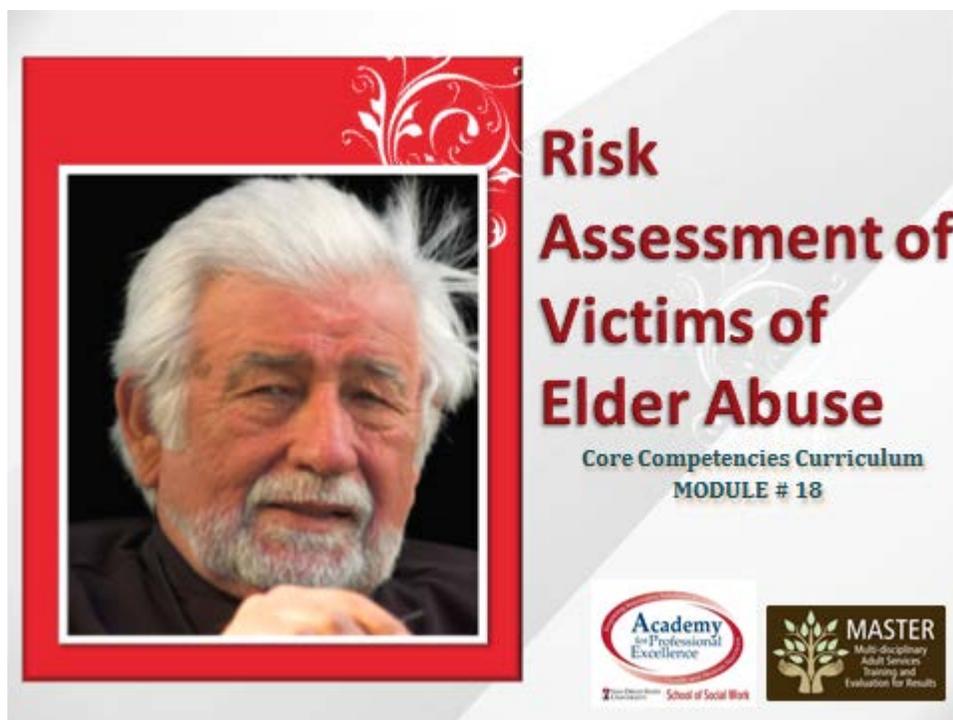


RISK ASSESSMENT OF VICTIMS OF ELDER ABUSE

PARTICIPANT MANUAL



MODULE 18

PARTICIPANT 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 an Archstone Foundation funded 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 their victims. 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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This training is the result of a collaborative effort between Adult Protective Services administrators, supervisors, staff development officers and workers across the State of California 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
Imperial County Department of Social Services
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

Regional Curriculum Advisory Committee

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Brenda Pebley, APS Manager, Imperial County
Carol Castillon, APS Supervisor, San Diego County
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Zachery Roman, Staff Development Officer, Los Angeles County

Committees

Project MASTER Steering Committee
APS Core Curriculum Committee
National Adult Protective Services Association Education Committee
Protective Services Operations Committee of the California Welfare Directors Association

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James Coloma, Evaluation Consultant
Jane Berdie, Evaluation Consultant
Cynthia Parry, Evaluation Consultant

