Evidence-Based Practices in Adult Protective Services: Survey Results

Completed by the National Council on Crime and Delinquency in conjunction with the National Adult Protective Services Resource Center

The National Adult Protective Services Resource Center (NAPSRC) partnered with the National Council on Crime and Delinquency to learn about evidence-based practices in adult protection services (APS). This effort included two surveys. The first was sent to adult protection services workers, supervisors, managers, and administrators on the NAPSRC distribution list and was available online between May 3 and June 4, 2012. This survey targeted individuals working in APS and asked them to identify evidence-based practices used by their agencies. Respondents were also asked to identify individuals who could be contacted for additional information on evidence-based practices. The second survey targeted only those individuals identified as information sources on evidence-based practices and was available online between June 20 and July 12, 2012. In this subsequent survey, the respondents were asked about the types of research that had been conducted on the assessments and programs identified as evidence based and for access to published and unpublished research.

Survey 1

Identifying Practices

The first survey was sent via email to individuals known to NAPSRC as APS administrators, managers, supervisors, or workers. Forty-six responses were received from 22 states. Table 1 shows the jurisdictions that had responses and the number of respondents from each jurisdiction.

Table 1

Responding Jurisdictions

Jurisdiction	Responses
Alabama	1
California	6
Colorado	3
Florida	1
Hawaii	2
Idaho	1
Illinois	2
Iowa	1
Maine	1
Maryland	1
Michigan	2
Minnesota	8
Montana	1
Nebraska	2
North Carolina	4
Ohio	1
Oklahoma	2
Pennsylvania	1

The National Adult Protective Services Resource Center (NAPSRC) is a project (No. 90ER0002/01) of the Administration for Community Living, US Administration on Aging, US Department of Health and Human Services (DHHS), administered by the National Adult Protective Services Association (NAPSA). Grantees carrying out projects under government sponsorship are encouraged to express freely their findings and conclusions. Therefore, points of view or opinions do not necessarily represent official Administration on Aging or DHHS policy.

Table 1 Responding Jurisdictions	
Jurisdiction	**Responses**
Rhode Island	1
Virginia	3
Wisconsin	1
Wyoming	1

Respondents were asked several introductory questions regarding the type of services provided by their agency. Nearly half the respondents (21, or 45.6%) reported that their jurisdiction provided only short-term services to clients. (Short-term was defined as services lasting less than 90 days or the duration of an investigation.) Six respondents (13.0%) indicated that their jurisdiction provided only long-term services. (Long-term was defined as services lasting 90 days or more.) Another 19 respondents (41.3%) indicated that their jurisdiction provided both short- and long-term services.

