National Voluntary Consensus Guidelines for State Adult Protective Services Systems

Updated | March 2020

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Preface

The Administration for Community Living (ACL) is providing these 2020 Voluntary Consensus Guidelines for State Adult Protective Services Systems (Guidelines) 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. The Guidelines also provide a core set of principles and common expectations to encourage consistency in the policies and practices of APS programs across the country. To develop the Guidelines, ACL served as facilitator and applied the Office of Management and Budget (2016) and National Institute of Standards and Technology (2001) process for creating field-developed, consensus-driven guidelines. To eliminate unnecessary duplication and complexity in the development and promulgation of the Guidelines, ACL's process remains consistent with the guidance provided by the National Institutes of Standards and Technology 15 CFR Part 287 (2020).

These Guidelines are informational in content and are intended to assist states in developing efficient and effective APS systems. They do not constitute a standard nor a regulation, and they do not create any new legal obligations nor impose any mandates or requirements. They also do not create nor confer any rights for, or on, any person.

Abbreviations and Acronyms

ACL	Administration for Community Living
APS	Adult Protective Services
CAPTA	Child Abuse Prevention and Treatment Act
CFR	Code of Federal Regulations
CPS	Child Protective Services
MDT	Multidisciplinary Team
NAMRS	National Adult Maltreatment Reporting System
NAPSA	National Adult Protective Services Association
NASUAD	National Association of States United for Aging and Disabilities
NASW	National Association of Social Workers

Rationale

The Administration for Community Living (ACL)[1] 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.

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 governments across the nation 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.

APS programs are not subject to federal rules and regulations. As a result, each state has designed its own unique system. In addition, there is no single funding stream for APS, forcing states to look to multiple sources for funding and often leaving states with inadequate resources for their APS programs. Yet data from state APS agencies show an increasing trend in reports of maltreatment and increasing caseloads for APS workers (AARP Public Policy Institute, 2011; Teaster et al., 2006). These challenges can present significant obstacles to responding in an effective and timely way to reports of adult maltreatment.

To support APS programs, it is more important than ever to demonstrate the effectiveness of APS programs and practices in improving client outcomes and provide states with tools to support effective and timely responses to adult maltreatment. To address this need, ACL facilitated the development of the National Voluntary Consensus Guidelines for State APS Systems in 2016 (original Guidelines) and the update of the Guidelines to provide the APS field with guidance about effective APS practices. The updates for these 2020 Guidelines are based on new published research and input from APS stakeholders and subject matter experts. For a glossary of terms used throughout the Guidelines, see Appendix 1; for an annotated bibliography of the research literature, see Appendix 2; and for feedback from stakeholders and experts upon which the update is based, see Appendix 3.

Background

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. Adult maltreatment violates these inherent rights.[2]

Data suggest that at least 10% of older adults experience maltreatment each year (Beach, Schulz, Castle, & Rosen, 2010). However, the prevalence of elder maltreatment (also referred to as "mistreatment") is likely underreported. For instance, a large study conducted in New York State found that the incidence rate of elder abuse was nearly 24 times greater than the actual number of cases referred or reported to authorities (Lifespan of Greater Rochester, 2011). Findings from a literature review conducted by Horner-Johnson and Drum (2006) showed increased prevalence of maltreatment among adults with disabilities, and Petersilia (2001) found that adults with developmental disabilities are 4 to 10 times more likely to become victims of maltreatment than persons without disabilities. Among adults with disabilities who use personal assistance services, 30% report one or more types of mistreatment (National Center on Elder Abuse, n.d.).

Adult maltreatment, including abuse (i.e., physical, sexual, emotional), neglect, self-neglect, and financial exploitation, is associated with significant and serious health consequences. For instance, older adults who experience even modest forms of maltreatment have dramatically higher (300%) morbidity and mortality rates (Lachs, Williams, O'Brien, Pillemer, & Charlson, 1998) and higher rates of emergency department use, hospitalization, readmission, skilled nursing placement, and hospice use compared to those who have not experienced maltreatment (Dong, 2015). For adults with a disability, maltreatment impacts the person's health, safety, and emotional well-being, but also greatly impacts their ability to engage in activities of daily living (National Center on Elder Abuse, n.d.).

According to the Elder Justice Roadmap (2014), it is clear that

> Adult maltreatment triggers a downward spiral for many victims, eroding their health, financial stability, and well-being. In addition, it causes untold suffering for millions of people of all ages. That suffering, in turn, needlessly depletes scarce resources of individuals, families, businesses, charities, and public programs (like Medicare and Medicaid). The cumulative toll of [adult maltreatment] has not yet been quantified but is estimated to afflict more than 5 million people and cost many billions of dollars a year.

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.

The Guidelines present a critical building block in this effort by helping to provide states with tools to support the implementation of effective and evidence-based strategies and practices for adult protective services (APS) programs. Specifically, it is ACL's mission with these Guidelines to

- provide a core set of principles and common expectations to encourage consistency;
- help ensure that adults are afforded similar protections and service delivery regardless of locale;
- support interdisciplinary and interagency coordination; and
- enhance effective, efficient, and culturally competent delivery.

Development and Updates of the Guidelines and Content

Development of the Guidelines and Updates

ACL first facilitated the development of the Guidelines in 2016. As part of the development, ACL applied the Office of Management and Budget (2016) and National Institute of Standards and Technology (2001) process for creating field-developed, consensus-driven guidelines. To eliminate unnecessary duplication and complexity in the development and promulgation of the Guidelines, ACL's process remains consistent with the guidance provided by the National Institutes of Standards and Technology 15 CFR Part 287 (2020). The development of both the Guidelines and its updates consisted of multiple steps, including a review of research available on what works in APS agencies and in other analogous systems throughout the United States, and an extensive and wide-reaching stakeholder engagement and outreach process.

The goal of the stakeholder engagement and outreach process 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.

For a detailed description of the development of the 2016 ACL APS Guidelines, see the **2016 ACL APS Guidelines**. For a detailed report on the methods for updating the Guidelines, see Appendix 3.

Updating the Original Guidelines

ACL used a similar multistep approach to update the original Guidelines, with each step building on the work from the previous step. These steps included: an updated literature review to identify new research evidence; draft revisions and additions to the Guidelines based on new evidence; a stakeholder engagement process to obtain feedback for the proposed updates; a comprehensive data analysis of the feedback received from stakeholders; and, finally, convening of a technical expert panel to refine and build consensus for the updates based on the proposed new research and feedback from stakeholders. For a detailed report on the method for the updates and feedback from stakeholders and the technical expert panel, see Appendix 3.

