the Department of Mental Health, or with the Department of Developmental Services or whoever it may be that bigger... I can't do it all at the grassroots level. So I want to do more of that but the way needs to be paved with MOUs or whatever it may be.”

“Just to go back to - those MOUs are so incredibly important and we've - we have found issues too where someone is being served by the DD system, there's a crisis situation and then the DD system is saying well no APS should handle this and APS is saying no the DD system should handle it. And the MOUs are silent to it. So, you know, they spend a lot of time creating an MOU that doesn't actually address the situation.”

IF. PROGRAM AUTHORITY, COOPERATION, CONFIDENTIALITY AND IMMUNITY

In this area, many of the concerns were related to having access to records that would help APS while investigating a case. Several stakeholders noted how lack of access can impede investigations substantially. More than 50% of the comments related to this theme came from APS stakeholders.

Stakeholders requested a recommendation that APS have greater ability to access legal, financial, medical, and criminal records needed for investigations.

“Add into the guidelines a recommendation that states develop legislation to compel entities to provide APS with access to financial and legal records without the need to subpoena records.”

“APS absolutely needs access to criminal history regarding suspects.”

“If there could be something that's clear, overarching authority for APS so that we could just show maybe one regulation that gives APS that authority to access documents. And especially when it's from the reporting parties because a lot of times we'll have banks or even medical professionals who are mandated reporters who will make reports of abuse but then when we contact them to follow through on the investigation they say that they can't release whatever information they have or whatever documents that they have that will allow us to further investigate. And so a lot of times if we don't get assistance from law enforcement

or consent from the client we have to just sort of walk away and close the case so it really cripples our ability to thoroughly investigate.”

IG. PROTECTING PROGRAM INTEGRITY

This section of the Guidelines made recommendations regarding creating policies to ensure integrity of the APS agency. Comments in this area primarily focused on expanding the conflict of interest section.

Stakeholders requested expansion on the concept of conflict of interest.

The Guidelines currently discuss conflict of interest in the context of maintaining program integrity and focus on incidents where the APS employee is the perpetrator of abuse. Stakeholders felt that this was too narrow a view of conflict of interest.

“NASOP believes the section on conflicts of interest should be expanded to include situations where immediate family of the APS worker have a financial interest in the case or more explicitly, employment in the last three years by a long-term care facility that provides care for a client of APS.”

—

“Conflict of interest should be expanded beyond just the caseworker to include the caseworkers knowing of family members, or of knowing or having a relationship with alleged perpetrators etc.”

IH. STAFFING RESOURCES

There were two primary themes related to APS agency staffing ratios. Again, with both of these themes, stakeholders are requesting more clarity in the Guidelines. Nearly half of the comments on staffing came from the APS network stakeholders.

Stakeholders requested the Guidelines specify recommended caseload sizes and how caseload is defined (i.e. New versus Ongoing cases).

“Caseload should specify how many cases that a worker carry on an on-going basis. This should differentiate between NEW cases and on-going cases”

—

“APS Worker Caseload Averages: Caseload counts need to distinguish ongoing caseload averages from the number of new cases assigned to a worker each month. A worker who is assigned 20 new client cases a month for six months, but maintains an average of 20 open cases, has worked 120 cases despite having an average caseload of 20 open cases a month. A worker who has carried a caseload of 20 for the same group of clients over a six month period has worked 20 cases.”

“Staffing Resources – Our team felt that there was a great need for clarification of what exactly the ACL is defining as caseloads. In New York State there are clear guidelines, requirements and standards for casework that include mandated timeframes for responding, investigating, visitation, opening and reviewing cases. These timeframes, including monthly home visits to APS clients, drive the number of cases a caseworker can manage. Without greater clarification of what the caseload roles and responsibilities are of an APS caseworker this portion of the document lacks clarification of what staffing resources should be, including the ratio of workers to supervisor. What number(s) is the document recommending?”

“Set recommended staffing guidelines. Define caseload average and the maximum standard...”

The second theme related to staffing ratios was concerning the ratio of supervisors to staff. Several stakeholders mentioned that many Child Protective Services (CPS) agencies offer concrete guidance on this topic.

Stakeholders requested specific recommended ratios of supervisors to staff.

“Recommend no more than 25:1 cases/caseworker and no more than 6:1 worker/supervisor.”

“Encourage APS national guidelines to model CPS in terms of supervisor to worker allocation and case distribution (workload vs caseload). In Oregon Child Welfare the staffing ratio of supervisors to protective service workers is 1 supervisor for each 6 child protective service workers.”

“A CPS colleague had informed me of the Child Welfare League's recommendation that APS Investigation units (short term, 30-60 Days) have 1:5 or 6 Supervisor to Investigator ratios, thus ensuring proper clinical supervision, oversight and QA on these challenging, and quick turn-over cases.”

IJ: CASE REVIEWS- SUPERVISORY PROCESS

Related to the above theme of addressing the amount of supervision, a theme emerged regarding how supervisors should use their time.

Stakeholders showed strong support for the Guidelines re: supervisor review, and wanted even more review of cases.

While eight different stakeholder groups commented regarding case oversight, over one-third of the comments were from the APS stakeholders alone.

“Strongly support the guidelines vis-à-vis supervisor involvement and case reviews.”

—

“Be more specific and recommend that the supervisor reviews and approves the investigation, assessment, case/service plan, and case closure for every case.”

—

“I think we have to stand-up for best practices and it doesn’t mean we have to do it. We can just, I mean, you can stay within the limits of your available resources but it is a best practice to look at, have a supervisor look at the case closings. We used to look at every single report that came in and we can’t do it anymore because when you have 13,000 and you only have, you know, a couple of supervisors, it’s impossible but that doesn’t mean that you can’t do just some random samples and that that we should be doing.”

—

“Quality Assurance It was reassuring that “over 70 percent of states have case review systems,” but this should be necessary for all states.”

DOMAIN 2: TIME FRAMES

In this domain, more specificity was the overarching theme. Although specificity was requested, stakeholders often diverged regarding what timeframes were appropriate for each aspect of the APS process; some made arguments for longer timeframes and others, for strict, shorter time frames.

2A. RESPONDING TO THE REPORT/2B. COMPLETING THE INVESTIGATION

Stakeholders request a specific, evidence-based timeframe both for responding to the report and for completing the investigation.

“Set a specific recommendation for responding to a report and needs to define what that response is and a specific time frame. Recommend 24 hours for emergency and non-emergencies in five working days or less”

“Please specify a recommended response time instead of a range.”

“Intake and Screening, Triaging, and Assignment of Screened in Reports – Our team felt there was a greater need for clarification of the timelines that were being recommended for intake, screening, triage and assignment of APS cases.”

“CPS guidelines of 30 days to complete an investigation are too short for complex APS investigations. For example, it can take over 30 days to identify, locate, and obtain financial, legal, or medical documents or obtain medical evaluations.”

2C. CLOSING THE CASE

Case closure was a theme that resonated across eight of the stakeholder groups with the APS and Disability stakeholders contributing over half of the comments.

Stakeholders requested articulation of best practices surrounding case closure, including specific timeframes and criteria for closure.

“Add the following criteria for closing: The client has been referred to other services that have accepted responsibility for the client and protective issues have been resolved. Client moves out of the APS agency’s jurisdiction, and if appropriate has been referred to another APS agency or investigative agency. Client dies Client is unavailable for services due to permanent long-term care placement.”

“Add to the criteria for case closure: client died; client left the jurisdiction; the criteria should mirror those in NAMRS.”

“Define a reasonable length of time for MOST APS cases to be resolved and closed.”

“ACL should provide examples of ‘reduced’ safety risks. ACL should add ‘client referral to another agency’ to case closure criteria for consistency with guideline 5c.”

One customer-service oriented theme emerged that was unaddressed in the Guidelines but would fit within Domain 2: Time Frames, and Domain 3: Receiving Reports of Maltreatment.

Stakeholders requested the Guidelines address communication from APS back to the reporter of abuse.

Several commenters shared personal experiences regarding lack of follow up in communication from APS and concerns about the impact of that lack of feedback. Comments including suggestions for notifying the reporter that the report was received and what the timeframe should be for such notifications.

“Why is it that APS doesn't inform family members who made complaint, that case is closed, when they have the contact information for the person? Almost a year had passed before I found out that case was closed. I received no letter, email or phone call notifying me of such! Valuable time had been lost when I wasn't informed the case was closed.”

—

“In a significant number of states, the WFA Elder Client Initiatives Team is unable to get any sort of confirmation, written or verbal, that the APS agency has screened in or out a matter that ECI referred to them; or that a case that was being investigated has since been closed. At the very least, it would be helpful to receive some sort of written confirmation that the APS agency did receive the report.”

—

“Confidentiality should delineate what information can be shared with the reporting party, the victim, and other support people in the victim's life. Lack of information makes accountability difficult. It also decreases motivation to make abuse reports, since seems like the report just fell into the ‘black hole.’”

—

“When we report to states, one of the problems is that sometimes we make the report and then there's no follow-up with us because of privacy laws. So we lose track of what's happening with that elder and it's one of our elders. And that's something that is in the guidelines. We can look at it and make sure that the language, you know, at least speaks to sharing information with tribes as well.”

DOMAIN 3: RECEIVING REPORTS OF MALTREATMENT

The most common theme within this domain related to intake hotlines. Approximately 50% of the comments on this theme came from disability advocate stakeholders.

3A. INTAKE

Stakeholders requested the Guidelines recommend that intake hotlines be accessible for all individuals and acknowledge that 24/7 intake is a best practice.

Even while acknowledging 24/7 access as a best practice, several stakeholders expressed concerns about APS agencies having the resources to staff a hotline, particularly in more rural areas.

“It is imperative that Hotline operators or other frontline staff be trained in receiving relay calls, talking with someone who uses augmentative communication devices or is difficult to understand.”

“The Coalition strongly agrees that systems must have a 24/7 hotline for reporting abuse that is fully accessible for adults with disabilities and for those who may not be fluent in English. We would also encourage implementation, where possible, of web-based reporting.”

