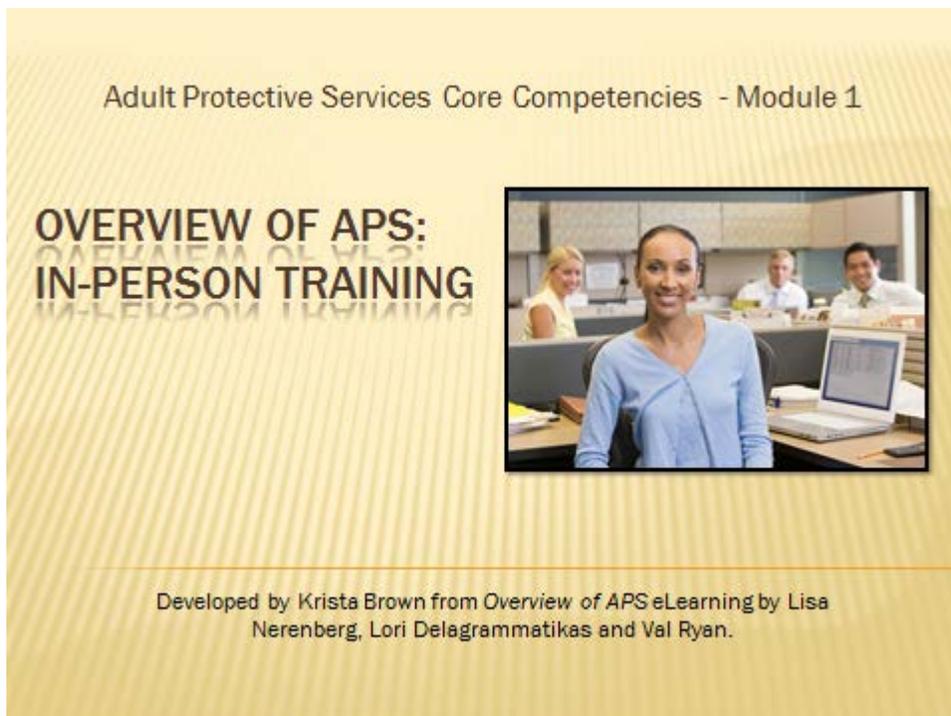


Overview of Adult Protective Services In-Person Training

TRAINER'S MANUAL



MODULE 1 HALF-DAY TRAINING

OVERVIEW OF APS: TRAINER'S MANUAL

TRAINER'S MANUAL

OVERVIEW OF ADULT PROTECTIVE SERVICES

HALF-DAY TRAINING



Developed by Krista Brown from *Overview of APS* eLearning by Lisa Nerenberg, Lori Delagrammatikas and Val Ryan (2010).

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OVERVIEW OF APS: TRAINER'S MANUAL

INTRODUCTION

The Adult Protective Services (APS) Training Project, comprised of the California Regional Training Academies, worked to identify training needs, priorities and emerging issues among county Aging & Adult Services staff - with an emphasis on APS and In-Home Support Services (IHSS) training priorities. The Project worked in numerous partnerships to develop APS training curriculum and deliver core and specialized training to enhance the skills and knowledge of county social workers who serve vulnerable seniors and adults with disabilities within the State of California.

The APS Training Project's overarching goal was to develop and deliver statewide, standardized core curricula for new APS/IHSS social workers and to share these trainings on a national scale through partnerships with the National Adult Protective Services Association (NAPSA). Professional training opportunities are a critical step toward ensuring APS social workers have the appropriate tools to serve their clients.

To date, there are 23 APS Core Modules recognized as a national standard. These modules are available in a variety of modalities (in-class, eLearning, Supervisor Workbooks, Webinar, etc.) and can be accessed at <http://theacademy.sdsu.edu/programs/master/core-curriculum/>.

The Project is a founding member of the National APS Training Partnership with NAPSA.

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 CA Regional Training Academy staff members. Thank you to the following individuals and agencies:

Agencies

National Adult Protective Services Association (NAPSA)
California Department of Social Services, Adult Services Branch
California Social Work Education Center Aging Initiative

Committees

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

OVERVIEW OF APS: TRAINER'S MANUAL

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HOW TO UTILIZE 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 Power Point:

It is recommended that you teach the curriculum as developed. However, you may also need to include program specific policies and procedures which may involve the addition of custom slides or a change in the timing of the course. The curriculum is set up to make this possible.

Once you decided on how you want to divide up your time in presenting this material, you may want to customize your Power Point. The Microsoft Office Power Point 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 Power Point slide making it easy to also customize your manual to match the slides you have decided to use, Just remove the unneeded pages.

OVERVIEW OF APS: TRAINER'S MANUAL

COURSE OUTLINE

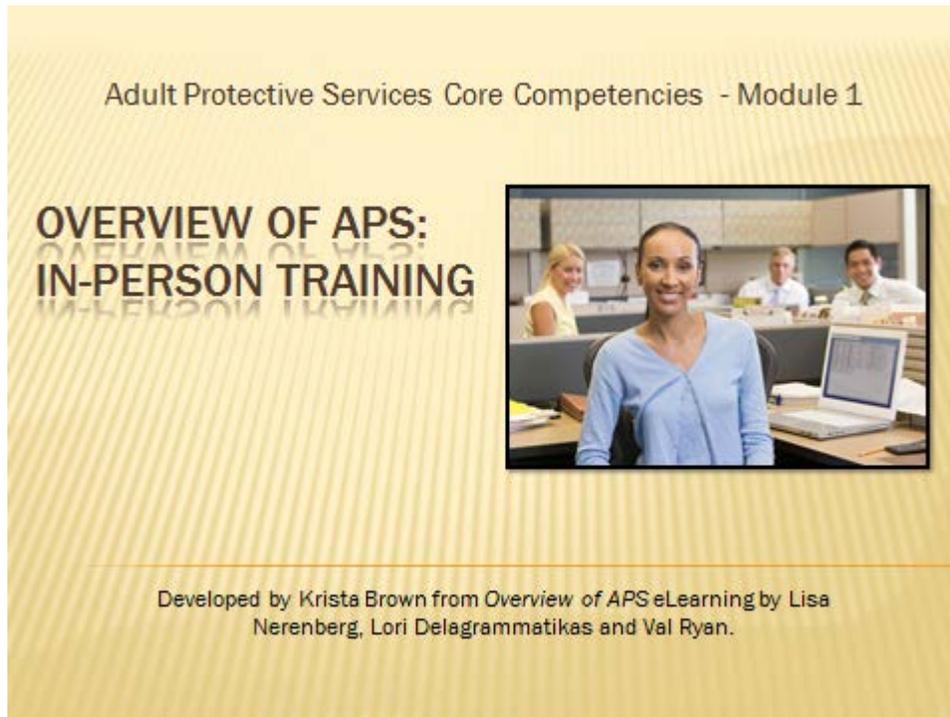
Content	Total Time	Activities	Slides/Handouts
Welcome, Introductions, Learning Objectives	15 min	Lecture Optional Pre-Test	Slides 1-6 Handouts 1-5
APS History & Practice Principles	15 min	Lecture/Discussion	Slides 7-10
APS Mandates & Clients	45 min	Lecture/Discussion	Slides 11-22 Handouts 6
Break	15 min		
Responding to Abuse Reports	60 min	Lecture/Discussion Videos Small & Large Group Activities	Slides 23-39 Handouts 7
Factors for Case Planning	60 minutes	Lecture/Discussion Small & Large Group Activity	Slides 40-48 Handouts 8-13
Closing: Q & A and Evaluations	30 minutes	Q & A Optional Pre-Test Review Evaluations	Slide 49 Evaluations

Total Time: 4 Hours

Course Timeline

9:00am	Welcome, Intro, Overview, Learning Objectives, Opt. Pre-Test
9:15	APS History & Practice Principles
9:30	APS Mandates & Clients
10:15	Break
10:30	Responding to Abuse Reports
11:30	Factors for Case Planning
12:30	Q and A, Evaluations
1:00	End

TRAINING GOALS AND OBJECTIVES



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

1. Describe APS Clients.
2. Explain APS worker's roles and responsibilities including APS practice principles and service goals.
3. Evaluate simple APS referrals.
4. Develop a basic case plan.
5. Apply key terminology used in APS.

OVERVIEW OF APS: TRAINER'S MANUAL

TRAINER GUIDELINES

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◆ Video clips◆ Participant guide (encourages self-questioning and interaction with the content information.◆ Embedded pre/post evaluation to assess training content and process (optional).
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◆ Video: <i>When Help Was There: Four Stories of Elder Abuse</i>. To buy DVD - \$169 / To rent DVD \$55. Terra Nova Films - http://terranova.org/film-catalog/when-help-was-there-four-stories-of-elder-abuse/◆ 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

NOTE: This training was designed as an orientation to APS - to help workers get started by describing the clients served, their role as APS workers, how to evaluate referrals, and develop case plans. You will need to collect agency specific information (regulation, etc) before delivering this training. Segments written in blue indicate areas where you will need to do research about the policies and procedures specific to your agency or jurisdiction.

GUIDE FOR THE COURSE ORGANIZER

This half-day training is recommended for new workers or workers needing remediation. This module should be presented to a small class of no more than 30 participants. Seating should be in small groups of 4-6 people to facilitate small group activities.

BEFORE the training, you may want to **send the Executive Summary** to each participant's supervisor to inform them about what the worker will learn in the course and to encourage them to promote transfer of learning activities.

Note: there is a 90 minute eLearning training on APS Overview eLearning available. Both the half day eLearning trainings meet the NAPSA Core Competency requirements.

EXECUTIVE SUMMARY

HANDOUT #1

Course Title: *Overview of APS – Half-Day In-Person Training*

APS workers need to have an understanding of the job they are expected to perform. This includes knowing who their clients are, under what circumstances they are expected to intervene, and what interventions they are expected to provide.

The following instructional strategies are used: lecture segments; interactive activities/exercises (e.g. small group discussion, case studies); question/answer periods; PowerPoint slides; video clips; participant guide (encourages self-questioning and interaction with the content information); and embedded pre/post evaluation to assess training content and process.

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.

Target Audience:

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

Outcome Objectives for Participants:

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

1. Describe APS Clients.
2. Explain APS worker's roles and responsibilities including APS practice principles and service goals.
3. Evaluate simple APS referrals.
4. Develop a basic case plan.
5. Apply key terminology used in APS.

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

OVERVIEW OF APS: TRAINER'S MANUAL

BEFORE the training

Supervisors can encourage line staff to attend the training and help them identify particular questions they have about APS clients, casework, etc. Training participants can ask questions during training.

AFTER the training

Supervisors can read the training executive summary. Supervisor can meet with trainee to learn what specific knowledge and skills they obtained from the training and how they intend to use them on the job. 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

Adult Protective Services Core Competencies - Module 1

OVERVIEW OF APS:
IN-PERSON TRAINING



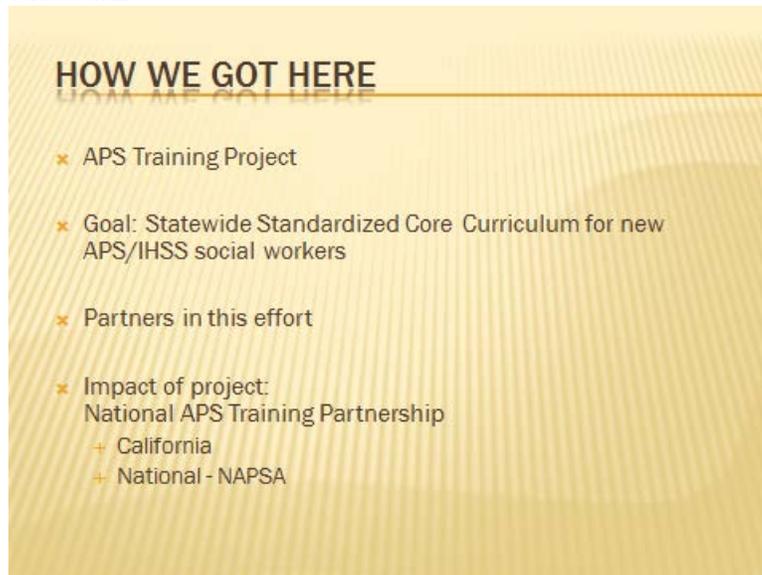
Developed by Krista Brown from *Overview of APS eLearning* by Lisa Nerenberg, Lori Delagrammatikas and Val Ryan.

WELCOME AND INTRODUCTIONS



TIME ALLOTTED: 15 minutes

Slide #2

A yellow slide with a subtle grid pattern. The title 'HOW WE GOT HERE' is at the top in bold black text. Below it is a bulleted list of four items, each preceded by a small orange 'x' icon. The list details the APS Training Project, its goal for standardized curriculum, its partners, and its impact through a national partnership with California and NAPSA.

HOW WE GOT HERE

- ✘ APS Training Project
- ✘ Goal: Statewide Standardized Core Curriculum for new APS/IHSS social workers
- ✘ Partners in this effort
- ✘ Impact of project:
National APS Training Partnership
 - + California
 - + National - NAPSA

TOPIC: How we got here

The Adult Protective Services (APS) Training Project, comprised of the California Regional Training Academies, worked to identify training needs, priorities and emerging issues among county Aging & Adult Services staff - with an emphasis on APS and In-Home Support Services (IHSS) training priorities. The Project worked in numerous partnerships to develop APS training curriculum and deliver core and specialized training to enhance the skills and knowledge of county social workers who serve vulnerable seniors and adults with disabilities within the State of California.

The APS Training Project's overarching goal was to develop and deliver statewide, standardized core curricula for new APS/IHSS social workers and to share these trainings on a national scale through partnerships with the National Adult Protective Services Association (NAPSA). Professional training opportunities are a critical step toward ensuring APS social workers have the appropriate tools to serve their clients.

Continued

OVERVIEW OF APS: TRAINER'S MANUAL

To date, there are 23 APS Core Modules recognized as a national standard. These modules are available in a variety of modalities (in-class, eLearning, Supervisor Workbooks, Webinar, etc.) and can be accessed at <http://theacademy.sdsu.edu/programs/master/core-curriculum/> .

The Project is a founding member of the National APS Training Partnership with NAPSA.

Slide #3:

HOUSEKEEPING AND INTRODUCTIONS

- ✦ Schedule for the day
- ✦ Location of restroom
- ✦ Set cell phones to vibrate
- ✦ Introductions



TOPIC: Housekeeping and Introductions

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

Review Housekeeping Items

- There will a 15-minute break.
- 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.

Participant Introductions & Warm-up Activity

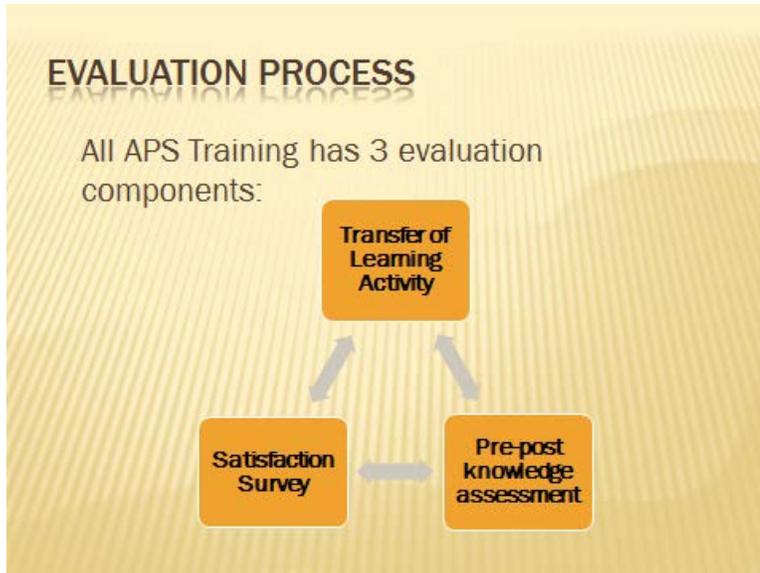
Ask participants to:

- make a brief self-introduction including name, job title, and organization and to share their questions they have about APS clients, casework, etc.

List answers on a flip chart. Note which issues will be addressed in this training.

