Adult Protective Services Field Guide

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With special thanks to Dawn Gibbons-McWayne and Barry Dewing for their contributions to this project.

Made possible by a grant from the Archstone Foundation

INTRODUCTION

The Field Guide for Adult Protective Services is intended to provide the APS supervisor with an organized system to ensure that the new APS social worker gains the experiences and formal training needed to be an effective professional. This guide outlines nineteen (19) Knowledge Areas identified as comprehensive for APS field work. These Knowledge Areas include basic field skills, as well as working with unique types of cases/situations. Although the Knowledge Areas are presented in order from basic to specialized areas, it is up to the supervisor to decide in what sequence these Knowledge Areas should be introduced. In other words, it is not necessary to introduce these in the specific order presented.

This guide may also be used to identify areas for needed development for the experienced social worker (whether experienced in APS or from a different agency), who may have mastered basic field skills (such *Professional Communication*-Knowledge Area 3), but require training in areas unique to APS (such as *Involuntary Case Planning-Knowledge* Area 16) or unique to the individual learner (such as remedial skills in *Documentation*-Knowledge Area 7).

HOW TO USE THE GUIDE

Each of the 19 Knowledge Areas has a checklist of activities designed to support the skill/knowledge development for the worker. The supervisor, in collaboration with the learning worker, should use the Knowledge Areas to develop an individualized learning plan for the worker. The supervisor will need to coordinate his/her time to meet consistently with the worker to debrief the learning activities and provide one-on-one discussion with the worker to ensure the transfer of learning.

All necessary assignment & transfer of learning documents are included in the Appendices. Active links to the documents are in the respective Knowledge Areas.

When assigning a new worker to a particular type of case (such as Self-Neglect-Knowledge Area 9), it is recommended that the worker perform the activities in that Knowledge Area as close to the field visit as possible (including the viewing of the associated e-learning, if indicated).

While this guide provides tools, resources and learning activities, it is not intended to remove the supervisor from the learning process. The supervisor's role is **vital** to ensure the transfer of learning. As the supervisor, you remain the **best resource** for encouraging/guiding the worker through the learning process and ensuring that the skills acquired are applied.

PRELIMINARY ACTIVITIES FOR THE SUPERVISOR

Prior to introducing the learning activities for the worker, the supervisor should perform the following tasks:

1. ☐ Identify existing staff who demonstrate "best practices" regarding particular types of abuse cases and/or knowledge areas. Secure the consent of the experience worker(s) to have the learning social worker to accompany on field visits/review documentation, etc.

2. ☐ Identify and have available case records which reflect best practices of documentation and organization

3. ☐ Ensure that the learning social worker has access to a computer with Internet access and that pop-up blockers are off. To register for e learning trainings, send training participant name, email address, county (within CA) or state (outside CA), department (APS, PG, IHSS, etc.), primary job assignment (line worker, supervisor, manager), and supervisor name and email to: AcademyLMS@projects.sdsu.edu. Please indicate in the email subject line the training name. You will be registered and obtain a username and password.

4. ☐ Provide the worker the list of **Common APS Abbreviations.** Be sure to add any agency-specific acronyms commonly used in your agency.

5. ☐ Obtain copies of the following DVD/on-line resources:

   ☐ "***Elder Physical and Sexual Abuse: The Medical Piece***" *(2003).* Available from California District Attorneys' Association. Cost=$35.98 (tax, postage, etc) Contact: Patty Reeves at preeves@cdaa.org or mail to: Office Manager, California District Attorneys Association, 921 11th Street, Suite 300, Sacramento, CA 95814. Telephone: 916-443-2017; Fax: 916-443-0540

   ☐ *"**Victims with Disabilities: The Forensic Interview**".* DVD available from the Office for Victims of Crimes Resources Center. Cost=Free. Call 800=8513420 or 301-519-5500. Order item NJC212894. This also viewable on-line by accessing the following web-link: http://www.ovc.gov/library/videoclips.html

   ☐ ***"In Their Words: Domestic Abuse in Later Life".*** (2010) DVD available from the Office for Victims of Crimes Resources Center. Cost=$5. Call 800=8513420 or 301-519-5500. Order item NJC 227928. This also viewable on-line by accessing the following web-link: http://www.ovc.gov/library/videoclips.html

Note: Available eLearnings are highlighted in **green**; registration instructions to view these trainings are given in the "Preliminary Tasks for Supervisors" on the previous page. All handouts/worker assignments are highlighted in **blue**; these are hyperlinked to the specific documents in the Appendices.

Knowledge Area I: Overview of APS (jurisdiction, client populations, self-determination)

- ☐ **Assignment 1:** Worker to view **Overview of APS eLearning**
- ☐ **Assignment 2**: Worker to review the **NAPSA Code of Ethics**
- ☐ **Assignment 3:** Worker to view **APS Regulations eLearning**
- ☐ **Assignment 4:** California worker to review and complete **Match the WIC codes**(applies to California APS-other states will need to provide this information related to their own jurisdictions)
- ☐ **Assignment 5**: Supervisor to review and discuss confidentiality with worker, using **Confidentiality Discussion Worksheet**
- ☐ **Assignment 6**: Worker to review types of abuse encountered in APS, using **Types of Abuse** handout
- ☐ **Assignment 7**: Worker to review Penal Code violations (*Only applicable in CA- other states need to provide this type of information for their own regulations*), using **Penal Code** handout
- ☐ **Assignment 8:** Worker completes **Define Autonomy, Capacity and Incapacity** worksheet
- ☐ **Assignment 9:** Worker reviews case files which exemplify various types of abuse and understandable documentation. Supervisor to discuss any questions with worker
- ☐ **Assignment 10:** Worker makes home visit(s) with experienced worker(s). If multiple home visits, arrange with different experienced worker each time. Supervisor to debrief with worker after each visit. **This assignment should be repeated throughout the worker's induction period.**

Knowledge Area 2: The Intake Process

- ☐ **Assignment 1**: Worker to view **Aging Process eLearning**
- ☐ **Assignment 2**: Worker to complete **Describe the Intake Process** worksheet
- ☐ **Assignment 3**: Worker to sit in on an intake call. Worker to complete the **Defining Risk Assessment and Its Functions**. Worker to review
- ☐ **Assignment 4:** Worker to complete **What is Risk Assessment** worksheet.
- ☐ **Assignment 4**: Home visit (any type) with another worker and debrief with the supervisor

Knowledge Area 3: Professional Communication/Interviewing/Trust

- ☐ **Assignment 1:** Worker view **Interviewing Skills for APS Workers eLearning** (soon to be available)
- ☐ **Assignment 2**: Worker to review and discuss with supervisor **Professional Interview Checklist** ***before*** home visit. (Note: Document may be used as to be used as a checklist, and later as a self-rating tool or rating tool by supervisor)
- ☐ **Assignment 3**: Worker to complete **Transforming Leading into Non-leading Questions** worksheet
- ☐ **Assignment 4**: Supervisor to introduce and review necessary forms to be given to clients
- ☐ **Assignment 5**: Worker to view the Introduction and Pre-Interview sections of "***Victims with Disabilities: The Forensic Interview***" video.
- ☐ **Assignment 6**: Worker to view the Interviewing section of "***Elder Physical and Sexual Abuse: The Medical Piece***" video.
- ☐ **Assignments 7**: Worker to make Home visit(s) focusing on interviewing issues (how rapport is developed, how to get in the door, communication issues around sensory deficits). Use **Professional Interview checklist** and debrief with the supervisor, comparing worker styles and how the worker would handle rapport issues.

Professional Communication is available as an in-person training

Knowledge Area 4: Dynamics of Abuse/ Investigations

☐ **Assignment 1**: Worker to view Domestic Violence section of ***Elder Physical and Sexual Abuse: The Medical Piece*** video (7 minutes)

☐ **Assignment 2:** Worker to review and discuss with supervisor **Abuser Justifications and Defenses-APS Considerations and Power and Control Wheel** handouts

☐ **Assignment 3:** Worker to make home visit on abuse by other case which focus on relationships. After visit, worker to debrief with supervisor re: how was abuse revealed; what questions were asked and what was the relationship between victim and abuser

☐ **Assignment 4:** Worker to view "*I Can't Believe I'm Free- Pat*" section from "***In Their Own Words: Domestic Abuse in Later Life***" video (15 minutes). Supervisor to discuss with why some clients refuse services in these situations

Dynamics of Abuse is available as an in-person training

Knowledge Area 5: Capacity

☐ **Assignment 1**: Worker to view "Dementia, Delirium and Depression" section of ***Elder Physical and Sexual Abuse: The Medical Piece***(19 minutes)

☐ **Assignment 2**: Supervisor to introduce agency-specific capacity assessment tools/ behavioral indicators/questions

☐ **Assignment 3**: Worker to review **Factors Affecting Decisional Impairment in APS Clients** handout and discuss with supervisor.

☐ **Assignment 4**: Worker to complete **Case Consultation Methods** worksheet and then discuss with supervisor

☐ **Assignment 5**: Using the agency's capacity assessment tool, worker complete an assessment of the client's cognition and then complete the **On the Job** handout.

Assessing Adult Protective Services Clients' Decision Making Capacity is available as an in-person training.

Knowledge Area 6: Risk Assessment

☐ **Assignment 1**: Worker to listen to an intake call, using the agency's tool for determining risk (e.g. SDM at Intake). Worker to complete **Risk at Intake** handout. Supervisor to discuss handout & how risk assessment process begins at intake and ways the worker can gain additional information to intake information (exploration of previous records, contacting law enforcement, contacting collaterals)

☐ **Assignment 2**: Worker to complete the **Identify Risk Factors in the Various Domains**" and discuss with supervisor

☐ **Assignment 3**: Worker to complete a home visit using the agency's risk assessment tool **or** use the framework of the **3 S's** (How **soon** might the abuse occur?, how **severe** would the abuse be? and how **sure** is the worker that the abuse will happen (likelihood) Worker to discuss with supervisor or with the lead worker.

☐ **Assignment 4**: Read the article on Domestic Violence available at: http://www.medicinenet.com/domestic_violence/article.htm

Extra Credit: Interview staff at a local domestic violence shelter about the services they provide.

Risk Assessment is available as an in-person training.

Knowledge Area 7: Documentation

- ☐ **Assignment 1**: Worker to view **Documentation eLearning** (available for review)
- ☐ **Assignment 2**: Worker to complete the worksheet **Writing Exercise** handout
- ☐ **Assignment 3**: Supervisor to do the **Experiential Activity** with the unit/entire staff to emphasize the importance of memory in documentation. Worker to review **General Guidelines to Improve Memory** (2nd page of Experiential Activity)
- ☐ **Assignment 4**: Worker to review the **Case Consultation** handout with supervisor
- ☐ **Assignment 5**: Worker to complete the **Observation and Writing Activity** handout
- ☐ **Assignment 6**: Worker to review documents from previous 3 cases, using the APS Regulations check list (if in California) or the documentation checklist required by agency
- ☐ **Assignment 7**: Supervisor to introduce forms needed by agency
- ☐ **Assignment 8**: Worker to document observations of a home visit made with an experienced worker.
- ☐ **Assignment 9**: Supervisor to review and discuss the worker's documentation (from home visit in Assignment 7.8 above), focusing on quantity (the right amount of information) and quality (the right information stated appropriately).

APS Documentation and Report Writing is available as an in-person training.

Knowledge Area 8: Service Planning and Community Resources

☐ **Assignment 1**: Supervisor to introduce any resources that are *always* given to clients (e.g. civil rights brochure, language form, Information on local Administration on Aging programs.)

☐ **Assignment 2**: Worker to complete handout **Influential Factors: What Would You Need to Consider before Initiating a Case Plan**

☐ **Assignment 3**: Worker to complete the **Ethical Questions** handout and discuss with supervisor

☐ **Assignment 4**: Worker to complete the **Scavenger Hunt** exercise. This exercise is intended to help worker learn all the various ways to access information about needed resources.

☐ **Assignment 5**: Worker to complete a home visit with another worker. After the HV, determine the services needed with the worker and arrange visits with agencies that provide those services to get them put in place.

Voluntary Case Planning is available as in-person training

Knowledge Area 9- 13: Go though each type of abuse, adjusting days to match available cases

Knowledge Area 9: Self-Neglect

☐ **Assignment 1**: Worker to complete the **5 Domains of Assessment** handout

☐ **Assignment 2**: Worker to complete the **Functional Assessment** handout.

☐ **Assignment 3**: Worker to watch a 60 minute presentation on hoarding by Dr. Frost: http://search.mywebsearch.com/mywebsearch/video.jhtml?searchfor=hoarding+videos+%2B+frost&p2=^HJ^xdm017^YY^us&n=77fc66e2&ss=sub&st=bar&ptb=71D74B9A-1530-40C5-85B1-2C7D29FD0BBB&tpr=&si=pconverter&vid=rySANlpJTgI

☐ **Assignment 4:** Worker to discuss the **Empathy to Counter Resistance** handout with supervisor

☐ **Assignment 5**: Supervisor to assign 1st case (simple looking self-neglect case) to do with an observer. Worker to review assignments 9.1, 9.2 and 9.4 in light of the home visit.

Self-neglect is available as an in-person training

Knowledge Area 10: Physical Abuse

☐ **Assignment 1**: Worker to view **Markers of Physical Elder Abuse and Neglect" eLearning**

☐ **Assignment 2**: Worker to complete the **Identifying Physical Abuse** handout

☐ **Assignment 3**: Worker to complete the **Discussion Activity** with supervisor

☐ **Assignment 4**: Worker to review **List of Medical Emergencies**

☐ **Assignment 5**: Worker to complete a Home Visit with another worker in which the allegation is physical abuse. The new worker may be the assigned worker or may be an observer depending on how many cases the new worker has already handled. (Supervisor must make the determination). The supervisor is to debrief the home visit with worker

Knowledge Area 11: Financial Abuse

☐ **Assignment 1**: Supervisor to discuss financial abuse as a part of the assessment; in other words, regardless of the type of abuse on the initial referral, ***always*** check for financial abuse.

☐ **Assignment 2**: Worker to view **Financial abuse mini-modules** (5- including Undue Influence. Supervisor may need to debrief Undue Influence)

☐ **Assignment 3**: Worker to complete the **Financial Abuse Quiz**

☐ **Assignment 4**: Worker to complete the **Case Record Review and Discussion**

☐ **Assignment 5:** Worker to complete a home visit on a financial abuse case and then complete the **APS Financial Abuse Investigation Checklist** (or agency equivalent). Supervisor to debrief visit

Financial Abuse is available as an in-person training

Knowledge Area 12: Caretaker Neglect

☐ **Assignment 1**: Worker to discuss caregiver neglect with supervisor, using the **Discussion and Types of Abuse** handouts.

☐ **Assignment 2**: Worker to complete the **Indicators of Caregiver Neglect** form after completing a home visit in which the allegation is caregiver neglect

☐ **Assignment 3**: Worker to review and discuss with supervisor **Responses to Behavioral Indicators of Caregiver Neglect**

EXTRA CREDIT: Worker to sit in on a caregiver support group

Caretaker Neglect is available as an in-person training

Knowledge Area 13: Sexual abuse

☐ **Assignment 1**: Worker to view Chapter 7, "Sexual Assault" section of the ***"Elder Physical and Sexual Abuse: The Medical Piece"*** video (7 minutes). Supervisor

☐ **Assignment 2**: Worker to view Chapter 10, "Special Interview Approaches in Sexual Assault and Domestic Violence Investigations" section of the "***Elder Physical and Sexual Abuse: The Medical Piece"*** video

☐ **Assignment 3**: Worker to view "I'm Having to Suffer for What He Did- Miss Mary" section of the "***In Their Own Words: Domestic Abuse in Later Life***" (20 minutes). Supervisor to debrief videos as needed

☐ **Assignment 4**: Worker to complete the entire **Elder Sexual Abuse TOL workbook** but only do **ONE** vignette per exercise

Sexual Abuse is available as in-person training

Knowledge Area 14: Clients with Communication Deficits

☐ **Assignment 1**: Worker to view **Physical and Developmental Disability eLearning**

☐ **Assignment 2**: Worker to view ***Victims with Disabilities: The Forensic Interview*** video:

☐ **Assignment 3**: Worker to make a home visit with client who has a sensory or developmental disability and debrief the experience with supervisor

Knowledge Area 15: Mental Health and Substance Abuse

☐ **Assignment 1**: Worker to view **Mental Health eLearning** (part 1 and 2)

☐ **Assignment 2**: Worker to review and print out List of Commonly Prescribed Psychotropic Medications (written list may helpful on home visits and in documenting)

☐ **Assignment 3:** Worker to view **Substance Abuse eLearning**

☐ **Assignment 4**: Home Visit with either a mentally ill client or substance abusing client. Debrief with Supervisor

Knowledge Area 16: Involuntary Case Planning

- ☐ **Assignment 1**: Worker to complete the **Case Vignettes** handout
- ☐ **Assignment 2**: Worker to complete **Identifying Resources for Involuntary Case Plans** handout
- ☐ **Assignment 3**: Supervisor to familiarize the worker with the policy, procedure and forms necessary to refer a client for a guardianship/conservatorship.
- ☐ **Assignment 4**: Supervisor to familiarize the worker with policy, procedures and agency expectations regarding Medical and Mental Health emergencies.
- ☐ **Assignment 5**: Worker to make a Home Visit on client for whom Involuntary Case Plan may be indicated. Debrief with supervisor
- ☐ **Assignment 6**: Worker to view **Involuntary Case Planning eLearning**

Involuntary Case Planning is available as an in-person training

Knowledge Area 17: Case closure

- ☐ **Assignment 1**: Worker to review agency policies related to case closure
- ☐ **Assignment 2**: Worker to complete **Identify Factors and Conditions which indicate Appropriateness/ Inappropriateness of Closing an APS Case**
- ☐ **Assignment 3**: Worker to complete **Case Consultation: How the Helping Relationship Affects Case Closure**
- ☐ **Assignment 4:** Worker to complete the exercise **Evaluate the Effectiveness of Service Delivery in 3 Key Areas (Risk, Satisfaction and Adherence to Policy)**
- ☐ **Assignment 5:** Worker to complete exercise **Write a case closure summary that includes all essential case elements** and review **Case Closure Checklist**
- ☐ **Assignment 6:** Worker to review case closures with supervisor, using tools from preceding assignments

Case Closure is available as an in-person training

Begin doing home visits with supervision

Knowledge Area 18: Collaboration

- ☐ **Assignment 1**: Worker to attend an Multi-disciplinary Team Meeting (or VAST, FAST, Death Review meeting)
- ☐ **Assignment 2**: Complete the **Case Example** questions

