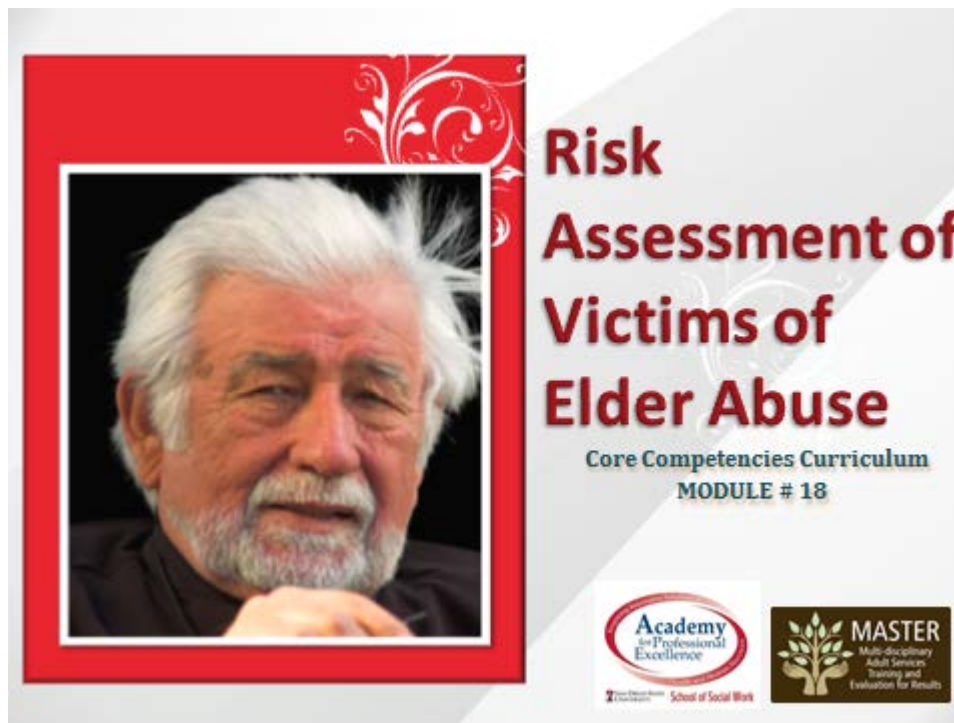


RISK ASSESSMENT OF VICTIMS OF ELDER ABUSE

TRAINER'S MANUAL



MODULE 18

TRAINER'S MANUAL

RISK ASSESSMENT OF VICTIMS OF ELDER ABUSE



This training was produced by the San Diego State University School of Social Work, Academy of Professional Excellence under grant #2009-SZ-B9-K008, awarded by the Office for Victims of Crime, Office of Justice Programs, U.S. Department of Justice. The opinions, findings, and conclusions or recommendations expressed in this training are those of the contributors and do not necessarily represent the official position or policies of the U.S. Department of Justice.

Curriculum Developers

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INTRODUCTION

THE ACADEMY FOR PROFESSIONAL EXCELLENCE

We are pleased to welcome you to the RISK ASSESSMENT OF VICTIMS OF ELDER ABUSE Training developed by Project MASTER, a program of the Academy for Professional Excellence.

The Academy for Professional Excellence was established in 1996 and provides training, technical assistance, organizational development, research, and evaluation to public and private health and human service agencies and professionals.

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.

The Academy has extensive experience in providing specialized services, including:

- multi-disciplinary competency-based trainings
- curriculum development
- needs assessment
- research
- evaluation
- meeting facilitation
- organizational development consultation services

MASTER is a program of the Academy for Professional Excellence which has the overarching goal is to develop standardized core curricula for new APS social workers and to share these trainings on a national scale. Professional training opportunities are a critical step toward ensuring APS social workers have the appropriate tools to serve victims of elder and dependent adult abuse and neglect. MASTER has worked extensively with state and national partner agencies in the development of this curriculum.

Our partners include:

- National Adult Protective Services Association Education Committee (NAPSA)
- The Statewide APS Training Project of the Bay Area Training Academy
- California Department of Social Services, Adult Services Branch
- California State University Sacramento IHSS Training Project
- Protective Services Operations Committee of the California Welfare Director's Association (PSOC)
- California Social Work Education Center Aging Initiative (CalSWEC)

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ACKNOWLEDGMENTS

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. Project MASTER would like to thank the following individuals and agencies:

Agencies

Bay Area Academy, Statewide APS Training Project
California Department of Social Services, Adult Services Branch
California Social Work Education Center Aging Initiative
Orange County Social Services Agency
Riverside County Department of Public Social Services
San Bernardino County Department of Aging and Adult Services
San Diego County Aging and Independence Services

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National Adult Protective Services Association Education Committee
Protective Services Operations Committee of the California Welfare Directors' Association

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HOW TO USE THIS TRAINING MANUAL

The course outline, provided in the next section of this manual, is the class schedule used during the piloting of this training. It can be used to help you determine how much time you might need to present each section. However, times will vary based on the experience and engagement of your audience.

Customizing the PowerPoint:

Once you decided on how you want to divide up your time in presenting this material, you may want to customize your PowerPoint. The Microsoft Office PowerPoint software allows you to hide any slides you don't want to use.

Hide a slide instructions

1. On the **Slides** tab in normal [view](#), select the slide you want to hide.
2. On the **Slide Show** menu, click **Hide Slide**.

The hidden slide icon appears with the slide number inside, next to the slide you have hidden.

Note: The slide remains in your file, even though it is hidden when you run the presentation.

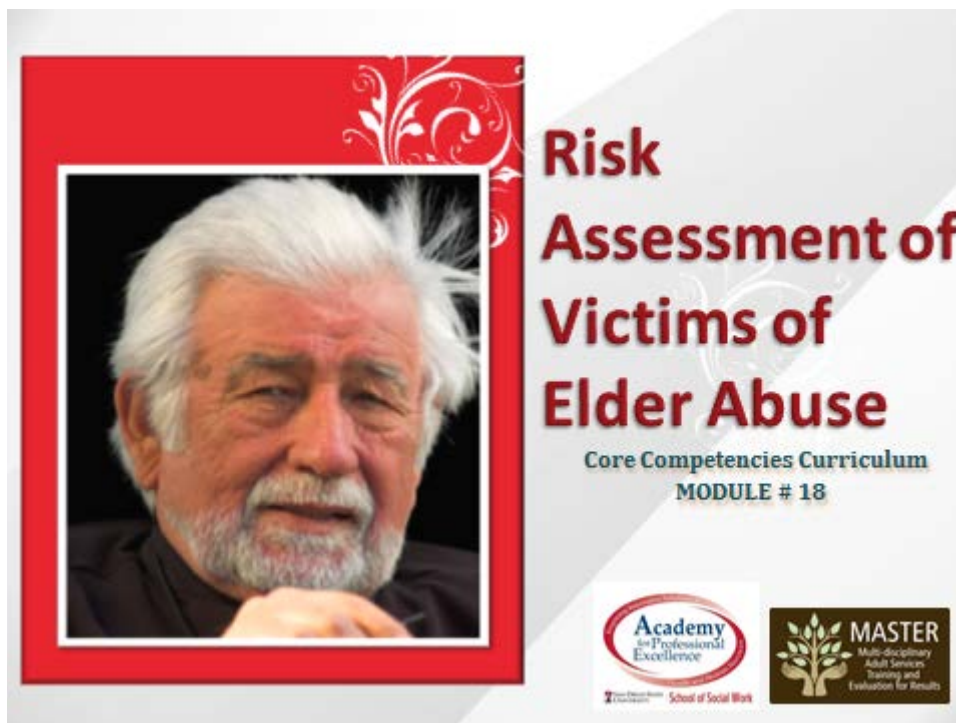
Please note that this manual is set up so that the trainer script/ background material is on the same page as the accompanying PowerPoint slide making it easy to also customize your manual to match the slides you have decided to use, Just remove the unneeded pages.

You may also decide to add slides showing specific program information, policies or procedures for your agency or jurisdiction. This will increase the applicability of the training but care must be taken not to try and pack too much additional content into the training.

COURSE OUTLINE

Content	Total Time	Activities	Slides/Handouts
Introductions, Overview, Learning Objectives	15 min	Lecture	Slides 2-6 Handouts 2-3
Defining Risk Assessment and its Function	45 min	Lecture/Discussion Case Scenario Activities	Slides 7-18 Handouts 4-6a-c
Assess Risk in Five Domains	30 min	Lecture/Discussion Small Group Activity Case Scenario Activities	Slides 19-32 Handouts 7-10
BREAK	15 min		
Assess Risk in Five Domains (cont.)	30 min	Lecture/Discussion Small Group Activity Case Scenario Activities	Slides 19-32 Handouts 7-10
Assess Overall Levels of Risk	45 min	Lecture/Discussion Large Group Activities Case Scenario Activities	Slides 33-44 Handouts 11-13
LUNCH	60 min		
Assess Overall Levels of Risk (cont.)	60 min	Lecture/Discussion Large Group Activities Case Scenario Activities	Slides 33-44 Handouts 11-13
Benefits & Limitations of Assessment Tools	15 min	Lecture	Slides 45-48 Handout 14
BREAK	15 min		
Develop Risk Reduction Service Plans	60 min	Lecture/Discussion Large/Small Group Activities Case Scenario Activity	Slides 49-60 Handout 15
Closing & Evaluation	30 min	Review/Q & A Post-Test/Evaluation	Slides 61-63 Handouts 16
TOTAL TIME	7 hrs (including 1 hour lunch)		

TRAINING GOALS AND OBJECTIVES



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

1. Define risk assessment and its function.
2. Assess risk factors in the five domains:
 - a. Physical and functional status
 - b. Mental health status and capacity
 - c. Living environment
 - d. Financial
 - e. Social (risk posed by others, including caretakers and family members)
3. Assess overall levels of risk in terms of severity, urgency and likelihood of harm occurring.
4. Describe the benefits and limitations of risk assessment tools.
5. Develop risk reduction service plans.

TRAINER GUIDELINES

NOTE: THE MOST IMPORTANT CONSIDERATION FOR A SUCCESSFUL TRAINING IS TO USE A TRAINER THAT HAS APS EXPERIENCE. If the trainer does not have APS experience (which is **not recommended**) then an APS subject matter expert **MUST** be in the room.

Teaching Strategies	<p>The following instructional strategies are used:</p> <ul style="list-style-type: none">◆ Lecture segments◆ Interactive exercises (e.g. Table Top Activities, experiential exercises, role plays)◆ Question/answer periods◆ Slides◆ Participant guide (encourages self-questioning and interaction with the content information)◆ Embedded evaluation to assess training process.◆ Transfer of Learning activity
Materials and Equipment	<p>The following materials are provided and/or recommended:</p> <ul style="list-style-type: none">◆ Computer with LCD (digital projector)◆ CD-ROM or other storage device with the slide presentations◆ Easel;/paper/markers◆ Red, Yellow and Green “Flags” (Flags can be created from colored paper, Flash cards, etc)◆ Trainer’s Guide: This guide includes the course overview, introductory and instructional activities, and an appendix with reference materials.◆ Participant Guides: This guide includes a table of contents, course introduction, all training activities/handouts, and transfer of learning materials.◆ Name tags/names tents.◆ Water access/snacks/restroom access/lunch plans
<p>NOTE: The blue boxes indicate the trainer will need to do research about the policies and procedures specific to your agency or jurisdiction.</p>	

COURSE OUTLINE

9:00am	Welcome and Introductions
9:15	Defining Risk Assessment and its Function
10:00	Assess Risk in Five Domains
10:30	Break
10:45	Assess Risk in Five Domains (continued)
11:15	Assess Overall Levels of Risk
12:00pm	Lunch
1:00	Assess Overall Levels of Risk (continued)
2:00	Benefits & Limitations of Assessment Tools
2:15	Break
2:30	Develop Risk Reduction Service Plans
3:30	Closing and Evaluation
4:00	End of Training

INTRODUCTION TO TRAINING MANUAL

Trainer Instructions - The following guidelines will assist you in preparing for a successful training:

1. Limit class size to 30 persons
2. Set up the classroom into "pods" (e.g. table groups) of 5-6 participants
3. Prepare flip charts with titles and post them around the room before class starts
4. Prepare red, yellow and green "flags" in advance of class (note: flags can be colored index cards or small pieces of cloth about 3x5 or 4x6 in dimension)

Trainer's Note: in this module we will use the terms client and victim interchangeably. Although the individual may be a victim of elder abuse, the individual also has many positive qualities that workers have the opportunity to examine and strengthen. It is important to see the victim of elder abuse as a viable, strong person with much to offer. In that way, the victim is also a client.

EXECUTIVE SUMMARY

Handout #1

Course Title: *RISK ASSESSMENT OF VICTIMS OF ELDER ABUSE*

Outline of Training:

In this interactive and dynamic introductory training, participants learn how to assess risk across five domains in terms of severity and urgency. Participants will learn the benefits and limitations of risk assessment tools and how to develop risk reduction service plans.

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 community partners working with adults at risk for abuse (e.g. conservatorship investigators, and workers in the aging and disability networks). This training is also appropriate for senior staff that require knowledge and/or skills review.

Outcome Objectives for Participants:

Learning goals – Upon completion of this training session, participants will be able to:

1. Define risk assessment and its function.
2. Assess risk factors in the five domains:
 - Health and Functional status
 - Mental health status and capacity
 - Living environment
 - Financial
 - Social (risk posed by others, including caretakers and family members)

RISK ASSESSMENT: TRAINER'S MANUAL

3. Assess overall levels of risk in terms of severity, urgency and likelihood of harm occurring.
4. Describe the benefits and limitations of risk assessment tools.
5. Develop risk reduction service plans

Transfer of Learning: *Ways supervisors can support the transfer of learning from the training room to on-the-job.*

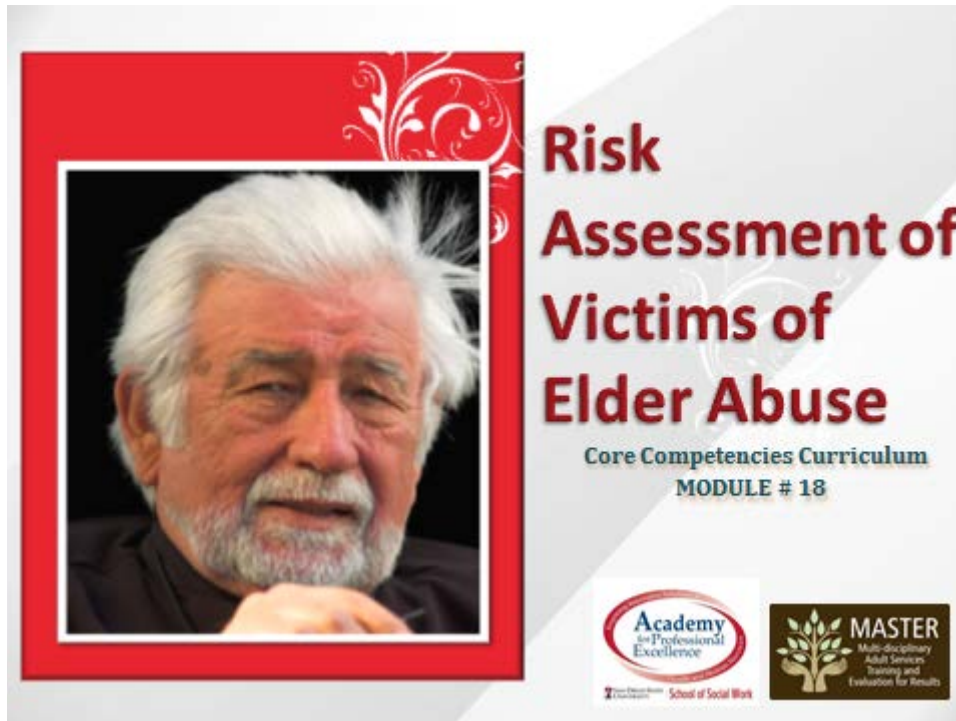
BEFORE the training

Supervisors can encourage line staff to attend the training and help them identify particular strengths and/or challenges that they have had with risk assessments and developing risk reduction plans for clients. 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 participants will then schedule a time to complete the activities 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.

