WORKING WITH CLIENTS WHO SELF-NEGLECT

PARTICIPANT MANUAL

MODULE 10

This training was developed by the Academy for Professional Excellence, which is funded by a generous grant from the Archstone Foundation.

Curriculum Developer
Version 1
Lisa Nerenberg

Curriculum revisions (version 2.0) was developed by the San Diego State University School of Social Work, Academy for Professional Excellence with funding from the California Department of Social Services, Adult Programs Division.

Curriculum Revision 2018
Version 2
Kevin Bigelow

INTRODUCTION

THE ACADEMY FOR PROFESSIONAL EXCELLENCE

We are pleased to welcome you to the APS- Working with Clients Who Self-Neglect Trainer Manual, developed by MASTER, a program of the Academy for Professional Excellence under a grant from the California Department of Social Services, Adult Programs Division.

The Academy for Professional Excellence, a project of San Diego State University School of Social Work, was established in 1996 to provide exceptional workforce development and organizational support to the health and human services community by providing training, technical assistance, organizational development, research, and evaluation. Serving over 20,000 people annually, the Academy continues to grow with new programs and a diversity of training focused on serving the health and human services community in Southern California and beyond.

The Academy is a project of San Diego State University School of Social Work (founded in 1963), which offers both a bachelor's and master's degree in Social Work. The School of Social Work at San Diego State University was founded in 1963 and has been continuously accredited by the Council of Social Work Education since 1966.

MASTER (Multi-disciplinary Adult Services Training and Evaluation for Results) is a program of the Academy for Professional Excellence. MASTER is designed to provide competency-based, multidisciplinary training to Adult Protective Services Workers and their partners. MASTER's overarching goal is the professionalization of Adult Protective Services workers to ensure that abused and vulnerable older adults and adults with disabilities receive high quality, effective interventions and services. In partnership with state and national organizations, MASTER has developed a nationally recognized Core Competency Training Curriculum for Adult Protective Services workers. This curriculum is reviewed and approved by experts in the elder and dependent adult abuse fields.

MASTER's partners include:

- National Adult Protective Services Association (NAPSA) Education Committee
- California Department of Social Services (CDSS), Adult Programs Division
- County Welfare Directors Association of California (CWDA), Protective Services Operations Committee (PSOC)

PARTNER ORGANIZATIONS

Lori Delagrammatikas
Program Manager, MASTER
Academy for Professional Excellence
https://theacademy.sdsu.edu/programs/
Version 1.0

Dawn Gibbons-McWayne
Program Manager, MASTER
Version 2.0

Krista Brown
APS Project Coordinator, MASTER
Academy for Professional Excellence
https://theacademy.sdsu.edu/programs/
Version 1.0

Kat Preston-Wager
Curriculum Development Specialist, MASTER
Version 2.0

Kathleen Quinn
Executive Director
National Adult Protective Services Association
napsa-now.org
Version 1.0

Trudy Gregorie
Executive Director
Version 2.0

Paul Needham
Chair
NAPSA Education Committee
napsa-now.org
Version 1.0

Paul Needham
Chair
Version 2.0

Lori Delagrammatikas
Adult Protective Services Liaison
Adult Protective Services Division
California Dept. of Public Social Services
cdss.ca.gov/Adult-Protective-Services
Version 2.0

Jennifer Bransford-Koons
Chair
Protective Services Operations Committee of the County Welfare Director's Association
cwda.org/about-cwda
Version 1.0

Stacey Lindberg & **Valerie Smith**
Co-Chair Co-Chair
Version 2.0

THE ACADEMY FOR PROFESSIONAL EXCELLENCE

6505 Alvarado Road, Suite 107, San Diego, CA 92120

Tel: (619)594-3546 – Fax: (619)594-1118 – http://theacademy.sdsu.edu/programs/

ACKNOWLEDGEMENTS

This training is the result of a collaborative effort between Adult Protective Services administrators, supervisors, staff development officers and workers across the state and the nation; professional educators; and the Academy for Professional Excellence staff members. MASTER would like to thank the following individuals and agencies:

Agencies

California Department of Social Services, Adult Programs Division
County of Los Angeles Workforce Development, Aging and Community Services
Orange County Social Services Agency
Riverside County Department of Public Social Services
San Bernardino County Department of Aging and Adult Services
County of San Diego Aging & Independence Services

Regional Curriculum Advisory Committee

Ralph Pascual, Human Services Administrator, Los Angeles County Carol Kubota, Senior Social Services Supervisor, Orange County
Jessica Paradee, Staff Development Officer, Riverside County
LaTanya Baylis, Training and Development Specialist,
San Bernardino County
Carlos Morales, APS Supervisor, San Diego County

Committees

APS Training Planning Committee
National Adult Protective Services Association Education Committee Protective Services Operations Committee of the County Welfare Directors Association of California

Curriculum Developer 2010

Lisa Nerenberg

Curriculum Revisions 2018

Kevin Bigelow

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General Information

Presentation

COURSE OUTLINE

CONTENT	MATERIALS	TIME
WELCOME, INTRODUCTIONS, COURSE OVERVIEW		**TOTAL: 15 minutes**
INTRODUCTION TO SELF-NEGLECT		**TOTAL: 25 minutes**
Activity #1- The Diverse Spectrum (Table groups)	*Maria and John fillable scenarios*	
Ethical Principals	*Handout #1: NAPSA Ethical Principals*	
CAUSES OF SELF-NEGLECT		**TOTAL: 15 minutes**
Absence or Breakdown of Caregiving System	*Handout #2: Neglect and Self-Neglect as the Absence or Breakdown of Caregiving System*	
ASSESSING SELF-NEGLECT IN THE FIVE DOMAINS		**TOTAL: 30 minutes**
Activity #2- Five Domains Game (Large group)		
ASESSING SEVERITY AND URGENCY		**TOTAL: 25 minutes**
Activity #3- Round Robin Assessment (Table groups)		
BREAK		**15 minutes**
SCREENING CAPACITY		**TOTAL: 30 minutes**
Capacity	*Handouts #3 & #4*	
Activity #4- Mrs. Green: Assessing Capacity (Class divided in half)	*Handout #5*	
SPECIAL ISSUES		**TOTAL: 30 minutes**

Activity #5- Hoarding Video and Reflection		
ASSESSMENT TOOLS	*Handout #6*	**TOTAL: 10 minutes**
LUNCH		**60 minutes**
INTERVENTIONS		**TOTAL: 90 minutes**
Results of Dubin Study	*Handout #7*	
Shout-Out: Decisional Worksheet (Large group) ***Or*** *Activity #6: Self-Neglect Home Visit (Individual)*		
Activity #7: Understanding Harm Reduction (Large group)	*Handout #8*	**5 minutes**
BREAK		**15 minutes**
DETERMINING APPROPRIATE INTERVENTIONS		**TOTAL: 60 minutes**
Types of Interventions	*Handout #9*	
Activity #8:Working the Self-Neglect Case (Small groups)	*Handout #10*	
DOCUMENTATION		**TOTAL: 15 minutes**
Activity #9: Case Scenarios	*Handout #10 and #11*	
PARTNERS IN SELF-NEGLECT	*Handout #12*	**TOTAL: 10 hours**
LESSONS LEARNED AND EVALUATIONS		**15 minutes**
TOTAL (INCLUDING LUCH AND BREAKS)		**7 hours**

Executive Summary

Course Title: *Working with Clients Who Self-Neglect*

Outline of Training:

In this interactive and thought provoking introductory training, new APS workers and their allied partners will learn the definition of self-neglect, how prevalent it is in our society and the risk factors and indicators to watch for when assessing a case. They will learn how to access self-neglect across five domains (medical, psychological, environmental, financial and social). They will be exposed to tools used to evaluate self-neglect cases and learn about promising methods to work with self-neglecting adult. They will learn how to develop interventions, how to document a self-neglect case and what agencies they might want to partner with to work these cases. This is the Instructor Led Training for Core Curriculum Module 10.