Assessment Use

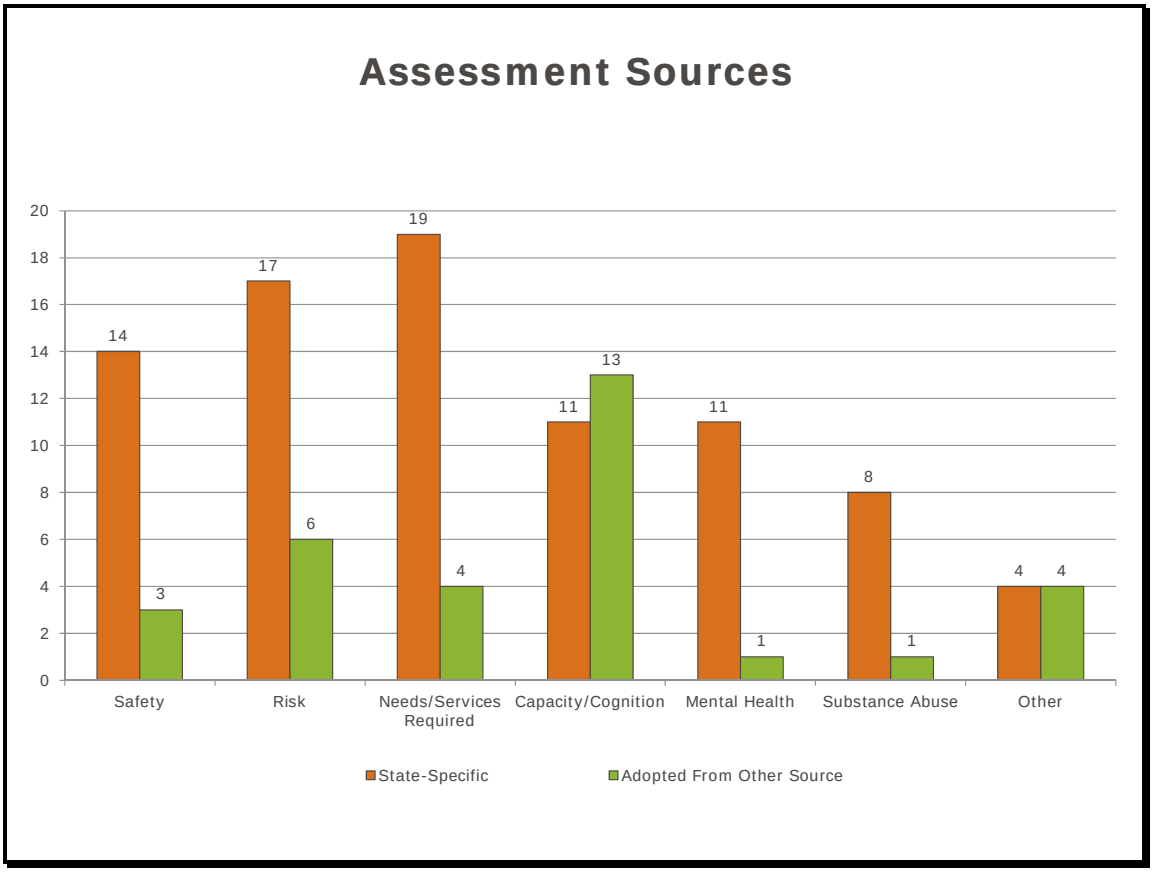
Next, survey respondents were asked about any assessments routinely used by APS workers in their agencies. More than half (26, or 56.5%) indicated that standard assessments were used statewide. Respondents were then asked to identify the purpose of each statement assessment. Table 2 shows the number of respondents who reported using each type of assessment statewide.

Table 2 Statewide Assessment Usage	
Assessment Purpose	**Number of Respondents Reporting Use**
Capacity/cognition	24
Risk	23
Needs/services required	23
Safety	17
Mental health	12
Substance abuse	9
Other	8

Risk, needs/services required, and capacity/cognition assessments were most commonly identified by respondents as being used statewide. Safety and mental health assessments were used by about half of respondents, with the use of substance abuse assessments being less common. "Other" reported assessments included "various," Companion Services Assessment, ASAPS investigation criteria, risk assessment, Katz ADL and Layton IADLs Intake assessment, APS community evaluation, and APS facility evaluation.