PRESENTATION




WELCOME AND INTRODUCTIONS



TIME ALLOTTED: 15 minutes

SLIDE #2

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The National APS Training Project is a project of the Academy for Professional Excellence, San Diego State University School of Social Work

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TOPIC: OVC Language

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SLIDE #3

Housekeeping and Introductions

- Schedule for the day
- CEU instructions
- Location of restrooms
- Set cell phones to vibrate
- Introductions



3

TOPIC: Housekeeping

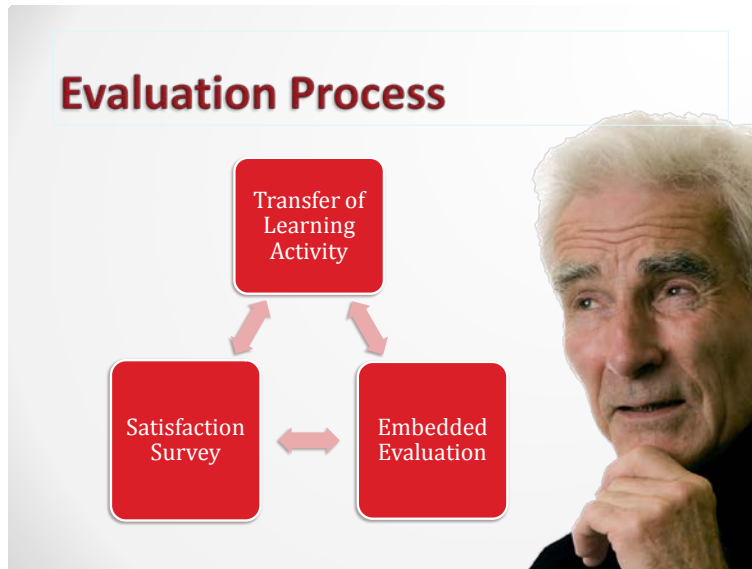
WELCOME the participants and introduce yourself by name, job title, organization, and qualifications as Trainer.

NOTE: If you wish, you can individualize the PowerPoint slides by adding information in the “notes” section of each slide

Review Housekeeping Items

- There will be two 15-minute breaks and an hour for lunch today: 12-1 pm in...
- Use the restrooms whenever you need to do so. The restrooms are located at....
- Please set your cell phones to vibrate for the duration of the training. If you must make or receive a call, please leave the training room and return as quickly as possible. Check the course outline to see what you have missed.

SLIDE #4



HANDOUT #2:
Letter to Participants

Participant Manual pg 15

TOPIC: Introducing participants to the evaluation process

For this training, you will be completing a training satisfaction survey, an embedded evaluation regarding question typology (completed in class) and a post-training transfer of learning exercise (to be turned in next week). All of these measures are intended to allow you to practice what you have learned and measure whether the training was effective. The goal of this curriculum is for APS training to become an evidence-based practice that truly provides the knowledge and skills we believe it provides. The purpose of the evaluation process is more fully explained in your “Letter to Participants”.

HANDOUT #2: Participant Letter of Consent

- Academy for Professional Excellence at San Diego State University School of Social Work, MASTER (Multi-disciplinary Adult Services Training & Evaluation for Results) has begun a process of evaluating training delivered to Adult Protective Service workers
- At certain points during this training series, in addition to the usual workshop evaluation forms, you will be asked to complete various training evaluation activities
- These training evaluation activities aim to: (1) improve trainings’ effectiveness and relevance to your needs, and help you better serve older adults and their families; and (2) see if the training has been effective in meeting course objectives.
- If you agree to participate, you will fill out a questionnaire administered before and after the training.
- The questionnaires will be coded with a unique identifier system and all responses will be confidential

RISK ASSESSMENT: TRAINER'S MANUAL

Handout #2

Dear Training Participant,

As a training program for the Academy for Professional Excellence at San Diego State University School of Social Work, MASTER (*Multi-disciplinary Adult Services Training & Evaluation for Results*) has begun a process of evaluating training delivered to Adult Protective Service workers. As part of this evaluation, we need your help.

At certain points during this training series, in addition to the usual workshop evaluation forms, you will be asked to complete various training evaluation activities.

These training evaluation activities have two main purposes:

1. To improve trainings' effectiveness and relevance to your needs, and help you better serve adults and their families; and
2. To see if the training has been effective in meeting course objectives.

Our goal is to evaluate training, NOT the individuals participating in the training.

In order to evaluate how well the training is working, we need to link each person's assessment data using a code. You will generate the code number using the first three letters of your mother's maiden name, the first three letters of your mother's first name, and the numerals for the day you were born. **Please put this 8-digit ID code on each of your assessment forms, exactly the same way each time.** ID code information will only be used to link demographic data to test data to ensure that the training is working equally well for all participants. Once this linking is done, we will only be looking at class aggregate scores, rather than individual scores.

Only you will know your ID code refers to you. All individual responses to evaluation exercises are confidential and will only be seen by the Academy's training program and evaluation staff. Only group averages and percentages will be reported. Individual results will not be reported to your employer. Aggregate data may be used for future research to improve training for Adult Protective Service workers.

If you agree to participate, you will fill out questionnaires administered before and after the training. The questionnaires will be coded with a unique identifier system and all responses will be confidential.

There are no foreseeable risks to you from participating. There is also no direct benefit to you. Your responses will contribute to the development of a series of evaluation tools that will help us assess the effectiveness of Adult Protective Services training. It is hoped that these tools will assist the Academy for Professional Excellence in improving

RISK ASSESSMENT: TRAINER'S MANUAL

training for Adult Protective Service workers and therefore improve services to older adults and their families.

Your participation is voluntary and you may withdraw your consent and participation at any time. Participation or non-participation will have no effect on your completion of this training series.

By completing and submitting the questionnaires, you agree to participate. You further agree to permit us to use your anonymous responses in written reports about the questionnaires.

Your help with this evaluation process is greatly appreciated. Your feedback will be instrumental in helping to improve Adult Protective Service training for future participants. If you have any questions about the evaluation or how the data you provide will be used, please contact:

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SLIDE #5

Developing an ID Code

- What are the first three letters of your mother's *maiden* name? **Alice *Smith***
- What are the first three letters of your mother's *first* name? **Alice *Smith***
- What are the numerals for the DAY you were born? **Nov *29*th**

Trainee ID Code **S M I A L I 2 9**

5

HANDOUT #3:
ID Code Assignment

Participant Manual pg 17

TOPIC: Developing an ID code

We are NOT evaluating you and no one from your agency will see your individual responses. To keep your responses confidential, we are going to develop your personal ID code. Follow along with your ID Assignment Handout and write in your ID code on the Handout:

YOUR IDENTIFICATION CODE:

In order for us to track your evaluation responses while maintaining your anonymity, we need to assign you an *identification code*. We would like you to create your own *identification code* by answering the following questions:

1. What are the first three letters of your mother's *maiden* name?
Example: If your mother's maiden name was Alice Smith, the first three letters would be: **S M I**. If the name has less than three letters, fill in the letters from the left and add 0 (zero) in the remaining space(s) on the right.
2. What are the first three letters of your mother's *First* name? Example:
Example: If your mother's maiden name was Alice Smith, the first three letters would be: **A L I**. If the name has less than three letters, fill in the letters from the left and add 0 (zero) in the remaining space(s) on the right.
3. What are the numerals for the DAY you were born?

CONTINUED

HANDOUT #3: MASTER Identification Code Assignment

- In order to track each of your evaluation responses while maintaining your anonymity, we need to assign you an identification code.
- You will generate the code number using the first three letters of your mother's maiden name, the first three letters of your mother's first name, and the numerals for the day you were born.
- Please put this 8-digit ID code on each of your assessment forms, exactly the same way each time. ID code information will only be used to link demographic data to test data to ensure that the training is working equally well for all participants.
- The questionnaires will be coded with a unique identifier system and all responses will be confidential. Only you will know your ID code refers to you.
- Aggregate data may be used for future research to improve training for Adult Protective Service workers.

RISK ASSESSMENT: TRAINER'S MANUAL

HANDOUT #3

Trainee ID Code

--	--	--	--	--	--	--	--

Date

M	M

 /

D	D

 /

Y	Y

YOUR IDENTIFICATION CODE:

In order for us to track your evaluation responses while maintaining your anonymity, we need to assign you an *identification code*. We would like you to create your own *identification code* by answering the following questions:

4. What are the first three letters of your mother's *maiden* name?
Example: If your mother's maiden name was Alice Smith, the first three letters would be: **S M I**. If the name has less than three letters, fill in the letters from the left and add 0 (zero) in the remaining space(s) on the right.

___ _ _

5. What are the first three letters of your mother's *First* name?
Example: If your mother's maiden name was Alice Smith, the first three letters would be: **A L I**. If the name has less than three letters, fill in the letters from the left and add 0 (zero) in the remaining space(s) on the right.

___ _ _

6. What are the numerals for the DAY you were born?
Example: If you were born on November 29, 1970, the numerals would be **2 9**. If your birth date is the 1st through the 9th, please put 0 (zero) in front of the numeral (example **0 9**).

___ _

Combine these parts to create your own identification code (example: **S M I A L I 2 9**). Please write your identification code in the space at the top right corner of all evaluation materials you receive.

Remember your identification code and write it at the top of every evaluation form provided to you throughout this training.

SLIDE #6

Learning Objectives

1. Define risk assessment and its function.
2. Assess risk factors in five domains.
3. Assess overall levels of risk in terms of severity, urgency and likelihood of harm occurring.
4. Describe the benefits and limitations of risk assessment tools.
5. Develop risk reduction service plans.

TOPIC: Learning Objectives

Review the learning objectives for the participants. Explain that there will be a lot of material covered, and some of it will reinforce what they have learned in other APS Core trainings.

DEFINING RISK ASSESSMENT AND ITS FUNCTIONS



TIME ALLOTTED: 45 minutes

Slide #7

What is Risk Assessment?

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

Help workers enhance clients' safety, health, independence, and rights.

Help managers optimize resources and ensuring quality, effectiveness, efficiency, and fairness.



TOPIC: What is Risk Assessment?

Risk assessment is a systematic process that guides decisions and judgments. The goal is to enhance the safety of adults who are vulnerable by providing guidance to individual workers and managers.

Risk and safety assessments represent a merging of 1) what workers discover as they conduct investigations and 2) what researchers and other practitioners have learned through studies, surveys, and practice.

Risk assessment tools, which will be covered later in the training, guide workers through investigations by making sure they collect the information that's needed to predict future risk. The tools can also help workers analyze and interpret that information and use it to develop care plans.

Slide #8

Why Risk Assessment?

- Need to make an initial determinations 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.



TOPIC: Why Risk Assessment?

APS staff are responsible for making determinations of clients' safety and risk.

- Is the person who's calling (or whom the call is about) in danger?
- Is this person frail and vulnerable, or able to take care of themselves?
- Are they in a safe place?

These determinations can be challenging due to many factors:

- Initial information provided at intake may be incomplete or not accurate and situations aren't always what they seem to be initially.
- Victims may deny that they've been abused or are at risk. Some downplay what has happened, while others overstate it.
- APS staff are dealing with increased workloads and increased case complexity and focus on clients with the most pressing need is important.
- APS staff need to take into account the chances they'll be able to improve a client's safety, security, and quality of life. The consequences of wrong decisions may be high.

It's not surprising that APS workers have identified assessment as one of the most difficult aspects of their work. That said risk assessments can assist staff in better serving clients by helping to manage and focus effort and activities.

Slide #9

How Risk Assessment Helps APS Workers

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

TOPIC: How Risk Assessment Helps APS Workers

Trainer Note: this slide is animated so that one bullet point comes onto the screen at a time.



Ask participants how risk assessment helps their work.

After the large group shout out, show the bullet points listed on the slide.

How Does Risk Assessment Help Workers?

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

Important point to highlight: Risk assessment helps workers assess clients' vulnerability and needs, develop and monitor care plans, and make decisions about how to use their time and resources.

Slide #10

How Risk Assessment Helps APS Managers

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

HANDOUT # 4
What is Risk
Assessment?

Participant Manual pg 21

TOPIC: How Risk Assessment Helps APS Managers

Trainer Note: this slide is animated so that one bullet point comes onto the screen at a time.

How Does Risk Assessment Help Managers?

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

Important point to highlight: Risk assessment provides managers with information they can use in program administration, planning, evaluation, and budgeting.

All the information on the previous slides can be found on **Handout #4 – “What is Risk Assessment?”** on **page 21** of the participant manual.

Handout #4 – What is Risk Assessment?

What is Risk Assessment?

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

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

How Does Risk Assessment Help Workers?







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

How Does Risk Assessment Help Managers?

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

Slide #11

When are Risk Assessments Conducted?

-  During initial phone contact
-  After first face to face interview
-  At substantiation
-  During the early stages of case planning
-  Periodically to identify changes and new needs
-  At case closure

TOPIC: When are Risk Assessments Conducted?

Trainer note: It's important to determine your agency's policy on when to conduct an assessment/reassessment in preparation for this training. If you are training workers from a variety of agencies, requirements for when to conduct assessment vary by jurisdiction.

Risk assessment is a process and different agencies make different decisions about when to conduct them. Risk assessment may be conducted:

- During initial phone contact
- After the first face-to-face interview
- At substantiation
- During the early stage of case planning
- Periodically during the life of the case to identify changes and new needs
- At case closure



*Ask: Why do you think it might be important to do more than one assessment?
How often does your agency ask you to do an assessment?*

CONTINUED

RISK ASSESSMENT: TRAINER'S MANUAL

According to the National Council on Crime and Delinquency, APS conducts Risk Assessments:

- At first face-to-face interview: 17 states
- At substantiation: 3 states
- At close of investigation: 15 states
- At reassessment/60 day follow-up: 9 states

11 states complete risk assessment at multiple points in time.