OVERVIEW OF APS: TRAINER'S MANUAL

Slide #4



Handout #2: Optional Pre-Test
Participant Manual pg. 13
HANDOUT #3:
Letter to Participants
Participant Manual pg. 14

TOPIC: Introducing participants to the evaluation process

OPTIONAL: Pre-Test HANDOUT #2:

- Please complete the brief pre-test – Handout #2
- At the end of today's training, we will correct and discuss answers.
- The assigned numbers on the tests are used to compare your knowledge before attending the training and after you have completed it.
- The tests are used only to measure the effectiveness of the training.

TRAINER NOTE: The answer key can be found in the Appendix.

Adult learners often want a measure of how much they have learned from a workshop. Pre and post-tests are useful tools for them to assess their own learning. Workshop sponsors and Trainers also find this tool useful to assess their impacts. As the Trainer, it is your choice whether and how to use the pre- test. Modify the directions you give participants based on your decision.

For this training, you will be completing a training satisfaction survey, an embedded evaluation (completed in class). All of these measures are intended to allow you to practice what you have learned and measure whether the training was effective. We want APS training to become an evidenced 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".

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HANDOUT #3: 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) 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 adults and their families; and (2) see if the training has been effective in getting its points across.
- 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.

OVERVIEW OF APS: TRAINER'S MANUAL

Handout #2 – Optional Pre-Test

Let's begin with a pre-test to measure what you already know about Adult Protective Services. Circle True or False.

1. Bankers are mandated to report elder abuse. True or False?
2. Under California law, anyone over 60 years old is an elder. True or False?
3. Kidnapping is a form of physical abuse. True or False?
4. Most victims of abuse are females. True or False?
5. All individuals with a mental health diagnosis are dependent adults. True or False?
6. Perpetrators of abuse are often motivated by a desire to control the victim. True or False?
7. APS in California investigates cases of self neglect. True or False?
8. Adults have the right to make bad decisions. True or False?
9. ADLs are Aids for Disabled Living. True or False?
10. One of the APS service goals is to empower victims. True or False?



HANDOUT #3 - Letter to Participants

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 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.

OVERVIEW OF APS: TRAINER'S MANUAL

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 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.

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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OVERVIEW OF APS: TRAINER'S MANUAL

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

HANDOUT #4:
ID Code Assignment
Participant Manual pg. 16

TOPIC: Developing an ID code

We are NOT evaluating you and no one from your agency will see your individual responses. We will be evaluating the training. 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

OVERVIEW OF APS: TRAINER'S MANUAL

HANDOUT #4: 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.

OVERVIEW OF APS: TRAINER'S MANUAL

HANDOUT #4

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?

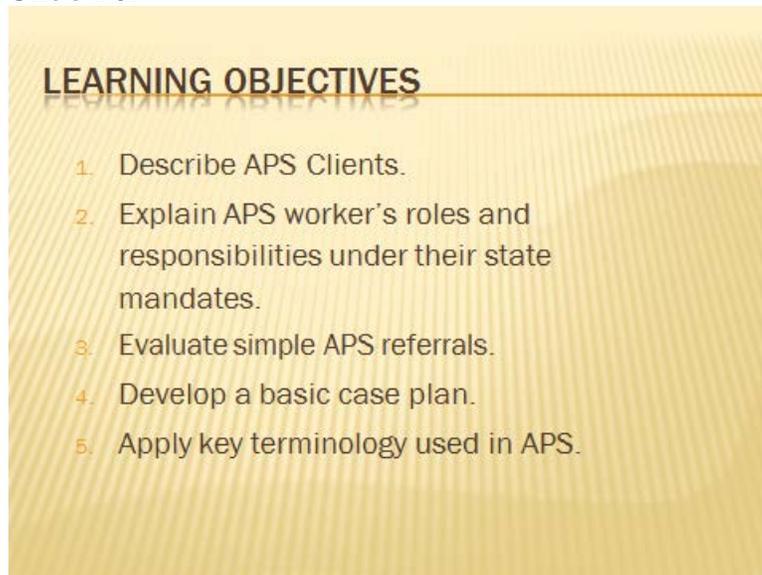
Example: If you were born on November 29, 1970, the numerals would be **29**. If your birth date is the 1st through the 9th, please put 0 (zero) in front of the numeral (example **09**).

___ ___

Combine these parts to create your own identification code (example: **S M I A L I 29**). 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:

A yellow slide with a subtle grid pattern. The title 'LEARNING OBJECTIVES' is at the top in bold, black, uppercase letters. Below it is a numbered list of five objectives.

LEARNING OBJECTIVES

1. Describe APS Clients.
2. Explain APS worker's roles and responsibilities under their state mandates.
3. Evaluate simple APS referrals.
4. Develop a basic case plan.
5. Apply key terminology used in APS.

**HANDOUT #5:
Glossary of Terms
Participant Manual pg. 18**

TOPIC: Learning Objectives

Training goal: APS workers need to have an understanding of the job they are expected to perform. This includes knowing who their clients are, under what circumstances they are expected to intervene, and what interventions they are expected to provide.

Whether you're just getting started, or have worked with elders or vulnerable adults before, you'll probably find APS to be among the most challenging areas of social service practice. It can also be one of the most rewarding.

Paraphrase learning objectives.

Refer participants to **Handout #5 – Glossary of Terms** which will be helpful as you move through the training and also back in the office.

OVERVIEW OF APS: TRAINER'S MANUAL

Handout #5 - Glossary of Terms

A	Activities of Daily Living Scale	ADL measure basic everyday functions needed to sustain life such as walking, bathing, eating, dressing, getting in and out of bed and chairs, and using the toilet
	ADLs	(see Activities of Daily Living Scale)
	Adult day health centers	Adult day health centers provide an array of services, including nursing care; physical, occupational, and speech therapy; and socialization to frail seniors.
	Assisted Living facilities	Assisted Living facilities provide supervision or assistance with activities of daily living. In California, they are overseen by the Community Care Licensing Division of the California Department of Social Services.
	Attendants	Attendants assist vulnerable people with their daily activities, including bathing, shopping, and preparing meals.
C	Case Management	A way of providing care for people who have multiple and changing needs. Case managers conduct comprehensive assessments of clients abilities and what they need help with. They then arrange for services and monitor them, responding to problems. Case management services in California include MSSP, Linkages.
	Cognitive Assessment tools	Cognitive Assessment tools help detect problems with mental impairments. A commonly used tool is the Folstein Mini-Mental State Examination. A tool that is being increasingly popular is the Montreal Cognitive Assessment (MoCA®), which is designed to assist health professionals detect mild cognitive impairment.
	Conservatorship	A mechanism by which a court appoints a person to handle the financial and/or personal affairs of individuals who are unable to protect themselves as the result of disability. LPS Conservatorships are for people who need help and supervision because of mental illnesses. (LPS stands for Lanterman, Petris, and Short, the legislators responsible for enacting the legislation establishing LPS conservatorships). Probate conservatorship is for people who need help and supervision as a result of other impairments, including dementia. Guardianship is for children under the age of 18. There are two types of conservatorships in California: <ul style="list-style-type: none"> • Conservatorship of person refers to the handling of an individual's personal needs through the provision of medical care, food, clothing and shelter

OVERVIEW OF APS: TRAINER'S MANUAL

		<ul style="list-style-type: none"> • Conservatorship of estate refers to the management of financial resources and assets
D	Daily Money Management (DMM)	Financial abuse frequently may occur when an older person has lost the ability to manage his or her finances. Arranging for trustworthy people to help can reduce this risk. The help may be informal, where the money manager simply helps the elder with simple tasks like paying bills, or it may involve formal transfers of authority, including representative payeeship, power of attorney, or guardianship.
	Dementia	Dementia refers to cognitive impairments severe enough to interfere with social functioning. The estimated prevalence of dementia is 3% to 6% for community-dwelling elders. By age 85, 50% of elders have dementia. The most common form is Alzheimer's disease.
	Delirium	Delirium refers to symptoms caused by disturbances in the normal functioning of the brain. An older person who suddenly becomes confused - but was alert and oriented hours or days earlier, is having an acute problem such as a medication side effect, a urinary track infection, stroke, or even a heart attack.
	Developmental Disabilities	Developmental Disabilities are birth defects that cause lifelong problems with how a body part or system works. They include nervous system disabilities, sensory-related disabilities, metabolic disorders, and degenerative disorders.
E	Executive function	These are higher level mental processes (as opposed to simple acts like recalling an event) such as planning for the future, organizing, and shifting attention from one topic to another.
G	Guardianship	(see conservatorship) Guardianship is another term for conservatorship. The two terms are used differently across the country. In California, guardianships are essentially the same as conservatorships but for persons under the age of 18. Most other states use the term guardian instead of conservatorship for people of all ages.
H	Home delivered meal programs	Home delivered meal programs deliver nutritious meals and social interaction to seniors to in their homes. Also called meals on wheels.

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I	Instrumental Activities of Daily Living Scale (IADLs)	Instrumental activities of daily living (IADL) are more complicated tasks like balancing checkbooks, housework, grocery shopping, preparing meals, arranging for outside services, managing finances, and taking medications.
L	LPS Conservatorship (see “conservatorship”)	LPS stands for Lanterman, Petris and Short, the three senators who passed California’s mental health conservatorship laws. This is a mental health conservatorship that has to be reviewed annually. It does not apply to organic (e.g. dementia) conditions.
M	Mental status exams	Tools that measure mental skills like memory, language, spacial abilities. A commonly used tool is the Folstein Mini-Mental State Examination. A tool that is being increasingly popular is the Montreal Cognitive Assessment (MoCA®), which is designed to assist health professionals detect mild cognitive impairment.
	Meals on Wheels	(See “home delivered meal programs”)
N	Nursing Home	(See “skilled nursing facility”)
O	Ombudsman Long-term Care Ombudsman Program (LTCOP)	Programs that recruit and train volunteers to visit long term care facilities and make themselves available to residents to discuss complaints of poor care. Ombudsmen report serious problems to state regulatory and licensing agencies and inform residents and their families of available resources and remedies. In California, LTCOPs are also mandated to investigate abuse and neglect reported in long term care facilities under the state’s mandatory reporting laws.
P	Power of Attorney (POA)	A document with which one person (the principal) grants authority to another (the “agent,” or “attorney in fact”) to act on the principal’s behalf with regard to the principal’s property, personal care or health care. POAs may be <i>limited</i> or <i>general</i> . Limited powers are for specific acts, such as authority to cash checks, while general powers grant authority to handle all of the principals’ financial affairs. “Durable” or “enduring” powers of attorney (DPA), which remain in effect beyond the onset of incapacity, authorize agents to handle principals’ affairs even if they become incapacitated. The powers may become effective at the time they are signed or, in the case of “springing powers of attorney,” at a specified time or event in the future (e.g. the DPA

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		will “spring” –become valid- only if and when the principal becomes incapacitated).
	Protective Orders (or restraining orders)	<p>Protective Orders (or restraining orders) are court-issued orders to protect people from harm or harassment. Criminal orders are usually issued by prosecutors or judges as part of criminal cases/ Civil orders are initiated by victims in civil actions. California has a domestic violence order and a special order for victims of elder and dependent adult abuse (W&I Code § 15657.03). Provisions that can be requested include:</p> <ul style="list-style-type: none"> • Personal conduct orders prevent restrained parties from abusing, attacking, striking, stalking, threatening, harassing, or contacting the protected party, or destroying their personal property. • Stay-away orders provide that restrained parties must stay a specified distance (e.g., 100 yards) away from protected persons and their homes, jobs, workplaces, vehicles, and/or other places. • Residence exclusions, or “move-out” orders, require restrained persons to move out of protected persons’ residences. • No-contact orders prohibit restrained persons from contacting victims. • Other. Orders may contain a variety of additional provisions such as requiring restrained persons to surrender firearms. <p>Emergency protective orders (EPOs) are typically issued at the request of law enforcement personnel who have been called to victims' residences (officers contact the court and speak with judicial officers who order the EPOs over the phone). Temporary orders of protection may be issued by civil courts when cases are first filed and are valid until the next court date is set.</p>
R	Residential care facilities	Also referred to as “board and care homes” or “assisted living facilities,” these facilities provide housing, meals, and personal services in a family-like atmosphere. RCFs serve people who are no longer able to perform all their activities of daily living but who do not require medical care.
	Respite Care	Respite Care offers relief to caregivers by giving them a break. Respite can be provided in many ways. Attendants, professionals or volunteers may come to the vulnerable person’s home to relieve a caregiver for a few hours, or the older person may be brought to an agency or day center. Some communities offer extended respite care in residential care or skilled nursing facilities

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	Regional Centers	Regional Centers are nonprofit private corporations that contract with the Department of Developmental Services to provide or coordinate services and supports for individuals with developmental disabilities. They have offices throughout California to provide a local resource to help find and access the many services available to individuals and their families.
	Restraining orders	(see protective orders)
S	Skilled nursing facilities	Commonly referred to as “nursing homes,” these facilities provide skilled care under the supervision of medical professionals.
T	Telephone reassurance programs	Telephone reassurance programs can make routine “check in” calls to isolated seniors or provide telephone counseling to seniors who are in emotional distress.

As you learn them, list new definitions here:

Slide #8:



Topic: History of APS (cont.)

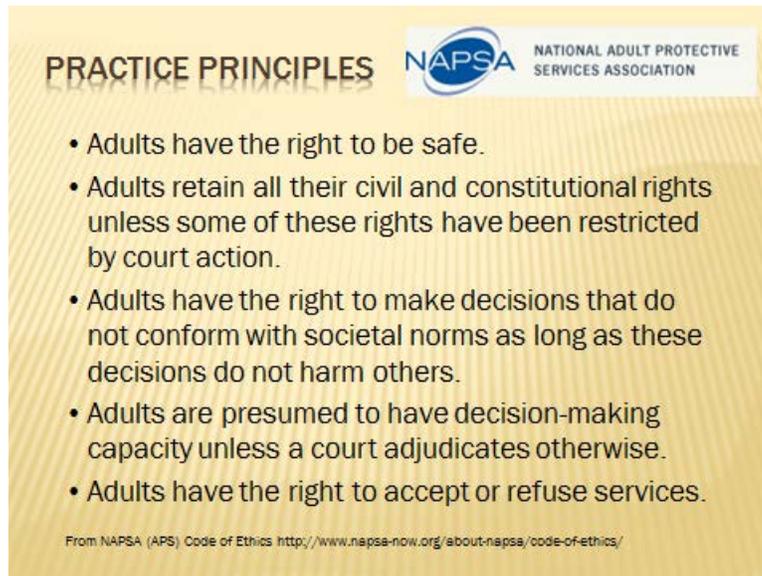
But then, in the late 1970s and early 1980s, Congress again got involved. Under the leadership of advocates like Claude Pepper, Congress held hearings on elder abuse around the country and encouraged states to address the problem.

Most states charged their APS programs to take the lead in investigating reports of abuse and neglect. They enacted laws that were very similar to those they'd enacted years earlier to combat child abuse.

Because each state has its own laws, APS programs vary across the states. Workers need to learn their own states' laws as far as who's covered, the kinds of abuse that must be reported and what the penalties are for failure to report.

For more information about how state laws differ, go to the National Center on Elder Abuse's Analysis of State Adult Protective Services Laws - <http://www.ncea.aoa.gov/>

Slide #9:



PRACTICE PRINCIPLES  NATIONAL ADULT PROTECTIVE SERVICES ASSOCIATION

- Adults have the right to be safe.
- Adults retain all their civil and constitutional rights unless some of these rights have been restricted by court action.
- Adults have the right to make decisions that do not conform with societal norms as long as these decisions do not harm others.
- Adults are presumed to have decision-making capacity unless a court adjudicates otherwise.
- Adults have the right to accept or refuse services.

From NAPSA (APS) Code of Ethics <http://www.napsa-now.org/about-napsa/code-of-ethics/>

Topic: NAPSA Practice Principles

These practice principles were developed for APS by the National Adult Protective Services Association.

- Adults have the right to be safe.
- Adults retain all their civil and constitutional rights unless some of these rights have been restricted by court action.
- Adults have the right to make decisions that do not conform with societal norms as long as these decisions do not harm others.
- Adults are presumed to have decision-making capacity unless a court adjudicates otherwise.
- Adults have the right to accept or refuse services.

