Mandated Reporting of Abuse of Older Adults and Adults with Disabilities

INTRODUCTION

This brief focuses on mandated reporting of abuse of older adults and adults with disabilities to Adult Protective Services (APS). While most APS programs consider mandated reporting an essential tool for addressing harm to older adults and adults with disabilities, this brief will explore the strengths of mandated reporting as well as the criticisms and questions raised by other professionals.

This brief will:

- Define mandated reporting and provide up to date information about who is required to report.
- Delve into the policy questions that arise from mandated reporting, including the pros and cons of requiring professionals and others to report. Two experts will weigh in with their divergent opinions on the topic.
- Review the available research and present the most pressing research questions.

Reporting Requirements Vary

Every state, with the exception of New York, has mandated reporters but the list of who is included varies considerably. For example, fifteen states have universal reporting. This means that *everyone* in that state is required to report abuse, neglect and exploitation as defined by that state's statute.

Many states[1] provide broad definitions of who should report (e.g. all medical personnel) making it important that professionals review the statute for their own state. These broad categories often include language such as "as defined in code section…" to help clarify who is and is not included. However, it may also be necessary to contact your local Adult Protective Services (APS) program or law enforcement office as, in some cases, legal opinions have determined that a profession that appears to be included by statute is exempt. To illustrate, in one state that requires "medical personnel" to report, counsel has determined that paramedics are not included as mandated reporters.

Across states, the most often named mandated reporters are law enforcement and medical personnel. In the Addendum to this report, you will find an up to date (as of June 2020) state by state list of each state's mandated reporter statute.

MANDATED REPORTING DEFINED

Mandated reporting of abuse of older adults and adults with disabilities is generally defined as ***the legal requirement of a specific profession to report suspected abuse, neglect and/or exploitation (ANE) of a person meeting the state's definitions of an adult eligible for special protection under the law****. Reports are made to that entity in the state required to investigate such allegations. Such entities may include adult protective services, law enforcement, and licensing agencies, among others. State laws define a) who is a mandated reporter, b) what situations they are required to report on, c) when they are required to report, and d) to whom they are required to report. Mandated reporting laws across states vary greatly as there are no federal laws defining abuse of older adults and persons with disabilities.*

Considerations for a Reporting System

As states build their reporting systems, one of the first questions they must consider is whether to make reporting mandatory. This is an issue both when first developing a system and when adding new reporters to an existing reporting system.

In the journal article "Building the adult protective services system of tomorrow: The role of the APS national voluntary consensus guidelines"[2], the authors described mandated reporting as a "contentious issue garnering comments from every stakeholder group." The comments included:

- Concern that there is not an evidence-base for the belief that reporting reduces incidence of adult maltreatment.
- Lack of consensus as to who should be a mandated reporter.
- Objections by domestic violence advocates for their inclusion as mandated reporters.
- Multiple calls for further research.

The authors remarked that comments were evenly split between support of and opposition to mandated reporting. In the end, the APS national voluntary consensus guidelines identified specific professionals to consider as mandated reporters and recommended that suspected crimes related to adult maltreatment be reported to law enforcement.

Potential Risks and Advantages of Mandating Reporting

RISKS

Lisa Nerenberg's book, "Critical Topics in an Aging Society: Elder Justice, Ageism, and Elder Abuse", explores Nina Kohn's[3] question of whether some reporting laws violate the civil rights of victims. Nerenberg points out that in Kohn's analyses, reporting laws may:

- Conflict with protected communications (e.g. between spouses, professionals and their clients, and clergy and their members)
- Discourage victims from seeking help
- Damage reputations and/or relationships
- Stigmatize parties
- Disclose confidential information if adequate safeguards are not in place or not clearly understood (e.g. questions about sharing information within MDTS)
- Not meet the required justification for state involvement if mandated reporting is not more effective than voluntary reporting and/or educational efforts.

Elsewhere, Nerenberg points out that little is known about why some reporters choose to report, and others are discouraged due to distrust of the system. She also notes that, internationally, many countries have explored mandated reporting but rejected it in favor of rights-based advocacy approaches.[4]

Leigh Ann Davis, Director of Criminal Justice Initiatives, The Arc of the U.S. points out that many in the disability community believe that mandated reporting takes away the client's right to self-determination and can re-traumatize them (see Expert Opinion in this brief for her full explanation).

