APS Supervisor Core: Supervising Complex Cases

Instructor Led Training (Virtual Course or In-Person)

PARTICIPANT MANUAL

Academy for Professional Excellence

APSWI
Adult Protective Services Workforce Innovations

The Academy for Professional Excellence is a project of the San Diego State University School of Social Work

Funding Sources

This training was developed by the Academy for Professional Excellence, with funding from the California Department of Social Services, Adult Programs Division.

Curriculum Developer, 2022

Brenda Wilson-Codispoti

Introduction

We are pleased to welcome you to **APS Supervisor Core: Supervising Complex Cases Participant Manual**, developed by Adult Protective Services Workforce Innovations (APSWI), 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 with the goal of revolutionizing the way people work to ensure the world is a healthier place. Our services integrate culturally responsive and recovery-oriented practices into our daily work to promote healing and healthy relationships. Providing around 70,000 learning experiences to health and human service professionals annually, the Academy provides a variety of workforce development solutions in Southern California and beyond. With five programs, three divisions and over 100 staff, the Academy's mission is to provide exceptional learning and development experiences for the transformation of individuals, organizations and communities.

APSWI is a program of the Academy for Professional Excellence. APSWI is designed to provide competency-based, multidisciplinary training to Adult Protective Services professionals and their partners. APSWI's overarching goal is the professionalization of Adult Protective Services professionals to ensure that abused and vulnerable older adults and adults with disabilities receive high quality, effective interventions and services.

APSWI partners with state and national organizations and experts in the older adult and adults with disabilities professions to empower APS professionals and those they serve to live safely, peacefully and in a world that is free from abuse and neglect.

APSWI'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)
- California's Curriculum Advisory Committee (CAC)

Partner Organizations

Dawn Gibbons-McWayne, Program Manager, APSWI

Academy for Professional Excellence

https://theacademy.sdsu.edu/programs/apswi/

Brenda Wilson-Codispoti, APSWI Supervisor Core Program Coordinator

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https://theacademy.sdsu.edu/programs/apswi/

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https://www.napsa-now.org/

Kim Rutledge , Adult Protective Services Liaison, Adult Protective Services Division

California Department of Public Social Services

https://www.cdss.ca.gov/adult-protective-services

Francisco Wong and Melinda Meeken, Co-Chairs, Protective Services Operations Committee of the County Welfare Director's Association

https://www.cwda.org/adult-protective-services

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. APSWI would like to thank the following individuals and agencies:

Agencies

California Department of Social Services, Adult Programs Division
Arizona Department of Economic Security, DAAS-Adult Protective Services
National Adult Protective Services Association

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Committees
National Adult Protective Services Association Education Committee
Supervisor Curriculum Advisory Committee

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Executive Summary

APS Supervisor Core: Supervising Complex Cases

APS supervisors face multiple challenges, managing multifaceted roles, and responsibilities that they carry out daily. One critical area of oversight is guiding staff with investigating, case planning, and navigating complex cases. The very definition of the word complex implies that the situation is complicated, intricate, involved, knotty meaning having confusing interrelated parts, it applies to what offers great difficulty in understanding, solving, or explaining. In this interactive training we will provide examples of complex cases and the role of the APS supervisor in providing oversight of these investigations. You will learn about tools, best practices, and strategies that you can share with your staff to guide and support them through the investigation process and that promote quality assurance, alignment with agency policy and procedures, and insure the well-being of the clients served in our communities.

Virtual Training:

- The following virtual instructional strategies are used throughout the course: short lectures (lecturettes), interactive activities/exercises including breakout groups, chat box discussions, large group discussions, self-reflection, poll options, and individual practice. PowerPoint slides and role playing/demonstrations are used to stimulate discussion and skill development.
- Participants will need access to a computer with video conferencing capability and be able to connect to the virtual platform being used to deliver this training. A headset or earbuds with microphone and a video camera are highly encouraged. Participant Manual is a fillable PDF if using Adobe Acrobat. Participants are encouraged to either print a hard copy or ensure access to Adobe Acrobat to allow for highlighting, typing in comments and filling out worksheets.
- **Course Requirements: None**
  Target Audience: This workshop is intended for new supervisors, APS Professionals that may be wanting to promote, or experienced staff who may require a refresher.

Outcome Objectives for Participants:

By the end of this training participants will be able to:

- Describe and provide examples of complex cases and role of the APS Supervisor with providing oversight of these challenging investigations.
- Explain the value of risk assessments and how risk assessments assist APS workers and supervisors with complex cases.
- Identify tools and strategies that APS supervisors can use to guide supervisory sessions with staff. APS supervisors will be able to train their

staff on using the tools and strategies to develop their competencies to assess and analyze complex cases pre-initial 1st visit/contact (pre-case planning), during initial face to face visit, and post visit.
- Understand the need for collaboration and coordination with community providers and the value and use of multi-disciplinary teams to address complex APS cases.

Establish guidelines and identify tools that APS supervisors can utilize to support quality assurance with case closure.

Course Outline

CONTENT	MATERIALS	TIME
WELCOME, INTRODUCTIONS, & COURSE OVERVIEW		20 minutes
Welcome, Housekeeping, Technology Overview, and Introductions	Lecture Slides 1-4	18 minutes
Learning Objectives	Lecture Slide 5	2 minutes
WHAT IS A COMPLEX CASE?		35 minutes
What is a Complex Case	Lecture and Break out Activity Slide 6	30 minutes
Examples of Complex Cases and Supervisor's Role	Lecture Slide 7-8	5 minutes
WHAT IS THE VALUE OF A RISK ASSESSMENT		15 minutes
What is a Risk Assessment	Lecture Slide 9	2 minutes
Why do a Risk Assessment	Lecture Slide 10	2 minutes
Do Risk Assessments help APS Professionals	Lecture Slide 11	5 minutes
How do Risk Assessments assist APS Professionals	Lecture Slide 12	3 minutes
How do Risk Assessments assist APS Supervisors	Lecture Slide 13	3 minutes
BREAK		10 minutes
RISK ASSESSMENT TOOLS AND STRATEGIES		65 minutes
The 3 S's of Risk Assessment	Lecture Slide 14	2 minutes

Handout # 1 The 3 S's Risk assessment tool	Lecture Slides 15-16	5 minutes
Ready-Set-Go! 5 Minute Coaching Questions	Slides 17-18	3 minutes
Case Planning with Voluntary Clients	Lecture Slide 19	5 minutes
Case Planning with Involuntary Clients	Lecture Slide 20	5 minutes
Considerations for Voluntary vs. Involuntary Clients	Lecture Slide 21	3 minutes
Phases of Risk Assessment	Slide 22	35 minutes
Break Out Group Activity # 2	Group Activity #2 Slide 24	11 minutes
Phases of Risk Assessment	Lecture Slide 27-28	3 minutes
Risk Factors vs. Risk indicators	Lecture Slide 29	7 minutes
What are the 5 Domains of Risk	Lecture Slide 30	2 minutes
Victim Related Risk Factors	Lecture Slide 31	2 minutes
Perpetrator-Related Risk Factors	Lecture Slide 32	2 minutes
Types of Risk Indicators	Lecture Slide 33	2 minutes
Assessing in 5 Domains	Lecture Slide 34	2 minutes
Signs of Medical Emergencies	Handout Slide 35	1 minutes
Activity # 3 Using the 3 S's of Risk and 5 Domains Assessment	Group Discussion Activity Slide 36	30 minutes
Service Plans	Lecture Slide 37	3 minutes
BREAK		10 minutes
COLLABORATION AND MDTS		50 minutes
What is a Multidisciplinary Team	Lecture Slide 38	5 minutes