Knowledge Area 19: Working with law enforcement

- ☐ **Assignment 1:** Worker to view "Overcoming Obstacles and Defenses" section of ***Elder Physical and Sexual Abuse: The Medical Piece"*** video
- ☐ **Assignment 2:** Worker to complete **The Language of the Criminal Justice System** handout
- ☐ **Assignment 3**: Worker to review **Terms and Their Meaning**

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Preliminary Task 4 (6 pgs)

COMMON APS ABBREVIATIONS and ACRONYMS

Keep this handout in your field book

A:)
AAA – Area Agency on Aging
AD – Alzheimer's Disease
ADD – Attention Deficit Disorder
ADA – Americans with Disabilities Act
ADC – Adult Day Care
ADHC – Adult Day Health Care
ADL – Activities of Daily Living
AIDS – Acquired Immune Deficiency Syndrome
ALANON – Alcoholics Anonymous Support for Families/Friends
ALS – Amyotrophic Lateral Sclerosis
AMA – Against Medical Advice
AP – Alleged Perpetrator
Approx. – Approximately
APS – Adult Protective Services
ASHD – Arteriosclerotic Heart Disease

B:)
B&C – Board & Care
BDI – Beck Depression Instrument
BP – Blood Pressure
BRO – Brother
bid/b.i.d – Twice Daily/Two Times a Day
bx - Behavior

C:)
CA – Cancer
CAD – Coronary Artery Disease
CAN – Certified Nursing Assistant
CCL – Community Care Licensing
CG – Care Giver
CHF – Congestive Heart Failure
CI – Court Investigator
COPD – Chronic Obstructive Pulmonary Disease
CVA – Cerebrovascular Accident (stroke)
CL – Client

CM – Case Manager/Case Management

D:)
DA – District Attorney
d/c – Discontinued
DD – Developmentally Disabled
DIL – Daughter-in-law
DJD – Degenerative Joint Disease
DM – Diabetes Mellitus
DNR – Do Not Resuscitate
DOB – Date of Birth
DPOA/HC – Durable Power of Attorney/Health Care
DSG – Dressing
DTR – Daughter
DV – Domestic Violence
DX or dx – Diagnosed/Diagnosis

E:)
EDRT – Elder Death Review Team
EMT – Emergency Medical Team
ESRD/ERD – Endstage Renal disease
ETOH – Alcohol

F:)
FA - Father
F.A.S.T. – Financial Abuse Specialist Team
FD – Fire Department
f/f – Face to Face
f/u – Follow Up

G:)
GDS – Geriatric Depression Scale
GI – Gastrointestinal
GP – General Practictioner
GSW – Gun Shot Wound
GRDDTR – Granddaughter
GRDS – Grandson
GYN – Gynecology

H:)
HA – Housing Authority
HBP – High Blood Pressure
HH – Home Health
HIPAA – Health Insurance Portability and Accountability Act
HIV – Human Immune Virus
HUSB – Husband
HOH – Hard of Hearing
HTN – Hypertension (High Blood Pressure)
HV – Home Visit
H&W – Health & Welfare
Hx – History

I:)
IADL – Instrumental Activity of Daily Living
IDDM – Insulin Dependent Diabetes Mellitus
IHSS – In-home Supportive Services
ILP – Independent Living Program
IM – Intramuscular
IV – Intravenous
IR – Incident Report
I&R – Information and Referral
IQ- Intelligence Quotient
INCL – Include/Including/Inclusive
INEL – Ineligible
INFO – Information
INIT – Initial

L:)
L – Left
LPS – Lanterman, Petris, Short
LTC – Long-Term Care

M:)
MC – MediCal
MCT – Mobil Crisis Team
MDT – Multi Disciplinary Team
meds – Medications
MH – Mental Health

MI – Myocardial Infarction
MMSE – Mini Mental Status Exam
MO – Mother
MOCA – Montreal Cognitive Assessment
MOW – Meals-on-Wheels
MR – Mentally Retarded
MS – Multiple Sclerosis
MSSP – Multi-purpose Senior Services Program
MVA – Motor Vehicle Accident

N:)
n/a – Not Applicable
NIDDM – Non-Insulin Dependent Diabetes Mellitus
NIFFI – No Initial Face-to-Face Investigation
NOS – Not Otherwise Specified
nv – Non-Verbal

O:)
O2 – Oxygen
OT –Occupational Therapy/Occupational Therapist

P:)
PA – Physician's Assistant
Para – Paraplegia
PCP – Primary Care Provider
PD – Police Department
PG – Public Guardian
PH –Public Health
PHN – Public Health Nurse
POA – Power of Attorney
PT – Physical Therapy/Physical Therapist
PTSD – Post Traumatic Stress Disorder
Psy – Psychiatric
PUD – Peptic Ulcer Disease
PVD –Peripheral Vascular Disease

Q:)
Q – Every
QD – Everyday

QH – Every Hour
QHS – Every Night
QID – Four times a day
QOD – Every other day
Quad – Quadriplegia

R:)
R – Right
RC – Regional Center
RCF – Residential Care Facility
RCH – Residential Care Home
RCU – Restorative Care Unit
RN – Registered Nurse
Rx – Prescription
RO – Restraining Order
ROM – Range of Motion
RP – Reporting Party
r/o – Rule Out

S:)
SA – Substance Abuse
SC – Subcutaneous
SED – Severely Emotionally Disturbed
SI – Suicidal Ideation
SIS - Sister
SNF – Skilled Nursing Facility
SOB – Shortness of Breath
SOC – Share of Cost
SRO – Single Room Occupancy (Hotel)
SSA – Social Security Administration
SSI – Social Security Supplement Income
SSNR – Social Security Number
ST – Speech Therapy/Speech Therapist
SW – Social Worker

T:)
t/c – Telephone Call
TIA – Transient Ischemic Attack

Thx – Therapy/Therapist
Tx – Treatment

U:)
UTI – Urinary Tract Infection
unk – Unknown

V:)
VA – Veterans Administration
VNA – Visiting Nurses Association
VW – Victim Witness Program

W:)
W&I Code – Welfare & Institutions Code
w/ - With
w/out – Without

Y:)
yo – Year Old

Click here to return to Preliminary Tasks for the Supervisor

Assignment 1.2 (2 pgs)

Adult Protective Services programs and staff promote safety, independence, and quality-of-life for older persons and persons with disabilities who are being mistreated or in danger of being mistreated, and who are unable to protect themselves.

Guiding Value

Every action taken by Adult Protective Services must balance the duty to protect the safety of the vulnerable adult with the adult's right to self-determination.

Secondary Value

Older persons and persons with disabilities who are victims of mistreatment should be treated with honesty, caring, and respect.

Principles

- Adults have the right to be safe.
- Adults retain all their civil and constitutional rights, i.e., the right to live their lives as they wish, manage their own finances, enter into contracts, marry, etc. unless a court adjudicates otherwise.
- Adults have the right to make decisions that do not conform with societal norms as long as these decisions do not harm others.
- Adults have the right to accept or refuse services.

NAPSA (or APS) Practice Guidelines

APS worker practice responsibilities include:

- Recognize that the interests of the adult are the first concern of any intervention.
- Avoid imposing personal values on others.
- Seek informed consent from the adult before providing services.
- Respect the adult's right to keep personal information confidential.
- Recognize individual differences such as cultural, historical and personal values.
- Honor the right of adults to receive information about their choices and options in a form or manner that they can understand.
- To the best of one's ability, involve the adult as much as possible in developing the service plan.
- Focus on case planning that maximizes the vulnerable adult's independence and choice to the extent possible based on the adult's capacity.
- Use the least restrictive services first whenever possible—community-based services rather than institutionally-based services.
- Use family and informal support systems first as long as this is in the best interest of the adult.
- Maintain clear and appropriate professional boundaries.

Assignment 1.2-cont.

- In the absence of an adult's expressed wishes, support casework actions that are in the adult's best interest.
- Use substituted judgment in case planning when historical knowledge of the adult's values is available.
- Do no harm. Inadequate or inappropriate intervention may be worse than no intervention.

Source: http://www.napsa-now.org/about-napsa/code-of-ethics/

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Assignment 1.4 (1 pg)

Match the WIC code to its text.

Match the WIC code on the left with its language on the right. This exercise is meant to familiarize you with the process of looking up laws related to APS. You can find the Welfare and Institution Codes at: http://www.leginfo.ca.gov/calaw.html

WIC codes:	
15610.65	Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be physical abuse, as defined in Section 15610.63, abandonment, abduction, isolation, financial abuse, or neglect, or is told by an elder or dependent adult that he or she has experienced behavior, including an act or omission, constituting physical abuse, as defined in Section 15610.63, abandonment, abduction, isolation, financial abuse, or neglect, or reasonably suspects that abuse, shall report the known or suspected instance of abuse by telephone or through a confidential Internet reporting tool, as authorized by Section 15658,immediately or as soon as practicably possible.
15630.b	"Protective order" means an order that includes any of the following restraining orders, whether issued ex parte, after notice and hearing, or in a judgment.
15633(a)	The reports made pursuant to Sections 15630, 15630.1, and 15631 shall be confidential and may be disclosed only as provided in subdivision (b). Any violation of the confidentiality required by this chapter is a misdemeanor punishable by not more than six months in the county jail, by a fine of five hundred dollars ($500), or by both that fine and imprisonment.
15610.17	"Care custodian" means an administrator or an employee of any of the following public or private facilities or agencies, or persons providing care or services for elders or dependent adults, including members of the support staff and maintenance staff.
15657.03b(3)	"Reasonable suspicion" means an objectively reasonable suspicion that a person would entertain, based upon facts that could cause a reasonable person in a like position, drawing when appropriate upon his or her training and experience, to suspect abuse.
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Assignment 1.5 (2 pgs)

Confidentiality

Read this short case study and then use the Confidentiality handout to help you answer the following questions.

Kevin Jones is a 38 year old man who suffers from a back injury requiring him to use crutches to ambulate. His home qualifies as a hoarder's home. There are clear paths between rooms but the rest of the floor is covered with stuff including used food containers and dirty diapers. Mr. Jones is the father of three young boys, ages 1, 3, and 6. Mr. Jones has a paid caregiver to help him with personal care but she is only paid to clean-up after him and can't manage cleaning-up after three active children and the hoarding mess. You note that Mr. Jones seems a bit confused about his medication and that there is medication within reach of the children. Mr. Jones is a very private person and, although he is willing to have people come in to help clean-up the home, he is unwilling to sign an authorization for you to talk to anyone else.

To whom can you talk about this case?

Can you talk to your supervisor?	___Yes ___No
Can you talk to child protective services?	___Yes ___No
Can you talk to the paid caregiver?	___Yes ___No
Can you talk to Mr. Jones' neighbors?	___Yes ___No
Can you talk to the home cleaning crew?	___Yes ___No
Can you talk to the children's absent mother?	___Yes ___No
Can you talk to county mental health?	___Yes ___No
Can you speak to Mr. Jones' doctor?	___Yes ___No
Can you talk to the original reporter?	___Yes ___No
Can you talk about this case to the multidisciplinary team?	___Yes ___No

Now, discuss these answers with your supervisor and be prepared to explain any limitations to your answers.

For example: Are there some people you can request information <u>from</u> but can't give information <u>to</u>?

Assignment 1.5 Confidentiality-continued

15633. (a) The reports made pursuant to Sections 15630, 15630.1, and 15631 shall be confidential and may be disclosed only as provided in subdivision (b). Any violation of the **confidentiality** required by this chapter is a misdemeanor punishable by not more than six months in the county jail, by a fine of five hundred dollars ($500), or by both that fine and imprisonment.

(b) Reports of suspected abuse of an elder or dependent adult and information contained therein may be disclosed only to the following:

(1) Persons or agencies to whom disclosure of information or the identity of the reporting party is permitted under Section 15633.5.

(2) (A)Persons who are trained and qualified to serve on multidisciplinary personnel teams may disclose to one another information and records that are relevant to the prevention,identification, or treatment of abuse of elderly or dependent persons.

(B) Except as provided in subparagraph (A), any personnel of the multidisciplinary team or agency that receives information pursuant to this chapter, shall be under the same obligations and subject to the same **confidentiality** penalties as the person disclosing or providing that information. The information obtained shall be maintained in a manner that ensures the maximum protection of privacy and **confidentiality** rights.

(c) This section shall not be construed to allow disclosure of any reports or records relevant to the reports of abuse of an elder or dependent adult if the disclosure would be prohibited by any other provisions of state or federal law applicable to the reports or records relevant to the reports of the abuse, nor shall it be construed to prohibit the disclosure by a financial institution of any reports or records relevant to the reports of abuse of an elder or dependent adult if the disclosure would be required of a financial institution by otherwise applicable state or federal law or court order.

15633.5. (a) Information relevant to the incident of elder or dependent adult abuse may be given to an investigator from an adult protective services agency, a local law enforcement agency, the office of the district attorney, the office of the public guardian, the probate court, the bureau, or an investigator of the Department of Consumer Affairs, Division of Investigation who is investigating a known or suspected case of elder or dependent adult abuse.

(b) The identity of any person who reports under this chapter shall be confidential and disclosed only among the following agencies or persons representing an agency:

(1) An adult protective services agency.
(2) A long-term care ombudsperson program.
(3) A licensing agency.
(4) A local law enforcement agency.
(5) The office of the district attorney.
(6) The office of the public guardian.
(7) The probate court.
(8) The bureau.
(9) The Department of Consumer Affairs, Division of Investigation.
(10) Counsel representing an adult protective services agency.

(c) The identity of a person who reports under this chapter may also be disclosed under the following circumstances:

(1) To the district attorney in a criminal prosecution.
(2) When a person reporting waives **confidentiality**.
(3) By court order.

(d) Notwithstanding subdivisions (a), (b), and (c), any person reporting pursuant to Section 15631 shall not be required to include his or her name in the report.

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Assignment 1.6 (2 pgs)

Identify the abuse:

In some cases, the abuse you are send out to investigate may not be the abuse you find, or may not be the only abuse you find. Read the following short case scenarios. Then, using the definitions in Adult Protective Services Program Regulations, section 33-130, determine what type(s) of abuse you would be investigating.

a. Virginia Booth, age 62, has diabetes and a personality disorder. She would walk very unsteadily in her mobile home park and yell at children, threatening them. She dumped trash on her neighbor's property. She had 10 cats and no litter boxes. The home smelled terrible and was in disrepair. Ms. Booth was very resistant to worker's intervention but the worker listened to her complaints and tried to address them. Ms. Booth felt that the neighbors were plotting against her and the neighborhood kids were harassing and making fun of her. Ms. Booth also said that park manager has raised her rent to try and get her to move. After further discussion, Ms. Booth indicated that she recently began watching a television preacher and, based on her understanding of his message, she threw away all her medications.

What type(s) of abuse should you be investigating in this case?

b. APS received a report that Marcus Lorenz, age 82, had been hospitalized after being beaten by his son and caregiver, David Lorenz. When APS arrived at the hospital, Mr. Lorenz's doctor stated that Mr. Lorenz has a severe head trauma, bruises over his upper body from being kicked, as well as malnutrition. Marcus Lorenz told APS that David beat him when he refused to give David permission to use his car. According to the police, David and the car are still missing.

What type(s) of abuse should you be investigating in this case?

c. Mrs. Evan, age 72, was referred to APS because she is facing eviction from her apartment. During the initial interview, Mrs. Evan stated that she had been doing ok with money until her son moved in with her. Since she had been paying his living expenses as well as her own for the last five months, she is now behind on all her bills. Besides worrying about her bills and her eviction, Mrs. Evan is worried about her son. He has disappeared. She doesn't know why he left and whether he is ok. And, since he was doing the grocery shopping and taking her to the doctor, Mrs. Evan is concerned about how she will manage now.

What type(s) of abuse should you be investigating in this case?

d. Mrs. Albertson is a 76 year old stroke victim who is confined to her bed. She is basically nonverbal and her husband is her paid (by the state) caregiver. Her doctor reported to APS that he believes that she is not getting adequate care. During the first visit, APS found that Mrs. Albertson had decubitus ulcers on her tailbone and bruises on her inner thighs. APS offered to arrange for additional care for Mrs. Albertson, but Mr. Albertson refused stating that he needs all the hours he is getting in order to pay their bills.

Assignment 1.6(con't)

What type of abuse should you be investigating in this case?

Read the following short scenarios and determine whether or not the client can refuse the **investigation*** based on W&IC 15636(a) which states "Any victim of Elder/Dependent adult abuse may refuse or withdraw consent at any time to an investigation or provision of services. APS shall act only with consent **UNLESS** a violation of a penal code is believed to have occurred." (See Penal Code Violations handout) *Clients retain the right to refuse **services**.

a) Mrs. Murphy's son told her that he would put her in a nursing home if she did not loan him money for a new car. They did complete and sign paperwork stating the terms of the loan and the interest to be paid. Can Mrs. Murphy refuse the investigation? ___Yes ___No

b) The allegation is that, when Janet's daughter is upset with Janet, she withholds pain medication from Janet and taunts her about it. Can Janet refuse the investigation? ___Yes ___No

c) Mr. Koffa stated that his nephew attempted to hit him but Mr. Koffa moved out of the way and so the nephew only punched a hole in the wall. Can Mr. Koffa refuse the investigation? ___Yes ___No

d) John Newman is reported, by a neighbor, to be having difficulty getting to his doctors' appointments, getting to the grocery store and doing his own laundry. He has no available relatives and can not afford a paid care provider. Can Mr. Newman refuse the investigation? ___Yes ___No

e) Ms. Mensa has stopped taking her medications for schizophrenia, forgets to buy groceries or pay her bills, is on the verge of being evicted and is concerned that her neighbors are using voodoo rituals to make her ill. Can Ms. Mensa refuse the investigation? ___Yes ___No

f) APS receives a call from Mrs. Vetta's neighbor stating that Mrs. Vetta's home looks "just like one of the houses you see on Hoarders". During the initial visit Mrs. Vetta shows no cognitive dysfunction beyond her attachment to all her junk. Can Mrs. Vetta refuse the investigation? ___Yes ___No

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Assignment 1.7 (2 pgs)

Penal Code Violations

Any victim of Elder/Dependent adult abuse may refuse or withdraw consent at any time to an investigation or provision of services. APS shall act only with consent **UNLESS** a violation of a penal code is believed to have occurred. W&IC 15636(a).