Additionally, in the research around this question in the field of child abuse, commentators have argued that mandated reporting leads to increased unsubstantiated reports which waste time and cause damage[5].

ADDITIONAL CONSIDERATIONS

Additional questions states should consider when designing or revising a reporting system include:

- What types of abuse, neglect and exploitation (ANE) must be reported? Should only criminal ANE be reported?
- Which occupations must report? Are there laws that limited that profession's ability to report (e.g. attorney privilege, sacramental confession, Long Term Care Ombudsman's advocacy role)? Are reports only required when ANE is discovered in the reporter's professional capacity?
- Does requiring "everyone" to report ANE dilute the effectiveness of mandated reporting statues? How is the requirement communicated to all reporters?
- How serious does the ANE need to be to be reported? Is the level of harm the same for all types of abuse? States often use conceptual terms like 'significant harm' or "failure to provide basic care" which, while allowing the reporter to exercise his/her professional judgement, have the disadvantage of being vague. Experts[6] recommend that legislation mandating reports should incorporate as much clarity as possible.
- Are reports required for past, present and/or suspected risk of future ANE? How is this defined?

EXPERT OPINION

Nancy Alterio

Executive Director, Commonwealth of Massachusetts, Disabled Persons Protection Commission

"If you see something, say something." It's such a familiar and well-worn adage that most of us overlook the responsibility it seeks to engender. While for the most part we each go about our days alone and independently—despite often being in a sea of people—we are part of something larger than ourselves.

Call it what you want—a community, or a city, or a society, or a global citizenry. We are parts of a whole. And, we owe an obligation to the greater good when we observe something that calls into question the health and safety of those around us. We do not need to rescue or render aid. But, we should, at a minimum, say something to someone who might be able to help.

Reporting suspicions is a universal concept. Mandating reporting of abuse of vulnerable people creates a system wherein those at the front lines who suspect abuse—first responders, teachers, doctors, etc.—are required to make an effort to remedy the situation and protect the individual by alerting the proper authorities. However, mandated reporting of abuse is not limited to "vulnerable" populations such as children, elders, or persons with disabilities. Most licensed professionals are, by law or code, required to report on peers when they engage in inappropriate or unethical conduct.

Employees are encouraged and protected under whistleblower laws from reporting misconduct by their employers. Mandated reporting is not unique to abuse. It extends to a wide array of circumstances and individuals, all in the promotion of the greater good.

As such, mandated reporting should not be construed as a constraint on an individual's self-determination; it should be viewed as a tool to help empower persons, including persons with disabilities who are being subjected to abuse. Safety is a cornerstone of self-determination; without feeling and being safe, self-determination is unlikely to be realized. Also, mandated reporting of abuse impacts at both an individual and societal level – it sends a message to abusers that we as a larger whole will not tolerate abusive behavior. We unite in this effort by reporting reasonable suspicions, not by remaining silent.

Mandated reporting of abuse should not be viewed as limiting or restricting the rights of a person with a disability any more than requiring a doctor or lawyer or electrician or realtor to report the malfeasance of a peer, or recommending someone attending a concert or ballgame alert security of a suspicious package. Mandated reporting is simply an extension of the well-recognized concept that in order to have a safe and functional society, we each share a small, but powerful role in looking out for the well-being of those around us by seeking help for those in need or trying to root out bad actors.

Permitting abuse to continue by failing to report does not empower the victim, it empowers his or her abuser. Individuals are empowered when they are provided with knowledge, choice and resources, including the choice to live a life free from abuse. If we see something, whether it is in a boardroom, at the ballgame, a bus stop, or at a group home—we should say something.

EXPERT OPINION

Leigh Ann Davis

Director of Criminal Justice Initiatives, The Arc of the U.S.

The primary goal of mandated reporting is to ensure safety of victims and potential future victims, while holding offenders accountable. The question we must ask when it comes to adults with disabilities is this: How are their lives safer when a report is made, and how are we as a society empowering or disempowering them in the goal of increasing access to safety and healing?

In this era of emphasis on supported decision making and self-determination (a process by which people control their own lives) within the disability community, how does mandatory reporting support or negate this, and the "nothing about us, without us" philosophy?

There is consensus to "assume competence" rather than assume people with disabilities do not have the ability or capacity to make decisions for themselves. How does this belief come into play when someone with a disability is being or has been abused and has no say about if, when and how the abuse is reported?