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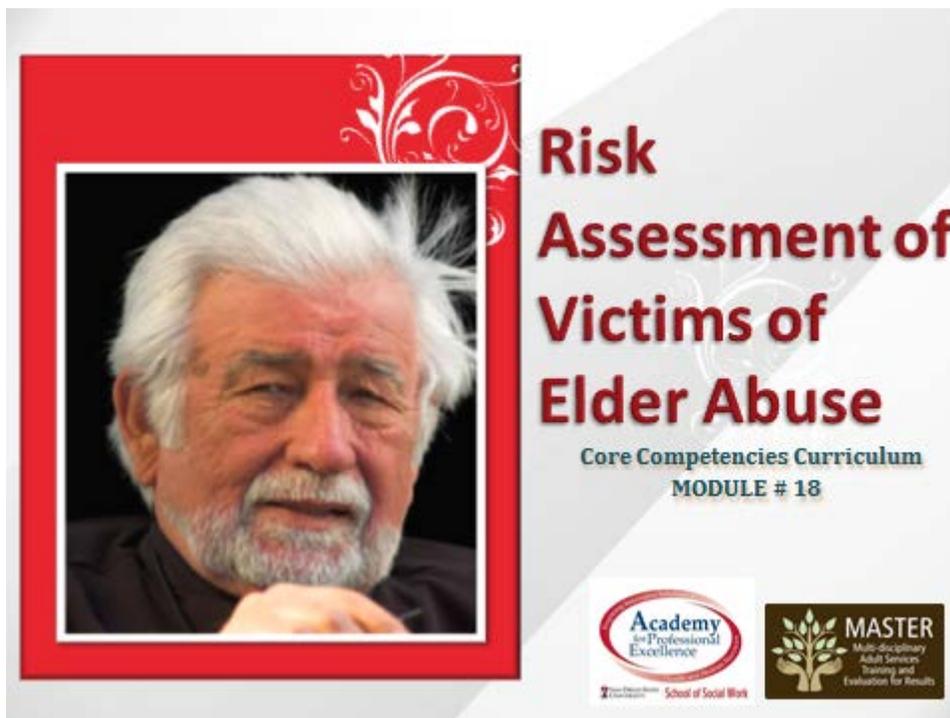
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COURSE OUTLINE

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.

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)

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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.*

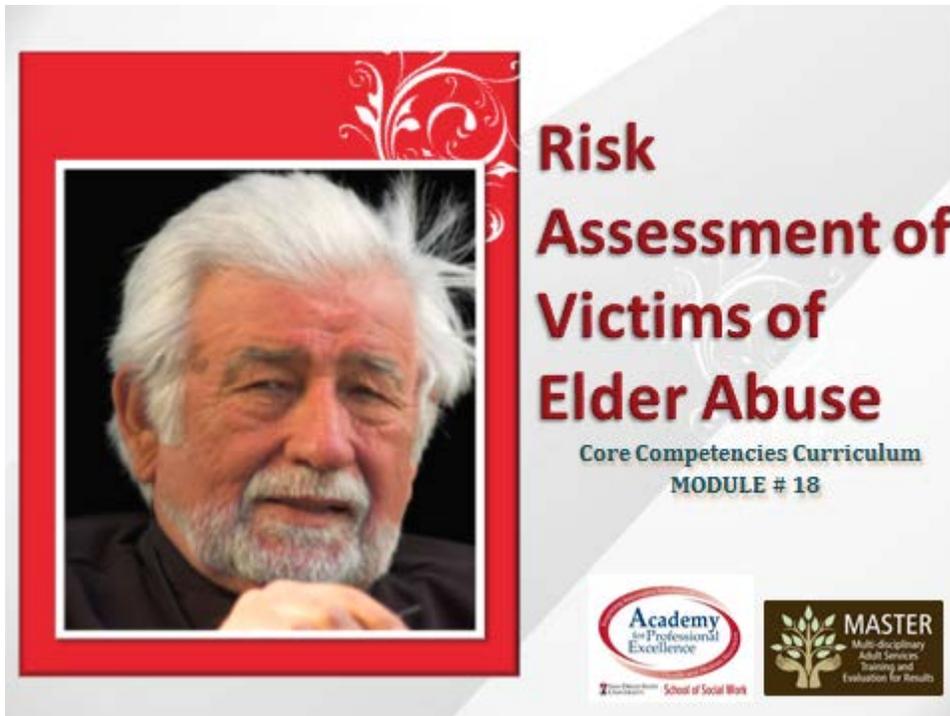
BEFORE the training

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



**Risk
Assessment of
Victims of
Elder Abuse**

Core Competencies Curriculum
MODULE # 18

Academy
for Professional
Excellence
School of Social Work

MASTER
Multi-disciplinary
Adult Services
Training and
Evaluation for Results

WELCOME AND INTRODUCTIONS



TIME ALLOTTED: 15 minutes

Slide #2:

This training was produced by the Academy for Professional Excellence under 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.