The following instructional strategies are used: lecture segments; interactive activities/exercises (e.g. small group discussion, case studies); question/answer periods; PowerPoint slides; participant guide (encourages self-questioning and interaction with the content information); embedded evaluation to assess training content and process; and transfer of learning activity to access knowledge and skill acquisition and how these translate into practice in the field.

Course Requirements:
Please note that training participants are expected to participate in a variety of in-class and post-training evaluation activities. These activities are designed to enhance the learning experience and reinforce the skill acquisition of training participants as well as determine the overall effectiveness of the trainings.
An executive summary of each training and directions for post-training evaluation activities will be provided to training participants and their supervisors. Certificates of course completion will be awarded upon completion of ALL course activities.

Target Audience:
This course is designed for new APS social workers as well as Vulnerable Adult Abuse partners (e.g. conservatorship investigators, workers in the aging and disability networks, law enforcement). This training is also appropriate for senior staff that require knowledge and/or skills review.

Learning Objectives:

1. Define Self-Neglect, its prevalence, risk factors, and indicators.
2. Assess self-neglect n the five domains.
3. Identify tools for evaluating self-neglect.
4. Describe promising techniques for working with adults who are self-neglecting, such as "Harm Reduction" and "Hoarding Treatment".
5. Identify safety and risk reduction interventions for adults who are self-neglecting.
6. Demonstrate and understanding of the elements to document in self-neglect cases.

7. Identify community partners to work with in self-neglect cases.

BEFORE the training
Supervisors can encourage line staff to attend the training and help them identify particular strengths and/or challenges that they have had in developing safety plans for clients in the past. Training participants can share these experiences during training.

AFTER the training
Supervisors can read the training executive summary and instructions for out-of-class transfer of learning activity. Supervisor and training participant will then schedule a time to complete the activity together – at this point the trainees can share what specific skills they obtained from the training. If further staff involvement is available, trainees may present an overview of what was learned to other staff members to encourage collaboration and a culture of learning.

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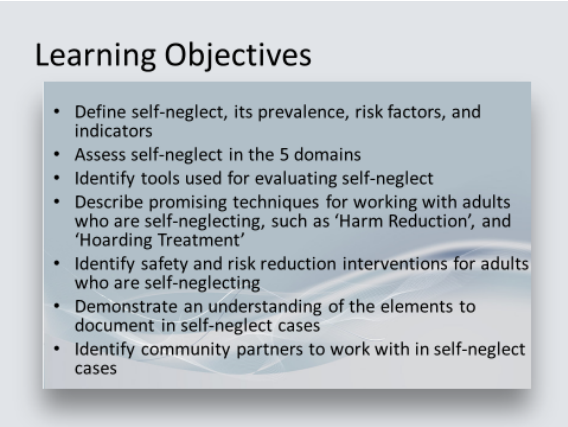

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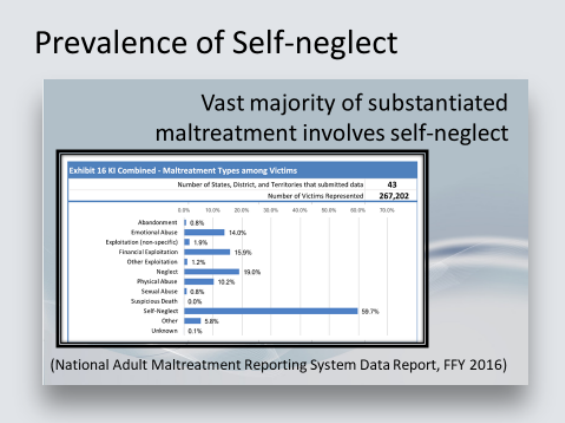
SLIDE #7



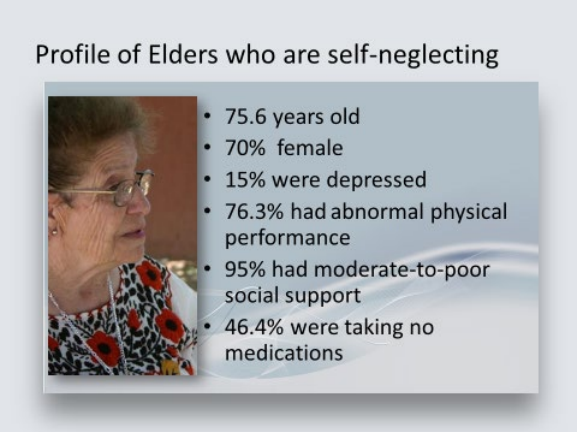
SLIDE #8

Activity #1

John is 76 years old and is described by his neighbors as a "hoarder." John lives in a _____ (place of living). You can tell that it is John's place because when you approach, you _____ (see/hear/smell). John lives _____ (with/what). When you talk with John, he is friendly but adamant that he cannot _____ (something to do with hoarding). When you ask to see what John has been eating, you see _____. When discussing his living situation, John seems _____ (emotion/behavior). In an effort to evaluate John and his situation, you _____ (assessment tool). As you leave, you are thinking that John may suffer from _____ (mental illness diagnosis).

Maria is 82 years old and her neighbors describe her as "unable to care for herself." When you make your home visit, Maria seems _____ (behavior/emotion). She invites you to come in and your first impression of her home is _____ (adjective). While you try and interview her, Maria continually _____ (behavior). When you ask about her diet, she says that _____ (behavior/feeling). You notice Maria has a couple of cats that do not look well cared for and when you ask about them, she says _____. During the interview you noticed a strong odor and you eventually concluded it was _____. The interview concluded when Maria _____.

SLIDE #9



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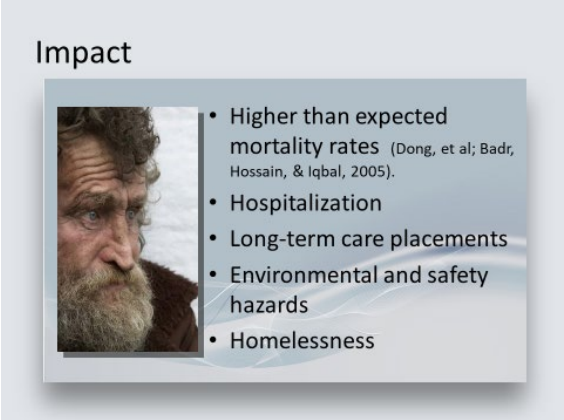
SLIDE #11

SLIDE #12



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HANDOUT #1

Ethical Principles and Best Practice Guidelines

Dedicated to the memory of Rosalie Wolf NAPSA 2018

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 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

Practice Guidelines

- 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
- 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

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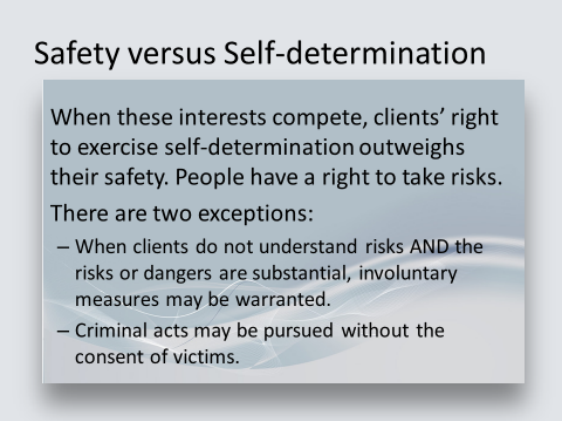