While mandated reporting can certainly increase a person's safety, has society, in its attempt to help people, neglected the impact mandatory reporting has on people with disabilities who may have little or no say about basic decisions affecting their lives? In this way, is the system re-victimizing or re-traumatizing the victim?

Other questions include:

- Does the victim fully comprehend the potential ramifications of making a report (while the ramifications can be serious and even dangerous for all people, for those with disabilities, the impact can be compounded)
- Thanks to the MeToo movement, we are becoming keenly aware of the power of people telling their stories when and how they choose. Shouldn't that decision be the victim's alone?
- The system is set up so that the victim will need to tell their story, possibly multiple times, before the criminal justice process is over. Will the person be supported through this process, and if so, how? Who works to ensure the support is available, and accessible, to people with disabilities?

Another consideration involves the aftermath of a report being filed. Victims with disabilities may have no idea of what the potential consequences might be when a report is filed. Will the mandated reporting be followed up with "mandated healing" for the victim, or will the victim be left to face the consequences alone? In this way, mandated reporting cannot be viewed as an isolated event, or seen in a vacuum. While trying to do good in a person's life, we must also strive to "do no harm."

POSSIBLE SOLUTIONS

We must take steps toward ensuring safety of people with disabilities to be able to report abuse without repercussions.

- Mandated reporters must explain, using plain language, that they are mandated reporters and what that means. They should provide accessible materials to help the person understand the basics about reporting. Mandated reporters can also ask the individual if they have any questions or concerns about the reporting process and talk through what could happen once a report is filed.
- The victim should be given the opportunity to report with the mandatory reporter to ensure the experience is a positive, empowering one.
- The victims should be provided regular updates about the case and access to the investigator anytime there are questions about what is going on, what is happening next, etc.
- While there are some people who are obligated to report, there must be other resources and people available for those with disabilities who need help after a victimization occurs but want their information to remain confidential.
- State agencies should request input and advisement from people with disabilities about their mandated reporting policies.

Perhaps the question when it comes to mandated reporting is not about if one should report or not, but is more about creating a balanced, fair and empowering process that allows victims the dignity of risk to speak their truth when they are ready. Have we done all that we can to respect their process, trust their process, and empower them to make their own decisions after victimization? That, after all, is the foundation to realizing justice and experiencing deep healing.

Research on Mandated Reporting

Although there is little research into mandated reporting of adult abuse, there is a body of research in child abuse. This issue brief relied heavily on a comprehensive review of the literature in child abuse conducted by Davies, Matthews and Read (2014) entitled "Mandatory Reporting? Issues to consider when developing legislation and policy to improve discovery of child abuse". That study conducted a well-documented examination of the pros and cons of mandated reporting across all English-speaking countries. They founded that the "most commonly identified reasons for professionals not reporting abuse and neglect are a) inadequate training in the indicators of child abuse leading to a lack of awareness of probable abusive situations, b) lack of knowledge of reporting obligations and procedure, c) fear of negative consequences for reporters, and d) fear of negative results of reporting for the child."[7] There is no reason to think that the same factors are not in play in adult abuse cases.

An older report by the Government Accountability Office (GAO), "ELDER ABUSE: Effectiveness of Reporting Laws and Other Factors" did not find enough evidence to support the case for mandatory reporting. In its concluding observations, the report stated: "State officials we surveyed agree that other factors – such as public awareness campaigns, interagency coordination, and in-home services and respite care – are more important than reporting laws."[8]

THE CHALLENGES TO RESEARCHING MANDATED REPORTING AND ELDER ABUSE IN GENERAL

The lack of uniformity in definitions of adult ANE and who is required to report has negatively impacted national efforts to trace and combat adult abuse according to the CDC[9]. This lack of uniformity causes methodological problems when researchers attempt to collect and analyze data. For this reason, the CDC has recommended the adoption of uniform definitions to improve research into the scope and nature of elder abuse.

LACK OF EVIDENCE THAT MANDATED REPORTING INCREASES CLIENT SAFETY

There is currently no research into whether or not mandated reporting increases the safety of APS clients. And, surprisingly, there is also no definitive research that children are safer in jurisdictions across the globe where mandated reporting is required. As a result of this, we are unable to draw any conclusions from that literature.