From NAPSA (APS) Code of Ethics, <http://www.napsa-now.org/about-napsa/code-of-ethics/>

Slide # 10:

APS CLIENTS' SERVICE GOALS

- Maximize independence
- Strengthen care giving systems
- Resolve crises
- Ensure safety
- Empower and support victims
- Preserve, protect and recover assets
- Ensure justice
- Provide resources to treat the physical, financial and emotional effects of abuse
- Ensure that elders who are unable to make critical decisions have trustworthy surrogates
- Reduce the risk of abuse and neglect
- Hold perpetrators accountable

Topic: APS Clients' Service Goals

Following the practice principles, APS workers seek to achieve multiple goals:

- Maximize independence
- Strengthen care giving systems
- Resolve crises
- Ensure safety
- Empower and support victims
- Preserve, protect and recover assets
- Ensure justice
- Provide resources to treat the physical, financial and emotional effects of abuse
- Ensure that elders who are unable to make critical decisions have trustworthy surrogates
- Reduce the risk of abuse and neglect
- Hold perpetrators accountable

APS MANDATES AND CLIENTS



TIME ALLOTTED: 45 minutes

Slide #11:

VICTIMS

More likely to:

- Be women
- Have physical and/or cognitive impairments
- Live with others
- Have suffered recent losses
- Have low social support



National Center on Elder Abuse, 2004; Ernst, Ramsey-Klawnsnik, Schillerstrom, Dayton, Mixson, & Counihan, 2014; Lachs & Pillemer, 2004; Quinn, 2002; Acierno, Hernandez-Tejada, Muzzy, & Steve, 2009

Topic: Victims

Factors that increase the likelihood of elder abuse and neglect vary, depending on the type of abuse. But in general, research has found:

- Victims are more likely to be women. This is true for all forms of abuse except abandonment. In 2004, fifteen states reported that 65.7% of elder abuse victims were female (National Center on Elder Abuse, 2004).
- Victims may have physical and/or cognitive impairments. Again, this is true for some forms of abuse but not others. For example, elders in declining health are targeted for some forms of financial abuse. 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).

Continued

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- Victims may have shared living arrangements - Victims are likely to live with others (Lachs & Pillemer, 2004; National Research Council, 2003; Pillemer & Finkelhor, 1988; Paveza et al,1992).
- Suffered recent losses – The loss of a spouse or other family member may increase older adults' need for care, which, when not responded to, results in neglect (Quinn, 2002).
- Have low social support - 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).

Slide #12:

ABUSERS

- Family members
- Friends and acquaintances
- Professionals
- Corporations and business entities
- Perpetrators of abuse in long term care facilities may include employees, other residents or visitors



Naughton et al, 2012; National Center on Elder Abuse, 2004

Topic: Abusers

Who are the perpetrators of abuse and neglect? Well, there's no single profile. And it depends on the type of abuse or neglect. But research shows us that the most common abusers are family members, including offspring, spouses, siblings and grandchildren.

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).

Friends and acquaintances may also abuse, and we also often see "new friends" whose motives for befriending clients are to exploit them.

There are some unscrupulous professionals out there too: Accountants, lawyers, health care providers and professional guardians. Corporations and business entities including, for example, telemarketers and mortgage brokers are among the worst offenders.

Perpetrators of abuse in long-term care facilities may include employees, other residents or visitors.

Slide #13:

CAUSES OR MOTIVES OF ABUSE OR NEGLECT

- Financial gain
- Malevolence
- Mental health problems
- Caregiver issues
- Power and control



Topic: Causes/Motives for Abuse of Neglect

Financial gain is emerging as one of the most common motives for abuse, and that isn't just limited to cases of financial abuse. Caregivers may withhold food or care to coerce someone into turning over money or property. In some cases a caregiver who stands to inherit may want to hasten the person's death.

Sometimes abuse is grounded in old resentments. It may be retaliatory.

Perpetrators with mental illnesses may not be able to control their behavior. They may become violent because of delusions or paranoia. Perpetrators with drug problems may also lash out in violence, or they may steal from elders to support their habits.

Caregivers may lack the skills or training that's needed to provide good care. They may be exhausted or under extreme stress. Abuse is more likely when caregivers and care receivers had bad relationships in the past, prior to the onset of disability.

Abuse by intimate partners may stem from the drive for power and control.

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Slide #14:

APS' STATE MANDATE (CALIFORNIA)

Under California's Welfare Institution and Code, APS is charged to investigate and respond to allegations of abuse, neglect and exploitation against elders and dependent adults who live in the community when these adults are unable to meet their own needs, or are victims of abuse, neglect or exploitation.



**HANDOUT #6:
California Codes
Participant Manual pg. 27**

Topic: APS' State Mandate (California)

TRAINER NOTE: Insert your State regulations and mandates into slides 14-17 and create a handout with your State codes.

Review slide

Here in California, APS investigates abuse to elders and dependent adults that occurs in the community. Abuse and neglect that occurs in nursing homes and other institutions is investigated by the Long Term Care Ombudsman programs.

Refer participants to **Handout #6 – California Codes** to review along with the next slides.

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HANDOUT #6 CALIFORNIA CODES WELFARE AND INSTITUTIONS CODE SECTION 15610-15610.70

15610. The definitions contained in this article shall govern the construction of this chapter, unless the context requires otherwise.

15610.05. "Abandonment" means the desertion or willful forsaking of an elder or a dependent adult by anyone having care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody.

15610.06. "Abduction" means the removal from this state and the restraint from returning to this state, or the restraint from returning to this state, of any elder or dependent adult who does not have the capacity to consent to the removal from this state and the restraint from returning to this state, or the restraint from returning to this state, as well as the removal from this state or the restraint from returning to this state, of any conservatee without the consent of the conservator or the court.

15610.07. "Abuse of an elder or a dependent adult" means either of the following:

- (a) Physical abuse, neglect, financial abuse, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering.
- (b) The deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering.

15610.10. "Adult protective services" means those preventive and remedial activities performed on behalf of elders and dependent adults who are unable to protect their own interests, harmed or threatened with harm, caused physical or mental injury due to the action or inaction of another person or their own action as a result of ignorance, illiteracy, incompetence, mental limitation, substance abuse, or poor health, lacking in adequate food, shelter, or clothing, exploited of their income and resources, or deprived of entitlement due them.

15610.13. "Adult protective services agency" means a county welfare department, except persons who do not work directly with elders or dependent adults as part of their official duties, including members of support staff and maintenance staff.

15610.15. "Bureau" means the Bureau of Medi-Cal Fraud within the office of the Attorney General.

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15610.17. "Care custodian" means an administrator or an employee of any of the following public or private facilities or agencies, or persons providing care or services for elders or dependent adults, including members of the support staff and maintenance staff:

- (a) Twenty-four-hour health facilities, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code.
- (b) Clinics.
- (c) Home health agencies.
- (d) Agencies providing publicly funded in-home supportive services, nutrition services, or other home and community-based support services.
- (e) Adult day health care centers and adult day care.
- (f) Secondary schools that serve 18- to 22-year-old dependent adults and postsecondary educational institutions that serve dependent adults or elders.
- (g) Independent living centers.
- (h) Camps.
- (i) Alzheimer's Disease day care resource centers.
- (j) Community care facilities, as defined in Section 1502 of the Health and Safety Code, and residential care facilities for the elderly, as defined in Section 1569.2 of the Health and Safety Code.
- (k) Respite care facilities.
- (l) Foster homes.
- (m) Vocational rehabilitation facilities and work activity centers.
- (n) Designated area agencies on aging.
- (o) Regional centers for persons with developmental disabilities.
- (p) State Department of Social Services and State Department of Health Services licensing divisions.
- (q) County welfare departments.
- (r) Offices of patients' rights advocates and clients' rights advocates, including attorneys.
- (s) The office of the long-term care ombudsman.
- (t) Offices of public conservators, public guardians, and court investigators.
- (u) Any protection or advocacy agency or entity that is designated by the Governor to fulfill the requirements and assurances of the following:
 - (1) The federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, contained in Chapter 144 (commencing with Section 15001) of Title 42 of the United States Code, for protection and advocacy of the rights of persons with developmental disabilities.
 - (2) The Protection and Advocacy for the Mentally Ill Individuals Act of 1986, as amended, contained in Chapter 114 (commencing with Section 10801) of Title 42 of the United States Code, for the protection and advocacy of the rights of persons with mental illness.
- (v) Humane societies and animal control agencies.
- (w) Fire departments.
- (x) Offices of environmental health and building code enforcement.
- (y) Any other protective, public, sectarian, mental health, or private assistance or advocacy agency or person providing health services or social services to elders or dependent adults.

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15610.19. "Clergy member" means a priest, minister, rabbi, religious practitioner, or similar functionary of a church, synagogue, temple, mosque, or recognized religious denomination or organization. "Clergy member" does not include unpaid volunteers whose principal occupation or vocation does not involve active or ordained ministry in a church, synagogue, temple, mosque, or recognized religious denomination or organization, and who periodically visit elder or dependent adults on behalf of that church, synagogue, temple, mosque, or recognized religious denomination or organization.

15610.20. "Clients' rights advocate" means the individual or individuals assigned by a regional center or state hospital developmental center to be responsible for clients' rights assurance for persons with developmental disabilities.

15610.23.

- (a) "Dependent adult" means any person between the ages of 18 and 64 years who resides in this state and who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or developmental disabilities, or whose physical or mental abilities have diminished because of age.
- (b) "Dependent adult" includes any person between the ages of 18 and 64 years who is admitted as an inpatient to a 24-hour health facility, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code.

15610.25. "Developmentally disabled person" means a person with a developmental disability specified by or as described in subdivision (a) of Section 4512.

15610.27. "Elder" means any person residing in this state, 65 years of age or older.

15610.30. (a) "Financial abuse" of an elder or dependent adult occurs when a person or entity does any of the following:

- (1) Takes, secretes, appropriates, obtains, or retains real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both.
 - (2) Assists in taking, secreting, appropriating, obtaining, or retaining real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud, or both.
 - (3) Takes, secretes, appropriates, obtains, or retains, or assists in taking, secreting, appropriating, obtaining, or retaining, real or personal property of an elder or dependent adult by undue influence, as defined in Section 1575 of the Civil Code.
- (b) A person or entity shall be deemed to have taken, secreted, appropriated, obtained, or retained property for a wrongful use if, among other things, the person or entity takes, secretes, appropriates, obtains, or retains the property and the person or entity knew

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or should have known that this conduct is likely to be harmful to the elder or dependent adult.

- (c) For purposes of this section, a person or entity takes, secretes, appropriates, obtains, or retains real or personal property when an elder or dependent adult is deprived of any property right, including by means of an agreement, donative transfer, or testamentary bequest, regardless of whether the property is held directly or by a representative of an elder or dependent adult.
- (d) For purposes of this section, "representative" means a person or entity that is either of the following:
 - (1) A conservator, trustee, or other representative of the estate of an elder or dependent adult.
 - (2) An attorney-in-fact of an elder or dependent adult who acts within the authority of the power of attorney.

15610.35. "Goods and services necessary to avoid physical harm or mental suffering" include, but are not limited to, all of the following:

- (a) The provision of medical care for physical and mental health needs.
- (b) Assistance in personal hygiene.
- (c) Adequate clothing.
- (d) Adequately heated and ventilated shelter.
- (e) Protection from health and safety hazards.
- (f) Protection from malnutrition, under those circumstances where the results include, but are not limited to, malnutrition and deprivation of necessities or physical punishment.
- (g) Transportation and assistance necessary to secure any of the needs set forth in subdivisions (a) to (f), inclusive.

15610.37. "Health practitioner" means a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, licensed clinical social worker or associate clinical social worker, marriage, family, and child counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, any emergency medical technician I or II, paramedic, or person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, a psychological assistant registered pursuant to Section 2913 of the Business and Professions Code, a marriage, family, and child counselor trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code, or an unlicensed marriage, family, and child counselor intern registered under Section 4980.44 of the Business and Professions Code, state or county public health or social service employee who treats an elder or a dependent adult for any condition, or a coroner.

15610.39. "Imminent danger" means a substantial probability that an elder or dependent adult is in imminent or immediate risk of death or serious physical harm, through either his or her own action or inaction, or as a result of the action or inaction of another person.

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15610.40. "Investigation" means that activity undertaken to determine the validity of a report of elder or dependent adult abuse.

15610.43. (a) "Isolation" means any of the following:

- (1) Acts intentionally committed for the purpose of preventing, and that do serve to prevent, an elder or dependent adult from receiving his or her mail or telephone calls.
 - (2) Telling a caller or prospective visitor that an elder or dependent adult is not present, or does not wish to talk with the caller, or does not wish to meet with the visitor where the statement is false, is contrary to the express wishes of the elder or the dependent adult, whether he or she is competent or not, and is made for the purpose of preventing the elder or dependent adult from having contact with family, friends, or concerned persons.
 - (3) False imprisonment, as defined in Section 236 of the Penal Code.
 - (4) Physical restraint of an elder or dependent adult, for the purpose of preventing the elder or dependent adult from meeting with visitors.
- (b) The acts set forth in subdivision (a) shall be subject to a rebuttable presumption that they do not constitute isolation if they are performed pursuant to the instructions of a physician and surgeon licensed to practice medicine in the state, who is caring for the elder or dependent adult at the time the instructions are given, and who gives the instructions as part of his or her medical care.
- (c) The acts set forth in subdivision (a) shall not constitute isolation if they are performed in response to a reasonably perceived threat of danger to property or physical safety.

15610.45. "Local law enforcement agency" means a city police or county sheriff's department, or a county probation department, except persons who do not work directly with elders or dependent adults as part of their official duties, including members of support staff and maintenance staff.

15610.47. "Long-term care facility" means any of the following:

- (a) Any long-term health care facility, as defined in subdivision (a) of Section 1418 of the Health and Safety Code.
- (b) Any community care facility, as defined in paragraphs (1) and (2) of subdivision (a) of Section 1502 of the Health and Safety Code, whether licensed or unlicensed.
- (c) Any swing bed in an acute care facility, or any extended care facility.
- (d) Any adult day health care facility as defined in subdivision (b) of Section 1570.7 of the Health and Safety Code.
- (e) Any residential care facility for the elderly as defined in Section 1569.2 of the Health and Safety Code.

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15610.50. "Long-term care ombudsman" means the State Long-Term Care Ombudsman, local ombudsman coordinators, and other persons currently certified as ombudsmen by the Department of Aging as described in Chapter 11 (commencing with Section 9700) of Division 8.5.

15610.53. "Mental suffering" means fear, agitation, confusion, severe depression, or other forms of serious emotional distress that is brought about by forms of intimidating behavior, threats, harassment, or by deceptive acts performed or false or misleading statements made with malicious intent to agitate, confuse, frighten, or cause severe depression or serious emotional distress of the elder or dependent adult.

15610.55. (a) "Multidisciplinary personnel team" means any team of two or more persons who are trained in the prevention, identification, and treatment of abuse of elderly or dependent adults and who are qualified to provide a broad range of services related to abuse of elderly or dependent adults.

(b) A multidisciplinary personnel team may include, but is not limited to, all of the following:

- (1) Psychiatrists, psychologists, or other trained counseling personnel.
- (2) Police officers or other law enforcement agents.
- (3) Medical personnel with sufficient training to provide health services.
- (4) Social workers with experience or training in prevention of abuse of elderly or dependent adults.
- (5) Public guardians.
- (6) The local long-term care ombudsman.

15610.57.

(a) "Neglect" means either of the following:

- (1) The negligent failure of any person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise.
- (2) The negligent failure of an elder or dependent adult to exercise that degree of self care that a reasonable person in a like position would exercise.

(b) Neglect includes, but is not limited to, all of the following:

- (1) Failure to assist in personal hygiene, or in the provision of food, clothing, or shelter.
- (2) Failure to provide medical care for physical and mental health needs. No person shall be deemed neglected or abused for the sole reason that he or she voluntarily relies on treatment by spiritual means through prayer alone in lieu of medical treatment.
- (3) Failure to protect from health and safety hazards.
- (4) Failure to prevent malnutrition or dehydration.
- (5) Failure of an elder or dependent adult to satisfy the needs specified in paragraphs (1) to (4), inclusive, for himself or herself as a result of poor cognitive functioning, mental limitation, substance abuse, or chronic poor health.