Content and Structure

ACL drew intentionally from published research to help the Guidelines reflect the most recent evidence and best practices. ACL did not draw from current state laws or regulation to avoid limiting the Guidelines to practices currently in use. References to the child welfare system or child protective services are also included in the Guidelines to illustrate federal guidance for other analogous social services systems. These references are not intended to serve as guidance to the APS system, but rather, they serve as justification for providing federal-level guidance for APS programs, and they provide stakeholders with direct access to examples from child welfare system or child protective services for topics similar to those in APS (e.g., response times).

The 2020 and 2016 Guidelines have an identical overall structure, with the content organized by seven broad domains (or topics) and a number of specific elements (or subtopics) within each domain. For each element, the Guidelines contain a background section followed by the actual guidance statements. The background and guidance are informed by the research identified through the literature search. For an annotated bibliography of the literature, see Appendix 2.

The following section presents a list of domains and elements within each domain.

List of Guidelines Domains and Elements[3]

1. **Program Administration**
    - 1A. Ethical Foundation of APS Practice
    - 1B. Protecting Program Integrity
    - 1C. Definitions of Maltreatment
    - 1D. Population Served
    - 1E. Mandatory Reporters
    - 1F. Coordination With Other Entities
    - 1G. Program Authority, Cooperation, Confidentiality, and Immunity
    - 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/Initiating the Investigation
    - 2B. Completing the Investigation
    - 2C. Closing the Case

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Guidelines Domains and Elements continued

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 Psychosocial Assessment
   - 4C. Investigations in Residential Care Facilities
   - 4D. Completion of Investigation and Finding
5. **Service Planning and Service Implementation**
   - 5A. Voluntary Service Implementation
   - 5B. Involuntary Service Implementation
   - 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. **APS Program Performance**
   - 7A. Managing Program Data
   - 7B. Evaluating Program Performance

The next section contains the updated 2020 APS Guidelines.

1 | Program Administration

1A

1A. Ethical Foundation of APS Practice

Background

A code of ethics provides a conceptual framework and practical guidance that workers can use when they are challenged by conflicting ethical duties and obligations. Most professions have developed their own codes of ethics, including social work (National Association of Social Workers, 2015) and adult protective services (APS; National Adult Protective Services Association [NAPSA], n.d.). 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 considers 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.

- **Supported decision-making**
  Supported decision-making is a series of relationships, practices, arrangements, and agreements, of more or less formality and intensity, designed to assist an individual with a disability to make, and communicate to others, decisions about the individual's life (Dinerstein, 2012).

Guideline

It is recommended that APS systems establish and adopt a set of ethical principles and codify these in their policies and program manuals. It is recommended that APS systems require all employees to sign a code of ethics that includes, at a minimum, those key concepts described above (i.e., least restrictive alternative, person-centered service, 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 preservice training and ongoing staff education. Finally, it is recommended that the code of ethics be reviewed with all staff on an annual basis.

1B. Protecting Program Integrity

Background

Policies related to program integrity build on the APS commitment to ethical practice (see 1A. Ethical Foundation of APS Practice) and 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. APS program policies and standards should be transparent and available to the public. 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 of interest 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" (NASW, n.d.). In instances when dual relationships are unavoidable, APS workers should make the client's protection their priority. The worker, not the client, is responsible for setting clear, appropriate, and culturally sensitive boundaries.

- **Receiving and handling complaints**
  APS programs should have a process for addressing complaints made about case findings or actions of APS employees.

- **Screening APS personnel**
  APS programs should have a process for screening potential APS employees for suitability.

- **Consistency of practice**
  APS programs should establish policy and standards regarding the process for handling a case from the point of intake through case closure. This should include APS workers as well as those with supervisory responsibilities (e.g., receiving, screening, and prioritizing maltreatment reports; identifying investigation procedures to be implemented; determining the validity of reports; defining findings; providing services to maltreated adults; and providing casework supervision) with the goal of consistent casework practice within the program.

- **Providing information on the APS program and process:**
  At the time of the initial investigation, APS programs should provide an explanation of the APS program and its goals,

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1B continued

in terms that are reasonably understandable, to those involved in the case.

- **Providing information on rights of alleged victims**
  At the time of the initiation of the investigation, APS programs should provide to alleged victims an explanation of their rights under state law. It is recommended that the explanation include information about their rights to:
  - Have confidentiality and privacy, explaining relevant exceptions;
  - Participate in the development of their service or treatment plan;
  - Refuse services and the possible consequence; and
  - Be informed of and to appeal a finding by the APS program.

- **Providing information on rights of perpetrators**
  When an APS program has made a finding that adult maltreatment has occurred, and if that maltreatment involves a perpetrator, APS should provide an explanation to the alleged perpetrator of any rights under state law that apply. It is recommended that the explanation include information about:
  - Their right to be informed of and to appeal a finding by the APS program;
  - Their placement on a registry for perpetrators, if a registry exists in that state.

1C. Definitions of Maltreatment

1C

Background

The APS Survey (NAPSA & National Association of States United for Aging and Disabilities [NASUAD], 2012) reveals that the vast majority of APS systems respond to reports of physical, emotional, and sexual abuse; financial exploitation; neglect; and self-neglect. Recent data (2017)[4] from the National Adult Maltreatment Reporting System (NAMRS) shows all states investigate or assess neglect,[5] 96.3% of states investigate or assess physical abuse,[6] 92.6% investigate or assess self-neglect,[7] 90.7% investigate or assess sexual abuse,[8] 83.3% investigate or assess financial exploitation,[9] and 75.9% investigate or assess emotional abuse.[10] In addition, states also reported investigating or assessing nonspecific exploitation[11] (50%), abandonment (42.6%), other exploitation[12] (40.7%), other type[13] (35.2%), and suspicious death[14] (16.7%; Aurelien et al., 2018a). It should be noted that definitions of adult maltreatment vary from state to state.

The child welfare system, including child protective services (CPS), specifies a minimum federal definition of what constitutes child abuse and who is eligible for services under various child welfare provisions (Children's Bureau, n.d.-a).[15]

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.

1D. Population Served

1D

Background

The APS Survey (NAPSA & NASUAD, 2012) 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 to maltreatment 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.

1E

1E. Mandatory Reporters

Background

According to the APS Survey, 49 states currently have mandatory reporting statutes (NAPSA & NASUAD, 2012). Some states require all citizens to report suspected adult maltreatment. Most identify professionals required by law to report. The federal system provides guidance and examples on establishing mandated reporting, as well as the role of various professions as mandated reporters (Children's Bureau, n.d.-b). In addition, states are required to identify in a state plan laws identifying categories of mandated reporters (Children's Bureau, n.d.-c).[15]

Researchers in one study found that reports made by mandated reporters to APS were more likely to be substantiated and less likely to result in service refusal than reports made by nonmandated reporters (Lees, 2018).