(Park, Johnson, Flasch, & Bogie, 2010)

Slide #12



TOPIC: Levels of Risk & the 3 S's

Before we discuss the phases of risk assessment – let's look at risk levels and the 3 S's which is a helpful framework for determining risk level.

Risk levels may be low, medium or high. What do we base these judgments on? These are the steps that experienced workers go through every time they think about the level of risk their clients are experiencing.

The 3 S's of risk – questions to ask yourself:

- How **S**oon might the client be harmed?
- How **S**evere might the harm be?
- How **S**ure are you that the harm will occur? (this can also be thought of in terms of likelihood)

Let's practice using the 3 S's of risk with the **case scenario which is located on page 22 of the participant manual.**

Trainer Note: Have a volunteer read the scenario aloud and then process the 3 S's – Soon, Severe, Sure - as a large group to determine level of risk.

CONTINUED

RISK ASSESSMENT: TRAINER'S MANUAL

Case Scenario:

Mr. K is an 83 year old retired business man who lost his wife last year. He suffered a mild stroke that left him with moderately impaired judgment. Mr. K's daughter called APS to report that her father has been befriended by a younger woman who claims to be in love with him. He has given the woman many pieces of jewelry and use of his credit cards. Mr. K has stated that he wants to take this woman to Las Vegas at the end of the month to get married. Mr. K's daughter has information that the woman is currently living with her boyfriend and has a history of marrying older men and quickly inheriting their assets.

- How **Soon** might the client be harmed?
 - *From the APS report, it appears Mr. K may already be harmed financially.*
- How **Severe** might the harm be?
 - *From the report, we don't know the extent of Mr. K's assets to start or after the jewelry purchases/access to credit cards but the harm could already be severe and compounded if he marries the woman.*
- How **Sure** are you that the harm will occur? (this can also be thought of in terms of likelihood)
 - *It is very likely that Mr. K is being harmed financially as per the APS report and it will only get worse if he marries the woman given her alleged history and his alleged cognitive issues.*

Mr. K's Level of Risk = High

We will continue to come back to these fundamental concepts throughout the training as they will help provide a framework to assess level of risk.

This framework combined with your clinical judgment will help you determine the appropriate intervention for the client.

Slide #13



HANDOUT # 5
Phases of Risk
Assessment

Participant Manual pg 24

TOPIC: Phases of Risk Assessment

Although no specific policies are recommended in this training, the following three phases of risk assessment will be used as guidelines:

- Initial Assessment and Emergencies
- Case Planning
- Reassessments and Case Closure

Cases don't usually roll out neatly. Workers may start thinking about long-term plans while they're still resolving emergencies. Similarly, emergencies may erupt after risk reduction plans are in place. We will look at the three phases of risk assessment and then a case example to apply what we learned.

Trainer note: Direct participants to page 24 of the participant manual **Handout #5 – Phases of Risk Assessment** which outlines the three phases.

RISK ASSESSMENT: TRAINER'S MANUAL

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?
- 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 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?

Slide #14

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**)



TOPIC: 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?

Initial assessments may begin as early as the initial call as workers determine whether or not to investigate, how quickly, if the person is in immediate danger, and why they (or someone else) is/are calling now.

In the early stages of risk assessment, workers are concerned with clients' immediate safety.

Slide # 15



HANDOUT #6a
Case Scenario – Mrs.
Anderson: Phase 1

Participant Manual pg 26



Time Allotted: 15 minutes

TOPIC: Case Scenario – Mrs. Anderson

Trainer note: This activity is broken down into three parts to demonstrate the three phases of risk assessment. Read the scenario and ask the questions at the end of each section in large group response format. Chart answers on easel paper.

This activity is designed to get participants to begin thinking about risk assessment, levels of risk, and what questions workers may need to ask themselves to determine appropriate client interventions.

Refer participants to page 26 of the participant manual – **Handout #6a – Case Scenario Mrs. Anderson: Phase 1 - Initial Report.**

CONTINUED

RISK ASSESSMENT: TRAINER'S MANUAL

Handout #6a – Case Scenario – Mrs. Anderson

Phase 1 - Initial Report:

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 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:

- Do you 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 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?

Mrs. Anderson's level of risk?


Slide #16

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?


EVALUATE:

- On-going risks
- Risk mitigation factors
- Informal support systems
- Client's view of the situation



HANDOUT #6b
Case Scenario – Mrs. Anderson: Phase 2

Participant Manual pg 28



TOPIC: 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?
- 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?

Later, after emergencies have been resolved and workers have additional information, they focus on predicting future risk and finding ways to eliminate or reduce it.

Refer participants to page 28 of the participant manual - **Handout #6b – Case Scenario Mrs. Anderson - Phase 2 - Case Planning with Mrs. Anderson**

Trainer note: Part two of the three-part activity to demonstrate the three phases of risk assessment. Again, read the scenario and ask the questions at the end of each section in large group response format. Chart answers on easel paper.

RISK ASSESSMENT: TRAINER'S MANUAL

Handout #6b – Case Scenario – Mrs. Anderson (continued)

Phase 2 - Case Planning with Mrs. Anderson:

Mrs. Anderson answered the door of her home after you knocked for an extended period of time. She was in a dirty nightgown and her hair was uncombed. When asked, “Are you Mrs. Anderson?” she nodded. When asked, “Are you here alone?” she nodded. When asked, “Where is your daughter?”, she just shrugged her shoulders. When asked, “When did your daughter leave?”, she shrugged and began to softly sob. Subsequent questions revealed that Mrs. Anderson’s verbal communication is impaired although she appeared to understand the questions being asked if they were simple sentences. She did seem to be confused about time.

You were able to locate Mrs. Anderson’s medications on the kitchen counter. Mrs. Anderson shrugged when you asked if it was okay to contact her doctor. You called the doctor and Mrs. Anderson got on the phone and indicated it was okay for him to speak to you. Dr. Elias stated that Mrs. Anderson has aphasia post-stroke coupled with limited executive functioning. He did not think that she is capable of providing for her own care and stated, “She probably shouldn’t be left alone for any extended period of time”. The doctor did have a cell phone number for the daughter but not for the son. Mrs. Anderson shrugged when you asked if it was okay to call her daughter.

Phone Interview with Jenna (Mrs. Anderson’s daughter):

Jenna sounded like she had been asleep when you called her. Jenna stated that she had been waiting on her mother, night and day, for the past three weeks and had been at her bedside for the whole week before that. She stated that she needed some time for herself and so had “taken the weekend off” from caring for her mother and would be back over later in the day to resume her care. You told her to please come over right away so that a plan for her mother’s care could be established.

Ask yourself:

- 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?
- Does Jenna pose an on-going risk for Mrs. Anderson?
- What factors mitigate risk (e.g. clients’ strengths and resources)?
- Are informal supports available to help?
- How does Mrs. Anderson view the situation? What does she want to do about it? Is she capable of making choices and assisting with care plans? Given Mrs. Anderson’s limited communication, how might you find this out?

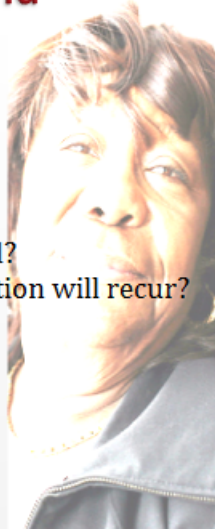
Mrs. Anderson’s level of risk?

Slide #17

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?



HANDOUT #6c
Case Scenario – Mrs.
Anderson: Phase 3

Participant Manual pg 29



TOPIC: Phase 3: Reassessments and Case Closure

After addressing immediate safety problems, workers need to continue to make judgments about risk. They need to know if problems are getting worse, if measures or services are working, and if new problems have emerged.

Factors to consider:

- 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?

Workers must decide when situations are stable enough to terminate protective services based on risk assessment, and what will happen if the situation recurs. Situations should be re-assessed. Agencies have their own policies and practices but the basic goals of re-assessment are the same: To determine if situations are getting worse or better, and modify care plans accordingly.

Refer participants to page 29 of the participant manual - **Handout #6c – Case Scenario - Mrs. Anderson: Phase 3 - Reassessment and Case Closure.**

Trainer note: Part three of the three-part activity to demonstrate the three phases of risk assessment. Again, read the scenario and ask the questions at the end of each section in large group response format. Chart answers on easel paper.

RISK ASSESSMENT: TRAINER'S MANUAL

Handout 6c – Case Scenario – Mrs. Anderson (continued)

Phase 3 - Reassessment and Case Closure:

When you arrive unannounced at the home, Mrs. Anderson and Jenna are at home. Also in the home is Margaret, a caregiver from the Home Health agency. Jenna tells you that Margaret is providing Mrs. Anderson with four hours of care a day and that there is also a weekend caregiver for 4 hours on Saturday and Sunday. Jenna stated that she has also moved in with Mrs. Anderson for the time being. Jenna's home in the next town is now up for sale. Jenna plans to move forward with a conservatorship/guardianship of her mother and to be put on the deed to Mrs. Anderson's home. Jenna stated that the free time provided by the home health agency has helped her manage her own life while caring for her mom.

Ask yourself:


- Has risk changed over time? Is Mrs. Anderson 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?

Mrs. Anderson's level of risk?

Slides #18

When to close a case...

- Client risk of abuse/neglect is reduced or eliminated.
- A client with capacity requests it.
- Client dies or leaves jurisdiction.
- Other jurisdiction specific situations.



TOPIC: When to Close Cases



Ask: Given what we know about Mrs. Anderson's current situation and her level of risk, would you the close case?

Risk assessments and re-assessment can help with case closure decisions. When to close a case:

- Client risk of abuse and/or neglect is reduced or eliminated
- A client with capacity requests their case be closed.
- Client dies or leaves jurisdiction.
- Other jurisdiction specific situations.

Note: Only clients who retain capacity may request their case be closed.



Ask: How do we screen for capacity to request closure?

Answers may include:

The client appears to understand the options, including the potential benefits of accepting services and the potential risks of discontinuing APS involvement.

Trainer Note: Check with your local jurisdiction to determine if there are any other situations in which cases are closed.

ASSESS RISK FACTORS IN FIVE “DOMAINS”



**TIME ALLOTTED: 30 minutes before break
30 minutes after break**

Slide #19

Risk: Indicators vs. Factors

<p>Risk Indicators – observable signs that you can see or hear that indicate risk may be present.</p>	<p>Risk Factors – conditions which put a person at risk of harm. Increases likelihood of that abuse or neglect has or will occur.</p>
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TOPIC: Risk Indicators vs. Risk Factors

Two important concepts that help to determine whether abuse or neglect has occurred or are likely to occur are “**risk indicators**” and “**risk factors**.”

- **Risk Indicators** are the observable signs, things you can see or hear, that indicate that risk may be present. Indicators may be physical, behavioral or environmental.

CONTINUED

RISK ASSESSMENT: TRAINER'S MANUAL

- ***Risk Factors*** are 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; Social.

Slide #20



HANDOUT # 7
Types of Risk Indicators

Participant Manual pg 32

TOPIC: Types of Risk Indicators

Trainer Note: Direct participants to page 32 of the participant manual **Handout #7 – Types of Risk Indicators**. Discuss a few of the examples below from each type of risk indicator and direct participants to additional examples in their handout.

- **Physical indicators are clues or signs that can be observed, collected, photographed, and/or recorded.** Observable evidence, such as, bruises or injuries that are unexplained, untreated or multiple; suspicious documents signed by persons who are visually impaired, sign, or comprehend the contents; "paper trails" that include documents signed by an older adult or someone else.
- **Behavioral Indicators include behaviors of the client or the perpetrator** such as caregivers who seem resentful, angry or over-taxed by responsibilities and clients who seem fearful or make excuses for caregiver behavior. They may include what victims, perpetrators, and witnesses tell you, how they tell you, and the interactions between them.
- **Environmental Indicators are clues found in the client's physical environment** such as a deteriorated home, lack of food, lack of amenities even though the older adult can afford them, signs of inappropriate restraints, such as locks on the outside of bedroom doors, etc.
- **Alternative Explanations** must also be considered. It may be difficult to differentiate indicators from accidental injuries or the effects of illness. Neglect may also result from an older adult refusing help.

RISK ASSESSMENT: TRAINER'S MANUAL

HANDOUT #7 - 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 contents)

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 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.

Slide #23



HANDOUT # 8
Victim-Related Risk
Factors
Participant Manual pg 34

HANDOUT # 9
Perpetrator-Related Risk
Factors
Participant Manual pg 36

TOPIC: Risk Factors: Five “Domains”

Trainer Note: this slide is animated so that one bullet point comes onto the screen at a time. Refer participants to **Handouts #8 – Victim-Related Risk Factors and Handout #9 – Perpetrator-Related Risk Factors** on pages 34 & 36 of the participant manual as you review the following slides.

Remember risk factors are 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 can be categorized in five domains: Health and Functional Status; Mental Health Status and Capacity; Living Environment; Financial; and Social.

The presence of one or more risk factors is a cause for heightened concern, but it doesn't mean that harm has definitely occurred or will inevitably occur in the future; it does mean that the odds are heightened.

The risk factors that have been identified for elder abuse are based on research and practice experience. Research tells us that certain traits, conditions, circumstances are associated with abuse. Some risk factors apply to victims and some apply to perpetrators. Studies show that risk factors vary depending on the type of abuse.



Ask: Can you think of any characteristics of victims or perpetrators that might be risk factors?

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HANDOUT #8 - 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	<ul style="list-style-type: none">• 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-Klawnsnik, 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	<ul style="list-style-type: none">• 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

RISK ASSESSMENT: TRAINER'S MANUAL

	<p>neglect (Quinn, 2002).</p> <ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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).

RISK ASSESSMENT: TRAINER'S MANUAL

HANDOUT #9 - PERPETRATOR-RELATED RISK FACTORS

Perpetrator characteristics with respect to:	Associated Risk Factors
Relationship to Victims	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• 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.

Slide #22

Principles of Risk: #1

The strongest predictor
of future victimization is
low social support.

(Acierno, R., Hernandez, M. A., Amstadter, A. E., Resnick, H. S.,
Steve, K., Muzzy, W., et al. (2010).)



TOPIC: Principles of Risk: #1

According to a 2010 study by Acierno et al low social support associated with triple the likelihood of abuse, regardless of the type of abuse. They also suggest that increasing the victim's social support may work to prevent future victimization.



Ask: Can you think of reasons why this might be the case?

Answers may include:


No one “watching the cookie jar” in financial abuse cases

No witnesses/ No one to report the abuse to authorities

No one to encourage the victim to stop bad acts before they reach the level of abuse.

Dependent on a single caregiver/ No one to provide respite care. Victims may feel that they have no other options for needed help except the abuser.