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15610.60. "Patients' rights advocate" means a person who has no direct or indirect clinical or administrative responsibility for the patient, and who is responsible for ensuring that laws, regulations, and policies on the rights of the patient are observed.

15610.63. "Physical abuse" means any of the following:

- (a) Assault, as defined in Section 240 of the Penal Code.
- (b) Battery, as defined in Section 242 of the Penal Code.
- (c) Assault with a deadly weapon or force likely to produce great bodily injury, as defined in Section 245 of the Penal Code.
- (d) Unreasonable physical constraint, or prolonged or continual deprivation of food or water.
- (e) Sexual assault, that means any of the following:
 - (1) Sexual battery, as defined in Section 243.4 of the Penal Code.
 - (2) Rape, as defined in Section 261 of the Penal Code.
 - (3) Rape in concert, as described in Section 264.1 of the Penal Code.
 - (4) Spousal rape, as defined in Section 262 of the Penal Code.
 - (5) Incest, as defined in Section 285 of the Penal Code.
 - (6) Sodomy, as defined in Section 286 of the Penal Code.
 - (7) Oral copulation, as defined in Section 288a of the Penal Code.
 - (8) Sexual penetration, as defined in Section 289 of the Penal Code.
 - (9) Lewd or lascivious acts as defined in paragraph (2) of subdivision (b) of Section 288 of the Penal Code.
- (f) Use of a physical or chemical restraint or psychotropic medication under any of the following conditions:
 - (1) For punishment.
 - (2) For a period beyond that for which the medication was ordered pursuant to the instructions of a physician and surgeon licensed in the State of California, who is providing medical care to the elder or dependent adult at the time the instructions are given.
 - (3) For any purpose not authorized by the physician and surgeon.

15610.65. "Reasonable suspicion" means an objectively reasonable suspicion that a person would entertain, based upon facts that could cause a reasonable person in a like position, drawing when appropriate upon his or her training and experience, to suspect abuse.

15610.67. "Serious bodily injury" means an injury involving extreme physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, organ, or of mental faculty, or requiring medical intervention, including, but not limited to, hospitalization, surgery, or physical rehabilitation.

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15610.70. (a) "Undue influence" means excessive persuasion that causes another person to act or refrain from acting by overcoming that person's free will and results in inequity. In determining whether a result was produced by undue influence, all of the following shall be considered:

(1) The vulnerability of the victim. Evidence of vulnerability may include, but is not limited to, incapacity, illness, disability, injury, age, education, impaired cognitive function, emotional distress, isolation, or dependency, and whether the influencer knew or should have known of the alleged victim's vulnerability.

(2) The influencer's apparent authority. Evidence of apparent authority may include, but is not limited to, status as a fiduciary, family member, care provider, health care professional, legal professional, spiritual adviser, expert, or other qualification.

(3) The actions or tactics used by the influencer. Evidence of actions or tactics used may include, but is not limited to, all of the following:

(A) Controlling necessities of life, medication, the victim's interactions with others, access to information, or sleep.

(B) Use of affection, intimidation, or coercion.

(C) Initiation of changes in personal or property rights, use of haste or secrecy in effecting those changes, effecting changes at inappropriate times and places, and claims of expertise in effecting changes.

(4) The equity of the result. Evidence of the equity of the result may include, but is not limited to, the economic consequences to the victim, any divergence from the victim's prior intent or course of conduct or dealing, the relationship of the value conveyed to the value of any services or consideration received, or the appropriateness of the change in light of the length and nature of the relationship.

(b) Evidence of an inequitable result, without more, is not sufficient to prove undue influence.

Source: <http://www.leginfo.ca.gov/cgi-bin/displaycode?section=wic&group=15001-16000&file=15610-15610.70>

OVERVIEW OF APS: TRAINER'S MANUAL

Slide #15:

APS CLIENT DEFINITIONS (CALIFORNIA)

Elders	Dependent Adults
	

Topic: APS Clients (California)

TRAINER NOTE: Insert your State regulations and mandates into slides 14-17 and create a handout with your State codes.

Here in California, APS workers serve elders and dependent adults. Let's look how elders and dependent adults are defined.

OVERVIEW OF APS: TRAINER'S MANUAL

Slides #16 & 17:

APS CLIENT DEFINITIONS (CALIFORNIA)	APS CLIENT DEFINITIONS (CALIFORNIA)
<p data-bbox="258 327 318 352">Elders</p>  <p data-bbox="440 363 646 533">Elders are persons residing in this state who are 65 years of age or older (WIC Section 15610.27).</p>	<p data-bbox="1060 327 1235 352">Dependent Adults</p>  <p data-bbox="756 338 1003 590">Dependent Adults are persons between the ages of 18 and 64, who have physical or mental limitations that restrict their ability to carry out normal activities or protect their rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age (WIC Section 15610.23).</p>

Topic: APS Clients (California)

Elder - As per the WIC Section 15610.27 “Elders” are persons residing in this state who are 65 years of age or older.

Dependent Adult - As per the WIC Sections 15610.23 “Dependent Adults” are persons between the ages of 18 and 64, who have physical or mental limitations that restrict their ability to carry out normal activities or protect their rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age.

Slide #18

A CLOSER LOOK AT DISABILITY

Physical or mental impairments that substantially limit daily activities. May be caused by:

- Chronic diseases
- Mental illnesses
- Dementias
- Developmental disabilities
- Accidents



Topic: Disability

Disabilities are physical or mental impairments that substantially limit daily activities. They may be caused by:

Chronic diseases, including heart disease, cancer and diabetes. These diseases cause major limitations for more than 1 of every 10 Americans (Centers for Disease Control and Prevention)

Mental illnesses, including depression, bipolar disorder and schizophrenia, account for nearly 25% of all disability across major industrialized countries (World Health Organization)

Dementias are cognitive impairments severe enough to interfere with social functioning. The estimated prevalence of dementia is 3% to 6% for community-dwelling elders. By age 85, 50% of elders experience dementia.

Developmental Disabilities are birth defects that cause lifelong problems with how body parts or systems work. They include nervous system disabilities, sensory-related disabilities, intellectual disabilities, metabolic disorders and degenerative disorders.

Accidents. The primary causes of disabling accidents vary by age. For example, young adults are at particularly high risk for road accidents, while elders are at high risk for falls.

Slide #19:

FACTORS AFFECTING DISABILITY & DEPENDENCE

- Age at the onset of disability
- Coping ability
- Social and emotional support
- Financial resources
- Attitude/acceptance
- Culture
- Environment

A photograph of an elderly woman with short white hair, wearing a dark patterned coat and light-colored pants. She is leaning forward and using a silver metal walker to support herself. The background is plain white.

Topics: Factors Affecting Disability & Dependence

Many adults with serious impairments, illnesses and disabling conditions live very independent lives. The extent to which adults are affected depends on a variety of factors. These factors include:

- The age of disability. Someone born with a disability faces different challenges than someone who acquires a disability later in life.
- The ability to cope may depend on the nature of the disability and its progression. But the ability to cope is also personal. It's related to personal attributes and beliefs.
- Social and emotional support can also affect a person's ability to cope.
- Financial resources. Assistive devices, attendants, therapy and rehabilitation programs and adapted living environments can enhance independence. While some are available through publicly financed programs, access to others depends on the adult's financial resources.
- Attitude/acceptance. Some people who become disabled go through stages in their attitudes. Immediately after a disabling event or setback, they may experience anger, fear or depression, which can affect their motivation to learn new skills or function independently. Over time, some become more accepting. Many experience ups and downs. Even people who are born with disabilities may go through changes in attitude as they reach critical milestones or face critical life decisions like whether to live independently marry or have children.
- Culture and environment can also affect an individual's disability and dependence.

Slide # 20:

VULNERABILITY

People with disabilities **may** be “at risk” (vulnerable) for:

- Premature decline
- Mental health problems, including depression, substance abuse and suicide
- Falls or other injuries
- Self-neglect
- Abuse and neglect by others

Topic: Vulnerability

Adults with impairments who depend on others for help MAY be at risk for the problems such as:

- Premature decline
- Mental health problems, including depression, substance abuse and suicide
- Falls or other injuries
- Self-neglect
- Abuse and neglect by others

“*At risk*” means that they are more likely to experience these problems than those who don't have impairments.

Slide #21

CAREGIVERS

 **Definition**
• Provide ongoing care to people with disabilities

 **Providers**
• Most care provided by family members, with women providing majority of care
• Most are unpaid. Payment can come from client, 3rd party, MediCal

 **Tasks**
• Variety of tasks including balancing checkbooks, grocery shopping, cooking, giving medications, assisting with bathing or dressing, etc

 **Laws**
• The "duty to care" may be imposed by law (through contract or family relationship)

Topic: Caregivers

Many APS clients have caregivers. Or, in some cases, APS workers arrange care for them. The term "caregiver" is very general and is applied to both formal and informal relationships. Caregivers who receive payment for their services go by a variety of names: helpers, attendants, aides, in-home support service workers, chore workers.

Definition of Caregivers: Caregivers are people who provide ongoing care to people with disabilities.

Who are Providers? Most care is provided by family members, and most family caregivers are women. Most caregivers are unpaid.

Paid caregivers may receive payment from the client, their families, or third parties like insurance companies or MediCal. Some work for agencies, while others work directly for clients or their families. Clients may hire family members or friends using public entitlements, including In Home Support Services (IHSS).

What are the tasks? Caregivers do a variety of tasks including balancing checkbooks, grocery shopping, assisting with doctors' appointments, giving medications, or helping people eat, bathe or dress.

Required by law to provide care? The "duty of care" may be imposed by law (through a contract or family relationship).

Slide #22

RELIANCE ON CAREGIVERS MAY HEIGHTEN RISK

- Imbalance in power
- Shortage of caregivers and inadequate screening
- Caregivers are likely to have access to adults' homes, finances and personal information
- Depending on the nature of the adults' disabilities, they may be less able to:
 - Understand or appreciate financial transactions, proposals or threats
 - Avoid, escape or flee from danger
 - Withstand manipulation, pressure, coercion or threats

Topic: Caregivers and Risk

Some of the factors contributing to risk have to do with elder and dependent adults' reliance on caregivers. Caregivers who control someone's access to food, medicine and social contact have a lot of power, which they can exploit.

We also have a critical shortage of workers and inadequate means for screening and monitoring them.

Caregivers may have routine access to the client's jewelry boxes, their ATM and credit cards, and their social security information.

Other factors that heighten risk are directly related to conditions or impairments. For example, we know that people with certain cognitive impairments are vulnerable to financial exploitation.

RESPONDING TO ABUSE REPORTS



TIME ALLOTTED: 60 minutes

Slides #23

RESPONDING TO ABUSE REPORTS

Under California's elder adult reporting law, certain individuals must report the following types of abuse committed against elders and dependent adults to APS (WIC Section 15610.07):



The diagram consists of seven brown rectangular boxes with white text, arranged in two rows. The top row contains four boxes: 'Physical Abuse', 'Psychological Abuse', 'Financial Abuse', and 'Abduction'. The bottom row contains three boxes: 'Abandonment', 'Isolation', and 'Neglect'. A thin yellow horizontal line runs behind the boxes in the bottom row.

Topic: Responding to Abuse Reports

TRAINER NOTE: Insert your State regulations and mandates into slides 24-31 and create a handout with your State codes.

Now, we're going to turn to abuse and neglect. Investigating and responding to reports of abuse and neglect is a primary role of APS. Under California's Welfare and Institutions Code, all of the forms of abuse that appear on the screen must be reported.

Slide #24:

PHYSICAL ABUSE (CALIFORNIA)

Includes:

assault, battery, assault with a deadly weapon, unreasonable physical constraint, prolonged or continual deprivation of food or water, sexual assault and rape (WIC Section 15610.63).



Topics: Physical Abuse (CA)

Physical abuse includes assault, battery, assault with a deadly weapon, unreasonable physical constraint, prolonged or continual deprivation of food or water, sexual assault and rape.

When we talk about physical abuse, it's important to keep in mind that the impact on elders and dependent adults may be much greater than the impact of the same abuse on a younger/healthier person. For example, simply shoving a frail elder may result in a fall that leads to a serious injury. And, when an older person sustains a fall, he or she might take much longer to heal.

Detecting physical abuse can also be tricky when the client is unable or unwilling to report what's happened. Trying to determine if injuries or bruises were inflicted or occurred accidentally can be extremely difficult. That's why there's been a lot of attention to "forensics" issues in elder abuse--using science and research to help us understand how injuries were caused.

Examples of Physical Indicators

- Bruises on the interior side of the arms or legs
- Spiral fractures of the arm (possibly from grabbing)
- Small round burns (possibly from cigarettes or burns in other shapes (e.g. shape of a clothes iron))

Slide #25:

PSYCHOLOGICAL ABUSE (CALIFORNIA)

Psychological or mental abuse is causing:

- Fear
- Agitation
- Confusion
- Severe depression
- Emotional distress

(WIC Section 15610.53)



Topic: Psychological Abuse (CA)

Psychological/mental abuse includes actions that result in fear, agitation, confusion, severe depression and other forms of serious emotional distress. The elder may be threatened, harassed or intimidated.

Sometimes people think of psychological injuries or harms as less serious than physical ones, but victims often tell us otherwise. It's not uncommon to hear a victim say "I could get over being slapped, but the hurt of being told I was a burden to my children never went away."

Some APS clients are told that if they don't comply with abusers' demands they'll be thrown into nursing homes or denied access to their grandchildren.

Slide #26:

FINANCIAL ABUSE (CALIFORNIA)

Taking, secreting or appropriating money or property of an elder or dependent adult by a person who has the care or custody of or who is in a position of trust to, that elder or dependent adult (WIC Section 15610.30).



Topic: Financial Abuse (CA)

Financial abuse includes the taking, secreting or appropriating money or property of an elder or dependent adult by a person who has the care or custody of, or who is in a position of trust to, that elder or dependent adult.

Financial abuse against elders and dependent adults seems to be a thriving industry these days. It can involve anything from the caregiver who runs an errand for his client and then shortchanges him or her, to very complex forms of exploitation. Some common forms of financial abuse include getting someone to sign a check, power of attorney, deed, will or other legal document that the person doesn't understand to the benefit of the abuser.

Everyday, we're hearing reports of "consumer" fraud as well, which may include getting elders to send checks to bogus charities or sweepstakes.

Slide #27:

ABDUCTION (CALIFORNIA)

Removal from state and/or restraint from returning to this state of any elder or dependent adult who does not have the capacity to consent to the removal from or restraint from returning to this state (WIC Section 15610.06)



Topic: Abduction (CA)

Abduction means the removal from this state and/or the restraint from returning to this state of any elder or dependent adult who does not have the capacity to consent to the removal from or restraint from returning to this state. If the client is taken to a location against his or her will but is not removed from the state, kidnapping charges can still be brought against the perpetrator by law enforcement.

Slide #28

ABANDONMENT (CALIFORNIA)

Desertion or willful forsaking of an elder or a dependent adult by anyone who has care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody (WIC Section 15610.05).



Topic: Abandonment (CA)

Abandonment means the desertion or willful forsaking of an elder or a dependent adult by anyone who has care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody.

An example is an elder with dementia being brought to the emergency room and left there without identification or contact information.

Slide #29

ISOLATION (CALIFORNIA)

Isolation means prevention from receiving phone calls or mail, false imprisonment or physical restraint from meeting with visitors (WIC Section 15610.43).



Topic: Isolation (CA)

Isolation means prevention from receiving phone calls or mail, false imprisonment or physical restraint from meeting with visitors. Persons with disabilities can also be isolated by withholding assistive devices like hearing aids, phone service for the hearing impaired, glasses or walkers.

Slide #30

NEGLECT (CALIFORNIA)

“Negligent failure” to:

- Assist with personal hygiene
- Provide food, clothing, shelter or medical care
- Protect from health and safety hazards
- Prevent malnutrition or dehydration

(WIC Section 15610.57)



Topic: Neglect (CA)

Neglect means the negligent failure of any person, including the individual having the care or custody of an elder or a dependent adult, to exercise that degree of care that a reasonable person, in a like position, would exercise. That includes the failure to assist in personal hygiene or in the provision of food, clothing or shelter; or failure to provide medical care, to protect from health and safety hazards, prevent malnutrition or dehydration.

