NATIONAL ADULT PROTECTIVE SERVICES ASSOCIATION

THE NATIONAL APS RESOURCE CENTER

Doing More with Less:

Replicable, Innovative and Cost-Saving Measures in Adult Protective Services

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ABOUT THE NATIONAL ADULT PROTECTIVE SERVICES RESOURCE CENTER

The National Adult Protective Services Resource Center (NAPSRC) is a project (No. 90ER0002/02) of the Administration for Community Living, U.S. Administration on Aging, U.S. 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.

ABOUT THE NATIONAL ADULT PROTECTIVE SERVICES ASSOCIATION

The National Adult Protective Services Association (NAPSA) is a national non-profit organization with members in all fifty states and abroad. Formed in 1989, the goal of NAPSA is to provide Adult Protective Services (APS) programs a forum for sharing information, solving problems, and improving the quality of services for victims of elder and vulnerable adult mistreatment.

The National Adult Protective Services Association's mission is to strengthen Adult Protective Services programs in order to improve the safety and independence of older persons and adults with disabilities who are victims of abuse, neglect, self-neglect, or financial exploitation.

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Kathleen Quinn
NAPSA Executive Director

Andrew Capehart
NAPSA Assistant Director

INTRODUCTION

As the safety net for abused, neglected and exploited vulnerable adults, adult protective services (APS) programs must be innovative, creative and forward-thinking in the manner in which they choose to serve the rapidly-growing and dynamic vulnerable adult population. Without a federal "home" for APS (i.e., without a federal government entity that assumes responsibility and oversight), states, and often counties, have developed their own unique programs to serve the needs of adults who cannot protect themselves. Some programs consist of state employee investigators in regional offices that may cover large geographic areas. Other programs consist of distinct county operations that can vary significantly in regards to the target population served, clinical assessment of clients/consumers and services provided to said consumers. Others yet may contract with private non-profit programs to carry out all of the functions of the APS program from intake to case closure. In addition, APS programs are administratively located in diverse systems, with about half affiliated with aging network agencies, about half in state human services agencies, and a few in other settings, including prosecutor offices or independent government agencies.

Given the variety of programs that exist, a certain freedom with respect to program design has developed among jurisdictions to best serve the needs of their local vulnerable adult population. This freedom can often be attributed to the smaller size of most APS programs, even in major metropolitan areas. In the broader world of protective services, child protective service (CPS) programs often dwarf their APS counterparts in staffing levels, resources and budget. For instance, in 2012, the City and County of Sacramento, with a population of just over 1.4 million, employed 330 caseworkers in the child protective services program while dedicating 37.8 full time equivalency (FTE) professionals to handle the population (vulnerable adults 18+) served by adult protective services. Per 2012 census data, this means that there is one APS front-line social worker for every 7949 potential consumers (adults with a disability age 21-64 and adults age 65 and older) compared to one CPS front-line social worker for every 1099 potential consumers (children under age 18) (US Census Bureau, 2014).

The budgets for APS programs, just like most other government programs, have shrunk over recent years or remained static in the face of growing elder and vulnerable adult populations. According to the NAPSRC 2012 survey of state APS programs, 47% experienced a reduction in staff while 87% reported an increase in reports and caseloads. As a result of these trends, NAPSRC set out to learn how APS programs were coping and "doing more with less" (National Adult Protective Services Resource Center, 2013).

The aforementioned lack of a federal government entity with purview of APS translates to the strong need for peer support between programs. Without national guidelines, standards or established best practices, programs have been forced to turn to each other, whether it be within a single state or between states, for lessons learned in a particular area. In the spirit of that peer support, this report seeks to bring unique programs within APS to the forefront so that they may be examined and replicated.

Nine innovative practices, varying in scope and housed within existing APS programs at both the state and local level, are highlighted in this report. Five of those programs received site visits from National Adult Protective Services Resource Center (NAPSRC) staff, and are the primary focus of this report. An additional four programs participated in telephone interviews and are also highlighted. Each practice offers a unique perspective on providing services to vulnerable adults in their communities as well as conducting day-to-day business in an ever-changing and evolving profession.

METHODS

A mass-marketing email, explaining the purpose of the project and requesting data on innovative practices via online survey, was sent in December 2012 to NAPSRC contacts and was also posted on the NAPSRC and National Center on Elder Abuse (NCEA) listservs. Forty-two responses to the online survey were received detailing innovative practices on both the state and local levels.

Subsequent to the online collection of innovative practices, a mass-marketing email was sent via the same methods listed above, requesting volunteers to review the collected practices. Eight professionals responded to this request (Appendix A) to form the Innovative Practices Report Workgroup. The workgroup volunteers varied from current APS investigators and supervisors, to consultants with significant experience working in and with APS programs. None of the workgroup members were employed or consulted with programs selected to highlight in this report.

The workgroup reviewed each of the 42 submissions and selected the five programs they subjectively assessed as the most interesting and promising practices. A rating tool was developed to attempt to quantify the selection of each workgroup member's five selections, and was administered via online survey. An effort was made to have a representative array of programs: urban and suburban; state and county administered; and geographically diverse, although the selected programs did end heavily weighted toward the mid-Atlantic region of the United States. The top five highest rated practices were selected to receive site visits from NAPSRC staff for this report. Due to travel budget constraints, one of the practices, housed at the Alaska Division of Senior & Disabilities Services, was unable to receive a site-visit and was instead interviewed via telephone. In its place, the Philadelphia Corporation for Aging was selected for a site-visit.