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

This training is a pilot and the materials are not intended for dissemination at this time.

2

Slide #3

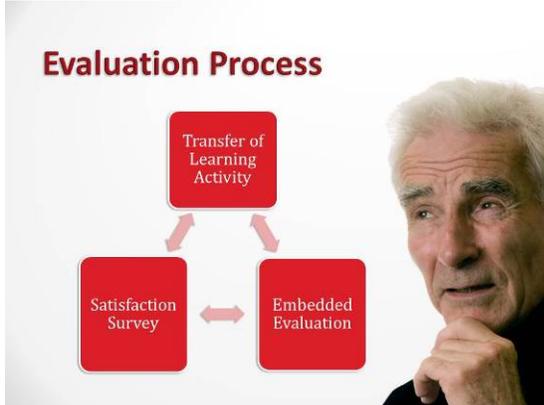
Housekeeping and Introductions

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



3

Slide 4



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 **29th**

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

5

RISK ASSESSMENT - PARTICIPANT 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 an embedded skills evaluation within the training day. This embedded skills evaluation will take about 15 minutes. You will be asked to determine what types of questions are being asked in a written interview.

This evaluation has 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 getting its points across.

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 a questionnaire administered before and after the training. The questionnaire 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

RISK ASSESSMENT - PARTICIPANT MANUAL

that will be able to accurately assess the effectiveness of adult protective service training. It is hoped that these tools will assist the Academy for Professional Excellence in improving training for adult protective service workers and therefore improve services to adults and families in California.

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 questionnaire, 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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RISK ASSESSMENT - PARTICIPANT 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:

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: 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?
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.

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.

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.

Slide #9



Slide #10



RISK ASSESSMENT - 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

RISK ASSESSMENT - PARTICIPANT MANUAL

Slide #11

When are Risk Assessments Conducted?

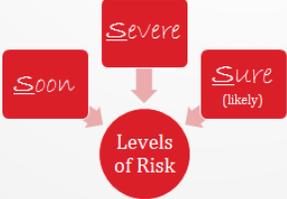
-  During initial phone contact
-  After first face to face interview
-  At substantiation
-  During the early stages of case planning
-  Periodically to identify changes and new needs
-  At case closure

Slide #12

Levels of Risk & the 3 S's

Levels of Risk → Low, Medium, High

3 S's of Risk:



```
graph TD; S[Soon] --> LR((Levels of Risk)); Se[Severe] --> LR; Su[Sure (likely)] --> LR;
```

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 **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)

Mr. K's Level of Risk?

Slide #13



RISK ASSESSMENT - PARTICIPANT 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**)

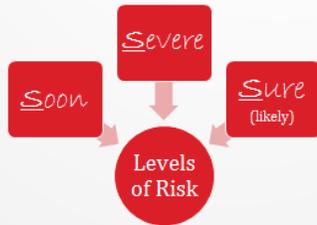


Slide #15

Activity: Mrs. Anderson

Levels of Risk → Low, Medium, High

3 S's of Risk:



RISK ASSESSMENT - PARTICIPANT 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



RISK ASSESSMENT - PARTICIPANT 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?

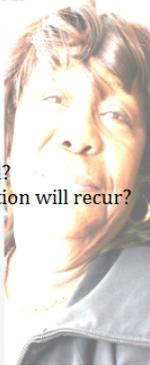
Mrs. Anderson’s level of risk?

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 (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 4 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?

Slide #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.