Examples of MDTs	Lecture Slide 39	3 minutes
Informal Supports and Community Providers	Lecture Slide 40	5 minutes
CASE CLOSURE AND QUALITY ASSURANCE		10 minutes
Planning for Case Closure	Lecture Slides 41-42	3 minutes
Reassessments and Case Closure	Slide 43	2 minutes
Transfer of Learning	Slide 44	5 minutes
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Handout # 1 The 3 S's Risk assessment tool	Lecture Slides 16-18	5 minutes
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Case Planning with Involuntary Clients	Lecture Slide 21	5 minutes
Considerations for Voluntary vs. Involuntary Clients	Lecture Slide 22	3 minutes
Break Out Group Activity # 2	Group Activity # 2 Slide 25	35 minutes
Phases of Risk Assessment	Lecture Slides 23-24, 26-27	11 minutes
Risk Factors vs. Risk indicators	Lecture Slide 28	3 minutes
What are the 5 Domains of Risk	Lecture Slide 29	7 minutes
Victim Related Risk Factors	Lecture Slide 30	2 minutes
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Reassessments and Case Closure	Slide 41	2 minutes
Transfer of Learning	Slide 42	5 minutes

APSWI
Adult Protective Services Workforce Innovations

APS Supervisor Core: Supervising Complex Cases

Instructor Led Training

We create experiences that transform the heart, mind, and practice.

Academy for Professional Excellence

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About the Academy & APSWI

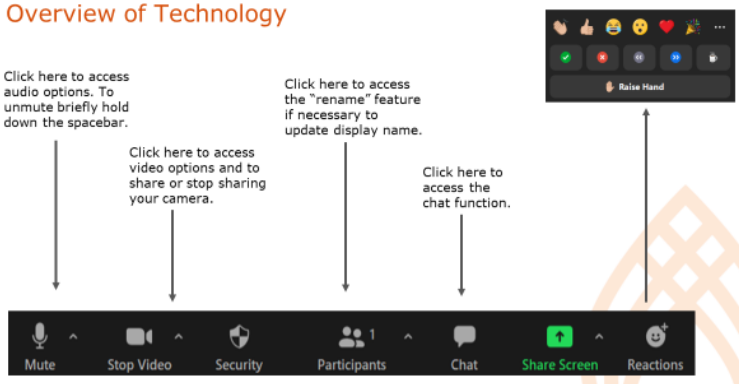
The Academy is a project of San Diego State's School of Social Work. Serving over 20,000 health and human services professionals annually, the Academy's mission is to provide exceptional workforce development and learning experiences for the transformation of individuals, organizations and communities.

APSWI, or Adult Protective Services Workforce Innovations, is a training program of the Academy that provides innovative workforce development to APS professionals and their partners.

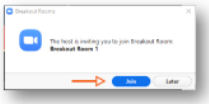
ACADEMY PROGRAMS

APEX APSWI CWDS LIA SACHS

Overview of Technology



Breakout Groups



Joining the breakout group:

- Click **join**

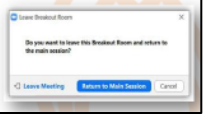
Asking for help:

If you click **Ask for Help**, it will notify the meeting host that you need assistance and they will be asked to join your breakout room.

Leaving the breakout group:

You can leave the breakout room and return to the main meeting session at any time, or you can leave the meeting entirely from the breakout room.

1. Click **Leave Breakout Room.**
2. Choose if you want to leave the breakout room or the entire meeting.
3. When the host ends the breakout rooms, you will be notified and given the option to return to the main room immediately, or in 60 seconds.



Learning Objectives

After completing this course, you will be able to:

1. Describe and provide examples of complex cases and role of the APS Supervisor.
2. Explain the value of risk assessments and how risk assessments assist APS professionals and supervisors with complex cases.
3. Identify tools and strategies that APS Supervisors can use to guide supervisory sessions with their staff.
4. Explain the need for collaboration and coordination with community providers and the value and use of multi-disciplinary teams.
5. Establish guidelines and identify tools that APS supervisors can utilize to support quality assurance with case closure.

Complex APS Cases

What is a complex case?

- Think about an APS case that was challenging
- What made it difficult?
- How did it differ from other investigations?
- What type of abuse did it involve
- What was your role as the APS Supervisor with supervising this case or other complex cases?

Examples of Complex APS Cases…

- Complex financial abuse/scams
- Reluctant self-neglect cases
- APS history/multiple reports
- Behavioral health issues
- Severe neglect
- Domestic abuse
- High profile/cases in the media
- Anything else you would add…

Examples of Tasks and Duties of Supervising Complex Cases as an APS Supervisor…

- Case consultation 1:1 supervision
- Case review
- Service planning
- Coaching
- Mentoring
- Field observation
- Quality assurance

- Follow policy & procedures & ensure case compliance
- Cross reporting to partner agencies
- Collateral contacts
- Knowledge of Trauma Informed supervision

What is a Risk Assessment

- Systematic process that guides decisions and judgements
- Goal is to enhance the safety of older adults and adults with disabilities
- Risk assessment tools guide workers and supervisors to predict future risk and develop relevant case plans

Why do a Risk Assessment

- Need to make an initial determination on safety and risk.
- Initial information may be incomplete or inaccurate.
- Increased workloads and case complexity.
- Need to know when interventions are likely to succeed.

Do Risk Assessments Help APS Professionals?

If so…
What do risk assessments help APS professionals with?

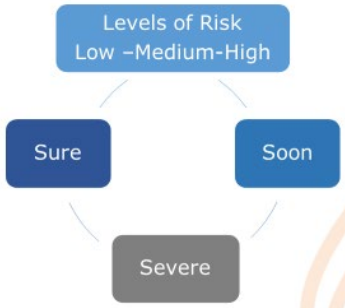
How Do Risk Assessments Assist APS Professionals?

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

How Does Risk Assessment Help APS Supervisors?

- 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

The 3 S's of Risk Assessment



The 3 S's of Risk Assessment Tool

- Handout #1, Page 1

Handout #1: The 3 S's of Risk Assessment Tool

Directions: Using a current case, complete the risk assessment chart based on your observations and the information gained during your investigation.

For each Risk Factor that you identify:

1. List the apparent risk next to the #.
   a. Circle or highlight whether you find that risk to be low, medium or high.
   b. Work through the 3 S's by noting how **Soon** might the client be harmed, how **Severe** might they be harmed and how **Sure** are you that the harm will occur (i.e. the likelihood).
      i. Make sure to include why you believe that to be true.
2. Discuss any risk indicators.
3. Provide a global assessment of that particular risk.
4. Note any factors that may mitigate that risk.
5. Create a service plan for each risk.

RISK ASSESSMENT CHART

RISK FACTORS (Conditions which put a person at risk of harm)	RISK INDICATORS (Observable signs that indicate that risk may be present)	GLOBAL ASSESSMENT (History and context around this particular risk)	FACTORS THAT MITIGATE THE RISK (Client's strengths, motivation, support network)	SERVICE PLAN (Identify services that might be of help and follow up if connections were made.)
#1. • Soon • Severe • Sure Based on the 3 S's, the level of risk is: Low, Med, or High?				