Slide #23



Principles of Risk: #2

The experience of previous traumatic events — including interpersonal and domestic violence — increases the risk for mistreatment.

(Acierno, R., Hernandez, M. A., Amstadter, A. B., Resnick, H. S., Steve, K., Muzzy, W., et al. (2010).)

TOPIC: Principles of Risk: #2

The research also shows that the experience of previous traumatic events — including interpersonal and domestic violence — increases the risk for mistreatment. “On the most obvious level, interpersonal environments characterized by exposure to traumatic events are probably also more likely to contain abusive individuals over time.”

It is important to discuss past trauma with clients. Workers can use the “Briefest Screen Ever” developed by Gabriella Grant, Director of the California Center of Excellence for Trauma Informed Care. It is comprised of three questions:

- Do you feel safe speaking to me today? If not, what would make you feel safer?
- Do you feel safe at home today? If not, how can we make you feel safer?
- Did you feel safe in your home of origin? If not, how does that affect you today?

The “Briefest Screen Ever” is provided on page 37 of the participant manual.

Slide #24

Lethality

- Women who were threatened with a gun are 20 times more likely to be murdered
- Women whose partners threatened them with murder are 15 times more likely to be killed.
- Choking is a high-risk indicator of eventual homicide

TOPIC: Lethality

“Research on lethal elder abuse and potential risk factors is scarce” according to Bonnie Brandl and Randy Thomas (2006) but extrapolating from research with younger domestic violence victims can provide some common risk factors. Along with the statistics listed on the slide, Brandl and Thomas report that experts in the field have identified the following perpetrator risk factors:

- Access to/ownership of guns
- Use of weapon in prior abusive incidents
- Threats with weapons
- Serious injury in prior abusive incidents
- Threats of suicide
- Drug or alcohol abuse
- Forced sex
- Obsessiveness/extreme jealousy/extreme dominance

However, separating from an abusive relationship or seeking help has been found to be a significant risk factor for serious injury or death. 75% of homicide victims and 85% of victims of severe but nonfatal violence had left or tried to leave in the preceding year.

In 45% of lethal domestic violence cases, a woman's attempt to leave the abuser was the precipitating factor for the killing (Block, 2003).

Collaborating with experts in the Domestic Violence field is recommended to ensure appropriate safety planning.

Slide #25

Key Questions to Determine Lethality

- **Has your partner ever used a weapon against you or threatened you with a weapon?**
- **Has he or she ever threatened to kill you or your children?**
- **Do you think he/she might try to kill you?**

TOPIC: Key questions to determine lethality

The following three questions are high predictors of deadly violence that are used in lethality assessments with younger women. There is reason to believe that they would also indicate increased risk to older victims of domestic violence as well.

- Has your partner ever used a weapon against you or threatened you with a weapon?
 - Has he or she ever threatened to kill you, your children or your pets?
- Do you think he/she might try to kill you?

Practice experience suggests that people are at heightened risk at certain times. They vary depending on the form of problem or abuse. Risk is heightened:

- After perpetrators have been served with restraining orders or asked to leave victims' homes (violence)
- After major losses, including the loss of a spouse (financial abuse)
- After victims of financial exploitation have suffered major losses (suicide)

Lethality questions are provided on page 38 of the participant manual.

Slide # 26

Example

Client states she is afraid to tell her caregiver when she has had a toileting accident.

- Risk Indicator?
- Risk Factors?
- Possible Harm?



Time Allotted: 10 minutes

TOPIC: Example

Refer participants to page 39 in the participant manual. Have participants work in pairs to identify the risk indicator, risk factors, and possible harm and process as a large group.

Example

Client states she is afraid to tell her caregiver when she has had a toileting accident.

Risk Indicator(s): Client says she is afraid to tell her caregiver when she has had a toileting accident (behavioral).

Risk Factor(s): functional limitations; poor health; possible poor relationship with caregiver; possible confusion/dementia, etc.

Possible harm: client feels belittled, client fears for safety, client has injuries, and client's incontinence leads to pressure ulcers.

Analysis: The client's fear is the indicator. We don't know for sure that this fear actually means that there is risk. For example, the client's fear may be unwarranted because the caregiver might not react at all in a way that harms the client. (Perhaps the client has dementia and misperceives the situation).

CONTINUED

RISK ASSESSMENT: TRAINER'S MANUAL

On the other hand, the fear may reflect the client's accurate assessment that the caregiver has already or will cause harm. We cannot conclude that the presence of the indicator (the client's fear) automatically means that harm caused by abuse or neglect has occurred or will occur, but the indicator increases the risk of that.

Slide #27

Factors that Mitigate Risk

Client's strengths, resiliency, and motivation

Interpersonal relationships

Support networks



TOPIC: Factors that mitigate risk

We also know that risk can be mitigated by internal and external resources. These include:

- Client's strengths, resiliency, and motivation
 - Health and mental health status, activity level, etc.
- Interpersonal relationships
 - Spouse, family, friends, etc.
- Support networks
 - Senior centers, faith community, social services, etc.



Ask: Can you think of other factors that may mitigate risk?

Slide #28



TOPIC: Caveats

Risk factors are based on statistical probabilities. They don't take into account cultural variations or individuals' strengths or perspectives. We need to consider those factors.

For example, although the research tells us that living with non-spousal family members is a risk factor, multigenerational family households may be a strength.

Benton (1998) found that "Multigenerational family units provide support and stability to members, and the sharing of family homes and resources has allowed families to subsist on minimal incomes."

Similarly, what is viewed as an indicator of abuse may not be seen that way by the older adult, his or her family, and other members of the cultural community. An example is the sharing of an older adult's income or property by other family members.

Brown (1998) found that "At the heart of their traditional culture (Navajo) was that family members had the obligation to relate to each other in interdependency and mutually share what they had, with no thought given to the idea that they had any rights as individuals."

CONTINUED

RISK ASSESSMENT: TRAINER'S MANUAL

In a study by Dakin and Pearlmutter (2009) it was found that Caucasian, African American and Latina women define elder abuse differently. For example, Latina respondents considered putting a relative in a nursing home as elder abuse. African American respondents considered asking elderly parents to raise grandchildren as elder maltreatment by adult children. Working class Caucasian women did not consider verbal abuse as a type of elder abuse.



Ask audience about their own experiences.

TRAINER NOTE: The following is an example of a cultural perspective. Please feel free to use one of your own.

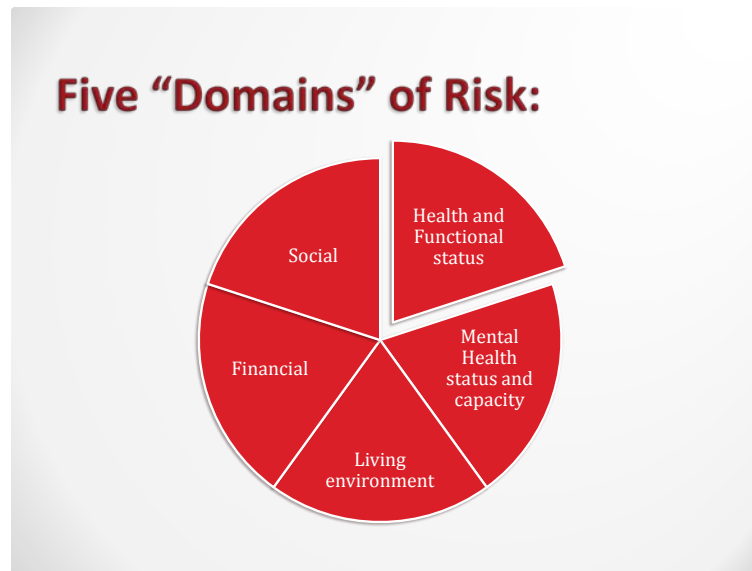
Example: Muslim woman and her “controlling” husband

A neighbor called APS to report that the older Arabic man next door appears to be keeping his wife isolated from the outside world. The wife is very rarely seen outside the house and never without her husband or one of her sons by her side. She never speaks to any of the neighbors. And, the only visitors to the home are family members. The neighbor is concerned that the wife is being kept a virtual prisoner in her own home by her controlling husband.

An APS worker went to interview the wife and found that she did not speak English. An interpreter was secured and the interview was conducted. The wife explained that she is Muslim and in her culture a proper woman does not leave her house without a male relative in attendance. In addition, she explained, her health is not good and going out is very taxing for her. She described her husband as a kind, honorable and pious man and had no complaints about her situation.

The APS worker found that this was not an abusive situation.

Slide #29



TOPIC: Assessing Risk in the Five “Domains”

Now that we have examined the types of risk indicators and risk factors let's discuss assessing risk in the five “domains”.

In assessing risk, workers consider a variety of “domains” :

1. In the Health and Functional Status domain, workers need to ask “Is this client in poor health? Do they need help with daily activities?”
2. In the Mental Health Status and Capacity domain, workers need to ask, “Is client capable making decisions for themselves? Do they have other mental health problems like depression, anxiety, or substance abuse?”
3. In the Living Environment domain, workers need to ask, “Is client in a safe and protected environment? Is their home unsafe or unhealthy?”
4. In the Financial Status domain, they need to ask, “What's the client's financial situation? Do they have the resources they need? Are their assets in jeopardy?”
5. Finally, in the Social Status domain, workers need to ask, “Are there people in clients' lives who can help? Are there people who pose a danger to them?”

CONTINUED

RISK ASSESSMENT: TRAINER'S MANUAL

Although “risk” generally refers to factors in the environment and “vulnerability” refers to individual characteristics that contribute to the risk, in using the term risk here, we are including both external and internal factors that increase the likelihood that the individual will experience abuse.

Trainer Note: Let participants know that the domains of Health and Functional Status and Mental Health Status and Capacity will be discussed first as they are routinely the most difficult to assess. Later in the training the other domains will be reviewed.

Also, note participants will receive specialized training on financial abuse/exploitation assessment in Core Module 12.

Slide #30

Assessing Health and Functional Status

- **Health assessments.** What is the client's health and medical status? Are they ill or injured?
- **Functional assessments:** Is the client able to perform daily tasks and meet their own needs?



TOPIC: Assessing Health and Functional Status

Two critical factors in assessing risk are clients' health and whether they can meet their own needs.


Functional assessments tell us how critical and urgent situations are. A situation that is relatively benign for an independent person may be an emergency to someone who can't manage independently. Functional assessments are used to determine whether older/dependent adults can meet their own needs for food, clothing, or shelter. Can they manage on their own? For how long?

Slide #31

Cognitive Assessments

- Help determine clients' vulnerability and level of risk
- Helps workers determine what actions are needed and whether clients are able to help with planning

Document behavior rather than diagnose (unless you are licensed to do so).



TOPIC: Cognitive Assessments

Understanding clients' mental skills is important for two reasons:

- 1) Cognitive deficits may contribute to risk or vulnerability.

Examples include forgetting to take meds, go to medical appointments, or pay bills; making poor financial decisions; trusting unscrupulous people; failing to care for their own needs; wandering; and being unduly influenced to act against their own best interest.

- 2) Determines what actions are needed and to what extent the client is able to help in planning for his/her safety.

Your service plan for an individual who is sharp intellectually is going to be very different from that for an individual who is severely cognitively impaired. However, you do need to involve the client in planning for his/her own safety as much as possible based on the extent of the disability. For example, even clients with memory problems can usually tell you whether or not they like a particular caregiver and want that caregiver to provide their care.

There are many different types of cognitive assessments, some that can be administered by a social worker and others that require specialized training and /or licensure.

CONTINUED

RISK ASSESSMENT: TRAINER'S MANUAL

Trainer's note: It's important to determine your agency's policy on which cognitive assessments workers are to use.

A word on documentation:

If the client seems to have a cognitive deficit, you should document the behavior that led you to that conclusion, rather than "diagnose" the client (unless you are licensed to do so). In other words, rather than say "Mrs. L suffers severe memory loss", you should document that "Mrs. L's memory appeared to be impaired as she could not recall the names of her two daughters and she stated that her deceased husband was at work".

Cognitive deficits may include any of the following:

- short or long term memory problems,
- problem-solving difficulty,
- impairments in visuospatial functioning;
- problems in language and communication;
- difficulty recognizing people and everyday objects;
- impaired decision-making ability;
- impaired attention;
- confusion;
- problems with judgment, insight, motivation, and ability to engage in goal-oriented behavior;
- bizarre ideations;
- hallucinations, and/ or mood fluctuations.

Slide #32

Activity: Assessing Risk in the Five Domains



**HANDOUT # 10 -
Assessing Risk in Five
Domains**

Participant Manual pg 42

Time Allotted: 20 minutes

TOPIC: Activity: Assessing Risk Factors in the Five Domains

Refer participants to page 42 in the participant guide **Handout 10 – Assessing Risk in Five Domains**. In small groups, have participants read the scenario and answer the following questions. Process answers as a large group.

Scenario - Mr. A

APS receives a call from a hospital discharge planner who just released Mr. A, who is 84 years old and lives alone. The discharge planner is concerned because Mr. A has been admitted to the hospital four times in the last 18 months for various problems, including two falls, a urinary tract infection, and dehydration. He is on medication for high blood pressure and diabetes. Mr. A has a daughter who lives several miles away who drops by 2-3 times a week to take him to appointments, shop, help with bill paying, and perform housekeeping tasks. Although the daughter wants to help, she thinks Mr. A needs more help than she can provide and feels guilty she can't do more. Although Mr. A used to be active socially, he is not going out to see neighbors or to do his shopping as he used to do.

When an APS Social Worker goes out to meet with Mr. A in his home, he states that he has lived in his house for over sixty years. Memories of his marriage and life with his now deceased wife and raising their four children are all present in the house. He states his children have urged him to move into an assisted living facility but he does not want to because he likes living alone and wants to stay in his own home. Mr. A is cordial to the APS SW but tells him that he does not need help. He states the reason that he has

stopped running errands and visiting friends is that he's afraid of falling again. However, he does not want anyone to know this because he's afraid his children will pressure him to move. When the APS SW asks about his need for help with personal care, he denies that he needs any help, even though he fell while getting out of the bathtub.

Assess Risk Level:

- Is Allan in immediate danger? How **soon** might they 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 Alan will be harmed without intervention?

What is Allan's level of risk?

Identify the risk indicator(s):

Physical:

Behavioral:

Environmental:

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

1. Health and Functional Status domain
 - Is this client in poor health?
 - Do they need help with daily activities?"
2. Mental Health Status and Capacity domain
 - Is client capable making decisions for themselves?
 - Do they have other mental health problems like depression, anxiety, or substance abuse?

3. Living Environment domain
 - Is client in a safe and protected environment?
 - Is their home unsafe or unhealthy?
4. Financial Status domain
 - What's the client's financial situation?
 - Do they have the resources they need?
 - Are their assets in jeopardy?
5. Social Status domain
 - Are there people in clients' lives who can help?
 - Are there people who pose a danger to them?

Are emergency or protective measures and services needed?