Neglect can be difficult to assess because it's not always clear if someone has actually assumed responsibility for the client's care. That may take some investigating.

Slide #31

SELF-NEGLECT (CALIFORNIA)

The negligent failure of an elder or dependent adult to exercise that degree of self care that a reasonable person in a like position would exercise.
(WIC Section 15610.57)



Topic: Self-Neglect (CA)

In cases of self-neglect, there is no abuser. The elders or dependent adults are either unable or unwilling to take care of themselves. Self-neglect cases pose a lot of challenges:

As we noted earlier, sometimes it's difficult to tell if anyone has assumed responsibility for the client's care. So, it's not clear if it's neglect or self-neglect. In either case, it's important to assess clients' needs. Self-neglect can have very serious consequences. It can even be life-threatening.

In some cases, it's hard to tell whether a client's situation is really self-neglect, or if their circumstances are the result of poverty. Eccentric behavior, unconventional lifestyles or the failure to accept medical care because of religious beliefs may also be mistaken for self-neglect.

Slide #32

INDICATORS OF ABUSE

Actual signs, symptoms or evidence. They include:

- Suspicious injuries, including bruises or fractures, or burns that are not likely to occur accidentally.
- Suspicious documents, such as recently executed wills, deeds or trusts executed by elders with severe impairments.
- Suspicious behaviors such as elders and their caregivers offering different explanations for injuries.

**HANDOUT #7:
Indicators of Abuse,
Neglect and Self-Neglect
Participant Manual pg. 43**

Topic: Indicators of Abuse

Refer participants to **Handout #7 – Indicators of Elder and Dependent Adult Abuse, Neglect and Self-Neglect**

Indicators are “red flags” -- signs, symptoms, or clues that abuse has occurred.

Physical Indicators may include:

- Bruises on the interior side of the arms or legs
- Spiral fractures of the arm (possibly from grabbing)
- Small round burns (possibly from cigarettes or burns in other shapes (e.g. shape of a clothes iron))

Suspicious documents may include:

- Changing a will immediately after surgery (while on strong drugs)
- Power of Attorney (POA) signed over to a brand new friend
- A person with Alzheimer's signing over his home

Indicators may be “behavioral”:

- How victims act.
 - Or how caregivers act.
-

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- Or how they relate to one another.
- Caregiver complains that she does everything for the client but the client is obviously not receiving proper care.
- Caregiver refuses to allow anyone to speak with the elder/dependent adult outside her presence.

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Handout #7

Indicators of Elder and Dependent Adult Abuse, Neglect, and Self-Neglect

Indicators are signs or symptoms of abuse or neglect. The presence of these signs does not necessarily mean that abuse or neglect is occurring; however they may suggest the need for further investigation, especially if multiple indicators are present.

Indicators may be physical symptoms or signs, environmental (there is something in the senior's residence that is suggestive of abuse, or behavioral (the way victims and perpetrators act or interact), or financial.

PHYSICAL SIGNS

- Injury that has not been cared for properly
- Injury that is inconsistent with explanation for its cause
- Pain from touching
- Cuts, puncture wounds, burns, bruises, welts, pressure marks, broken bones, abrasions
- Dehydration or malnutrition without illness-related cause
- Weight loss
- Poor coloration
- Sunken eyes or cheeks
- Inappropriate administration of medication
- Soiled clothing or bed
- Frequent use of hospital or health care/doctor-shopping
- Lack of necessities such as food, water, or utilities
- Lack of personal effects, pleasant living environment, personal items
- Forced isolation

SIGNS OF FINANCIAL ABUSE

- Frequent expensive gifts from elder to caregiver
- Sudden change in financial situations
- Elder's personal belongings, papers, credit cards missing
- Numerous unpaid bills
- A recent will when elder seems incapable of writing will
- Caregiver's name added to bank account
- Elder unaware of monthly income
- Elder signs on loan
- Frequent checks made out to "cash"
- Unusual activity in bank account
- Irregularities on tax return
- Elder unaware of reason for appointment with banker or attorney
- Caregiver's refusal to spend money on elder

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- Signatures on checks or legal documents that do not resemble client's

BEHAVIORAL SIGNS

- Fear
- Sudden change in alertness
- Anxiety, agitation
- Anger
- Isolation, withdrawal
- Depression
- Non-responsiveness, resignation, ambivalence
- Contradictory statements, implausible stories
- Hesitation to talk openly
- Confusion or disorientation

SIGNS BY CAREGIVER

- Prevents elder from speaking to or seeing visitors
- Anger, indifference, aggressive behavior toward elder
- History of substance abuse, mental illness, criminal behavior, or family violence
- Lack of affection toward elder
- Flirtation or coyness as possible indicator of inappropriate sexual relationship
- Frequent arguments
- Belittling or threats
- Conflicting accounts of incidents
- Withholds affection
- Talks of elder as a burden

SELF NEGLECT

- Isolation and declining physical ability
- Hoarding
- Failure to seek medical treatment or take needed medications
- Poor hygiene
- Clutter; lack of housecleaning
- Wandering and confusion
- Leaving the stove or water faucet unattended

Prepared by Lisa Nerenberg, 2009 and revised January 2015

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Slide #33

VIDEOS



Physical Abuse **Psychological Abuse** **Financial Abuse**

Activity Time: 10-15 minutes

Topic: Videos

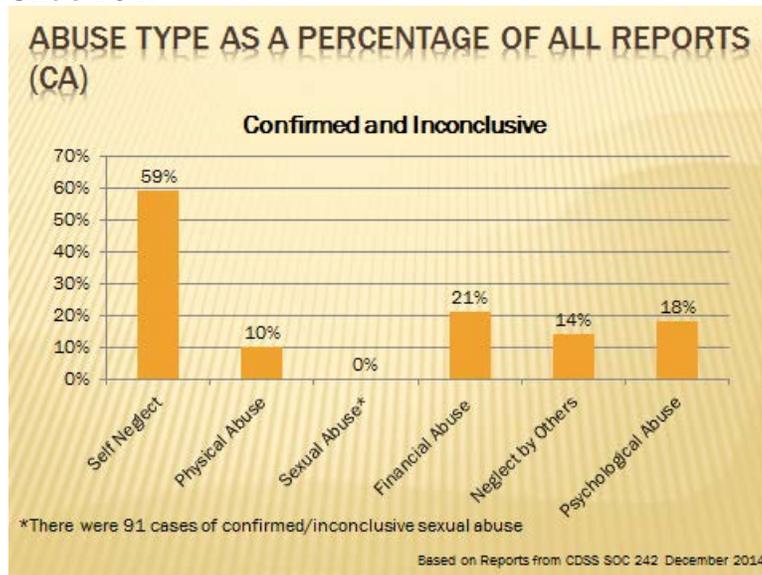
Trainer Note: As time allows, show video(s) from *When Help Was There: Four Stories of Elder Abuse*. Mrs. Allen covers Physical Abuse/Domestic Violence; The Rens covers Psychological Abuse; and Glenn covers Financial Exploitation.

Prior to training access *When Help Was There: Four Stories of Elder Abuse* – To buy DVD - \$169 / To rent DVD \$55. Terra Nova Films - <http://terranoval.org/film-catalog/when-help-was-there-four-stories-of-elder-abuse/>

Now we're going to take a deeper look at the various forms of abuse and what some communities are doing about it.

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Slide #34:



Topic: Abuse Types Confirmed as a % of All Reports (CA)

Self-neglect cases account for the largest category of APS confirmed and inconclusive cases as a percentage of all reports at 59%. Financial Abuse is second at 21% and Psychological Abuse is third at 18%.

This data comes from the California Department of Social Services (CDSS) SOC 242 Statistical Report, December 2014.

Trainer note: The totals come out to more than 100% because one report can have multiple allegations which can have multiple findings. At this point, CDSS does not collect “X” number of reports of each type of abuse that is why confirmed/inconclusive data is used. CDSS also doesn't collect unfounded by type.

TRAINER NOTE: Insert your States' percentages

Slide #35:

WHO IS REQUIRED TO REPORT?

In California: “Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not that person receives compensation, including administrators, supervisors and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member or employee of a county adult protective services agency or a local law enforcement agency, is a mandated reporter.” (WIC Section 15610.17)

Topic: Who is Required to Report?

In California, “Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not that person receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency, is a mandated reporter.”

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Slide #36:

Which of the following individuals are mandated reporters?
Why?

Paramedic	Adult Day Health	Neighbor	Daughter providing volunteer respite care
Doctor	Priest	Banker	Public Notary

Topic: Mandated Reporter Activity

Shout-out Activity: Ask participants which of the following people are mandated reporters? Why?

Answers:

- Paramedics – yes, Paramedics provide care to elders and dependent adults as part of their job duties and are therefore mandated reporters.
- Adult Day Health – yes, Workers at an Adult Day Health agency are mandated reporters if they engage with elders and dependent adults as part of their duties. Custodians, back office staff and the cook are normally not mandated reporters but the rest of the staff would be required to report.
- Neighbor – no, Neighbors aren't required to report unless they've assumed responsibility for providing care.
- Daughter (providing voluntary respite care) - Even though the daughter is not a full-time caregiver, she is responsible for reporting any abuse or neglect she sees or suspects being perpetrated by other caregivers.
- Doctor - Doctors routinely provide care to elders and dependent adults and are mandated reporters.
- Priest - With the exception of statements made in confession, clergy are mandated reporters because they provide spiritual care for their congregation.

Continued

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- Banker – In California, bank employees are mandated reporters for elder and dependent adult abuse because their customers trust them with their financial well-being.
- Public Notary - Public notaries are currently not required to report abuse.

Slide #37:

RESPONDING TO ABUSE – JURISDICTION (CALIFORNIA)	
If the abuse occurred in:	Then the report goes to:
Private homes	APS
Long Term Care Facility	Ombudsman
State Mental Health Hospital	State Dept. of Mental Health
State Developmental Center	State Dept. of Developmental Services
Penal code violations in any setting	Law Enforcement

Topic: Responding to Abuse: Jurisdiction (CA)

APS isn't the only agency charged with investigating and responding to abuse and neglect. Depending on the nature and severity of abuse, reports are made to:

APS when the abuse occurs in private homes, apartments or other residences.

Long-Term Care Ombudsmen when abuse occurs in long-term care facilities, such as nursing homes or residential care facilities.

The state department of mental health investigates abuse that occurs in state mental hospitals.

The state department of developmental services takes reports when abuse occurs in state developmental centers.

And, the abuse must be reported to local law enforcement when the conduct is believed to be criminal.

Slide #38:

APS SERVICES ARE VOLUNTARY

Exceptions:

- When adults are incapable of consenting as a result of impairment (*acting under the principle of *parens patriae**)
- When crimes have been committed



Topic: APS Services are Voluntary

APS services are strictly voluntary, which means that clients can stop investigations and refuse workers help at any time. There are two exceptions though.

1) When adults are incapable of consenting as a result of impairment. Acting under the principle of *parens patriae* (the “state as parent”), public agencies may initiate involuntary protections such as psychiatric hospitalization, guardianship or conservatorship to people who are gravely disabled or who pose a threat to themselves or others.

2) When crimes have been committed. Society also has an obligation to protect the public welfare. When offenders or victims break the law, law enforcement officers can intervene to stop harm, the threat of harm, the loss of assets and property and public nuisances. APS workers are required to cross report to law enforcement suspected instances of penal code violations.

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Slide #39:

WHO IS ELIGIBLE FOR APS SERVICES?

Based on what you have learned so far, please read each of the following case vignettes and determine whether or not it is an appropriate APS referral.

This is an APS Case I need more information This is NOT an APS Case

Activity Time: 20-25 minutes

Topic: Eligibility for APS Services – Case Vignette Activity

TRAINER NOTE: Make sure the answers reflect your State regulations and mandates, activity developed for CA.

Divide participants into table groups for the following activity. Process answers as a large group. **This activity is located on page 47 of the participant manual.** The trainer version is below.

Instructions: Based on what you have learned so far, please read each of the following case vignettes and determine whether or not it is an appropriate APS referral.

Who is eligible for APS Services? Case Vignette Activity Trainer Version

Vignette 1

A 78-year-old woman dated a man she met at church, but after a few weeks, she decided she didn't want to see him again. When she told him, he became verbally abusive and shoved her, causing her to fall. He has made harassing phone calls and now she is frightened of him and afraid to leave her house.

-APS Case

-Need More Information

-Not APS Case

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Vignette 2

An 82-year-old man calls to complain that his upstairs neighbors are playing music so loud that he cannot sleep.

-APS Case

-Need More Information

-Not APS Case

Additional info for discussion: For those APS workers who aren't sure if this is an APS case and need more information - you may want to know if the client has had any contact with the landlord. Does the client have mental health issues? What is the client's relationship with the neighbors? Does the client have other problems like health problems or self-neglecting? And, has the client contacted law enforcement?

Vignette 3

A man calls to report that his 84-year-old mother's house is so cluttered that she refuses to let anyone come in to visit.

-APS Case

-Need More Information

-Not APS Case

Additional info for discussion: For those APS workers who aren't sure if this is an APS case and need more information – you may want to know what the health and safety issues are. How bad is the hoarding? Does the client have cognitive impairments? What is the history of the hoarding behavior? And can the client meet her basic needs?

Vignette 4

A 46-year-old woman is beaten by her boyfriend.

-APS Case

-Need More Information

-Not APS Case

Additional info for discussion: More information needed, specifically is the woman a dependent adult, is the boyfriend the caregiver, and what the woman's capacity is.

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Vignette 5

An 82-year old man was befriended by a 38-year-old woman at his church. His family is concerned because whenever they call, the woman answers and tells them that he cannot come to the phone.

-APS Case

-Need More Information

-Not APS Case

Additional info for discussion: For those APS workers who aren't sure if this is an APS case and need more information – you may want to know if the client is mentally competent. What is the history of the client's relationship with the woman? Is the client physically able to come to the phone? Who has seen the client face-to-face recently? What is the frequency of contact attempts? And are there financial irregularities?

Vignette 6

A bank teller calls and reports that an elderly man (age unknown) just came in with his caregiver. The caregiver filled out a withdrawal slip for \$6,000. The man signed the slip but didn't seem to understand what he was signing.

-APS Case

-Need More Information

-Not APS Case

Vignette 7

A man calls to report that he believes that a 52-year-old co-worker who is receiving worker's compensation for an injury is not really injured.

-APS Case

-Need More Information

-Not APS Case

FACTORS FOR CASE PLANNING



TIME ALLOTTED: 60 minutes

Slide #40:

GOALS OF APS PRACTICE (CALIFORNIA)

1. Determine if vulnerable adults' basic needs are being met.
2. Determine if abuse, neglect or exploitation have occurred or are likely to occur.
3. Provide or arrange for services to reduce vulnerability, stop misconduct that is occurring and treat the effects.
4. Hold perpetrators accountable.

Topic: Goals of APS Practice (CA)

TRAINER NOTE: You may need to change the slide to reflect your States' goals of APS practice.

Your case planning needs to reflect the goals of APS Practice. The goals of APS practice in the state of California include:

1. Determining if vulnerable adults' basic needs are being met.
2. Determining if abuse, neglect or exploitation have occurred or are likely to occur
3. Providing or arranging for services to reduce vulnerability, stop misconduct that is occurring and treat the effects
4. Holding perpetrators accountable.

Next, we'll discuss some resources for you to use to achieve these goals.

Slide #41:

DETERMINING IF VULNERABLE ADULTS' BASIC NEEDS ARE BEING MET

APS workers typically make home visits to determine how vulnerable elders are managing. They may use functional assessment tools:

- Activities of Daily Living (ADL) Scales
- Instrumental Activities of Daily Living (IADL) Scales

HANDOUT #8:
Katz Index of Independence in ADL Skills
Participant Manual pg. 50

HANDOUT #9:
Lawton IADL Scale
Participant Manual pg. 52

Topic: Determining if Basic Needs are Being Met

A variety of tools have been developed to help those who work with elders and dependent adults determine if their everyday needs are being met, and what they need help with.