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, paraprofessionals, and volunteers be mandated to report. It is recommended that states mandate reporting from groups, including, but not limited to,

- county, state, and federal law enforcement
- first responders;
- medical, behavioral health services, and social service providers;
- educational organizations;
- disability organizations;
- victim service providers;
- long-term care providers, including home health providers;
- financial services providers;
- aging services providers; and
- anyone engaged in the care of or providing services to a vulnerable adult.

Clear guidelines and mechanisms for taking reports from both mandatory and nonmandatory reporters should be established. Exemptions to mandatory reporting requirements should be consistent with professional licensing requirements and state and federal laws. For example, representatives of the office of the state long-term care ombudsman are exempt from mandatory reporting under the Code of Federal Regulations (CFR), per 45 CFR 1324.19(b)(3)(iii).

It is further recommended that mandated reporters be immune from civil and criminal 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 to law enforcement suspected crimes related to adult maltreatment.

1F. 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 (NAPSA, 2013).

Formal multidisciplinary teams (MDTs) that convene in order to review complex maltreatment cases have been shown to increase effectiveness, satisfaction of workers, and rates of prosecution, and be associated with a reduction in future mistreatment risk (Navarro, Gassoumis, & Wilber, 2013; Rizzo, Burnes, & Chalfy,

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Guideline

To improve communities' responses to adult maltreatment, it is recommended that APS systems create policies and protocols, including the development of memoranda of understanding, (including contracts and other types of agreements), cross-training, and colocation of staffs (when permitted) to promote their collaboration with other entities, as needed, during investigations and service implementation to benefit clients. It is recommended that APS collaborate with organizations or agencies, including, but not limited to,

- county, state, and federal law enforcement;
- state offices that handle scams and frauds;
- medical providers;
- social service providers;
- disability service organizations (including the state office responsible for disability issues);
- alcohol and drug abuse service providers;
- domestic violence, sexual assault, and victim services providers;
- financial services providers;
- legal service providers;
- aging services providers (including the state offices responsible for older adult issues);
- dementia service providers;
- long-term care ombudsman;
- licensing and certification agencies;
- animal welfare organizations; and
- 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.

2015; Wiglesworth, Mosqueda, Burnight, Younglove, & Jeske, 2006). Findings from Rizzo et al. (2015) showed a significant reduction in future mistreatment risk for clients who received services through an MDT model consisting of social workers and lawyers under the same roof (co-located), compared to clients receiving social work services only. Additional research has shown that another MDT model—the elder abuse forensic center model—is an effective approach for determining whether cases should be referred to a public guardian or whether guardianship should be established, to ultimately ensure the safety of clients who require the highest level of protection (Gassoumis, Navarro, & Wilber, 2015).

Research focusing on coordination with other entities, including mental health and substance use services, have also shown positive outcomes, including increased willingness of clients to accept treatment (Sirey et al., 2015; He & Phillips, 2017; Susman, Lees, & Fulmer, 2015).

The APS Survey revealed that most APS systems participate in some kind of MDT (NAPSA & NASUAD, 2012). About 50% of the states that do so have formal agreements to facilitate interagency cooperation.

1G. 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 (NAPSA & NASUAD, 2012).

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 alleged 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**
  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 APS client.

- **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:
  - other APS and/or law enforcement programs outside of the jurisdiction in which the report was made; and
  - non-APS members of MDTs 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:
  - whether APS has or has not opened an investigation as a result of the report;
  - that APS has not opened an investigation as a result of the report; and
  - 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.

1H

1H. Staffing Resources

Background

The APS Survey indicates that APS worker caseloads vary from 0 to 25 per worker (13 states) to 100+ per worker (four states; NAPSA & NASUAD, 2012). 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.[15] For example, in a nationwide survey, state child welfare system administrators identified reducing caseloads, workloads, and supervisory ratios as the most important action for child welfare agencies to take to retain qualified frontline staff (Cyphers, 2001). Research in child welfare also points to supportive supervision as a critical factor in reducing turnover (Zlotnick, DePanfilis, Daining, & Lane, 2005).

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

Guideline

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

- **Ratio of supervisor to direct APS service personnel.**
  There should be a limit on the number of APS workers assigned to each supervisor in order to ensure consistency in casework, quality assurance, and sufficient worker support. Failure to implement a limit on the number of APS workers assigned to each supervisor may result in serious risks to clients' safety and worker safety and well-being, limit supervisors' ability to provide professional development, and limit the utilization of best practices.

APS programs should develop a target and/or cap for the number of APS workers per supervisor. In developing a worker to supervisor ratio, consideration should be given to:

- the important role of the supervisor in

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reviewing and approving cases during critical supervisory junctures;
- the amount of time needed to supervise complex cases;
- the role of the supervisor as trainer, especially of new APS workers;
- the role of the supervisor as mentor and advisor;
- the role of the supervisor in representing the APS system at community engagement outreach; and
- the role of the supervisor on multidisciplinary teams.

Further, programs should consider the challenge to supervisors of simultaneously supervising workers from different programs (e.g., APS, CPS, in-home support services, aging services). Finally, it is recommended that there be a limit on the number of workers supervised by each supervisor.

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

Furthermore, research shows that when APS 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, cases that require guardianship, and self-neglect cases take significant time and expertise).

1I

1I. Access to Expert Resources

Background

Often it is helpful or necessary to consult with content or clinical experts when handling APS cases. Nearly every state APS system reported in the APS Survey that they had some access to legal consultation. Over half of the states surveyed reported that they have access to physicians, while over 60% indicated that they had access to mental health professionals as well as nurses and physician assistants. The APS Survey also noted that, while financial exploitation is one of the top areas in APS, access to forensic specialists and accountants were not available in over 60% of the states. Several states, but not all, indicated that they could consult with law enforcement, faith-based groups, the attorney general's office, and domestic violence agencies (NAPSA & NASUAD, 2012).

Recently, technology has been used to address the scarcity of expert resources for APS client assessments (Burnett, Dyer, Clark, & Halphen, 2018). Researchers in Texas created a Forensic Assessment Center Network that uses a Web-based portal and low-cost videophone technology to connect an APS agency and its clients to a centralized geriatric and elder mistreatment expert medical team for virtual in-home assessments.

Researchers in child welfare (Brink, Thackeray, Bridge, Letson, & Scribano, 2015) studied the differences in child welfare case determinations between cases that went to a multidisciplinary team and cases that went to CPS.[15] The authors suggest that the results highlight the importance of the forensic interview in CPS decisions of child sexual abuse, and the potential role for child advocacy centers in providing trained professionals to conduct a high-quality interview during the initial assessment. The findings may also support the use of forensic interviewing in APS cases.

Guideline

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

- civil and criminal law;
- medicine;
- forensic science, forensic interview specialists;
- mental health, behavioral health;
- disability organizations;
- finance, accounting, real estate;
- domestic violence, sexual assault;
- long-term care; and
- substance use.