“3. Receiving Reports of Maltreatment 3a. Intake Again, although it is good ‘that 75 percent of states had intake lines for reporting alleged maltreatment 24-hours a day,’ we agree that all states should be capable of ‘receiving reports of alleged maltreatment 24 hours a day.’”

“The Guidelines should recommend the availability of a wide range of communication methods. Strongly support the recommendation that there be 24-hr staffed hotlines and email inboxes to receive reports of maltreatment. Further guidance is needed on how APS can set up infrastructure that allows the use of other forms of communication such as text messages and online chat platforms”

“I’m calling through a sign language interpreter. I just wanted to make a comment. I’m talking about filing a complaint or any kind of issue like that with APS. I think it’s important again that staff can understand and communicate with sign language because many deaf people don’t understand written English. So sometimes if we have a complaint or something that we need to file we’ll need help with the language and we’ll need to see that in American Sign Language so that we can express ourselves. I think it’s important that we have clear communication whether that means an interpreter there or somebody who is fluent in sign language. It’s really important that we have someone to help us look at through the language and staff that are well-trained and well versed in communicating with deaf adults.”

“Just on the intake and screening and assignment of reports we talked a little bit about the 24-hour seven day week referral. And it probably ties in with one of the earlier comments because it really has to do with funding. Today our ACS is not a 24-hour service seven days a week. We think the idea is important. But the implementation piece was where we had a concern.”

Stakeholders also noted that accessible communication must extend beyond intake, to the investigative phase of the process as well.

Stakeholders requested Guidelines on accessibility include assistive technology and translation services.

“Section 3 of the guidelines recommends that APS phone data intake processes should be accessible to disabled clients and witnesses by means of TTY services. However, the guidelines do not mention the use of Augmentative and alternative communication (AAC) devices, interpreters, or other auxiliary aids and services when interviewing clients and witnesses who permanently or temporarily require these auxiliary aids or services for effective communication. We request that state APS programs be required to provide AAC devices, ASL interpreters, and other communication supports to these clients and witnesses when collecting information about their experiences. In the case of someone with a communication disability for whom a form of assistive communication cannot be identified, every effort should nevertheless be made to understand the individual’s desires and preferences. These preferences may be expressed through facial expressions, behavior, sounds or signs. APS should consult with those familiar with the individual, who often have important information about how the individual communicates.”

“I don’t have time to read the entire document, however, have seen a number of both children and adults enter the protective systems with no interview during the process due to their use of assistive technology. There are not attempts to find people who can use a Dynavox or other technology so the process is very flawed because it leaves the person at issue out of the communication. I see this as access to translation services. Would we do this if the person spoke Spanish or used sign language? I hope you are able to find language that would deal with this bad and common practice on my behalf. Thank you.”

DOMAIN 4: CONDUCTING THE INVESTIGATION

4A: DETERMINING IF MALTREATMENT HAS OCCURRED

Within this domain there were two themes that emerged. Once again, stakeholders asked for evidence to support the recommendations that are made in the Guidelines.

Some stakeholders disagreed with the Guidelines regarding unannounced visits in certain circumstances.

Contrary to what the Guidelines currently recommend, several stakeholders suggested that an unannounced visit may not be the best care in every situation and did not seem consistent with person-centered care.

“An initial unannounced visit requirement is not conducive to the social service, person centered approach of the program for assessments of self-denial of critical care. An unannounced visit might be necessary but attempting to contact the person first in these cases may lay a better foundation. IDHS would support an initial unannounced visit pertaining to those intakes requiring evaluations of abuse with an alleged perpetrator.”

—

“Often the initial visit should be announced in order to be more successful in gaining entry, to reflect respect for the older adult, and to be consistent with ethical concepts around APS intervention.”

—

“We believe that each situation should be carefully considered and unannounced visits should only be done under certain circumstances.”

Stakeholders commenting on the topic of involuntary intervention at different points in the APS process often had very strong opinions either in support or opposition of it. There was not a consensus on this topic, even within some stakeholder groups.

Stakeholders requested the standard on involuntary intervention be very clear, and some raised serious concerns with involuntary investigation.

Eight different stakeholder groups made comments related to this topic. Disability advocates and APS stakeholders expressed more concern about involuntary intervention in general than the other stakeholder groups though some APS stakeholders also supported involuntary intervention, indicative of how complex this issue is. There were diverging opinions on whether or not the investigation of abuse could be refused.

Listed below are some examples of comments in support of involuntary investigation:

“While acceptance of APS services is voluntary, the investigation of maltreatment is not. The investigation of the maltreatment is not voluntary. APS Workers must do their due diligence to try to investigate. But the investigation may not be able

to be completed due to a variety of factors including the unwillingness of the client to cooperate. d) (page 33) Indicators of any type of maltreatment, whether alleged in the report or not should be noted ‘and investigated’ (add ‘and investigated’ to the guideline) add section about what constitutes due diligence in locating a client (document all earnest attempts and the risk level of the report should be considered in the intensity of the search for the client).”

—

“Strongly agree that investigation should be mandatory”

—

“I run an adult day program. That’s very similar to what we used to see years ago when abused women would make reports and then take it all back when it came to go to court because they’d made up and he was being nice in this kind of stuff. So requiring that the investigation continue is a huge thing because these people are already in a precarious situation. And it’s very easy for someone to change their mind or force them to take it back and that kind of stuff. So I was very impressed to see that this was going to be the investigative apart at least was mandatory.”

—

“And one of the things that I noticed in the screening, triaging and assignment of screened in report that I really was pleased to see is the guideline when establishing standards of practice included the acknowledgment that accepting Adult Protective Services is voluntary but the investigation of the maltreatment is not because that’s something that we encounter is in making a referral to Adult Protective Services if the person is deemed by the phone call to be - to have full capacity then they will not conduct the investigation. And that’s been a very critical source of frustration for us as an organization a referring organization.”

The comments below are examples of those opposed to involuntary investigation:

“Related to the Section 5b problem is the recommendation in Section 4a that acceptance of APS services be voluntary but that the investigation not be voluntary. We believe that, absent a court order to the contrary, the adult must be allowed to refuse investigatory services as well as other interventions”

—

“Terrific draft! Thorough and right in line with my experience being a worker, then supervisor, then manager in two different states' APS agencies. Just one thing stuck out as needing further discussion: ‘While acceptance of APS services is voluntary, the investigation of maltreatment is not.’ There is a strong argument to be made that if an APS client retains cognitive capacity, they should have the right to deny consent to an investigation, as well as interventions. In my current

state, Massachusetts, APS clients can refuse an investigation as long as they are capable of making that decision.”

—

“In most states, a report triggers an investigation by APS within a specified period of time, and the investigation itself can be a significant intrusion on the right to privacy and self-determination. Thus we disagree with the recommendation in 4.a. that acceptance of an APS investigation is not voluntary, while it is recommended that other forms of intervention should be voluntary.]”

4B. CONDUCTING A PSYCHOSOCIAL ASSESSMENT

For this section of the Guidelines, stakeholders again requested specificity and concreteness to enable them to better operationalize the Guidelines’ recommendations. Approximately one-third of the comments related to this theme came from APS network stakeholders.

Stakeholders requested specific examples of recommended screening and assessment tools, especially related to assessment of capacity.

“Conducting a Psycho-Social Assessment...Would appreciate examples of screening tools here. There are many out there and I question the ability to screen accurately.”

—

“The report should provide a more detailed description re: how to define and measure the client’s decision-making capacity”

—

“APS systems should use multiple tools that are appropriate and those tools should allow investigators to note if they suspect cognitive impairment and whether there is an identifiable caregiver who is not reported as the suspected abuser”

—

“Screening Tools • Consider having examples of assessment/risk assessment tools from different states on a national website.”

—

“Comment on Capacity Assessments: Any evaluation or assessment should be evidence-based. Capacity assessments must be developed that are appropriate for victims of scams (romance, lottery, etc.), who frequently do not appear to lack

financial capacity, and who as frequently refuse protective services, leaving them vulnerable to total financial ruin.”

DOMAIN 5: SERVICE PLANNING AND INTERVENTION

5B: INVOLUNTARY INTERVENTIONS

Comments on this topic largely focused on involuntary intervention during the investigation phase. See 4a for more information.

DOMAIN 6: TRAINING

Training was a significant concern to stakeholders, with over 70 comments across 10 stakeholder groups, and was particularly of concern to APS and disability stakeholders, with over 50% of the comments from those two groups. Two main themes emerged related to this domain.

6A: CASE WORKER AND SUPERVISOR MINIMUM EDUCATIONAL REQUIREMENTS

Stakeholders supported that APS workers should at a minimum have a bachelor's degree with master's degree generally preferred.

Many stakeholders saw increased education as a way to ensure APS workers have the tools to provide better services and awareness. Several stakeholders also voiced support for the specific fields of study suggested in the guidelines.

“Recommend that at minimum, APS workers should have an undergraduate degree, and preferably, this degree be in social work, human services, or gerontology.”

“We recommend it be required for all staff have at minimum an undergraduate degree in social work, gerontology, public health or other related fields. Staff with the proper education are aware of the many challenges a client could face and are educated on preventative measures to be taken.”

“I would recommend a MSW or other related Master's level education for all Adult Protective Social Workers (minimum level of education) unless there is a hardship for communities to attract this level, then a waiver could be submitted to hire at the bachelor degree level.”

6B: CASE WORKER INITIAL AND ONGOING TRAINING AND

6C: SUPERVISOR INITIAL AND ONGOING TRAINING

Stakeholders suggested specific trainings that should be included.

While the Guidelines specifically list various topics to be included in training, stakeholders suggested several additional explicit, specialized trainings. Capacity and cultural competence with different populations were major topics suggested for training.

“Training should be a formal process and should include robust training in: assessment, particularly related to capacity, cognitive impairment, cultural competency particularly with people from traditionally marginalized groups such as those with disabilities and American Indians, trauma, and worker safety, and be provided by subject matter experts”

“Training be more robust on issues that challenge workers, including geriatric syndromes, common diseases and capacity recognition”

“And I think that it really is important for people to be able to identify some things very quickly about a situation because financial abuse happens so quickly. So we’re going to have more inexperienced APS workers than we’ve had in the past. And I have a real concern about the timeliness and being able to identify things - issues quickly. APS workers need training on assessing risk, including risk of financial abuse.”