Two additional programs were selected via NAPSRC staff for telephone interviews. These agencies were consulted on known practices within their agencies; one involves the co-location of law enforcement officers within APS, and the other adopted "hoteling," which means that employees are no longer provided their own individual work stations, but work more independently and utilize shared work space when in the office. It is a way to reduce expenditures on rent and mileage, as well as to provide APS employees, who spend much of their time in the field, with more flexibility.

SITE	PRACTICE	GOALS
New York City APS	Preventive visits and financial management	Prevention of abuse and reduction in recidivism*
Philadelphia APS	Financial task force	Improved communications with banks and criminal justice agencies; improved investigation and resolution of cases, including more prosecutions*
Maryland APS	Revamp of how services are provided	More involvement of family and community from beginning of case; more efficient use of APS time*
Fairfax County, Virginia, APS	Use of contracted psychologist and nurse practitioner	Regular access to specialized expertise available to APS and to clients; improved services and credibility in court*
Sacramento, California APS	Contracts with hospitals to provide specialized services to clients who are frequent hospital users	Income for APS; stabilization of self-neglect clients; lower hospital usage and reduced reports to APS*
Alaska APS	Increased use of community professionals and of video communications	Improved and more timely communications with clients and reduced travel costs and time to visit remote areas*
Massachusetts APS (18 – 59)	Co-location of state police in APS unit	Improved rate of criminal investigation and prosecution
Florida APS	Hoteling	Cost savings and increased staff flexibility and improved use of time*
New York City Elder Abuse Center	Multi-disciplinary attention to elder abuse cases	Improved communications among APS, health care providers, banks and criminal justice agencies; improved investigation and resolution of cases*
*All programs were asked for documentation/evidence of program evaluation.		

PREVENTION EFFORTS AT THE NEW YORK CITY HUMAN RESOURCES ADMINISTRATION

The New York City Human Resources Administration Department of Social Services (HRA) provides temporary help to individuals and families with social service and economic needs to assist them in reaching self-sufficiency. HRA serves more than 3 million New Yorkers through essential and diverse programs and services that include: temporary cash assistance, public health insurance, food stamps, home care for seniors and the disabled, child care, adult protective services, domestic violence, HIV/AIDS support services and child support enforcement.

New York City, with 8.4 million residents, is the nation's largest metropolis; its population exceeds the combined populations of the next two largest cities, Los Angeles and Chicago. The residents are 44% white, 29% Hispanic, 26% black, 13% Asian, and virtually every ethnic group in the world is represented. Nearly 20% of residents are below federal poverty level (US Census Bureau, 2014).

The adult protective services department at HRA receives more than 1500 reports of vulnerable adult abuse each month. With seven offices in the five boroughs of New York City (HRA maintains two offices for both Manhattan and Brooklyn, forming the North and South offices of those areas), HRA employs more than 220 caseworkers and maintains a caseworker to supervisor ratio of 1:5 – 1:6. Multiple divisions exist within the structure of the APS program, including: Administration, Assessment, "Undercare," Prevention Services and Financial Management. The term "Undercare" within HRA refers to a unit made up of staff that assume responsibility of a case after the initial investigation phase; i.e., the client continues to be under the care of the department. At any given time, APS has approximately 7,000 active cases. In 2010, HRA suffered a 10% cut to front-line staff positions, which resulted in APS losing 24 staff.

Two unique programs within HRA were selected for focus in this report: the Prevention Services Program (PSP) and Financial Management Services (FMS). PSP was designed to provide an appropriate level of service (mainly financial management and homecare) to stabilized APS clients who do not require intensive case management. Begun over 10 years ago, HRA has offered the program to APS clients who, at some point after the investigation, have been referred by the Assessment or Undercare departments. Eligibility is determined by how stable the client is assessed to be. Clients of the program live in the community (not in a licensed facility) and receive minimal intervention and services. These are less intensive cases than traditional APS cases and are designed to prevent future abuse.

The PSP program is further divided into two sub-programs – PSP1 and PSP2. A unique feature of the PSP1 program involves the use of an unpaid, volunteer "Contact Person" who agrees to visit with the client monthly and to provide status reports to HRA PSP staff. Contact Persons, as defined by HRA include, "stable and involved family members, friends, or agency representatives who see the client (or receive reports from other agency staff) at least once a month." It is important to note that the Contact Person is required

to have a face-to-face visit in order for the monthly contact to qualify. Contact Persons are not required to visit the client during the months when APS staff visit the client, which occurs quarterly. HRA has developed strict guidelines around who can and cannot serve as a Contact Person. Obviously, any validated perpetrator involved with the case cannot serve in this capacity. The average caseload for HRA staff who work in this program is 55, significantly higher than the currently recommended APS standard of 25 (National Adult Protective Services Association, 1997). Since clients receiving services through the PSP program require less intense case management than traditional APS cases and are considered stable, PSP caseworkers are able to assume a higher caseload.

PSP2, only active since the latter part of 2012 after a pilot of the program concluded, is a similar program although does not make use of Contact Persons. In PSP2, HRA staff are required to visit the client every other month. The client must demonstrate stability in the community to be eligible, just like the PSP1 program, although benefit from a more frequent schedule of visits from APS staff due to higher complexity or lack of a Contact Person. The obvious benefit of placing a client in the PSP2 program is that they receive more observation from HRA professionals in lieu of lay volunteers.