What factors may mitigate the risk of harm?

- Client's strengths, resiliency, and motivation -
- Interpersonal relationships –
- Support networks/Support Services –

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Handout #10 – Assessing Risk in Five Domains

Scenario - Mr. A

APS receives a call from a hospital discharge planner who just released Mr. A, who is 84 years old and lives alone. The discharge planner is concerned because Mr. A has been admitted to the hospital four times in the last 18 months for various problems, including two falls, a urinary tract infection, and dehydration. He is on medication for high blood pressure and diabetes. Mr. A has a daughter who lives several miles away who drops by 2-3 times a week to take him to appointments, shop, help with bill paying, and perform housekeeping tasks. Although the daughter wants to help, she thinks Mr. A needs more help than she can provide and feels guilty she can't do more. Although Mr. A used to be active socially, he is not going out to see neighbors or to do his shopping as he used to do.

When an APS Social Worker goes out to meet with Mr. A in his home, he states that he has lived in his house for over sixty years. Memories of his marriage and life with his now deceased wife and raising their four children are all present in the house. He states his children have urged him to move into an assisted living facility but he does not want to because he likes living alone and wants to stay in his own home. Mr. A is cordial to the APS SW but tells him that he does not need help. He states the reason that he has stopped running errands and visiting friends is that he's afraid of falling again. However, he does not want anyone to know this because he's afraid his children will pressure him to move. When the APS SW asks about his need for help with personal care, he denies that he needs any help, even though he fell while getting out of the bathtub.

Assess Risk Level:

- Is Allan in immediate danger? How **soon** might they 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 Alan will be harmed without intervention?

What is Allan's level of risk?

Identify the risk indicator(s):

Physical:

Behavioral:

Environmental:

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

1. Health and Functional Status domain

- Is this client in poor health?
- Do they need help with daily activities?"

2. Mental Health Status and Capacity domain

- Is client capable making decisions for themselves?
- Do they have other mental health problems like depression, anxiety, or substance abuse?

3. Living Environment domain

- Is client in a safe and protected environment?
- Is their home unsafe or unhealthy?

4. Financial Status domain

- What's the client's financial situation?
- Do they have the resources they need?

- Are their assets in jeopardy?

5. Social Status domain

- Are there people in clients' lives who can help?
- Are there people who pose a danger to them?

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 –

ASSESSING OVERALL LEVELS OF RISK



**TIME ALLOTTED: 45 minutes before lunch
60 minutes after lunch**

Slide: #33



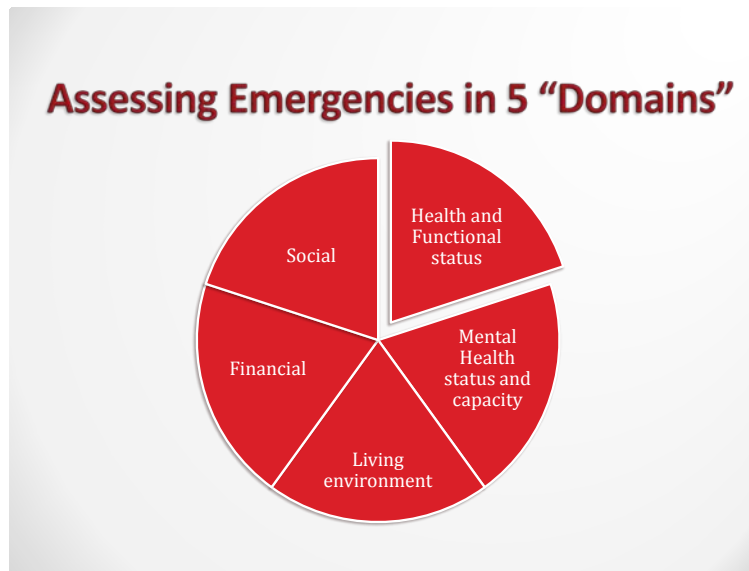
TOPIC: Levels of Risk & the 3 S's

Now let's discuss and practice assessing overall levels of risk continuing to use the five domains. Remember the framework of the 3 S's to determine whether risk level is low, medium, high.

The 3 S's of risk – questions to ask yourself:

- How **S**oon might the client be harmed?
- How **S**evere might the harm be?
- How **S**ure are you that the harm will occur? (this can also be thought of in terms of likelihood)

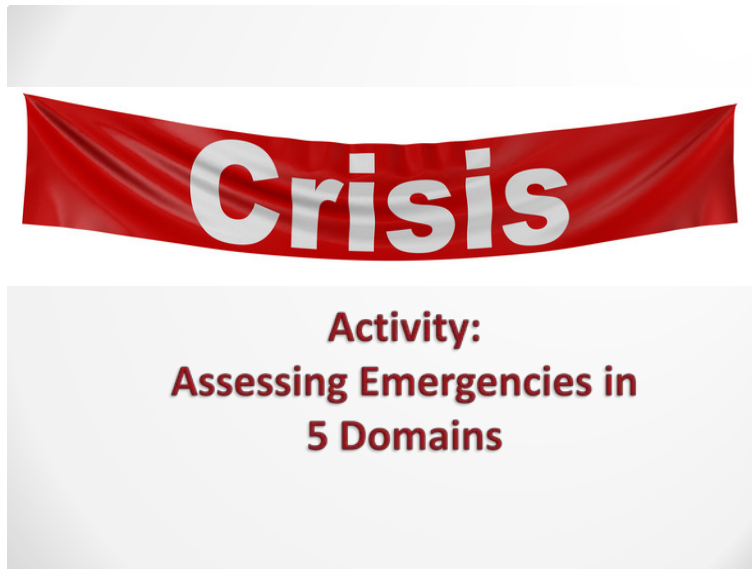
Slide: #34



***TOPIC:* Assessing Emergencies in 5 “Domains”**

Let's begin with assessing emergencies. Usually, when we think of emergencies, we think of medical crises or accidents, but APS workers are likely to encounter emergencies in any of the five risk factor domains.

Slide #35



Flip chart activity

Time allotted: 15 minutes

Topic: Activity: Assessing Emergencies in 5 Domains

Trainer Note: You may want to set-up this activity prior to the training or during the break.

Activity Preparation: Set up 5 flipcharts around the room labeled with a heading (one for each of the 5 risk factor domains). Provide markers at each flip chart station.

Activity instructions

1. Have people walk around and complete the flip charts. Ask them to list emergencies in each domain. Allow 5 minutes.
2. Report back responses as large group - allow 10 minutes. Supplement responses from the list below as needed.
3. Go over the following slides covering any emergency aspects that were not covered on flip chart responses

Trainer note: Use the following to supplement participant responses if needed.

1. Health and Functional Status

- Clients who are unable to meet their own needs are alone.
- Caregivers have been terminated, arrested, or become unavailable.
- Clients' needs have changed.

CONTINUED

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- Medical emergencies including stroke, heart attack, heat stroke, or accident.
- The client is frail and/or in declining health or a fall risk.
- Client is in need of medical treatment or health care.

2. Mental health status and capacity

- Clients are hallucinating, a danger to themselves or others, or gravely disabled as a result of mental illness, dementia, pseudo-dementia, medication interactions, sepsis, substance abuse, etc.
- Clients are suicidal.
- The client is unable to manage their own finances (e.g. bills are unpaid resulting in utilities being shut-off and/or eviction/foreclosure).

3. Living environment

- Client's living environment is unsafe as a result of disrepair.
- Clients living environment is unhealthy as a result of rodents, insect infestations, human or animal waste.
- The client is homeless or at risk of becoming homeless.
- The client's living environment does not meet his or her needs.

4. Financial

- The offender has access to the client's finances through a POA, contract, checks, (e.g. an older adult with diminished mental capacity signed a contract, check, advance or other document).
- A client with diminished capacity is being pursued, courted by disreputable, unscrupulous, or opportunistic persons.

5. Social (risk posed by others, including caretakers and family members)

- An offender has made threats against a client, particularly if he or she is in possession of firearms.
- The client resides with someone who has been violent toward him or her or others in the past.
- A client who is unable to provide for his or her own needs is left alone or isolated.

Slide: #36



TOPIC: Medical Emergencies

Medical emergencies are covered in another module but this list represents the most common medical emergencies.

- Stroke
- Drug related emergencies
- Heart attack
- Heat stress and heat stroke
- Injuries (burns, hip fractures, head injuries)


However, because the population we deal with can be so medically fragile, all types of victimization can lead to a medical emergency. Any type of abuse can exasperate pre-existing medical conditions, even emotional abuse.

For example, physical abuse (even if it doesn't cause direct physical injury) can over stress a victim with a heart condition and cause a cardiac incident.

Caretaker neglect could include over and/or under medicating a victim so that their medical condition is no longer under control.

So, assess a victim's physical condition is an important aspect of your job.

Slide: #37



APS Workers Role

- Recognize signs and symptoms
- Call 911
- Provide information
- Alert medical professionals to concerns about abuse and neglect

HANDOUT # 11
Signs of Medical
Emergencies

Participant Manual pg 47

Topic: APS Worker's Role in Medical Emergencies

APS workers can play an important role in medical emergencies, by recognizing emergencies and alerting emergency professionals about immediate and ongoing risks.

This role includes:

- Recognize signs and symptoms of medical emergencies.
- Calling 911.
- Providing information about client's medical conditions, medications, and baseline health to health care professionals.
- Alerting medical professionals to concerns about abuse and neglect:
 - Requesting forensics examinations if needed (sexual assault exam, photo documentation of injuries).
 - If clients are hospitalized, alerting hospital personnel about active restraining orders, persons who pose an ongoing threat, etc.
 - Informing discharge planners about the home environment and ongoing risks at home.

Refer participants to page 47 in the participant manual **Handout #11 – Signs of Medical Emergencies** to review on their own.

RISK ASSESSMENT: TRAINER'S MANUAL

Handout #11 - Signs of Medical Emergencies

Emergency	Signs
Stroke	<ul style="list-style-type: none">• 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 emergencies (includes adverse drug reactions and non-compliance)	Factors associated with drug related emergencies include non-compliance with medication regimens, poor recall of medication regimens, seeing numerous physicians, multiple drugs, and switching to complementary and alternative treatment.
Heart attack	<ul style="list-style-type: none">• Chest discomfort or pain, stomach pain.• Shortness of breath, anxiety, lightheadedness, sweating, nausea and vomiting.• Women are more likely than are men to also have heart attack symptoms without chest pain.
Heat Stress	<p>Older adults (people aged 65 years and older) are more prone to heat stress than younger people for several reasons:</p> <ul style="list-style-type: none">• 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

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	<p>if emergency treatment is not provided.</p> <p>Symptoms of Heat Stroke include:</p> <ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• Confusion• Headache• Fluid from the nose or ears• Unwitnessed head/face injury
Strangulation:	<ul style="list-style-type: none">• Difficulty breathing• Hoarse voice• “Sniffing position” (nose pointed upwards, stretching neck to allow freer breathing)
Hip fracture	<ul style="list-style-type: none">• Difficulty walking• Pain in hips• One leg shorter than the other in the presence of pain• Leg deformity
Other	<ul style="list-style-type: none">• Acute burns• Nonresponsiveness• Rapid breathing• Agitated behavior• Respiratory distress• Confusion, delirium

Slide: #38



Mental Health Emergencies

- Recognize signs and symptoms
- Changes in mental status
 - Hallucinations and delusions
 - Abrupt changes in mental status
 - Risk factors for suicide
- Role of APS in mental health emergencies
 - Provide information to health care professionals
 - Alert mental health professionals to concerns about abuse and neglect

HANDOUT #12
Signs of Psychiatric & Mental Health Emergencies

Participant Manual pg 50

Topic: Mental Health Emergencies

Abuse and neglect can exacerbate or precipitate a mental health emergency for some victims.

For example, an elderly man who finds out that his children have sold his home and raided his bank account may become severely depressed or even suicidal.

An individual with a mental health history who is denied his medications or is not receiving nutrition and hydration may exhibit increased symptoms.

It is important to be able to recognize signs and symptoms of mental health emergencies and understand your role.

Refer students to page 50 in the participant manual **Handout #12 – Signs of Psychiatric and Mental Health Emergencies**.

Some signs and symptoms include:

- Changes in mental status
 - Hallucinations and delusions
 - Abrupt changes in mental status
 - Risk factors for suicide – see **Handout # 12** for risk factor and warning signs.

What is the role of APS in mental health emergencies?


- Call 911
- Provide information about clients mental health conditions, medications, and baseline mental health status to health care professionals
- Alert mental health professionals to concerns about abuse and neglect

RISK ASSESSMENT: TRAINER'S MANUAL

Handout #12 - Signs of Psychiatric/Mental Health Emergencies

Psychiatric Emergency	Is the older adult a danger to him or herself or others? Is he or she hallucinating, exhibiting delusional thinking, or disoriented?
Changes in mental status	Changes in mental status may be signs of stroke, drug interactions, or infections. They should be treated as emergencies.
Suicide	<p>Risk factors for suicide:</p> <ul style="list-style-type: none">• Recent loss of a spouse, loved one, or pet• Debilitating or life-threatening illness• Pain, especially if pain is severe, chronic, and/or inescapable• Loss of independence and/or mobility• Inability to live alone• Loss of employment or productive activities• Financial difficulties• Depression• Alcohol abuse and/or dependence• Loss of role or stature in family and community• Feelings of hopelessness and helplessness• Physical, social, and emotional isolation <p>Warning signs for suicide:</p> <ul style="list-style-type: none">• Statements about death and suicide• Reading material about death and suicide• Statements of hopelessness or helplessness (e.g., "I don't know if I can go on")• Disruption of sleep patterns• Increased alcohol or prescription drug use• Failure to take care of self or follow medical orders• Stockpiling medications• Sudden interest in firearms• Social withdrawal or elaborate good-byes• Rush to complete or revise a will• Overt suicide threats

Slide: #39



Caregiver Emergencies

If functional or cognitive deficits are present, emergencies can happen very quickly. For example:

- A caregiver leaves a frail elder unattended
- A caregiver quits or is fired, arrested, missing, etc.
- Other examples?

Topic: Caregiver Emergencies

Situations involving clients' with functional and cognitive deficits can become emergencies very quickly.

For example, if an older adult who is unable to provide self-care is left alone for even a few minutes, it is potentially a serious problem. Or if a caregiver quits or is fired, arrested, missing, etc.



Ask participant for other examples of caregiver related emergencies.

Possible example – caregiver is hospitalized unexpectedly without a backup plan for care.

Slide: #40



Living Environment Emergencies

- Unsafe - disrepair
- Unhealthy - rodents, insect infestations, human or animal waste
- Homeless or at risk of becoming homeless
- Does not meet the needs of the client.

Topic: Living Environment

A situation may become an emergency if the client's home is unsafe or unhealthy. For example:

- Client's living environment is unsafe as a result of disrepair.
- Clients living environment is unhealthy as a result of rodents, insect infestations, human or animal waste.
- The client is homeless or at risk of becoming homeless.
- The client's living environment does not meet his or her needs.