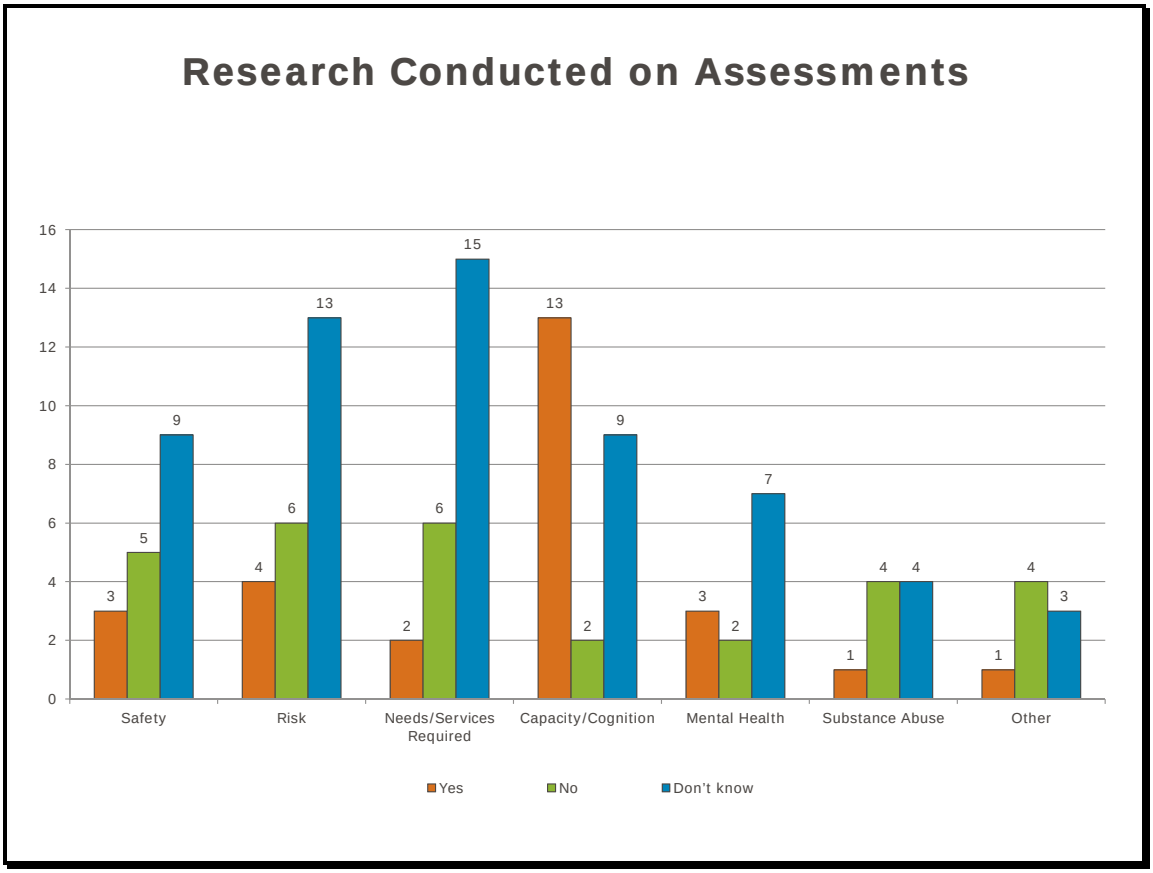
When asked how these assessments had been developed, most respondents indicated that the assessments were state-specific, while a small number were adopted from other sources (e.g., another state, or an assessment developed by a researcher independently of the jurisdiction), as shown in Figure 1. The only exception was the capacity/cognition assessment, which was almost as likely to be state developed or adopted from another source.