“Training should include signs of cognitive impairment, referral options for clinical assessment, dementia-related behaviors, and the degenerative nature of dementia. A client with a dementia may decline during the months or years of case management and the case worker should be prepared accordingly. Initial training should also include intake processes.”

“It is imperative that Hotline operators or other frontline staff be trained in receiving relay calls, talking with someone who uses augmentative communication devices or is difficult to understand.”

“Advanced training: This information should include cultural competency on serving people with disabilities and this training should be provided by professionals with expertise in the disability field outside the APS system.”

“Training for APS Workers that serve Native American Populations on cultural awareness & cultural sensitivity -APS Training for staff at Tribal Aging Unit’s on the APS process, procedures, policies, and local laws”

“Yes one of the things about the guidelines that was concerning for me especially as it relates to self-neglect is the lack of cultural awareness or cultural norms embedded into the APS guidelines as we see changing population and both as recipients of care and as providers to those who need care. It seems like something we might want to think about. So what I found lacking in the APS guidelines is it didn’t differentiate what we might find in different races and ethnicities around what is normative whether it may or may not be abuse or even if it is abuse if it’s normative in that culture. It would be good to have some language around how APS workers and investigators can navigate that, how they can become more culturally aware using the trauma informed model. I think those are very important so that we don’t re-traumatize our victims and also so that we can help change family dynamics.”

DOMAIN 7: EVALUATION & PROGRAM PERFORMANCE

Eight different stakeholder groups made comments related to this domain with over one-third of the comments made by APS network stakeholders. Here again, stakeholders wanted more detail than the Guidelines currently provide. In particular for those who commented on performance measures, outcome measures were a popular topic.

Stakeholders requested more specific guidance and best practices for outcome measures.

“It would be optimal to have outcome measures that helped the APS Worker determine when the situation was stabilized, protective plan is working, and safety risks have been reduced. We don’t have specific recommendations for outcome measures, but it is an important issue that should be considered.”

“Tracking outcomes is crucial information. One recommendation would be to include language under the program evaluation and performance section on how to evaluate effectiveness across states. The data would be helpful to determine the impact of the federal guidelines on practice.”

“One of the things that I noticed is not really listed out very much is expectations for outcomes for APS. I see sections on case closure, and substantiating and not substantiating but whether there are expectations or best practices or guidelines for APS to do anything with those investigations once they’re done whether that’s pursuing criminal charges or working with licensing agencies to, you know, get corrective action plans in place things like that so I wonder if you could speak to that?”

In addition to outcome measures, stakeholders sought further guidance on data as a whole. Several voiced a desire for more national standardization in what data is collected.

Stakeholders requested specific information about collecting and sharing data nationally.

“Recommend that APS agencies fully participate in federal efforts to collect, understand, and utilize APS data for statistical reporting purposes.”

“Perhaps national questions that have to be included on every assessment that would allow you to analyze and collect data across the state that is the same that would give us a more accurate picture of elder abuse here in America especially with the growing baby boomer population.”

“Implement a National Adult Protective Services Data Collection System We understand that this system will be named the National Adult Maltreatment Reporting System (NAMRS) and that “the first states submitting data between October – December 2016, and the first annual report on NAMRS by March 2017.” We would suggest that copies be provided to legislators and other policymakers as well as the advocacy community.”

OVERARCHING THEMES

Several themes were broad and did not apply to only one domain but to the Guidelines as a whole, their process, or their purpose. One such theme that was quite prevalent had to do with values underpinning Adult Protective Services:

Stakeholders suggested autonomy, supported decision-making and least restrictive alternatives should be woven throughout the Guidelines.

While seven different stakeholder groups made comments related to this theme, 50% of the comments were from the Disability Advocates stakeholder group. The Guidelines do address

these values in 1a: Ethical Foundation; commenters were requesting that these values imbue every step of the APS process.

“An exploration of the ‘...ethical issues in the decision to use involuntary intervention’ is not enough to ensure that individuals’ autonomy is appropriately preserved. There must also be a requirement to explore and use less restrictive interventions, including interventions that respond to findings of serious danger to health and safety.”

—

“Therefore, the guidelines should recommend that states require their APS programs to identify all of the assistance and/or accommodations that a client needs in order to make their own life decisions. APS programs must identify and offer all the assistance and accommodations that the client needs, but must not provide assistance that the client does not want.”

—

“The overarching principle guiding APS workers should be that of compliance with the Olmstead mandate of the least restrictive setting.”

—

“We strongly agree with the use of supported decision-making and highly recommend this resource on the topic found at <http://supporteddecisionmaking.org/> using the philosophy that ‘everyone has the right to make choices.’”

—

“We strongly agree with the values of self-determination in decision-making, but recommend that the concepts of ‘person-centered planning’ and ‘supported decision-making’ be reflected in the guidelines.”

Another theme that was broader than any one domain was that of the availability of resources. Approximately one-third of comments related to this domain came from APS stakeholders.

Stakeholders expressed concerns that APS is underfunded and the limited resources may make implementation of the Guidelines difficult.

“Creating guidelines for nationwide response and effectiveness is a great idea, however, our experience with APS is that they have great intentions and are effective when available but they are extremely under staffed and unavailable after hours and on weekends. Abuse doesn't only happen M_F 9-5 pm, so

availability is essential for effectiveness. Funding for APS must be addresses for these guidelines to be effective.”

—

“In addition, our group shared grave concerns about mandating 24-hour, 7 day a week referral without adequate funding to each community/state to insure proper funding of the services”

—

“APS does not have the capacity to investigate all exploitation cases.”

—

“We strongly advocate for resources to be allocated to support the implementation of the guidelines and to assist with providing consistency of implementation in all states. Protection from abuse is important and our citizens deserve the ability to move across the nation and experience the same level of attention and concern regardless of the locality.”

—

“The 24/7 access, you know, the call line or the receiving of reports that’s also going to be a big hurdle for us. We don’t have the staff to man that right now nor do we have funding to get more staff to man something like that”

—

“One of the things that we are facing on the federal side is difficulties with APS is the elimination of the Title XX funding which our Adult Protective Services uses for in-home support. It’s really one of the most productive things that gets done as far as Adult Protective Services goes from the federal level in our state. Because as we all know, you know, it’s one thing to go out do an investigation and substantiate and another is to be able to provide some help based on that substantiated investigation. And so the concern that we have and currently, you know, the most productive thing that is done from the federal level is to support that in-home service that really makes Adult Protective Services worthwhile because we’re able to do something to ultimately provide better outcomes to people.”

Another theme that did not fit particularly into any one domain was related to perpetrators. The topic of perpetrators was not extensively addressed in the Guidelines.

Stakeholders shared general concern about how to track perpetrators.

“Federal government should develop a statewide perp registry. Guidelines should imply that a registry be developed”

—

“Also, while being worked on at various levels at the federal and state level, the importance of a registry of elder abuse offenders like is available for sexual offenders is critical. This is not necessarily a responsibility of APS but is something that involves their cooperation.”

—

“One of the things that we’re concerned about, and what you’re guidelines are silent about, is the issue of perpetrator registries. Have you given any thought to providing some guidelines about that? This would be perhaps in cases where someone was not criminally prosecuted. We have a county-based system here and one of the biggest problems APS has is trying to get DAs to prosecute cases even when they’re significant. And we had a number of fairly prominent cases where a perpetrator is operating in one county and they’re just moving from county to county and doing the same thing and leaving just a trail behind them, a big mess. And there was no way for, you know, another county to know that there have been problems.”

SUGGESTIONS FOR NEW CONTENT NOT COVERED IN ORIGINAL GUIDELINES

One theme noted the absence of guidance on worker safety in the Guidelines. More than 50% of the comments on this topic were from APS network stakeholders.

Stakeholders requested a section on Worker Safety.

“Recommend adding a section relative to protecting worker safety.”

—

“Develop a section on Worker Safety”

—

I didn’t see anything that would maybe specifically address policies and recommendations around worker safety and worker safety issues. That’s one the, you know, we touch on when we do our initial training but I think it’s something that’s really important to do on an ongoing basis with the workers.

Stakeholders also gave feedback related to pets, the important roles pets play in people’s well-being, and the potential health and safety concerns related to the pets themselves. While the quantity of comments was small, this topic came up across many domains. One stakeholder

from the general public reviewed the Guidelines and suggested various sections to incorporate pets.

“For many elders and people with disabilities pets are a very important part of their lives. In fact they assist in a variety of ways, including emotional well-being. Base on this here are my thoughts. I'm referring to the document "full guidelines with citations (PDF). On page 9 of 65, ‘services may include’ add assistance regarding pets. On page 14 of 65 last paragraph add animal welfare. Page 26 of 65, c) cross-jurisdiction & interdisciplinary cooperation, add to other disciplines animal welfare organizations. Page 29 of 65 protocols to allow expert consultation add animal welfare experts. Page 33 of 65 in conducting investigation add conditions of pets. Add resources so that victims can care and keep their pets. On page 42 of 65 in advanced training add train on the link between animal abuse and people abuse. Thanks for the opportunity to give input.”

“We observed an inadvertent oversight which can be easily corrected. To create a truly integrated, comprehensive, multidisciplinary system supporting interagency coordination, we suggest that APS agencies should take into account the emotional support, individual and public health issues, and environmental and safety risks presented by clients’ pets. Interagency coordination between APS and animal services currently exists in several areas but has not been codified into a national guidelines. APS collaborations with other entities, as needed, should include veterinary and animal welfare and control agencies.”

“Screening reports should identify presence of abused, dangerous or hoarded animals in the home.”

While not mentioned enough to constitute a theme in the comments, another noteworthy suggestion was increasing APS agencies’ community engagement. Stakeholders were concerned about whether the public really understands what services APS offers and recommended that APS engage in community outreach in order to increase understanding and improve relationships between local APS agencies and the community

“I also think along that thread with people not knowing Adult Protective Services and what it does the more transparency I think, you know, that each APS could be encouraged to have would be better for them.”