The 3 S's of Risk Assessment Tool

- Handout #1, Page 2

• Severe • Sure Based on the 3 S's, the level of risk is: Low, Med, or High?				
#3. • Soon • Severe • Sure Based on the 3 S's, the level of risk is: Low, Med, or High?				
#4. • Soon • Severe • Sure Based on the 3 S's, the level of risk is: Low, Med, or High?				
#5. • Soon • Severe • Sure Based on the 3 S's, the level of risk is: Low, Med, or High?				

Why Use the 5 Minute Coaching Questions?

The 5-Minute Coaching questions allows the supervisor to conference with the APS worker to identify possible risks, options/interventions, and implement best strategies.

Ready-Set-Go! 5-Minute Coaching Questions

Handout #2: Ready-Set- Go! 5-Minute Coaching Questions

- What options do you see regarding this situation?
- What do you see as a challenge?
- What are your thoughts about the best way to approach this?
- What might get in your way?
- What do you think is the next step?
- How can I support you?
- When can I check back with you?

How Does the Coaching Session Assist Case Planning/Goal Setting?

Case Planning/Goal Setting with Voluntary Clients…some Considerations

- The Client's Wishes
- Alleged Abuser
- Urgency of Situation
- Ethical Considerations
- Cultural Considerations
- Other Considerations

How Does the Coaching Session Assist Case Planning/Goal Setting?

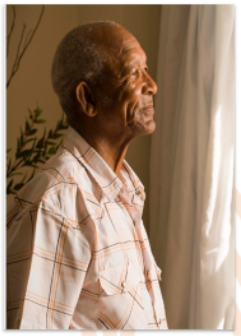
Case Planning/Goal Setting with Involuntary Clients…some Considerations

- The Client's Wishes
- Level of Risk
- Client's Capacity
- Least Restrictive Alternative
- Ethical Considerations
- Cultural Considerations
- Other Considerations

Considerations for Voluntary Vs. Involuntary Clients

Does the client:

- Understand information that's needed to make an informed decision?
- Give a plausible explanation for decisions?
- Weigh the risks and benefits of options?
- Appreciate his/her own situation and its consequences?
- Communicate a choice?



Phases of Risk Assessment

Initial assessments and emergencies

Case planning

Reassessments and case closure

Phases of Risk Assessment

Phase 1: Initial Assessment and Emergencies

Helps workers decide:

- Whether/how quickly to investigate
- Immediate danger? (**soon**)
- Consequences if delayed? (**severe**)
- Why is the reporter calling now?
- Is client able to understand/make decisions?
- What is at risk?
- What, if any, immediate measures are needed?
- What is the likelihood that they will be harmed without intervention? (**sure**)

Break out Group Activity:

- Read the case scenario Handout #3 Mrs. Anderson.
- Create responses using Handout #1 (3 S's of Risk Assessment), identifying **one risk factor.**
- Then identify a few of the Ready-Set-Go questions that you would use with your staff and/or other open-ended questions, or comments to assist the APS professional with critically thinking, exploring case concerns, and engaging in case planning.
- Participants will be given 15 minutes for the activity in the break-out groups

Handout# 3: Case Scenario Mrs. Anderson

You have received a report on a Monday morning that Mrs. Anderson has not been seen by her neighbor for the last three weeks since coming home from the hospital after a stroke or heart attack (she was not sure which). Mrs. Anderson's daughter's car had been in the driveway until last Friday when the daughter left Mrs. Anderson alone and she has been gone all weekend. The daughter's name is Jenna and she lives about 20 miles away. There is also a son, Paul, but the neighbor didn't have any contact information for him. The neighbor believes that Mrs. Anderson has been home alone since last Friday. The neighbor doesn't know whether or not Mrs. Anderson can provide for her own care. The neighbor did see Mrs. Anderson walk into the home when she returned from the hospital so she knows that Mrs. Anderson can ambulate on her own. The neighbor has no other information about Mrs. Anderson's current condition.

Ask yourself:

- Does APS investigate the report? Does the situation meet the criteria of a client being at risk?
- How quickly should your investigation be initiated? Do you need a worker to go out immediately?
- Is Mrs. Anderson in immediate danger? How soon might she come to harm?
- Why is the neighbor calling now? Did something just happen?
- Does the client understand what's going on? Is the client's cognitive status affected to the point they do not understand they are at risk?
- Is the client capable of making decisions?
- What's at risk (life, health, property)?
- What are the consequences of delay? How severe might the harm be?
- What emergency or protective measures and services are needed?
- What is the likelihood (or how sure are you) that Mrs. Anderson will be harmed without intervention?

What other collaterals might the worker need to gather information on and speak with (i.e. primary care physician, hospital)

Handout #1: Risk Assessment Chart

Directions: Using a current case, complete the risk assessment chart based on your observations and the information gained during your investigation.

For each Risk Factor that you identify:

1. List the apparent risk next to the #.
    a. Circle or highlight whether you find that risk to be low, medium or high.
    b. Work through the 3 S's by noting how **Soon** might the client be harmed, how **Severe** might they be harmed and how **Sure** are you that the harm will occur (i.e. the likelihood).
        i. Make sure to include why you believe that to be true.
2. Discuss any Risk indicators.
3. Provide a global assessment of that particular risk.
4. Note any factors that may mitigate that risk.
5. Create a service plan for each risk.

RISK ASSESSMENT CHART

RISK FACTORS (Conditions which put a person at risk of harm)	**RISK INDICATORS** (Observable signs that indicate that risk may be present)	**GLOBAL ASSESSMENT** (History and context around this particular risk)	**FACTORS THAT MITIGATE THE RISK** (Client's strengths, motivation, support network)	**SERVICE PLAN** (Identify services that might be of help and follow up if connections were made.)
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#2. • Soon • Severe • Sure Based on the 3 S's, the level of risk is: Low, Med, or High?				
#3. • Soon • Severe • Sure Based on the 3 S's, the level of risk is: Low, Med, or High?				
#4. • Soon • Severe • Sure Based on the 3 S's, the level of risk is: Low, Med, or High?				
#5. • Soon • Severe • Sure				

Based on the 3 S's, the level of risk is: Low, Med, or High?				

Handout #2: Ready-Set- Go! 5-Minute Coaching Questions

- What options do you see regarding this situation?
- What do you see as a challenge?
- What are your thoughts about the best way to approach this?
- What might get in your way?
- What do you think is the next step?
- How can I support you?
- When can I check back with you?

HANDOUT #4: Types Of Risk Indicators

Risk Indicators: observable signs, things you can see or hear, that indicate that risk may be present.

Abuse indicators may be **physical** evidence that you can see, collect, or photograph.

Indicators may be **behavioral**. They may include what victims, perpetrators, and witnesses tell you, how they tell you, and the interactions between them.

There may be signs of abuse or risk in the person's physical **environment**.

Physical indicators are clues or signs that can be observed, collected, photographed, and/or recorded.