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

1J. Case Review—Supervisory Process

Background

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

The APS Survey revealed that over 70% of states have case review systems and about 75% of those states review every case (NAPSA & NASUAD, 2012). 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), and
- at case closure.

For APS systems where cases may be open for periods longer than 6 months, a supervisory consultation and case review should be conducted at least every 6 months (e.g., for redetermination of eligibility or ongoing service provision).

1K

1K. Worker Safety and Well-being

Background

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

A 2018 study revealed that APS workers reported experiencing an average of 3.42 different hazard exposures per month, with the most common exposures being dangerously cluttered living spaces, garbage or spoiled food, insect infestations, and being yelled at, cursed at, or belittled by a client or client's family. The authors note that the findings highlight the importance of building a positive and supportive work environment for APS workers, and that results can help inform management strategies for the prevention of burnout among APS workers. In addition, based on previous studies in child welfare, the authors suggest that if work stressors identified in this study were addressed effectively, worker turnover in APS might decrease (Ghesquiere, Plichta, McAfee, & Rogers, 2018).

Guideline

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

- APS programs should have systems in place to know where their workers are when conducting investigations in the field.
- 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.
- Workers should have access to resources to protect them from biological hazards that may be encountered during home visits (e.g., gowns, masks).
- 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.
- Workers should be provided with work/agency cell phones.
- 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 and using agency vehicles or other means to keep their personal car license confidential.
- Workers should never be required to respond to a situation that would put the worker at risk without adequate safety supports available.
- Workers should have access to available supportive, professional counseling for job-related trauma and stress.

1L. Responding During Community Emergencies

Background

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

Guideline

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:

- **Planning for emergencies before they occur,**
  - through multiagency planning and coordination, by 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.
- **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.
  - APS personnel shall be provided 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

1M. Community Outreach and Engagement

Background

Although the public's awareness of adult maltreatment is rising, the awareness of how to respond to suspicions of that maltreatment and how to reduce repeat visits is still lacking. Recent research sheds light on the kinds of maltreatment cases that are not reported to APS. 90% of financial maltreatment perpetrated by family and friends and 85% of emotional maltreatment regardless of relationship to perpetrator go unreported (Acierno, 2018). Recent research also indicates that lack of awareness and miscommunication may indicate a need for education interventions for professionals, families, and communities to help reduce repeat visits (Susman et al., 2015). APS programs should play a role in educating the public about adult maltreatment, the way to report it and to whom, and the goals and services of the APS program.

Recent efforts have identified effective communications strategies for the community to talk about elder abuse and related issues to build public understanding and support (FrameWorks Institute, 2019).

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

- defining adult maltreatment,
- guidance on when and how to report, and
- 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 those impacted by adult maltreatment 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/National Committee for the Prevention of Elder Abuse Research Committee has provided information on how APS programs may participate in research. See **http://www.napsa-now.org/wp-content/uploads/2018/03/Guiding_Principles_2018.pdf**

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 levels;
- 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

2A. Responding to the Report/Initiating the Investigation

Background

According to the APS Survey, most APS systems prioritize reports into either emergency or nonemergency situations and have time frames for responding in either a few hours or a few days, as deemed appropriate (National Adult Protective Services Association [NAPSA] & National Association of States United for Aging and Disabilities [NASAUD], 2012). In more than 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. Recent data (2017) from the National Adult Maltreatment Reporting System (NAMRS) shows that, on average, states took 4.5 days from receipt of a report of alleged maltreatment to the time APS made contact with the client (Aurelien et al., 2018a).

The federal child welfare system provides guidelines for determining the needed response time (DePanfilis & Salus, 2003).[15]

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. There are two levels of response:

- Immediate response—for cases that involve risk of death, irreparable harm, or significant loss of assets and/or property—should occur in person within the first 24 hours after receiving the report, or sooner.
- Less immediate response—for less imminent and less severe risk—should occur 1 to 5 business days after the report is received, or sooner.

2B. Completing the Investigation

2B

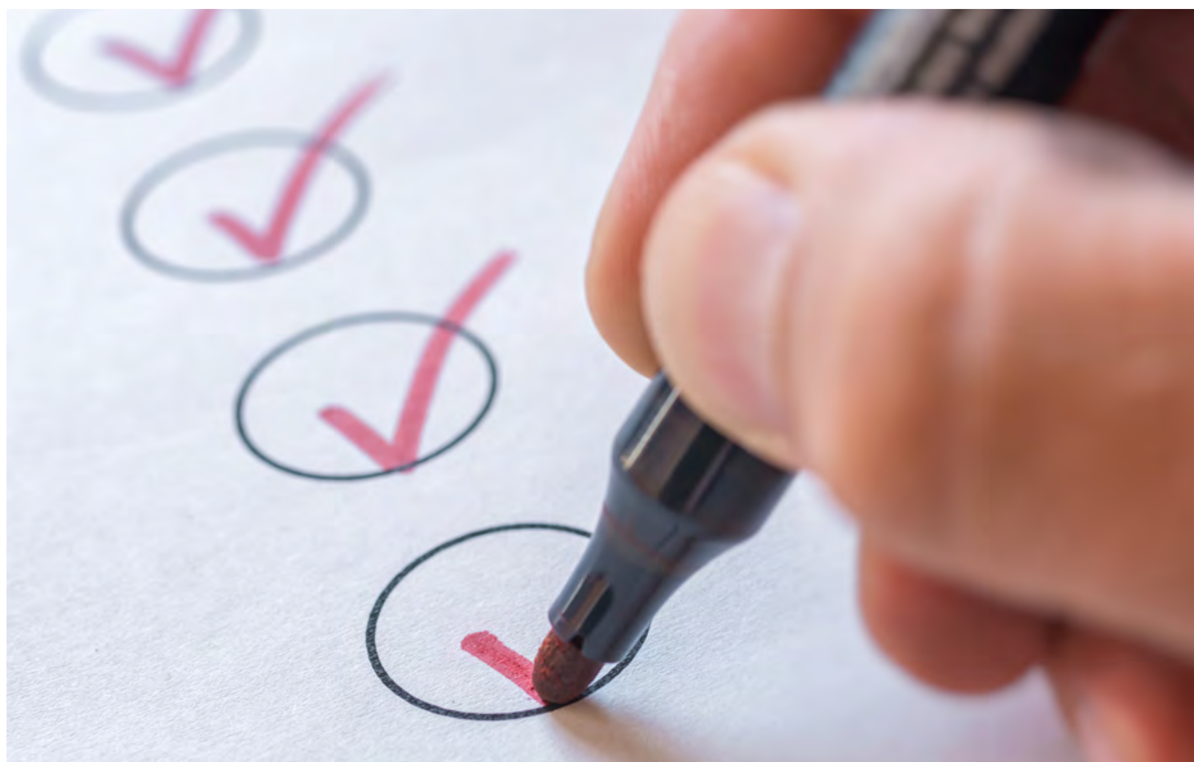
Background

The time frame 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, and 42% states allow the investigation to be completed in more than 30 days. Eight states have no time frame for completing the investigation (NAPSA & NASUAD, 2012). Based on the 2017 NAMRS data, states took on average of 47.7 days to complete investigations. Out of 26 states that provided additional data, 17.8% reported investigations were closed within 15–30 days of receipt of report, 31.5% reported investigations were closed within 31–60 days of receipt of report, and 13.6% reported investigations were closed within 61–90 days of receipt of report (Aurelien et al., 2018a).