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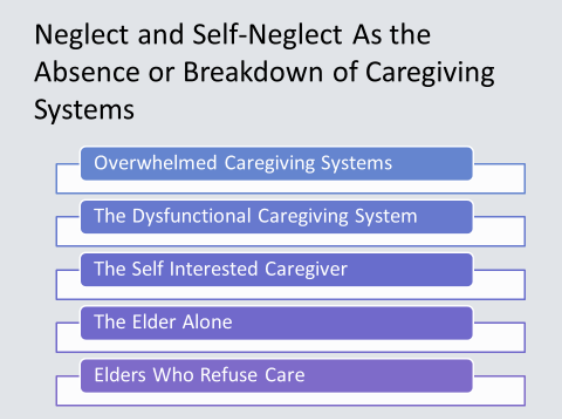

HANDOUT #2

Neglect and Self-Neglect as the Absence or Breakdown of Caregiving Systems^ (Part 1)

1. Overwhelmed Caregiving Systems
   - Definition: The older person has family, friends, or paid caregivers who are actively involved in providing care but are not doing everything that's necessary.
   - Examples:
     - The caregiving system was adequate at one time - but then there were changes, a gradual deterioration or an abrupt incident - a stroke for example - which rendered the care inadequate.
     - The caregiver is trying to balance caregiving with a job or other responsibilities.
     - The elder really should be in nursing home - they need extensive care - but they're refusing to go
     - The family cannot afford nursing home care or support services

2. The Dysfunctional Caregiving System
   - Definition: A caregiving system is in place but the dynamics between caregivers, or between caregivers and older person are characterized by dysfunction.
   - Examples:
     - The older person is difficult and alienates others – house workers/caregivers quit or the older person fires them
     - Family members are estranged
     - Feuding families. You may have sibling feuding with each other or with the older person.
     - Families with substance use disorders

3. The Self Interested Caregiver
   - Definition: Someone has responsibility for providing but the care is inadequate because the caregiver is really just in it for the money.
   - Examples:
     - Caregiver is being paid or stands to inherit.
     - Caregiver is concerned or preoccupation with their own interests.
   - (Accounted for the fewest number of cases)

Neglect and Self-Neglect as the Absence or Breakdown of Caregiving Systems^ (Part 1)

4. The Elder Alone
   - Definition: Elders who have no one to provide care. Since the neglect in these situations cannot be attributed to anyone other than the elders themselves, these cases are often referred to as self-neglect.
   - Examples:
     - Elder recently lost close friends or relatives, or spouses who were providing care and alternative arrangements haven't been made.
     - Elders who have chosen to be alone or to live with animals.
     - Debilitated couples where neither member is capable of providing care to the other.

5. Elders who Refuse Care
   - Definition: Same as above but senior has refused help.
   - Examples:
     - Senior is depressed. May be close to death and wants to die
     - Senior doesn't want to have their affairs scrutinized
     - Senior is committing slow form of suicide

^ Dubin, T., Garcia, R., Lelong, J., & Mowesian, R. (1986). Family neglect and self- neglect of the elderly: Normative characteristics and a design for intervention. Austin, TX: Hogg Foundation for Mental Health, Family Eldercare, Inc.

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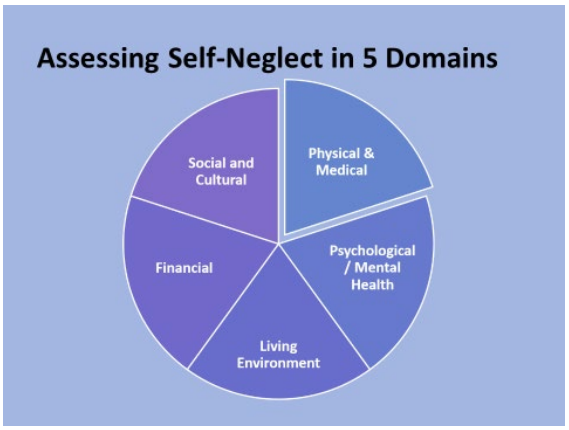
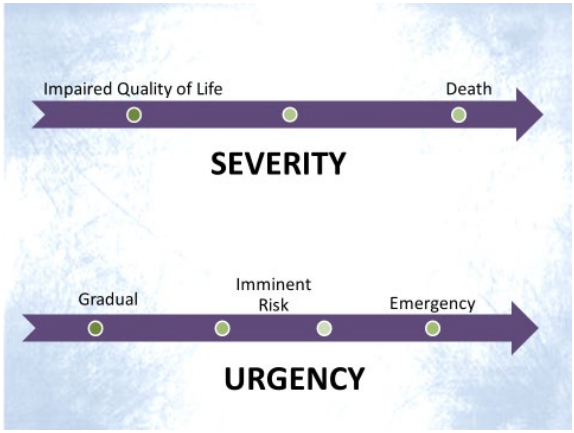


SLIDE #17

Physical & Medical	Psychological & Mental Health	Environmental	Financial	Social
100	100	100	100	100
200	200	200	200	200
300	300	300	300	300
400	400	400	400	400
500	500	500	500	500

SLIDE #18

SLIDE #19



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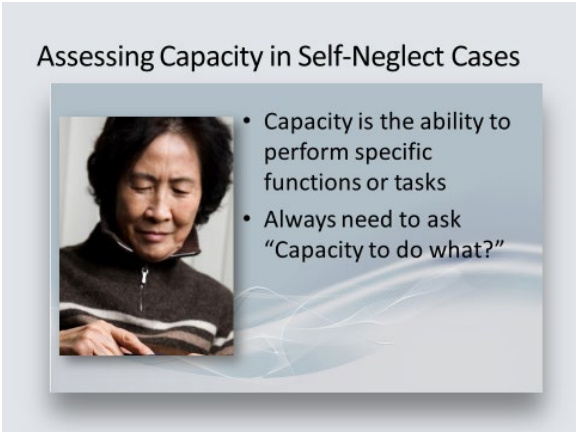

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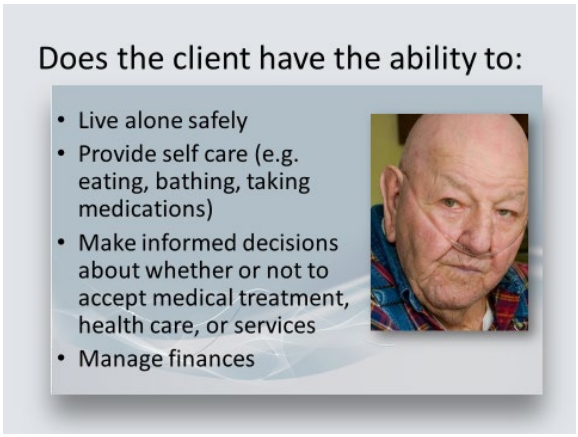

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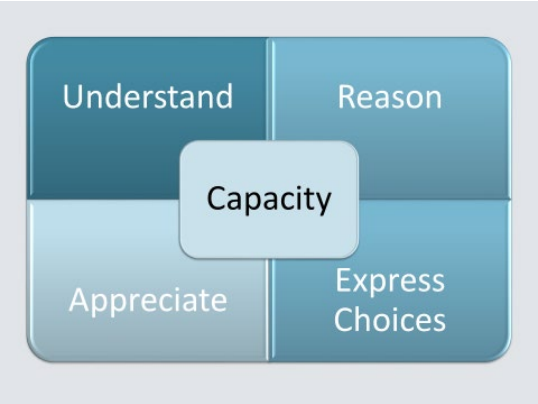


HANDOUT #3

Dimensions of Capacity

- **Understanding**: Ability to comprehend information and to demonstrate that comprehension.

- **Appreciation**: The ability to determine the significance of a decision relative to one's own situation, focusing on beliefs about the actual situation and the possibility that outcome of the decision would be beneficial; involves insight, judgment, and foresight.