- Bruises or injuries (multiple, unexplained, untreated)
- Inappropriate money transfers
- Untreated pressure ulcers
- Unexplained weight loss
- Suspicious documents (e.g. documents signed by persons who are visually impaired or can't comprehend the content)

Behavioral Indicators include behaviors of the client or the perpetrator

- Caregivers who seem angry or resentful of caring for the older adult
- Caregivers who are over-taxed with responsibilities
- Older adults who seem fearful of caregivers
- Older adults who make excuses for caregiver's behavior
- Caregivers take older adults to several different hospitals or emergency rooms
- Caregivers take older adults to a hospital or emergency room further from older adult's home

Environmental Indicators are clues in the older adult's living environment

- Deteriorated home
- Lack of food

Continued

- Lack of amenities even though the older adult can afford them
- Human or animal waste
- Smells
- Signs of inappropriate restraints, such as locks on the outside of bedroom doors
- Extreme clutter
- Animal(s) that isn't cared for properly

Alternative Explanations must also be considered. It may be difficult to differentiate indicators from accidental injuries or the effects of illness such as weight loss. Neglect may also result from an older adult refusing help and acting freely

Handout #5: Phases of Risk Assessment

Phase 1: Initial Assessment and Emergencies

Helps workers decide:

- Whether to investigate a report - Does the situation meet the criteria of a client being at risk?
- How quickly an investigation should be initiated - Do you need to go out immediately?
- Are older/dependent adults in immediate danger - e.g. Are they alone and unable to manage? How **soon** might they come to harm?
- Why are they calling now? Did something just happen?
- Does the client understand what's going on? Is the client's cognitive status affected to the point they do not understand they are at risk?
- Is the client capable of making decisions?
- What's at risk (life, health, property)?
- What are the consequences of delay? How **severe** might the harm be?
- What emergency or protective measures and services are needed?
- What is the likelihood (or how **sure** are you) that they will be harmed without intervention?

Phase 2: Case Planning

Matching Services to Types and Levels of Risk:

- Are protective services needed on an ongoing basis to prevent future harm or abuse?
- How likely is it that harm or abuse will occur?
- What factors make it likely that abuse will occur in the future?

Factors to consider:

- Do abusers pose on-going risk?
- What factors mitigate risk (e.g. clients' strengths and resources)?
- Are informal supports available to help?

Continued

- How do older adults view the situation? What do they want to do about it? Are they capable of making choices and assisting with care plans?

Phase 3: Reassessments and Case Closure

- Has risk changed over time? Is the client at higher or lower risk?
- What accounts for the changes? Are new issues emerging? Are perpetrators out of the picture? Have threats been removed? Have interventions reduced risk? Has the client changed his or her mind about accepting services?
- Are changes to the care plan needed? What preventative measures are needed?

What is the likelihood that the situation will recur?

Handout# 3: Case Scenario Mrs. Anderson

You have received a report on a Monday morning that Mrs. Anderson has not been seen by her neighbor for the last three weeks since coming home from the hospital after a stroke or heart attack (she was not sure which). Mrs. Anderson's daughter's car had been in the driveway until last Friday when the daughter left Mrs. Anderson alone and she has been gone all weekend. The daughter's name is Jenna and she lives about 20 miles away. There is also a son, Paul, but the neighbor didn't have any contact information for him. The neighbor believes that Mrs. Anderson has been home alone since last Friday. The neighbor doesn't know whether or not Mrs. Anderson can provide for her own care. The neighbor did see Mrs. Anderson walk into the home when she returned from the hospital so she knows that Mrs. Anderson can ambulate on her own. The neighbor has no other information about Mrs. Anderson's current condition.

Ask yourself:

- Does APS investigate the report? Does the situation meet the criteria of a client being at risk?
- How quickly should your investigation be initiated? Do you need a worker to go out immediately?
- Is Mrs. Anderson in immediate danger? How soon might she come to harm?
- Why is the neighbor calling now? Did something just happen?
- Does the client understand what's going on? Is the client's cognitive status affected to the point they do not understand they are at risk?
- Is the client capable of making decisions?
- What's at risk (life, health, property)?
- What are the consequences of delay? How severe might the harm be?
- What emergency or protective measures and services are needed?
- What is the likelihood (or how sure are you) that Mrs. Anderson will be harmed without intervention?

What other collaterals might the worker need to gather information on and speak with (i.e. primary care physician, hospital)

- **Handout #3: Case Scenario Mrs. Anderson**

HANDOUT #4: TYPES OF RISK INDICATORS

Risk Indicators: observable signs, things you can see or hear, that indicate that risk may be present.

Abuse indicators may be **physical** evidence that you can see, collect, or photograph.

Indicators may be **behavioral**. They may include what victims, perpetrators, and witnesses tell you, how they tell you, and the interactions between them.

There may be signs of abuse or risk in the person's physical **environment.**

Physical indicators are clues or signs that can be observed, collected, photographed, and/or recorded.

- Bruises or injuries (multiple, unexplained, untreated)
- Inappropriate money transfers
- Untreated pressure ulcers
- Unexplained weight loss
- Suspicious documents (e.g. documents signed by persons who are visually impaired or can't comprehend the content)

Behavioral Indicators include behaviors of the client or the perpetrator

- Caregivers who seem angry or resentful of caring for the older adult
- Caregivers who are over-taxed with responsibilities
- Older adults who seem fearful of caregivers
- Older adults who make excuses for caregiver's behavior
- Caregivers take older adults to several different hospitals or emergency rooms
- Caregivers take older adults to a hospital or emergency room further from older adult's home

Environmental Indicators are clues in the older adult's living environment

- Deteriorated home
- Lack of food
- Lack of amenities even though the older adult can afford them
- Human or animal waste
- Smells
- Signs of inappropriate restraints, such as locks on the outside of bedroom doors
- Extreme clutter
- Animal(s) that isn't cared for properly

Alternative Explanations must also be considered. It may be difficult to differentiate indicators from accidental injuries or the effects of illness such as weight loss. Neglect may also result from an older adult refusing help and acting freely

- **Handout #4: Types of Risk Indicators**

Phases of Risk Assessment

Phase 2: Case planning matching services to types and levels of risk	Are protective services needed?	How likely is harm or abuse?	What factors indicate future harm?
How does the client view their situation?	On-going risks	Risk mitigation factors	Informal support systems

Phase 3: Reassessments and Case Closure

Factors to consider:

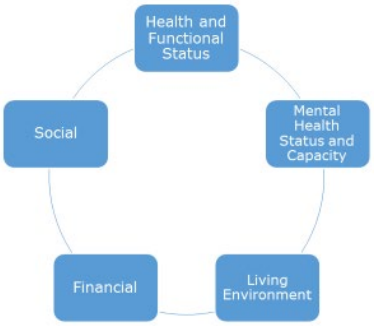
- Has risk has changed over time?
- What accounts for the changes?
- Are changes to the care plan needed?
- What is the likelihood that the situation will recur?

What are Factors vs. Indicators of Risk?

Risk Factors – conditions which put a person at risk of harm. Increases likelihood of that abuse or neglect has or will occur.

Risk Indicators – observable signs that you can see or hear that indicate risk may be present.

What are the Five Domains of Risk



HANDOUT #6: Victim-Related Risk Factors

Risk Factors: conditions which put a person at risk of harm. If a risk factor is present, it increases the likelihood that abuse or neglect has already occurred or will occur in the future. They are sometimes called "predictors". Risk factors fall into five domains: Health and Functional Status; Mental Health Status and Capacity; Living Environment; Financial; and Social.