The FMS program is a Social Security representative payee program with clients that receive services through HRA (not just APS). Through a staff of 20 the program accepts all forms of Social Security income that a client receives (Supplemental Security Income, Social Security Disability, etc.) and then expends those funds for the client's utilities, rent, etc. The FMS and PSP programs share many clients. At any given time, approximately 2,300 clients are active within FMS. Although HRA has discussed the possibility of serving as payee for additional sources of income, the current focus in on Social Security benefits only, as 52% of married couples and 74% of unmarried persons receive 50% or more of their income from Social Security (Social Security Administration, 2014). At this time, the program only acts as payee for Social Security income.

The allocation of client funds to various payees on their behalf is based upon a budget which is jointly developed by a client and their designated HRA employee. As funds are received by HRA, they are moved to subaccounts for each individual client. From there, bills are expended and excess funds disbursed, after a small portion is deposited to a savings account in the client's name, which can be used for unforeseen costs. The client and their designated HRA APS employee develop a budget together that meets the client's needs and ensures stabilization of the client's living arrangements (rent) and basic needs (grocery funds, electricity). Budgets can be updated as needed, should a client's rent increase or income change.

The preventive benefits of both the PSP and FSM programs are evident. Much of what APS does to assess clients' ongoing safety involves direct observation of the client and his or her living environment. Recidivism of cases is an issue that all APS programs struggle with, as familiar clients are referred and investigated repeatedly, often within a year. Having regular and direct observation, even infrequently compared to traditional APS case management, is a huge contributing factor to stabilizing clients that could easily fall back into undesirable circumstances and be referred to APS for investigation again and again.

A case example can help to illustrate this point. Mrs. Smith[1] is an elderly, African-American woman living in a small, subsidized apartment in Manhattan's Harlem neighborhood. She had been referred to APS for self-neglect several years ago. The case was investigated and stabilized. Suffering from mild dementia and limited in ambulation, her inability to pay her bills is clear. Despite being made aware of the fact, Mrs. Smith has not retained the knowledge that her rent has increased. After correspondence regarding this has been received by HRA, Jane is visited and her monthly budget is adjusted. Her HRA PSP caseworker is able to observe during the visit that the client's home is clean, free from hazards and accessible. No evidence of self-neglect is observed and her rent is kept current. Without the services of the PSP and FSM programs she would clearly deteriorate, possibly to a greater extent than when she was initially referred to APS, and neglect herself, as she did when she was initially referred to APS.

According to Lin Saberski, Deputy Commissioner with HRA, "The target population has experienced a savings in legal and late fees, reduced shut off notice for utilities, expedited benefits issuances, accurate benefit issuance and improved accounting." As both of the HRA programs have been in place ten years or more, there is no current evaluation of the programs rooted in rigorous scientific evaluation of data before and after the programs were put in place. As HRA currently migrates to a tailored computer system, comparing data on the program could be quite useful.

INVESTIGATION OF FINANCIAL EXPLOITATION ENHANCEMENT EFFORTS AT THE PHILADELPHIA CORPORATION FOR AGING

Philadelphia Corporation for Aging (PCA) is a private, non-profit organization serving as Philadelphia County's Area Agency on Aging since 1973. One of the region's largest non-profit organizations, PCA's mission is to improve the quality of life for older Philadelphians and people with disabilities and to assist them in achieving their maximum level of health, independence and productivity.

Philadelphia, with 1.6 million residents, is the fifth largest US city, and has a large older adult population at 19% age 60 years and older. Additionally, 43% of the older adult population are living below 200% of the poverty level (Philadelphia Corporation for Aging, 2011). Its residents are 46% white; 44% black, 13% Latino and 7% Asian (US Census Bureau, 2014).

PCA administers the APS program for older persons in Philadelphia. Staffed with 20 investigators, the department handles more than 2,000 reports of abuse, neglect and exploitation annually. As a response to increasing and increasingly difficult cases of financial exploitation, PCA has instituted several programs tailored to their community's needs. These include the Philadelphia Financial Exploitation Prevention Taskforce (PFEPT), an investigator within the APS unit that specializes in and investigates only

[1] Names have been changed to protect confidentiality.

financial exploitation cases, and a volunteer accountant (non-forensic) who reviews complicated client financial documents for staff upon request.

The PFEPT currently comprises eight entities of both private and public origin. Local banks, APS staff and prosecutors are typical attendees of the meetings. While the review of specific cases of financial exploitation are a function of the group, it is not the primary focus. Taskforce members most frequently discuss issues related to interagency cooperation, new financial scams targeting seniors, and improving services to the community. The impact of growing technology and seniors' access to such is also often discussed. As online banking grows, bank branches shrink. For a population that may be more likely to visit a branch office than use the internet, the challenges to seniors are apparent. Among other ramifications in the growth of online banking is the fact that it means many otherwise-isolated elders will no longer be regularly seen by familiar branch bank personnel.

During a meeting of the taskforce in May of 2013, taskforce members were given a presentation on "gypsy scams" from the Pennsylvania State Police, Criminal Intelligence Center. Education of this sort is important to taskforce members who need to stay abreast of the specifics of such scams. Knowing what warning signs to listen for when a senior comes into the bank to withdraw funds, helps bank personnel identify when to contact protective services or police to investigate. PCA staff, having become familiar with these same warning signs, are now aware of when they should look to the criminal justice system to hold perpetrators accountable. They can then also better educate older people themselves through the PCA's many other senior services programs.