Slide: #41



Financial Emergencies

- Insufficient funds to meet critical needs
- The potential perpetrator has access to finances through a POA, contract, or checks.
- Pursued or courted by disreputable, unscrupulous, or opportunistic persons

Topic: Financial

Examples of financial emergencies are when clients don't have enough money to meet their needs or when their assets are in jeopardy. They may include:

- Insufficient funds to meet critical needs like medical care or prescriptions.
- The potential perpetrator has access to the client's finances through a POA, contract, checks, (e.g. an older adult with diminished mental capacity signed a contract, check, advance or other document)
- A client with diminished capacity is being pursued or courted by disreputable, unscrupulous, or opportunistic persons

Slide: #42



Social Emergencies

Result from action or inaction of others and may underlie risks associated with other domains.
For example:

- Threats, particularly if firearms are involved.
- Living with someone who has been violent in the past.
- Left alone and unable to provide for themselves.

Topic: Social

Social risks result from the actions (or inactions) of others. They may underlie the risks associated with the other domains.

For example, client's living situation may be endangered or jeopardized as the result of financial abuse. Other examples include:

- An offender has made threats against a client, particularly if he or she is in possession of firearms
- The client resides with someone who has been violent toward him or her or others in the past.
- A client who is unable to provide for his or her own needs is left alone.

Slide #43



Activity: Levels of Risk

- What is at risk (assets, independence, safety)?
- What is the level of risk? (low, medium, high?)
- What additional information do you need to assess Mrs. Brown's level of risk?
- What actions would you take to reduce future risk?

HANDOUT # 13

Levels of Risk Activity:
Mrs. Brown

Participant Manual pg 53

Time allotted: 20 minutes

Topic: Level of Risk Activity: Mrs. Brown

Activity Instructions:

1. Divide the class into small groups of approximately 5 - 6 persons per group.
2. Instruct each group to assign a scribe and reporter.
3. Refer to page 53 in the participants manual **Handout #13 - Levels of Risk Activity: Mrs. Brown**
4. Assign half of the groups Scenario 1 and the other half of the groups Scenario 2.
5. Allow 10 minutes for the groups to review the cases and answer the following questions.
 - a. What is at risk (assets, independence, safety)?
 - b. What is the level of risk? (low, medium, high?)
 - i. Use the 3 S's – Soon, Severe, Sure
 - c. What additional information do you need to assess Mrs. Brown's level of risk?
 - d. What actions would you take to reduce future risk?
6. Large group debrief for 5-10 minutes.

Talking Points:

- Case 1 should be considered low/medium risk as the client's major assets are secure and she understands the risk.
- Case 2 should be considered high risk as the client's assets and home are in jeopardy and Mrs. Brown does not appear to understand what she stands to lose.

RISK ASSESSMENT: TRAINER'S MANUAL

HANDOUT #13 - LEVELS OF RISK ACTIVITY: Mrs. 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.

Scenario 1

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."

Scenario 2


Sandy called Mrs. Brown and informed her of the bank's concerns. Mrs. Brown was very agitated and did not seem to understand what Sandy wanted. Sandy asked if she could visit Mrs. Brown.

During Sandy's home visit, Mrs. Brown said that she is not concerned about her son's actions and that the real problem is that she's being harassed. She showed Sandy a stack of mail, which included threatening notices from a collection agency and an eviction notice from her landlord. When Sandy asked her about them, Mrs. Brown says, "I'm too tired to discuss this right now. Maybe you can come back another time."

Answer the following questions for your assigned scenario:

1. What is at risk (assets, independence, safety)?
2. What is the level of risk? (low, medium, high?)
 - a. Use the 3 S's – Soon, Severe, Sure
3. What additional information do you need to assess Mrs. Brown's level of risk?
4. What actions would you take to reduce future risk?

Slide # 44



Activity: Red Flags

Red = High Risk
Yellow = Moderate Risk
Green = Low/No Risk

Provide the students with “Flags” (colored index cards or small flags)

Time allotted: 15 minutes

Topic: Activity: Red Flags

Preparation: Provide students with red, yellow, or green flags (or index cards).

Activity Instructions:

Read the following scenarios to the class and ask participants to wave their red flags to indicate a high risk situation, yellow to indicate medium risk, or green for low risk. Call on participants to explain their decisions.

1. A social worker at an adult day health center called APS to report that a program participant Maria Santos has been coming to the program in dirty clothes, and with unpleasant body odor for the last week. The last two days she has seemed confused and disoriented. Although she has mild dementia, she has always been clean, oriented and friendly to other participants and staff.

The APS worker investigated and found Maria Santos still in bed at 11:30 am. Maria Santos lives with her daughter, Sophie. Upon questioning, Maria Santos explained that that she had been unable to sleep the previous evening and was just getting off to a slow start. When the worker talked to Sophie, the daughter started to cry and said that she was working two jobs on top of providing care to her mother and was feeling too tired and overwhelmed to get her mother up and ready when the van came to pick her up. *Ask students to raise the flag that indicates the level of risk (red=high, yellow=medium, green=low).*

CONTINUED

RISK ASSESSMENT: TRAINER'S MANUAL

2. A neighbor called APS to report that his 88-year-old neighbor, Mr. Woods, hadn't made his daily morning walk for three days and hadn't left his house at all. Mr. Woods had told him recently that he'd been diagnosed with pancreatic cancer and had seemed despondent. He'd talked about being ready to "give it all up." The neighbor had knocked on the door to see if he'd like him to pick up anything for him at the supermarket. Mr. Woods did not answer and did not respond to phone calls either. *Ask students to raise the flag that indicates the level of risk (red=high, yellow=medium, green=low).*
3. An apartment manager called APS to report that an 84-year-old tenant, Mrs. Rasmussen, hadn't paid rent in four months and the owner had initiated an eviction. When the manager tried to discuss the matter with Mrs. Rasmussen, she told him "I'm really bad with those things; my son makes all the money decisions". The manager had attempted to contact the son multiple times but he didn't the return phone calls. *Ask students to raise the flag that indicates the level of risk (red=high, yellow=medium, green=low).*
4. APS received a report about Mary Newlon from her sister. Ms. Newlon's sister told the worker that her Mary "doesn't think right" and lives with a man who takes her SSI checks and slaps her around. Ms. Newlon's sister hadn't been able to reach Mary and was afraid that she's in serious trouble. *Ask students to raise the flag that indicates the level of risk (red=high, yellow=medium, green=low).*
5. APS received a call about Mrs. Allen from her daughter. Mrs. Allen is 93 years old and lives independently in an apartment. Since suffering a stroke a few years ago. Mrs. Allen has a home care provider, who is paid to come in twice a day to help her get up and dressed, prepare meals, and do the shopping.

On a recent visit, the daughter found her mother still in bed at 2:00pm. The daughter was concerned that her mother wasn't being moved. Mrs. Allen's is quite large and difficult to move. Sometimes when the care giver tries to get her up she is combative.

Another daughter has control over Mrs. Allen's money and hired the care giver. When the caller told her sister about her concerns, she said, "Mind your own business." Her repeated attempts to get her sister to find a new worker have been ignored. *Ask students to raise the flag that indicates the level of risk (red=high, yellow=medium, green=low).*

CONTINUED

RISK ASSESSMENT: TRAINER'S MANUAL

6. Mr. Blair has been living alone for the last fifteen years. His neighbors called APS concerned that he wasn't eating right and was losing weight. He also appeared to be increasingly confused. Upon investigating, the APS worker found that Mr. Blair had little food in his home. He stated that he sent much of his savings to pay the interest on a sweepstakes prize he'd won. As a result, he didn't have much money left for food, but the situation will change once he receives his winnings. *Ask students to raise the flag that indicates the level of risk (red=high, yellow=medium, green=low).*

(Note that this is a case of financial fraud rather than abuse or exploitation by a person in a position of trust and so may not be an APS case in some jurisdictions)

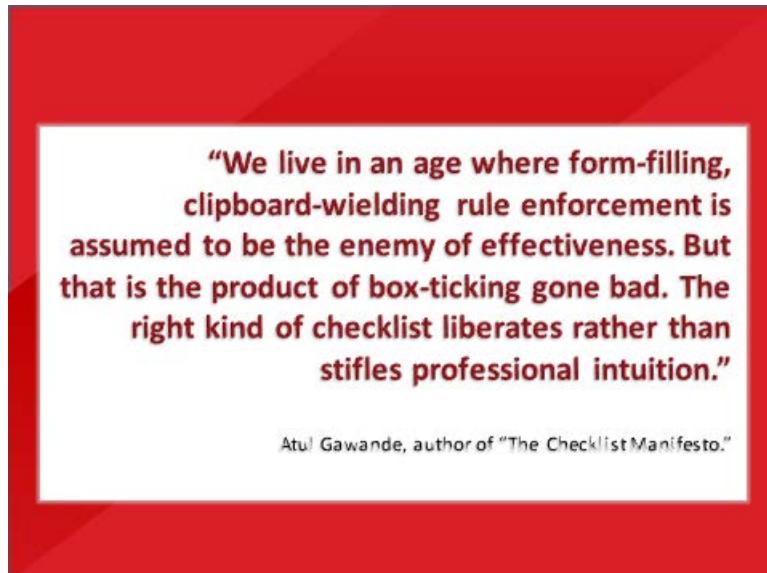
7. An apartment manager called APS to report that one of his tenants, Mary Anne, had recently been visited several times by her daughter who had just relocated from out of state. After each visit, Mary Anne was quite upset. During the most recent visit, Mary Anne fell while her daughter was with her, and the manager suspected that the daughter may have shoved her. *Ask students to raise the flag that indicates the level of risk (red=high, yellow=medium, green=low).*

BENEFITS AND LIMITATIONS OF RISK ASSESSMENT TOOLS



TIME ALLOTTED: 15 minutes

Slide #45



Topic: Quote

Atul Gawande, a surgeon and writer, had this to say about checklists in his book "The Checklist Manifesto." Dr. Gawande was involved in a research project that found that when surgeons used a simple checklist to make sure they'd performed all the tasks they were supposed to during surgery it reduced the rates of mistakes by 40%. They'd borrowed the approach from the Boeing Company, which developed a checklist for pilots.



Ask: Can you think of any situations in which failing to ask the right question or assess a particular risk could place a client in extreme danger?

Slide #46



Topic: Types of Assessment Tools

Assessment tools fit into five broad categories:

- **Functional assessment tools** measure the ability to perform daily tasks and meet their own needs.
- **Cognitive assessment tools** measure mental skills, including decision-making
- **Self-Care tools** measure individuals' capacity to carry out everyday life-supporting tasks.
- **Lethality assessment tools** predict dangerousness
- **Trauma assessments** gauge victims' response to trauma.

Slide #47

Risk Assessment Tools: +/-

Goals (+):

- Guide investigations (what to look for and what questions to ask)
- Develop service plans
- Evaluate changes over time
- Provide objective measures on which to compare and prioritize cases.

Criticisms (-):

- Experts disagree about their effectiveness
- Time-consuming and cumbersome
- Interfere with client-worker rapport

Topic: Risk Assessment Tools: Goals

In recent years, there's been growing interest in risk assessment tools. Tools take what we know about abuse from research and practice and helps us use it to evaluate risk and plan interventions.

APS programs around the country use a wide variety of tools. Many state and local units have drawn from standardized tools to design their own.

The goals of risk assessment tools are to guide investigations; help develop service plans; help evaluate changes over time; and provide objective measures on which to compare and prioritize cases.

Criticism of risk assessment tools:

- Experts disagree about their effectiveness
- Time-consuming and cumbersome
- Interfere with client-worker rapport

Many experienced workers are very adept at evaluating risk. Some sense risk almost instinctively. These workers may think it's unnecessary or cumbersome to use tools.

Some even fear they may have negative consequences such as exposing individuals or agencies to liability if they document risks and fail to effectively stop the problem. But increasingly, experts in a wide range of professions from surgeons to pilots are recognizing that in the age of complexity, even simple checklists can save lives.

Slide #48

Specialized Tools

- IDEAL protocol (Bennett Blum)
- Self-neglect Severity Scale (SSS)(Consortium for Research in Elder Self-Neglect of Texas)
- Structured Decision Making (SDM)®
- SHIELD Assessment Tools (Texas DFPS)
- APS-TRIO (Ventura County HSA)

HANDOUT # 14
Risk Assessment and
Geriatric Assessment
Tools

Participant Manual pg 56

Topic: Specialized Tools

The risk assessment tools that most APS programs use are really hybrids of other tools. These are a few risk assessment tools that have been developed to assess various types of abuse while some have been created to assess the risk for specific forms of abuse.

- IDEAL protocol, developed by forensic and geriatric psychiatrist Bennett Blum, describes psychological and social factors that commonly co-exist in undue influence situations (American Bar Association Commission on Law and Aging, & American Psychological Association, 2008).
- Self-Neglect Severity Scale (SSS) developed by the Consortium for Research in Elder Self-Neglect of Texas takes about 5-10 minutes to administer and utilizes observer ratings, interview responses, and assesses clients' physical and environmental domains. It also assesses functional status as it relates to health and safety issues (Dyer CB, Pavlik VN, Kelly PA, Lee J, Doody RS, Regev C, Pickens S, Burnett J, Smith SM, 2006).
- Structured Decision Making (SDM) ® is a research based process designed to help APS workers assess levels of risk; clients' and families' strengths; and plan interventions. The goal is to increase consistency and accuracy when assessing vulnerable adults at critical decision points. It very specifically defines Safety and Risk. **Note:** More information on SDM ® is located in the appendix of both the trainer and participant manuals.

CONTINUED

RISK ASSESSMENT: TRAINER'S MANUAL

- SHIELD (Strategies that Help Intervention and Evaluation Leading to Decisions) assessment tools were developed and used by Texas APS. Their goal is to “promote client safety, identify strengths and needs, and reduce current and future abuse, neglect, and financial exploitation.” (Texas DFPS, (n.d.)). There are three tools: Safety Assessment; Risk of Recidivism Assessment; and Strengths and Needs Assessment
- The Adult Protective Services Tool for Risk Interventions and Outcomes (APS-TRIO) was developed and used by Ventura County, CA. The goal of the tool is to eliminate or reduce the protective issue and frames elder/dependent abuse/neglect as a process similar to disease progression, not as an event. Stages in the process include: Pre-intervention; Allegation; Response time/cross reports; Investigation/assessment; Intervention; Eliminate/reduce protective issue/decrease rate of decline; Safety Net services in place; and Recurrence (Henderson, L, (n.d.)).

Refer participants to page 56 in the participant manual **Handout #14: Risk Assessment and Geriatric Assessment Tools** for tools they can research and access on their own. More information about Structured Decision Making (SDM)[®] can be found in the appendix on page 77.

RISK ASSESSMENT: TRAINER'S MANUAL

Handout # 14 - Risk Assessment and Geriatric Assessment Tools

The following are examples of assessment tools used by APS workers.