Two common tools are the *Activities of Daily Living (ADL) Scale* and the *Instrumental Activities of Daily Living (IADL) Scale*.

The *Activities of Daily Living (ADL) Scale* measures basic everyday functions needed to sustain life such as walking, bathing, eating, dressing, getting in and out of bed and chairs and using the toilet.

Refer participants to **Handout #8 – Katz Index of Independence in Activity of Daily Living Skills**

The *Instrumental Activities of Daily Living (IADL) Scale* measures more complicated skills like balancing checkbooks, housework, grocery shopping, preparing meals, arranging for outside services, managing finances and taking medications.

Refer participants to **Handout #9– Lawton Instrumental Activities of Daily Living Scale**



Issue Number 2, Revised 2012

Editor-in-Chief: Sherry A. Greenberg, PhD(c), MSN, GNP-BC
New York University College of Nursing

Katz Index of Independence in Activities of Daily Living (ADL)

By: Mary Shelkey, PhD, ARNP, Virginia Mason Medical Center, and
Meredith Wallace, PhD, APRN, BC, Fairfield University School of Nursing

WHY: Normal aging changes and health problems frequently show themselves as declines in the functional status of older adults. Decline may place the older adult on a spiral of iatrogenesis leading to further health problems. One of the best ways to evaluate the health status of older adults is through functional assessment which provides objective data that may indicate future decline or improvement in health status, allowing the nurse to plan and intervene appropriately.

BEST TOOL: The Katz Index of Independence in Activities of Daily Living, commonly referred to as the Katz ADL, is the most appropriate instrument to assess functional status as a measurement of the client's ability to perform activities of daily living independently. Clinicians typically use the tool to detect problems in performing activities of daily living and to plan care accordingly. The Index ranks adequacy of performance in the six functions of *bathing, dressing, walking, transferring, continence, and feeding*. Clients are scored yes/no for independence in each of the six functions. A score of 6 indicates full function, 4 indicates moderate impairment, and 2 or less indicates severe functional impairment.

TARGET POPULATION: The instrument is most effectively used among older adults in a variety of care settings, when baseline measurements, taken when the client is well, are compared to periodic or subsequent measures.

VALIDITY AND RELIABILITY: In the forty-eight years since the instrument has been developed, it has been modified and simplified and different approaches to scoring have been used. However, it has consistently demonstrated its utility in evaluating functional status in the elderly population. Although no formal reliability and validity reports could be found in the literature, the tool is used extensively as a flag signaling functional capabilities of older adults in clinical and home environments.

STRENGTHS AND LIMITATIONS: The Katz ADL Index assesses basic activities of daily living. It does not assess more advanced activities of daily living. Katz developed another scale for instrumental activities of daily living such as heavy housework, shopping, managing finances and telephoning. Although the Katz ADL Index is sensitive to changes in declining health status, it is limited in its ability to measure small increments of change seen in the rehabilitation of older adults. A full comprehensive geriatric assessment should follow when appropriate. The Katz ADL Index is very useful in creating a common language about patient function for all practitioners involved in overall care planning and discharge planning.

MORE ON THE TOPIC:

Best practice information on care of older adults: www.ConsultGerN.org.

Graf, C. (2006). Functional decline in hospitalized older adults. *JGIM*, 21(1), 56-67.

Hartigan, I. (2007). A comparative review of the Katz ADL and the Barthel Index in assessing the activities of daily living of older people. *International Journal of Older People Nursing*, 2(3), 204-212.

Katz, S. (1963). Assessing self-maintenance: Activities of daily living, mobility and instrumental activities of daily living. *JAGS*, 11(12), 721-736.

Katz, S., Down, TD., Cash, H.R., & Grots, R.C. (1970) Progress in the development of the index of ADL. *The Gerontologist*, 10(1), 20-30.

Katz, S., Ford, A.B., Moskowitz, R.W., Jackson, B.A., & Jaffe, M.W. (1963). Studies of illness in the aged: The index of ADL: A standardized measure of biological and psychosocial function. *JAMA*, 185(12), 914-919.

Krajcovic, D.M. (2012). Assessment of physical function. In M. Bolts, E. Capenuti, T.T. Fulmer, & D. Zwicker (Eds.), A. O'Meara (Managing Ed.), *Evidence-based geriatric nursing protocols for best practice* (4th ed., pp 69-103). NY: Springer Publishing Company, LLC.

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CASE CLOSURE: TRAINER'S MANUAL

Katz Index of Independence in Activities of Daily Living

ACTIVITIES POINTS (1 OR 0)	INDEPENDENCE: (1 POINT) NO supervision, direction or personal assistance	DEPENDENCE: (0 POINTS) WITH supervision, direction, personal assistance or total care
BATHING POINTS: _____	(1 POINT) Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area or disabled extremity.	(0 POINTS) Needs help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing.
DRESSING POINTS: _____	(1 POINT) Gets clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	(0 POINTS) Needs help with dressing self or needs to be completely dressed.
TOILETING POINTS: _____	(1 POINT) Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.	(0 POINTS) Needs help transferring to the toilet, cleaning self or uses bedpan or commode.
TRANSFERRING POINTS: _____	(1 POINT) Moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable.	(0 POINTS) Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE POINTS: _____	(1 POINT) Exercises complete self control over urination and defecation.	(0 POINTS) Is partially or totally incontinent of bowel or bladder.
FEEDING POINTS: _____	(1 POINT) Gets food from plate into mouth without help. Preparation of food may be done by another person.	(0 POINTS) Needs partial or total help with feeding or requires parenteral feeding.

TOTAL POINTS = _____ 6 = High (patient independent) 0 = Low (patient very dependent)

Slightly adapted from Katz, S., Down, T.D., Cash, H.R., & Grotz, R.C. (1970) Progress in the development of the index of ADL.

The Gerontologist, 10(1), 20-30.

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HANDOUT #9



Issue Number 23, Revised 2013

Editor-in-Chief: Sherry A. Greenberg, PhD(c) MSN, GNP-BC
New York University College of Nursing

The Lawton Instrumental Activities of Daily Living (IADL) Scale

By: Carla Graf, PhD(c), MS, RN, GCNS-BC, University of California, San Francisco

WHY: The assessment of functional status is critical when caring for older adults. Normal aging changes, acute illness, worsening chronic illness, and hospitalization can contribute to a decline in the ability to perform tasks necessary to live independently in the community. The information from a functional assessment can provide objective data to assist with targeting individualized rehabilitation needs or to plan for specific in-home services such as meal preparation, nursing and personal care, home-maker services, financial and medication management, and/or continuous supervision. A functional assessment can also guide the clinician to focus on the person's baseline capabilities, facilitating early recognition of changes that may signify a need either for additional resources or for a medical work-up (Gallo & Paveza, 2006).

BEST TOOL: The Lawton Instrumental Activities of Daily Living Scale (IADL) is an appropriate instrument to assess independent living skills (Lawton & Brody, 1969). These skills are considered more complex than the basic activities of daily living as measured by the Katz Index of ADLs (See Try This: Katz Index of ADLs). The instrument is most useful for identifying how a person is functioning at the present time and for identifying improvement or deterioration over time. There are 8 domains of function measured with the Lawton IADL scale. Historically women were scored on all 8 areas of function; men were not scored in the domains of food preparation, housekeeping, laundering. However, current recommendations are to assess all domains for both genders (Lawton, Moss, Fulmer, & Kleban, 2003). Persons are scored according to their highest level of functioning in that category. A summary score ranges from 0 (low function, dependent) to 8 (high function, independent).

TARGET POPULATION: This instrument is intended to be used among older adults, and may be used in community clinic, or hospital settings. The instrument is not useful for institutionalized older adults. It may be used as a baseline assessment tool and to compare baseline function to periodic assessments.

VALIDITY AND RELIABILITY: Few studies have been performed to test the Lawton IADL scale psychometric properties. The Lawton IADL Scale was originally tested concurrently with the Physical Self-Maintenance Scale (PSMS). Reliability was established with twelve subjects interviewed by one interviewer with the second rater present but not participating in the interview process. Inter-rater reliability was established at 0.85. The validity of the Lawton IADL was tested by determining the correlation of the Lawton IADL with four scales that measured domains of functional status, the Physical Classification (5-point rating of physical health), Mental Status Questionnaire (10-point test of orientation and memory), Behavior and Adjustment rating scales (4-6-point measure of intellectual, person, behavioral and social adjustment), and the PSMS (5-item ADLs). A total of 180 research subjects participated in the study, however, few received all five evaluations. All correlations were significant at the 0.01 or 0.05 level. To avoid potential gender bias at the time the instrument was developed, specific items were omitted for men. This assessment instrument is widely used both in research and clinical practice.

STRENGTHS AND LIMITATIONS: The Lawton IADL is an easy to administer assessment instrument that provides self-reported information about functional skills necessary to live in the community. Administration time is 10-15 minutes. Specific deficits identified can assist nurses and other disciplines in planning for safe hospital discharge.

A limitation of the instrument includes the self-report or surrogate report method of administration rather than a demonstration of the functional task. This may lead either to overestimation or under-estimation of ability. In addition, the instrument may not be sensitive to small, incremental changes in function.

FOLLOW-UP: The identification of new disabilities in these functional domains warrants intervention and further assessment to prevent ongoing decline and to promote safe living conditions for older adults. If using the Lawton IADL tool with an acute hospitalization, nurses should communicate any deficits to the physicians and social workers/case managers for appropriate discharge planning.

MORE ON THE TOPIC:

Best practice information on care of older adults: www.ConsultationRN.org.

Gallo, J.J., & Paveza, G.J. (2006). Activities of daily living and instrumental activities of daily living assessment. In J.J. Gallo, H.R. Bogner, T. Fulmer, & G.J. Paveza (Eds.), *Handbook of Geriatric Assessment* (4th ed., pp. 193-240). MA: Jones and Bartlett Publishers.

Graf, C. (2006). Functional decline in hospitalized older adults. *AJRN*, 30(1), 58-67.

Graf, C. (2008). The Lawton Instrumental Activities of Daily Living Scale. *AJRN*, 30(4), 52-62.

Lawton, M.P., & Brody, E.M. (1969). Assessment of older people: Self-maintaining and instrumental activities of daily living. *The Gerontologist*, 9(3), 179-186.

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Pearson, V. (2000). Assessment of function. In R. Kane, & R. Kane (Eds.), *Assessing Older Persons: Measures, Meaning and Practical Applications* (pp. 17-46). New York: Oxford University Press.

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The Lawton Instrumental Activities of Daily Living Scale

A. Ability to Use Telephone

1. Operates telephone on own initiative; looks up and dials numbers..... 1
2. Dials a few well-known numbers..... 1
3. Answers telephone, but does not dial..... 1
4. Does not use telephone at all..... 0

B. Shopping

1. Takes care of all shopping needs independently..... 1
2. Shops independently for small purchases..... 0
3. Needs to be accompanied on any shopping trip..... 0
4. Completely unable to shop..... 0

C. Food Preparation

1. Plans, prepares, and serves adequate meals independently..... 1
2. Prepares adequate meals if supplied with ingredients..... 0
3. Heats and serves prepared meals or prepares meals but does not maintain adequate diet..... 0
4. Needs to have meals prepared and served..... 0

D. Housekeeping

1. Maintains house alone with occasion assistance (heavy work)..... 1
2. Performs light daily tasks such as dishwashing, bed making..... 1
3. Performs light daily tasks, but cannot maintain acceptable level of cleanliness..... 1
4. Needs help with all home maintenance tasks..... 1
5. Does not participate in any housekeeping tasks..... 0

E. Laundry

1. Does personal laundry completely..... 1
2. Launders small items, rinses socks, stockings, etc..... 1
3. All laundry must be done by others..... 0

F. Mode of Transportation

1. Travels independently on public transportation or drives own car..... 1
2. Arranges own travel via taxi, but does not otherwise use public transportation..... 1
3. Travels on public transportation when assisted or accompanied by another..... 1
4. Travel limited to taxi or automobile with assistance of another..... 0
5. Does not travel at all..... 0

G. Responsibility for Own Medications

1. Is responsible for taking medication in correct dosages at correct time..... 1
2. Takes responsibility if medication is prepared in advance in separate dosages..... 0
3. Is not capable of dispensing own medication..... 0

H. Ability to Handle Finances

1. Manages financial matters independently (budgets, writes checks, pays rent and bills, goes to bank); collects and keeps track of income..... 1
2. Manages day-to-day purchases, but needs help with banking, major purchases, etc..... 1
3. Incapable of handling money..... 0

Scoring: For each category, circle the item description that most closely resembles the client's highest functional level (either 0 or 1).

Lawton, M.P., & Brody, E.M. (1969). Assessment of older people: Self-maintaining and instrumental activities of daily living. *The Gerontologist*, 9(3), 179-186.

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Slide #42:

CAPACITY ASSESSMENTS

May be needed to:

- Determine if abuse has occurred
- Determine what interventions are available and appropriate

Several simple screening tools are available to help detect problems. Examples include:

- The Montreal Cognitive Assessment (MoCA®)
- Clock Drawing Test/Mini Cog Assessment
- Trail Making Test

HANDOUT #10:

MoCA

Participant Manual pg. 55

HANDOUT #11:

Clock Drawing Test

Participant Manual pg. 56

HANDOUT #12:

Trail Making Test

Participant Manual pg. 58

Topic: Capacity Assessments

Understanding what clients understand is also critical in APS practice.

One of the first questions a worker might ask in deciding if an elder was financially abused, is “Did Mrs. Jones understand that deed her daughter asked her to sign?” If she didn’t, the transaction is not proper and may constitute abuse.

The interventions and remedies that are available to Mrs. Jones also depend on her mental capacity. Involuntary interventions, like conservatorship, may be necessary if she doesn’t understand what has happened and can’t take action herself.

A commonly used tool is the *Folstein Mini-Mental State Examination*. However, it is being replaced in many agencies due to copyright laws.

A tool that is increasingly popular is the *Montreal Cognitive Assessment (MoCA®)*, which is designed to assist health professionals to detect mild cognitive impairment. Refer participants to **Handout #10 – The Montreal Cognitive Assessment**.

The *Clock Drawing Test/Mini Cog Assessment Instrument for Dementia* is an excellent resource for geriatric assessment. Refer participants to **Handout #11– Clock Drawing Test**.

The *Trail Making Test* is another resource you can use for geriatric assessment. Refer participants to **Handout #12– University of Iowa Trail Making Test**.