Present at the taskforce meeting was Carlotta Bulls, Financial Exploitation Specialist at PCA older adult protective services. Carlotta is a former detective with the Philadelphia Police Department, having served there for 22 years in various departments. Despite Carlotta's extensive law enforcement work history, she states she did not find it difficult to transition to social services. Carlotta does not investigate all of the PCA financial exploitation cases, but concentrates on the more complex and involved cases. She maintains a caseload of approximately 20 to 25 cases at any given time. Contacts within the banks are paramount for her, and the taskforce meetings help her facilitate those contacts. Pennsylvania law permits and requires banks to provide financial statements on demand to PCA APS staff. Carlotta reports that she has very little difficulty obtaining documents from banks when she needs them.

Carlotta's work involves extensive contact with local banks. Most of the clients that she serves have accounts with the top five largest banks in Philadelphia. When she is involved with a particular client and does not know where the client's accounts are located, she is typically able to use her contacts at these banks to locate the accounts. As the primary investigator of financial exploitation cases, she is able to maintain these contacts well and stay abreast of personnel changes at banks. Her unique background as a detective helps her to navigate the law enforcement and criminal justice systems well, and she does testify in court when needed, just as traditional adult protective services staff.

Working in tandem with Carlotta is a volunteer accountant with extensive experience reviewing financial documents. Having seen a story in the local paper on the investigation of financial exploitation, Howard Glickman contacted PCA to volunteer his services. He comes to the office several times a week to review financial documents and is bound by a confidentiality agreement. Most of the documents that Glickman reviews are at the request of Carlotta Bulls, but requests can come from other PCA APS staff as well. At an average of $53.91 an hour ($112,132 annually for a full-time senior accountant) (Robert Half International, 2013), Glickman's volunteer services are indispensable to PCA and its exploitation efforts.

Having all of these resources at PCA's disposal makes for a strong response to financial exploitation. PCA is well-equipped to investigate the most complicated financial exploitation cases through multidisciplinary teamwork and specialization. As one in nine seniors reported being abused, neglected or exploited in the past twelve months (Acierno, et al., 2010), financial exploitation is not likely to decrease in frequency anytime soon. APS staff specialization contributes to a unified response to the problem and bolsters the department's ability to face the growing challenge.

Investigation into financial exploitation presents its own challenges, especially in cases that involve complex financial arrangements. Familiarity with financial documents and connections with those in the community most involved insure the most thorough investigation.

APS REALIGNMENT AT THE MARYLAND DEPARTMENT OF HUMAN RESOURCES

The Maryland Department of Human Resources (DHR) is the state's primary social service provider, serving over one million people annually. The Department, through its 24 local departments of social services, aggressively pursues opportunities to assist people in economic need, provides preventive services, and protects vulnerable children and adults in each of Maryland's 23 counties and Baltimore City. The state's population is 5.9 million; 61% of whom are white; 30% are black; 9% are Hispanic and 6% are Asian (US Census Bureau, 2014).

DHR administers the adult protective services program for Maryland. APS has had no increase in funding since 2008. Two other programs within DHR, the respite care and adult foster programs, have experienced decreased funding of 25% and 9% respectively, indirectly impacting the APS program. In 2009, DHR began the Adult Services Policy and Practice Initiative (ASPPI), a three-fold response to the growing problem of vulnerable adult abuse. While conducting a caseload priority analysis, realigning practice to family and community based practice, and developing resilience to vicarious or secondary trauma, the department has successfully armed themselves to cope with a growing number of cases without an increase in funding. To measure success of the program, measurable outcomes were developed for each area of focus.

Beginning with the caseload priority analysis, DHR attempted to focus primary intervention efforts toward cases with the most need. Clients that are assessed with higher risk levels are given priority within a caseload with the goal of stabilizing them. Assessment of risk via state-developed tool, is a joint effort between the APS line staff and their supervisor. A systematic review was also put in place to reassess client's service plans at regular intervals to determine need of services and case closure. To measure these goals, DHR monitors recidivism and achievement of case plan goals.

DHR also chose to refocus their overall approach to intervention. Before ASPPI, DHR staff were often working with APS clients for long periods of time and providing services that could be transitioned to external informal and formal support systems, when appropriate. The movement from a model totally focused on the individual client, to a model that incorporates the community and family from the beginning of the case, has enabled DHR to develop better relationships with community partners and has also reduced the time needed to provide intervention. Measureable outcomes include: a documented increase in family and community involvement, an increase in service plans that reflect community involvement, and a documented increase during intervention and assessment periods in the number of contacts made to family and the community on behalf of a client.

Lastly, as a way to help the staff dealing with the increased caseloads, DHR placed emphasis on their staff's resiliency to vicarious trauma. Vicarious trauma occurs when an individual who was not an immediate witness to the trauma absorbs and integrates disturbing aspects of the traumatic experience into his or her own functioning (Wendt Center for Loss and Healing, 2011). APS cases frequently involve the observation of disturbing events and their aftermath. Vicarious trauma is a significant concern for all people in the helping professions. To assist staff who may experience this, DHR began providing staff training on the subject of identifying the symptoms of vicarious trauma and on providing self-care. In addition, DHR developed resources, procedures and policies that target vicarious trauma and its effects.

DHR first piloted their Adult Services Policy and Practice Initiative efforts in seven offices across the state and then moved the model to all counties. An advisory group was formed as the heart of the initiative to guide and monitor the process. Members of the group included those at all levels of the organization, from directors to line-staff. Additionally, "change teams" were created to facilitate the transition to the aforementioned goals. Change teams consisted of two or three employees at the local level to facilitate the transition and to problem-solve as the changes were implemented. This approach created a higher degree of buy-in from staff, as their peers were intimately involved with the initiative. After the pilot was completed, DHR implemented the initiative in the rest of the state.