1. Elder Mistreatment Screening Instruments are located on the University of Iowa, Department of Family Medicine Elder Mistreatment/ Elder Abuse website at <http://www.medicine.uiowa.edu/familymedicine/emscreeninginstruments/> . Tools located at this site are available for download and include:
 - Actual Abuse Tool
 - Brief Abuse Screen for the Elderly (BASE)
 - Caregiver Abuse Screen (CASE)
 - Elder Abuse Suspicion Index © (EASI)
 - Elder Assessment Instrument (EAI)
 - Health, Attitudes Toward Aging, Living Arrangements, and Finances (HALF) Assessment
 - Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST)
 - Indicators of Abuse (IOA) Screen
 - Partner Violence Screen (PVS)
 - Questions to Elicit Elder Abuse
 - Risk of Abuse Tool
 - Screen for Various Types of Abuse or Neglect (American Medical Association)
 - Suspected Abuse Tool
 - Vulnerability to Abuse Screening Scale (VASS)
 - Instrument Psychometrics Summary
2. The University of Iowa, Iowa Geriatric Education Center <http://www.healthcare.uiowa.edu/igec/tools/> provides a variety of Geriatric Assessment Tools in the following categories:
 - Caregivers
 - Dementia and Delirium
 - Depression
 - Functional Assessment / ADLs
 - Gait and Immobility / Fall Risk
 - Nutrition / Weight Loss
 - Oral Health
 - Pain
 - Pressure Ulcers
 - Sensory Perception
 - Urinary Incontinence
3. Check for Safety: A Home Fall Prevention Checklist for Older Adults on the CDC website includes good questions to ask to determine the risk of falls within the home:

RISK ASSESSMENT: TRAINER'S MANUAL

<http://www.cdc.gov/HomeandRecreationalSafety/Falls/CheckListForSafety.html>

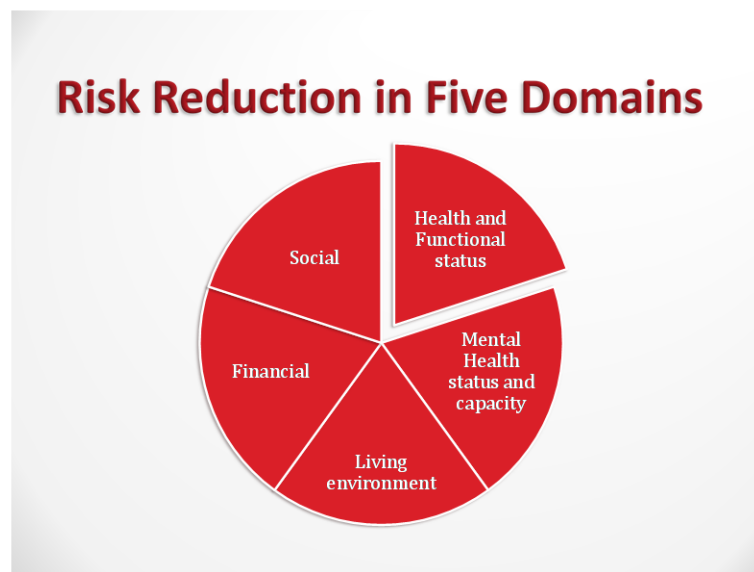
4. A variety of assessment tools are available at the Hartford Geriatric Nursing Center 'Try This' series available at:
http://www.hartfordign.org/Resources/Try_This_Series/
5. IDEAL (Isolation, Dependency, Emotional manipulation and/or Exploitation of vulnerability, Acquiescence, Loss) information about the IDEAL tool and undue influence worksheet based on IDEAL can be found at:
http://www.bennettblummd.com/coercion_undue_influence.html

DEVELOP RISK REDUCTION SERVICES PLANS



TIME ALLOTTED: 60 minutes


Slide #49



***Topic:* Risk Reduction in Five Domains**

Service plans to reduce risk and ensure safety will reflect the five domains of risk. They also reflect the level of risk, ranging from services to prevent problems from occurring to those that stop serious problems and prevent them from recurring. Workers need to stay up to date on services and legal interventions that are available in their states and communities. Interventions are discussed in greater detail in other modules.

Slide # 50



Health and Functional Capacity

Goals of service plans in this domain are to reduce the risk of:

Illness	Accidents	Dependency
Neglect	Abuse	



Flip chart activity

Topic: Health and Functional Capacity

Goals of service plans in this domain are to reduce the risk of illness, accidents, dependency, neglect, and abuse.



Ask the participants how this might be done and record the answers on the flip chart. Answers should include:

- Assess clients' ability to provide self-care
- Promote health and reduce the risk of accidental injury through health education, fall prevention strategies, etc.
- Reduce dependency by providing assistive devices
- Reduce the risk of falls or ensure that clients can get help if they do fall
- Careful screening and monitoring of workers of in-home health care providers



Ask participants what services could be put in place to mitigate risk and record the answers on the flip chart.

Point out any of the service plan elements not mentioned by the participants.

Slide # 51



Mental Health Status and Capacity

Goals of service plans in this domain are to reduce the risk or mitigate the impact of mental health problems.



Flip chart activity

Topic: Mental Health Status and Capacity

Goals of service plans in this domain are to reduce the risk or mitigate the impact of mental health problems.



Ask the participants how this might be done and record the answers on the flip chart. Answers should include:

- Reduce isolation
- Assess clients' cognitive abilities
- Treatment for depression, substance abuse
- Ensure that clients have advance directives and/or trustworthy surrogate decision-makers (powers of attorney, trusts, conservatorship/guardianship)
- Suicide prevention programs



Ask participants what services could be put in place to mitigate risk and record the answers on the flip chart.

Point out any of the service plan elements not mentioned by the participants.

Slide # 52



Flip chart activity

Topic: Living Environment

Goals of service plans in this domain are increase safety in the home.



Ask the participants how this might be done and record the answers on the flip chart. Answers should include:

- Home safety assessments
- Home repair
- Treatment for hoarding/cluttering



Ask participants what services could be put in place to mitigate risk and record the answers on the flip chart.

Point out any of the service plan elements not mentioned by the participants.

Slide # 53



Financial

Goals of service plans in this domain are to ensure that clients have adequate resources, reduce the risk of financial loss or abuse, and secure finances that in jeopardy.



Flip chart activity

Topic: Financial

Goals of service plans in this domain are to ensure that clients have adequate resources, reduce the risk of financial loss or abuse, and secure finances that in jeopardy.



Ask the participants how this might be done and record the answers on the flip chart. Answers should include:

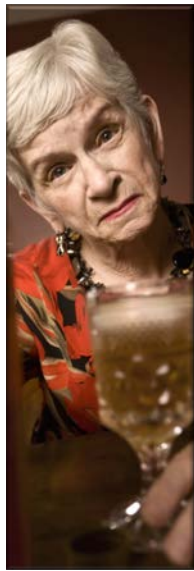
- Assess clients' ability to manage finances.
- Make sure that financial documents, identification, credit cards, etc. are secure
- Daily money management
- Freeze assets that are in jeopardy (in accordance with state law and circumstance).



Ask participants what services could be put in place to mitigate risk and record the answers on the flip chart.

Point out any of the service plan elements not mentioned by the participants.

Slide # 54



Social (including risk posed by others)

Goals of service plans in this domain are to reduce the risk of abuse and neglect by others.



Flip chart activity

Topic: Social

Goals of service plans in this domain are to reduce the risk of abuse and neglect by others.



Ask the participants how this might be done and record the answers on the flip chart. Answers should include:

- Reduce isolation through socialization programs, peer support, telephone reassurance
- Provide support to caregivers including information on respite, support groups, financial benefits, counseling
- Safety plans for those at risk of domestic abuse by a spouse, adult child, other family member, or caregiver.



Ask participants what services could be put in place to mitigate risk and record the answers on the flip chart.

Point out any of the service plan elements not mentioned by the participants.

Slide # 55



Topic: Safety Planning-The Basics

Safety planning helps people who are at risk decide what to do if they are in danger. It is often used during periods of heightened risk (e.g. after a victim has told someone about the abuse or secured an order of protection). It assumes that victims who have made plans in advance are more likely to take steps to protect themselves during crisis or trauma. They can also help break through denial about what has happened and the consequences.

NOTE: Safety planning may require addressing physical and communication barriers (e.g. older adults with mobility problems may need mobile phones).

The basic steps of safety planning include:

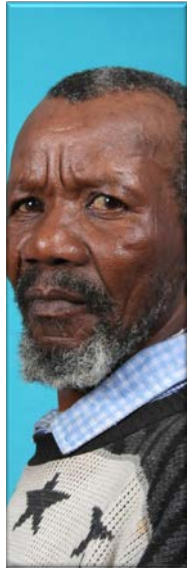
- Identifying safe contacts.
- Deciding where to go in emergencies.
- Practicing how to leave safely.
- Developing lists with phone numbers for emergency services including shelters, transportation, and home care relief workers.
- Packing a bag with clothes, important documents, and money and leaving with friends or family.
- Devising code words to use with family or friends in front of abusers to let them know that the client needs help.
- Obtaining consent to contact family members, churches, synagogues, and service providers to inform them of concerns.

CONTINUED

RISK ASSESSMENT: TRAINER'S MANUAL

Trainer Note: This topic is also covered in-depth in APS Core Module 19 - “Voluntary Case Planning”. Also, encourage participants to attend a Safety Planning class delivered by an expert in Domestic Violence to get a fuller understanding of the many complexities of safety planning.

Slide #56



Assessing Capacity to Consent to Help

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?

Topic: Assessing Capacity to Consent to Help

A primary consideration in developing service plans is whether victims are capable of giving (or refusing to give) consent. These are some of the factors we look for:

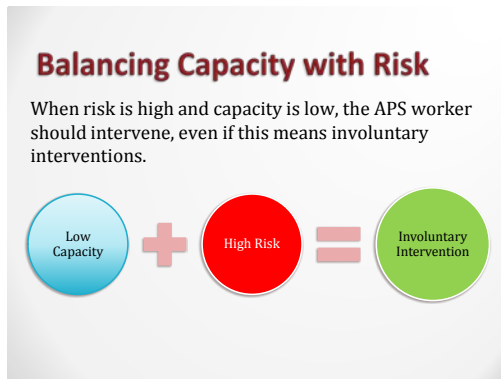
Does the client:

- 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?

RISK ASSESSMENT: TRAINER'S MANUAL

Slide # 57-59

Trainers: Provide examples from your own experience.



Topic: Balancing Capacity with Risk

Workers also need to consider the level of risk and balance it with clients' capacity.



Ask participants to work in pairs to come up with examples for the situations. Be prepared to provide examples from your own practice.

CONTINUED

RISK ASSESSMENT: TRAINER'S MANUAL

Explain that in situations that pose moderate or low risk to clients who have moderate to low capacity, the APS worker should pursue interventions that are geared toward encouraging the adult to accept services, increasing capacity, and/or reducing or eliminating risks (motivational counseling, risk reduction).

Slide #60

Case Planning Activity



- 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 # 15
Case Planning Activity

Participant Manual pg 63

Time allotted: 20 minutes

Topic: Case Planning Activity

Activity Instructions:

1. Divide the class into small groups of approximately 5 - 6 persons per group.
2. Instruct each group to assign a scribe and reporter.
3. Refer to page 63 in the participant's manual **Handout #15 – Case Planning Activity**.
4. Assign each group a case scenario
5. Allow 10 minutes for the groups to review their cases and answer the following questions
 - a. **What type of abuse do you suspect?**
 - b. **What is at risk?**
 - c. **What is the level of risk (low, medium, high)?**
 - i. **Use the 3 S's (Soon, Severe, Sure)**
 - d. **What services or supports can be employed to reduce or eliminate the risk(s)?**
6. Large group debrief of cases for 5-10 minutes.

CONTINUED

Talking Points:

- Case 1 should be considered high risk as Mr. Parks has deficits in all 5 risk domains and has already had a kitchen fire and a fall. May be able to work with daughter and neighbor in case planning as they are present although inconsistent support.
- Case 2 should be considered high risk as physical abuse and possibly neglect have occurred. Mrs. Fairbanks daughter has admitted striking her mother on several occasions out of frustration and the home is not set-up to keep Mrs. Fairbanks from wandering at all hours. May be able to work with daughter and other children to access caregiver training, home care, day programs and/or placement.
- Case 3 should be considered high risk – make sure to discuss lethality issues and questions; safety planning; and partnering with domestic violence advocates.

HANDOUT #15 – Case Planning Activity

Case Scenario I

An APS worker 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 worker 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)?**

Case Scenario 2

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 in the morning. 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 had Alzheimer's disease and often wandered 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)?**

Case Scenario 3

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)?**

CLOSING AND EVALUATIONS



TIME ALLOTTED: 30 minutes

Slide #61

Innovations & Changes in APS

Stay informed!

- Join community forums, including multidisciplinary teams, elder abuse prevention coalitions, and task forces.
- Subscribe to journals, newsletters, listservs
- Suggest to supervisors that resources and new services be brought up at staff meetings, posted on bulletin boards, etc.
- Attend trainings and webinars

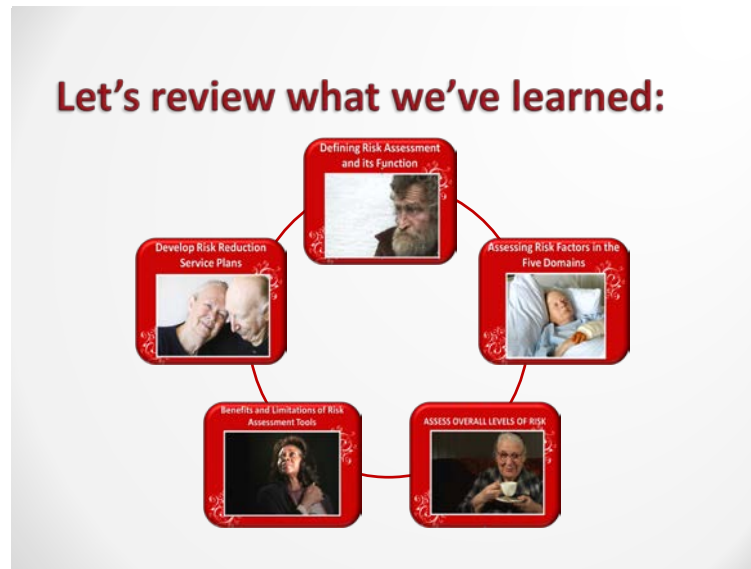
National Adult
Protective
Services
Association
(NAPSA)
napsa-now.org

National Center
on Elder Abuse
(NCEA)
ncea.aoa.gov

Topic: Keep up with innovations and changes in the field

Workers should stay apprised of new services and resources in their communities. This can be done by participating in community forums, such as multidisciplinary teams, attending trainings and webinars on promising practices, subscribing to the National Center on Elder Abuse's Newsletter and Listserv, or joining professionals organizations like the National Adult Protective Services Association (NAPSA).