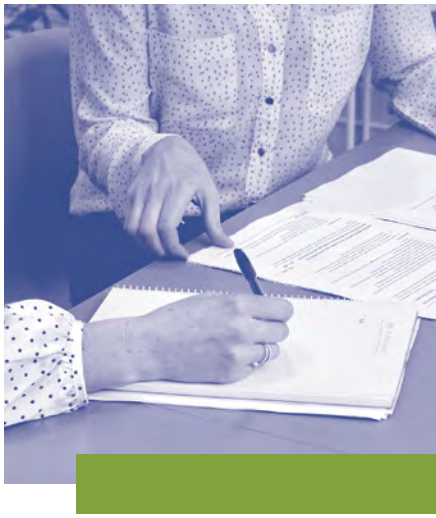
What is clear from the child abuse literature, according to Davies, Mathews and Read (2014)[10], is that more abused and neglected children are seen by professionals in those jurisdictions requiring mandated reporting and the substantiation rates are higher. They also found that the resulting investigations frequently uncovered additional problems requiring interventions.

FACTORS THAT INHIBIT REPORTING

There are factors inherent in identifying ANE that may naturally inhibit reporting. There are health conditions that cause symptoms which mimic indicators of caregiver neglect. For example, a client's weight loss can be caused by health issues (e.g. an undiagnosed cancer) but also by the caregiver failing to provide adequate calories or by the client's failure to thrive due to emotional issues. These can be difficult for medical professionals to confidently diagnosis as being caused by abuse versus natural disease processes.

There are also some types of injuries that can be caused by either accident or abuse. For example, disorders of coagulation can result in bruising that can look like abuse, and individuals with brittle bone disease can break bones with or without abuse. Without extensive training in recognizing ANE, medical professionals may not be able to differentiate between accidental and abusive causes. For those professionals already disinclined to report, this ambiguity can provide a justification for not reporting. And even for those who want to report, the fear of being wrong is an inhibiting factor in these cases.

Another factor that has been identified in the review of child abuse research is the impact of negative experiences with law enforcement/protective services upon reporting rates.[11] When reporters feel that their reports don't lead to increased protection for the alleged victim, they are less likely to report in the future.



Because of strict confidentiality requirements, APS usually cannot update the reporter on the case, leading some reporters to conclude "nothing was done." This can be especially true in cases where APS does not take outwardly visible actions because the client does not want them taken.

Perhaps most importantly, people generally prefer to avoid conflict. There is a risk in making a report and getting it wrong. For this reason, it has been postulated that reporters rationalize not getting involved. Excuses include "I might make things worse for the adult", "I am not certain it is abuse", or "Reporting won't change anything". It takes courage to intervene.

Being mandated to report provides some protection from these fears of getting involved, getting it wrong or being unsure. For these reasons, professions who are not mandated to report stated that they experience anxiety about potential complaints from families and fear of disciplinary action if the abuse is not substantiated.

INCREASE THE EFFECTIVENESS OF REPORTING

Training to identify abuse and overcome barriers to reporting has been suggested as one way to increase the effectiveness of reporting. Studies in child abuse have repeatedly found that mandated reporters often do not have the training required to equip them to fulfil their role. However, it is unclear what components and mechanisms of training are most effective for respective reporter groups.[12]

ADDITIONAL RESEARCH QUESTIONS THAT NEED ANSWERS

- **What do specific professional groups know about their duty to report?** Are they adept at identifying indicators of ANE? If a report is not indicated, do they know how else to help? Under what circumstances, when they suspected ANE, have they decided not to make a report? Why were they reluctant to report? What is their attitude about reporting? What is their perception of the effectiveness of the current systems (APS and law enforcement) in addressing ANE?
- **Across professional groups**, what factors influence or impede effective reporting? Are some professionals more effective in identifying ANE? Why?
- **What is the impact of training** on the effectiveness of reporting? What type of training is most effective?
- **How effectively do investigative systems interact with reporters?**
- **What are the professional, attitudinal, political, cultural, ethical, and systemic barriers** to reporting and how can they be minimized or removed?
- **Are we intervening at the right time with the right intervention?** A public health model would suggest that, rather than focusing on treating the effects of abuse (once reported), we should be attempting to prevent the abuse from occurring in the first place by applying primary prevention programs. This model would suggest that we collect better incidence and prevalence data and evaluate the effectiveness of interventions rather than focusing on mandating reporting after the fact.