The ASPPI has allowed DHR to re-examine the way they provide services and to decrease client dependency on the system while still meeting the client's needs. By targeting those in most need and working to develop informal and formal supports, DHR has decreased the time needed both to intervene in a case and to meet the ongoing need for support. At the same time they have also targeted the mental wellness of their staff to ensure that the

often traumatic aspects of working with abuse victims does not hinder their performance or their own quality-of-life.

ENHANCED ASSESSMENT OPTIONS AT THE FAIRFAX COUNTY DEPARTMENT OF FAMILY SERVICES

The Fairfax County, Virginia Department of Family Services (DFS) promotes the well-being of their diverse community by protecting and improving the lives of children, adults and families through advocacy, education and supportive services. Housed within DFS, the adult protective services program employs a staff of 22 to serve Virginia's most populated county, with over 1.1 million residents. Located in the suburban Washington, DC area, Fairfax County is a growing area that grew 11.5% from 2000 to 2010. Its population is 67% white; 19% Asian; 16% Hispanic and 10% black (US Census Bureau, 2014). Although a wealthy area, with a median income of over $109,000, the county nevertheless experienced recent budget cuts, which led to a reduction in the amount of training provided and to hiring freezes.

To increase the efficiency and effectiveness of their APS staff, DFS currently has contracted with both an experienced nurse practitioner and a licensed psychologist to provide expert consultation and capacity assessments. Many APS cases involve complex and debilitating illnesses and conditions that affect not only an individual's physical condition but their cognitive capacity as well. APS professionals must often be a "jack-of-all-trades" in regard to the level of medical knowledge they need to have to do their jobs. A client diagnosed with Multiple Sclerosis may have very different issues compared to someone with a traumatic brain injury. Both require a modicum of understanding of the conditions, their outcomes and their treatments, at the very least. The nurse practitioner is available on an ongoing basis to answer questions and to refer the workers to sources of additional information or assistance for the client.

The accurate assessment of a vulnerable adult's physical and cognitive abilities is paramount in an APS investigation. Making a decision regarding a vulnerable adult's continued physical ability to live as they are, or the ability to make decisions for themselves, is one of the hardest decisions an APS professional faces. It is also one that must be made frequently. A multidisciplinary approach that includes high-level, professional expertise ensures accurate conclusions.

A case example helps to illustrate this point. Mrs. Jones is an elderly Vietnamese woman with significant cognitive impairment. She does not speak English and often relies on her son, her primary caregiver who lives with her, to translate when others are speaking. Local law enforcement report multiple occasions of wandering by Mrs. Jones, to the extent that she has been found alone on a busy highway nearby. The issue has repeatedly been addressed with her son who has been made aware that these instances are not acceptable. Her son speaks some English, but also relies on an interpreter to communicate with APS staff. An in-home consultation with the licensed psychologist was made to assess the caregiver's cognitive ability. Via an interpreter, the psychologist assesses the caregiver in the home, while direct observation of the client and their living environment can also be

made. The psychologist issued a report on his findings to DFS, for review by the caseworker and supervisor. The report helped to guide APS staff toward intervention possibilities, such as petitioning for guardianship. The professional guidance provided by the psychologist lends a high degree of credibility and certainty to the APS' decisions to pursue this particular, very significant intervention.

APS staff also use the nurse practitioner to assess clients in the home. While the nurse practitioner cannot provide direct medical care, she is able to assess the client's medical condition and need for care, thus enabling the caseworker to bring in the appropriate clinicians. In addition to home visits, the nurse practitioner attends APS staff meetings where cases are discussed and medical conditions are explained. Additionally, the nurse practitioner is available to testify in court on behalf of APS as to what has been observed and to provide her expert opinion.

DFS utilizes both the nurse practitioner and the psychologist to consult on an average of three cases per month, each. Per Barbara Antley, Division Director at DFS, "The in-home capacity assessments save time for social workers, who don't have to make multiple trips to set up and carry out assessments in office settings. The in-home assessments provide a more comprehensive and accurate picture of the clients and help set the direction for the service plan. Clients' rights are protected, as very few situations are actually referred for guardianship, and services are more efficient."

PUBLIC-PRIVATE PARTNERSHIPS AT THE SACRAMENTO COUNTY SENIOR AND ADULT SERVICES

Sacramento County, CA Department of Health and Human Services (DHHS) delivers health, social, and mental health services to the Sacramento community. Sacramento's population of over 1.4 million is 65% white, 22% Hispanic, 15% Asian and 11% black (US Census Bureau, 2014). DHS directs resources toward creative strategies and programs which prevent problems, improve well-being, and increase access to services for individuals and families. To further this mission, DHS seeks close working relationships among staff, with other government offices, and within the community.

The APS program at DHS is unique in its public-private partnership with area hospitals. DHHS has partnered with hospitals at two local medical centers, Sutter Medical Center and Kaiser Permanente Medical Center. Each of these hospitals directly contribute to the APS budget with $25,000 each ($50,000 total). For that contribution, each have a dedicated APS investigator who case manages patients that frequently use their services and are at the highest risk for neglect and/or self-neglect. Eschewing typical APS investigation timeframes, the program follows each client for up to six months and provides more intensive case management services. Additionally, cases referred by the hospital to APS receive a response within 24 hours to three days, as opposed to the current response time of up to 10 days that California law allows.