- **Reasoning**: The process of comparing alternatives in light of consequences by integrating, analyzing, and manipulating information. It involves the ability to:

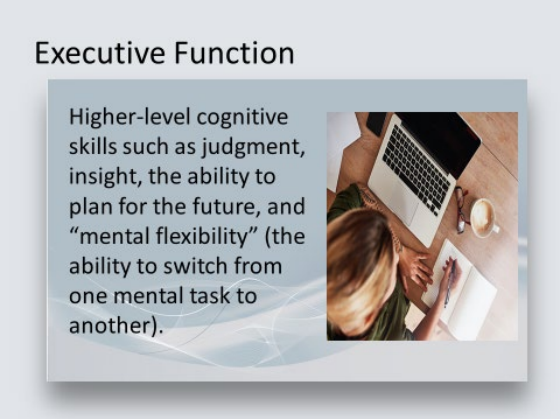
    - Provide rational reasons for a decision
    - Manipulate information rationally
    - Generate consequences of decisions for one's life
    - Compare those consequences in light of one's values

- **Expressing a choice**: The ability and willingness to make and communicate decisions.

HANDOUT #4

CAPACITY FOR MEDICAL TREATMENT		
Dimensions of Capacity	Definition	Questions used to demonstrate this dimension
Understanding	The ability to comprehend diagnostic and treatment-related information and to demonstrate that comprehension.	• Can you tell me the purpose of the treatment? • What will this procedure accomplish?
Appreciation	The ability to determine the significance of treatment information relative to one's own situation, focusing on beliefs about the actual presence of the diagnosis and the possibility that treatment would be beneficial; involves insight, judgment, and foresight.	• How would you prepare for (surgery)? • What do you see your life being like if you have surgery? • What do you see your life being like if you don't have surgery?
Reasoning	The process of comparing alternatives in light of consequences by integrating, analyzing, and manipulating information. It involves the ability to: • Provide rational reasons for a treatment decision, • Organize information rationally • Generate consequences of treatments for one's life • Compare those consequences in light of one's values	• How did you reach the decision? • What factors did you consider? • If you don't have this procedure, what will you do instead (e.g. are there other treatments that can offer relief?)
Expressing a choice	The ability and willingness to make and communicate decisions about treatment	• Can you explain to me what you've decided and why? • How did you reach this decision?

SLIDE #23



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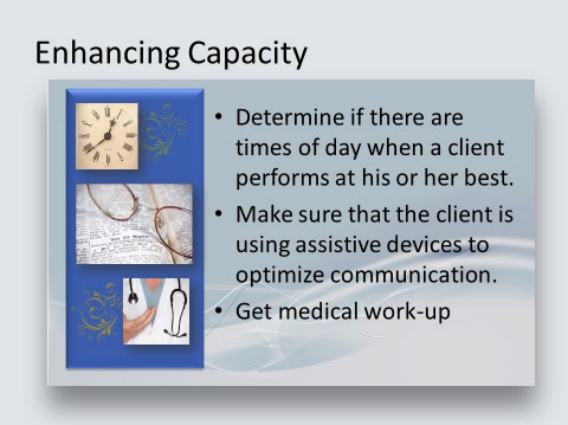


HANDOUT #5

CASE STUDY: Mrs. Green

APS intake receives a call from a neighbor, who is concerned because she has not seen Mrs. Green in more than a week. APS intake receives another call the next day from Mrs. Green's son, who lives out of state, who had been alerted by the same neighbor. He reports that he called his mother and she "doesn't sound right."

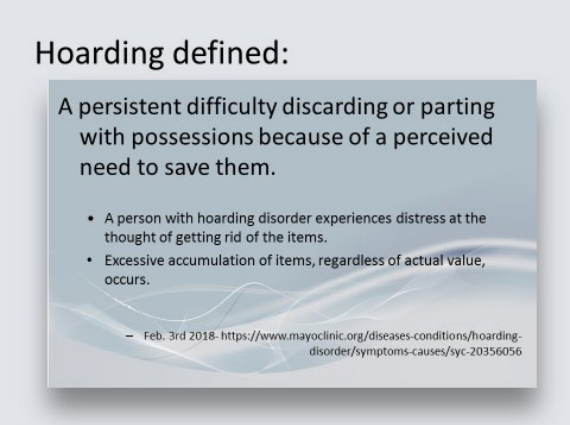
Bruce, an experienced professional is assigned the case and makes a visit. Mrs. Green welcomes him into the house and insists that she is fine and doesn't need anything. In the kitchen, Bruce finds a sink filled with unwashed dishes and the odor of rotting garbage. He looks in the refrigerator, and finds only an old container of milk, the "use by" date three weeks ago, some slices of moldy cheese and a few eggs. They talk for a while and Mrs. Green continues to insist that she doesn't need anything. She adds that she usually does her own grocery shopping, but occasionally doesn't feel up to going out.

Although Mrs. Green is neglecting many household tasks, during the interview her memory appeared to be intact. Mrs. Green tells him that she thinks her medications are making her sick so she doesn't take them and mentions that she has blacked out a few times. When Bruce asks to see the medication bottles, Mrs. Green gets very angry and insists that she has thrown them all out. She then tells Bruce that "this conversation is over."

The next week, Bruce receives another call from Mrs. Green's son. He has received a call from a collections agency reporting that his mother has not paid her bills. When he called Mrs. Green, she got angry. She said she has always paid her bills on time.

SLIDE #25

SLIDE #26



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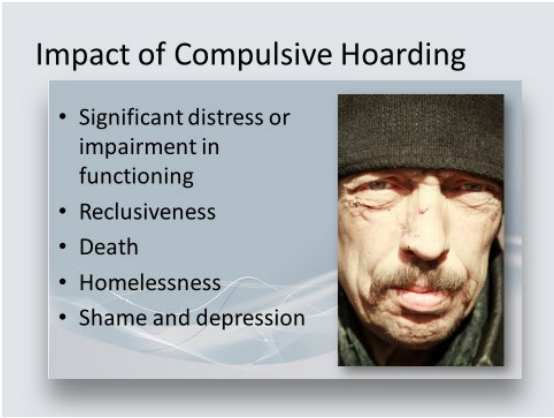


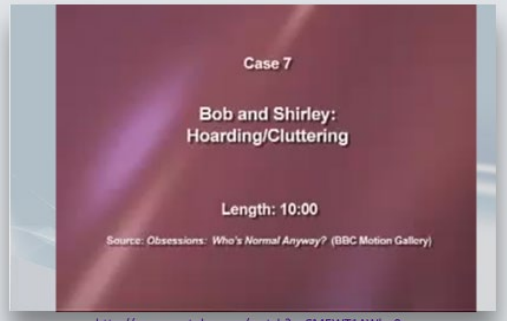
SLIDE #28

What Causes Hoarding?