Recommendations

This overview of mandated reporting of adult maltreatment opens the door to a number of recommendations. Based on the information provided, we hope that APS professionals, researchers, advocates, and policy makers will seriously consider prioritizing the following recommendations:

1. Advocating for national standardized definitions of adult ANE
2. Developing a national research agenda that includes a review of the effectiveness of mandated reporting
3. Developing and evaluating training for reporters from various professions to determine what training is needed and effective for which professions.
4. Seriously evaluating the potential of preventative public health models to address the issue before reporting is necessary.

Conclusion

This brief has provided an overview of the issue of mandated reporting of abuse of older adults and adults with disabilities to Adult Protective Services (APS). It defined mandated reporting and provided up to date information about who is required to report. A review of the list in the addendum clearly shows that there is great variance in who is required to report ANE across the country.

The questions and critiques raised by the review of child abuse literature and scant research into mandated reporting and adult maltreatment provides ample food for thought as APS professionals, researchers, advocates, and policy makers, especially those reviewing legislative proposals to develop and/or improve their reporting systems. A list of research questions has been provided to help both researchers and APS professionals think about what is and is not known about the effectiveness of mandated reporting. Although APS professionals for the most part are strongly in support of mandated reporting, there is ample room for philosophical and practical discussions around this topic and it is hoped that this brief has provided background for those conversations.

[1]See addendum: List of State Statutes
[2]https://www.tandfonline.com/doi/full/10.1080/08946566.2017.1382414
[3]Kohn, N.A. (2009). Outliving civil rights. Washington University Law Review, 86(5),1053-1115. Retrieved from https://openscholarship.wustl.edu/law_lawreview/vol86/iss5/1
[4]Critical Topics in an Aging Society: Elder Justice, Ageism, and Elder Abuse, Lisa Nerenberg, 2019, page 81
[5,6,7,10,11,12]Mandatory Reporting? Issues to consider when developing legislation and policy to improve discovery of child abuse DOI: https://doi.org/10.14296/islr.v2i1.2110
[8]https://www.gao.gov/assets/220/214127.pdf
[9]Elder Abuse Surveillance: Uniform Definitions And Recommended Core Data Elements https://www.cdc.gov/violenceprevention/pdf/EA_Book_Revised_2016.pdf

RESOURCES & REFERENCES

National Center on Law and Elder Rights
Elder Abuse: Mandatory and Permissive Reporting for Lawyers
Chapter Summary, April 2019
https://ncler.acl.gov/getattachment/Legal-Training/Mandatory-Reporting-Ch-Summary.pdf.aspx

Critical Topics in an Aging Society: Elder Justice, Ageism, and Elder Abuse
Lisa Nerenberg. 2019
Springer Publishing Company, LLC
ISBN: 978-0-8261-4756-1

NCEA National Center on Elder Abuse

NAPSA National Adult Protective Services Association

Keck School of Medicine of USC

This material was completed for the National Center on Elder Abuse situated at Keck School of Medicine at the University of Southern California in Collaboration with the National Adult Protective Services Association and is supported in part by a grant [No. 90ABRC000101-02] from the Administration for Community Living, U.S. Department of Health and Human Services (HHS). 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 ACL or HHS policy.

NATIONAL ADULT PROTECTIVE SERVICES ASSOCIATION & NATIONAL CENTER ON ELDER ABUSE

Understanding and Working with Adult Protective Services (APS)

Part I: Overview of APS Programs

By: Holly Ramsey-Klawsnik, PhD, LCSW, LMFT, NAPSA Director of Research

With contributions from:
Carol Dayton, ACSW, LISW, Retired APS Chief, Cuyahoga County, Ohio, NAPSA-NCPEA Research Committee Co-Chair
Trudy Gregorie, NAPSA Executive Director
B. Lynn Koontz, APS Administrator, Retired, State of New Hampshire, Past President, NAPSA

ABSTRACT

This is the first of a three-part resource developed by the National Adult Protective Services Association in collaboration with the National Center on Elder Abuse. The goal is to provide information for understanding and collaborating with Adult Protective Services (APS) in order to benefit older adults and adults with disabilities who are subjected to abuse, neglect, or exploitation (ANE).