PENAL CODE § 186.10

Money Laundering

PENAL CODE § 187

Murder

PENAL CODE § 206

Torture

PENAL CODE § 207

Kidnapping

PENAL CODE § 209

Kidnapping for ransom, reward, or extortion, or to commit robbery or rape; punishment

PENAL CODE § 211

Robbery

PENAL CODE § 220

Assault with intent to commit mayhem, rape, sodomy, oral copulation, rape in concert with another, lascivious acts upon a child, or penetration of genitals or anus with foreign object; punishment

PENAL CODE § 237 (b)

False imprisonment; elder or dependent adult

PENAL CODE § 289 (b), (c)

Forcible acts of sexual penetration; lack of capacity

PENAL CODE § 368

Crimes against elder or dependent adults

PENAL CODE §§ 422.55; 422.6

Hate crime; disability is protected class

PENAL CODE § 459

Burglary

PENAL CODE §§ 470-476

Forgery

PENAL CODE § 483.5

Deceptive identification documents; requirements for manufacture, sale or transport; punishment

PENAL CODE §§ 484, 487, 488

Theft; grand theft; petty theft

PENAL CODE §§ 484d-484j

Credit card theft

PENAL CODE § 496

Receiving stolen property

PENAL CODE § 240

Assault

PENAL CODE §§ 242; 243

Battery

PENAL CODE § 243.25

Battery against person of elder or dependent abuse; punishment

PENAL CODE § 243.4 (b)

Sexual battery of serious disabled or medically incapacitated

PENAL CODE § 245

Assault with deadly weapon or force likely to produce great bodily injury; punishment

PENAL CODE § 261 (a)(1)

Rape; lack of capacity

PENAL CODE § 270c

Failure of adult child to provide for indigent parent

PENAL CODE § 286 (g), (h)

Sodomy; lack of capacity

PENAL CODE § 288 (b)(2), (c)(2)

Lewd or lascivious acts; lack of capacity

PENAL CODE § 288a (d), (g), (h)

Oral copulation; lack of capacity

PENAL CODE § 502

Unauthorized access to computers, computer systems, and computer data

PENAL CODE § 503

Embezzlement

PENAL CODE §§ 518; 519

Extortion; Fear used to extort; threats inducing

PENAL CODE § 529

False personation

PENAL CODE § 529.5

Counterfeit documents

PENAL CODE § 530.5

Identity Theft

PENAL CODE § 532a

False financial statements; punishment

PENAL CODE § 594

Vandalism

PENAL CODE § 664

Attempts; punishment

Click here to return to Knowledge Area 1:

Overview of APS

Assignment 1.8 (2 pgs)

Questions for Discussion: Define autonomy, capacity and incapacity

Note: By discussing these issues up front, supervisors can get a sense of the new worker's attitude towards their role in APS. Many new workers are zealous in their desire/need to protect their clients, even if the client has capacity. Setting the tone for respecting the client's autonomy, even if the decisions are not comfortable for the worker, is an ongoing process.

Questions for Discussion

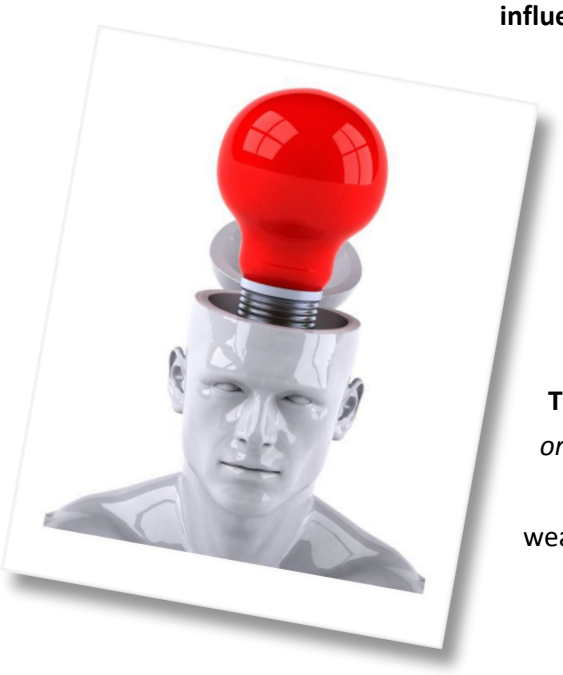
1. **What does autonomy mean to you? How would you define it?**

2. **Have you ever made a bad decision? What happened as a result? Did anyone interfere with that decision? How did it make you feel?**

3. **Under what circumstances should APS intervene when we see a bad decision being made?**

4. **How do we know when our clients have the capacity to make their own decisions?**

5. **There are times when the ability to make a decision may vary. Can you tell me what could influence that ability?**



6. **How would you determine if your client has the capacity to make decisions?**

Thoughts on Capacity: *You may want to share these or share your own examples.*

- All clients have strengths and weaknesses. A professional determination is

characterized by how well it addresses both the capacities and the incapacities of the client.

- Age, eccentricity, poverty, or medical diagnosis alone do not justify finding incapacity.
- APS workers have an ethical responsibility to protect the client's autonomy and self-determination by making certain that general incapacity is not assumed.
- Determining incapacity requires comprehensive and systematic assessment: the ability of the professional to view the client's whole life in context, to evaluate the skills needed to sustain that way of life, and to identify accurately authentic incapacities is the key to determinations that prove humane in the long-term.

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Assignment 2.2 (2 pgs)

Describe the Intake Process Worksheet

Research the Intake process by reading the law/regulations, policy manual, obtaining the forms, and interviewing workers who receive referrals, and then answer the following questions:

1. **What does the APS law say about receiving referrals? How is intake defined?** (*Who is responsible? What are the time frames? What is the legal framework around anonymity, confidentiality, reporting mandates?*)

2. **How are reports received in your agency**

3. **What forms are used for the intake process and what information is obtained?**

4. **If intake is done outside your unit, how are cases assigned and what is the responsibility of the assigned worker regarding the initial information and reporting party?**

5. **The following are the goals of the intake process. For each one, explain the most effective way to reach the goal.**

   - **Set the tone for an introduction to the agency and the program**

   - **Obtain the most relevant information on the situation**

   - **Determine if the situation meets the criteria for APS investigation**

   - **Provide clear explanations to the reporting party**

Click here to return to Knowledge Area 2: Intake Process

Assignment 2.3 (1 page)

Defining Risk Assessment and Its Function

Please sit in on an intake call. Identify possible risk factors from the information provided to you by the referring party. Answer the following questions and explain/ justify your answers.

- **Does the situation meet the criteria of a client being at risk?** (*This requires their knowledge of the legal guidelines of your APS statute/program).*
- **Do you need to go out immediately or can you wait until after you have handled more urgent cases?** (*This requires their knowledge of APS policy as well as awareness of what constitutes immediate risk*)
- **Are elders/dependent adults in immediate danger?** (*This requires them to ask specific questions about what the referring party observed as well as asking about support systems, medical issues, psychiatric history, condition of the home, etc)*
- **Why are they calling now? Did something just happen?** (*This may require them getting some history of previous calls, cases, relationship issues*)
- **Does the client understand what's going on?** (*This requires them to ascertain details of what was observed, the credibility/professional judgment of the referring party)*

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- **Is the client capable of making decisions?** (*Who says so and how do they know? What has been tried in the past?)*
- **What's at risk** (life, health, property)? (*This will help them decide what kind of intervention may be needed and what other disciplines or collaterals need to be contacted)*
- **What are the consequences of delay?** (*Is there someone available to supervise? If a perpetrator is arrested, can the victim manage alone*?)
- **Are emergency or protective measures and services are needed?** (*This requires them know when it is appropriate to call law enforcement or mental health screeners)*

Note: the risk assessment process begins at intake. Although information at intake is not always reliable, effective questioning can help in determining risk. Think about how might explore some of these risk factors/indicators prior to making a visit.

Assignment 2.4 (1 page)

What is Risk Assessment?

An analysis that uses information from investigations, research, and practice experience, to:

- Help workers protect clients' safety, health, independence, and rights.
- Help managers optimize resources and ensuring quality, effectiveness, efficiency, and fairness.

How Does Risk Assessment Help Workers?

- Plan interviews/investigations
- Develop plans to ensure clients' immediate safety and reduce future risk
- Prioritize cases, allocate time and resources
- Detect changes over time
- Determine if interventions are successful in reducing risk
- Decide when to close cases

How Does Risk Assessment Help Managers?

- Target services to those in greatest need
- Reduce the rate of re-referrals
- Increase consistency and accuracy in assessment and case management
- More effectively target outreach
- Assign cases equitably
- Evaluate workers' performance
- Understand risk factors, patterns, trends, and clients

Click here to return to Knowledge Area 2: Intake Process

Assignment 3.2 (3 pgs)

PROFESSIONAL INTERVIEW CHECKLIST

Directions for the use of the checklist: This checklist is designed to use on yourself for an interview that you conduct. For each statement, rate yourself on the following scale:

0 = Did Not Attempt **1 = Attempted & Needs Improvement** **2 = Adequate**

Note: Some of the items in this list are present in more than one section because they apply to more than one activity. In some cases, you may need or want to repeat or emphasize the item by covering it more than once.

A: PREPARING FOR THE INTERVIEW

1. Review the report.
2. Check for previous APS history.
3. Determine what information you need and who should be contacted.
4. Determine what other agencies need to be involved.
5. Determine what agency policies/procedures apply.
6. Determine safety issues.
7. Determine whether any accommodations are needed for the client's disability.
8. Determine if a translator will be needed.

B: ESTABLISHING AND MAINTAINING RAPPORT

1. Introduce yourself to the client and explain your helping role.
2. Separate the client from the suspected abuser.
3. Minimize noise- check for hearing (hearings aids w/working batteries?).
4. Make sure the client is comfortable (i.e. not tired, thirsty, hot/cold, bathroom breaks, pain?).
5. Give the client your full attention (ask if it is ok to take notes).
6. Check-in on your own assumptions, fears, and stereotypes.

0 = Did Not Attempt **1 = Attempted & Needs Improvement** **2 = Adequate**

7. Begin with non-emotional questions.
8. Verify client's identifying information (name spelling, DOB, contact information).
9. Find common ground with the client.
10. Be patient and give the client time to answer questions.
11. Refrain from being judgmental, discounting, morally outraged, etc.
12. Be reassuring if the client is emotional.
13. Accurately reflect the client's emotions.
14. Acknowledge the client's anxiety and attempt to discern its cause.
15. Acknowledge the client's anxiety and attempt to discern its cause.

C: BODY LANGUAGE OF THE INTERVIEWER

1. Maintain eye contact (if culturally appropriate).
2. Use a quiet, warm tone of voice.
3. Lean forward and keep body position open.

D: FRAMING THE INTERVIEW PROCESS

1. Explain your job as it relates to the interview.
2. Ask the client to explain why they think you are visiting them.
3. Explain what is going to happen during the interview, reassure him/her of your helpful intentions.
4. Ask him/her to correct you if you misunderstand anything his/she says.
5. Ask him/her to let you know if something is hard to talk about so that you can find an easier way to share it.

E: INVESTIGATIVE QUESTION STYLE AND USE OF LANGUAGE

1. Begin the investigative portion of the interview with open-ended, general questions.

0 = Did Not Attempt **1 = Attempted & Needs Improvement** **2 = Adequate**

2. Move into more focused open ended abuse questions as rapport is built.
3. Use open-ended questions more than 50% of the time.
4. Use invitational style questions (e.g. “Tell me more”) to encourage responses.
5. Use narrative cues (e.g. “Uh huh.” “I see.” “What else?”) to keep the client talking.
6. Avoid using leading questions.
7. Avoid using multiple choice questions (unless the client is unable to verbalize answers).
8. Avoid using yes/no and either/or questions (unless the client is unable to verbalize answers).
9. Avoid using “tag” questions (e.g. “…, didn’t you?”).
10. Don’t repeat a question to try and get the “right” answer (coercive).
11. Follow-up on abuse disclosures to “drill down” for more details after the client discloses abuse.
12. Use open-ended questions to ask for the specifics of the abuse (who, what where, when and how).
13. Don’t ask the client to explain “why” the abuse occurred.

F: SPECIAL CONSIDERATIONS

1. Identify barriers to communication and determine what adaptations can be made (e.g. translators, assistive devices, pace of the interview, etc.).
2. Check the client’s hearing and minimize noise/ provide assistance or assistive devices.
3. Check the client’s vision and make needed adjustments to the setting.
4. Provide the client with breaks if he/she gets tired or needs the restroom.
5. Keep tabs on the client’s level of pain if pain is an issue.
6. Be reassuring if the client has been traumatized.
7. Speak directly to the client, not the caregiver or translator.
8. Consider how cultural differences may influence your communication with the client.
9. Adapt your interview style to the functional level of the client. (Simpler language and more concrete questions).

10. Anchor your questions in the salient events in the client's life.

H: COMMENTS ABOUT THE INTERVIEW PROCESS

Click here to return the Knowledge Area 3-Communication

Assignment 3.3 (3pgs)

Transforming Leading into Non-leading Questions

Instructions: Please rewrite each question on the left so that it is no longer a leading question.

LEADING	NON-LEADING
1. Does your son cook your dinner?	
2. This picture must be of your care provider.	
3. I understand that you are having a problem with your son.	
4. Does your daughter use your credit cards?	
5. Did your grandson remember to give you your medications today?	

6. Your caregiver didn't take you to the doctor, did she?	
7. Did your husband take away your car keys?	
8. Did he take you to his lawyer's office?	
9. Does she lock you in your bedroom every night?	
10. That must have made you very angry.	
11. Was watching pornography your son's idea?	

12. Isn't it true that you knew she couldn't repay you?	
13. How many times did he strike you?	
14. Did she force you to write the checks?	
15. Did he tell you not to tell anyone?	

Adapt with permission from Paul Needham

Click here to return to Knowledge Area 3-Professional Communication

Assignment 4.2 (5 pgs)

ABUSER JUSTIFICATIONS AND DEFENSES[1]

APS CONSIDERATIONS

FORM OF ABUSE	Justification / Defense	Investigation Considerations
Physical	"She fell."	• Does the medical or physical evidence match suspect's/victim's/witness' description of events?
	"He's just clumsy."	• Does the medical or physical evidence match suspect's/victim's/witness' description of events?
	"I was trying to help."	• Does the medical or physical evidence match suspect's/victim's/witness' description of events?
	"She bruises easily."	• Does the medical or physical evidence match suspect's/victim's/witness' description of events? • Is the victim taking medications that can cause a person to bruise easily?
	"It was an accident."	• Does the medical or physical evidence match suspect's/victim's/witness' description of events?

[1] Excerpts taken from Barron, T. (1998) *Financial Exploitation of Infirm Adults: A Prosecutor's Perspective*. Violence Against the Elderly and Disabled. 1(4), 53 – 64.

	"He has Alzheimer's disease or he's crazy. You can't believe what he says	• Do the medical history and/or mental health experts support this assertion? • What are your observations of victim/suspect/witness at different periods of time?
	"I was defending myself."	• Is there sign of a defensive injury? • Who is the predominant (or primary) physical aggressor?
Neglect	"She has always lived like this. She's not a good housekeeper."	• Are there sufficient resources to provide for the victim's needs? • Has the victim's capacity changed over time? • Is there a caregiver? • Do friends or family members support this statement?
	"I'm doing the best I can. Taking care of him is very difficult."	• Does the victim have sufficient capacity to make informed decisions about care, including refusing to accept care or treatment? • Does the victim have a history of refusing help? • Does the suspect have a duty to provide care? • Is the suspect receiving payment to provide care? • Has the caregiver been instructed on the victim's condition, care needs and how to provide care? • Does caregiver have any special training in providing care? • Are the victim's care needs obvious and would be apparent to the average person?
	"He doesn't want medication/medical treatment. I'm honoring his wishes."	• Is there documentation of person's wishes (for example, a do not resituate order [DNR])? • What is the victim's capacity, as documented by a trained professional? • Are there historical statements of intent or the desires of the victim?

	"She refused to eat."	• What is the health history of the person's condition?
	"I didn't know how sick she was or what she needed."	• Is there a medical history indicating how often victim was taken to a doctor and what was told to the caregiver about the patient's condition?
	"I'm just doing what she (the victim) wants."	• Do wills or advanced directives describing what the victim wants exist?
Sexual	"She wants to have sex with me." or "She likes watching pornographic movies with me." (Suspect is trying to show consent.)	• If the victim has capacity, what is the victim's account of what happened? • If the victim does not have capacity, the victim cannot consent.
	"She's my wife/girlfriend."	• If the victim has capacity, what is the victim's account of what happened? • If the victim does not have capacity, the victim cannot consent.
	"I was just cleaning or bathing him. This is not sexual abuse."	• What does a health care provider say about whether appropriate caregiving techniques were being used?
	"She came on to me."	• If the victim has capacity, what is the victim's account of what happened? • If the victim does not have capacity, the victim cannot consent.

	We're consenting adults."	• If the victim has capacity, what is the victim's account of what happened? • If the victim does not have capacity, the victim cannot consent.
	"She acted like she liked it."	• If the victim has capacity, what is the victim's account of what happened? • If the victim does not have capacity, the victim cannot consent.
	"She's my wife. I have the right."	• Check state marital rape laws. If the victim has capacity, what is the victim's account of what happened? • If the victim does not have capacity, the victim cannot consent.
Financial Exploitation	Loan	• What is the capacity of lender? • Is there written proof of the loan including the amount and period of loan and were other loans made? • What are the terms of repayment and were any repayments made?
	Gift for self or children	• What is the capacity of the donor? • What is the value of the gift? • What is relationship between donor & victim? • Is there evidence of donor's intent to make a gift? • Why was a gift made? (Any promises or other inducements?)
	Services Provided	• What is the capacity of the person seeking the services? • What were the services; were they needed; how often were services provided; how well performed; were supplies provided? • What is the value of services vs. amount paid for them?

	Permission	• What is the capacity of the victim? • Is there evidence of actual permission? • Were there promises or other inducements to get permission? • Who benefited? • How often was permission used? • What is the value of items obtained? • Did victim understand what permission was used to do?
	Quid Pro Quo ("She lets me live with her in exchange for helping with errands.")	• What is the capacity of the victim? • Was the marriage reasonable given the relationship between the parties? • Was the suspect legally able to marry? • Are there any suspect misrepresentations? •
	Favor ("She freely gave me use of her car as a favor to me.")	• What is the capacity of the victim? • Who benefits from the favor; what did victim receive in return; is the benefit reasonable? • How does it fit prior financial planning and actions of the victim? • Did suspect receive payment to provide care? • What is victim's relationship to business or person?
	Lack of Knowledge ("But I do not know her PIN")	• What is the contrary evidence? • Did the suspect have access to information? • Were there other acts for same goal? (e.g., forged her signature to get an ATM card in victim's name)
	Legal authority	• What is the capacity of the victim? • Is there legal authority in writing? • What does the legal authority cover and expressed or implied limitations?