Slide #62



Topic: Review

Review briefly each of the sections that were covered and ask the participants what they will be taking away about that section.

Trainer Note: Below are the highlights from each of the areas covered in today's training module.

1. Defining Risk Assessment and its Function

- a. Risk assessment is an analysis that uses information from investigations, research, and practice experience, to:
 - Help workers protect clients' safety, health, independence, and rights
 - . Help managers optimize resources and ensure quality, effectiveness, efficiency, and fairness.
- b. Risk Levels and the 3 S's
 - How **S**oon might the client be harmed?
 - How **S**evere might the harm be?
 - How **S**ure are you that the harm will occur? (likelihood)
- c. Phases of Risk Assessment
 - Initial Assessment and Emergencies
 - Case Planning
 - Reassessments and Case Closure

CONTINUED

2. Assessing Risk Factors in the Five Domains

- a. The Five Domains
 - Health and Functional Status
 - Mental Health status and capacity
 - Living environment
 - Financial
 - Social
- b. Evaluate indicators and risk factors in each domain
 - **Risk factors** are conditions which put a person at risk to harm. Factors may apply to victims, perpetrators, or others
 - **Indicators** are the observable signs, things you can see or hear, that indicate that risk may be present.
There are 3 types: physical, behavioral, environmental

3. Assessing Overall Levels of Risk

- a. Using the 3 S's
- b. Assess emergencies in the 5 domains

4. Benefits and Limitations of Assessment Tools

- a. Benefits
 - Guide investigations (what to look for and what questions to ask)
 - Develop service plans
 - Evaluate changes over time
 - Provide objective measures on which to compare and prioritize cases.
- b. Limitations
 - Experts disagree about effectiveness
 - Time-consuming/cumbersome
 - Interfere with rapport building
- c. Types
 - Functional assessment tools
 - Cognitive assessment tools
 - Self Care tools
 - Lethality assessment tools
 - Trauma assessments

5. Develop Risk Reduction Service Plans

- a. Service plans reflect 5 domains of risk
- b. Service plans address the levels of risk


Slide # 63

Evaluation

Just a few final tasks...

- Post Test
- Training Satisfaction Survey

Thank you!



HANDOUT #16
Risk Evaluation Case Study

Participant Manual pg 69

Time allotted: 20 minutes

Topic: Evaluations

Ask the participants to complete the post test and the training Satisfaction survey.

Instructions for the Evaluation of Risk Case Study Post-test:

- Remind the participants that the purpose of the Post test is to determine whether the module was effective in teaching the learning objectives. It is the course that is being evaluated, NOT the participants. No one will be given their scores.
- Have the participants remove the **answer sheet, found on page 68** of the Participant Manual (Trainer Manual page 120). The Answer sheet will be turned in at the end of the post test but before the post test is debriefed.
- Refer participants to **Handout # 16 - Risk Evaluation Case Study** (Participant Manual page 69; Trainer Manual page 121).
- Participants are to read the Initial report and answer the first 3 questions on the answer sheet BEFORE turning to the second page. Answers are recorded by circling the letter corresponding with the correct answer. The reason they are not to turn the page is because, on the "Interview with Mrs. Lai" page, they will get additional information that could inform their decisions.

Participants are to read "Interview with Mrs. Lai" and answer questions 4 - 7 BEFORE reading the final section "Interview with Mrs. Lai and Cara two weeks later" and answering questions 8 - 9.

CONTINUED

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- Once they have record their answers in each section on the answer sheet, they can move on to the remaining section and questions.
- Once everyone has completed and turned in their answer sheets, debrief the post test. Ask participants to discuss their decisions.

Then remind participants to complete the Training Satisfaction Survey. (Please pass this form out as it is NOT in the Participant Manual). And, thank them for their attention and their participation.

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Trainee ID Code

--	--	--	--	--	--	--	--

Date

		/			/		
M	M		D	D		Y	Y

Evaluation of Risk - Answer Sheet

Please read the following case and answer the questions regarding risks to the client. You may refer to your participant materials if you would like.

Please circle the correct answer below and turn this answer sheet in at the end of the evaluation period.

Question 1	a	b	c	d	e	f
Question 2	a	b	c	d		
Question 3	a	b	c	d	e	
Question 4	a	b	c	d	e	
Question 5	a	b	c			
Question 6	a	b	c	d	e	
Question 7	a	b	c	d		
Question 8	a	b	c			
Question 9	a	b	c			

HANDOUT #15 - Risk Evaluation Case Study

Initial Report:

You receive a report at 3:00 pm on a Friday afternoon. The report comes from Mrs. Allen who states that her neighbor, Mrs. Lai, has a very odd 3 inch diameter circular bruise on her shoulder. Mrs. Lai has mild Parkinson's, her hands shake pretty badly but she ambulates alone. Mrs. Allen is sure that the bruise is definitely not "natural". Mrs. Allen isn't sure if there are other bruises. According to Mrs. Allen, Mrs. Lai says that her daughter, Cara, who lives with her in a small apartment, did it to "make her be better". Mrs. Allen says that she often hears Mrs. Lai and Cara raising their voices at each other but she doesn't know what they are fighting about because she doesn't speak Vietnamese. Except for the bruises, Mrs. Allen says that she thinks that Cara is taking pretty good care of her mother. Cara took Mrs. Lai to the doctor last week for a very bad cold and seemed to be very attentive to her. Mrs. Allen says that Mrs. Lai has limited English proficiency so you should probably bring a Vietnamese interpreter when you come.



1. Based on the report, what is the risk to Mrs. Lai?
 - a. Physical abuse
 - b. Mental suffering
 - c. Neglect
 - d. Physical abuse and mental suffering
 - e. Abandonment
 - f. There is no risk in this report
2. What is the worst possible outcome resulting from this risk?
 - a. She may experience permanent harm as the result of this risk.
 - b. She may experience temporary harm of a serious nature as the result of this risk.
 - c. She may experience mild or temporary harm as a result of this risk.
 - d. There is no risk in this report.
3. How soon do you think you should investigate this case, given the risk to Mrs. Lai?
 - a. Immediately
 - b. Within the next 24 hours
 - c. First thing on Monday morning
 - d. Within the next ten days
 - e. No investigation is needed

STOP HERE - DO NOT GO ON UNTIL YOU HAVE ANSWERED THESE QUESTIONS



Interview with Mrs. Lai:

A Vietnamese speaking co-worker accompanies you on the interview. You are greeted at the door by Mrs. Lai who is clean and neatly dressed. She invites you in and tells you that her daughter is at work. You explain, through the interpreter, that you are concerned that she has bruises and ask if you can see them. Reluctantly, she shows you her bruises. To the left is a photograph of the bruises on Mrs. Lai's back. Mrs. Lai states, through the interpreter, that the bruises are the result of a medical treatment called "cupping". Mrs. Lai's daughter took her to a community based practitioner to help her "get her blood moving". There are no other bruises on her body.

You ask Mrs. Lai what kinds of assistance she needs with her personal care and she states that her daughter, Cara, helps her with dressing and bathing. Her daughter does all the housework, shopping and laundry. Cara also takes her to the doctor regularly. Mrs. Lai seems very pleased with the care and attention she receives from her daughter, bragging about how lucky she is to have such a good daughter.

You ask Mrs. Lai what kind of social life she has and Mrs. Lai gets very quiet. Mrs. Lai says that she no longer sees any of her friends or family because of her Parkinson's disease. She is an "embarrassment to her family" because she "eats very messy" and can't stop shaking. No one else in the family will come to see her and, when they come to see her daughter, she stays in the back bedroom.

While you are talking to Mrs. Lai, her daughter Cara returns home. At first she is very upset that Mrs. Lai has let strangers into the home, calling her a "stupid old woman" according to the interpreter. However, she quickly changed her tone when she realizes that your co-worker speaks Vietnamese. You explain that there was concern about her mother's bruises and Cara tells you the name and contact information of the practitioner who performed the cupping. The practitioner confirms that cupping is a culturally accepted medical practice. You ask Cara about her mother's social life and she assures you that Mrs. Lai is welcome to participate in family gatherings. However, Mrs. Lai is old fashioned and believes herself to be an embarrassment. The younger members of the family don't feel the same way. You ask Mrs. Lai if she would like family members to talk to her every day on the telephone. Mrs. Lai liked the idea. You arrange with Cara for various family members, on a rotating basis, to have daily telephone contact with Mrs. Lai so she doesn't feel so left out.

4. Based on this contact, what is the risk to Mrs. Lai?
 - a. Physical abuse
 - b. Mental suffering

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- c. Neglect
 - d. Physical abuse and mental suffering
 - e. There is no risk
5. Do you think that you need to keep the case open for on-going protective services?
- a. Yes
 - b. Need to talk to other family members before making that decision.
 - c. No
6. How likely do you think it is that Mrs. Lai will experience future harm?
- a. Very likely
 - b. Somewhat likely
 - c. Somewhat unlikely
 - d. Very unlikely
 - e. Unsure
7. Based on the limited information presented here, do you believe that Mrs. Lai is able to assist in the development of her care plan?
- a. Yes
 - b. There is currently no evidence to the contrary, so yes
 - c. It is questionable and more information is needed
 - d. No

STOP HERE DO NOT GO ON UNTIL YOU HAVE ANSWERED THESE QUESTIONS

Interview with Mrs. Lai and Cara two weeks later:

Your supervisor asks you to return to Mrs. Lai's home two weeks later to check on her status. When Mrs. Lai lets you and the interpreter in, she looks happy. She says that she has been getting daily calls from family members and old friends. Yesterday, an old friend from her home town in Vietnam came to visit her for the first time in 5 years. Her friend made it clear that she didn't care about the Parkinson's symptoms and that she had missed Mrs. Lai's company. The friend has promised to return regularly. Mrs. Lai also says that, because she has "news" to discuss with her daughter, she doesn't feel like she is so much work for Cara.

8. Based on this limited information, do you feel that Mrs. Lai is at higher or lower risk than when you first saw her?
 - a. Higher risk
 - b. The same
 - c. Lower risk
9. Do you believe that changes are needed to Mrs. Lai's care plan?
 - a. Yes
 - b. Not at this time but may be needed in the future
 - c. No

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Texas Department of Family and Protective Services: 2400 shield assessment tools information available at:

http://www.dfps.state.tx.us/handbooks/aps/files/APS_pg_2400.asp#APS_2410

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APPENDIX



**Structured Decision Making®
Special Bulletin
Adult Protective Services Program
APS Best Practices**

- Over 500,000 incidents of adult maltreatment occur in the United States each year.
- A 2004 study of state Adult Protective Services (APS) programs showed a 61% increase in the number of adult maltreatment reports since 2000 (Teaster et al. 2006)
- Breaking down the complexity of APS interventions into key decision points can increase consistency and accuracy in the assessment of vulnerable adults.
- With a reliable and valid method of discerning which clients are at the highest risk for future maltreatment, APS agencies can more effectively manage limited resources.

APS agencies provide social services and legal aid to adults who need assistance to defend or care for themselves (Otto, 2000). A primary task of these agencies is to respond to allegations of maltreatment, including abuse (physical, emotional, and sexual), financial exploitation, neglect by another person, and self-neglect. State APS agencies vary in terms of the extent of service provision beyond initial investigation, which is more often than not defined by state law. But while APS policies and procedures may differ, all APS agencies face very similar case management decisions. For example, as part of their investigations, APS workers must evaluate the current safety of their clients as well as the risk to their clients' future well-being.

APS workers' decisions are made more difficult by limited resources and increasing caseloads. For instance, workload does not allow for the immediate investigation of every abuse and neglect report. A worker and/or supervisor must decide, often based on little information, if an investigation must be conducted immediately to prevent imminent harm to an adult. Similarly, APS staff must decide which adults should be offered services in a manner that makes the most effective use of existing resources. Identifying adults who are at high risk of subsequent involvement with APS agencies may help workers target engagement efforts more effectively towards those adults most in need of long-term services.

The Benefits of Structuring Decisions in APS

Decades of research support the conclusion that, for complex decisions, structured frameworks result in more reliable and accurate decisions than clinical judgment alone, even for highly skilled professionals. Decisions in adult protection are among the most complex in the social services field, given difficulties in reliably assessing older adults' capacity for decision making (Braun, Gurrera, Karel, Armesto, & Moye, 2009) and ethical dilemmas raised when adults refuse services (Killick & Taylor, 2009).

Given these complicating factors, APS agencies are recognizing the value of structured assessment tools to guide key decisions at critical points in their involvement with a client. Structuring these decisions can lead to valid and reliable decision making and ultimately help an APS agency identify its most vulnerable clients. Interventions can then be targeted to individuals who may need them most.

The SDM® System for APS

RISK ASSESSMENT: TRAINER'S MANUAL

The simple notion of directing resources to those clients most in need of them is at the heart of the decision-support model known as the Structures Decision Making® (SDM) system. Currently, the National Council on Crime and Delinquency (NCCD) is working with three U.S. jurisdictions to develop and implement SDM® assessments to support the work of APS practitioners. This work is based on over 20 years of experience in developing structured decision-support processes in social services. Based on a national model of best practices, the SDM system is intended to promote the safety of vulnerable adults, identify and address their needs, decrease the incidence of self-neglect and maltreatment, enhance service delivery, and provide data needed for program administration. The SDM system for APS includes assessments, definitions, and policies and procedures to assist APS staff in performing intakes, investigations, and case planning by providing a consistent approach to obtaining evaluating information.

One of the central principles of the SDM system is identification and differentiation of decision points. APS workers make critical decisions based on limited information, they must decide whether the adult maltreatment reports they receive should be investigated, how quickly an investigation should be initiated, whether there are safety concerns, and whether to offer protective services at the close of each investigation. An assessment focused on a specific decision is more likely to be concise, which may increase the assessment's reliability and field utility (Bonnie & Wallace, 2003).

The goal of this approach is increased consistency and accuracy when assessing vulnerable adults at critical decision points during APS involvement. Using this approach can help workers accurately identify clients at highest risk and focus resources on them, increasing the efficiency of APS operations. Use of structures assessments also provides data that managers can use to monitor practice and evaluate service provision.

A Research-based Approach to APS

Breaking down the complexity of APS work into critical decision points and applying structured assessments accordingly creates a decision-support framework for caseworkers that can increase consistency and equity in service delivery recommendations and improve outcomes for clients. Essentially, research-based risk assessment will provide APS agencies with 1) an evidence basis for determining which clients are at greatest risk for future harm, 2) data that can be shared with community partners and government bodies to advocate for increased resources, and 3) mechanisms to evaluate staffing levels and caseworker workload distribution based on assessed risk levels on individual cases. Using a research-based risk assessment instrument that can validly classify investigated adults by their likelihood to future maltreatment enables APS agencies to make informed policy and practice decisions about how to direct and utilize limited resources on behalf of the adults who need them most.

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