“APS should provide ongoing public awareness & community engagement piece”

Similar to the topic of community engagement, emergency preparedness was only mentioned a few times but is an emerging and important topic to be considered. One stakeholder suggested adding a whole section to the Guidelines on the topic of emergency preparedness. The comments discussed preparing for natural disasters, but also situations like the emergency displacement of an adult with a disability because his/her residential facility is closing.

“I would like to see more guidance on the EMERGENCY relocation requirements for APS Systems, especially focused on reducing transfer trauma when disabled adults are relocated to new accommodations due to facility closures. Many times in California, residents are forced to relocate to MORE restrictive levels of care because a community placement closes (due to sale, foreclosure, bankruptcy, enforcement action, etc.) If the APS System is contacted, there needs to be both a practical and financial mechanism and guidance for states that will mitigate trauma AND also comply with Olmstead.”

—

“Older adults and people with disabilities are also at risk after disasters and other significant events. I don't see this addressed in the document.”

—

“Executive Order 13347, Individuals with Disabilities in Emergency Preparedness. This... calls for a coordinated effort among Federal agencies to ensure that the Federal Government appropriately supports safety and security for individuals with disabilities in all hazard situations. Vulnerable adults are at great risk for personal and financial exploitation after emergencies. The HHS CMS, LTCOP and others have responsibilities related to emergency preparedness and assistance to people with access and functional needs. I suggest adding the topic of emergency preparedness, especially post disaster recovery response, to the APS voluntary guidelines.”

OTHER COMMENTS

In addition to the themes that emerged, stakeholders offered compliments for the Guidelines and made general suggestions of ways to strengthen them. For example, they suggested various resources that could be attached to the Guidelines to help make them a more practical tool for APS to use.

“...There are tools to guide this assessment in real world settings, like The Assessment of Capacity for Everyday Decision-making (the ACED),² developed by Drs. Lai and Karlawish.”

—

“Additionally, ACL needs to include website with tools such as the ‘Domestic Violence Safety Planning tool’”

“Page 6 of 10 We strongly agree with the concept of person-centered planning and recommend the resources on Home and Community Based Services found at http://rwjms.umdnj.edu/departments_institutes/boggscenter/products/GettingtheCommunityLifeYouWant.html and the Person-Centered Planning Tool for individuals with disabilities found at: <http://www.nj.gov/humanservices/ddd/documents/Documents%20for%20Web/PCPT%203-13-13.pdf>.”

“One thing I wanted to bring up was in your environmental scan that you didn’t utilize the Bureau of Indian Affairs APS Handbook that we have linked on our Web site. And that really does a good job talking about cross jurisdictional issues, and what laws kick in, and who should investigate and all of those kinds of things.”

A large number of stakeholders made very specific comments requesting that certain parts of the Guidelines needed further clarification, examples, or refinement. The most detail-oriented comments came from the APS and disability stakeholders. Though the nature of the comments did not lend themselves to explicit themes, the prevailing desire was for more detail in the Guidelines on the design and implementation of the described processes. In particular, many stakeholders requested that definitions of key concepts be more explicit. For example:

“Specify the defining criteria for Confirmed, Inconclusive, and Unfounded.”

“My second question is back to definitions. I think if you could put something in there about encouraging where we stumble all the time is not being able to perform tasks for yourself. And I think the key point is a lot of us cannot perform the tasks for ourselves but we have the capacity to direct that care. And I think that is the key is that the individual has the capacity to direct their care more so than perform it themselves – this is a very strong distinction that would I think alleviate a lot of fear for people.”

“Elder Justice Act defines ‘abuse’ as KNOWING infliction of physical or psychological harm. W and I 15610.07 does not require knowledge on part of perpetrator. I think the result should govern whether it is abuse, though intent

should come into play for prosecution. -Categories still not very clear—omission (neglect) vs commission, actual harm vs. endangerment”

—

“We recommend that under Definitions of Maltreatment, ‘psychological’ be included in the guideline alongside physical and emotional.”

—

“The Guidelines discuss the need for state and federal definitions of abuse, neglect, financial exploitation and self-neglect, but fail to suggest model definitions or suggest adoption of existing federal and state definitions, such as those found in the Elder Justice Act or existing federal child protection statutes”

Comments in this area also asked for models and examples to help guide APS agencies in implementing the Guidelines. Once again, stakeholders requested to make the Guidelines a very practical tool for the field.

“The Guidelines do not offer state agencies practical policies and procedures despite evidence cited in the Guidelines that structured tools and procedures increased outcomes (citing Carter, ‘Improving child protection...’ ACL should offer model policies, protocols and procedures for evaluations, investigations, documentation and closure of cases.”

—

“I had hoped to see more concrete, specific recommendations of minimum standards or model practices for states/local agencies to follow. That a policy on a certain topic is needed is not especially helpful.”

Further, the stakeholders specifically asked for certain documents or concepts to be included to make the Guidelines more practical.

“Include a Table of Authority providing citations to current federal laws applicable to adult protective service systems. Ethical Foundation of APS Practice ‘Least restrictive alternative’ – In *Olmstead v. L.C.*, 527 U.S. 581, the United States Supreme Court reinforced federal policy that encourages the delivery of supports and services in the most integrated setting. For individuals with disabilities who want to live in the community, federal initiatives such as Medicaid Home and Community Based Services waivers, Money Follows the Person, and the growth of federally funded housing options are expanding this possibility. As the country’s service systems continue to move away from institutional-based models to those that ensure greater independence and community participation, it will be necessary for APS to understand this legal precedence and enforce the rights of individuals to live in the community.”

“Include reference to the NAPSA/CA core competency trainings <http://theacademy.sdsu.edu/programs/master/>.”

“Incorporate the NAMRS project so that the guidelines are fully comprehensive. In many of the specific guidelines I do not believe the ACL has gone far enough to specifically identify standards of practice. These guidelines are essentially telling states that they should ‘develop a process’ ACL should be very specific about expectations in some key concepts to start moving states into tighter alignment of basic program standards”

Another set of comments suggested minor textual changes such as simple word addition or subtraction, or minor changes in terminology. These suggestions tended to be less content driven and more seeking to clarify a section or sentence. A list of all suggested textual changes is appended as Appendix 6. Below are a few examples:

“Change “Psychosocial” Assessment to ‘Bio-psychosocial’ Assessment.”

“As a general comment - in some parts of the guidelines the term ‘people’ with disabilities is used. And in other ‘adults’ with disabilities. It should be ‘adults’ in all instances.”

“Recommend the following change – Indicators of any type of maltreatment, whether alleged in the report or not should be noted ‘and investigated’”.

LIMITATIONS

The degree to which the findings of the present study can be generalized is unclear. The decentralized nature of the provision of Adult Protective Services to older adults suggests that it may not be possible to select a single model of service provision that can be used as a national model. Levels of funding, numbers of employees, qualifications and training vary considerably across states and jurisdictions and each of these factors can have an influence on how and which services are selected, implemented, and evaluated (Brownson, Colditz, & Proctor, 2012; Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004). Accordingly, caution is warranted when generalizing the findings of this study. However, to assist with the transferability of the research, detail on the methods and data analysis of our study is provided so that other researchers can have the opportunity to apply the procedures of this study.

Another limitation is the utilization of a purposive rather than random sampling strategy for the interviews. ACL intentionally sought out targeted groups of professionals, as well as the general public, through their stakeholder engagement process. Further, commenters who voluntarily made the effort to participate may have been more likely to have changes to suggest, which could make it more likely that the comments were biased toward making changes or toward those who had more disagreements with the recommendations in the Guidelines.

Comments from the public input sessions were limited to 550 comments from 113 discrete commenters, a fact that could have limited the representativeness of our sample. However, due to the qualitative nature of the study, the methods selected, including public input from multiple stakeholder groups in a variety of formats, were intentionally designed to capture a wide range of responses.

Finally, the researchers were specifically engaged with ACL in this process to analyze the data for the purpose of producing a report to inform the expert work group that will be determining how to incorporate comments into the guidelines. This focus on research for the sake of informing the revision of the guidelines could have influenced the results. Because the researchers viewed part of their role to help the expert work group consider what changes may be necessary to the draft guidelines, this could create bias toward comments that recommend action, such as change or edits to the Guidelines.

CONCLUSION

While the comments showed a great diversity of viewpoints, interests, and concerns, the overriding principle of the majority of themes is the desire for more specificity and more guidance. However, the comments also confirm that the guidelines are generally a step in the right direction, and will prove useful to regional and local APS agencies as they move forward.