	Victim is crazy	• Is there a medical opinion of victim's mental health? • Are there statements from friends and family about victims behavior prior to and after suspect came into life? • Does the victim take any medications? • What was the victim's behavior around time of questioned events? Is this conduct consistent with earlier times?
	I'm the real victim	• Who is benefiting financially?
	"We're in love" married/in a relationship": "We're family"; "She's like a mother to me; therefore, we share resources."	• Who is benefiting financially? • What is true nature of relationship? • Are any cultural norms relevant for consideration? • Does suspect have other relationships or marriage licenses? • Does suspect have other income or debts? • Are victim's basic needs met?
	Purchase made as part of care	• Is there evidence of purchase being used to provide care? • Is the purchase necessary for care?

Click here to return to Knowledge Area 4- Dynamics of Abuse/ Investigations

Assignment 4.2(con't)

POWER AND CONTROL WHEEL

Abuse in Later Life Wheel

Created by the National Clearinghouse on Abuse in Later Life (NCALL), a project of the Wisconsin Coalition Against Domestic Violence (WCADV)
307 S. Paterson St., Suite 1, Madison, WI 53703 608-255-0539
www.ncall.us/www.wcadv.org

This diagram adapted from the Power and Control/Equality wheels developed by the Domestic Abuse Intervention Project, Duluth, MN

Permission to Adapt 2006

Click here to return to Knowledge Area 4-Dynamics of Abuse

Assignment 5.3 (2 pgs)

Factors Affecting Decisional Impairment in APS Clients

Chronic Pain	May become the focus of attention and inhibit the ability to listen**.** A recent study found a relationship between untreated pain and increased depression among the elderly.
Dehydration	Can cause altered mental status, agitation or lethargy, lightheadedness and confusion. Speech difficulty, sunken eyes, weakness and lethargy are often attributed to other conditions. Chronic and acute-medical conditions, malnutrition and severe hot and humid weather can all cause dehydration.
Delirium	An acute, reversible disorder. It occurs suddenly, over a short period of time and fluctuates during the day. It may be caused by existing cognitive impairment, severe physical illness, stroke, Parkinson's disease or dehydration, and can be aggravated by acute pain. Symptoms include changes in the way the patient uses information and makes decisions, inability to focus, and uncharacteristic behavior. The patient reports feeling "mixed up."
Dementia	Involves a significant, persistent decline in functioning over a period of time. Depending on the type of dementia, the patient may lose memory as well as some or all of cognitive functions such as language, motor activities, ability to recognize familiar stimuli, and/or executive functioning. Accurate diagnosis requires a detailed history as well as physical and neurological examinations. Some dementias are reversible.
Depression	The patient reports feeling sadness, emptiness, detachment, loss of interest in usual activities, sleep disturbances, and/or weight loss. Speech is slowed, diminished or repetitive. Patient may show anxiety or panic. Condition persists for more than two weeks and is not related to situational loss.
Disease	Thyroid, diabetes, cancer, Parkinson's, heart disease, stroke and AIDS may cause diminished capacity as the diseases progress.
Grief	Intense grief reaction may result in temporary confusion, dependency, exhaustion and inability to make decisions.
Hearing/Vision Loss	Can mimic or exacerbate cognitive impairment. Communication difficulties due to sensory or physical impairments are often mistaken for confusion.
Low Blood Pressure	Can be due to medication error, causing dizziness, weakness and falling which could result in head injury.
Low IQ	May affect patient's understanding of choices, risks and benefits.
Malnutrition	Protein energy malnutrition and low levels of vitamin D lead to weakness, diminished ability to provide self-care and ultimately to decreased cognition.

Medication Mismanage-ment	Drug interactions and adverse reactions are common and can be serious. May be due to Patient's visual or cognitive impairment, inability to afford prescriptions, or functional illiteracy. Medication misuse frequently causes mental impairment. Antibiotics and cardiovascular drugs are the most frequent causes of adverse effects.
Physically Ill	May result in electrolyte imbalances that cause confusion and prevent rational decision making.
Psychosis	Difficult to detect. Symptoms include delusions, hallucination, agitation.
Substance Abuse	Older adults become inebriated with lower levels of alcohol consumption—leads to malnutrition and alcohol dementia. Also, alcohol intake in conjunction with certain medications can have a greater impact on older individuals than younger individuals.
Stress/Anxiety	Anxiety disorder is more prevalent than depression among the elderly. Older women are more at risk than men. May be the result of family violence or Post Traumatic Stress Disorder.
Traumatic Brain Injury	May be the result of physical abuse or a fall. Falls are the most common injury in the elderly due to weakness, environmental hazards, dizziness, alcohol, medications or stroke. A patient with sudden changes in mental status after a fall may have subdural hematoma.
Urinary Tract Infection	Most common infection in the elderly. Can present as acute change in cognitive status. May result in delirium.

Source: Otto.2007

Click here to return to Knowledge Area 5-Capacity

Assignment 5.4 (1 page)

Methods Case Consultation

When the new worker has questions about the capacity of an APS client, you may use these questions as a guideline:

1. **Can the client understand relevant information?**
   - *Please give me an example of "relevant information".*

2. **What is the quality of the client's thinking process?**
   - *What is an example of how you would assess the "quality of client's thinking process"?*

3. **Is the client able to demonstrate and communicate a choice?**
   - *Give an example of a client who demonstrates and communicates a choice.*

4. **Does the client appreciate the nature of his/her own situation?**
   - *What questions could you ask to determine if the client appreciates the nature of his/her own situation?*

Click here to return to Knowledge Area 5-Capacity

Assignment 5.5 (1 page)

On the Job Training:

Explain to worker that they do not perform a total capacity assessment, but they get enough information between the interview questions and from the agency tool to know when it is appropriate to take the next step.

For this OJT, the worker will go out on a real case where there is an issue of capacity, and interview the client, using the tool the agency requires. After the visit, spend some time processing it with the worker and then ask for feedback on:

- **What was your experience like using this tool?**
- **What information did it give you?**
- **What information do you still need?**
- **How will you get that information?**
- **What is your next step?**

Click here to return to the Knowledge Area 5-Capacity

Assignment 6.1 (2 pgs)

Risk at Intake

Have new workers receive an intake call. Ask them to identify possible risk factors from the information provided to them by the referring party. Ask them the following questions and have them explain/ justify their answers.

- **Does the situation meet the criteria of a client being at risk?** (*This requires their knowledge of the legal guidelines of your APS statute/program).*

- **Do you need to go out immediately or can you wait until after you have handled more urgent cases?** (*This requires their knowledge of APS policy as well as awareness of what constitutes immediate risk*)

- **Are elders/dependent adults in immediate danger?** (*This requires them to ask specific questions about what the referring party observed as well as asking about support systems, medical issues, psychiatric history, condition of the home, etc)*

- **Why are they calling now? Did something just happen?** (*This may require them getting some history of previous calls, cases, relationship issues*)

- **Does the client understand what's going on?** (*This requires them to ascertain details of what was observed, the credibility/professional judgment of the referring party)*

- **Is the client capable of making decisions?** (*Who says so and how do they know? What has been tried in the past?)*

- **What's at risk** (life, health, property)? (*This will help them decide what kind of intervention may be needed and what other disciplines or collaterals need to be contacted)*

- **What are the consequences of delay?** (*Is there someone available to supervise? If a perpetrator is arrested, can the victim manage alone*?)

- **Are emergency or protective measures and services are needed?** (*This requires them know when it is appropriate to call law enforcement or mental health screeners)*

Click here to return to Knowledge Area 6-Risk Assessment

Assignment 6.2 (1page)

Identify Risk Factors in the Various Domains

Please think of as many risk factors as you can under each domain. Share with your supervisor.

1. Health and functional status (e.g. needs help ambulating)

2. Mental health status and capacity (e.g. unable to make a grocery list)

3. Living environment (e.g. leaking roof)

4. Financial (e.g. caregiver has access to client's ATM)

5. Social (risk posed by others, including caretakers and family members) (e.g. caregiver is neglectful)

Click here to return to Knowledge Area 6-Risk Assessment

Assignment 7.2 (1 page)

Written Exercise:

Demonstrate the use of clear, concise, and objective language

Read the following statements and rewrite them so they are clear, factual, objective, and concise, adding information to support the observations.

1. Client was inappropriately dressed.

2. Daughter was very controlling and made the client afraid to speak.

3. Client was depressed and cried a lot.

4. This family is enmeshed and will not respond to therapy.

5. Son is mooching off his mother. He hasn't worked in years.

6. Caregiver has issues and treats the client very poorly.

Click here to return to Knowledge Area 7-Documentation

Assignment 7.3 (2 pgs)

Experiential Activity:

Discuss the importance of accurate recall and identify at least 3 memory improvement techniques

This activity is best done as part of a staff meeting to get feedback and sharing from a variety of individuals. If done with a large group, you may use the activity from the training module.

Instructions: Before the meeting select 15-20 small items that can be found in an APS household. These could include a prescription bottle (with name and dose written on it), an over the counter drug, a knife, a pet (stuffed, of course), an insect (plastic cockroach?), stuffed mouse, doilies, broken eyeglasses, a piece of rotten/fresh food, playing cards, hearing aide, knitting needles, matches, dirty clothing, a plant, social security check, cash, a beer can, etc- just make sure there are a variety and some are significant and should be noticed. Make a list of all the items for your reference.

Put all the items in a blanket or sheet, so they cannot be seen by the participants and put the closed blanket on a table in the front of the room. Ask participants to come around the table. Tell participants that when they go into a client's home, there will be a lot to notice other than the client. The cues in the environment may give them information which will help with their assessment. It is important for them to notice and remember what they observed.

Tell them that in the blanket are ____ number of items that they might see in a client's home. Tell them you will open the blanket and give them **one minute** (no more) to observe the items in the blanket. After one minute, quickly close up the blanket and ask participants to take their seats. Then ask them to list everything they saw. Give them a few minutes**.**

Ask if anyone got all ____ (number) correct? Then ask them what they found and write all items on flip chart. Check against your master list to see if anything was missing. Discuss reasons for missing things, ask them which items stood out for them, comment how different items may have different meaning to different people.

General guidelines to improve memory

In addition to exercising your brain, there are some basic things you can do to improve your ability to retain and retrieve memories:

1. Pay attention. You can't remember something if you never learned it, and you can't learn something — that is, encode it into your brain — if you don't pay enough attention to it. It takes about eight seconds of intent focus to process a piece of information through your hippocampus and into the appropriate memory center. So, no multitasking when you need to concentrate! If you distract easily, try to receive information in a quiet place where you won't be interrupted.

2. Tailor information acquisition to your learning style. Most people are visual learners; they learn best by reading or otherwise seeing what it is they have to know. But some are auditory learners who learn better by listening. They might benefit by recording Information they need and listening to it until they remember it.

3. Involve as many senses as possible. Even if you're a visual learner, read out loud what you want to remember. (If you can recite it rhythmically, even better.) Try to relate information to colors, textures, smells and tastes. The physical act of rewriting information can help imprint it onto your brain.

4. Relate information to what you already know. Connect new data to information you already remember, whether it's new material that builds on previous knowledge, or something as simple as an address of someone who lives on a street where you lready know someone.

5. Organize information. Write things down in address books and datebooks and on calendars; take notes on more complex material and reorganize the notes into categories later. Use both words and pictures in learning information.

6. Understand and be able to interpret complex material. For more complex material, focus on understanding basic ideas rather than memorizing isolated details. Be able to explain it to someone else in your own words.

7. Rehearse information frequently and "over-learn". Review what you've learned the same day you learn it, and at intervals thereafter. What researchers call "spaced rehearsal" is more effective than "cramming." If you're able to "over-learn" information so that recalling it becomes second nature, so much the better.

8. Be motivated and keep a positive attitude. Tell yourself that you want to learn what you need to remember, and that you can learn and remember it. Telling yourself you have a bad memory actually hampers the ability of your brain to remember, while positive mental feedback sets up an expectation of success.

Click here to return to Knowledge Area 7- Documentation

Assignment 7.4 (1 pg)

Case Consultation:

Discuss confidentiality as it affects documentation relating to clients, law enforcement, and other professionals

Distribute and discuss your APS policy regarding confidentiality.

When discussing their documentation on cases in individual supervision, you may use the following guidelines to make sure that workers understand the confidentiality rules

- Check the wording of the documentation for statements that may have been exaggerated or minimized. Explore what worker wanted to achieve by distorting the documentation… was it to protect the client at any cost, was it to protect the worker's liability. Discuss the danger of biased documentation. Ask how that type of information may come back to haunt them.
- Ask if that documentation will be shared with anyone – who is allowed access to it and why.
- Ask who may need to scrutinize this documentation… and share any concerns about the way the material has been organized or documented, asking worker what could be improved.
- Explain that some of the complaints about APS include lack of sharing information on the outcome of an investigation. Ask how they would explain this to a referral source- a family member, neighbor, attorney, another agency

Click here to return to Knowledge Area 7-Documentation

Assignment 7.5 (2 pgs)

Observation and Writing Activity:

Discuss documentation needed for court including statements, evidence, and language.

The following page contains a photo of a hoarder house. Have the worker look at the photo and document her/his observations in a clear, objective, and concise manner. Tell the worker that this photo is the evidence that will be presented in court.

Review the documentation summary with the worker providing feedback on the accuracy, objectivity, and relevance of what is written. If there is more than one worker, workers can exchange documentation and provide feedback to each other… make sure, you point out items that they miss.

Here is a photo of an APS client's home. Below please document what you observe in this photo. Make sure your documentation is clear, objective, and concise. This documentation would be used if you were to take this case to court.

Assignment 7.6 (3 pgs)

California Regulations Transfer of Learning

To help you retain the information that you learned in this module, it's important that you apply the information in your work. Please review one of your recent cases with your supervisor using the following template. If you can't remember the specifics of any of the regulations, please review your handouts.

How does your client meet the definition of an APS client?	Explain:
Was the reporting party a mandated reporter? □ Yes □ No	
How did you handle confidentiality issues in this case? (Was there someone you had to talk to but had to watch what you said?)	Explain:
Did you discuss this case with a Multidisciplinary Team?	
Did this case qualify for No-initial-face-to-face investigation (NIFFI)? Why or why not?	Explain:
What was the response time for this case? Why?	Explain:
Did you get permission to enter the client's residence? □ Yes □ No	

Did you complete the Assessment within the deadline?

- □ Yes
- □ No

Did your Assessment documentation include:

- □ reason for referral
- □ summary of investigative findings
- □ summary of concerns/needs
- □ summary of strengths, limitations & risk factors
- □ client's history with APS and other agencies

Did you complete the Service Plan within the deadline?

- □ Yes
- □ No

Did your Service Plan:

- □ Promote the goal of client's safety in the least restrictive environment
- □ Reflect the goals of the client/family
- □ Outline strategies to achieve goals
- □ Get approved by first level supervisor within 5 calendar days of completion.

If you case was open more than 30 days beyond the initial face to face, did you monitor the case every 30 days?

- □ Yes
- □ No

Did you do a Reassessment within 90 days?

- □ Yes
- □ No

Did you document:

□ Appropriateness of service plan □ Need for continued APS involvement
If you have closed the case, did you document: □ Reason for case closure □ Services provided □ Resources now in place □ Achievement of Service Plan goals

From California
APS Regulations
eLearning module

Assignment 8.2 (1page)

Influential Factors:
What would you need to consider before initiating a case plan

Client Wishes (What do we need to know about the client?)	
Perpetrator Issues (What do we need to know about the perpetrator?)	
Urgency of Situation (What are the most urgent emergency situations?)	
Ethical Considerations (What dilemmas do we face when deciding how to intervene?	
Cultural Considerations (What cultural values must we consider?)	

Click here to return to Knowledge Area 8- Service Planning & Community Resources

Assignment 8.3 (2 pgs) **Ethical Questions**

Vignette #2: Jack and Jim

You recently accepted a job at a county social services office located in a small rural community where there are limited social services resources. You are anxious to fit in and make this your permanent home and were delighted when the social club at a local church invited you to join them at a potluck. You feel like you have made the beginnings of some new friendships and enjoy having a "home church" to attend.

The first case you are asked to investigate involves two elderly men, Jack and Jim. Jim broke his hip last year and uses a walker. Jack was recently diagnosed with Alzheimer's.

When you visit the home you quickly realize that they could really benefit from home health care services as both men need assistance with some ADLs. It is also likely that Jack will eventually need to move to a 24 hour residential facility. The men tell you that they are gay and have been in a committed relationship for 40 years.

A private organization operates both the local home health care services and the residential care center. It is the only home health and residential care provider in the area. Jack and Jim tell you that the organization is not "gay friendly", in fact, the director stated that there is no need to serve "those people in our town because no gays live here". Jack and Jim are worried about what they will do when Jack needs residential care. They realize that they will not be able to manage on their own much longer. They are concerned that Jack will be mistreated if he enters the facility as a gay man. They ask you to help them figure out how to proceed.

The director of the facility is a deacon at the local church which is openly opposed to homosexuality. This is the same church that has been so welcoming to you.

What will you do?

Assignment 8.3 (con't)

Vignette #3: Bill

An APS report comes in for a 79 year old man living in a residential hotel. The man, Bill, is an amputee due to complications from diabetes. He does not receive regular medical care and has been known to sell his insulin syringes to buy money for alcohol. Upon investigation you find the man confined to his bed that is soaked in urine and feces. His intact leg looks seriously infected. There are several empty bottles of alcohol, a half liter of diet cola, and some bread and bologna in the mini-fridge by his bed. He does not appear to be under the influence and is oriented to his surroundings. You tell him he needs immediate medical care and begin to call 911. He states in no uncertain terms that he does not want to go to the hospital or see a doctor. He says if you want to provide care you can, "go buy him some booze and leave him in peace." What will you do?