Guideline

It is recommended that APS systems create policy establishing the time frame 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 with supervisory approval.



2C

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 time frame for closing cases, and eight required closure within 90 days (NAPSA & NASUAD, 2012). 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 time frame for ongoing case review, as well as a maximum time limit for determinations of case status (Children's Bureau, n.d.-c).[15]

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

Cases may be closed for a variety of reasons. Based on 2017 NAMRS reporting from 19 states, half of cases were closed because the investigation was completed,[16] 29.3% of cases were closed because the investigation/protective services were completed,[17] or for another closure reason (7.2%).[18] States also reported closing cases even if the investigation had not been completed, due to client refusal (2%),[19] client death (1.5%),[20] client decision (1.7%),[21] or nonspecific reasons (4.9%[22]; Aurelien et al., 2018b).

Guideline

It is recommended that APS systems establish case closure criteria and the frequency with which open cases should be reviewed. Cases should remain open for the time needed to resolve the client's safety issues. A procedure for closing cases is also recommended. The criteria for case closure should include, but are not limited to, situations in which

- the service plan is completed (e.g., the client's situation is stabilized, safety issues have been resolved or mitigated, client goals have been achieved to the extent feasible);
- the client was referred to another APS agency;
- the client has moved out of the APS jurisdiction;
- the client has died (some programs will continue to investigate if death is considered suspicious);
- the client having capacity to consent refuses continued services.

APS should allow for extensions for good cause.

3 | Receiving Reports of Maltreatment

3A

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 nonbusiness hours. In states without a 24-hour intake line, callers were urged to contact law enforcement to report maltreatment (National Adult Protective Services Association [NAPSA] & National Association of States United for Aging and Disabilities, 2012). Recent data (2017) from the National Adult Maltreatment Reporting System shows that 51.9% of states provide a centralized statewide hotline or call-in number as a single point of entry for reports of maltreatment. Approximately a quarter of states (24.1%) provide a combination of both statewide and local hotlines or call-in numbers, and 20.4% provide decentralized regional or county hotlines or call-in numbers only (Aurelien et al., 2018a).

The Council on Accreditation recommends that a child abuse report intake system be available 24 hours a day. The majority of child welfare systems addressed this recommendation in policy and met this guideline as of 2003 (Office of the Assistance Secretary for Planning and Evaluation, 2003).[15]

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, 7 days a week (e.g., toll-free telephone hotline, teletypewriter [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;

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3A continued

- the location of the alleged 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 alleged 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 time frames for APS response associated with identified risk levels.

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.

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

- a prompt process to screen and investigate reports;
- a review of safety and risk factors, using a consistently-applied screening tool;

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- agency decision-making criteria to review and assign cases, report to other authorities and initiate court action when required; and

- 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 (NAPSA, 2013).

The federal child welfare system provides significant guidance and examples to the states on assessment tools, screening tools, and protocols for children suspected of being victims of child abuse and neglect (Children's Bureau, n.d.-d).[15]

4 | Conducting the Investigation

4A

4A. Determining if Maltreatment has Occurred

Background

The response of APS 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.

To ascertain whether maltreatment has occurred, information is gathered through interviews with the client, the alleged perpetrator, and other involved parties, and through review of relevant documents and records. Evidence gathered during investigation includes, but is not limited to,

- client statements,
- direct observations,
- physical evidence (e.g., injuries, cluttered home, no utility service),
- corroborating evidence (e.g., witness statements, physician records, other information),
- circumstantial evidence,
- unobserved/third-party suspicions, and
- client history.

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

A 2016 study on variability of APS findings in California concluded that differing interpretations of definitions of confirmed, inconclusive, and unfounded case findings, along with differences in worker expertise and practices, were the major contributors to variation in elder abuse data. The authors suggest establishing clear definitions and conducting training to standardize the assignment of findings for elder abuse/neglect cases (Mosqueda et al., 2016).

As noted elsewhere, the federal child welfare system provides significant guidance and examples to the states on assessment tools, screening tools, and protocols for children suspected of being victims of child abuse and neglect (Children's Bureau, n.d.-d).[15] In addition, studies examining differences in child abuse and neglect determinations have shown that a multidisciplinary team (MDT) approach, including a forensic interview, is an effective approach for conducting the initial assessment (Brink et al., 2015). Similar findings have been published in the area of elder abuse, showing that MDT/forensic centers significantly increase prosecution rates and guardianships for cognitively impaired older adults, and reduce the rate at which cases reenter the APS system (Wilber, Navarro, & Gassoumis, 2014).

Guideline

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

- 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,
  - alleged victim safety,
  - worker safety, and
  - cognitive status of client (e.g., clients with dementia may not respond well to an unannounced visit).
- APS programs are encouraged to use MDTs to support decision-making during the initial assessment.
- 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.
- Other vulnerable adults that are affected by the alleged maltreatment, or appear to be alleged victims of possible maltreatment, are identified and reported to APS.
- While the investigation may continue, the client has the right not to participate in the investigation.
- 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.
- Immediate attention has been given to clients in crisis, in imminent risk, or in an emergency situation.
- APS programs are encouraged to utilize standardized and validated screening tools for assessing decision-making ability and for determining whether mistreatment has occurred.
- APS workers are trained on and have a clear understanding of the definitions of case findings (e.g., "confirmed," "unfounded," or "inconclusive").
- 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 Service Implementation, below).
- 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 who have mental health issues, with residents of institutions, or with minority populations).

4B

4B. Conducting an APS Client Assessment

Background

The adult protective services (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. Based on the 2017 National Adult Maltreatment Reporting System (NAMRS) data, 75% of states use a common instrument or tool throughout the state to conduct assessments. For other states (25%), assessment instruments are determined by each county or left to the worker's discretion (Aurelien et al., 2018a).