APPENDIX 6. TEXTUAL CHANGES SUGGESTED BY PUBLIC COMMENT

Original Guideline Text	Textual Changes Suggested by Public Comment
<p>Entire document Throughout, where “people,” “persons,” or “individuals” with disabilities is mentioned. (<i>i.e.</i> in the Exec. Summary, Part I.A., I.C., I.D.2, 1c., and in various footnotes)</p>	<p>As a general comment - in some parts of the guidelines the term "people" with disabilities is used. And in other "adults" with disabilities. It should be "adults" in all instances.</p>
<p>Background: Intro/Title In the title and throughout where the document refers to its title “Draft Voluntary Consensus Guidelines for State Adult Protective Services Systems”</p>	<p>Change current title from “Voluntary Consensus Guidelines for State APS Systems” to “Guidelines for State APS Systems” --- The name should have more "teeth"- recommended "Guidelines for APS Programs"</p>
<p>Background: Intro/Title Throughout, where the document uses the word “voluntary,” and somewhere in the background/introduction.</p>	<p>We also recommend that the final version (1) substitute the word “voluntary” with “recommended” to signal that the guidelines represent best practices and (2) that it be clear that they are to apply to all APS programs regardless of structure and administrative setting (e.g., state, county, local or tribal).</p>
<p>Background: Title/Intro Throughout, where the document references “national” guidelines</p>	<p>Change all references to “national” guidelines to “federal” guidelines</p>
<p>Background: I.A. Problem of Maltreatment In part I.A. generally, where there are the bulleted definitions</p>	<p>Add “financial abuse” to the definition --- Add resident to resident as an abuse type</p>
<p>Background: I.A. Problem of Maltreatment Bullet defining abuse:</p> <ul style="list-style-type: none"> • “Abuse: ‘the knowing infliction of physical or psychological harm or the knowing deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm’” 	<p>Incorporate “negligence” into the definition of Abuse The draft’s definition of abuse is being a “knowing” act. However, abuse may also occur through negligence. I suggest that the draft be changed to reflect this. The definition can be changed to read as follows: • Abuse: “The intentional or negligent infliction of physical or psychological harm or intentional or negligent infliction deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm”.</p>
<p>Background: I.A. Problem of Maltreatment Bullet defining exploitation:</p> <ul style="list-style-type: none"> • “Exploitation: ‘the fraudulent or otherwise illegal, unauthorized, or improper act or 	<p>Adding to the definition of “exploitation” The proposed definition of “exploitation” uses the terms “fraudulent or otherwise illegal” These are legal determinations that require the existence, and knowing of specific elements</p>

Original Guideline Text	Textual Changes Suggested by Public Comment
<p>process of an individual, including a caregiver or fiduciary, that uses the resources of an elder for monetary or personal benefit, profit, or gain, or that results in depriving an elder of rightful access to, or use of, benefits, resources, belongings, or assets”</p>	<p>of actual state and/or federal statutes. It might be suitable to add the words “wrongful use”, which express the same activities but without requiring any legal determinations.</p> <p>---</p> <p>The definition of exploitation could be changed to read as follows: • Exploitation “the wrongful, fraudulent or otherwise illegal, or improper act or process of an individual, including a caregiver or fiduciary that uses the resources of an elder for monetary or personal benefit, profit, or gain, or that results in depriving an elder of rightful access to, or use of, benefits, resources, belongs, or assets”.</p>
<p>Background: Part I.C. Federal Efforts to Address Adult Maltreatment 2nd bullet:</p> <ul style="list-style-type: none"> • “The first Protection and Advocacy system was created by the Developmental Disabilities Assistance and Bill of Rights (DD) Act of 1975 to pursue legal, administrative, and other appropriate remedies to protect and advocate for the rights of individuals with developmental disabilities under federal and state laws.” <p>and the first paragraph of Part I.C.: “These activities range from prevention efforts, such as creating and distributing information alerts and bulletins and public service announcements, to training activities for various professionals, as well as research on the scope and magnitude of the <i>phenomenon</i> of adult maltreatment and primary, secondary, and tertiary prevention.”(emphasis added).</p>	<p>We would like to see a clarification in the definition of the DD Act that states: The P&A system is charged with investigating incidents of abuse and neglect of persons with ID/DD, as well as monitoring the compliance of the rights and safety of individuals with ID/DD.</p> <p>---</p> <p>I.C. Federal Efforts to Address Maltreatment –We would like to see a better definition of P&A network in this section. •We think it would enhance this work if adult maltreatment was not classified as a “phenomenon.” There are years of evidence based research that would negate this statement.</p>
<p>Background: I.C. Federal Efforts to Address Adult Maltreatment The bullet on PAIMI:</p> <ul style="list-style-type: none"> • “In 1986, the Protection and Advocacy for Individuals with Mental Illness Program was established to protect and advocate for the rights of people with mental illness, and to investigate reports of abuse and neglect in facilities that care for individuals with mental illness.” <p>And the bullet on PAIR:</p>	<p>In reference to PAIMI, it should state that the P&A programs are linked. The ACL bullets on PAIMI and PAIR are not clear on the fact that the entity is the same for the DD Act. This section should also include the monitoring role under PAIMI, which is the same as under the DD Act. •NDRN would like to see this bullet on PAIR be rewritten as follows: Amendments in 1993 to Title V of the Rehabilitation Act created the Protection and Advocacy for Individual Rights which extended the ability of the P&A system to investigate suspected incidents of abuse and neglect and advocate for the protection of rights to all persons with disabilities</p>

Original Guideline Text	Textual Changes Suggested by Public Comment
<ul style="list-style-type: none"> “The Rehabilitation Act in 1993 created the Protection and Advocacy for Individual Rights Program, essentially extending advocacy for the rights of all persons with disabilities.” 	
<p>1a. Ethical Foundation of APS Practice Throughout this element.</p> <p>AND</p> <p>In the Background section – bullet on Supported decision-making:</p> <ul style="list-style-type: none"> “Supported decision-making: Supported decision-making starts with the assumption that people with intellectual and developmental disabilities and older adults with cognitive impairment should retain choice and control over all the decisions in their lives. It is not a program. Rather, it is a process of working with the person to identify where help is needed and devising an approach for providing that help.” 	<p>Ethical Practice • Consider adding ‘person first’ language</p> <p>---</p> <p>1a: “Supported decision-making” should be re-defined as “a series of relationships, practices, arrangement, 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.” - Robert Dinerstein, 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, 19 Human Rights Brief 8, 10 (Winter 2012). Based on the above definition, ACL should remove the last sentence under supported decision-making we do not see that as supported decision-making. If ACL is trying to provide guidelines to APS workers, we think that a more refined recommendation should be included in the guidelines.</p>
<p>1b. Definitions of Maltreatment <u>“Background:</u> The APS Survey reveals the vast majority of APS systems respond to reports of physical, emotional, and sexual abuse; financial exploitation; neglect; and self-neglect. Although states may use other terms to define the different categories of maltreatment, these six types are reflected in the Older Americans Act.</p> <p><u>Guideline:</u> 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.”</p>	<p>ACL should add “suspicious injury” and “suspicious death” to the categories of maltreatment.</p> <p>---</p> <p>Adult maltreatment is not an accurate phrase to describe APS clients. Younger domestic violence and sexual assault victims without disabilities are adults and yet they are not potential APS clients. Maltreatment implies an offender yet 60% of APS clients are often self-neglectors. Maltreatment minimizes and sanitizes sexual assault and violent physical assault</p>
<p>1c. Population Served: <u>“Background:</u> The APS Survey reveals the vast majority of APS systems serve adults (18+ years) who are the subject of an APS report and who also meet the</p>	<p>Delete “criteria” and expand to after develop “a standard protocol, based on their state statutes . . .”</p> <p>---</p> <p>Definition of a Vulnerable Adult should be re-defined. An elder or disabled who has medical or mental</p>

Original Guideline Text	Textual Changes Suggested by Public Comment
<p>state’s eligibility criteria for being vulnerable or at risk (terms and definitions vary from state to state). Most elders and people 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 (either 60 or 65 years) without requiring an additional finding of vulnerability. The population served by APS may reside in the community or in institutions depending on state statute or policy.</p> <p><u>Guideline:</u> It is recommended that APS systems develop <i>criteria</i> for determining eligibility of adults (18+ years) who are the alleged victims of maltreatment for their services and then serve those adults. The terms <i>client</i>, <i>victim</i> and <i>survivor</i> are used interchangeably within this document.” (emphasis added)</p>	<p>conditions making them "vulnerable" even if they are not on state services or have a caregiver.</p> <p>---</p> <p>The terms of client, victim, and survivor are used interchangeably, but they are different and reflect different disciplines and systems and therefore problem approaches.</p>

APPENDIX 7. LISTING OF CONTRIBUTORS

ADMINISTRATION FOR COMMUNITY LIVING STEERING GROUP

ADMINISTRATION ON AGING, OFFICE OF ELDER JUSTICE & ADULT PROTECTIVE SERVICES

Stephanie Eliason, MSW
Team Lead

Aiesha Gurley, BSW
Program Specialist

Mary Twomey, MSW
Expert Consultant

Catherine Butler, BA
Law Student Intern, American University School of Law

ADMINISTRATION ON INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

Clare Huerta, JD
Program Specialist

CENTER FOR POLICY AND EVALUATION

Jane Tilly, DrPH
Senior Policy Advisor, Aging

ENVIRONMENTAL SCAN

ADMINISTRATION FOR COMMUNITY LIVING

Jane Tilly, DrPH
Senior Policy Advisor, Aging

Kendra Kuehn, MSW
MSW Intern, Catholic University of America

DEPARTMENT OF JUSTICE

Erica L. Smith
Chief, Law Enforcement Statistics Unit
Bureau of Justice Statistics

James Fort
Librarian
National Criminal Justice Reference Service

Scott Hertzberg
Librarian
National Criminal Justice Reference Service

DATA ANALYSIS

HEALTH AND AGING POLICY FELLOWS

Rebecca A. Mabe, MSW LCSW
Jamie Kuhne, MSW, LISW-S
Julie Bobitt, PhD
Julie Carter, JD

SUBJECT MATTER EXPERT WORKING GROUP ONE

Mary Counihan, MSW
Consultant & Subject Matter Expert, Elder and Vulnerable Adult Abuse

Beth Engelking, MSW
Assistant Commissioner, Adult Protective Services
Texas Department of Family and Protective Services

Becky Kurtz, JD
National Long-Term Care Ombudsman
Administration for Community Living
U.S. Department of Health & Human Services

Paul Needham, MSW
APS Program Field Representative

Oklahoma Department of Human Services
Member, National Adult Protective Services Association (NAPSA) Board of Directors
Chairperson, NAPSA Education Committee

Holly Ramsey-Klawnsnik, Ph.D., LCSW, LMFT
Consultant & Trainer, Klawnsnik & Klawnsnik Associates
Director of Research, National Adult Protective Services Association

SUBJECT MATTER EXPERT WORKING GROUP TWO

Nancy A. Alterio, Executive Director
Massachusetts Disabled Persons Protection Commission
Co-Chair, MA Building Partnerships for the Protection of Persons with Disabilities Initiative
Board Member, MA Sexual Assault Nurse Examiner (SANE) Program
Appointed Member, Governor's Council to Address Sexual Assault and Domestic Violence