CASE CLOSURE: TRAINER'S MANUAL

HANDOUT #10

MONTREAL COGNITIVE ASSESSMENT (MOCA)
Version 7.1 Original Version

NAME :

Education :

Date of birth :

Sex :

DATE :

VISUOSPATIAL / EXECUTIVE							POINTS		
		Copy cube	Draw CLOCK (Ten past eleven) (3 points)						
[]	[]	[]	[]	[]	[]	___/5			
NAMING									
							___/3		
[]	[]	[]							
MEMORY		Read list of words, subject must repeat them. Do 2 trials, even if 1st trial is successful. Do a recall after 5 minutes.		FACE	VELVET	CHURCH	DAISY	RED	No points
		1st trial							
		2nd trial							
ATTENTION		Read list of digits (1 digit/ sec.).		Subject has to repeat them in the forward order		[] 2 1 8 5 4			
				Subject has to repeat them in the backward order		[] 7 4 2	___/2		
		Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors		[] FBACMNAAJKLBAFAKDEAAAJAMOF AAB		___/1			
		Serial 7 subtraction starting at 100		[] 93	[] 86	[] 79	[] 72	[] 65	___/3
				4 or 5 correct subtractions: 3 pts , 2 or 3 correct: 2 pts , 1 correct: 1 pt , 0 correct: 0 pt					
LANGUAGE		Repeat : I only know that John is the one to help today. []		The cat always hid under the couch when dogs were in the room. []		___/2			
		Fluency / Name maximum number of words in one minute that begin with the letter F		[] _____ (N ≥ 11 words)		___/1			
ABSTRACTION		Similarity between e.g. banana - orange = fruit		[] train - bicycle	[] watch - ruler	___/2			
DELAYED RECALL		Has to recall words WITH NO CUE	FACE []	VELVET []	CHURCH []	DAISY []	RED []	Points for UNCUED recall only	___/5
Optional		Category cue							
		Multiple choice cue							
ORIENTATION		[] Date	[] Month	[] Year	[] Day	[] Place	[] City	___/6	
© Z.Nasreddine MD		www.mocatest.org		Normal ≥ 26 / 30		TOTAL		___/30	
Administered by: _____						Add 1 point if ≤ 12 yr edu			

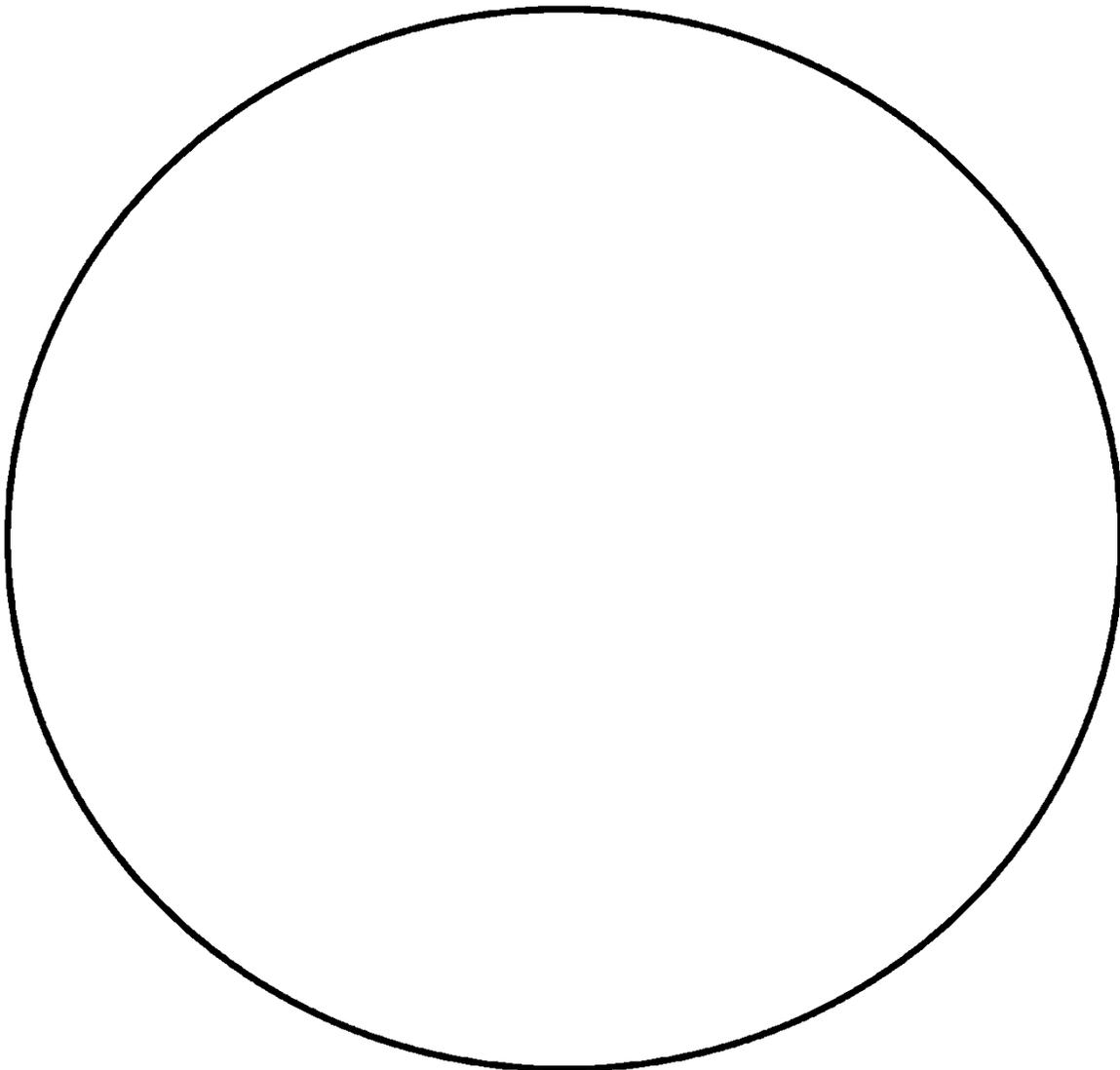
CASE CLOSURE: TRAINER'S MANUAL

HANDOUT #11

Clock Drawing Test

Patient's Name: _____

Date: _____



CASE CLOSURE: TRAINER'S MANUAL

Instructions for the Clock Drawing Test:

- Step 1: Give patient a sheet of paper with a large (relative to the size of handwritten numbers) predrawn circle on it. Indicate the top of the page.
- Step 2: Instruct patient to draw numbers in the circle to make the circle look like the face of a clock and then draw the hands of the clock to read "10 after 11."

Scoring:

Score the clock based on the following six-point scoring system:

Score	Error(s)	Examples
1	"Perfect"	No errors in the task
2	Minor visuospatial errors	a) Mildly impaired spacing of times b) Draws times outside circle c) Turns page while writing so that some numbers appear upside down d) Draws in lines (spokes) to orient spacing
3	Inaccurate representation of 10 after 11 when visuospatial organization is perfect or shows only minor deviations	a) Minute hand points to 10 b) Writes "10 after 11" c) Unable to make any denotation of time
4	Moderate visuospatial disorganization of times such that accurate denotation of 10 after 11 is impossible	a) Moderately poor spacing b) Omits numbers c) Perseveration: repeats circle or continues on past 12 to 13, 14, 15, etc. d) Right-left reversal: numbers drawn counterclockwise e) Dysgraphia: unable to write numbers accurately
5	Severe level of disorganization as described in scoring of 4	See examples for scoring of 4
6	No reasonable representation of a clock	a) No attempt at all b) No semblance of a clock at all c) Writes a word or name

(Shulman et al., 1993)

Higher scores reflect a greater number of errors and more impairment. A score of ≥ 3 represents a cognitive deficit, while a score of 1 or 2 is considered normal.

Sources:

- Kirby M, Denihan A, Bruce I, Coakley D, Lawlor BA. The clock drawing test in primary care: sensitivity in dementia detection and specificity against normal and depressed elderly. *Int J Geriatr Psychiatry*. 2001;16:935-940.
- Richardson HE, Glass JN. A comparison of scoring protocols on the clock drawing test in relation to ease of use, diagnostic group, and correlations with Mini-Mental State Examination. *J Am Geriatr Soc*. 2002;50:169-173.
- Shulman KI, Gold DP, Cohen CA, Zuccherro CA. Clock drawing and dementia in the community: a longitudinal study. *Int J Geriatr Psychiatry*. 1993;8:487-496.

CASE CLOSURE: TRAINER'S MANUAL

HANDOUT #12

Trail Making Test (TMT) Parts A & B

Instructions:

Both parts of the Trail Making Test consist of 25 circles distributed over a sheet of paper. In Part A, the circles are numbered 1 – 25, and the patient should draw lines to connect the numbers in ascending order. In Part B, the circles include both numbers (1 – 13) and letters (A – L); as in Part A, the patient draws lines to connect the circles in an ascending pattern, but with the added task of alternating between the numbers and letters (i.e., 1-A-2-B-3-C, etc.). The patient should be instructed to connect the circles as quickly as possible, without lifting the pen or pencil from the paper. Time the patient as he or she connects the "trail." If the patient makes an error, point it out immediately and allow the patient to correct it. Errors affect the patient's score only in that the correction of errors is included in the completion time for the task. It is unnecessary to continue the test if the patient has not completed both parts after five minutes have elapsed.

- Step 1: Give the patient a copy of the Trail Making Test Part A worksheet and a pen or pencil.
- Step 2: Demonstrate the test to the patient using the sample sheet (Trail Making Part A – *SAMPLE*).
- Step 3: Time the patient as he or she follows the "trail" made by the numbers on the test.
- Step 4: Record the time.
- Step 5: Repeat the procedure for Trail Making Test Part B.

Scoring:

Results for both TMT A and B are reported as the number of seconds required to complete the task; therefore, higher scores reveal greater impairment.

	Average	Deficient	Rule of Thumb
Trail A	29 seconds	> 78 seconds	Most in 90 seconds
Trail B	75 seconds	> 273 seconds	Most in 3 minutes

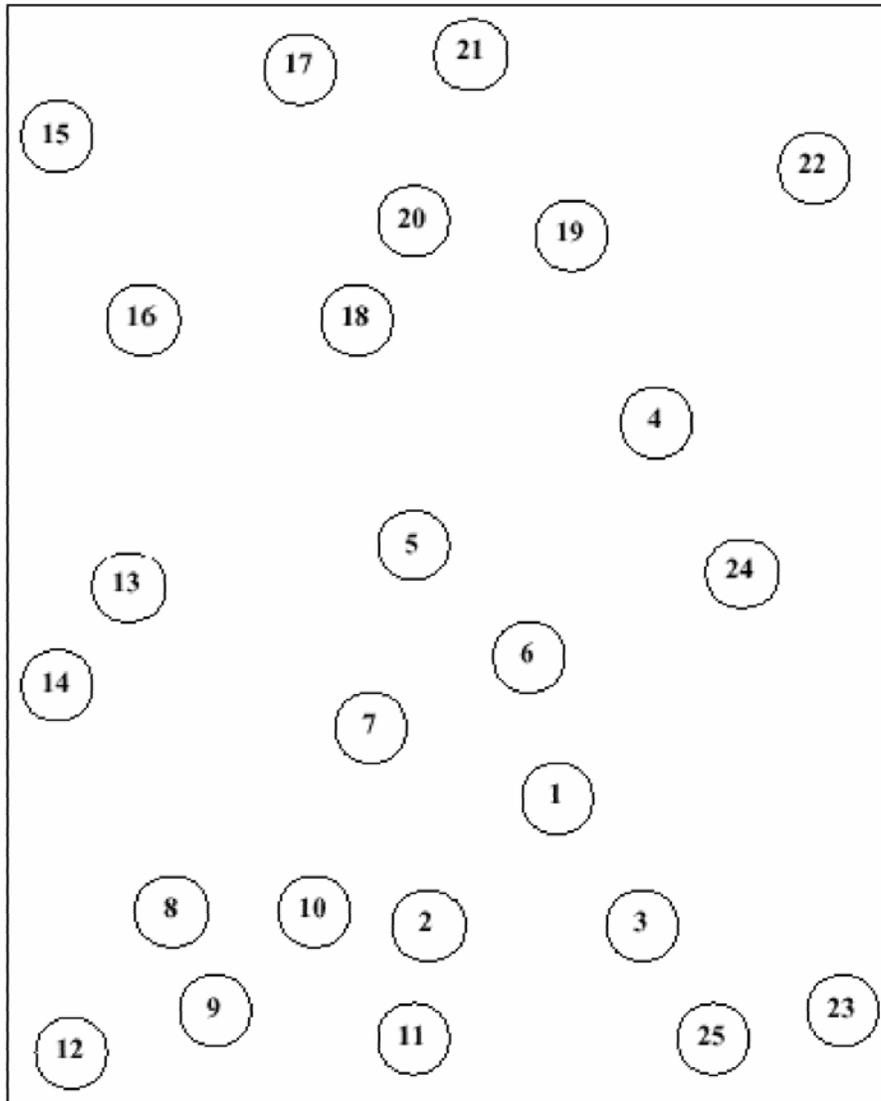
Sources:

- Corrigan JD, Hinkeldey MS. Relationships between parts A and B of the Trail Making Test. *J Clin Psychol.* 1987;43(4):402–409.
- Gaudino EA, Geisler MW, Squires NK. Construct validity in the Trail Making Test: what makes Part B harder? *J Clin Exp Neuropsychol.* 1995;17(4):529-535.
- Lezak MD, Howieson DB, Loring DW. *Neuropsychological Assessment.* 4th ed. New York: Oxford University Press; 2004.
- Reitan RM. Validity of the Trail Making test as an indicator of organic brain damage. *Percept Mot Skills.* 1958;8:271-276.

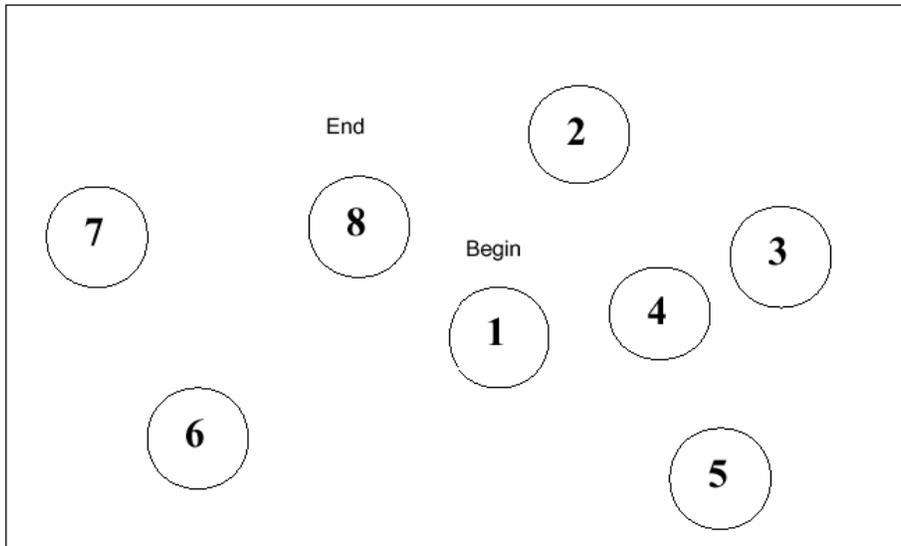
Trail Making Test Part A

Patient's Name: _____

Date: _____



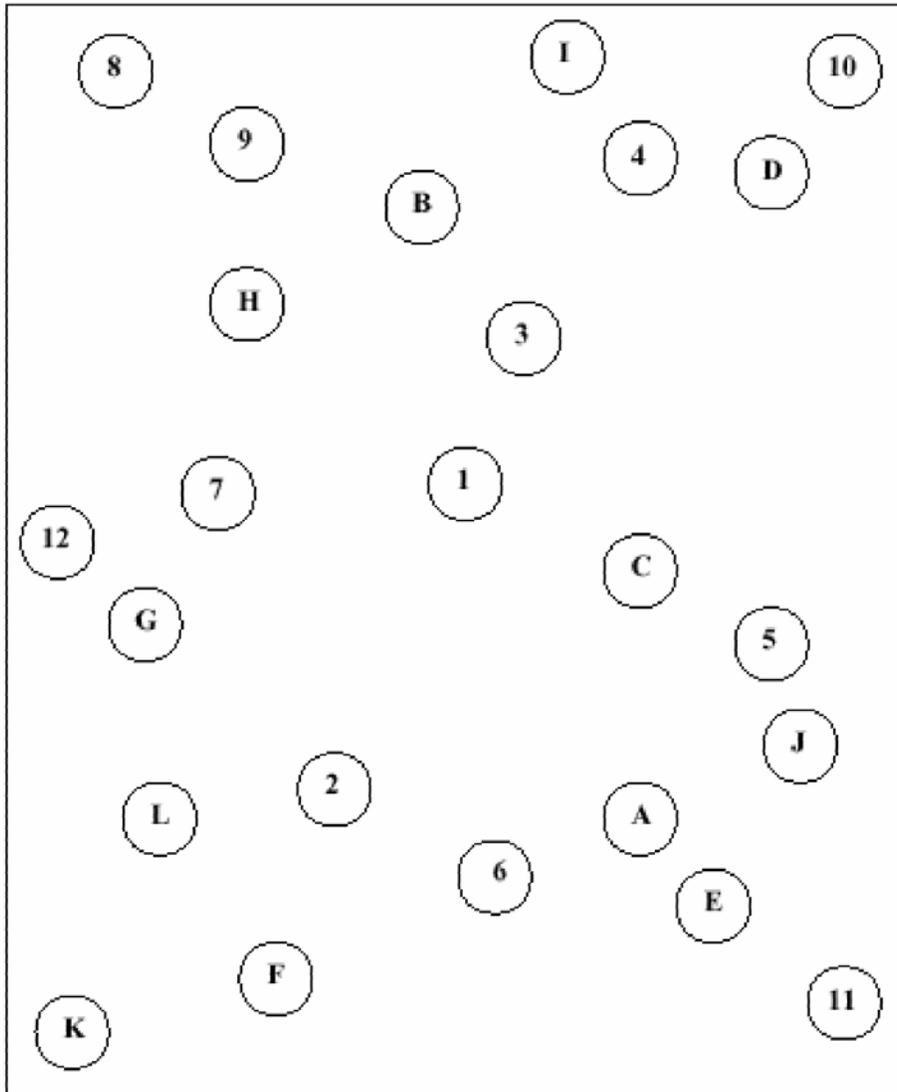
Trail Making Test Part A – *SAMPLE*



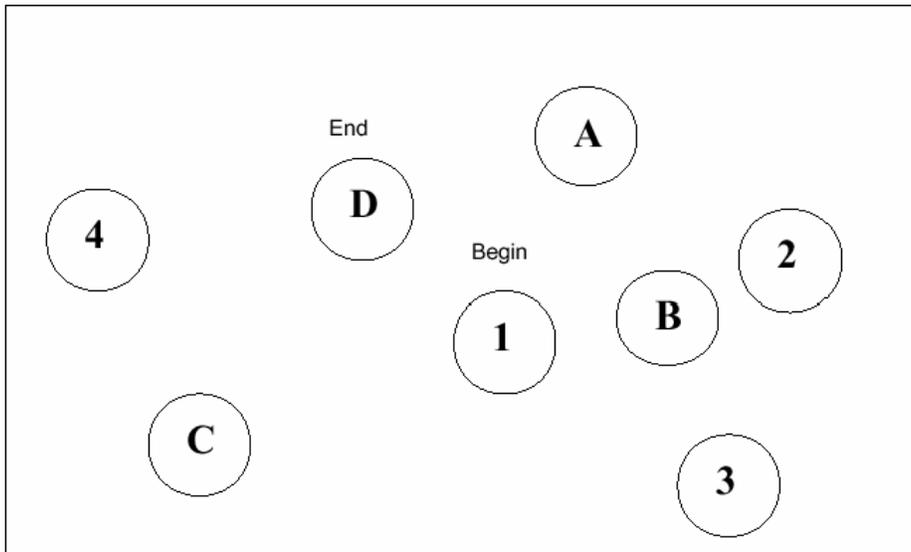
Trail Making Test Part B

Patient's Name: _____

Date: _____



Trail Making Test Part B – *SAMPLE*



Slide #43:

PRINCIPLES OF CAPACITY ASSESSMENT

Capacity is specific to the task at hand. Various tasks and decisions required different types and levels of capacity.

Does your client understand their situation?

Does your client understand the risks of their behavior?

Does your client understand the benefits of accepting help?

Topic: Principles of Capacity Assessment

Here are some examples of different types and levels of capacity:

- To leave money for their heirs through wills, adults must understand the extent of their assets and know who the recipients are.
- Capacity to accept medical treatment requires that adults understand the nature of the treatment, the risks involved, and the potential consequences of foregoing procedures.

The more critical the decision, the more important the capacity assessment. APS workers may need to consult with lawyers, physicians, psychologists or ethicists to determine if an elder has capacity when critical decisions need to be made (e.g. if the person needs a life-saving medical procedure or conservatorship).

APS workers do not make capacity determinations. Their role is to screen for capacity issues and to refer the client to the appropriate expert if there appear to be problems.

Let's examine some of the ways that capacity can shape your interventions.

Slide #44:

Does your client understand their situation?



Your assessment of whether the client has the mental facility to understand the elements of their situation as well as the risks and benefits will determine whether you can walk away if they refuse services or whether you need to refer the client for a full geriatric assessment.

Topic: Principles of Capacity Assessment (con.)

Your assessment of whether the client has the mental facility to understand the elements of their situation as well as the risks and benefits will determine whether you can walk away if they refuse services or whether you need to refer the client for a full geriatric assessment.

In the case of financial abuse, you might need to ask:

1. Does your client know how much money they have in the bank?
2. Do they know who else has access to their money?
3. Do they know how much their monthly bills are?
4. Do they know what other tangible assets they have (for example, savings, stocks, property)?
5. Do they have a reasonable emotional response to threats to their finances?

Inability to answer these kinds of questions should trigger a referral for a geriatric assessment. Correct answers may allow you to determine the client is able to make their own decisions about their finances.

Slide #45:

The slide has a light yellow background with a subtle grid pattern. In the top left, there is a brown-bordered box containing the text "Does your client understand the risks of their behavior?". To the right of this box is a small photograph of a bar scene with a bottle and a glass. Below the box and photo, there is a paragraph of text.

Does your client understand the risks of their behavior?

People of all ages have the right to make poor decisions and engage in risky behaviors. However, you need to determine whether your client understands the risk.

Topic: Principles of Capacity Assessment (con.)

People of all ages have the right to make poor decisions and engage in risky behaviors. However, you need to determine whether your client understands the risk. So, if the allegation is that your client is self-neglecting due to excessive drinking, you might ask:

1. What might happen if you take a hard fall?
2. If you break your hip, who will care for you?
3. What might happen if you drink and drive?
4. What might be the result of spending all your money on alcohol?
5. If you don't pay your rent, what will happen and how will you handle it?

If the client is unable to answer these types of questions, you may need to make a referral to the Public Guardian for a conservatorship.

On the other hand, if your client can answer the questions but says that she wants to continue to drink anyway, you may be dealing with a life style issue and you may have to walk away.

Slide #46

Does your client understand the benefits of accepting help?



You will also need to assess whether your client is able to understand the benefits of accepting help. Sometimes clients are able to articulate the risks of their behavior but they can't image those small changes that would minimize those risks and allow them to stay somewhat safely in their own home.

Topic: Principles of Capacity Assessment (con.)

You will also need to assess whether your client is able to understand the benefits of accepting help.

Sometimes clients are able to articulate the risks of their behavior (often because others have been nagging them about the risks for years!) but they can't image those small changes that would minimize those risks and allow them to stay somewhat safely in their own home. In the case of someone with balance problems, you might ask:

1. Would you be willing to use a shower chair?
2. Would you wait to bathe until someone else was here?
3. Would you be willing to contract for an emergency response pendant?
4. Would you be willing to pay for help with cooking, cleaning, dressing, as needed?

An extreme inability to understand why such measures would increase safety (as opposed to an inability to pay or a preference for privacy) might indicate a need to look at placement as a safety option.

Slide #47



Topic: Factors for Case Planning

No two APS cases are alike, which means that there is no single “correct response.” But APS workers abide by principles that guide them in their work.

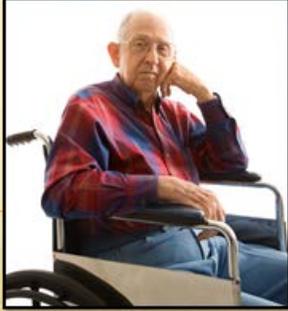
In developing a service plan workers consider the following factors:

- The client’s capacity to consent to (or refuse) services.
- The client’s perception of the problem.
- The client’s wishes and motivation.
- Your perception of the problem and the level of threat.
- What services is the client eligible for?
- What formal/informal resources does the client have?

Slide #48

CASE STUDY ACTIVITY

Read the case study about Mr. Adams and decide how you might proceed.



Allotted Time: 30 minutes

Topic: Case Study Activity

Let's take a look at a specific case example.

Case Study Activity

Directions: In your small groups, choose a note taker and read the scenario and answer the questions that follow. Be prepared to share your answers with the large group.

Direct participants to **Handout 13 - Case Study Mr. Adams on page 65 of the participant manual.**

Trainer Note: Trainer version with answers is below. Give small groups 15 minutes to work and then process answers as a large group for 15 minutes.

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Handout #13 Case Study – Mr. Adams – Trainer Version

Directions: In your small groups, choose a note taker and read the scenario and answer the questions that follow. Be prepared to share your answers with the large group.

APS Report

Mr. Adams is 86 years old. He suffers from diabetes and is confined to a wheelchair. After his wife died two years ago, he moved in with his two daughters who share a two-bedroom apartment. The older man sleeps on the living room couch. The arrangement was intended to be temporary, but the daughters have not been able to find him another place to live.

A neighbor called APS reporting that the older man is left sitting in front of the television for many hours at a time, often in urine. The last time she visited him, he asked her for a glass of water and drank two glasses in rapid succession. She also noted that he seems to have lost weight. She expressed her concerns to the daughters who became very defensive. Since then, they have not allowed her to visit.

1. What type of abuse or neglect do you suspect? Choose all that apply.

- | | |
|--|---|
| <input checked="" type="checkbox"/> Physical Abuse | <input type="checkbox"/> Abandonment |
| <input type="checkbox"/> Psychological Abuse | <input checked="" type="checkbox"/> Isolation |
| <input type="checkbox"/> Financial Abuse | <input checked="" type="checkbox"/> Neglect |
| <input type="checkbox"/> Abduction | <input type="checkbox"/> Self-Neglect |

2. For each type of abuse you suspect above, what are the abuse indicators?

Type of Abuse	Indicators	Concerns
Physical abuse includes assault, battery, assault with a deadly weapon, unreasonable physical constraint, prolonged or continual deprivation of food or water, sexual assault and rape.	<ul style="list-style-type: none">Mr. Adams is being deprived of water.Mr. Adams is being physically restrained.Mr. Adams is not getting enough to eat.	<ul style="list-style-type: none">Prolonged or continual deprivation of food or water is part of the definition of physical abuse. However, there may be other reasons that Mr. Adams drank so much water when his neighbor visited.Diabetics drink more than othersIt may have been a very hot dayFailing to leave him water

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		<p>may have been a one-time omission</p> <ul style="list-style-type: none"> • Besides the fact that Mr. Adams has limited mobility due to his wheelchair, there is no indication that his daughters are intentionally limiting his physical activity. • Failure to provide adequate food falls under both physical abuse and neglect. Mr. Adams may be losing weight because he is not eating enough. However, this could be because: <ul style="list-style-type: none"> • He has been ill and has no appetite • The family income is limited and no one in the family is getting enough to eat • The daughters are not giving him enough food
<p>Psychological abuse which includes fear, agitation, confusion, severe depression and other forms of serious emotional distress that are brought about by threats, harassment and intimidation.</p>	<p>There are no indications that Mr. Adams is experiencing psychological or mental abuse.</p>	
<p>Financial abuse includes the taking, secreting or appropriating money or property of an elder or dependent adult by a person who has the care or custody of, or who is in a position of trust to, that elder or dependent adult.</p>	<p>There are no direct indicators of financial abuse in the report however neglectful caregivers are often motivated by financial gain.</p>	<p>You might want to ask whether the daughters are being paid to provide care, whether Mr. Adams is bringing money into the household or whether the daughters are expecting an inheritance.</p>
<p>Abduction means the removal from this state and/or the restraint from returning to this state of any elder or dependent adult who does not have the capacity to consent to the removal from or restraint from returning to this state.</p>	<p>There are no indicators of abduction in this report.</p>	

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<p>Abandonment means the desertion or willful forsaking of an elder or a dependent adult by anyone who has care or custody of that person under circumstances in which a reasonable person would continue to provide care and custody.</p>	<p>There are no indicators of abandonment in the report.</p>	
<p>Isolation means prevention from receiving phone calls or mail, false imprisonment or physical restraint from meeting with visitors.</p>	<p>Mr. Adams may be experiencing isolation since his daughters do not allow the neighbor to talk to Mr. Adams.</p>	<p>However, there may be legitimate reasons why they are keeping the neighbor away from Mr. Adams. You will need to find out whether they are isolating Mr. Adams from other people as well.</p>
<p>Neglect means the negligent failure of any person, including the individual having the care or custody of an elder or a dependent adult, to exercise that degree of care that a reasonable person, in a like position, would exercise.</p>	<p>On the face of the allegations, neglect is the most obvious type of abuse that Mr. Adams is experiencing.</p> <ul style="list-style-type: none"> • Mr. Adams has lost weight. • Mr. Adams is sleeping on the couch. • Mr. Adams is left sitting, without care, for long periods. • Mr. Adams' hygiene is not being attended to. 	<ul style="list-style-type: none"> - Failure to provide adequate food falls under both physical abuse and neglect. Mr. Adams may be losing weight because he is not eating enough. However, this could be because: <ul style="list-style-type: none"> • He has been ill and has no appetite • The family income is limited and no one in the family is getting enough to eat • The daughters are not giving him enough food - Because of Mr. Adams age and health problems, sleeping on the couch is not a good long term plan. This, taken by itself, is not neglect but is a warning sign and more questions need to be asked. - Left sitting without care for long periods is definitely an indicator of neglect and a concern due to Mr. Adams health problems and his inability to provide his own care. This could

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		<p>have serious consequences, however, keep in mind that Mr. Adams may be refusing care.</p> <ul style="list-style-type: none"> - Failure to provide needed help with hygiene is neglect. And, given Mr. Adams' diabetes, skin breakdown is a serious concern.
<p>Self-neglect means the negligent failure of an elder or dependent adult to exercise that degree of self-care that a reasonable person in a like position would exercise.</p>	<p>There are no indicators of self-neglect in the report.</p>	

Planning the Home Visit

1. If this was your case, think about who you would want to talk to during your home visit. Check all that apply.

Mr. Adams

Linda and Barbara

Mr. Adam's Doctor

Mr. Adam's Wife

Neighbor/Reporter

2. What information would you want to collect from the interviewees? Would the order of the interviews matter?

- Mr. Adams - APS workers are always required to speak with the client. You need to get his perception of the problem (assuming he thinks there is a problem) and to find out how he would like the situation to be handled.
- Mr. Adam's Doctor - You need a release of information from Mr. Adams to get any information from his doctor. So, you need to speak to Mr. Adams first.
- Linda and Barbara - It's important to talk to the suspected perpetrators to get their side of the story. They may have a logical explanation of what the neighbor saw, they may be struggling because they don't know about available resources or they may be exploiting their father.

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- Neighbor/Reporter - You may want to talk to the reporter to get more details or to cross check statements made by others in the case.
- Mr. Adam's Wife - This was a trick question because Mr. Adams' is a widower. One of the challenges of being an APS worker is keeping straight all the people involved in your client's life.

Service Planning

1. As part of your case plan, what services would you suggest be put in place for Mr. Adams and his family? Why?

- A paid caregiver or adult day health care to improve Mr. Adams safety, health and socialization.
- Assisted living facility where Mr. Adams can have his own room/bed and more care.
- Rehab for Mr. Adams to learn how to transfer to a bedside commode
- Meals on Wheels for consistent nutrition
- Friendly visitor to spend time with Mr. Adams to reduce isolation
- Caregiver training/support for Linda and Barbara

CLOSING: Q & A AND EVALUATIONS



TIME ALLOTTED: 30 minutes

Slide #49:

A yellow slide with a subtle grid pattern. The word "CLOSING" is at the top left. Below it is a bulleted list: "Optional Pre-Test", "Q & A", and "Evaluations". At the bottom, it says "Thank you for your time and energy!!!".

CLOSING

- ✘ Optional Pre-Test
- ✘ Q & A
- ✘ Evaluations

Thank you for your time and energy!!!

Topic: Closing and Evaluations

Trainer Note: If you had participants complete the Pre-Test, Handout #2, this is a good time to review and correct answers. Answer key is located in the Appendix.

Answer any remaining questions, ask participants what they will remember most from the day and remind them to complete their evaluations. Thank them for their participation.

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APPENDIX

Optional Pre-Test Answer Key

1. Bankers are mandated to report elder abuse. True or False? **Correct Answer is True**
2. Under California law, anyone over 60 years old is an elder. True or False? **Correct Answer is False**
3. Kidnapping is a form of physical abuse. True or False? **Correct Answer is False**
4. Most victims of abuse are females. True or False? **Correct Answer is True**
5. All individuals with a mental health diagnosis are dependent adults. True or False? **Correct Answer is False**
6. Perpetrators of abuse are often motivated by a desire to control the victim. True or False? **Correct Answer is True**
7. APS in California investigates cases of self neglect. True or False? **Correct Answer is True**
8. Adults have the right to make bad decisions. True or False? **Correct Answer is True**
9. ADLs are Aids for Disabled Living. True or False? **Correct Answer is False**
10. One of the APS service goals is to empower victims. True or False? **Correct Answer is True**