The entire three-part brief is designed to:

1. Promote effective multi-disciplinary collaboration regarding vulnerable adult ANE by informing policy-makers, researchers, and practitioners (including health and mental health, law enforcement, social services, aging, disability, financial, and related professionals) about APS program features, functions, and responsibilities;
2. Be used by APS programs as a tool to promote community education and collaboration;
3. Serve as a resource for concerned citizens wishing to learn about APS programs.

INTRODUCTION

"APS is a social services program provided by state and local government nationwide serving older adults and adults with disabilities. In all states, APS is charged with receiving and responding to reports of maltreatment and working closely with clients and a wide variety of allied professionals to maximize clients' safety and independence" (Administration for Community Living, 2016, iii). In 1975 Title XX of the Social Security Act created the Social Services Block Grant (SSBG), providing funding to states for social services programs, including APS. Individual states determine how to allocate their SSBG dollars and have developed their own APS programs. Historically, there has been no federal "home" for APS, no dedicated federal funding stream, and no national legislation governing the operation of APS programs. As a result, APS programs vary from state to state with differences in policies and practices. State legislation governs APS programs, including how abuse and neglect are defined, eligibility criteria for services, and program policies and regulations, such as those pertaining to how and when investigations of alleged abuse must be conducted. APS administrators and staff must develop and implement all program regulations, policies, and procedures to insure compliance with their state laws. This explains the variability among APS programs; i.e., laws vary from state to state, hence APS policies and procedures following those laws vary. Overall, however, there is much consistency among APS programs nationwide.

VARIABILITY AMONG APS PROGRAMS

Program location, administration, and funding:

APS programs vary in where they are located within state and local government and how they are administered. Most programs are state-administered and operated. Some are state-supervised but administered by counties. In a few states APS programs are county-operated, and in others the state contracts with local agencies, such as Area Agencies on Aging, to provide adult protective services.

Across the country, APS programs are housed in various state and county departments, including social and human services, public health, and aging and disability services. Sources of funds used by states to support their APS programs also vary. In addition to the SSBG, state general revenue funds, the Older Americans Act, and other sources such as local levies are used to finance the operation of APS programs. The lack of a dedicated federal funding stream to support APS services often results in locations struggling to sufficiently fund their APS programs, which profoundly affects the services that can be provided.

Eligibility for APS services and clients served:

There is variation in eligibility criteria for APS services. In many states, people aged 18 and over who have disabilities are eligible. In other states, individuals with a disability aged 18 through a certain age (typically 59 or 64) are eligible; in addition, all older adults (with or without disability) may be served by APS. A few state APS programs only serve older adults, with that age group defined by law as 60+, 62+ or 65+. There is variation regarding whether older adults served must be impaired physically, cognitively, or both, or eligibility is more simply defined by age alone. Some states have structured their abuse and neglect response system such that APS responds to alleged maltreatment that occurs in both community and care facility settings. In other states, APS only handles alleged abuse and neglect occurring in community settings.

Reporting requirements:

States differ in regard to laws requiring individuals with reason to suspect that a vulnerable adult is subjected to ANE to report concerns to APS. In most states, individuals in certain professions or job positions, referred to as "mandated reporters," are legally required to report. Mandated reporters commonly include health and mental health care, law enforcement, aging, social services, disability services, and financial institution personnel. A few states require that all adults, regardless of role, report suspected vulnerable adult ANE.

State laws also vary somewhat in terms of types of allegations that must be reported. Commonly, concerns of physical, emotional or psychological, and sexual abuse; neglect by care providers; financial exploitation; and self-neglect are included in mandated reporting laws. Types of maltreatment, such as physical abuse, are also defined by state law, creating somewhat differing, although over-all very similar, national ANE definitions.

Individuals in doubt as to whether or not they are mandated to report ANE concerns should err on the side of reporting a suspicion of maltreatment, than overlook a needed investigation.

Information regarding APS programs operating in specific states, including mandated reporting requirements, maltreatment definitions, and types of maltreatment handled, is available at: **www.napsa-now.org/get-help/help-in-your-area**.