Georgia J. Anetzberger, Ph.D., ACSW
Elder Abuse Expert Consultant
Adjunct Assistant Professor of Medicine at Case Western Reserve University

Doris S. Ball, Director
Adult Protective Services
Alabama Department of Human Resources

Racquel M. Boyd
Elder Abuse Project Coordinator
Menominee Indian Tribe of Wisconsin
Wisconsin Department of Aging & Long-Term Care

Janine Brady, RN, BSN, PHN
Senior Adult Protective Services Nurse
San Diego County Adult Protective Services
Chair, National Coalition Adult Protective Services Nurses

Andrew Capehart
Assistant Director
National Adult Protective Services Association

Carmen Castaneda, MSW, LICSW
Program Manager
Hennepin County Adult Protection Services
Regional Representative for Central States, National Adult Protective Services Association (NAPSA)
Member Minnesota Elder Justice Center
Member Hennepin County Sexual Abuse Multidisciplinary Response Team
Chair, Hennepin County Adult Protection/Law Enforcement Team

Paul Caccamise, LMSW, ACSW
Vice President for Program
Lifespan of Greater Rochester
Rochester, NY
Member, National Adult Protective Services Association
Member, International Network for the Prevention of Elder Abuse

Lori Delagrammatikas, MSW
APS Liaison
California Department of Social Services, Adult Programs Division
National Adult Protective Services Association Board of Directors

Joy Swanson Ernst, PhD, MSW
Associate Dean for Academic Affairs
Wayne State University School of Social Work
Member, National Committee for the Prevention of Elder Abuse Board of Directors Member,
NAPSA/NCPEA Research Committee

Justin DeFour, MA
Adult Protective Services Program Manager
Washington State Department of Social & Health Services

Sharon Jackson
Director
Adult Protective Services
Louisiana Office of Aging and Adult Services

B. Lynn Koontz
APS Administrator, Retired
New Hampshire Department of Health and Human Services
Elderly and Adult Services

Paige L. McCleary, MSW
Director, Adult Protective Services Division
Virginia Department for Aging and Rehabilitative Services

Heidi Richardson, MSW, LCSW
Program Planner, Senior and Adult Services
Sacramento County, California Department of Health and Human Services

Peggy Rogers
APS Program Manager
Colorado Department of Human Services

Catherine Stack, MA
Dependent Adult Protection Program Manager
Iowa Department of Human Services

Lauren Z. Villa, Esq.
Senior Adult Protective Services Policy Attorney
Texas Department of Family & Protective Services

ENDNOTES

-
- ¹ ACL brings together the efforts and achievements of the Administration on Aging, the Administration on Intellectual and Developmental Disabilities, and the HHS Office on Disability to serve as the Federal agency responsible for increasing access to community supports, while focusing attention and resources on the unique needs of older Americans and adults with disabilities across the lifespan.
- ² GAO, *Elder Justice: Stronger Federal Leadership Could Enhance National Response to Elder Abuse* [Reissued on March 22, 2011], GAO-11-208 (Washington, D.C. March 2, 2011); and Quinn, K. M., & Benson, W. F. (2012). *The States' Elder Abuse Victim Services: A System in Search of Support. Generations, 36(3), 66-72.*
- ³ GAO, *Elder Justice: More Federal Coordination and Public Awareness Needed*, GAO-13-498 (Washington, D.C.: July 10, 2013).
- ⁴ Universal Declaration of Human Rights; Convention on the Rights of People with Disabilities; United Nations Principles for Older Persons; Elder Justice Act of 2009; Administration for Community Living Strategic Plan 2013 - 2018
- ⁵ Acierno R, Hernandez MA, Amstadter AB, et al. Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the United States: the National Elder Mistreatment Study. *American Journal of Public Health.* 2010; 100:292-297.
- ⁶ Petersilia JR. Crime victims with developmental disabilities: A Review Essay. *Criminal Justice & Behavior* 2001; 28(6): 655–94.
- ⁷ Bureau of Justice Statistics. (2011). *Crime Against Persons with Disabilities, 2008-2010 – Statistical tables.* Accessed from www.bjs.gov/index.cfm?ty=pbdetail&lid=2238
- ⁸ Teaster PB, Dugar T, Mendiondo M, Abner EL, Cecil KA, Otto JM. *The 2004 Survey of Adult Protective Services: Abuse of Vulnerable Adults 18 Years Of Age And Older.* National Center on Elder Abuse: Washington, DC. Retrieved May 8, 2015 from: http://www.ncea.aoa.gov/Resources/Publication/docs/APS_2004NCEASurvey.pdf
- ⁹ Multiple studies to measure the incidence and prevalence of adult maltreatment have been undertaken in recent years. Including:
- National Research Council. (2003) *Elder Mistreatment: Abuse, Neglect and Exploitation in an Aging America.* Washington, D.C.: The National Academies Press;
- Lachs, Mark, et al. (2011); *Under the Radar: New York State Elder Abuse Prevalence Study Final Report.* Lifespan of Greater Rochester, Inc.: Weill Cornell Medical Center of Cornell University and New York City Department for the Aging.
- Acierno, R, Hernandez, M, et al. (2010) *Prevalence and Correlates of Emotional, Physical, Sexual, and Financial Abuse and Potential Neglect in the United States: The National Elder Mistreatment Study.* *Am J Public Health;* 100(2): 292–297.
- ¹⁰ Lachs, Mark, et al. (2011) *Under the Radar: New York State Elder Abuse Prevalence Study Final Report.* Lifespan of Greater Rochester, Inc.: Weill Cornell Medical Center of Cornell University and New York City Department for the Aging.
- ¹¹ National Research Council. (2003). *Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America.* Panel to Review Risk and Prevalence of Elder Abuse and Neglect. Richard J. Bonnie and Robert B. Wallace, Editors. Committee on National Statistics and Committee on Law and Justice, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press.
- ¹² Elder Justice Act of 2009, Title XX of the Social Security Act (42 U.S.C. 1397), §2011.
- ¹³ Lachs MS, Williams CS, O'Brien S, Pillemer KA, Charlson, ME. The Mortality of Elder Mistreatment. *Journal of the American Medical Association* 1998; 280:428-432.
- ¹⁴ Lachs, M., Williams, C.S., O'Brien, S., & Pillemer, K. (2002). Adult Protective Service use and nursing home placement. *The Gerontologist, 42(6), 734-739.*
- ¹⁵ Dong, X.Q., & Simon, M.A. (2013). Elder abuse as a risk factor for hospitalization in older persons. *JAMA Internal Medicine, 173(10), 911-917.*
- ¹⁶ Bitondo Dyer C, Pavlik VN, Murphy KP, Hyman DJ. The high prevalence of depression and dementia in elder abuse or neglect. *Journal of the American Geriatrics Society.* 2000; 48:205-208.
- ¹⁷ Burt M, Katz B. Rape, robbery, and burglary: responses to actual and feared criminal victimization, with special focus on women and the elderly. *Victimology: An International Journal.* 1985; 10:325-358.

-
- ¹⁸ Mouton CP, Espino DV. Problem-orientated diagnosis: health screening in older women. *American Family Physician*. 1999; 59:18-35.
- ¹⁹ Fisher BS, Regan SL. The extent and frequency of abuse in the lives of older women and their relationship with health outcomes. *The Gerontologist*, 2006; 46:200-209.
- ²⁰ Coker A, Davis K, Arias I, et al. Physical and mental health effects of intimate partner violence for men and women. *American Journal of Preventive Medicine*. 2002; 23:260-268.
- ²¹ Stein M, Barrett-Connor E. Sexual assault and physical health: findings from a population-based study of older adults. *Psychosomatic Medicine*. 2000; 62:838-843.
- ²² Comijs HC, Penninx BWJH, Knipscheer KPM, and van Tilburg W. Psychological distress in victims of elder mistreatment: the effects of social support and coping. *Journal of Gerontology*, 1999; 54B:240-245.
- ²³ Stein M, Barrett-Connor E. Sexual assault and physical health: findings from a population-based study of older adults. *Psychosomatic Medicine*. 2000; 62:838-843.
- ²⁴ Briere J, Runtz M. Symptomatology associated with childhood sexual victimization in a nonclinical adult sample. *Child Abuse & Neglect*, 1988, 12, 51-59. Courtois CA, Watts DC. Counseling adult women who experienced incest in childhood or adolescence. *The Personnel and Guidance Journal*, 1982, 60, 275-279.
- Browne A, Finkelhor D. Impact of child sexual abuse: A review of the research. *Psych Bull*, 1986, 99, 66-77.
- Cunningham J, Pearce T, Pearce P. Childhood sexual abuse and medical complaints in adult women. *Journal of Interpersonal Violence*, 1988, 3, 131-144.
- Faria G, Belohlavek N. Treating female adult survivors of childhood incest. *Social Casework*, 1984, 65, 465-471.
- Murphy PA. Taking an abuse history in the initial evaluation. *NARPPS*, 1992, 7, 187-190.
- Ratican KL. Sexual abuse survivors: Identifying symptoms and special treatment considerations. *J Counsel Dev*, 1992, 71, 33-38.
- ²⁵ Alexander, M. J., and Muenzenmaier, K. (1998). Trauma, addiction, and recovery: Addressing public health epidemics among women with severe mental illness. In B L. Levin, A. K. Blanch, and A. Jennings (Eds.), *Women's mental health services: A public health perspective* (pp. 215-239). Thousand Oaks, CA: Sage.
- Briere, J., et al. (1997). Lifetime victimization history, demographics, and clinical status in female psychiatric emergency room patients. *Journal of Nervous and Mental Disease* 185, 95-101
- Wile, J. (1997). Inpatient treatment of psychiatric women patients with trauma. In M. Harris and C. L. Landis (Eds.), *Sexual abuse in the lives of women diagnosed with serious mental illness* (pp. 109-36). Amsterdam, The Netherlands: Harwood Academic Publishers.
- ²⁶ Goodman, L. A., et al. (2001). Recent victimization in women and men with severe mental illness: Prevalence and correlates. *Journal of Traumatic Stress* 14, 615-32.
- ²⁷ MetLife Mature Market Institute (MMI). (2011). *The MetLife Study of Elder Financial Abuse: Crimes of Occasion, Desperation, and Predation Against America's Elders*. Report prepared for the MetLife Mature Market Institute by the National Committee for the Prevention of Elder Abuse and the Center for Gerontology at Virginia Polytechnic Institute and State University. Retrieved November 26, 2013 from: <https://www.metlife.com/mmi/research/elder-financial-abuse.html> .
- ²⁸ Stanton MW, Rutherford MK. (2005). The high concentration of U.S. health care expenditures. Rockville (MD): Agency for Healthcare Research and Quality. Research in Action Issue 19. AHRQ Pub. No. 06-0060. Retrieved from: <http://www.ahrq.gov/research/ria19/expendria.pdf> .
- ²⁹ Teaster PB, Dugar T, Mendiondo M, Abner EL, Cecil KA, Otto JM. The 2004 Survey of Adult Protective Services: Abuse Of Vulnerable Adults 18 Years Of Age And Older. National Center on Elder Abuse: Washington, DC. Retrieved May 8, 2015 from: http://www.ncea.aoa.gov/Resources/Publication/docs/APS_2004NCEASurvey.pdf
- ³⁰ Senator John Breaux: The Elder Justice Proposal of 2002
- ³¹ GAO, *Elder Justice: National Strategy Needed to Effectively Combat Elder Financial Exploitation*, GAO-13-110 (Washington, D.C.: November 15, 2012).
- ³² Senator John Breaux: The Elder Justice Proposal of 2002
- ³³ Circular No. A-119, Revised, dated January 27, 2016.
- ³⁴ Timmermans, S and Epstein, S (2010). A World of Standards but not a Standard World: Toward a Sociology of Standards and Standardization. *Annu. Rev. Sociol.* 2010, 36-69-89.
- ³⁵ The databases were Applied Social Sciences Index and Abstracts (ASSIA), ERIC, National Criminal Justice Reference Service (NCJRS) Abstracts Database, PILOTS: Published International Literature on Traumatic Stress, Social Services Abstracts, Sociological Abstracts, EBSCOhost Academic Search Complete, EBSCOhost