The benefit of the partnership is not only apparent in the budgetary contribution that the hospitals provide, but also in decreasing re-admissions to the hospital and costly

emergency department services. In a sample of 33 clients being served by the program, there was a 63% decrease in usage of hospital services. Hospital social workers, while responsible for discharge planning, cannot impose intervention on someone who refuses, for instance, transfer to a nursing facility. While APS may not necessarily impose this intervention involuntarily, they can follow the client in the community and refer to needed services. Without doubt, these high-risk clients would be referred to APS even if the program did not exist. The partnership allows the hospital and DHHS to work more closely toward client stabilization than they would without the program.

DHHS and hospital staff meet regularly throughout the year to discuss logistical issues and specific cases. Meetings include the APS supervisor and investigator, along with key hospital social work or nursing staff. Each client receiving services through the partnership is discussed at these meetings. Hospital staff provide updates on any new admissions or emergency department visits, while DHHS provides a brief synopsis of each case, explaining issues being addressed and any community services that are put in place.

While APS staff that serve a specific medical center often visit clients at the hospital, they are currently not co-located (i.e. do not have office space at the hospital). This idea was initially explored as part of the partnership, but hospital space constraints negated implementation. Personnel decisions on who should serve in positions affiliated with the hospitals is key, according to DHHS. As the staff person will serve as the primary contact for nearly all communications with the hospital, it is important to fill positions with proven and capable personnel.

ADDITIONAL PRACTICES

Alaska Division of Senior & Disabilities Services

The mission of the Alaska Division of Senior & Disabilities Services at the Department of Health and Social Services is to promote health, well-being and safety for individuals with disabilities, seniors and vulnerable adults by facilitating access to quality services and supports that foster independence, personal choice and dignity. With a staff of 11 investigators for a small population of only 735,000 dispersed throughout the largest geographic state in the US at over 570,000 square miles (more than twice the size of Texas), Alaska regularly spends a large portion of its APS budget on travel, both via car and airplane. Many areas are remote and difficult to access, depending on the weather. Alaska is majority white (67%), and has the largest American Indian proportion of the population of any area studied at 15%. Hispanics (7%) and Asians (6%) each comprise a small percentage of the population, as well as African-Americans at 4%. It has as relatively young population with 9% age 65 or older

To reduce costs, Alaska has put two distinct practices in place. The first includes using community “designees” to survey the health and welfare of clients that may be difficult to access due to their locations. Designees are volunteer professionals in fields such as nursing or law enforcement that are located in the given area and can visit the client to

directly observe their well-being. Designees are most frequently used in times of crisis intervention when distance and/or weather are factors in completing a face-to-face visit with a consumer, and report back immediately to APS staff on status.

The second practice to deal with clients in remote locations involves the use of video conferencing. With the growing availability of technology that utilizes both traditional internet and even satellite technology, video communication becomes more and more accessible. Alaska utilizes this technology to both meet amongst staff and to evaluate clients. The practice allows for direct observation of a client without traveling, although a key piece missing to any APS assessment is observation of the home.

Massachusetts Disabled Persons Protection Commission

Massachusetts is a relatively small state geographically with a population of 6.7 million; over three-quarters of whom are white (83%) while 11% are Latino, 8% are black and 6% are Asian (US Census Bureau, 2014). The mission of the Massachusetts Disabled Persons Protection Commission (DPPC), which is an independent state agency, is to protect adults with disabilities ages 18 to 59 from the abusive acts or omissions of their caregivers through investigation, oversight, public awareness and prevention.

Massachusetts has a bifurcated adult protective services system; i.e. it has two separate APS agencies, one for older adults and one for younger adults with disabilities. One of only a very few states with this sort of system, Massachusetts is dedicated to providing disability-centric service for younger vulnerable adults.

To that end, DPPC is statutorily mandated to house five law enforcement officers in their commission in addition to more traditional APS social service investigators. The law enforcement personnel are not employed by DPPC, rather they are state police detectives employed by Massachusetts State Police. Responsible for adjunct criminal investigations of abuse or neglect, having these detectives located within DPPC allows for a synergy between them and APS staff that would not occur in separate environments. In addition to conducting joint visits to investigate concerns, APS staff and detectives frequently brief each other on cases to ensure that both the disciplines of social services and law enforcement collaborate and respond fully.

In addition, the law enforcement officers train all the DPPC investigators on how to conduct investigations, and they also provide training to other police departments throughout the state. DPPC provides assistance to law enforcement through providing the emergency and follow-up services the clients need, and by providing information on the client's and alleged abuser's histories. The following example from the DPPC website illustrations this cooperation:

"In the case of a domestic violence complaint, police are called to a home and are forced to arrest the husband for assaulting his wife. If the wife has a physical disability, perhaps as a result of a stroke or multiple sclerosis, and her husband is responsible for providing her personal care, his care-giving responsibilities will need to be replaced immediately.

If the victim can stay in their home alternative PCA services will be provided and monitored. If there is no family to assist and a PCA is unavailable, obtaining emergency residential placement may be necessary. In this situation DPPC can assist with obtaining support for the victim (Disabled Persons Protection Commission, 2014)."

Florida Department of Children and Families

The Florida Department of Children and Families (DCF) is committed to working in partnership with local communities to ensure safety, well-being, and self-sufficiency for the people they serve. Florida is the state with the largest number of older adults (Himes, 2000) in the US and the largest proportion (19%) of its population age 65 and older. Its population is 78% white, 24% Hispanic, and 17% black (US Census Bureau, 2014). Given the large older adult population, the state's APS program must be well-prepared.