Click here to return to Knowledge Area 8-Service Planning and Community Resources

Assignment 8.4 (6 pgs)

Scavenger Hunt

Service Need	Agency (Include address and phone)	Service Provided	Eligibility Requirements	Cost	Referral Process
Major Home Cleaning					
Home Health Care					
Emergency Shelter					

Service Need	Agency (Include address and phone)	Service Provided	Eligibility Requirements	Cost	Referral Process
Respite Care					
Home Delivered Meals					
Pet food/care					
Podiatrist (home visit)					

Service Need	Agency (Include address and phone)	Service Provided	Eligibility Requirements	Cost	Referral Process
Emergency food					
Medical Transportation					
Friendly visitor					

Service Need	Agency (Include address and phone)	Service Provided	Eligibility Requirements	Cost	Referral Process
Help with Utility Bills					
Substance Abuse treatment					
Caregiver support					

Service Need	Agency (Include address and phone)	Service Provided	Eligibility Requirements	Cost	Referral Process
Financial Management					
Elder Abuse Restraining Orders					
Conservator-ship referrals					

Service Need	Agency (Include address and phone)	Service Provided	Eligibility Requirements	Cost	Referral Process
In- Home Caregiver					

Click here to return to Knowledge Area 8-Service Planning & Community Resources

Assignment 9.1 (1 page)

The 5 Domains of Assessment

For each domain, list as many possible indicators of self-neglect as you can think of:

Domain 1: Physical/Medical Factors:

Domain 2: Psychological/Mental Health

Domain 3: Environmental

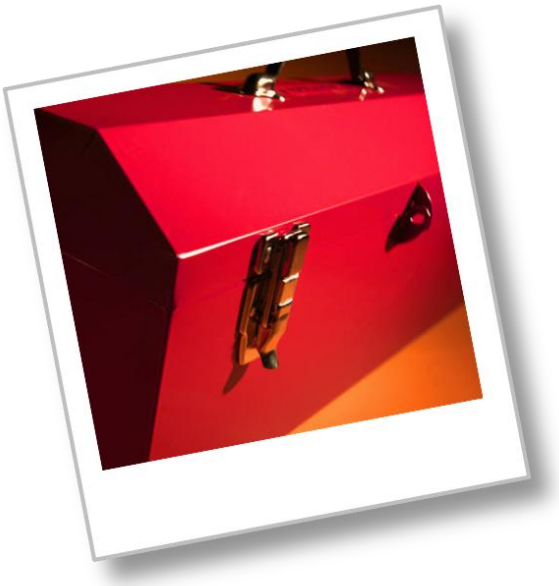
Domain 4: Financial

Domain 5: Social and Cultural

Click here to return to Knowledge Area 9-Self Neglect

Assignment 9.2 (1 page)

Functional Assessment



- Mrs. F is a frail 85 year old woman. She recently fell and hurt her wrist. The doctor doesn't want her lifting anything weighing more than 5 lbs.
    - **What assistance might she need?**
    - **How severe or urgent is this situation?**

- Mrs. S. is 76 and a recent widow. She is depressed and has not paid her utility bills. Her home is in disrepair. She says she has never handled money and her husband used to take care of everything. She has isolated herself from others. She does not drive.
    - **What assistance might she need?**
    - **How severe or urgent is this situation?**

- Mr. G. age 80 has some dementia and is taking Coumadin, Aricept, blood pressure medication. He often forgets to take his medications and is unsteady on his feet. His home is full of clutter and trash. There are newspapers stacked to the ceiling. He is dirty, his clothing is soiled and ill-fitting and he is wearing his boxer shorts over his pants. There is little food in the house.
    - **What assistance might he need?**
    - **How severe or urgent is this situation?**

Click here to return to Knowledge Area 9- Self-Neglect

Assignment 9.4 (1 page)

Using Empathy to Counter Resistance

Causes of Resistance

- Dementia
- Anxiety
- Grief
- Depression
- Lack of insight
- Personality problems
- Shame
- Distrust
- Fatigue
- Fear
- Pain
- Anger

Express Empathy

- Listen
- See the world through the client's eyes
- Think about things as the client thinks about them
- Feel things as the client feels them
- Share in the client's experiences
- Respect the client's perceptions
- Take your time
- Do not rush to judgment

Benefits to using empathy

- Lessens resistance and denial
- Helps you get more information
- May make client more open to suggestions and incremental change

Click here to return to Knowledge Area 9 - Self-Neglect

Assignment 10.2 (1 page)

Identifying Physical Abuse

Answer the following questions related to physical abuse. This activity may be done as a group discussion, or done individually and discussed with a supervisor or other mentor.

1. **Identify some examples of normal age related changes? How are the changes you observed different from similar physical abuse related signs or symptoms?**

2. **How might you approach a new client that you are interviewing when you observe the following:**

   a. A 'black eye'

   b. A hand shaped bruise on the arm

   c. Bruising to the inner thigh

3. **How might a client display anxiety or fearfulness during an interview?**

5. **Provide one brief example of each of the following types of abuse** (what would you see?)**:**

   a. Hitting, pushing, or slapping

   b. Strangulation

   c. Force feeding

   d. Misuse of medications

   e. Abuse of restraints

Click here to return to Knowledge Area 10 - Physical Abuse

Assignment 10.3 (2 pages)

Discussion Activity*:*

The activity can be done as a group activity or as one to one training tool. The priority in this activity is not to obtain identical answers, but rather to be able to see that participants are thinking about physical abuse and applying some of the information they learned from the Markers of Physical Elder Abuse and Neglect eLearning as well as from this transfer of learning workbook.

Please read the following brief scenarios and consider possible physical abuse. Answer the questions following each scenario.

1. You receive a report of possible psychological/emotional abuse and/or physical abuse of 82y/o Mr. Schneider by his live-in son, Robert. When you knock on the door, Mr. Schneider seems very anxious when you explain that you need to talk to him. He steps outside the door with you and tells you in a whisper, I can't talk now, come back at 4PM, after my son goes to work. You return at 4:30PM and he asks you inside. He tells you that he doesn't like to upset his son, and that the son leaves for work at 4PM. Mr. Schneider's son is 58y/o. Mr. When you mention concerns about Mr. Schneider's safety, he becomes more evasive, saying repeatedly that his son is really a good man, but that he just loses his temper sometimes. As you talk with Mr. Schneider, you notice an unusual red mark on his arm that has a loop in it. You also notice that one of his wrists is bruised and see several small finger-sized bruises on his other arm.

    a) What might the looped red mark on his arm be?

    b) What is the medical term for bruising?

    c) If the bruising about the wrist is from physical abuse, what kind of activities or actions might have caused it?

    d) What might the finger-sized bruises indicate?

    e) What behavioral indicators might also contribute to your suspicions that he may have been physically abused?

2. Mrs. Mays is an 85y/o woman who is confined to her bed most of the time. She is diabetic, suffers from dementia, and has severe Osteoporosis. A report of abuse is received from a paid caregiver who was recently fired when she told Mrs. Mays daughter, Gloria, that she was being too rough with Mrs. Mays. When you visit the home, Mrs. May's daughter, Gloria answers the door. Gloria is pleasant and invites you in. Gloria tells you that her mother is asleep now, but will be awakened soon for her lunch. Gloria then says "I bet this is about some complaint from the caregiver I fired." You tell Gloria that you cannot disclose information that brought you to see Mrs. Mays, and you then engage Gloria in talking about Mrs. Mays. Gloria tells you how much she loves her mother, but also describes at length how frustrating it is to care for her. Gloria tells you that "I have no life" and describes how confused her mother is, always wandering around

the house, being incontinent, and falling. Mrs. Mays Osteoporosis makes her especially vulnerable to fractures if she falls; however, she is too confused to remember her daughter's entreaties that she not walk alone. Gloria tells you that it is difficult to get Mrs. Mays to eat, and that she has to push her to eat. At this point you hear Mrs. May calling out to Gloria. You accompany Gloria into Mrs. May's room and find Mrs. Mays to be frail, very thin, and from her facial expression, apparently confused. Gloria introduces you to her mother, and then tells her mother that she will bring in lunch. She tells Mrs. Mays-"remember you have to eat, if you don't, you know what will happen". As Gloria goes to get the food, you notice that there are soft ties, similar to terry cloth robe belts tied around the head board on each side, and that Mrs. Mays wrists are red. You also notice that Mrs. Mays has some bruising around her lips, and has a very congested cough.

a) Did Gloria's frustration raise a possible red flag?

b) Gloria made the statement too her mother: "remember you have to eat, if you don't, you know what will happen. Why is this concerning?

c) What might the belts tied around the head board on each side indicate?

d) What concerns might the bruising around her lips raise?

e) Mrs. May has a very congested cough, what concerns might this raise?

3. You go to Mrs. Smith's home to investigate a report made by a neighbor that said that they have heard Mr. Smith shouting loudly at his wife and the sound of objects being thrown inside the home. Mr. Smith is allegedly an alcoholic with a bad temper. When you interview Mrs. Smith, Mr. Smith is asleep. Numerous liquor bottles can be seen around the home. You notice that Mrs. Smith keeps extending her neck forward while you talk, and rubbing her throat. When you ask her about this, she says that she has had a sore throat. You also note that she has a fading discoloration around both of her eyes, and a bruise behind her ear. She tells you that she is clumsy, and that she ran into a door frame while she was bringing in groceries. She complains that she has had a severe headache for several days.

a) What significance does Mrs. Smith rubbing her throat and extending her neck have to your investigation?

b) What red flags may be raised by apparent discoloration or bruising around both of her eyes?

c) What significance might the bruising behind her ear have?

d) Does the coloration of Mrs. Smith's apparent injuries provide proof of how long ago she was injured?

Click here to return to Knowledge Area 10 - Physical Abuse

Assignment 10.4 (1 page)

Recognizing medical emergencies

According to the American College of Emergency Physicians, the following are warning signs of a medical emergency:

- Bleeding that will not stop
- Breathing problems (difficulty breathing, shortness of breath)
- Change in mental status (such as unusual behavior, confusion, difficulty arousing)
- Chest pain
- Choking
- Coughing up or vomiting blood
- Fainting or loss of consciousness
- Feeling of committing suicide or murder
- Head or spine injury
- Severe or persistent vomiting
- Sudden injury due to a motor vehicle accident, burns or smoke inhalation, near drowning, deep or large wound, etc.
- Sudden, severe pain anywhere in the body
- Sudden dizziness, weakness, or change in vision
- Swallowing a poisonous substance
- Upper abdominal pain or pressure

From: http://www.nlm.nih.gov/medlineplus/ency/article/001927.htm

Click here to return to Knowledge Area 10 - Physical Abuse

Assignment 11.3 (1 page)

The Financial Abuse Quiz

	Question	True	False
1	Most reports of financial exploitation are initiated by the victim		
2	It is estimated that 1 in 14 cases of financial exploitation is reported.		
3	Ageism can be a factor in financial exploitation		
4	Elders who do not speak English are connected to their community and therefore are less likely to be exploited		
5	Many people believe that finances are a private matter		
6	Immigration status may keep elders or families from seeking help.		
7	Older victims are the first to blame their exploiters, especially if they are family members		
8	Victims often will protect the abuser		

List the barriers that would keep an older victim from reporting?

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

Click here to return to Knowledge Area 11 - Financial Abuse

Assignment 11.4 (1 page)

Case Record Review and Discussion

Identify and discuss at least six (6) indicators of financial exploitation, Describe common victim and perpetrator characteristics of financial exploitation

1. Have the worker read case records where financial exploitation was indicated/substantiated. From what they read, have them make a list of indicators. After they submit the list to you, share the Indicators of Financial Exploitation handout with them and compare.

2. From the case records reviewed, have them make a list of types of perpetrators they find (family member, friends, care providers, fiduciaries, etc.) Ask what these have in common.

3. Share Handout # 3: Who are the Victims? .Using that handout, have them read case records and explore what risk factors those victims had for financial exploitation (over age 75, socially isolated, dependent, frail, mentally or physically ill, female, low to moderate financial resources).

4. If your APS program requires investigation of financial crimes by perpetrators not know to victims, have worker research types of sweepstakes/ lottery scams and other types of confidence scams. Ask them to list the types of scams and explain them to you or to peers at a unit meeting. If shared at a unit meeting, have more experienced workers share their challenges working with those types of crimes.

5. Show segment from the US Postal Inspection Service video – Dialing for Dollars: Telemarketing Fraud. http://www.youtube.com/watch?v=wJb6ou6Oi58 Segment runs approximately 6 minutes. It shows a retired man being pressured into "investing" more money into "stock" by his "broker" who is king of the telemarketing boiler room.

   Allow a few minutes to debrief the video as it will stimulate conversation. APS jurisdiction may come up - APS would refer to law enforcement (local, FBI, Secret Service), and may partner with victim services and credit services in a case like this.

Click here to return to Knowledge Area 11 - Financial Abuse

Assignment 11.5 (4 pages)

APS Financial Abuse Investigation Checklist

I. Determine the relationship of the alleged perpetrator and the client

- ❑ **Interview victims and alleged abusers separately.**

It is important to maintain a neutral stance when interviewing alleged abusers. Encourage them to tell their side of the story. Documenting their version of events initially, allows you to catch any future inconsistencies in their story.

It is important, when at all possible, to obtain signed releases from the victim for medical and financial information during this initial interview. *Please note – Very important that releases not be sought if victim lacks capacity, especially if the case may involve criminal conduct.*

(Check all that apply) The alleged perpetrator is:

- ❑ A relative
- ❑ A friend/neighbor/religious leader
- ❑ IHSS chore provider of record
- ❑ Holds a position of trust
- ❑ Lives with the victim
- ❑ Alleged abuser is employed/has a separate source of income

II. Cognitive and other deficits

- ❑ **Assess the victim for cognitive, vision, or hearing deficits. Is the client literate?**

Such impairments may cause the victim to be unaware of what documents he or she has signed. It is often instructive, when initially interviewing the alleged abuser separately, to get his or her opinion on these issues. The degree of the client's impairment, as reported by the alleged abuser, often changes in subsequent accounts of the victim's abilities and circumstances.

If cognitive impairment is suspected, attempt to obtain mental/cognitive evaluations and histories from the victim's family members, physician, friends or other service agencies involved with the victim. A neuropsych evaluation may be needed (through Tangible Services) to establish the victim's current level of cognitive functioning and document any areas of incapacity or vulnerability to undue influence. A neuropsych expert can/may be able to offer an opinion on capacity at a prior time as well.

(Check all that apply)

- ❑ Client exhibits signs/symptoms of memory loss
- ❑ Client exhibits signs/symptoms of psychosis
- ❑ Alleged abuser states client's memory is good
- ❑ Alleged abuser states client's memory is poor
- ❑ Alleged abuser's story changes about client's memory
- ❑ Client has substance abuse problem which may impair cognition
- ❑ Neuropsychological evaluation needed
- ❑ Client has vision problem
- ❑ Client has glasses/does not have access to them
- ❑ Client is hearing impaired
- ❑ Client has hearing aid(s)/ does not have access to them
- ❑ Client is unable to read
- ❑ Client is unable to write
- ❑ Client is unable to speak/speak coherently

III. Extent of client's estate (Check all that apply)

- ❑ Client owns own home
- ❑ Client owns other real property
- ❑ Client has bank account(s) and/or CD(s)
- ❑ Client has a brokerage account and/or other stocks owned
- ❑ Account(s) are in client's name only
- ❑ Alleged abuser's name is on account(s)
- ❑ Joint account is an "or" account
- ❑ Joint account is an "and" account
- ❑ Changes reported in client's deposit/withdrawal habits
- ❑ Client home furnishings/other personal property of value reported missing
- ❑ Vehicle(s) owned by client
- ❑ Client's name only name on vehicle title
- ❑ Alleged abuser's name only name on vehicle title
- ❑ Auto insurance in force/insurance in client's name
- ❑ Client's auto is registered with DMV in abuser's name
- ❑ Client is unable to drive
- ❑ Alleged abuser drives client's vehicle
- ❑ Client's vehicle is kept at the abuser's address
- ❑ Big screen TV seen in client's home

IV. Ownership of real property (Check all that apply)

- ❑ Assessor's records have been searched
- ❑ An in-house "Property Research Request" is needed to establish chain of title
- ❑ Client and alleged abuser's claims of ownership agree
- ❑ Client and alleged abuser's claims of ownership don't agree
- ❑ Client's name is only name on the deed

- ❑ Alleged abuser's name has recently been added to the deed
- ❑ Alleged abuser has removed client's name from the deed.
- ❑ Client pays mortgage, or is on the rental agreement/lease
- ❑ Client's real property has been refinanced.
- ❑ Client is aware/understands property has been refinanced
- ❑ Client is aware/understands the amount/terms of the refinance
- ❑ Client's real property(s) has been refinanced frequently and equity depleted
- ❑ Evidence of shopping addiction on the part of client
- ❑ Evidence of gambling problem on the part of client
- ❑ Evidence of a shopping addiction on the part of the abuser
- ❑ Evidence of a gambling addiction on the part of the abuser
- ❑ String of garbage liens on the real property(s)
- ❑ Garbage/other liens are inconsistent with client's income
- ❑ Property taxes have been paid for current year
- ❑ There are gaps in record of property tax payments
- ❑ Client is responsible for paying property taxes
- ❑ Someone else is responsible for paying property taxes
- ❑ Client believes property taxes have been paid
- ❑ Client's home is currently in, or approaching, foreclosure or tax sale for unpaid property taxes

V. Client's finances (Check all that apply)

- ❑ Client handles own finances
- ❑ Client pays own bills
- ❑ Client has representative payee
- ❑ Alleged abuser is rep. payee for client
- ❑ Alleged abuser is supposed to pay the client's bills
- ❑ Client has a DPOA for finances
- ❑ Client has DPOA for health care decisions
- ❑ DPOA(s) dated before/after onset of dementia
- ❑ A copies of the DPOA(s) have been obtained
- ❑ Alleged abuser is named as DPOA
- ❑ Client's income received in paper check form
- ❑ Client's income is direct deposited
- ❑ Method of client receiving income has recently changed
- ❑ Clients bank statements and other records are missing from home
- ❑ Client has an ATM card
- ❑ Client is not aware of having ATM card
- ❑ Alleged abuser has access to an ATM card for client's account(s)
- ❑ Client unaware of having credit cards/debt
- ❑ Alleged abuser using client's identity/credit
- ❑ Sample of alleged abuser's signature has been obtained
- ❑ Sample of client's signature has been obtained

VI. Follow-up on misused bank accounts

1. Contact the bank immediately and request that it "flag" the account, and observe with caution.

2. You can access information regarding the client's account by visiting the bank with the client, requesting the DPOA for finances (if appropriate) to act, or have the client sign a release of information for financial information. If the bank is willing, a home visit by bank personnel to a homebound client can be made.

3. Encourage the client to close any misused accounts and open new ones. This can be done in person by the client, or via a letter signed by the client. Make sure that any direct deposits are transferred to the new account. Note: If misuse of the client's account was done via ATM transactions, recommend that the client not authorize an ATM card for the new accounts.

4. Request copies of past bank statements and pertinent cancelled checks.
   Note- it's important to request copies from before the suspicious transactions began to determine the routine spending patterns and habits of the victim.