MEDLINE Complete, Google Scholar, Sage Publications Database, Dissertations Abstracts, Lexis-Nexis U.S. Law Reviews and Journals.

- ³⁶Carter, Y. H., Bannon, M. J., Limbert, C., Docherty, A., & Barlow, J. (2006). Improving child protection: A systematic review of training and procedural interventions. *Archives of Disease in Childhood*, 91(9), 740-743.
- Connell-Carrick, K., & Scannapieco, M. (2008). Adult Protective Services: State of the workforce and worker development. *Gerontology & Geriatrics Education*, 29(2), 189-206.
- 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.
- Jogerst, G. J., J. M. Daly, et al. (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). Evaluation of an in-service training program for child welfare practitioners. *Research on Social Work Practice*, 19(1), 31-41.
- ³⁷Jogerst, G. J., J. M. Daly, et al. (2004). APS investigative systems associated with county reported domestic elder abuse. *Journal of Elder Abuse & Neglect* 16(3): 1-17.
- ³⁸Kelly, M. J., & Sundet, P. (2007). Using 360 degree evaluation to improve clinical skill development by first line Child Protective Services supervisors. *Journal of Evidence-Based Social Work*, 4(3-4), 145-161.
- ³⁹Cross, T. P., Finkelhor, D., & Ormrod, R. (2005). Police involvement in Child Protective Services investigations: Literature review and secondary data analysis. *Child Maltreatment*, 10(3), 224-244.
- 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.
- Wiglesworth, A., Mosqueda, L., Burnight, K., Younglove, T., & Jeske, D. (2006). Findings from an elder abuse forensic center. *The Gerontologist*, 46(2), 277-283.
- ⁴⁰Carter, Y. H., Bannon, M. J., Limbert, C., Docherty, A., & Barlow, J. (2006). Improving child protection: A systematic review of training and procedural interventions. *Archives of Disease in Childhood*, 91(9), 740-743.
- ⁴¹Estes, C. L., Lohrer, S. P., Goldberg, S., Grossman, B. R., Nelson, M., Koren, M. J., & Hollister, B. (2010). Factors associated with perceived effectiveness of local long-term care ombudsman programs in New York and California. *Journal of Aging and Health*, 22(6), 772-803.
- Hollister, B. A., & Estes, C. L. (2013). Local long-term care ombudsman program effectiveness and the measurement of program resources. *Journal of Applied Gerontology*, 32(6), 708-728.
- ⁴²National Adult Protective Services Association and the National Association of State Units on Aging. (2012). *Adult Protective Services in 2012: Increasingly Vulnerable*. Retrieved May 8, 2015 from http://www.nasuad.org/sites/nasuad/files/hcbs/files/218/10851/NASUAD_APS_Report.pdf
- ⁴³National Adult Protective Services Association (2013). *Adult Protective Services Recommended Minimum Program Standards*, developed by the NAPSA Education Committee (September, 2013), and adopted by the NAPSA Board of Directors (October, 2013).
- ⁴⁴Comparison of Federal Involvement in Child Welfare and Adult Protective Services Systems (internal ACL document, undated)
- ⁴⁵CAPTA Reauthorization Act of 2010
- ⁴⁶Exceptions to mandatory reporting laws exist. For example, Long-term Care Ombudsman personnel may not divulge information about maltreatment that was disclosed to them by a resident without the resident's permission. State laws may also contain exceptions for certain professional groups (e.g., clergy, attorneys).
- ⁴⁷See: <https://www.childwelfare.gov/responding/iia/screening/>
- ⁴⁸U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, et al. (2003). National Study of Child Protective Services Systems and Reform Efforts: Review of State CPS Policy. This report is available on the Internet at: <http://aspe.hhs.gov/hsp/cps-status03/state-policy03/>
- ⁴⁹Child and Family Services Improvement and Innovation Act
- ⁵⁰Jogerst, G. J., J. M. Daly, et al. (2004). APS investigative systems associated with county reported domestic elder abuse. *Journal of Elder Abuse & Neglect* 16(3): 1-17.
- ⁵¹Daly, 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.
- ⁵²The program has a broad interdisciplinary focus, and fellows come from both academic and practice settings with a wide-range of career experiences. The Health and Aging Policy Fellows Program began in 2008, and is

-
- supported by The Atlantic Philanthropies and the John A. Hartford Foundation. For more information about the Health and Aging Policy Fellows, please visit the [website of the Health and Aging Policy Fellows Program](#).
- ⁵³ National Association of Social Work Code of Ethics retrieved from <http://www.socialworkers.org/pubs/code/code.asp> on June 24, 2015.
- ⁵⁴ National Adult Protective Services Code of Ethics retrieved from <http://www.napsa-now.org/about-napsa/code-of-ethics/> on June 24, 2015.
- ⁵⁵ Trauma-informed approach, retrieved from <http://www.samhsa.gov/nctic/trauma-interventions>.
- ⁵⁶ Dinerstein, Robert, 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, 19 Human Rights Brief 8, 10 (Winter 2012).
- ⁵⁷ 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
- ⁵⁸ See: <https://www.childwelfare.gov/responding/mandated.cfm>
- ⁵⁹ Adoption Assistance and Child Welfare Act of 1980; Child and Family Services Improvement and Innovation Act; Adoption and Safe Families Act of 1997
- ⁶⁰ National Adult Protective Services Association (2013). *Adult Protective Services Recommended Minimum Program Standards*, developed by the NAPSAs Education Committee (September, 2013), and adopted by the NAPSAs Board of Directors (October, 2013).
- ⁶¹ 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.
- ⁶² Wiglesworth, A., Mosqueda, L., Burnight, K., Younglove, T., & Jeske, D. (2006). Findings from an elder abuse forensic center. *The Gerontologist*, 46(2), 277-283.
- ⁶³ National Association of Social Workers. Retrieved from <https://www.socialworkers.org/pubs/code/code.asp>
- ⁶⁴ Cyphers, G. (2001). *Report from the child welfare workforce survey: State and county data and findings*. Washington, DC: American Public Human Services Association.
- ⁶⁵ Zlotnick, J, et al. (2005) Improving Retention in Public Child Welfare Agencies. Systematic Reviews: Child Welfare Workforce Series. IASWR Research Brief 2. University of Maryland, Baltimore, School of Social Work.
- ⁶⁶ Jogerst, G. J., J. M. Daly, et al. (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). Evaluation of an in-service training program for child welfare practitioners. *Research on Social Work Practice*, 19(1), 31-41.
- ⁶⁷ Office on Child Abuse and Neglect, Administration for Children and Families. 2003. *Child Protective Services: A Guide for Caseworkers*. Washington, DC: National Clearinghouse on Child Abuse and Neglect Information. Retrieved from: <https://www.childwelfare.gov/pubs/usermanuals/cps/cps.pdf> .
- ⁶⁸ Adoption Assistance and Child Welfare Act of 1980; Child and Family Services Improvement and Innovation Act; Adoption and Safe Families Act of 1997
- ⁶⁹ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, et al. (2003). National Study of Child Protective Services Systems and Reform Efforts: Review of State CPS Policy. This report is available on the Internet at: <http://aspe.hhs.gov/hsp/cps-status03/state-policy03/>
- ⁷⁰ National Adult Protective Services Association (2013). *Adult Protective Services Recommended Minimum Program Standards*, developed by the NAPSAs Education Committee (September, 2013), and adopted by the NAPSAs Board of Directors (October, 2013).
- ⁷¹ See: <https://www.childwelfare.gov/responding/iaa/screening/>
- ⁷² See: <https://www.childwelfare.gov/responding/iaa/screening/>
- ⁷³ Ramsey-Klawnsnik, H, Teaster, P. (2012) Sexual Abuse Happens in Healthcare Facilities—What Can Be Done To Prevent It? *Generations*, Number 3/Fall 2012, pp. 53-59(7), American Society on Aging
- ⁷⁴ National Adult Protective Services Association (2013). *Adult Protective Services Recommended Minimum Program Standards*, developed by the NAPSAs Education Committee (September, 2013), and adopted by the NAPSAs Board of Directors (October, 2013).
- ⁷⁵ 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> on June 25, 2015.