Risk Domain	Associated Risk Factors
Health and functional status	• Older adults in poor health and who have functional limitations are at heightened risk (Fisher & Regan, 2006). • Poor health was identified as a specific risk factor in financial neglect cases (Acierno, Hernandez-Tejada, Muzzy, & Steve, 2009). • Because neglect involves older adults who depend on others for care, neglect victims tend to be in poor health and have functional limitations (County Welfare Directors Association of California, 2004). • Mistreated or neglected elders were more likely to have worse performance on IADLs and worse executive function performance (Ernst, Ramsey-Klawsnik, Schillerstrom, Dayton, Mixson, & Counihan, 2014). • Certain types of abuse presume cognitive impairment. For example, inducing someone who lacks decision-making capacity to surrender property is a form of financial abuse (Flint, Sudore, Widera, 2010). • Substantiated reports of elder abuse in persons over the age of 60+, 42.8% were 80 years old and over (National Center on Elder Abuse, 2004). • The risk of abuse increases with age. Older adults 80 years old and older are 2 to 3 times more likely than other older adults to be the victims of all

	categories of abuse (National Center on Elder Abuse, 1998, CWDA 2004).
Mental Health Status and Capacity	• Some studies show that victims are more likely than non-victims to have dementias. Some suggest that it is violent or disruptive dementia-related behavior that increases risk (Bonnie & Wallace, 2003). • Victims are likely to experience mental health problems, including depression, low self-esteem, and substance abuse (Dyer, Pavlik, Murphy, & Hyman, 2000; Fisher & Regan, 2006). • On average, maltreated older adults are in their late 70's, frail, and cognitively impaired (Choi & Mayer, 2000; Amstadter et al, 2011). • The loss of a spouse or other family member may increase older adults' need for care, which, when not responded to, results in neglect (Quinn, 2002). • Individuals who have experienced very traumatic events in the past may be more inclined to stay in environments that facilitate risk (e.g. emotional, sexual or financial mistreatment) (Acierno, Hernandez-Tejada, Muzzy, & Steve, 2009).
Living Environment	• Victims are likely to live with others (Lachs & Pillemer, 2004; National Research Council, 2003; Pillemer & Finkelhor, 1988; Paveza et al,1992). • A vast majority of elder abuse reports occur in domestic settings (National Center on Elder Abuse, 2004).
Financial	• Low income status (below $35,000 per year) was associated with increased risk for neglect in older adults (Acierno, Hernandez-Tejada, Muzzy, & Steve, 2009). • The Social Care Institute (2011) identified the following risk factors for financial abuse cases involving elders - low levels of financial literacy (capability or ability to deal with financial products

	and services); increased assets and low-cost lifestyles; and overly trusting nature. • An increased risk of neglect in older adults of minority ethnic status may indicate fewer resources for their potential caretakers (Acierno, Hernandez-Tejada, Muzzy, & Steve, 2009).
Social	• Victims are likely to be socially isolated (Compton, et al, 1997). • Social support emerged as a central risk (low/no social support) or protective factor (social supports in place) for all forms of elder mistreatment (Acierno, Hernandez-Tejada, Muzzy, & Steve, 2009). • In 2004, fifteen states reported that 65.7% of elder abuse victims were female (National Center on Elder Abuse, 2004). • Institutionalized oppression, including racism, classism, heterosexism, and ageism increase the vulnerability of women to both individual acts of violence and to institutionalized acts of violence (Domestic Abuse Intervention Project of Duluth, Minnesota). • Economic, social and political status of women and the older adult, as well as the cumulative effects of ageism and sexism, contribute to elder abuse (Nerenberg, 2002). • Older women are more likely to be mistreated than older men (Biggs et al., 2009). • Minority ethnic status is related to a higher likelihood of being referred to APS for maltreatment (NCEA,1998).

Handout #7 – Perpetrators-Related Risk Factors

Perpetrator characteristics with respect to:	Associated Risk Factors
Relationship to Victims	• Among perpetrators adult children (50%) were most frequently identified. (Naughton et al, 2012) • 65% of perpetrators are family members (including adult children, spouse/intimate partners and other family) (National Center on Elder Abuse, 2004). • Abuse by adult children is reported most often than spousal abuse (National Center on Elder Abuse, 1998; Teaster, Dugar, Mendiondo, Abner, & Cecil, 2006). • Approximately half of perpetrators of elder emotional mistreatment are family members, with a third of perpetrators living with the victim (Amstadter et al, 2011). • 83% of perpetrators of physical abuse on women are relatives with 80% of these perpetrators living with the victim. For male victims, 40.5% of the perpetrators of physical abuse are relatives. (Amstadter et al, 2011). • Amstadter et al also found that approximate 36% of sexual perpetrators were family members (2011).
Mental health and behavioral problems	• Perpetrators are likely to have mental health, substance abuse, and behavioral problems (Anetzberger, 2005). • 20% of perpetrators struggle with addiction according to Naughton et al (2012). • Sexual assault by family members is often associated with mental health or substance abuse problems (Teaster & Roberto, 2004). • Murder-suicide cases are distinct in that either domestic violence is involved or the men are caregivers to their wives. In either case, the men suffer from depression. The marriage may have been a happy one, but serious medical conditions and a lack of family /outside support gave the husband a sense of hopelessness and helplessness (Malphur and Cohen, 2005)
Dependency	• Perpetrators of physical mistreatment against men are more likely to be unemployed (67%) compared to 31% for female victims (Amstadter et al, 2011). Naughton et al (2012) found that 50% of perpetrators in their study were unemployed.

HANDOUT #8: Assessing Risk in Five Domains

Assess Risk Level:

- Is the client in immediate danger? How **soon** might the client come to harm?

- Do you need to go out immediately? What are the consequences of delay? How **severe** might the harm be?

- What is the likelihood (or how **sure** are you) that the client will be harmed without intervention?

What is the client's level of risk?

Identify the risk indicator(s):

Physical:

Continued

Behavioral:

Environmental:

Identify the risk factor(s) and consider the following questions:

1. Health and Functional Status domain

- Is this client in poor health?
- Does the client need help with daily activities?

2. Mental Health Status and Capacity domain

- Is the client capable of making decisions for him/her(self)?
- Does the client have other mental health problems like depression, anxiety, or substance abuse?

3. Living Environment domain

- Is client in a safe and protected environment?

Continued

- Is client's home unsafe or unhealthy?

4. Financial Status domain

- What's the client's financial situation?
- Does client have resources?
- Are client's assets in jeopardy?

5. Social Status domain

- Are there people in client's life who can help?
- Are there people who pose a danger to the client?

Continued

Are emergency or protective measures and services needed? Why or why not?

What factors may mitigate the risk of harm?