Policies regulating case practice:

There is also variability among APS policies governing practice. For example, all programs have policies regarding timeframes during which ANE reports must be screened to determine if an investigation is warranted. Timeframes are also established for commencing investigations. These range from within a few hours to 20 days, and are tied to the "triage level" (perceived level of danger for the subject of the report). Triage categories include the following designations: emergency, urgent, rapid, and routine. Timeframes are also established for completing investigations ranging from five to 90 days with a few programs not establishing an upper limit. State laws vary in terms of requirements for APS personnel to notify law enforcement when ANE reports contain allegations of criminal conduct. In many jurisdictions, immediate police or prosecution notice is required.

CONSISTENCY AMONG APS PROGRAMS

Despite APS program variability, there is much consistency among APS programs across the nation. As stated in the National Adult Protective Services Adult Protective Services Code of Ethics (NAPSA, 2013), "Adult Protective Services programs and staff promote safety, independence, and quality-of-life for older persons and persons with disabilities who are being mistreated or are in danger of being mistreated, and who are unable to protect themselves" (Adult Protective Services Recommended Minimum Program Standards, p.6, www.napsa-now.org/wp-content/uploads/2014/04/Recommended-Program-Standards.pdf). This code provides guiding values and practice guidelines, stressing the rights of individuals served by APS, including the right to informed consent and least intrusive interventions. The code contains the imperative to "do no harm" in serving clients and can be accessed at: www.napsa-now.org/about-napsa/code-of-ethics.

In addition to shared goals, all APS programs are authorized by their state legislatures to receive and respond to reports of alleged ANE. All conduct investigations, make determinations as to the veracity of reports received and investigated, and seek to provide appropriate, effective, and ethical intervention services to alleviate danger and suffering experienced by victims. All must create and follow policies and practices consistent with state laws and professional standards of practice. All must protect the confidentiality of people served and of those who report suspected

ANE. All programs seek to protect their staff from job-related danger, and to engage in effective collaboration with concerned community partners and government agencies to benefit their clients.

A goal delineated by the US Department of Health and Human Services Administration for Community Living in their preface to the Voluntary Consensus Guidelines for State Adult Protective Service (Administration for Community Living, 2016) is "to promote an effective adult protective services (APS) response across the country so that all older adults and adults with disabilities, regardless of the state or jurisdiction in which they live, have similar protections and service delivery from APS systems," (p. ii). Throughout the country, efforts are underway to support effective APS policies and practice. These efforts address conducting and applying findings from sound research, seeking strategies to increase needed program funding, establishing multi-disciplinary teams for case review, creating and implementing sufficient APS caseworker and supervisor training, and increasing APS collaboration with governmental and community organizations and professionals invested in providing safety to vulnerable adult victims.

REFERENCES

Administration for Community Living. (2016). *Voluntary Consensus Guidelines for State Adult Protective Service*. Washington, DC: US Department of Health and Human Services Administration for Community Living.

NAPSA. (2013). *Adult Protective Services Recommended Minimum Program Standards*. Washington, DC. Available at: http://www.napsa-now.org/wp-content/uploads/2014/04/Recommended-Program-Standards.pdf

NCEA National Center on Elder Abuse

Keck School of Medicine of USC

NAPSA National Adult Protective Services Association

This material was completed for the National Center on Elder Abuse situated at Keck School of Medicine at the University of Southern California in Collaboration with the National Adult Protective Services Association and is supported in part by a grant (No. 90ABRC000101-02) from the Administration for Community Living, U.S. Department of Health and Human Services (DHHS). Grantees carrying out projects under government sponsor-ship are encouraged to express freely their findings and conclusions. Therefore, points of view or opinions do not necessarily represent official ACL or DHHS policy.

NATIONAL ADULT PROTECTIVE SERVICES ASSOCIATION & NATIONAL CENTER ON ELDER ABUSE

Understanding and Working with Adult Protective Services (APS)

Part II: The Reporting and Investigation of Alleged Abuse

By: Holly Ramsey-Klawsnik, PhD, LCSW, LMFT, NAPSA Director of Research

With contributions from:
Carol Dayton, ACSW, LISW, Retired APS Chief, Cuyahoga County, Ohio
Trudy Gregorie, NAPSA Executive Director
B. Lynn Koontz, APS Administrator, Retired, State of New Hampshire

ABSTRACT

Part I of this brief (released May 2018) describes APS program functions, responsibilities, policies, practices, clients served, and constraints. It is available at: http://eldermistreatment.usc.edu/wp-content/uploads/2018/05/Understanding-and-Working-with-APS_May2018.pdf.