Figure 1



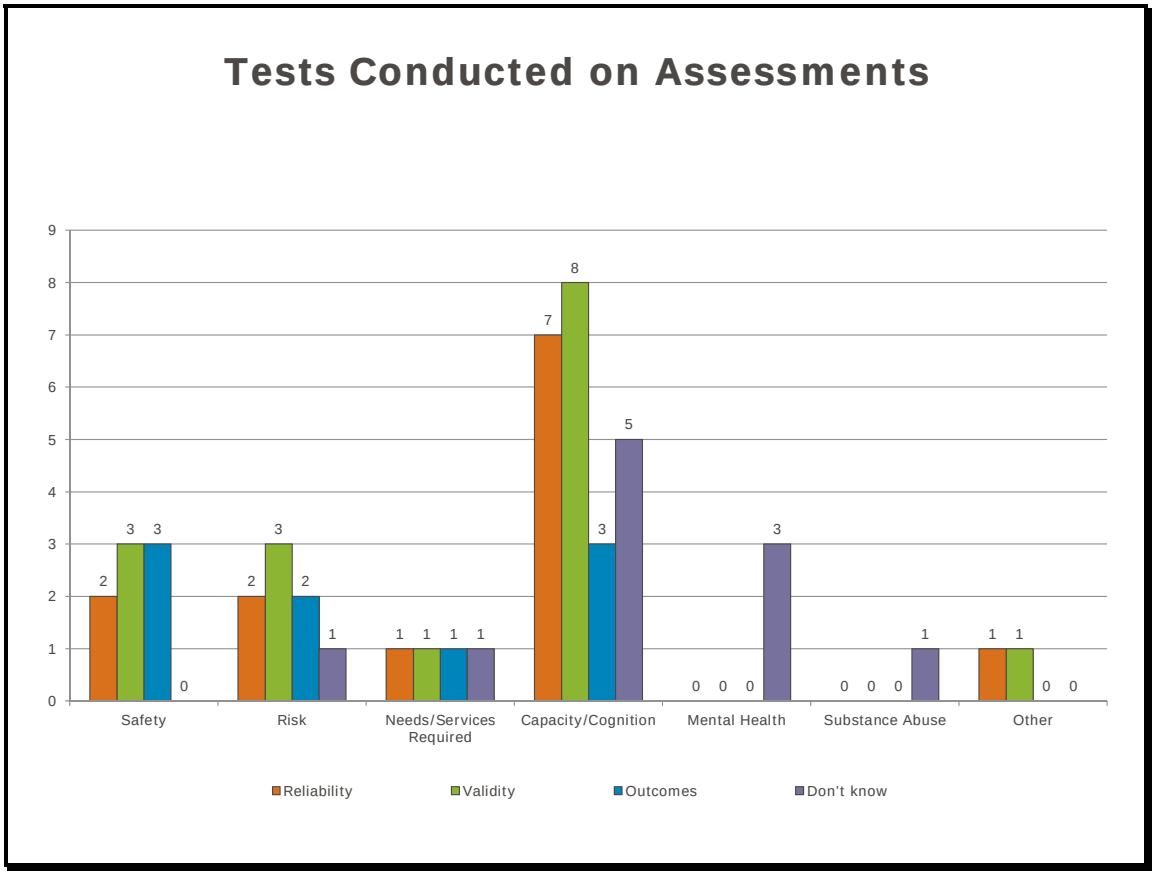
After these foundational questions about the purpose and origin of the assessments used in APS agencies were answered, respondents were asked if research had been conducted regarding each assessment used by their agency. Responses are shown in Figure 2. In most cases, respondents either believed that the assessments used had not been researched, or did not know if research had been conducted. One notable exception was assessments of capacity/cognition, which respondents most often identified as being research based.

Figure 2



The next set of questions was asked only of respondents who indicated that their assessments were evidence based. Many respondents indicated that the assessments had been tested for reliability, validity, and their ability to support positive outcomes for clients. A smaller number of respondents indicated that while they believed an assessment was evidence based, they did not know what type of research had been conducted. (Full data are shown in Figure 3.)

Figure 3



Programs

Next, survey respondents were asked to identify evidence-based programs or services that their agency provided to clients. Ten respondents indicated their agencies had participated in research studies to create an evidence base for practice, and 11 indicated that their agency currently makes evidence-based programming available to clients. (For purposes of this survey, "evidence-based programs" were defined as those that "used the scientific method to evaluate outcomes and are based on observable and measurable data.") The reported purposes of these programs identified as evidence based are show in Table 3. The most common purpose of evidence-based programs was to address emotional/coping concerns, with addressing cognitive, dementia concerns the second most commonly identified purpose.

Table 3 Purposes of Evidence-Based Programs	
Purpose	**Number of Programs Identified**
Address emotional/coping concerns	4
Address cognitive/dementia concerns	2
Address financial concerns	1
Address mobility concerns	1
Caregiver assistance/support program	1
Other	4

Respondents were asked to indicate if any programs were intended to address developmental disability concerns. This category was not selected by any respondents.

Directions for Future Research

At the end of the first survey, respondents were asked about promising practices offered in their agencies—services not yet evaluated, but that they believe to be helpful. In the first question regarding promising practices, respondents were asked to identify promising practices from a list of common practices. Services identified as promising practices are shown in Table 4.