Because adult maltreatment may have a traumatizing effect on the alleged victim, it is important that APS programs utilize principles of trauma-informed care in order to facilitate a respectful and sensitive approach to working with the alleged victim, starting with the APS client assessment. The Centers for Disease Control and Prevention (CDC) have identified six key elements of a trauma-informed approach: safety; trustworthiness and transparency; collaboration and mutuality; peer support; empowerment and choice; and cultural, historical, and gender issues. (CDC, n.d.). More information can be found at **https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm**.

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

Guideline

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

APS programs are encouraged to integrate principles of trauma-informed approaches when conducting the client assessment and throughout the APS investigation.

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

The needs and risk assessments should include criticality or safety of the client in all the following significant domains (not an exhaustive list):

- nature of the maltreatment (e.g., origins, severity, duration, frequency, etc.);
- physical health;
- cognitive functioning (e.g., memory, IQ);
- decisional ability (including understanding and appreciation of consequences of decisions, perception of choice, and reasoning);
- mental health status/behavioral issues;
- functional ability (e.g., to perform activities of daily living and instrumental activities of daily living;
- personal relationships (including presence of combative and conflictual relations);
- support system (formal and informal);
- environmental conditions (including presence of abused, dangerous, or hoarded animals in the home); and
- financial circumstances.

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 noninvasive 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 an alleged victim of adult maltreatment.

4C

4C. Investigations in Residential Care Facilities

Background

Approximately 50% of APS programs conduct investigations in congregate care facilities (i.e., facilities or institutions). Based on 2017 NAMRS data, in 38 states, APS investigates allegations of maltreatment when they occur in at least some type of "residential facilities"; in 14 states, APS never investigates allegations of maltreatment in facilities (Aurelien et al., 2018a).

APS systems that are responsible for investigating and intervening in cases of maltreatment in residential care facilities 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 residential care cases, including exercising caution to avoid escalating danger to those involved (Ramsey-Klawsnik & Teaster, 2012).

Whether or not the APS system investigates reports of maltreatment in residential care facilities, it is critically important that APS systems coordinate with agencies such as the long-term care ombudsman, state regulatory agencies, law enforcement, and others that also play a role in safeguarding the health and welfare of congregate care residents. Memoranda of understanding and other formal documents can help to facilitate local- and state-level coordination. For example, consultation with law enforcement about the timing of the APS investigation may ensure that an APS investigation does not compromise a law enforcement investigation.

In 2015, the Code of Federal Regulations (CFR) was amended to include regulations governing states' long-term care ombudsman programs (45 CFR Part 1324). The regulations include the following requirement:

> Through adoption of memoranda of understanding and other means, the [State Long-Term Care] Ombudsman shall lead state-level coordination, and support appropriate local Ombudsman entity coordination, between the Ombudsman program and other entities with responsibilities relevant to the health, safety, well-being or rights of residents of long-term care facilities including, but not limited to: Adult Protective Services (45 CFR Section 1327.13[h]).

Guideline

It is recommended that APS systems responsible for responding to alleged and confirmed maltreatment of vulnerable adults residing in residential care facilities 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 residential care facilities, develop formal agreements and protocols with the entities that play a role in safeguarding the health and welfare of these residents in order to facilitate local- and state-level coordination, in particular, the long-term care ombudsman program, state licensing, other regulatory bodies, and law enforcement. It is recommended that, whenever possible, APS notify the long-term care ombudsman when APS is investigating allegations of maltreatment in residential care facilities.

4D. Completion of Investigation and Finding

4D

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 (NAPSA, 2013).

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.

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

5 | Service Planning and Service Implementation

5A

5A. Voluntary Service Implementation

Background

Adult protective services (APS) is a voluntary service, and its interactions with clients are based on principles of ethical practice including, but not limited to, person-centered planning, least restrictive alternatives, and supported decision-making. 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 (or their designated representative's) involvement, to facilitate services that 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 National Adult Protective Services Association (NAPSA) Minimum Standards state that the guiding principles for APS person-centered practice, summarized below, be followed when developing service plans.

- Respect the integrity and authority of clients to make their own life choices.
- Hold perpetrators, not clients, accountable for the maltreatment and for stopping their behavior. Avoid blaming questions and statements.
- Take into consideration clients' concepts of what safety and quality of life mean.
- Recognize resilience, and honor the strategies that clients have used in the past to protect themselves.
- Redefine success: success is defined by the client, not by what professionals think is right or safe (NAPSA, 2013).

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

- Identify with the client the factors that influence service plan risks and needs.
- Engage the client and caregiver as appropriate, in an ethical manner, with useful strategies to develop mutual goals to decrease risk of maltreatment.
- Determine with the client and other reliable sources (such as family members, friends, and community partners) the appropriate services or other interventions that may decrease risk of maltreatment.
- In some cases, the use of a proper domestic violence safety planning tool is warranted (NAPSA, 2013).

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Several studies on adult maltreatment have yielded findings that may inform current APS practice. For example, a study by Jackson & Hafemeister (2014) indicates that interventions tailored to meet the unique characteristics associated with each type of mistreatment may lead to greater client safety. In addition, specific services or supports, such as social support and participation in supportive community social outlets, may be effective for mitigating against negative outcomes of elder mistreatment, such as depression, generalized anxiety, and poor health (Acierno, Hernandez-Tejada, Anetzberger, Loew, & Muzzy, 2017) as well as future risk of mistreatment (Burnes, Rizzo, & Courtney, 2014). It has also been shown that APS clients with mental health needs are often willing to accept an offer of additional mental health services at the same time that they are receiving mistreatment resolution services (Sirey et al., 2015). Research on mental health highlights the importance of also addressing mental health issues, such as depression, as it affects an individual's perception of their need for care and their motivation, initiative, and energy to seek help and engage in services (DiMatteo, Lepper, & Croghan, 2000; Sirey, Bruce, & Alexopoulos, 2005).

The APS Survey reveals that once a case is initiated through APS, 63% of the programs reporting require regular communication with the client either by phone or in person (NAPSA & National Association of States United for Aging and Disabilities [NASUAD], 2012). Close to 90% of the states stated that, once a month, an in-person visit is required while a case is open, although most also indicated that ongoing investigations may require more frequent contact. Once-a-month phone calls are required in 64% of the states. Research indicates that longer-term, relationship-based interventions may be effective for entrenched elders who are reluctant to receive services (Mariam et al., 2015).

Guideline

It is recommended that programs intervene in adult maltreatment cases as early as possible and develop targeted safety planning for clients experiencing different forms of abuse and/or neglect. For clients who may be reluctant to receive services, APS is encouraged to consider providing longer-term interventions focused on building a working alliance with the client and applying motivational interviewing techniques.

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

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Together [PROTECT] intervention described in Sirey et al., 2015). In areas where it is difficult to connect clients to social supports in person, APS can explore referring clients to programs that use technology to connect individuals to others (e.g., Senior Center Without Walls).