House of hoarder 'out of control'; officials order clean up (Los Angeles Times, June 02, 2016)

SLIDE #29

"Who's Normal Anyway?"



http://www.youtube.com/watch?v=CMEWT1AWhq0

SLIDE #30

Health Literacy Defined:

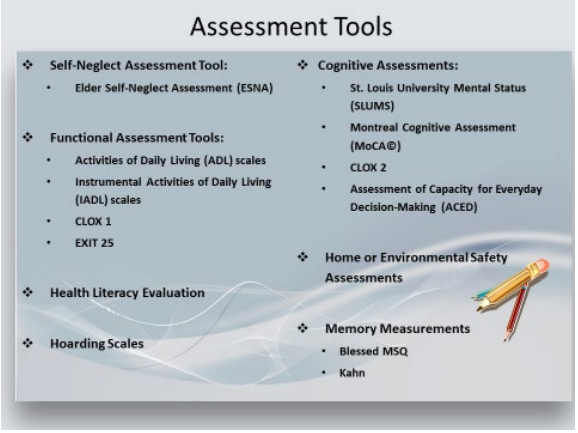
- How well a person can get the health information and services that they need, and how well they understand them.
  - Using them to make good decisions.
- Access to information that they can understand
- Finding information, communicating with health care providers, managing a disease
- Knowledge of medical words, and of how their health care system works

(medlineplus.gov/healthliteracy)

SLIDE #31

SLIDE #32

SLIDE #33



HANDOUT #6

COGNITIVE ASSESSMENT AND SELF-NEGLECT SCREENING TOOLS

Cognitive assessment scales and tools can help provide a framework for more consistent and thorough assessments of cognitive functioning in APS clients. There is no one best tool for measuring decision-making capacity, as none of these tools measure capacity directly, but rather aspects of cognitive functioning. It is important to choose the tool that best fits the concerns you have for each client. *Consult your supervisor, state and local laws and policies to learn which tools are approved for use by your agency.*

Elder Self Neglect Assessment (ESNA)	Currently, this is the only validated tool specific to self-neglect assessment. A 77-item assessment as well as a short form are available for use by APS professionals. Items are arranged in order of severity and this clustering can help the assessor in determination of the severity of self-neglect. The ESNA focuses on assessing Behavioral Self-Neglect and Environmental Self-Neglect.
SLUMS St. Louis University Mental Status	11-item scale to detect mild cognitive impairment and dementia includes orientation, word memory, arithmetic, naming, clock drawing, story memory. It is free, quick, and easy. It is relatively well-known and integrates the even better known Clock Drawing tool. There are scoring options, or education corrected norms, which differentiate between clients with a high school education and those with less than a high school education. Unfortunately, language translations are in development but are not yet available. Some stimuli are very small, thus reducing the overall reliability in some areas, but that is an issue common to many of the shorter tools. Utilizing SLUMS would in many cases require staff-retraining and outside providers may be less familiar with it. It is not useful for clients who are visually or hearing impaired.
MoCA® Montreal Cognitive Assessment	30-point cognitive screening instrument that assesses visuospatial/executive, naming, memory, attention, language, abstraction, delayed recall, and orientation to time. It is also free, and translations are available in many languages. It is more sensitive than some other tools, and interest in the MoCA is increasing. Challenges include that it is more complicated and takes longer to administer than some of the shorter tools, and some of the directions are not printed on the form. It doesn't include age and education norms, provides relatively small normative data, and some stimuli very small. Outside providers less familiar with the MoCA than they are with other tools. http://www.mocatest.org/

CLOX 1 & 2	Like two tools in one. Each provides distinctly different information and can be used together or independently. It is free, fast, and easy to use. CLOX 1 measures for executive function, which few do. The second part, the CLOX 2 integrates the old familiar Clock Drawing in an improved and measurable fashion to key in on possible dementia. Interest in tool increasing. Challenges include the fact that it isn't very flexible. You must use the actual form as it is printed for it to be interpretable, and you must follow the instructions and give the instructions exactly as they are written. And, outside providers are less familiar with these tools.
Exit 25	A newer tool developed by Dr. David Royall which tests for executive function, or executive control function (EFC). It is free to use. It utilizes a bedside scale which includes 25 items derived from frontal lobe sequelae. With training and practice the test can easily be completed in 15 minutes, and is designed to be administered by a lay interviewer. When properly administered, the tool is extremely accurate, which allows for a high level of confidence that the scoring reveals the level of care needed. Like CLOX 1 & 2, the form must be used and instructions must be given as written, but the Exit 25 is more complicated and takes longer to administer. Training and practice are key for ensuring proper use and optimal efficiency. Dr. Royal has also developed a "QUICK-EXIT" version of the tool which reduces the number of items to 14 and according to the conclusions from a Rasch Analysis may even further improve the internal consistency and enhanced the validity.

ADDITIONAL TOOLS AND RESOURCES

ACED Assessment of Capacity for Everyday Decision-Making	The first tool designed specifically for APS use, to effectively address a common clinical issue: is a patient who refuses an intervention to help manage an instrumental activity of daily living (IADL) disability capable of making this decision? The ACED is useful for assessing the capacity to solve functional problems of older persons with mild to moderate cognitive impairment from disorders such as Alzheimer's disease. Its reliability and validity are supported by data. Practitioners should be aware that the instrument is designed to guide what is ultimately a clinical interview; hence, practice and judgment are essential. In addition, issues of the client's literacy and trust in the interviewer can affect how they perform on the interview.
Clock Drawing MINI-COG	This tool is a quick method of assessing for cognitive impairment. It is a single task or tool which won't establish capacity but it will help identify clients who need further cognitive assessment.

COGNITIV ASSESSMENT AND SELF-NEGLECT SCREENING TOOLS

Environmental Safety Assessments	Many focus on reducing the risk of falls, fires, and crime. An example is the Cougar Home Safety Assessment for Older Persons, Version 4.0. It contains 78 criteria that can be answered by observation, testing of certain home items, and questioning the resident.
Hoarding Scale	The Clutter Hoarding Scale assesses hoarding in five areas: Structure and Zoning, Animals and Pests, Household Functions, Health and Safety, and Personal Protective Equipment (PPE) needed on entering. It was developed by the National Study Group on Chronic Disorganization (NSGCD).
Trail Making	Connect the dots type puzzle with letter number letter sequence to be completed in 1 minute. A person with executive dysfunction will take much longer with this task, or may be unable to do it at all.
Blessed MSQ	This tool is one which will help you assess orientation, memory and concentration. A score of 10 or more indicates moderate cognitive impairment and capacity should be in question. The worker will need to screen for biases, since a person with limited education or with hearing problems is not a good candidate for this tool. It will not give you a complete capacity assessment unless the client's orientation, memory and concentration are what is placing the client at-risk.
Kahn	This instrument measures short and long term memory only. In addition to the standard tools the, Kahn, Blessed MSQ, Parables, and obtaining background information, which may be used, there are other tools which help determine Executive Functioning or impairments which other tools don't measure.
Verbal Fluency	Unimpaired persons will generate 9 to 10 words in 1 minute from a category provided by the worker. Impaired person will show fatigue and difficulty with switching sets with repeated categories.
Luria Hand Sequence	Unimpaired person will accurately mimic the examiners alternating hand movements.
Background information	Using historical knowledge of the client to frame questions to assess the client's short and long term memory is another method of assessment, and one which is less offensive to the client.

SOURCE: Oklahoma APS Academy Core Training on CAPACITY – 2015, found in Assessing APS Clients' Decision-Making Capacity eLearning

*revised for Working with Self-Neglecting Clients Module 10

SLIDE #34


Results of the Dubin Study
Overwhelmed Caregiving Systems
The Dysfunctional Caregiving System
The Self Interested Caregiver
The Elder Alone
Elders Who Refuse Care

HANDOUT #7

Neglect and Self-Neglect as the Absence or Breakdown of Caregiving Systems^ (Part 2)

1. Overwhelmed Caregiving Systems.

- Definition: The older person or adult dependent has family, friends, or paid caregivers who are actively involved in providing care but are not doing everything that's necessary.
- Examples:
    - The caregiving system was adequate at one time - but then there were changes, a gradual deterioration or an abrupt incident - a stroke for example - which rendered the care inadequate.
    - The caregiver is trying to balance caregiving with a job or other responsibilities.
    - The older adult or adult dependent really should be in nursing home or board and care - they need extensive care - but they're refusing to go.
    - The family cannot afford nursing home care or support services.
- **Prognosis:** _____
  _____
- **Promising Approaches:** _____
  _____