Table 4 Promising Practices	
Promising Practice	**Number of Respondents Identifying**
Multi-disciplinary teams – case review teams	27
Multi-disciplinary teams – elder abuse coalition	17
Multi-disciplinary teams – other	13
Family group or case conferences	13
Multi-disciplinary teams – financial abuse specialist teams	11
Co-located services (e.g., law enforcement in Aging and Disability Resource Centers)	9
Multi-disciplinary teams – elder death review teams	8
DA/AG crime prevention unit	8
Volunteer home visitors	7
Forensic center	3

Most respondents identified multi-disciplinary teams (MDT) as a promising practice. The top three most common responses fell into this category—MDT: case review teams (27 respondents); MDT: elder abuse coalition (17 respondents); and MDT: other (13 respondents). Family group or case conferences (13 respondents) and MDT: financial abuse specialist teams (11 respondents) were also identified as promising.

The survey then allowed respondents to write in additional practices regarded as promising. A full listing of responses may be found in Appendix A. Some themes that emerged from responses to this item include:

- Collaboration with law enforcement (e.g., training for officers, victim of crime programs);
- In-home support programs (e.g., caregiver grants, in-home referrals, visiting physicians);
- Alzheimer's services;
- Domestic violence services;
- Emergency support programs (e.g., to address homelessness or the effects of poverty);
- System supports (e.g., reporter training, referral programs to share information with system partners, fatality review boards, regional meetings);
- Prevention services (e.g., community teams);
- Technology programs (e.g., e-consults); and
- Guardianship and conservator programs.

Finally, respondents were asked what research agenda they would sent for the APS field. Respondents were asked to identify three priorities from a list. Their responses are shown in Table 5. Most identified immediate risk assessment and capacity/cognition assessment as priorities. Future/predictive risk assessment, needs/services required assessments, services to address cognitive/dementia concerns, and services to address financial concerns were also frequently selected.

Table 5

Research Priorities

Priority	Number of Respondents Selecting
Immediate risk assessment	31
Capacity/cognition assessment	28
Services to address financial concerns	18
Services to address cognitive/dementia concerns	15
Future/predictive risk assessment	10
Needs/services required assessment	10
Safety assessment	9
Services for caregiver assistance/support program	9
Services to address mobility concerns	2

Table 5 Research Priorities	
Priority	**Number of Respondents Selecting**
Services to address developmental disability concerns	1
Services to address emotional/coping concerns	1

When asked to define a "successful outcome" for APS, the definitions shown in Table 6 were given.

Table 6 Successful Outcomes	
Outcome	**Number of Respondents Identifying**
Client's safety is improved	44
Protection of the client's financial assets	41
Risk reduced	40
Prevention/mitigation of future abuse, neglect, or exploitation	39
Improvement in the client's quality of life	38
Supportive and other services provided to the client	35
Arrest and prosecution of abusers	27
Client accepted services	23
Legal interventions sought	20
All required case activities and documentation completed on time	19
Reporter, family members, and/or community of client are satisfied	11

Most respondents identified improved safety, reduced risk, and protection of financial assets as successful outcomes. Other frequent outcomes included the prevention/mitigation of future abuse, neglect, or exploitation; improvement in the client's quality of life; and supportive services provided to the client. It is interesting to note that "reporter, family members, and/or community of client are satisfied" was the least-frequently selected successful outcome.

When allowed a free response to this question, answers fell among the following themes. (A full list of responses is given in Appendix A.)

- Client/family satisfaction;
- Client self-determination (e.g., client remains in home, least restrictive interventions are used, client's opinions are respected);
- Reduced recurrence/recidivism;

- Mitigation of risk (e.g., client and family are educated about APS issues, client is aware of community resources);

- Legal outcomes (e.g., prosecution, recovery of assets); and

- Improved client physical/mental health.

Some respondents noted that successful outcomes in adult protection are difficult to assess because clients retain the right to refuse services (therefore, subsequent events may reflect client choice more than worker recommendations or efforts), and because some clients have conditions that naturally worsen over time and no intervention by APS could prevent subsequent negative outcomes.

After the initial survey findings were compiled, two follow-up surveys were launched. One survey was sent to all persons or institutions identified in the first survey as sources of additional information on evidence-based assessments. A different survey was sent to sources identified as having more information on evidence-based programs. These online surveys were available from June 30 to July 12, 2012.