ASSESS RISK FACTORS IN FIVE “DOMAINS”



TIME ALLOTTED: 60 minutes

Slide #19

Risk: Indicators vs. Factors

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

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

Slide #20

Types of Indicators:



Physical



Behavioral



Environmental



RISK ASSESSMENT - PARTICIPANT 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

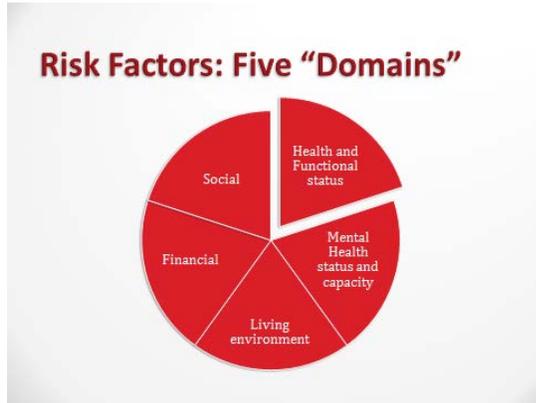
- Caregivers who seem angry or resentful of caring for the older adult
- Caregivers who are over-taxed with responsibilities
- Older adults who seem fearful of caregivers
- Older adults who make excuses for caregiver behavior
- Caregivers take older adults to several different hospitals or emergency 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 #21



RISK ASSESSMENT - PARTICIPANT MANUAL

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 - PARTICIPANT 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 - PARTICIPANT 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. B., Resnick, H. S., Steve, K., Muzzy, W., et al. (2010).)



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).)

It is important to discuss past trauma with clients. The “Briefest Screen Ever” was 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?

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.

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?

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?

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?



Example

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

Risk Indicator(s):

Risk Factor(s):

Possible harm:

Slide #27

Factors that Mitigate Risk



Client's strengths, resiliency, and motivation

Interpersonal relationships

Support networks

Slide #28

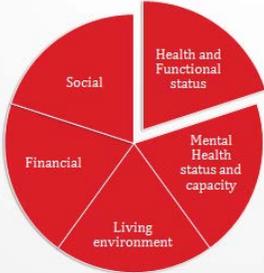
Caveats

- Cultural variations
- How clients view their situations



Slide #29

Assessing Risk in Five "Domains"



Health and Functional status

Mental Health status and capacity

Living environment

Financial

Social

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?



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).



Slide #32

Activity: Assessing Risk in Five Domains



RISK ASSESSMENT - PARTICIPANT MANUAL

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?

RISK ASSESSMENT - PARTICIPANT MANUAL

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?

RISK ASSESSMENT - PARTICIPANT MANUAL

- 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

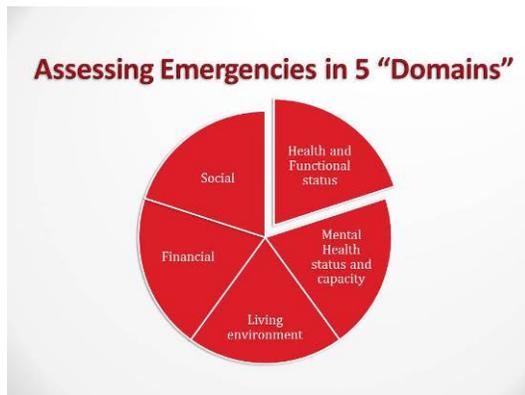


TIME ALLOTTED: 105 minutes

Slide #33



Slide #34



Slide #35



Activity:
Assessing Emergencies in 5 Domains

Slide #36



Medical Emergencies

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

Slide #37



APS Workers Role

- Recognize signs and symptoms
- Arrange for emergency care
- Provide information
- Alert medical professionals to concerns about abuse and neglect

RISK ASSESSMENT - PARTICIPANT 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	Older adults (people aged 65 years and older) are more prone to heat stress than younger people for several reasons: <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

RISK ASSESSMENT - PARTICIPANT MANUAL

	<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

RISK ASSESSMENT - PARTICIPANT 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?