- Client's strengths, resiliency, and motivation

- Interpersonal relationships

- Support networks/services

Handout #9 - Signs of Medical Emergencies

Emergency	Signs
Stroke	• Sudden numbness or weakness of the face, arm or leg, especially on one side of the body. • Sudden confusion, trouble speaking or understanding. • Sudden trouble seeing in one or both eyes. • Sudden trouble walking, dizziness, loss of balance or coordination. • Sudden, severe headache with no known cause. (American Stroke Association, http://www.strokeassociation.org)
Drug related	Factors associated with drug related emergencies include: • Adverse drug reactions • Non-compliance with medication regimens • Poor recall of medication regimens • Seeing numerous physicians • Multiple drugs • Switching to complementary and alternative treatment.
Heart attack	• Chest discomfort or pain • Stomach pain • Shortness of breath • Anxiety • Lightheadedness • Sweating • Nausea • vomiting • Women are more likely than are men to have heart attack symptoms without chest pain.
Heat Stress	Older adults (people aged 60 years and older) are more prone to heat stress than younger people for several reasons:

	• Older adults do not adjust as well as young people to sudden changes in temperature. • They are more likely to have a chronic medical condition that changes normal body responses to heat. • They are more likely to take prescription medicines that impair the body's ability to regulate its temperature or that inhibit perspiration.
Heat Stroke	Heat stroke, the most serious heat-related illness, occurs when the body cannot control its temperature. The body's temperature rises rapidly, the body loses its ability to sweat, and it is unable to cool down. Body temperatures rise to 106°F or higher within 10 to 15 minutes. Heat stroke can cause death or permanent disability if emergency treatment is not provided. **Symptoms** of Heat Stroke include: • Extremely high body temperature (defined as above 103°F) • Red, hot, and dry skin (no sweating) • Rapid, strong pulse • Throbbing headache • Dizziness • Nausea
Head Injury	• Confusion • Headache • Fluid from the nose or ears • Unwitnessed head/face injury
Strangulation	• Difficulty breathing • Hoarse voice • "Sniffing position" (nose pointed upwards, stretching neck to allow freer breathing)

Hip fracture	• Difficulty walking • Pain in hips • One leg shorter than the other in the presence of pain • Leg deformity
Other	• Acute burns • Nonresponsiveness • Rapid breathing • Agitated behavior • Respiratory distress • Confusion • Delirium

Victim-Related Risk Factors...

HANDOUT #6 - VICTIM-RELATED RISK FACTORS

Risk Factors: conditions which put a person at risk of harm. If a risk factor is present, it increases the likelihood that abuse or neglect has already occurred or will occur in the future. They are sometimes called "predictors". Risk factors fall into five domains: Health and Functional Status; Mental Health States and Capacity; Living Environment; Financial; and Social.

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Mental Health States and Capacity	• Some studies show that victims are more likely than non-victims to have dementias. Some suggest that it is violent or disruptive dementia-related behavior that increases risk (Bowie & Wallace, 2003). • Victims are likely to experience mental health problems, including depression, low self-esteem, and substance abuse (Dyer, Pavlik, Murphy, & Hyman, 2000; Fisher & Regan, 2006). • On average, maltreated older adults are in their late 70's, frail, and cognitively impaired (Choi & Mayer, 2000; Amstadter et al, 2011) • The loss of a spouse or other family member may increase older adults' need for care, which, when not responded to, results in neglect (Quinn, 2002). • Individuals who have experienced very traumatic events in the past may be more inclined to stay in environments that facilitate risk (e.g. emotional, sexual or financial mistreatment) (Acierno, Hernandez-Tejada, Muzzy, & Steve, 2009).
Living Environment	• Victims are likely to live with others (Lachs & Pillemer, 2004; National Research Council, 2003; Pillemer & Finkelhor, 1988; Phelan et al.1992). • A vast majority of elder abuse reports occur in domestic settings (National Center on Elder Abuse, 2004).
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Perpetrator-Related Risk Factors...

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Dependency	• Perpetrators of physical mistreatment against men are more likely to be unemployed (67%) compared to 31% for female victims (Amstadter et al, 2011). Naughton et al (2012) found that 50% of perpetrators in their study were unemployed.

Types of Risk Indicators

HANDOUT #4: TYPES OF RISK INDICATORS

Risk Indicators: observable signs, things you can see or hear, that indicate that risk may be present.

Abuse indicators may be **physical** evidence that you can see, collect, or photograph.

Indicators may be **behavioral**. They may include what victims, perpetrators, and witnesses tell you, how they tell you, and the interactions between them.

There may be signs of abuse or risk in the person's physical **environment.**

Physical indicators are clues or signs that can be observed, collected, photographed, and/or recorded.

- Bruises or injuries (multiple, unexplained, untreated)
- Inappropriate money transfers
- Untreated pressure ulcers
- Unexplained weight loss
- Suspicious documents (e.g. documents signed by persons who are visually impaired or can't comprehend the content)

Behavioral Indicators include behaviors of the client or the perpetrator

- Caregivers who seem angry or resentful of caring for the older adult
- Caregivers who are over-taxed with responsibilities
- Older adults who seem fearful of caregivers
- Older adults who make excuses for caregiver's behavior
- Caregivers take older adults to several different hospitals or emergency rooms
- Caregivers take older adults to a hospital or emergency room further from older adult's home

Environmental Indicators are clues in the older adult's living environment

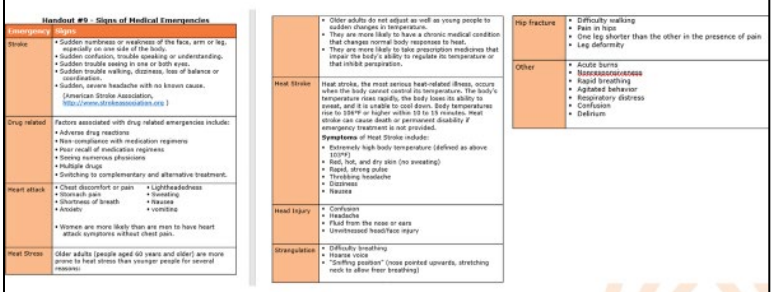
- Deteriorated home
- Lack of food
- Lack of amenities even though the older adult can afford them
- Human or animal waste
- Smells
- Signs of inappropriate restraints, such as locks on the outside of bedroom doors
- Extreme clutter
- Animal(s) that isn't cared for properly

Continued

Alternative Explanations must also be considered. It may be difficult to differentiate indicators from accidental injuries or the effects of illness such as weight loss. Neglect may also result from an older adult refusing help and acting freely

Assessment in Five Domains....

Signs of Medical Emergencies



Small Group Activity

You will be given a Complex Case Scenario and then asked to identify 1 risk indicator and 1-2 Risk Factors from the case to use for the 5 Domains of Risk Assessment chart

In your small group discuss the following questions:

- What was one risk indicator and was it Physical, Behavioral, or Environmental?
- What are 1-2 risk factors and what did you identify about the risk factors in each of the 5 domains?
- What are some factors that you identified that would mitigate the risk of harm?
- Did either of the tools help identify services and interventions for the case?
- What are the important elements of these tools that you would want to emphasize with your staff?
- Additional thoughts about this activity?

Handout #10: Case Scenario # 1- Gavin Parks

An APS professional receives a report about Gavin Parks from a neighbor. Mr. Parks is eighty-four years old, has diabetes, and is legally blind. He lives alone in a house that is cluttered but livable. Mr. Parks is becoming increasingly forgetful and recently started a cooking fire. Although it wasn't serious, the neighbor is worried.