-
- ⁷⁶ National Adult Protective Services Association (2013). *Adult Protective Services Recommended Minimum Program Standards*, developed by the NAPSA Education Committee (September, 2013), and adopted by the NAPSA Board of Directors (October, 2013).
- ⁷⁷ National Adult Protective Services Association (2013). *Adult Protective Services Recommended Minimum Program Standards*, developed by the NAPSA Education Committee (September, 2013), and adopted by the NAPSA Board of Directors (October, 2013).
- ⁷⁸ National Adult Protective Services Association (2013). *Adult Protective Services Recommended Minimum Program Standards*, developed by the NAPSA Education Committee (September, 2013), and adopted by the NAPSA Board of Directors (October, 2013).
- ⁷⁹ National Adult Protective Services Association (2013). *Adult Protective Services Recommended Minimum Program Standards*, developed by the NAPSA Education Committee (September, 2013), and adopted by the NAPSA Board of Directors (October, 2013).
- ⁸⁰ National Adult Protective Services Association (2013). *Adult Protective Services Recommended Minimum Program Standards*, developed by the NAPSA Education Committee (September, 2013), and adopted by the NAPSA Board of Directors (October, 2013).
- ⁸¹ Kohn, N, Blumenthal, J and Campbell, A (2013). Penn State Law Review. Vol. 117:4.
- ⁸² National Adult Protective Services Association (2013). *Adult Protective Services Recommended Minimum Program Standards*, developed by the NAPSA Education Committee (September, 2013), and adopted by the NAPSA Board of Directors (October, 2013).
- ⁸³ Office on Child Abuse and Neglect, Administration for Children and Families. 2003. Child Protective Services: A Guide for Caseworkers. Washington, DC: National Clearinghouse on Child Abuse and Neglect Information. Retrieved from: <https://www.childwelfare.gov/pubs/usermanuals/cps/cps.pdf> .
- ⁸⁴ Jogerst, G. J., J. M. Daly, et al. (2004). APS investigative systems associated with county reported domestic elder abuse. *Journal of Elder Abuse & Neglect* 16(3): 1-17.
- ⁸⁵ 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.
- ⁸⁶ CAPTA Reauthorization Act of 2010
- ⁸⁷ Office on Child Abuse and Neglect, Administration for Children and Families. 2003. Child Protective Services: A Guide for Caseworkers. Washington, DC: National Clearinghouse on Child Abuse and Neglect Information. Retrieved from: <https://www.childwelfare.gov/pubs/usermanuals/cps/cps.pdf> .
- ⁸⁸ Connell-Carrick, K., & Scannapieco, M. (2008). Adult Protective Services: State of the workforce and worker development. *Gerontology & Geriatrics Education*, 29(2), 189-206.
- Jogerst, G. J., J. M. Daly, et al. (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). Evaluation of an in-service training program for child welfare practitioners. *Research on Social Work Practice*, 19(1), 31-41.
- ⁸⁹ Zlotnick, J, et al. (2005) Improving Retention in Public Child Welfare Agencies. Systematic Reviews: Child Welfare Workforce Series. IASWR Research Brief 2. University of Maryland, Baltimore, School of Social Work.
- ⁹⁰ The Social Security Act, Title IV-E
- ⁹¹ 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
- ⁹² Office on Child Abuse and Neglect, Administration for Children and Families. 2003. Child Protective Services: A Guide for Caseworkers. Washington, DC: National Clearinghouse on Child Abuse and Neglect Information. Retrieved from: <https://www.childwelfare.gov/pubs/usermanuals/cps/cps.pdf> .
- ⁹³ Adoption and Safe Families Act of 1997
- ⁹⁴ Child and Family Services Improvement and Innovation Act
- ⁹⁵ National Adult Protective Services Association and the National Association of State Units on Aging. (2012). *Adult Protective Services in 2012: Increasingly Vulnerable*. Retrieved May 8, 2015 from http://www.nasuad.org/sites/nasuad/files/hcbs/files/218/10851/NASUAD_APS_Report.pdf
- ⁹⁶ National Adult Protective Services Association and the National Association of State Units on Aging. (2012). *Adult Protective Services in 2012: Increasingly Vulnerable*. Retrieved May 8, 2015 from http://www.nasuad.org/sites/nasuad/files/hcbs/files/218/10851/NASUAD_APS_Report.pdf

-
- ⁹⁷ Developing a National Strategy to Respond to Abuse, Neglect, and Exploitation of Older Adults and Adults with Disabilities. Task: Research Review on APS Administrative System Practices (undated).
- ⁹⁸ National Adult Protective Services Association and the National Association of State Units on Aging. (2012). Adult Protective Services in 2012: Increasingly Vulnerable. Retrieved May 8, 2015 from http://www.nasuad.org/sites/nasuad/files/hcbs/files/218/10851/NASUAD_APS_Report.pdf
- ⁹⁹ However, the tools that are described in this section are not generally risk assessment tools, but tools to assess cognitive capacity.
- ¹⁰⁰ Discussion of [GAO] Report on Increased Federal Efforts Needed To Better Identify, Treat, and Prevent Child Abuse and Neglect. December 1980. Retrieved from: <http://archive.gao.gov/f0202/113892.pdf>
- ¹⁰¹ Foster Care Independence Act of 1999; Child Abuse Prevention, Adoption, and Family Services Act of 1988; Child Abuse Amendments of 1984
- ¹⁰² CAPTA Reauthorization Act of 2010
- ¹⁰³ Child and Family Services Improvement and Innovation Act
- ¹⁰⁴ CAPTA Reauthorization Act of 2010
- ¹⁰⁵ Adoption Promotion Act of 2003
- ¹⁰⁶ Office on Child Abuse and Neglect, Administration for Children and Families. 2003. Child Protective Services: A Guide for Caseworkers. Washington, DC: National Clearinghouse on Child Abuse and Neglect Information. Retrieved from: <https://www.childwelfare.gov/pubs/usermanuals/cps/cps.pdf> .
- ¹⁰⁷ Child Abuse, Domestic Violence, Adoption, and Family Services Act of 1992
- ¹⁰⁸ 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
- ¹⁰⁹ CAPTA Reauthorization Act of 2010
- ¹¹⁰ Office on Child Abuse and Neglect, Administration for Children and Families. 2003. Child Protective Services: A Guide for Caseworkers. Washington, DC: National Clearinghouse on Child Abuse and Neglect Information. Retrieved from: <https://www.childwelfare.gov/pubs/usermanuals/cps/cps.pdf> .
- ¹¹¹ Child and Family Services Improvement and Innovation Act
- ¹¹² 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
- ¹¹³ Child Abuse Amendments of 1984
- ¹¹⁴ Office on Child Abuse and Neglect, Administration for Children and Families. 2003. Child Protective Services: A Guide for Caseworkers. Washington, DC: National Clearinghouse on Child Abuse and Neglect Information. Retrieved from: <https://www.childwelfare.gov/pubs/usermanuals/cps/cps.pdf> .
- ¹¹⁵ CAPTA Reauthorization Act of 2010
- ¹¹⁶ See: https://www.childwelfare.gov/management/workforce/retention/studies_reports.cfm
- ¹¹⁷ Child and Family Services Improvement and Innovation Act
- ¹¹⁸ Child and Family Services Improvement Act of 2006
- ¹¹⁹ Safe and Timely Interstate Placement of Foster Children Act of 2006
- ¹²⁰ CAPTA Reauthorization Act of 2010
- ¹²¹ Office on Child Abuse and Neglect, Administration for Children and Families. 2003. Child Protective Services: A Guide for Caseworkers. Washington, DC: National Clearinghouse on Child Abuse and Neglect Information. Retrieved from: <https://www.childwelfare.gov/pubs/usermanuals/cps/cps.pdf> .
- ¹²² Adoption Assistance and Child Welfare Act of 1980; Child and Family Services Improvement and Innovation Act; Adoption and Safe Families Act of 1997
- ¹²³ Office on Child Abuse and Neglect, Administration for Children and Families. 2003. Child Protective Services: A Guide for Caseworkers. Washington, DC: National Clearinghouse on Child Abuse and Neglect Information. Retrieved from: <https://www.childwelfare.gov/pubs/usermanuals/cps/cps.pdf> .
- ¹²⁴ CAPTA Reauthorization Act of 2010
- ¹²⁵ Keeping Children and Families Safe Act of 2003
- ¹²⁶ See: <https://www.childwelfare.gov/responding/mandated.cfm>
- ¹²⁷ CAPTA Reauthorization Act of 2010
- ¹²⁸ See: <https://www.childwelfare.gov/responding/ia/screening/>
- ¹²⁹ Family Preservation and Support Services Program Act of 1993; Adoption Assistance and Child Welfare Act of 1980; Child Abuse Prevention and Treatment Act (CAPTA) of 1996, 1974; Child and Family Services

Improvement and Innovation Act; Safe and Timely Interstate Placement of Foster Children Act of 2006; Promoting Safe and Stable Families Amendments of 2001

¹³⁰ Family Preservation and Support Services Program Act of 1993; CAPTA Reauthorization Act of 2010; Deficit Reduction Act of 2005

¹³¹ The Interethnic Provisions of 1996

¹³² Child and Family Services Improvement and Innovation Act

¹³³ Adoption and Safe Families Act of 1997

¹³⁴ See: <https://www.childwelfare.gov/pubs/umnew.cfm>

¹³⁵ Child and Family Services Improvement and Innovation Act; Fostering Connections to Success and Increasing Adoptions Act of 2008; Child and Family Services Improvement Act of 2006; Safe and Timely Interstate Placement of Foster Children Act of 2006; Deficit Reduction Act of 2005; Promoting Safe and Stable Families Amendments of 2001; Family Preservation and Support Services Program Act of 1993; Adoption Assistance and Child Welfare Act of 1980

¹³⁶ See: <https://www.childwelfare.gov/systemwide/courts/reform/>