2. The Dysfunctional Caregiving System

- Definition: A caregiving system is in place but the dynamics between various caregivers, or between caregivers and older person are characterized by dysfunction.
- Examples:
    - The older person is difficult and alienates others - house keepers and/or caregivers quit or the older person fires them
    - Family members are estranged
    - Feuding families. You may have sibling feuding with each other or with the older person.
    - Families with substance use disorders
- **Prognosis:** _____
  _____
- **Promising Approaches:** _____
  _____

3. The Self Interested Caregiver

- Definition: Someone has responsibility for providing but the care is inadequate because the caregiver is really just in it for the money.
- Examples:
    - Caregiver is being paid or stands to inherit.
    - Caregiver is concerned or preoccupation with their own interests.
- Accounted for the fewest number of cases

Neglect and Self-Neglect as the Absence or Breakdown of Caregiving Systems^ (Part 2)

- **Prognosis**: _____
  _____
- **Promising Approaches:** _____
  _____

4. The Elder Alone

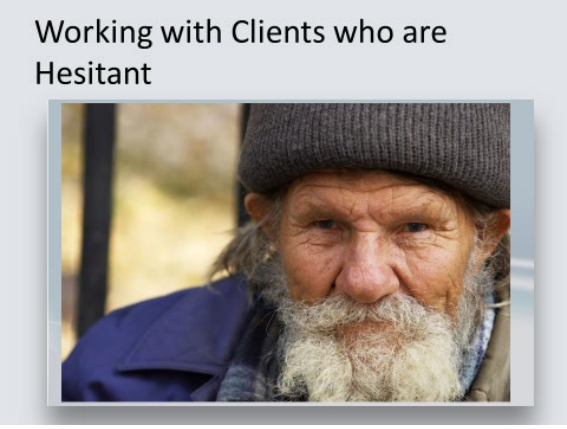
- Definition: Elders who have no one to provide care. Since the neglect in these situations cannot be attributed to anyone other than the elders themselves, these cases are often referred to as self-neglect.
- Examples:
  1. Elder recently lost close friends or relatives, or spouses who were providing care and alternative arrangements haven't been made.
  2. Elders who have chosen to be alone or to live with animals.
  3. Debilitated couples where neither member is capable of providing care to the other.
- **Prognosis:** _____
  _____
- **Promising Approaches:**_____
  _____

5. Elders who Refuse Care

- Definition: Same as above but senior has refused help.
- Examples:
  - Senior is depressed. May be close to die and wants to die
  - Senior doesn't want to have their affairs scrutinized
  - Senior is committing slow form of suicide.
- **Prognosis:** _____
  _____
- **Promising approaches:** _____
  _____

^ Dubin, T., Garcia, R., Lelong, J., & Mowesian, R. (1986). Family neglect and self- neglect of the elderly: Normative characteristics and a design for intervention. Austin, TX: Hogg Foundation for Mental Health, Family Eldercare, Inc.

SLIDE #35



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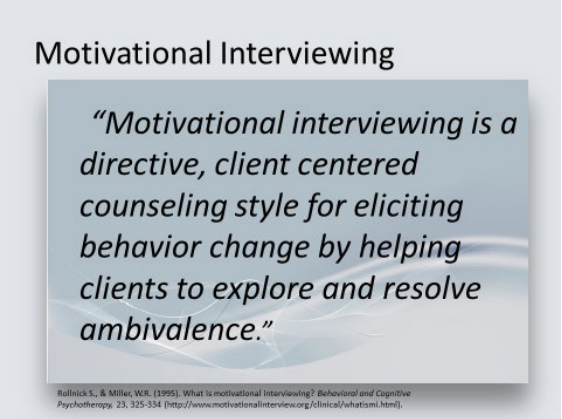

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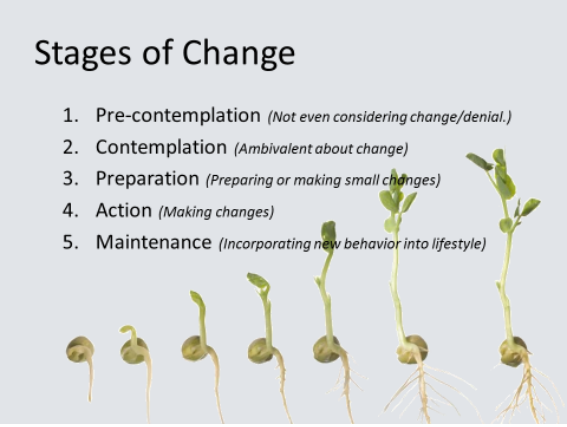

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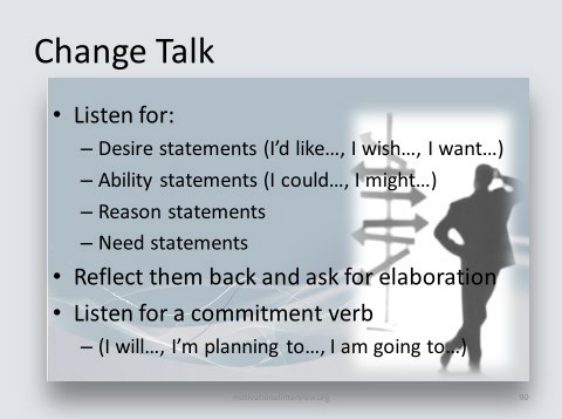

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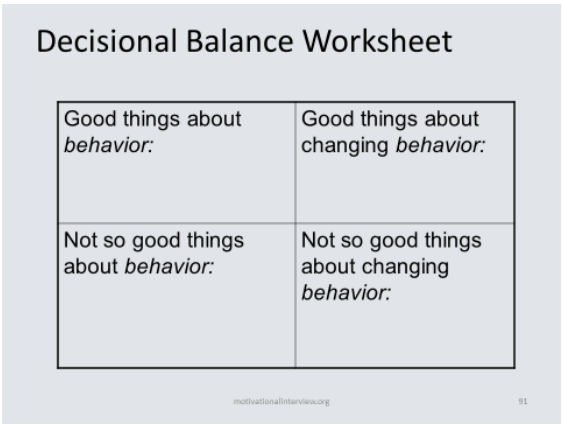

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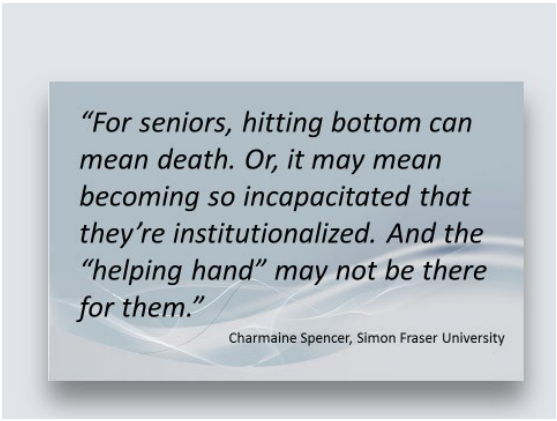


SLIDE #44

Harm Reduction Coalition Principals

-a set of practical strategies and ideas aimed at reducing negative consequences with drug use.

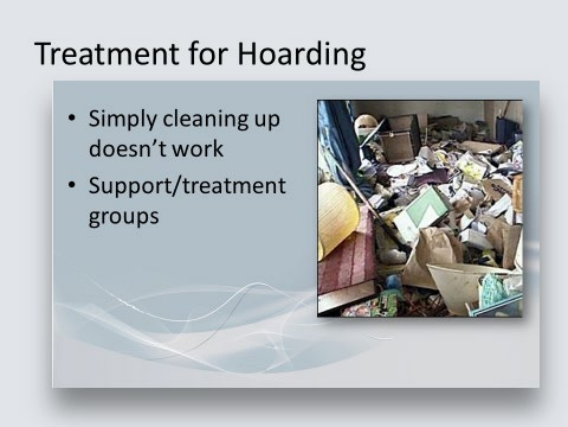
HANDOUT #8

The Harm Reduction Coalition Principles

The Harm Reduction Coalition considers the following principles central to harm reduction practice.