In 2006, DCF began the practice of "hoteling." Hoteling is a method of supporting unassigned seating in an office environment. APS assessments, taking place most commonly in a vulnerable adult's home, often involve large amounts of travel time traveling to and from office and client homes. Transit times, especially in state administered programs where APS staff may cover multiple counties, can be lengthy. In an effort to maximize efficiency, Florida provides mobile computer equipment to its APS employees in the form of a mobile phone and laptop equipped with mobile internet access. Armed with this equipment, staff are encouraged to spend most of their time in the field where the majority of work occurs. DCF partners with several community resources, such as local libraries, for office use when workers are nearby and require it. Although work stations are present at APS offices, the stations are unassigned and available to any worker who may need them. DCF typically sees their employees once a week in the office, although constant contact is maintained with APS staff on an almost daily basis.

The benefits of this practice are apparent in cost savings of a 79% leased space reduction as well as in retention of employees. Workers often perceive the practice as a benefit that can be taken away if abused, resulting in increased employee satisfaction and retention.

New York City Elder Abuse Center at Weill Cornell Medical College

The New York City Elder Abuse Center (EAC) at Weill Cornell Medical College coordinates and facilitates three multidisciplinary teams, two in the Manhattan borough and one in the Brooklyn borough. The first Manhattan-based multidisciplinary (MDT) team was launched in 2006 while the Brooklyn multidisciplinary team was launched in 2010. Through its partners and programs, the EAC seeks to prevent abuse, and assists people 60 and over who are abused or at risk of abuse – as well as their family members, friends, caregivers, and witnesses – by helping to improve how professionals, organizations and systems respond to their needs.

At one particular meeting of the Brooklyn team in May of 2012, attendees included staff from Brooklyn APS, a local prosecuting attorney, a local bank representative, and several

community partners. One particular case that was brought forward by local bank staff involved "Mrs. Johnson". Mrs. Johnson has been witnessed coming into her bank frequently accompanied by two men that appear to be escorting her. The banks; concerns included the frequency and amount of funds that are withdrawn, as well as the Mrs. Johnson's mental status when she arrives. A subsequent discussion of the case revealed that no crime has been witnessed, although several leads were discussed in investigating the case further, which included contacting a car service that transports Mrs. Johnson to the bank. Although this case had not been referred to APS at the time of the meeting, a group recommendation was that it be referred.

Multidisciplinary teams are a growing trend in adult protective services. The EAC has standing members from professions such as APS, banking, prosecution, and other community partners. Any member of the MDT is able to bring forth a case for discussion by the group. As individual cases are discussed, care is taken among each group member, as well as the facilitator, to ensure that feedback is of a constructive nature and not a source of individual criticism over quality of service. All members foster an environment of sharing and respect for each other's professional boundaries and for each client's privacy.

FINDINGS

Several patterns emerge from the program initiatives studied:

1. APS clients are remarkably similar in every location. Based on the home visits conducted, APS clients seem to be very much alike although in different parts of the country. They present with many of the same conditions and barriers.

2. APS services are also fundamentally similar, although they may be provided through very different administrative structures with varying levels of resources. All rely on highly skilled social work, are client-focused, resourceful in problem-solving, persistent, and trying to provide the most effective services in the most efficient manner possible.

3. Multi-disciplinary cooperation is at the heart of APS work, whether it is accomplished formally through established multi-disciplinary teams, or done informally by APS workers who establish relationships within other systems which they can call on to help individual clients.

4. Faced with ever increasing caseloads as well as increased case complexity, and suffering under significant budget and staff reductions over the past several years, APS administrators, supervisors, and front-line staff have worked to insure that services to clients are affected as minimally as possible. Creative solutions include several listed in this report, such as changing the way client services are provided to bring in the family and the community as early as possible in the case; working intensively, with hospital funding, to stabilize self-neglectors in the community

and thus reduce hospital costs while improving the client's health and well-being; allowing employees to work more flexibly with less time in the office, thus reducing administrative overhead; and over and over again, working ever more closely with other systems to provide clients with the highest level of services possible with the fewest resources necessary

5. Two of the highlighted programs have also focused on helping their staffs cope with the increased workloads and the difficult nature of APS work. Both the Maryland and Fairfax County, VA APS programs have consciously invested in addressing these issues. Such concern for the workers can only translate into more compassionate care for clients.

RECOMMENDATIONS

1. Peer Support - To enable APS programs throughout the country to grow and improve, they must be able to learn from one another; therefore, ongoing support to facilitate communications and peer support among APS programs is necessary. Such support can be achieved through conferences, through other NAPSRC efforts and through direct one-on-one connections among APS administrators. The issues experienced with each of the programs highlighted in this report are surely not specific to their particular geographic area. There is no need to "reinvent the wheel" when programs can learn from each other about what is most effective.

2. Multidisciplinary Approach – Nearly all of the programs profiled in this report utilize a multidisciplinary approach, often in very unique ways. Whether formal resources such as multidisciplinary staff or informal resources in connecting with community partners, each of these programs demonstrate that APS cannot conduct its job in a vacuum. Reaching out and working with others is clearly a benefit.

3. Specialization - APS programs provide services to a very diverse population with even more diverse needs. Given the varying nature of investigations of abuse, neglect, and exploitation, innovation and forward-thinking are paramount to providing the highest level of relief to the growing problem of adult abuse. Programs with staff that specialize in a particular area are better prepared to combat this problem.

4. Flexibility – The use of technology and non-traditional work environments has served many of these programs well. Rethinking the way they work has paid off both from a budget and service standpoint. Given that all APS programs spend

much of their time in the field completing home visits, the cubicle dwelling professional in front of a computer may not always be the best model.