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.

Slide #41



Financial Emergencies

- Insufficient funds to meet critical needs
- The offender has access to finances through a POA, contract, or checks.
- 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.

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?

RISK ASSESSMENT - PARTICIPANT 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

BENEFITS AND LIMITATIONS OF RISK ASSESSMENT TOOLS



TIME ALLOTTED: 15 minutes

Slide #45

“We live in an age where form-filling, clipboard-wielding rule enforcement is assumed to be the enemy of effectiveness. But that is the product of box-ticking gone bad. The right kind of checklist liberates rather than stifles professional intuition.”

Atul Gawande, author of “The Checklist Manifesto.”

Slide #46

Types of Assessment Tools

- Functional assessment tools**
- Cognitive assessment tools**
- Self Care tools**
- Lethality assessment tools**
- Trauma assessments**

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

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

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)

RISK ASSESSMENT - PARTICIPANT MANUAL

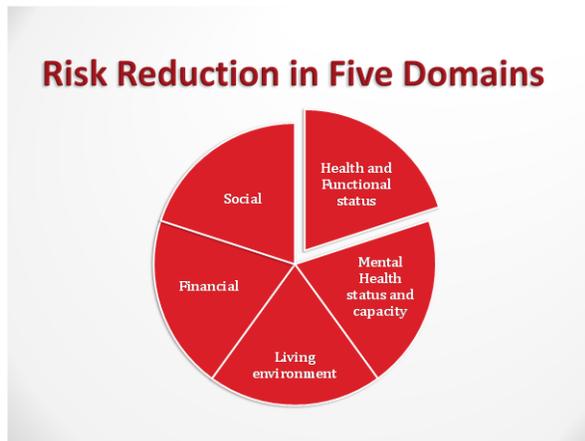
- Indicators of Abuse (IOA) Screen
 - Partner Violence Screen (PVS)
 - Questions to Elicit Elder Abuse
 - Risk of Abuse Tool
 - Screen for Various Types of Abuse or Neglect (American Medical Association)
 - Suspected Abuse Tool
 - Vulnerability to Abuse Screening Scale (VASS)
 - Instrument Psychometrics 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:
<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



Slide #50

Health and Functional Capacity

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

- Illness
- Accidents
- Dependency
- Neglect
- Abuse

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.

Slide #52



Living Environment

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

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.

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.

Slide #55

Safety Planning- The Basics



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?

Slide #57

Balancing Capacity with Risk

When risk is high and capacity is low, the APS worker should intervene, even if this means involuntary interventions.

A diagram showing a blue circle with 'Low Capacity', a red circle with 'High Risk', and a green circle with 'Involuntary Intervention'. A plus sign is between the first two circles, and an equals sign is between the second and third circles.

Slide #58

Balancing Capacity with Risk

When clients' capacity is high, their decisions must be respected even if the risk is high

A diagram showing a blue circle with 'High Capacity', a red circle with 'Any Level of Risk', and a yellow circle with 'No Intervention without consent'. A plus sign is between the first two circles, and an equals sign is between the second and third circles.

Slide #59

Balancing Capacity with Risk

When clients' capacity is in question or moderate, the level of risk needs to be taken into account.

A diagram showing a blue circle with 'Capacity' and a question mark below it, a red circle with 'Any Level of Risk', and a red circle with 'Risk Determines Intervention'. A plus sign is between the first two circles, and an arrow points from the second circle to the third.

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

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

Slide #62

Let's review what we've learned:



Slide #63

Evaluation

Just a few final tasks...

- Post Test
- Training Satisfaction Survey



Thank you!

RISK ASSESSMENT- PARTICIPANT MANUAL

Trainee ID Code

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

Date

		/			/		
M	M		D	D		Y	Y

Evaluation of Risk

Please read the following case and answers 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

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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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