   Review withdrawals from the account to look for forgery or unusual activity. If forgery or misuse of funds is apparent, have the client sign an affidavit with the bank and it will be investigated. The police, FBI, postal inspectors and secret service may get involved at this point.

VII. Contact Law Enforcement

Remember, law enforcement is an important partner in financial exploitation cases and they may be contacted before, during or after your initial investigation depending on the intake referral/allegations. Law enforcement wants to know if a crime has occurred and the elements of the crime. **Handout 1** on crimes and statutes will come in handy when interacting with law enforcement.

Client Name_____ Case No._____

Click here to return to Knowledge Area 11 - Financial Abuse

Assignment 12.1 (2 pgs)

Questions for Discussion:

1. What does neglect mean to you and how would you define it? Does the legal definition of neglect in our state conflict with your personal values? (Provide worker with legal definition) How will you reconcile those differences, if any?
   Answers may include some or all of the following elements: Neglect involves the failure to provide essential goods or services such as food, water, clothing, shelter, personal hygiene medicine, comfort, personal safety, and other essentials that are necessary to maintain the health or safety of an elder or dependent adult. The salient concept to remember is that neglect involves the failure to provide essential services. Neglect is an act of omission, not commission.

2. Provide participants with **"Types of Neglect" (following page)**. Review the types of neglect listed and for each category of neglect ask workers: "What questions or observations would help you to evaluate for neglect when doing a home visit?"
   Answers may include:

   i. **Lack of medical treatment:** When was your last medical appointment? How did you get there? Who makes your medical appointments? How are decisions made about when you see the doctor? Have you ever wanted to see your doctor but been unable to go? Can you tell me about that incident?

   ii. **Lack of assistive devices:** Do you wear or need hearing aid, eyeglasses, dentures? Have you ever been without any of these aids and can you tell me more about that? Have you ever been without your wheelchair/walker or has it been out of reach and you had no way to get to it?

   iii. **Hazardous environment:** Is the home too hot/cold for you? Is it okay for you to turn up the heat/air conditioning or does someone else decide that? How would you get out of the house if there was a fire?

   iv. **Isolation:** Please describe a typical day. How often do you have visitors or phone calls? Are you able to access the phone and to get and make phone calls? How often do you go out and where do you go?

   v. **Lack of social/emotional support:** Can you tell me about your friends and family? How often do you see them? When you need assistance or support who can you ask for help? Do you ever feel unsafe or unsupported?

   vi. **Lack of appropriate clothing or hygiene:** Is clothing and bedding adequate for the current weather conditions? Is the shower/bathtub, sink and toilet in working order? Are clothing or bedding soiled? If assistance is needed with bathing is it provided?

   vii. **Abandonment:** Is the person who has assumed responsibility for the older person or who has physical custody available to provide care?

Assignment 12.1 con't

TYPES OF NEGLECT

A victim may experience several types of neglect at the same time that may vary in intensity. Neglect may worsen existing medical conditions leading to the victim's compromised ability to make informed choices or to complain about the lack of care. The boundaries between neglect and abuse are often blurred. In some cases the neglect is so severe that it becomes abuse.

- ***Lack of medical treatment.*** It may be medical, meaning that the victim has not received appropriate and/or timely medical attention for his/her physical well-being. Medical neglect may also include the fact that the victim is not getting needed prescribed medications, that the medications are outdated, or that the victim is being over or under medicated in order to keep him/her easy to manage.

- ***Inadequate nutrition and/or hydration*** mean that the victim is not receiving enough food or liquids, or that what is provided is not appropriate for the victim's condition.

- The ***lack of assistive devices*** may have devastating effects on the victim. Without dentures, for example, the victim's nutrition is compromised. A lack of assistive devices can result in the victim being more dependent on the caregiver, and thus more subject to the caregiver's control.

- A ***hazardous environment*** puts the victim at risk of fire, disease, heat exhaustion or hypothermia. Lack of sanitation may mean unsafe drinking water. Vermin thrive in dirty dwellings, spreading disease.

- An ***isolated*** *victim* has no one to oversee his/her level of care, as well as little or no social support and stimulation, which put him/her at risk of depression, neglect, abuse and exploitation.

- The ***lack of social / emotional support*** means that the victim has no friends, family and/or advocates assuring his/her safety and well-being.

- ***Lack of appropriate clothing or hygiene*** means that the victim may suffer from hypothermia or over-heating, and that he/she may be more susceptible to infections due to lack of cleanliness.

- ***Abandonment*** is the desertion of an elderly person or vulnerable adult by an individual who has assumed responsibility for providing care for the person, or by an individual who has physical custody of the person. *Note: Not all state elder abuse/APS statutes include abandonment as a specific form of elder/vulnerable adult abuse. However, when a person who has assumed responsibility for providing care to an elder/vulnerable adult deserts the person for whom he/she has assumed responsibility that constitutes neglect, which is included in every state elder abuse/APS statute.*

- Some states, such as Texas, also include the ***failure to provide mental health treatment*** as a form of neglect. This includes the following: The failure to provide the mental health treatment necessary to avoid harm or pain.

Click here to return to Knowledge Area 12 - Caretaker Neglect

Assignment 12.2

INDICATORS OF CAREGIVER NEGLECT

CHECKLIST: INDICATORS OF CAREGIVER NEGLECT

Indicator Present		Physical Indicators
YES	**NO**	
		Unsafe living environment (trash, vermin, lack of heat/cooling, water, electricity, running water)
		Malnutrition (sunken eyes, discoloration of the skin, oversized clothes, weight loss) Ask for permission to check refrigerator.
		Dehydration (pinched skin does not return to normal; it stays up in pinched position; how often is victim using restroom or drinking liquids?) Ask for permission to check refrigerator.
		Lack of medical care; untreated medical conditions (are dates on medications current or expired? Does victim appear feverish or chilled?)
		Over or under use of medication (is the amount of medication available congruent with the prescribed dosage?)
		Abandonment
		Poor personal hygiene/soiled clothing (does victim have a foul odor?) Workers are encouraged (with victim's permission) to lift bedclothes and/or clothing to observe the condition of the bedding and the victim's skin condition, especially at pressure points such as the shoulder blades, elbows, buttocks and backs of heels
		Skin breakdown/decubitus ulcers (see above)
		Diarrhea/urine burns (see above)
		Physically/emotionally isolated
		Lack of assistive devices
		Inappropriate, inadequate or soiled clothing
		Behavioral Indicators of victim
		Fearful: Hesitates to talk openly; Hand over mouth; Withdraws physically/increases space
		Anxious/agitated: Pacing; Restless; Trouble following conversation; Nervous laugh; Eyes averted
		Angry: Raised voice; Yelling; Cussing; Defensive: Blames others
		Isolated/Withdrawn: Not speaking at all; Closed off body language; Avoids eye contact
		Depressed: Flat affect; Low personal hygiene/unkempt; Expresses hopelessness/despair: Gestures others away with hand
		Ambivalent: Makes contradictory statements
		Confused/Disoriented: No orientation of date/time/place: Unable to comprehend environment
		Perceives self as helpless/powerless: Manifestations of poor self-esteem/confidence; Expresses insecurity
		Reluctant to criticize perpetrator: Defends perpetrator: Doesn't complain or want to bother: Blames self
		Ashamed: Not forthcoming with information; Refuses help; Refuses to accept/acknowledge situation
Emergency Intervention Indicated?		
Yes	**No**	**Explain:**

Click here to return to Knowledge Area 12 - Caretaker Neglect

Assignment 12.3 (1 page)

RESPONSES TO BEHAVIORAL INDICATORS OF CAREGIVER NEGLECT

It is helpful to consider in advance how to frame questions in order to gather the information needed to assess for caregiver neglect. The following suggestions will assist you to elicit information from victims with behavioral indicators of neglect.

Behavioral Indicator	**Possible Responses by the worker**
The victim appears fearful and reluctant to talk openly about the situation.	• How can people offer you the right kind of support?
	• Where do you think I can fit into the picture?
	• How do you decide what to worry about?
	• What happens when you don't know whom you can trust?
	• What's your approach to things you don't particularly want to deal with?
The victim's demeanor changed when the caregiver enters the room (after the caregiver leaves) ask the following questions.	• What happens when you have to deal with a person's behavior that you don't understand?
	• What are some of the things about relationships you wish could be different?
The victim seems isolated and withdrawn - turning away from contact.	• How does a person go about reassuring you?
	• What happens to the things you worry about?
	• What do you do with the things you'd rather not talk about?
The victim appears listless - exhibiting flat affect.	• What is the best way to approach something you'd rather not talk about?
The victim acts indecisive, ambivalent - makes contradictory statements and decisions.	• How much can you depend on the people around you?
	• What are some things you'd like to change?
	• What have we left out of the picture, so far?
	• Well, how does this add up to you?
The victim appears confused or disoriented.	• Please tell me your name.
	• Where are we right now?
	• Who is taking care of you ?
The victim is reluctant to criticize the perpetrator or complain about lack of care.	• How are we going to talk about things that don't seem to be working the way we hoped?
	• How do you know when to let a person know what you are really thinking?
	• How do you know when a situation is beginning to become too hard to handle?

Click here to return to Knowledge Area 12 - Caretaker Neglect

Assignment 13.4 (Complete Module-15 pgs)

Module 14

Elder Sexual Abuse– Kevin Bigelow

The Topic: Sexual abuse is often difficult to investigate, and even difficult to discuss without feeling awkward. Talking about sexuality, let alone sexual abuse often touches on the feelings and values of the investigator. Despite feelings of discomfort, in order to investigate sexual abuse thoroughly and be of assistance to clients, APS workers must be familiar with the issues of sexual abuse, and be comfortable with discussing sexual abuse and sexual situations. Through the Elder Sexual Abuse training and this workbook, participants will gain experience in discussing sexual abuse, identifying possible sexual abuse, and will learn some techniques for intervening in sexual abuse situations.

By the end of this training, and through the use of this workbook, participants will be able to:

- Learn the myths and realities of sexual violence as it relates to APS clients
- Learn to discuss sexual victimization
- Recognize potential sexual abuse among their clients
- Effectively screen for and interview clients regarding sexual abuse
- Learn to offer helpful interventions to victims

Supervisor Activities:

The following pages offer information and activities to enhance the learning experience of participants that have completed the Elder Sexual Abuse training. We suggest reviewing the Elder Sexual Abuse Trainer Manual as it will provide further information and resources to expand training participants' knowledge and skills related to sexual abuse investigation.

Suggested readings:

Eckert, L. & Sugar, N. (2008). Older victims of sexual assault: An under recognized population. American Journal of Obstetrics & Gynecology, 198, 688.e1–688.e7.

Ramsey-Klawsnik, H. (2004c). Interviewing suspected victims. Victimization of the Elderly and Disabled, 7(3), 35 – 36, 48.

Ramsey-Klawsnik, H. (2004b). Investigating alleged victimization. Victimization of the Elderly and Disabled, 7(2), 17, 31 – 32.

Teaster, P. & Roberto, K. (2004). The sexual abuse of older adults: APS cases and outcomes. The Gerontologist, 44, 788-796.

Burgess, A. (Dec 2006) "Elderly Victims of Sexual Abuse and Their Offenders access 5/17/2012 at https://www.ncjrs.gov/pdffiles1/nij/grants/216550.pdf

http://www.preventelderabuse.org/nexus/hrklawsnik.html

Myths versus Reality Discussion Questions **(Activity #1):**

Sexuality and sexual abuse in particular are often difficult topics to discuss with others. Early social learning, societal mores, and a reluctance to discuss something that would be considered by some to be offensive cause many people to avoid open discussion of these kinds of topics. As Adult Protective Services or other community workers, however, it is part of our job to discuss unpleasant realities, and to be able to bring events to light that cause harm to our clients. A discussion of some of the following questions may provide trainees with an opportunity to express their fears and hesitations when talking about sexual abuse.

1. When you think about sexual abuse and feel reluctant to discuss it, what do you feel? *(Possible answers: shame, embarrassment, fear of offending, giving others a negative impression of yourself, concern that you will seem insensitive)*

2. What are some of the myths that you have heard with regard to elder sexual abuse? *(Possible answers: elders are not 'sexual', sexual abuse only happens to young people, rape and sexual abuse are crimes of passion and can't happen with elderly people because they are not considered attractive, only women are victims of sexual abuse, if sexual abuse occurred— it must somehow have been precipitated by the elder)*

3. Have you heard of or worked a case where elders have been victims of sexual abuse? Was it difficult to discuss with the client, with other staff, with other professionals, or with your supervisor? *(Workers, especially new workers often have difficulty interviewing clients about sexual abuse and discussing the details with other staff or professionals. Discussing these experiences may make them more comfortable with these topics in the future)*

Myths versus Realities [Handout #1]:

Read the following short scenarios, and then answer the questions after each scenario.

1. Mark had been working as a van driver for a local senior center for six months. Mark assaulted Mr. Norman, 72 years old, during a routine trip to his home after an activity at the senior center. Mr. Norman was the last passenger on the van, Mark diverted from his route and parked the van in a remote location. Mark initially told Mr. Norman that he was tired and had to rest before he took him home, then he came and sat next to Mr. Norman before assaulting him. Mr. Norman is blind and physically frail. He uses a cane to walk. Soft spoken, Mr. Norman is never heard to complain about anything. After the assault, Mr. Norman was frightened and said nothing. He avoided the senior center and Mark. The assault did not come to light until several weeks later when Mr. Norman, a widower, was found to have a sexually transmitted disease.

Question: Do you think that Norma's sexual assault was a crime of opportunity or did Mark choose his victim and plan his assault?

2. Mrs. Margo's grandson came to live with her after his own parents threw him out of their home. Gary was 21 years old with a history of drug abuse and a criminal background. Mrs. Margo remembered Gary as a little boy and could not resist his request to stay with her. For the first two weeks, Gary was well behaved, went shopping for Mrs. Margo, and did some repairs around her home. After that, some of Gary's friends began to hang around and she suspected that Gary was drinking and using drugs. Mrs. Margo gave Gary the ultimatum that he either stop using drugs and seeing his drug related friends or move out. Gary left the house very angry and returned to the home late that night. He entered Mrs. Margo's bedroom and raped and beat her. After his arrest, Gary claimed that he was not at fault because he was under the influence of drugs and could not remember the assault.

Question: Gary's drug abuse and poor impulse control have caused him many problems. Aside from Gary's legal prosecution, does his impaired impulse control due to drug use limit his responsibility for his actions toward Mrs. Margo? If Gary was not under the influence of drugs, and still assaulted Mrs. Margo, would this change the situation?

3. When Mrs. Gore, aged 70, moved in with her niece Brandy and her husband Carl, she was initially welcomed. Mrs. Gore needed a place to stay and Brandy and Carl needed the extra income, which they received from Mrs. Gore as rent. Over time, however, Carl and Brandy began to treat Mrs. Gore as an intruder, and blamed her for their financial and other difficulties. One night, when Brandy was away from home on a business trip, Carl became very drunk and attacked Mrs. Gore. He physically abused her, and then sexually assaulted her. Episodes of physical assaults and sexual assaults went on for hours until Carl locked Mrs. Gore in the garage and passed out. Mrs. Gore was able to escape and call the authorities, and Carl was arrested.

Question: Was Carl's assault on Mrs. Gore motivated primarily by sexual attraction or by power and control issues?

Characteristics of sexual abuse victims

[Handout #2]:

- Most identified victims of all ages, including elders, are female
- Male victims, including elders, have also been identified
- Age is not a protective factor for sexual abuse, victims as old as 100 have been identified
- Most identified elderly victims experienced cognitive, functional, and/or physical limitations
- Disabilities of victims often interfere with taking steps to self-protect, including reporting to authorities
- Fear of the perpetrator and familial bonds to abusive kin can inhibit victims from reporting or seeking help
- Many older people who have reported sexual abuse have not been believed. Some have been presumed demented or psychotic

Discussion Questions:

1. If most sexual abuse victims of all ages are female, what are some possible reasons for this?

2. Is it surprising to hear that males are also victims of sexual abuse? If so, why?

3. Why would one assume that older persons are less likely to be victims of sexual abuse

4. Why would elderly victims with cognitive, functional, and/or physical limitations be considered preferred targets for perpetrators? *(*How might the disabilities of victims interfere with taking steps to self-protect, including reporting to authorities?

5. How would fear of the perpetrator and familial bonds to abusive kin inhibit victims from reporting or seeking help?

Characteristics of Sexual Abuse Perpetrators [Handout #3]:

Complete the sentence using the options listed below

1. The majority of sexual abuse perpetrators are_____.
2. Female perpetrators exist and have been_____.
3. Age range for sexual abuse perpetrators_____.
4. Perpetrators may access victims through their _____.
5. The most commonly alleged perpetrators in facilities are_____.
6. Most substantiated sexual abuse perpetrators in facilities are_____.
7. Sexual abuse perpetrators are rarely _____.
8. Domestic Sexual Violence is perpetrated by _____.

A. Employees
B. Fellow residents
C. Substantiated in APS cases
D. Male
E. Spouses and partners, as well as other relatives
F. Juveniles to elders
G. Held accountable in the criminal justice system
H. Relationships, employment, or activities

The Prevalence of Elder Sexual Abuse is Unknown [Handout #4]

Unlike some other forms of abuse, the prevalence of elder sexual abuse is unknown. There are many contributing factors to this lack of specific knowledge. Limited research has been done, and the usual channels for obtaining data are often ineffective to researching elder sexual abuse. One source of data on sexual abuse cases are hospital emergency room records. While ER records are an effective means of gathering statistical information for some types of abuse, less than 5% of sexual assault victims seen in hospital emergency departments are over age 60.