Survey 2

Assessments

Respondents to the first survey identified and provided contact information for 11 unique assessments or assessment systems that they believed to be evidence based. To learn more about these assessments, a secondary survey was sent to the experts identified for each assessment. These experts were informed of the first survey and given the option to forward the secondary survey to another person whom they believed to be more "expert." The assessments identified for the secondary survey are shown in the list below; those for which respondents completed the secondary survey are shown in bold. This secondary survey had a 55.5% response rate.

Assessments included in follow-up survey:

- **ASCAP: Adult Services Comprehensive Assessment Program**
- **Clox**
- Domestic Violence Safety Plan
- FASE
- The Mini Mental Status Exam
- **IADL**
- **The Montreal Cognitive Assessment**
- **NC APS Facility Evaluation**
- Saint Louis University Mental Status Examination
- Six Pillars
- **The Virginia UAI (Uniform Assessment Instrument)**

Information for the six responding assessments is summarized in Table 7. When interpreting these results, it is important to remember that the findings reflect only the information provided by the survey respondents, whose information may have been incomplete.

Table 7

Research on Assessments Identified as Evidence Based

Assessment	Tested for Reliability	Tested for Validity	Evaluated Under Field Conditions
ASCAP	No	No	No
Clox	Yes	Yes	Unknown
IADL	Yes	No	Unknown
Montreal Cognitive Assessment	Yes	Yes	Yes
NC APS Facility Evaluation	No	No	Unknown
Virginia UAI	Yes	Yes	Yes

Respondents were also asked to identify if any research (in addition to reliability or validity testing or an evaluation) had been conducted. No respondents identified additional research on any of the assessments. Because the secondary survey respondents were unable to describe the research basis for the ASCAP or the NC APS Facility Evaluation, these assessments have been dropped from the current report. The survey respondent with information regarding the ASCAP noted "Rather than an assessment tool, it is more a way for adult services staff (this includes 3 separate adult programs) to document contacts, data regarding the client, investigations, etc. We utilize the program to extract data but it is used more as a tool than an evidence- or outcomes-based program at this time."

The **Clox** assessment was tested for reliability using correlational coefficients, alpha coefficients, and Rasch modeling; and for validity, using face validity, predictive validity, construct validity, and concurrent validity tests. The respondent was able to identify many published studies that documented the reliability and validity of the Clox assessment. Citations for this research were provided by the respondent, and may be found in Appendix B.

The **IADL** was piloted by Ventura County and tested for reliability and validity; however, the survey respondent was not familiar with the specific tests used and was unable to provide citations for these studies.

The **Montreal Cognitive Assessment** was tested for reliability and validity; however, the survey respondent was unable to identify the specific tests used and was unable to provide citations for these studies. In addition to these tests, a process evaluation had been conducted. Citations for the process evaluation are included in Appendix B.

The **Virginia UAI** has been tested for reliability using percentage agreement and percentage agreement with an expert score. The validity of this assessment was tested using face validity and predictive validity tests. A process evaluation was conducted by the Virginia Commonwealth University, which found that the assessment helped workers identify service needs for APS clients that were similar (to a statistically significant degree) to those of an experienced group of professionals. In addition, trained assessors with different backgrounds arrived at similar recommendations for clients. Citations for this work were provided and are included in Appendix B.

Programs

Respondents to the first survey identified and provided contact information for 12 unique programs for APS clients that they believed to be evidence based. To learn more about these programs, a secondary survey was sent to the experts identified for each program. These experts were informed of the first survey and given the option to forward the secondary survey to another person whom they believed to be more "expert." The programs identified for the secondary survey are shown in the list below; those for which respondents completed the secondary survey are shown in bold. This secondary survey had a 41.7% response rate.

Programs included in the follow-up survey:

- **California APS Standards for Consistency in Determining Findings**
- Center for Excellence in Aging and Geriatric Health
- **Depression Screening and Falls Prevention Program**
- **Elder Abuse Decision Support System**
- Estate Management
- Oklahoma Risk Assessment
- Preventative In-Home Partnership
- Range Women's Advocates
- Rapid Response Expert Team
- **Stepping On**
- **Structured Decision Making®**
- TRIO-UC San Diego

Information for the five responding programs is summarized below. When interpreting these results, it is important to remember that the findings reflect only the information provided by the survey respondents, whose information may have been incomplete.