- Accepts, for better and/or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
- Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviors from severe abuse to total absinence and acknowledges that some ways of using drugs are clearly safer than others.
- Establishes quality of individual and community life and well-being – not necessarily cessation of all drug use – as the criteria for successful interventions and policies.
- Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which the live in order to assist them in reducing attendant harm.
- Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.
- Affirms drug users themselves as the primary agents of reducing the harms of their drug use and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use.
- Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.
- Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.

SLIDE #45



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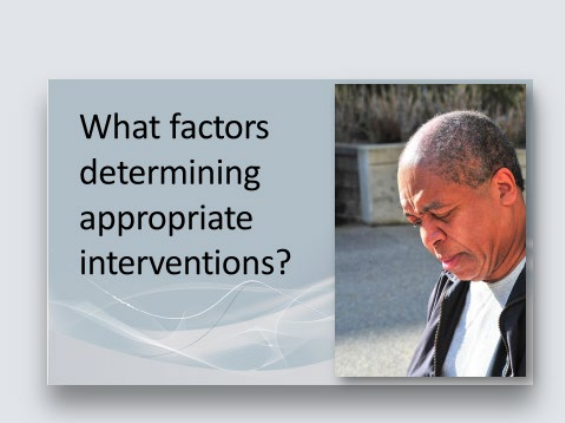


SLIDE #47

HANDOUT #9

SUPPORT AND SERVICES TO CLIENTS OR CAREGIVERS TO PREVENT SELF-NEGLECT

Social Support:
Research has shown that social support can be a key intervention and prevention component in elder abuse. Those involved in various community agencies or have ties to organizations like church or volunteering are less likely to become isolated. The National Elder Mistreatment Study indicates that the rates of emotional, physical and sexual abuse were lower in older adults who had high social support verses those with low social support.

Social Services and Programs:

- **Attendant Care**. Attendants assist vulnerable people with their daily activities, including bathing, shopping and preparing meals.
- **Caregiver Support Services** reduce the stress and strain on caregivers that may cause them to abandon or neglect elders and dependent adults. They include:
    - **Support Groups** address the emotional demands and stresses of providing care. They also provide instruction and guidance in meeting the older person's needs and handling difficult behaviors. They may relieve the tensions, resentments and stresses that give rise to abuse and neglect.
    - **Respite Care** offers relief to caregivers by giving them a break. Respite can be provided in many ways. Attendants, professionals or volunteers may come to the vulnerable person's home to relieve a caregiver for a few hours or the older person may be brought to an agency or day center. Some communities offer extended respite care in residential care or skilled nursing facilities.
- **Case Management.** A way of providing care for people who have multiple and changing needs. Case managers may work for public programs like the Multipurpose Senior Services program (MSSP) and Linkages or in private practice. Case managers conduct comprehensive assessments of clients' abilities and what they need help with. They then arrange for services and monitor them, responding to problems. Specifically, they:
    - Conduct comprehensive assessments of the older person's general health, mental capacity and ability to manage in the home and community
    - Develop "care plans," often in consultation with other professionals from several disciplines, for meeting cleints' service needs
    - Arrange for needed services
    - Respond to problems or emergencies
    - Conduct routine re-assessments to detect changes in the person's health or ability to manage, and anticipate problems before they occur

SUPPORT AND SERVICES TO CLIENTS OR CAREGIVERS TO PREVENT SELF-NEGLECT

- **Conservatorship**. A mechanism by which a court appoints a person to handle the financial and/or personal affairs of individuals who are unable to protect themselves as the result of disability. This is also called a guardianship in some states. States differ in whether they compartmentalize the duties of a conservator but they are often divided as follows:
    - **Conservatorship of person** refers to the handling of an individual's personal needs through the provision of medical care, food, clothing and shelter
    - **Conservatorship of estate** refers to the management of financial resources and assets
- **Counseling** may be needed to alleviate the immediate and long-term traumatic stress associated with abuse. Some groups address such issues as co-dependency depression and diminished self-esteem.
- **Daily Money Management (DMM).** Financial abuse frequently may occur when an older person has lost the ability to manage his or her finances. Arranging for trustworthy people to help can reduce this risk. The help may be informal, where the money manager simply helps the elder with simple tasks like paying bills or it may involve formal transfers of authority, including representative payeeship, power of attorney, or guardianship.
- **Emergency funds** may be needed for temporary caregivers, housing, food, rent, mortgage payments, shelter, transitional housing, transportation, utilities, new locks to secure clients' homes, attorney's fees, court filing fees, repairs, relocation costs, security deposits, respite care, and home modification. In cases of serious neglect, a one-time "deep cleaning service" may be needed to make the client's home habitable, thus preventing placement in a more restrictive environment.
- **Home delivered meal programs.** Programs deliver nutritious meals to older adults or adult dependents in their homes. Also called Meals on Wheels.
- **Friendly Visitor.** A number of senior organizataions offer a friendy visitor or similar option where volunteers check in with designated people. This type of intervention can help promote social interaction, help build relationships and provides another pair of eyes to see how the client is doing and to contact APS if the person seems to be at risk again.
- **Mental health** assessments are often needed to determine if an older or dependent adult is capable of meeting his or her own basic needs, making decisions about services, offering testimony, and protecting him or herself against abuse. Assessments of alleged abusers' mental status are sometimes needed to determine if they pose a danger to others and are in need of treatment. Assessments range from simple exams that can be performed quickly by persons with minimal training to geriatric assessments, which involve multiple professionals performing a comprehensive battery of tests.

SUPPORT AND SERVICES TO CLIENTS OR CAREGIVERS TO PREVENT SELF-NEGLECT

- **Regional Centers** are nonprofit, private corporations that contract with the Department of Developmental Services to provide or coordinate services and supports for individuals with developmental disabilities. They have offices throughout California to provide a local resource to help find and access the many services availabel to individuals and their families.
- **Shelter.** Clients may need shelter when they have been evicted from their homes or apartments as a result of the abuse; when caregivers have abandoned them or have been terminated or arrested; or when their homes are unsafe or unhealthy. Shelter options may include beds or rooms in senior apartment houses or board and care homes, to free-standing elder shelters.
- **Telephone reassurance programs** can make routine "check in" calls to isolated older or dependent adults or provide telephone counseling to seniors who are in emotional distress.