Some of the reasons that data on elder sexual abuse is so limited are listed below:

- There is widespread disbelief that elders are sexually assaulted
- Victim conditions often prohibit reporting
- Sexual abuse markers are often missed or misinterpreted in older bodies
- Professional training is insufficient
- Response to allegations is often insufficient
- Many cases never reach APS or law enforcement

Discussion Questions:

Why do you think that sexual abuse markers are often missed or misinterpreted? *(Possible answers: Not all physicians are trained to work with geriatric patients, disbelieving that elders are sexually abused-they may look for other causes for sexual abuse indicators, the elder may be fearful or too ashamed to admit they have been sexually abused and may claim other causes for injuries)*

What are some of the reasons that professional training regarding elder sexual abuse may be insufficient? *(Possible answers: few physicians or other health care professionals specialize in geriatrics, some health care professionals are drawn to other specialties since aging cannot be 'cured', funding for health care for the aged is limited so geriatrics is not necessarily considered a lucrative field of training to pursue)*

Why do you think that responses to allegations are often insufficient? *(Possible answers: many persons do not believe that elder sexual abuse takes place, elders who report sexual abuse may not be believed, health care professionals do not always screen for sexual abuse, so it is not found or pursued, if reported-professionals may feel that the elder is just 'confused')*

What reasons can you think of for many cases failing to reach APS or law enforcement attention? *(Possible answers: Elders themselves do not report, those who suspect possible abuse may not want to believe the abuse actually occurred, some facilities are fearful of word getting out that abuse has occurred at their facility, if uncovered-some people may feel that the elder is "too out of it" to really care and use this excuse to avoid the scandal/investigation)*

Range of Sexually Abusive Behavior

[Handout #5}

Untrained persons often assume that sexual abuse only involves non-consensual vaginal penetration of a female perpetrated by a male. In reality, sexual abuse can involve a range of additional sexually related behaviors. APS workers must be aware of the various types of behavior that constitutes sexual abuse. Although it sometimes feels awkward to discuss the specific behaviors associated with sexual abuse; an APS worker must be comfortable with discussing these details so that they can help make the client comfortable enough to share details of their abuse event with the worker. The full range of sexually abusive behavior includes:

1. Contact ("touching") offenses i.e. rape, molestation, kissing

2. Non-contact ("non-touching") offenses i.e. harassment, threats, forced pornography viewing, taking photos, exhibitionism

3. Harmful genital practices i.e. unnecessary, obsessive, or painful touching of or insertion into the genital/anal area when not part of a prescribed medical or nursing plan

Comprehension Check

Utilizing the range of sexually abusive behaviors described above, read the brief descriptions of situations below, and then select the type of sexually abusive behavior -contact, non-contact, or harmful genital practices

Behavior	Type of Sexually Abusive behavior: contact, non-contact, or harmful genital practices
Example: Forced vaginal penetration of a female by a male	*Contact*
Excessive painful washing of the perineal area though not medically prescribed	
Non-consensual fondling of breasts or genital areas	
Medically unnecessary vaginal examinations or enemas without the client's permission	
Exhibiting of genitals to an unwilling viewer	
Forcible 'kissing'	
Forcing an elder to watch pornography	
Taking sexual photos without permission	
Intentionally rubbing genitals against another person without their consent	
Threatening sexual activity in a harassing manner	
Forcing a hand into others' clothing to touch breasts or genitals	

Self Care When Handling Disturbing Cases

It is important to realize that some sexual abuse cases will be more disturbing than others. Each worker will be more or less emotionally affected by each case that they encounter. Some of the factors that may influence the depth and extent of these disturbing reactions in the worker may include: the type and severity of sexual abuse and related injuries, the expressed emotional pain of the victim, and the associations that the worker may consciously or unconsciously make related to the case. For example, a sexual assault against a woman that reminds the worker of a grandparent may be harder to handle emotionally for that worker than another case might be.

Discussion Questions (note: these questions may be used in one-on-one supervision or a unit meeting):

1. Have you ever had an investigative case that you found particularly disturbing? If so, discuss the impact of the case on you (without disclosing any confidential information). What did you do to help you deal with these feelings? Did you find something in particular that helped you to feel better?
2. Have you encountered a situation where you felt uncomfortable discussing graphic case details with another authorized professional partner? How did you deal with your discomfort?
3. What signs and symptoms might be red flags that you have been traumatized by case events?
4. What services does your agency have in place for help if you have been traumatized? *(talk with your supervisor about employee assistance that is available)*

Forensic Interviewing in Sexual Abuse Cases: Desk Reference* [Handout #6]

(Use with the following exercise)

Preparing for the Interview Discussion Questions [Handout #7]

For each of the following brief situations, describe how you might prepare for, or respond to the elements of the situation or interaction.

1. Helen is a 76 year old female with cancer who is alleged to be a victim of sexual abuse by her physical therapist. Helen is frail, and the reporting party says that she is often drowsy, especially in the afternoon. They also report that she has a tracheostomy that prevents her from speaking unless a plug has been inserted into the tracheostomy opening in her neck. She has a live-in caregiver who is not the alleged perpetrator.
   What might you do to prepare to meet with Helen for the first time?

2. Maninder is an 80 year old woman from Pakistan. She lives with her son and daughter-in-law. She speaks minimal English, and is cared for primarily by the daughter-in-law. Sexual abuse by an uncle that often visits the family home is alleged. Maninder is said to have suspicious bruises to her perineal area as well as some bruising to her arms and torso that may be physical abuse. The situation is complicated by the fact that Maninder is diagnosed with Leukemia, which can account for unusual bruising.
   What considerations would you need to take into account, and what considerations will you need to make preparations for?

3. Michaela is a 40 year old developmentally disabled female who was allegedly molested by a bus driver who was transporting her to her sheltered workshop from the board and care where she lives. She has a speech impediment, and is said to have the mental age of a six years old.
   What considerations and preparations will you need to make as you prepare to go out and interview her?

4. Mr. Smith is a 75 year old man with a history of chronic obstructive pulmonary disease that makes it difficult for him to catch his breath or to talk at length. He was allegedly molested by an X-Ray technician when he was in the hospital. He is home now, and said to be fearful of strangers. He also has hearing deficits. You go to his home to talk with him and he takes a long time to come to the door. When he does, he is breathing heavily. You begin to introduce yourself, and he becomes anxious and agitated saying loudly, “What do you want?!”
   How will you commence your interview with Mr. Smith and try to put him at ease?

<u>Vignette-Mrs. Joel</u> [Handout #8]

Part 1

Mrs. Joel is a 69 year old Romanian woman living with her family in a closely knit Romanian community. Mrs. Joel has hearing difficulties and is undergoing chemotherapy for breast cancer. The allegation is her husband is an alcoholic, and has been raping and beating her. You have been warned in advance that she speaks very little English and the Romanian subculture that she is a part of resists sharing any information with authorities.

- What are some of the things that you might do to you to talk to Mrs. Joel?

Part 2

You learn from the reporting party (RP) that most of the male members of the household are away at work during the day. The RP is a member of the Romanian community, however, she tells you that she cannot reveal herself as the reporting party or she will be shunned by the entire community. She does tell you that Mrs. Joel's primary caregiver is her daughter Katya, and that she knows Katya is concerned for her mother. With your supervisor's permission, you speak with one of the In-Home Supportive Services Registered Nurses about chemotherapy, and she tells you some of the potential side effects. You find an approved Romanian interpreter who works for another county agency, and have them sign a confidentiality agreement.

When you make the initial visit, you go to Mrs. Joel's home at 9:30 am, after the male members of the household have left for work. The door is opened by Katya, the client's daughter, who is initially very guarded; however, when the interpreter tells her that you are worried about her mother, she relents and allows you in. Mrs. Joel agrees to talk with you and the interpreter alone. To your surprise, you find that Mrs. Joel speaks English fairly well, and you only have to use the interpreter to assist at times when Mrs. Joel's English fails her.

You begin with general questions about Mrs. Joel's health and how her treatments are going. Mrs. Joel remains fairly positive through these questions, but when you finally ask her if she feels frightened or if anyone has hurt her, her face darkens and you sense her withdrawing. After a long pause, she replies, "most of the time everything-okay." You sense that you have hit upon a possible abuse situation, and that you must ask more focused questions now.

In proceeding with the interview, please consider the following questions, and respond with the best answer. In actual practice, you will need to find your own language, this exercise is designed to help you identify some appropriate words that you could use in this type of interview:

1. Mrs. Joel has given you a 'hint' that something is wrong, and you need to find out more. Which question below might be the best way to delve further into what Mrs. Joel has said?
   a. I think you've been sexually abused, have you?
   b. It's your husband hurting you, isn't it?
   c. I'm sorry to hear that you are frightened sometimes; can you tell me more about that?
   d. Some women that have been abused are frightened, what do you think about that?

2. While interviewing, sometimes the interviewer must think a step ahead and anticipate what they may ask next depending on how the client is responding. Suppose that Mrs. Joel was to tell you that her husband has hurt her; select the best response from the possible 'next' questions below:
   a. So is your husband sexually assaulting you?
   b. Have you been raped?
   c. Why are you putting up with someone scaring or hurting you?
   d. Can you tell me more about what's been happening?

3. Mrs. Joel's situation is a difficult one. If she discloses that her husband has been sexually assaulting her against her will, she may be ostracized from her family. In this type of situation, it is especially important that you build a strong rapport with her. To be sensitive to her situation, and to help further build rapport with her, what might you say to Mrs. Joel? Please select the best answer from those below.
   a. I promise not to tell anyone what you tell me.
   b. I know this may be very hard for you, and that you do not want to get anyone from your family into trouble, but I am concerned about your safety, and the safety of others.
   c. Everything is going to be alright
   d. In this kind of situation, the police are going to be involved anyway; wouldn't you rather tell me than have me call the police?

Part 3

You are in the middle of your first interview with Mrs. Joel. You ask open-ended questions such as "it sounds like you're worried about something, can you tell me about it; maybe I can help." She eventually discloses that sometimes her husband drinks and when he drinks he is "not the man I married." She indicates that he is loud and sometimes makes improper demands of her "things that a man should not make his wife do, especially if she is sick." Mrs. Joel seems to be avoiding something, and you suspect that her husband may have been physically or sexually hurting her, but she avoids saying this.

You feel that you need to ask more specific questions, so you ask if Mrs. Joel's husband has hurt her or made her do things that she did not want to do. Mrs. Joel hesitates, and seems like she will share something with you, then she says "that is something personal between a man and a woman." She ends the interview soon thereafter. As her adult daughter walks you to the door, you have the feeling that Mrs. Joel may be being abused, and you are concerned about her. You feel frustrated that

you were not able to earn her confidence. Her daughter pauses with you at the front door, out of ear shot from Mrs. Joel. Her daughter tells you that she is worried about her mother, because her father gets drunk and 'mean'. You ask her for more information, but she does not share more with you. You resolve to keep the case open and to talk with Mrs. Joel at least once more.

About ten days later, you are surprised to receive a message from Mrs. Joel's daughter asking you to come and see Mrs. Joel as soon as you can. You call and arrange to make a visit later the same day. When you talk with Mrs. Joel this time, she seems anxious and eager to talk with you. She says, "I need talk with you now." You tell her that you will be glad to listen. Mrs. Joel discloses to you that her husband is an alcoholic, and that he has been getting very drunk several times a week and has raped her on several occasions. When Mrs. Joel has objected to his doing this, her husband has struck her, sometimes leaving bruises. She says that she needs help right now. When you ask her about why she decided to disclose this now, she tells you that recently her husband was drunk and made advances to her 25 year old daughter. She tells you, "I can't let this happen to her." You ask when Mrs. Joel's husband will be home, and you are told that he will be home at about 8PM that evening, in about 5 hours. You tell Mrs. Joel that you need to report what she has told you to the police, and she reluctantly agrees to this.

- **What do you do now that Mrs. Joel has disclosed sexual abuse?**

- **Do you foresee any danger to Mrs. Joel or her daughter?**

- **Who will you contact now?**

- **How can you help with cultural considerations for Mrs. Joel and her daughter?**

- **What interventions would you attempt at this point?**

Part 4

Following Mrs. Joel's disclosure to you about her husband physically and sexually abusing her, you contacted your supervisor, and with Mrs. Joel's permission you contacted law enforcement. Mrs. Joel was very anxious about what would happen, and you waited with her for the police and sat with her while the police interviewed her. After the interview, police personnel collected evidence from the home such as sheets, clothing that Mrs. Joel had worn, and a towel with blood stains on it from her recent injuries. A forensic examination at a nearby hospital was arranged and Mrs. Joel was transported by law enforcement personnel in an unmarked car to the local hospital where she was examined by a Sexual Abuse Nurse Examiner. Mrs. Joel's daughter accompanied her mother to the hospital.

During Mrs. Joel's exam, you talk with a hospital social worker, and obtain information about a local rape crisis center where Mrs. Joel can obtain a sexual assault advocate if she wants one. You talk with Mrs. Joel's daughter who is frightened for her mother, but glad that the truth has come out. She tells you that she knew that something was wrong, but that her mother would never say what it was. She tells you that family disapproval and perhaps disbelief may be a problem for her mother. Many of the neighbors are relatives or friends of her father (Mrs. Joel's husband). Mrs. Joel's daughter calls her sister who lives nearby, and tells her what has happened. Mrs. Joel's sister invites Mrs. Joel and her daughter to come and stay with her. When the forensic examination is over, the result of the

examination is that it appears that Mrs. Joel has been sexually assaulted on more than one occasion. She has recent and older vaginal tears and some intra-vaginal injuries as well as a large green bruise on her back from where her husband recently struck her. Police officers tell Mrs. Joel that they will be arresting her husband and charging him with spousal rape and assault. They also tell her that they will automatically request a restraining order to prevent her husband from coming within 100 feet of her in case he is released.

Mrs. Joel is tearful and anxious. She talks with her daughter and tells you that she wants to go and stay with her sister. The police notify you and Mrs. Joel that they are going to her husband's place of business to arrest him. A police officer agrees to accompany Mrs. Joel's daughter to their house to allow her to pick up clothing and toiletries. The plan is made that Mrs. Joel's daughter will also pick up her car, and transport Mrs. Joel to her sister's home. You discuss the Sexual Assault advocate with Mrs. Joel, and she tells you that she is too overwhelmed to talk with anyone like that now. You provide Mrs. Joel with the contact information for the rape crisis center and make a note to yourself to provide it to her daughter as well in case Mrs. Joel is interested in these services later on. You return to the office to document the events of the day.

- *Now that Mrs. Joel has disclosed to law enforcement and has had her forensic examination what do you think will happen next?*
- *What physical and psycho-social issues will Mrs. Joel likely face now?*
- *How may her sexual abuse affect her relationship with her family?*
- *Will her sexual abuse experiences necessitate her having to move to a new place to live?*
- *What else can you do to assist Mrs. Joel before you eventually close your case?*
- *Will you have to testify in court?*

(Possible answers: Law enforcement personnel have told you that they will arrest Mrs. Joel's husband and pursue prosecution. Police have told you that they will arrest him today, however, they do not know whether he will be released pending trial or not. As an APS worker you must be aware that Mrs. Joel's husband may or may not be found guilty despite the evidence against him. It will be important that Mrs. Joel and her daughter be kept safe. If law enforcement does not seem to be assisting with this, you may have to assist Mrs. Joel with finding another place to stay, renewing her restraining order, seeking legal counsel, etc.

Mrs. Joel was already ill, suffering from breast cancer and undergoing chemotherapy. The emotional toll placed on her by the abuse will not be helpful for her recovery. Although her physical symptoms are not medically serious, she will likely have serious emotional scars from her ordeal. Her Romanian community is very close-knit, and they may reject her if they side with her husband and he denies that the abuse happened. She may experience feelings of fear, ambivalence, guilt, personal responsibility for what happened to her, and shame following her sexual abuse. In addition, her daughter may face similar social isolation from family members, and Mrs. Joel may feel that this is her fault as well.

Mrs. Joel will likely not be able to return to where she was living. Prior to her abuse, she lived in a comfortable neighborhood where most residents shared her same cultural history. Now she may have to live somewhere new, where she does not relate to her neighbors as well. As her APS worker, you will need to follow up with her before closing her case, and to do everything possible to try to assure that she is safe and will receive the services that she

needs. She may need help with renewing her restraining order, finding new housing, transportation to medical appointments, and referrals for counseling.

It is your responsibility to assure that your documentation of Mrs. Joel's case, and especially of her disclosure of abuse is thorough, accurate, and up to date. Yes, you may have to testify in court, and the thoroughness of your notes will be very helpful if you do testify.)

Culture, Gender, Age, and Disability Considerations [Handout #9]

Sexual abuse occurs in all cultures and to all age groups. All victims of sexual abuse need and deserve assistance and protection. It is important, however, to remember that differing groups and ages of victims will affect how they respond to sexual abuse, whether they will be able to talk about it, and whether they will feel that it is safe to disclose sexual abuse. Some age groups of victims may be more or less comfortable discussing issues of sexuality let alone sexual abuse. In addition, some cultures have strong social mores about sexual contact and may, unfortunately, tend to reject sexual abuse victims as somehow being 'at fault' for what happened to them.

Discussion Questions:

Read through the following brief situations and describe important considerations related to the victim's age, cultural, or gender issues:

1. A 70 year old man is molested by his 25 year old nephew while the nephew is staying at his house.

2. A 56 year old disabled woman using a wheelchair is molested by a cousin while they are both at home alone.

3. An 84 year old female with dementia symptoms begins resisting bathing and changing clothing and appears anxious without telling anyone why. On physical examination she is found to have vaginal tearing, perineal bruising, and a vaginal infection.

4. A 28 year old developmentally disabled woman is used to taking direction from the staff at the Board and Care home. One evening, while the other residents are busy with an activity, a staff member takes her into her room and molests her.