Table 8

Program Information

Program	Process Evaluation	Outcomes Evaluation	Other Research Conducted
California APS Standards for Consistency in Determining Findings	No	No	No
Depression Screening and Falls Prevention Program	Yes	Yes	Unknown
Elder Abuse Decision Support System	Yes	No	No
Stepping On	No	Yes	Unknown
Structured Decision Making	Yes	No	Yes

Because the survey respondent for the California APS Standards for Consistency in Determining Findings program was unable to describe the research conducted on the service, this program has been dropped from this study.

The **Depression Screening and Falls Prevention Program** was subject to both a process and an outcomes evaluation. The study found that older adults participating in the program had fewer symptoms of depression, decreased physical pain, better ability to recognize and self-treat symptoms, and improved well-being. Additional benefits were identified for service providers, including expanded capacity to address depression, better communication and stronger partnerships with mental health providers, and improved staff knowledge and confidence in helping clients. The respondent was able to provide citations for this research, which are collected in Appendix B.

The **Elder Abuse Decision Support System** was subject to a process evaluation at seven provider sites in Illinois. The program is a web-based screening that considers suspected abuse and incorporates interviews with alleged victims, collaterals, and alleged abusers. This research is summarized in a study provided by the respondent. The citation for this study is listed in Appendix B.

Stepping On was evaluated for outcomes. This fall-prevention program demonstrated a 31% reduction in falls among program participants. Further information on the program is available through the sources listed in Appendix B.

The **Structured Decision Making** system for APS was subject to a process evaluation in New Hampshire, where the state APS agency is implementing four assessments to inform social worker decision making in APS cases. The evaluation found that early practice was promising, but varied by office. Additional research on this model included reliability testing of the four assessments (intake, safety, risk, and strengths and needs) as well as a validation study to determine the predictive validity of the risk assessment. The available research on this system is collected in Appendix B.

Discussion

The survey findings described in this report begin to scratch the surface of evidence-based practice in APS in the United States. Respondents to the initial survey represented 22 states, and the findings of these surveys should be regarded as suggested directions for future exploration, rather than as a definitive description of current practice. Findings of interest include:

- Many respondents indicated that their agencies do use standardized assessments that are implemented statewide. This may indicate an interest in supporting the consistency of decision making within jurisdictions.

- Most of the assessments used by APS agencies are specific to the individual state and were not adapted from another source. The exception is assessments of capacity/cognition, which were almost as likely to have been internally or externally developed.

- For most assessments (excluding capacity/cognition assessments), respondents either did not know if the assessments were evidence based or believed that they were not evidence based. This finding may reflect many causes: a lack of evidence-based assessments for use in APS, a lack of information about/dissemination of evidence-based assessments in APS, or a lack of funding to evaluate state-developed systems.

- Most respondents did not identify that their agency made evidence-based programming available to clients. Again, this may be due to a lack of research, lack of communication, or a lack of funding to test local programming.

- When asked to identify promising practices and successful outcomes, respondents had many suggestions for future research efforts. This may indicate that a lack of knowledge regarding evidence-based practice is due to a lack of research and research funding, rather than any lack of seeking such research by the field.

- The follow-up surveys identified a handful of evidence-based practices and assessments that other jurisdictions may choose to explore further when making their own programming choices.

Appendix A

Responses to Open-Response Questions

Responses to Open-Response Questions
(Responses are presented below exactly as they were typed into the online survey.)

If your APS community has other "promising practices" in addition to those mentioned above, please list them below. (By promising practices, we mean programs, services, or other approaches that have not been evaluated or researched, but seem to produce good results for your clients.)