Mr. Parks used to get out and do his own shopping but fell recently and has been afraid to leave the house ever since. He has a daughter who visits occasionally. The neighbor checks in on Mr. Parks every few days and has bought him groceries a few times. Although the neighbor doesn't mind helping out, she is worried that she can't do everything that needs to be done.

When the APS professional tried to call Mr. Parks, she found that the phone was disconnected so she made a home visit. Mr. Parks was friendly and appeared to be oriented. He was willing to accept help but unwilling to move. He told the worker that the phone had been disconnected for nonpayment. He cannot see well enough to pay his bills but says he will ask the neighbor to write a check and mail it for him. When the worker suggests a daily money manager, Mr. Parks responds that he doesn't want to "be beholden to anyone."

- **What type of abuse do you suspect?**
- **What is at risk?**
- **What is the level of risk (low, medium, high)**

Use the 3 S's (Soon, Severe, Sure)

What services or supports can be employed to reduce or eliminate the risk(s)?

Handout #10: Case Scenario # 2- Denise Fairbanks

An APS on-call worker receives a report from the Police Department about Denise Fairbanks, a 79 year old woman who they found wandering around her neighborhood at 3:00 am. A neighbor directed the police officer to the woman's house and said that she lived with her daughter Cathy. The police officer brought Mrs. Fairbanks home. When Cathy answered the door, she was very upset. She thanked the officer and explained that her mother has Alzheimer's disease and often wanders at night and she had difficulty keeping track of her. She admitted that she occasionally locked her in her room at night to keep her safe. She also admitted that she had once or twice struck Mrs. Olson out of frustration.

The next day, the APS worker made a home visit. Cathy admitted that she had struck her mother on several occasions. She was upset about these incidents but insisted that she didn't want her mother in a nursing home. Cathy said that she had two brothers who lived close by, but never helped out. They believed it was Cathy's responsibility as the daughter to care for their mother.

Cathy is a single mother with two teenage sons. During the visit, Mrs. Fairbanks occasionally interrupted to say that she needed to get home to make dinner for her husband, who had died twelve years earlier.

- **What type of abuse do you suspect?**

- **What is at risk?**

- **What is the level of risk (low, medium, high)**

  Use the 3 S's (Soon, Severe, Sure)

What services or supports can be employed to reduce or eliminate the risk(s)?

Handout #10: Case Scenario # 3- Evelyn Adams

APS received a referral about Evelyn Adams from a neighbor. Mrs. Adams lives with her husband in a small apartment. Over the years, Mrs. Adams has confided to the neighbor that her husband has been physically abusive. Since Mrs. Adam's husband retired, he appears to become more abusive.

Recently, the neighbor heard Mrs. Adam's husband shouting at her and threatening to kill her. The neighbor made an APS report.

When an APS worker went to the home and spoke to Mrs. Adam's, she admitted that her husband was abusive but said that she had learned to live with the situation and wished the neighbor would mind her own business.

- **What type of abuse do you suspect?**

- **What is at risk?**

- **What is the level of risk (low, medium, high)**

  Use the 3 S's (Soon, Severe, Sure)

What services or supports can be employed to reduce or eliminate the risk(s)?

Handout #10:Case Scenario # 4- Dolores Brown

APS received a report from a bank employee about a customer, Dolores Brown. Mrs. Brown's son came to the bank and tried to make a withdrawal from his mother's account. He produced a power of attorney for finances. The bank typically requires customers to sign a special bank POA and explained this to the son, who became very angry. The employee contacted Mrs. Brown, who said the son did not have her permission to withdraw cash. She asked to talk to her son, and he began shouting at her over the phone. When they'd finished their exchange, Mrs. Brown asked to speak to the bank employee again and told her to go ahead and release the funds. When the son left, the teller called APS. A worker, Sandy Holms, was assigned to investigate.

Sandy called Mrs. Brown and informed her of the bank's concerns. Mrs. Brown stated that she had been intimidated into giving her son permission to make the withdrawal and that he used the money to get his car repaired. It is not the first time he has used the POA for his own benefit without her knowledge or by bullying her.

Mrs. Brown stated that she wants her son to have the POA, even though her other children have been trying to convince her to revoke it. She said, "He is a good boy and is just having a rough time. He is too proud to ask for help and thinks I won't notice. I only keep a little money in this account. My savings are in another bank and he doesn't have a POA for that one. This is what I want."

- **What type of abuse do you suspect?**

- **What is at risk?**

- **What is the level of risk (low, medium, high)**

Use the 3 S's (Soon, Severe, Sure)

Handout #1: The 3 S's of Risk Assessment Tool

Directions: Using a current case, complete the risk assessment chart based on your observations and the information gained during your investigation.

For each Risk Factor that you identify:

6. List the apparent risk next to the #.
    a. Circle or highlight whether you find that risk to be low, medium or high.
    b. Work through the 3 S's by noting how **Soon** might the client be harmed, how **Severe** might they be harmed and how **Sure** are you that the harm will occur (i.e. the likelihood).
        i. Make sure to include why you believe that to be true.
7. Discuss any Risk indicators.
8. Provide a global assessment of that particular risk.
9. Note any factors that may mitigate that risk.
10. Create a service plan for each risk.

RISK ASSESSMENT CHART

RISK FACTORS (Conditions which put a person at risk of harm)	RISK INDICATORS (Observable signs that indicate that risk may be present)	GLOBAL ASSESSMENT (History and context around this particular risk)	FACTORS THAT MITIGATE THE RISK (Client's strengths, motivation, support network)	SERVICE PLAN (Identify services that might be of help and follow up if connections were made.)
#1. • Soon • Severe • Sure Based on the 3 S's, the level of risk is: Low, Med, or High?				

#2. • Soon • Severe • Sure Based on the 3 S's, the level of risk is: Low, Med, or High?				
#3. • Soon • Severe • Sure Based on the 3 S's, the level of risk is: Low, Med, or High?				
#4. • Soon • Severe • Sure Based on the 3 S's, the level of risk is: Low, Med, or High?				
#5. • Soon • Severe • Sure				

Based on the 3 S's, the level of risk is: Low, Med, or High?				

Service Plans…

Service Plan Goals and the 5 Domains

- **Health and Functional Capacity**: Reduce the risk of illness, accidents, dependency, neglect, and abuse.
- **Mental Health Status and Capacity**: Reduce the risk or mitigate the impact of mental health problems.
- **Living Environment:** Victims are likely to live with others.
- **Financial:** Reduce the risk of financial loss or abuse, and secure finances that are in jeopardy.
- **Social:** Goals of service plans in this domain are to reduce the risk of abuse and neglect by others.

What is a Multidisciplinary Team?

- A Multidisciplinary Team is a collaborative effort with other professionals
- It consists of group of individuals committed to a common purpose
- Collaborative elder mistreatment alliances typically focus on one or more of the following: prevention, awareness, intervention, and systems review
- The established teams may be short term or long-lasting community members
- They can involve, two, three, or more members from different disciplines.