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 Service Implementation

5B

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 suggests the following in its Minimum Standards:

> 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 file.
>
> 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 (NAPSA, 2013).

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 interventions, which incorporate the elements listed above.

It is recommended that APS systems adopt promising models which draw on multidisciplinary experts to help make the difficult determination as to whether or not APS should petition the court for a guardianship.

The NAPSA program standards recognize that "lack of capacity may also limit the client'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" (NAPSA, 2013). The NAPSA standards go on to emphasize that, although involuntary service planning may involve a client who lacks capacity in some areas, principles of supportive decision-making should be utilized (NAPSA, 2013). The law has traditionally responded to cognitive disability by authorizing surrogate decision-makers to make decisions on behalf of individuals with cognitive disabilities. However, supported decision-making, an alternative paradigm for addressing cognitive disability, is rapidly gaining support. According to its proponents, supported decision-making empowers individuals with cognitive challenges by ensuring that they are the ultimate decision-makers but are provided support from one or more others, giving them the assistance they need to make decisions for themselves (Kohn, Blumenthal, & Campbell, 2013) Working with the individual requires the recognition that the individual also has strengths and may be able contribute to the decision-making process.

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

- determine when involuntary intervention may be indicated;

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- 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 means;
- document information needed to justify the use of involuntary interventions, and identify the appropriate resources needed to be able to implement an involuntary case plan;
- develop and defend an involuntary plan; and
- have in place a systematic method to continue to provide protective services to those clients who are being provided involuntary protective services (NAPSA, 2013).

Research has shown that the elder abuse forensic center model, with its multiple disciplines and perspectives, can be an effective approach for determining whether or not cases should be referred to guardianship (Gassoumis et al., 2015).

5C. Closing the Case

5C

Background

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

The child welfare system provides guidelines on the process for closing cases (DePanfilis & Salus, 2003).[15]

Guideline

It is recommended that APS systems establish case closure criteria and determine the frequency with which open cases should be reviewed. Cases should remain open for the time needed to resolve the client's safety issues. A procedure for closing cases is also recommended. The criteria for case closure should include, but are not limited to, these situations:

- The service plan is completed (e.g., the client's situation is stabilized: safety issues have been resolved or mitigated; client goals have been achieved to the extent feasible).
- The client was referred to another APS agency.
- The client has moved out of the APS jurisdiction.
- The client has died (though some programs will continue to investigate if death is considered suspicious).
- 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

6A. Caseworker and Supervisor Minimum Educational Requirements

Background

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

The APS Survey shows that at least 35 states report that supervisors and caseworkers must have a college degree (National Adult Protective Services Association [NAPSA] & National Association of States United for Aging and Disabilities [NASUAD], 2012).

The federal child welfare system requires states to establish minimum education and qualification requirements of child protective services (CPS) workers (CAPTA Reauthorization Act, 2010). Child welfare guidelines promote the recruitment of, including the direction of federal funds toward, individuals with higher educational attainment and backgrounds in social work education (DePanfilis & Salus, 2003).[15]

Guideline

It is recommended that APS direct service personnel and supervisors be 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 2 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.
- It is recommended that APS programs have in place adequate human resource procedures to screen potential candidates for suitability for employment.
- In states that employ nurses in their APS programs, it is recommended that preference be given to those with a bachelor's degree in nursing.

6B. Caseworker Initial and Ongoing Training

Background

It is in the best interest of clients that APS caseworkers receive initial and on-the-job training in the core competencies of their challenging job. For instance, research has shown that differing interpretations of definitions of confirmed, inconclusive, and unfounded case findings, along with differences in worker skill, expertise, and training, may contribute to variability in APS case decisions on allegations and findings (Mosqueda et al., 2016).

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

In the child welfare system, research shows that well-trained staff are able to complete tasks accurately and in a timely manner.[15] In addition, studies suggest that educational programs provide workers with both competencies and increased commitment to their jobs, which are associated with retention (Zlotnick et al., 2005). Child welfare agencies deliver a variety of training initiatives to build competencies and align skills with new practice models. Some states have formed university-agency partnerships that provide training and, in some cases, funding for child welfare staff to pursue graduate social work degrees (Social Security Act, Title IV-E). In the federal child welfare system, states are required to provide certain types of training for CPS workers (Children's Bureau, n.d.-e). Federal child welfare guidelines promote ongoing training and certification of caseworkers to maintain competency (DePanfilis & Salus, 2003).

The APS Survey revealed that 18 APS systems provided less than a week of training, 10 one week or more, and four states provided no training to new caseworkers (NAPSA & NASUAD, 2012). 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, standardized 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: orientation to the job, supervised fieldwork, core competency training, and 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, workbook exercises, case conferences, shadowing experienced workers, online courses, and virtual-reality- or simulation-based trainings for experiential learning. APS systems are encouraged to be creative in content delivery.

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

- **Orientation to the job**
  The purpose of the orientation is for workers to acquire knowledge and skills in key areas and 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:
  - concepts articulated in the APS System's Code of Ethics, including the principles of autonomy, least restrictive alternatives, person-centered service, trauma-informed practice, and supported decision-making;
  - the role of APS and how the program fits into the larger long-term services and support network;
  - common legal issues with which APS is involved, including confidentiality, conflict of interest, and guardianship/conservatorship (including alternatives to guardianship and conservatorship);
  - the types of maltreatment covered by their state's statute, including their definition, signs, and symptoms;
  - the case documentation process, including tracking and documenting attainment of client goals;
  - the goals and process for conducting an APS investigation, including both

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the determination of maltreatment and the client assessment;
- the process for screening for decisional capacity;
- the process for determining whether or not maltreatment has occurred, including clear definitions of confirmed, inconclusive, and unfounded case finding determinations;
- guidance for serving clients with disabilities;
- the importance of culturally competent service;
- the way to incorporate person-centered planning into service planning and implementation; and
- criteria for closing the case and applying a standardized process to determine level of progress towards client goals.

■ **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).

■ **Core competency training:**
It is recommended that APS systems provide ongoing training to workers on a regular basis. It is suggested that training on the following core competencies for APS workers be provided within the worker's first 24 months:
- APS ethical issues and dilemmas
- APS philosophy, values and cultural competence
- The aging process
- Cognitive deficits, including dementia
- Serving clients with physical and intellectual disabilities
- Motivational interviewing
- Mental health issues
- Substance abuse
- Dynamics of abusive relationships
- Professional communication skills (written and verbal)
- Self-neglect
- Caregiver neglect
- Financial exploitation
- Physical abuse
- Sexual abuse
- Emotional/psychological abuse
- APS case documentation/report writing
- Initial investigation and worker safety
- Assessing decision-making capacity
- Supported decision-making models
- Risk assessment
- Public benefits eligibility (e.g., Medicare, Medicaid, Social Security)
- Voluntary case planning/intervention process
- Involuntary case planning/intervention process
- Collaboration and resources (including working in multidisciplinary teams [MDTs])
- Laws related to APS work (e.g., guardianship/conservatorship, mental health

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commitments, domestic violence)
- Working with the criminal justice system
- Case closure and 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.