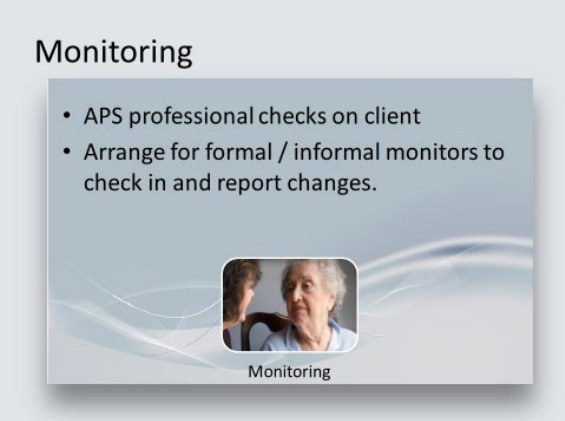
SLIDE #48

SLIDE #49

SLIDE #50

SLIDE #51

SLIDE #52



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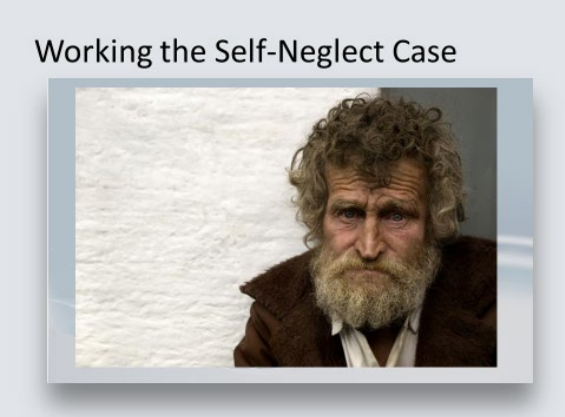


HANDOUT #10

SELF-NEGLECT CASE STUDIES

CASE #1 John Sumner

Robert, an APS professional, receives a call from Sara, who is the manager of a senior apartment building. Sara is concerned abuot a tenant in her apartment building, 80-year-old John Sumner. John has not left his apartment for the past two weeks and yells, "Go away!" whenever Sara knocks on the door. John has not paid his rent for the last two months, nor has he picked up his mail. His neighbors have complained about the smells coming from his apartment. Sara can hear the sound of many cats when she comes to John's door. She doubts that John or the cats have sufficient food and wonders if John is caring for himself. Robert makes a home visit and finds that John is willing to talk with him.

Questions: What should Robert do? (e.g. what should he do next, what additional information should he gather, what should he consider?)

CASE #2. Mrs. Albertson

Mrs. Albertson called the fire department about a kitchen fire. When the firefighters arrived, they found Mrs. Albertson confused and paranoid. They brought her to a hospital Emergency Room and called APS. Trudy was assigned to the case and when she followed up with the firefighters, they told her that Mrs. Albertson is a "frequent flyer" (she has similar incidents every few months.) When Trudy went to the hospital ER to talk to Mrs. Albertson, she was told that she'd felt better and left. The next day, Trudy visited Mrs. Albertson in her home. When she expressed concern about the incident, Mrs. Albertson insisted that it was the medication her doctor had given her and that she had thrown it away. With Mrs. Albertson's permission, Trudy contacted the physician who informed her that Mrs. Albertson was on multiple medications and that he was aware of the problems. He felt she would be better off in an assisted living facility where someone could help her, but she had refused. On further investigation, she discovered that Mrs. Albertson had had several falls and on one occasion had been on the floor for several hours before the mailman heard her shouting and called the police.

Questions: What should Trudy do? (e.g. what should she do next, what additional information should she gather, what should she consider?)

SLIDE #54


Importance of Good Documentation
• Continuity of care
• Provides a baseline for detecting gradual changes
• May be needed in legal proceedings

HANDOUT #11

Documentation in Self-Neglect

Physical signs and symptoms

- Bruises and other injuries (photographs, descriptions and body maps, which are drawings of the front, sides and back of a human figure, can be used to describe injuries)
- Pressure ulcers
- Weight loss
- Dental problems
- Detreriorated or dilapidated living conditions, filth, pest infestations
- Signs of hoarding and cluttering
- Adequacy of facilities. Are there hazards or dangers, adequate heating, etc.
- Evidence of medication mismanagement, non-compliance, etc.
- Adequate clothing and assistance devices
- Evidence of alcohol or substance abuse

Behavioral Signs and Symptoms

- Lethargy
- Depression
- Signs of post-traumatic stress disorder (PTSD), including withdrawal, hypervigilance and fear
- Patient's demeanor (the patient is crying, shaking, angry, agitated, upset, calm or happy)
- Sexual "acting out" (may be a sign of sexual assualt).
- Fearfulness, distrust
- Hallucinations
- Alertness
- Flat affect
- Agitation and anxiety

Indications of Capacity and Consent

- Changes over time. Has there been a gradual or rapid decline?
- Statements that indicate that clients do not realize how dangerous or serious their situations are
- Client's judgment is impaired
- What services were offered and refused?
- Number of times offered and refused
- Client's stated reasons for refusing services

1 of 2

Documentation in Self-Neglect (continued)

- How well is the client "tracking" or following what is being said
- Memory

Indicators of Clients' Preferences, Values and Lifestyles

Indicators of preferences, values and lifestyles can be documented by recording client (or others) statements about:

- Treatment and service preferences
- Wishes and preferences as told to others or as indicated in advance directives
- Values
- Life-style

APS Professional Actions

- Actions taken by professionals
- Reasons for actions not taken
- Indicators that workers followed agency chain of command, such as consulting with supervisors, following rules concerning documentation, etc.

SLIDE #55

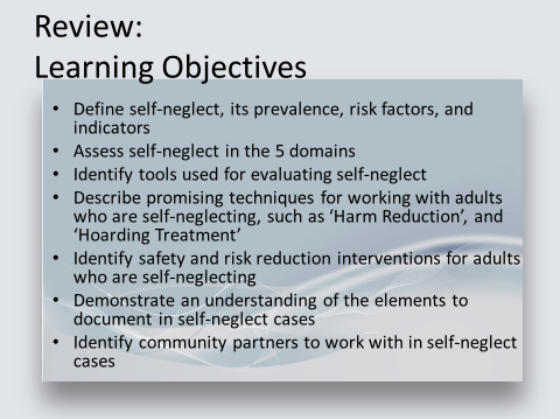
Partners in Self-Neglect:
With whom should you partner?

HANDOUT #12

Community Partners in Self-Neglect Cases	
Professional, entity or group	***Role in self-neglect cases***
Mental Health professionals, including county geriatric mental health program personnel or professionals in private practice (geriatric psychologists, psychiatrics, etc.)	• *Can assess clients' mental status* • *Can arrange for psychiatric hospitalization under W&I Code §5150.* • *Can diagnose and treat depression and other mental conditions*
Geriatric physicians and nurses	• *Can diagnose, assess and treat medical conditions* • *Can complete medical declarations (doctors) for conservatorship* • *Can review medical records and distinguish injuries from effects of aging and disease*
Conservators, including private professionals	• *Can file for and provide conservatorship services*
Public Guardians	• *Can file for and provide conservatorship services*
Clergy	• *Can provide emotional and spiritual support to clients* • *Can provide or arrange for informal support services*
Local law enforcement, including police and sheriffs	• *Can assist with well-being checks, psychiatric hospitalizations, protective custody, freezing assets*
Animal Welfare Organizations (municipal animal care and control) agencies, humane societies, SPCAs and rescue organizations	• *Can provide information and assist with finding homes for animals* • *Can make home visits to check on the welfare of the animals in the home*

Ethics Committees (most are convened by hospitals and nursing homes)	• *Can identify and address ethical issues raised in self-neglect cases*
Multidisciplinary teams, including elder abuse multidisciplinary teams and death review teams	• *Can provide suggestions for interventions* • *Provides a "checks and balances" to ensure that all multiple options and points of view are considered* • *Can ensure that workers' actions reflect community standards of practice*

SLIDE #56



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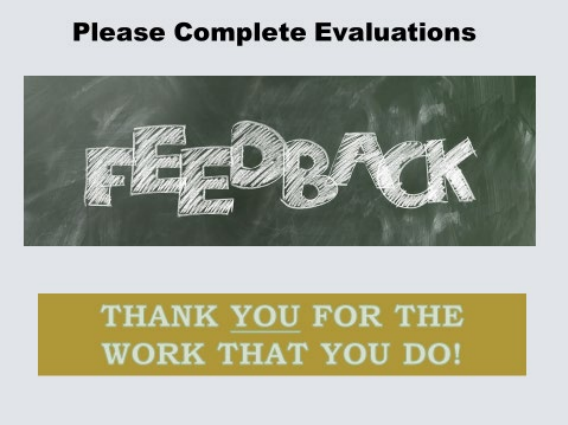

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