Examples of MDTs

- Service Coordination/Coordinated Community Response
- Domestic Abuse Response Teams
- Family Violence Councils
- Fatality/Death Review Team
- Financial Abuse Specialist Team
- Code Enforcement/ Hoarding Task Force
- Medical Case Management

Informal Supports and Community Providers

- Family, Friends, Neighbors
- Law enforcement
- Ombudsman
- Home Health Private Caregiving Agencies
- Private Physicians
- Adults with Disabilities Service providers
- Adult Daycare Programs
- Home Delivery Meal Program
- Probation or Parole if there is someone system/justice involved
- Behavioral Health
- Public Guardian
- Code Enforcement
- Area Agency on Aging
- Community Senior Service Providers

Planning for Case Closure

- Peer Review Tool on the APS Technical Assistance Resource Center (TARC),
- Peer review tool can be used by the APS Supervisor prior to case closure on a complex case

Planning for Case Closure

Handout #11 –Checklist for Case Closure Questions to Consider

- Has the protective issue been addressed or resolved? If the protective issue has not been resolved, was it due to the client's choice to decline services or interventions? Are the client's choices well documented?
- If the client chose not to engage in services, has the client's capacity to act as their own decision maker been assessed/evaluated/determined, either by the APS Professional or by a physician, psychologist, geriatric specialist, neurologist, or licensed mental health clinician?
- Was the client's capacity/mental status assessed in general, whether or not the client chose to engage in services? If indicated per agency guidelines, was a dementia/neurocognitive disorder screening tool used?
- Was the client assessed for suicidal/homicidal ideation? Were appropriate mental health interventions and/or consultations sought if suicidal and/or homicidal ideation was identified as a concern?
- Were any firearms/weapons identified to be in the home and if so, has this been sufficiently addressed per agency guidelines?
- Were required demographic and SOGI (sexual orientation and gender identity) questions asked and updated in demographics portion of the case record?

Continued

- Did all necessary collaboration with community partners occur?
- Was the reporting party contacted (or attempts made to contact)?
- Was pertinent information gathered from collateral contacts and other involved parties?
- Was there a review of external documentation, such as legal, financial, and medical records?
- Was there an attempt to connect the client with supportive resources, services/programs, and/or longer-term case management?
- Were all service plan goals met, and if goals were not met, is this explained in the documentation?
- Is case documentation complete?
- Were all required cross-reports made? (Such as cross-reporting confirmed abuse to law enforcement, etc.)
- Are the case findings accurate, in alignment with Consistency In Findings standards, and well supported in the documentation?
- Were all documents imported into the record keeping system per agency protocols?

Handout #11 –Checklist for Case Closure Questions to Consider

- Has the protective issue been addressed or resolved? If the protective issue has not been resolved, was it due to the client's choice to decline services or interventions? Are the client's choices well documented?

- If the client chose not to engage in services, has the client's capacity to act as their own decision maker been assessed/evaluated/determined, either by the APS Professional or by a physician, psychologist, geriatric specialist, neurologist, or licensed mental health clinician?

- Was the client's capacity/mental status assessed in general, whether or not the client chose to engage in services? If indicated per agency guidelines, was a dementia/neurocognitive disorder screening tool used?

- Was the client assessed for suicidal/homicidal ideation? Were appropriate mental health interventions and/or consultations sought if suicidal and/or homicidal ideation was identified as a concern?

- Were any firearms/weapons identified to be in the home and if so, has this been sufficiently addressed per agency guidelines?

- Were required demographic and SOGI (sexual orientation and gender identity) questions asked and updated in demographics portion of the case record?

- Did all necessary collaboration with community partners occur?

Continued

- Was the reporting party contacted (or attempts made to contact)?

- Was pertinent information gathered from collateral contacts and other involved parties?

- Was there a review of external documentation, such as legal, financial, and medical records?

- Was there an attempt to connect the client with supportive resources, services/programs, and/or longer-term case management?

- Were all service plan goals met, and if goals were not met, is this explained in the documentation?

- Is case documentation complete?

- Were all required cross-reports made? (Such as cross-reporting confirmed abuse to law enforcement, etc.)

- Are the case findings accurate, in alignment with Consistency In Findings standards, and well supported in the documentation?

- Were all documents imported into the record keeping system per agency protocols?

Reassessments and Case Closure

Handout # 5

Phase 3: Reassessments and Case Closure

- Has risk changed over time? Is the client at higher or lower risk?
- What accounts for the changes? Are new issues emerging? Are perpetrators out of the picture? Have threats been removed? Have interventions reduced risk? Has a client changed his or her mind about accepting services?
- Are changes to the care plan needed? What preventative measures are needed?
- What is the likelihood that the situation will recur?

Supervisor Complex Cases Transfer of Learning

- **Goal # 1**– Reach out to one of your peers this week to be your accountability partner for the next 30 days.
- **Goal # 2-** Demonstrate how to use the 3 S's of Risk tool (Handout # 3) and Assessing Risk in the 5 Domains tool (Handout # 8) with 2 of your staff in a conference with staff prior to a pre-initial/1st face to face contact visit on a complex case.
- **Goal # 3-** Conference with your staff after their face-to-face visit on the case. Discuss the information they gathered, the findings, and risks they identified using the 3 S's of Risk and Assessing Risks and using the 5 Domains tools. Use the Ready-Set-Go-5-minute Coaching Questions or other open-ended questions (Handout # 2) to further explore and support staff in using their critical thinking skills for the case planning process.
- **Goal # 4–** Touch base with your accountability partner a minimum of once a week to provide feedback on your staff's use of the 3 S's of Risk and 5 Domains tools and use of coaching questions in your conferences.
- **Goal # 5-** Use Handout # 12 Checklist for Case Closure and Handout # 4, Phase 3 Reassessments and Case Closure to review the 2 complex cases prior to case closure. Provide feedback to your accountability partner.

Closing Thoughts

- Questions?
- Reflections?
- Takeaways?

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Thank You!

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Continued

Web Resources

A Developmental Model for Understanding Adult Protective Services: Risk Assessment Curve (ventura.org)

Adult Protective Services Handbook (state.tx.us)

APSWI/Supervising_Complex_Cases/402-Clinical-Aspects-of-Supervising-APS-Practice-1.pdf

APS TARC - Toolkits (acl.gov)

Issues in Capacity: Balancing Empowerment and Protection (acl.gov)

National Adult Protective Services Association (NAPSA): membership information available at National Adult Protective Services Association (napsa-now.org)

NCEA - Tools Inventory (acl.gov)

PerformanceManagementCycle.pdf

QABrief-APSTARC.pdf

Training Supervisors in Adult Protective Services: Guidance and Resources (acl.gov) (TARC Brief)

VASS Tool.pdf

Training Resources for APS Supervisors

- Center APS Technical Assistance Resource
- https://apstarc.acl.gov/Education/toolkits.aspx
- APSWI Adult Protective Services Workforce Innovations
- https://theacademy.sdsu.edu/programs/apswi/

Trauma Informed Resources for APS Supervisors

ACESAware.org (https://www.acesaware.org/

Advancing Trauma Informed Responses to Elder Abuse:

- Webinar: https://www.elderjusticecal.org/recording---advancing-trauma-informed-responses-to-elder-abuse.html
- Report: https://ncea.acl.gov/NCEA/media/Publication/WCEJ_Trauma-Symposium-report-2020.pdf

SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. (2014). https://ncsacw.samhsa.gov/userfiles/files/SAMHSA_Trauma.pdf

Trauma Informed Approaches for Adult Protective Services Brief (APS TARC). https://apstarc.acl.gov/getattachment/Education/Briefs/Trauma-InformedApproachtoAPS.pdf.aspx?lang=en-US

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