- **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 content 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 (NAPSA & NASUAD, 2012).

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

Guideline

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

- understanding oneself as supervisor;
- foundations of effective supervision;
- teambuilding for APS professionals; and
- APS supervisor as trainer.

Additional topics for advanced training for supervisors may include

- management of personnel issues;
- data and fiscal operations;
- worker safety and self-care; and
- collaboration and resources (Brown, 2019).

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

7 | APS Program Performance

Adult protection services (APS) programs can only be as effective as their individual practices and procedures. Thus, evaluation of program performance and well-designed research assessing the impact of specific practices on APS clients and workers are key to identifying best practices for the field.

APS research has grown significantly over the past few years, with studies focusing on a variety of topics, such as client satisfaction (Booker, Breaux, Abada, Zia, & Burnett, 2018), factors that predict alleviation of risk in APS clients (Burnes et al., 2014), and APS workers' perceptions of repeated referrals and recidivism to APS (Susman et al., 2015). However, well-designed research is still much needed to demonstrate the effectiveness of APS programs and practices in improving client outcomes and supporting APS workers and supervisors do their best work.

7A

7A. Managing Program Data

Background

Program data serve a key role in telling the story of the important work of APS, and effective data management is a key for ensuring the story is accurate. Significant variability exists in data collection and management across the nation. For example, some states keep case data for up to 10 years; other states purge data at 6 months, or 1 to 2 years.

Guideline

The National Adult Protective Services Association (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 (NAPSA, 2013)."

APS programs are encouraged to keep program data long enough to ensure their availability for quality assurance needs (e.g., tracking client recidivism rates over time, identifying trends in maltreatment types, etc.), and for research purposes (see Susman et al., 2015, regarding availability of longitudinal data). It is recommended that the data collected be congruent with the National Adult Maltreatment Reporting System.

7B. Evaluating Program Performance

Background

The process of evaluating APS programs' performance has several goals. First, it provides information on how the program helps its clients. Second, it provides information that helps workers and supervisors do their best work. Third, it provides the APS program with information it can use to tell a compelling story about the program and its effectiveness to decision-makers, other providers, and the community as a whole.

The APS Survey reveals that 43 states have developed benchmarks and metrics for program evaluation (NAPSA & National Association of States United for Aging and Disabilities [NASUAD], 2012). Generally, however, annual evaluations of program performance 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 federal child welfare system requires the Department of Health and Human Services to establish outcome measures to monitor and improve state performance (Adoption and Safe Families Act, 1997). In addition, the child welfare system requires states to implement child welfare improvement policies (Child and Family Services Improvement and Innovation Act, 2011).[15]

Guideline

It is recommended that APS systems compile a written report on APS programs' performance and make that report available to state and federal bodies and the public on a regular basis. APS program performance measures should assess programmatic aspects and service areas, to determine whether interventions were executed timely and services met clients' needs, as well as client-centered outcomes, to determine whether clients were satisfied with the services and whether goals specific to the clients were attained. Innovative measurement strategies that allow for client variability and that are capable of tracking change on an individualized set of outcome indicators, such as goal attainment scaling (Burnes et al., 2018), may be effective to assess client-centered APS intervention outcomes.

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Endnotes

1. ACL brings together the efforts and achievements of the Administration on Aging, the Office of Intellectual and Developmental Disability Programs, and the Department of Health and Human Services 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. 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
3. As part of the updates to the Guidelines, element 1G, Protecting Program Integrity, was moved up to become element 1B. The title for element 4C was changed from "Investigations in Congregate Settings" to "Investigations in Residential Care Facilities"; and the title for element 4D was changed from "Completion of Investigation and Substantiation Decision" to "Completion of Investigation and Finding." The title for domain 5 was changed from "Services Planning and Intervention" to "Service Planning and Service Implementation"; element 5A was changed from "Voluntary Intervention" to "Voluntary Service Implementation"; and element 5B was changed from "Involuntary Intervention" to "Involuntary Service Implementation." The title for domain 7 was changed from "Evaluation/Program Performance" to "APS Program Performance," and the content was divided into two elements: 7A, Managing Program Data, and 7B, Evaluating Program Performance.
4. In federal fiscal year 2017, all 50 states, DC, and four territories provided data related to their APS agency profile information and investigation data (agency component data).
5. The failure of a caregiver or fiduciary to provide the goods or services necessary to maintain the health or safety of a person. Includes acts of omission and of commission; includes willful deprivation, etc.
6. The use of force or violence resulting in bodily injury, physical pain, or impairment. Excludes sexual abuse.
7. A person's inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks, including obtaining essential food, clothing, shelter, and medical care; obtaining goods and services necessary to maintain physical health, mental health, or general safety; or managing one's own financial affairs. Includes hoarding.
8. Nonconsensual sexual contact of any kind, including sexual contact with any person incapable of giving consent.
9. The illegal or improper use of an individual's funds, property, or assets for another person's profit or advantage.
10. The infliction of anguish, pain, or distress through verbal or nonverbal acts. This includes but is not limited to verbal assaults, insults, threats, intimidation, humiliation, and harassment.
11. The illegal or improper use of an individual or of an individual's funds, property, or assets for another's profit or advantage.

12. The illegal or improper use of an individual for another person's profit or advantage, including exploitation of person, servitude, etc.

13. A type of maltreatment not included in the categorizations provided.

14. An unexpected fatality or one in which circumstances or cause are medically or legally unexplained.

15. References to the child welfare system or child protective services herein are included to provide the reader with information about how and what the federal government requires of the professionals working in that system. These references are not intended to provide guidance to the APS system; they are intended to show the contrast between what is provided by way of guidance for the child welfare system versus the guidance provided herein for the APS system.

16. The case was closed after a finding was made on the allegation of maltreatment; the investigation was closed, and no ongoing protective services case was opened

17. The case was closed after the investigation was completed, additional protective services were provided, and the protective services case was closed.

18. The protective services case was terminated prematurely; reason not specified

19. The client refused to cooperate with the investigation worker, the investigation was terminated without a finding, and the case was closed.

20. The client died during the investigation, the investigation was terminated without a finding, and the case was closed.

21. The client decided not to continue work with the protective services agency, and the case was closed.

22. A finding could not be made on the allegations of maltreatment for an unspecified reason, and the case was closed.

Administration for Community Living
Office of Elder Justice and Adult Protective Services
U.S. Department of Health and Human Services
Washington, DC 20201