- Law enforcement training on elder issues for both new officers and current officers.
- caregiver grant, referrals for in home assistance, visiting physicians. Outreach/education to professionals who report a/n/e
- Referral process in place to share APS information with Attorney General's Office, Medicaid Fraud Control Unit; with county police departments; with licensing authority for residential care settings (care homes; foster homes; nursing homes).
- Emergency resources services for emergency APS cases that involve homelessness, poverty or poor nutrition due to lack of food
- Community Teams focused on prevention Will be implementing FAST and Adult Fatality Review Team
- e-consult
- Victim of Crime Program Volunteer Guardianship Program
- I selected one above - we do not do any of the above.
- Contracted Guardianship & Conservatorship Meetings
  Regional AP Meetings every other month
- We don't have the above, but, the system required one be checked
- Developed framework for determining dependent adult status and turning the materials into an eLearning to be delivered statewide in Fall 2012.
- Coordination with the Alzheimer's Community Care Association for in-home and placement services to dementia clients. This group is unique to Palm Beach County, Florida and receives national support.
- Domestic Violence Prevention, Range Intervention Program, Children's Services
- At the state level we've partnered with the Conference of DAs to improve access to the justice system for victims of abuse, neglect and exploitation in NC.

- services to dementia clients. This group is unique to Palm Beach County, Florida and receives national support.
- Domestic Violence Prevention, Range Intervention Program, Children's Services
- The 100 local DSS agencies that provide APS may have practices we're not aware of. At the state level we've partnered with the Conference of DAs to improve access to the justice system for victims of abuse, neglect and exploitation in NC.

What other indicators would tell you that a service or practice has resulted in a successful outcome?

- Expressed appreciation by the client and family
- Client's self-determination is honored.
- We measure the goal of elimination or reduction of the protective issue. We measure progress toward goal in 4 areas. We measure prognosis of recurrence
- Improved physical and or mental health of Client
- client is able to remain in his or her home.
- Increase in prosecution of perpetrators
- Reduced recidivism rates.
- least restrictive interventions attempted before more restrictive interventions
- The reduction in re-opened cases.
- education of family members, etc. re: APS, community resources, available services
- This is a hard area to manage as adults have the right to refuse so there may not be a lot of "success" and that does not measure the volume of work that workers handle
- client's rights and opinions have been respected whether agreed upon or "professionals" feel it is best for the client.
- client is aware of available community resources
  client is aware of how to improve safety
- Client/Customer satisfaction
- Client's feels that satisfied and sees the improvement. There are less re-offenses
- Recovery of assets

- maltreatment is stopped or plan in place to keep client safe if remaining in same environment, plan is in place to prevent future maltreatment. The question which is subjective in nature would be Is the client better off as a result of insertion of APS into their lives? Objective outcome measures could be developed to establish 'better off'. Such as assists protected, surrogate decision maker in place. client self-reports (with capacity). markers for stability or maintenance, recognizing that many APS client will deteriorate due to health and that sustaining a person is a safe environment while they are in the dying process is as good as it gets with some clients.

Appendix B

Citations for Research Identified by Survey Respondents

Citations for Research Identified by Survey Respondents

Clox Assessment

Allen, S. C., & Baxter, M. (2009). A comparison of four tests of cognition as predictors of inability to perform spirometry in old age. *Age Ageing, 38*(5):537–541.

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Montreal Cognitive Assessment

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Visual Impairment

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Other

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NORMATIVE DATA

Low education:

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REVIEWS

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The Virginia UAI

Long-Term Care Information System Assessment Process by Angela Falcone, BSN, MPH, of Patient Care Management Systems, Inc., PO Box 393, Lenox Hill Station, New York, NW 10021 (formerly LTC Assessment Training Center at Cornell University Medical College). The original report date is 1982.

Additional Resources – Programs

The Depression Screening and Falls Prevention Program

http://careforelders.org/default.aspx?menugroup=healthyideas

Quijano, L. M., Stanley, M. A., Petersen, N. J., Casado, B. L., Steinberg, E. H., Cully, J. A., & Wilson, N.L. (2007). Healthy IDEAS: A depression intervention delivered by community based case managers serving older adults. *Journal of Applied Gerontology, 26,* 139–156.

Elder Abuse Decision-Support System

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Stepping On

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Structured Decision Making®

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