5. A 47 year old female with Cerebral Palsy is molested by a caregiver. He threatens her not to tell anyone.

Read the following statements and respond as to whether they are true or false:

Question	True	False
Prosecuting the perpetrator is the first priority of the APS worker		
Following a disclosure the APS worker should take control and make as many decisions for the client as possible		
Seek informed consent from the client before providing services		
An important part of APS worker ethics is to do no harm to the client		
Sexual Assault victims may or may not need to be offered a forensic exam		
Sexual assault victims should not bathe before forensic exams		
Forensic exams may only be done by physicians		
Forensic exams should be done within 3 days of the alleged incident		
An APS worker can enter a civil order by themselves to keep the victim safe		
Restraining orders are unnecessary if law enforcement is investigating an alleged perpetrator		
Protective orders may be needed for clients who lack the capacity to consent		
Laws regarding reporting criminal activity to law enforcement are standardized across the country		
State laws and agency protocols must be considered when cross reporting to law enforcement		
Client may need emotional support from APS workers to help minimize the trauma of a law enforcement investigation		

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Assignment 15.2 (1 pg)

Commonly Prescribed Psychotropic Medications

http://nami.org/Template.cfm?Section=Policymakers_ContentManagement/HTMLDisplayToolkit&Template=/.cfm&ContentID=18971

Antipsychotics (*used in the treatment of schizophrenia and mania)*	**Anti-depressants**	**Anti-obsessive Agents**
Typical Antipsychotics	***Tricyclics***	
Haldol (haloperidol)	*Anafranil (clomipramine)	Anafranil (clomipramine)
Loxitane (loxapine)	Asendin (amoxapine)	Luvox (fluvoxamine)
Mellaril (thioridazine)	Elavil (amitriptyline)	Paxil (paroxetine)
Moban (molindone)	Norpramin (desipramine)	Prozac (fluoxetine)
Navane (thiothixene)	Pamelor (nortriptyline)	Zoloft (sertraline)
Prolixin (fluphenazine)	Sinequan (doxepin)	
Serentil (mesoridazine)	Surmontil (trimipramine)	**Antianxiety Agents**
Stelazine (trifluoperazine)	Tofranil (imipramine)	Ativan (lorazepam)
Thorazine (chlorpromazine)	Vivactil (protiptyline)	BuSpar (buspirone)
Trilafon (perphenazine)		Centrax (prazepam)
	SSRIs	*Inderal (propranolol)
Atypical Antipsychotics	Celexa (citalopram)	*Klonopin (clonazepam)
Abilify (aripiprazole)	Lexapro (escitalopram)	Lexapro (escitalopram)
Clozaril (clozapine)	*Luvox (fluvoxamine)	Librium (chlordiazepoxide)
Geodon (ziprasidone)	Paxil (paroxetine)	Serax (oxazepam)
Risperdal (risperidone)	Prozac (fluoxetine)	*Tenormin (atenolol)
Seroquel (quetiapine)	Zoloft (sertraline)	Tranxene (clorazepate)
Zyprexa (olanzapine)		Valium (diazepam)
	MAOIs	Xanax (alprazolam)
Mood Stabilizers (*used in the treatment of bipolar disorder*)	Nardil (phenelzine) Parnate (tranylcypromine)	**Antidepressants, especially SSRIs, are also used in the treatment of anxiety.*
Depakene (valproic acid)		
Depakote	***Others***	**Stimulants**
Eskalith	Desyrel (trazadone)	**(used in the**
Lithobid (lithium)	Effexor (venlafaxine)	**treatment of ADHD)**
Lithonate	Remeron (mirtazapine)	Adderall (amphetamine
Lithotabs	Serzone (nefazodone)	and dextroamphetamine)
*Lamictal (lamotrigine)	Wellbutrin (bupropion)	Cylert *(pemoline)*
*Neurontin (gabapentin)		Dexedrine
*Tegretol (carbamazepine)	**Anti-Panic Agents**	(dextroamphetamine)
*Topamax (topiramate)	Klonopin (clonazepam)	Ritalin (methylphenidate)
	Paxil (paroxetine)	**Antidepressants with*
	Xanax (alprazolam)	*stimulant properties,*
	Zoloft (sertraline)	*such as Norpramin and*
	**Antidepressants are also used in treatment of panic disorder.*	*Wellburtrin, are also used in the treatment of ADH*

Click here to return to Knowledge Area 15: _Mental Health and Substance Abuse

Assignment 16.1 (2 pages)

Case Vignettes:

dentify those situations where the client's immediate safety takes precedence over the lclient's right to self determination; explore the ethical issues in the worker's decision to use involuntary intervention

Sadie Miller, age 87, lives with her 82 year old sister Thelma in the family home. Neither sister has ever been married. Both worked as nurses and have been retired for many years. They had been connected to their temple but, due to their ages and infirmities, have not been in touch with their community in a few years. There are no other surviving siblings but there is a niece who lives 500 miles away. Sadie has been diagnosed with dementia and Thelma has been her caregiver. . Thelma just suffered a stroke and was hospitalized, leaving Sadie alone in the home. Sadie is very upset about her sister and has become more agitated. She has been known to wander.

- What is the level of risk?
- Does the client have the ability to consent?
- What is the urgency?
- What are the cultural and ethical issues?
- What is the least restrictive alternative?
- What other information would you need to make a determination?

Mr. Rodriguez, age 74, is an insulin-dependent diabetic who is moderately depressed. He was widowed 2 years ago and still seems to be grieving. He has lost a lot of weight and has not been following his diabetic diet. Besides this, he has recently begun drinking and has become unsteady on his feet. His SS income is $750/month and lives in subsidized affordable housing. He was found on the floor by a neighbor. He seemed dizzy. His foot was swollen and discolored. The neighbor offered to call the ambulance, but Mr. Rodriguez refused.

- What is the level of risk?
- Does the client have the ability to consent?
- What is the urgency?
- What are the cultural and ethical issues?
- What is the least restrictive alternative?
- What other information would you need to make a determination?

Assignment 16.1-cont

Salima Kahn is a 60 year old recent immigrant from Kerala, India. She was brought here by her 35 year old son Arshad who is a physician. Arshad came to this country for medical school. He works in a local hospital. He has an American wife and an infant child. He planned that his mother would care for the child so his wife could go back to work. Salima Kahn speaks little English and is not familiar with the culture or customs in her son's home. She is Muslim, but her son's family does not practice her religion. She has had mental health problems for many years and her behavior in her son's house has been very strange. Lately she has begun making threatening gestures towards her daughter in law. Her son has been keeping her in the basement but now says he cannot care for her any more.

- What is the level of risk?
- Does the client have the ability to consent?
- What is the urgency?
- What are the cultural and ethical issues?
- What is the least restrictive alternative?
- What other information would you need to make a determination?

Click here to return to Knowledge Area 16 - Involuntary Case Planning

Assignment 16.2 (1 page)

Identifying Resources for Involuntary Case Plans

Identify the appropriate resources needed to be able to implement an involuntary case plan

As the saying goes, it takes a village…. And it takes more than just APS to be able to resolve a crisis especially when it entails involuntary intervention. You must be able to answer: Who do I need? Who do I call? To do this, I must be able to answer the following questions:

- What do I want to happen?
- Which agency/entity can make that happen?
- Who is the best contact person?
- What can that agency do: what is its legal mandate or responsibility?
- What is the agency NOT able to do: what are its limitations?
- What is the inside scoop? What are special conditions?

Identify some agencies that might be helpful to you in developing a service plan which includes involuntary interventions. Research the agencies, obtaining information from direct contact, brochures, consultation with supervisor, recommendations of coworkers. Complete the form and then share it with your supervisor. This form may be of much value to you when you are trying to develop appropriate case plans with and for your clients.

Click here to return to Knowledge Area 16 - Involuntary Case Planning

Assignment 17.2 (2 pgs)

Identify factors and conditions which indicate appropriateness/ inappropriateness of closing an APS case

Provide your agency's APS case termination policy to new worker for review before you meet with her/him. Then, ask:

- According to the policy, what is the goal of APS intervention?

- According to policy, what are the circumstances under which a case can be closed?

- According to the policy, what is required of worker in order to close a case? (*specific documentation, reports, etc)*

Assignment 17.2-cont

Discussion Questions: Identify factors and conditions which indicate appropriateness/ inappropriateness of closing an APS case

New workers to APS may have varied backgrounds. Some may have been in the social work field for many years, others may be fresh out of school, others may have come from a completely different field. Although case termination is discussed in most social work schools, APS termination is more complex and involves more than just the emotional piece that is normally addressed. These questions will start new workers thinking about the issues around terminating APS clients and well as some of the ethical principles.

- What are the most common reasons for terminating a case in APS? (*Risk ameliorated or reduced, unable to locate, client refused services, client referred to another agency, client placed, client deceased)*
- What do you see as some of the challenges facing workers when deciding whether to terminate a case? (*doing too much, not doing enough, dealing with the community or family response, something bad happening to the client right after the case is closed, newspaper articles about what APS did or didn't do..)*
- What are some of the ethical issues involved with closing an APS case? (*share NASW ethics handout and use for discussion if desired)*
- How do you know if you have done enough, covered all your bases? (*made a thorough risk assessment, made sure the client understood all her options, contacted all appropriate collaterals, made sure that worker actions were not a result of personal issues..)*

Click here to return to Knowledge Area 17-Case Closure

Assignment 17.3 (3 pgs)

Case Consultation Methods:

Explain how aspects of the helping relationship affect the outcome of the case at termination

Using a new case, help worker connect how the establishment of a helping relationship can help them in the successful termination of the case.

- Discuss the following stages of the helping relationship as it pertains to their particular case situation. Have there been challenges? What has the worker done to address the challenges? Alternately you can go through these stages at a unit meeting and let coworkers listen to challenges and make suggestions.

    - **Help clients to clarify the key issues calling for change**. *Challenges may include: client mental status, client not seeing a problem or a need for change, client resistance to agency intervention, client fear or shame regarding actions of a caregiver/abuser,*

    - **Help clients determine outcomes**. *Challenges may include: how do I get a resistant or confused or mentally ill client to take part in the process? My goals and the client's goals are not the same.*

    - **Help clients develop strategies for accomplishing goals**. (*Challenges may include: client doesn't see a way out due to depression or hopelessness or loyalty to abuser, strategies are sabotaged, resources are limited or non-existent, there is not enough time to build a relationship because caseloads are so high and demanding, worker's goal may be different from the client's goal)*

- An important element in case termination is determining whose needs were met. Was the intervention provided primarily to help the worker sleep at night, or to appease the community, or because it was the least restrictive alternative which respected the client's wishes as much as possible? Ask how personal issues may get in the way when deciding when it is appropriate to terminate a case.

- Individually or in a unit meeting, read the worker statements and ask what might be going on with the worker:

    - "That client was so abusive to me. She was never satisfied with what I was offering her. She reminded me of my mother, always critical. I got so tired of going there and accomplishing nothing. This client probably has a personality disorder and there is no treatment for that. The last straw was putting in a home health aide- the client called and yelled at me, saying she didn't want "those people" in her home. She is a racist and nobody will be able to help her."

    - "That place was so scary. I thought I would fall through the porch and break my ankle. I have never seen such a disgusting home. And there were at least 10 cats. The smell was awful. I had to take my clothes off as soon as I got home from the visit… there must

have been fleas and I got bitten. The client chooses to live this way. This is her lifestyle and I need to respect that. The neighbors may not like it, but I am closing the case."

- "He is such a sweet old man. I seem to be the only one who understands him. I got him meals on wheels, and a home health aide, and a friendly visitor. I used emergency funds to clean up his home. I found furniture for him. I enjoy listening to his stories about the war and about his life. I can't close the case yet. He really needs me and I know that no other worker will take the time to understand him the way I do."

- "This case has been referred 3 times before. The abusive son moves in.. case opened. He is arrested for some infraction, case closed. I tried to get her to file a restraining order. She promises she won't take him back, but she always does. They have such a codependent relationship. Can't she see that he is no good?

  I've had the case opened for a long time, I admit, but it is not worth closing it. The son will be out of jail in 3 months and the client is worried about him. I can't imagine going through all the paperwork again, so I might as well just sit on it and wait."

Individually or at a unit meeting ask worker how these feelings may surface for clients and workers… ask for examples.

Feeling	Client	Worker
Dependence		
Fear		
Guilt	.	
Anxiety		
Relief		
Cultural values		
Resistance		

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Assignment 17.4 (2 pgs)

Case Vignettes: Evaluate the effectiveness of service delivery in 3 key areas
(Risk, Satisfaction and Adherence to Policy)

In order to ensure that APS intervention is working, we need to find a way to figure out if our work has been successful. It is helpful to look at these 3 factors when we are determining if the desired outcome has been reached. We look at risk/safety issues (is client safer/healthier and how do we know that), quality of life issues (what might be the client's perspective on the outcome) and the legal-ethical- procedural issues (has intervention met those criteria). Share this vignette and ask them to answer the questions.

Henrietta Pulowski, age 62, was referred to APS due to self-neglect. She has multiple sclerosis and a personality disorder. She would walk very unsteadily in her neighborhood and yell at children, threatening them. She dumped trash on her neighbor's property. She had 10 cats and no litter boxes. The house smelled terrible and was in disrepair. It took 3 visits to be able to assess the situation as client refused worker's entry in the beginning. She was very resistant to worker's intervention but worker listened to her complaints and tried to address them. Ms. Pulkowski felt that the neighbors were plotting against her and the neighborhood kids were harassing and making fun of her. Ms. Pulkowski asked that worker not contact her daughter. Worker felt the need to contact the daughter for more collateral information, since client would not share any information. Daughter was very angry and said she was tired of these complaints. She then called her mother and told her to behave. At worker's next visit, she was denied entry. Ms. Pulkowski said worker had betrayed her. She used very abusive language to the worker and told worker that she needed no help and she was fine. Worker contacted the Mental Health Screeners and asked them to evaluate Ms. Pulkowski's dangerousness to others to see if she was committable. The screeners did not find that client met the criteria. Case was terminated due to refusal of services.

1. What is the evidence that the client is safer and no longer at risk (or at reduced risk)? *There is no clear evidence. Worker covered herself by using the Mental Health Screeners as proof that client was not at risk. There was no evidence that the client was demented and no mental health involvement.*

2. What is the evidence that client's self determination was respected and the least restrictive interventions were taken? *Client's wishes were not respected – the calling of her daughter –*

perhaps the reasons she didn't want worker to call daughter could have been explored with her. It is unclear if calling the Mental Health Screeners was a result of concern for client's dangerousness or to cover the worker's decision to terminate.

3. What is the evidence that the case was handled ethically and legally, and agency procedures were followed? *It seems that worker's buttons were pushed by this type of client and interventions were taken in spite of the client instead of necessarily for her benefit. There are some ethical questions regarding worker's behavior.*

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Assignment 17.5 (1 page)

Write a case closure summary that includes all essential case elements

Using a case of your own in the office, please prepare the case for termination (when it is appropriate, of course). Please use handouts 12 from the in-person training as a guide to determine whether to close the case and how to write the case summary.

- Answer the Measuring Outcomes questions
  1. What is the evidence that the client is safer and no longer at risk (or at reduced risk)?
  2. What is the evidence that client's self determination was respected and the least restrictive interventions were taken?
  3. What is the evidence that the case was handled ethically and legally, and agency procedures were followed?

- Follow the Case Closure Checklist
  1. All risk factors, including the root causes of problems, have been identified
  2. Adequate attempts have been made to collect evidence
  3. Allegations have been appropriately investigated and documented;
  4. All protective services have been provided before the completion of the investigation
  5. All reasonable efforts have been made to ensure that the client is not in a state of abuse, neglect, or exploitation because of a lack of APS effort
  6. Notifications to external agencies and licensing boards have been made according to policy
  7. The client has been informed of case closure. If the client lacks capacity to consent, another person involved in the client's care may be informed on the client's behalf
  8. The case summary is submitted the supervisor for review.

- Write a Case Summary as required by the agency. If the agency does not require a summary, please write one using the information given to you in the handouts.

- Submit the materials to your supervisor for discussion and feedback in a supervisory session.

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Assignment 17.5 (1pg)

Case Closure Checklist

- ✓ Evidence as required
- ✓ Investigate and document all allegations
- ✓ Make/Update risk assessment
- ✓ Verify protective services have been offered/provided
- ✓ Make sure all reasonable efforts have been tried
- ✓ Notify other agencies or boards as needed
- ✓ Inform client of case closure. If the client lacks capacity to consent, notify a significant other
- ✓ Closing Case Summary to Supervisor

Adapted from Texas APS IH January 2010

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Assignment 18.2 (1 pg)

CASE EXAMPLE

L is a frail, 83 year old widow whose only son is deceased. L's only living relatives are an adult grandson, granddaughter and ex-daughter-in-law. The grandson moved in with L after L's husband's death, but she later asked him to leave because he contributed nothing to the household, was allegedly abusing drugs, and wrecked a car she bought for him. He had also become verbally and physically abusive. The grandson refused to move out.

The first report of the grandson's abusive behavior came to APS from the ex-daughter-in-law (i.e. his mother); the second, from the domestic violence specialist referred by APS after the first report. APS confirmed physical and verbal abuse. As a result of the investigation, the APS worker advised L to take out restraining orders on all three of her relatives because of concerns about possible financial abuse. L refused to request a restraining order against the grandson, and a temporary restraining order against the women was withdrawn after L hired an attorney to defend them. L sought support through her church. Her minister did a home visit. Since L had last attended church, the minister noted that she had lost weight, wasn't eating, and was recovering from pneumonia. He also noted that her arthritis was making it more difficult to ambulate and to complete routine household chores such as shopping, cleaning and cooking. He spoke to the grandson. The visit from her minister triggered another argument with her grandson. After the minister left, the grandson slapped L so forcefully that she fell to the ground. L was taken to the hospital and treated for her injuries. L's former daughter-in-law reported the abuse, and all three women cooperated with the law enforcement investigation. The suspect claimed that his grandmother was demented and had attacked him.

Discussion questions:

1. What are L's strengths?

2. What are your hypotheses about what might is happening with L/what she might need?

3. Name some of the stakeholders/MDT partners who might become involved in this case, and benefits of involving those agencies/partners.

4. What might be sources of conflict in the ways that various MDT members might view this case?

5. What might be some areas of assessment/need that MDT members might agree on?

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Assignment 19.2 (1page)

The Language of the Criminal Justice System

Activity: List the term(s) used by the criminal justice system to describe common terms used by Adult Protective Services/Protective Services:

Adult Protective Services Term	Criminal Justice Terminology
Adult Protective Services Worker	
Alleged Perpetrator (May be called Suspected perpetrator or suspected abuser)	
Client	
Collateral	
Emotional or Psychological Abuse	
Financial Exploitation	
Neglect	
Physical Abuse	
Reporting Party	
Sexual abuse	

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Assignment 19.3 (1 page)

Terms and Their Meaning

Instructions: Match the Term in the First Column with Its Definition in the Second Column

Term	Definition
Felony	a. A judicial order issued at the request of the prosecutor to protect a victim or witness from intimidation or dissuasion
Misdemeanor	b. More evidence in favor of guilt than against it
Right of Allocution	c. Anything with a tendency in reason to prove an element of a crime
Discovery	d. An out of court statement offered to prove the truth of what it contains
Restraining Order (may be called protection order, protective order, order of protection)	e. The right to speak and provide personal views at sentencing (may include victim impact statement)
Subpoena	f. Criminal defendant's constitutional right to cross examine witnesses called by the prosecution
Probable cause	g. The right to receive certain information from the other side in a criminal case
Hearsay	h. Ruling on an objection that requires the witness to answer the question that was asked
Arraignment	i. A crime punishable by no more than a year in county jail, a fine, or both
Direct examination	j. Civil order to provide specific protection such as stay away from specific persons or locations, no contact, or prohibiting certain behaviors
Defendant	k. Crime punishable by imprisonment in state prison or death
Right of confrontation	l. Burden of proof required of the prosecution in a criminal case
Beyond a reasonable doubt	m. The first court appearance in a criminal case
Evidence	n. Person charged with a crime
Overruled	o. Evidence from which an inference must be drawn to prove a fact or element that must be established
Circumstantial Evidence	p. Ordinarily the first testimony of a witness; usually asking of questions by the side with which the witness is naturally aligned

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