5. Data Collection - Efforts must continue to expand the ability to collect data by and about APS programs. Even though the programs in this report were selected for their innovative approaches, even these programs, to varying degrees, face a challenge in evaluation of their efficacy.

CONCLUSION

Without a unified federal home for adult protective services, state and county programs develop quite independently. While each unique locale presents its own set of issues, the issues at hand for APS programs are largely the same – how do you continue to provide help to the ever-increasing numbers of those that need it when resources shrink, or, at best, remain static?

In addition to the lack of a federal home for APS, there is also no dedicated federal funding stream. State and county programs vary widely in the sources of funding. While Social Service Block Grant (SSBG) funds are frequently used to fund APS, and do originate from the federal government, state use of SSBG is quite diverse and funds a wide variety of social services such as children's day care and home delivered meals. This wide variety of funded services often puts programs at competition for these funds.

Program diversity is a natural outcome of de-unified programs. As a result, peer support among programs and through multi-disciplinary work has been increasingly important to adult protective services.

In the absence of funds, programs must seek out new, creative ways to fulfill their mission of protection. Connecting programs with one another allows programs to become informed of what their fellow APS programs are doing to meet the unique challenges of investigating cases and providing protective services. While the programs referenced in this report may target urban or suburban locales, they are replicable on smaller scales. The PSP program in New York City, for instance, could be replicated in a rural area provided via partially dedicated personnel of even one full-time equivalency (FTE). It can be extrapolated that investment of time in prevention services for individuals previously substantiated for abuse, neglect or exploitation keeps them from returning to the system as a new case and, thus, adding to the caseloads of APS staff with traditional cases being investigated.

Many APS programs are looking at, and have made changes to, the criteria for what is accepted to investigate. While reducing the population served by these programs, they are indeed saving money but potentially at the cost of not investigating valid cases of maltreatment when other systems do not have the arsenal of legal interventions to appropriately intervene. The Adult Services Policy and Practice Initiative in Maryland can serve to be exemplary for programs considering changing the criteria of accepted cases. By continuing to accept all cases that meet Maryland's criteria for APS, the program has

shifted its focus from longer-term case management to shorter-term intervention and transition to community services post-stabilization.

Others programs still are shifting from dedicated APS professionals to general protective services staff that investigate cases of both children *and* adults. While this tactic may reduce the number of personnel needed, many professionals that handle child cases are not well-instructed on the often subtle aspects of when to uphold self-determination and when to provide involuntary services. With regulations on training that child protective service staff must complete, education opportunities often compete with non-regulated APS trainings that are paramount to understanding the issues in working with older adults who are victims of maltreatment. The financial benefit of private-public partnerships, such as the one offered by Sacramento County DHHS, could allow retention of dedicated APS staff when replicated elsewhere.

Travel costs and time are a necessary portion of costs for program staff that must visit consumers in their respective homes. Geographically large areas, especially in state-administered programs that do not necessarily have distinct county offices, suffer from the extremes of travel costs that can include airfare, overnight stays and hundreds of miles in mileage reimbursement. While there is no substitute for direct face-to-face assessment of a consumer in their own home, video technology that allows APS staff to directly observe the vulnerable adult could be a front-end program investment, as in the case of Alaska, that pays off for years to come as a preliminary assessment of an individual can be made prior to initiating a visit to their home.

Many consider the field of adult protective services to be relatively new in the protective services realm. States established authority to remove children from neglectful environments as early as 1825[2]. It was not until the 1960's that APS demonstration programs began[3]. Considering these facts, the field is very much in its infancy and subject to considerable development. Innovation and progress, such as the programs reference in this report are important strides in that development.

[2] Pecora *et al.* (1992), pp. 230-31; Petr (1998), p. 126.
[3] http://www.napsa-now.org/about-napsa/history/history-of-adult-protective-services/

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APPENDIX A
INNOVATIVE PRACTICES REPORT WORKGROUP

Robert Bennett
Manager – Adult Protective Services
Department of Aging and Adult Services
San Bernadino, CA

Mary Counihan
Consultant
San Francisco, CA

Heather Crutchfield
Social Work Supervisor
Norfolk Department of Human Services
Norfolk, VA

Kathleen Downing
Consultant
Cuyahoga Falls, OH

Shannon Flasch
Associate Director
National Council on Crime and Delinquency
Madison, WI

Joanne Otto
Consultant
Denver, CO

Barbara Pastirik
Section Manager
Division of Aging and Adult Services
Atlanta, GA

Marta Sprague
Senior Social Worker
Human Services Department
Santa Cruz, CA

APPENDIX B
PRIMARY POINTS OF CONTACT PER AGENCY

Lin Saberski
Deputy Commissioner
New York City Human Resources Administration, Adult Protective Services

Joe Snyder
Director, Older Adult Protective Services
Philadelphia Corporation for Aging

April Seitz
Director, Office of Adult Services
Maryland Social Services Administration

Barbara Antley
Division Director
Fairfax County (VA) Department of Family Services

Debra J. Morrow
Division Manager, Senior and Adult Services Division
Sacramento County (CA) Department of Health & Human Services

Brenda Mahlatini
Social Services Program Officer
Alaska Department of Health and Social Services, Senior and Disabilities Services

Nancy Alterio
Director
Massachusetts Disabled Persons Protection Commission

Robert Anderson
State Director
Florida Department of Children and Families, Adult Protective Services

Risa Breckman
Director, New York City Elder Abuse Center
Weill Cornell Medical College, Division of Geriatrics and Palliative Medicine