The goals of Part II are to:

1. Promote understanding of APS abuse reporting, intake, screening, triaging, and investigation processes, and
2. Promote community and professional collaboration with APS during abuse reporting and investigation. Part III (forthcoming) addresses collaborating with APS to remediate substantiated abuse, neglect, and exploitation (ANE) cases.

INTRODUCTION

Victimization of older adults and adults with disabilities is a public health, justice, social, and community problem that cannot be resolved by one individual or agency acting alone. APS must collaborate with community members, and other professionals, and organizations to effectively serve people who have experienced maltreatment. Key roles for APS collaborators in responding to situations of ANE include:

1. Understanding and complying with ANE reporting laws
2. Providing needed information to APS and assistance to people who have been mistreated during investigations
3. Collaborating with APS to remediate substantiated ANE (topic of Brief Part 3).

REPORTING SUSPECTED ANE

Most APS programs accept reports via telephone, protected web-based programs, and in writing. Information regarding APS operating in specific states, including reporting requirements and processes, maltreatment definitions, client eligibility requirements, and ANE types handled, is available at: **www.napsa-now.org/get-help/help-in-your-area**.

Key information to provide in a report (to the extent that it is known to the reporter):

- Alleged victim name; birthdate or age; address and current location; physical and mental health conditions and diagnoses, disabilities, special needs, needed medications and assistive devices; self-care and self-protection abilities and limitations; primary language and communication barriers; significant others including service-providers, and best access method
- Suspected perpetrator name; birthdate or age; relationship to alleged victim; address and current location; conditions and factors relevant to allegations (substance abuse, mental illness, criminal history, or weapon possession)
- Suspected abuse – What, specifically, does reporter suspect may have occurred during what time frame? Is alleged victim currently in danger? If so, what is the source and nature of danger? Is emergency response needed? If so, call 911 then also report to APS.
- Reasons for suspicions including victim statements, witnessed events, abuse signs and symptoms **http://eagle.trea.usc.edu/types-of-abuse**
- Describe actions taken to protect, treat, shelter, or otherwise assist the alleged victim
- Known hazards in alleged victim's home (menacing animals, infestation, contagious illness, unsafe structure, illegal activity, weapons, or dangerous individuals)
- Reporter's name, address, relationship to alleged victim, professional or caregiving role if any, and how reported information came to be known.

APS does accept anonymous reports from non-mandated reporters; however, reporters are encouraged to provide their name and contact information. Without this, APS cannot recontact them to correct report errors, such as incorrect alleged victim address. Laws require APS to protect the identity of reporters and typically protect from liability those making good faith reports.

Reporters are not required nor barred from informing a vulnerable adult of an ANE report. In some cases, informing the alleged victim is beneficial. When that person is alert and oriented and trusts the reporter, informing can pave the way for APS contact and also preserve the trust. For example, a physician observes imprint injuries on a vulnerable patient and hears from the patient, "The aide who comes to bathe me is too rough, and, she makes the water too hot even though I tell her it hurts." A statement such as this can be helpful, "Thank you for telling me. I am sorry that happens. You deserve kindness and respect and I care about your safety. I will report this to APS so that steps can be taken to stop that. The law also requires me to report this." Should the patient object, informing her, "I am sorry to go against your wishes on this but by law I must." Discussing the report may lead to further disclosures or recognition of steps to ease the process for the patient. Informing alleged perpetrators of reports, however, is NOT recommended, even when they are surrogate decision-makers such as guardians. Notice to perpetrators can further endanger victims and lead to efforts to hide abuse evidence.

INTAKE, SCREENING AND TRIAGING OF REPORTS

During intake information provided by the reporter is collected and documented. This is followed by report screening to determine if, based upon that information, (1) the reported adult meets APS eligibility criteria, (2) a reportable condition and allegation exist, and (3) the adult is in a location served by the receiving APS program. Efforts are made to refer the reporter to an agency with jurisdiction or ability to assist the alleged victim when reports are deemed ineligible for APS services. Screened-in reports proceed to investigation and are triaged and responded to according to the perceived level of danger to the reported adult.

APS INVESTIGATION PROCESSES

"The purpose of the investigation is to collect information about the allegations of maltreatment, assess the risk of the situation, determine if the client is eligible for APS services, and make a finding as to the presence or absence of maltreatment," (ACL Guidelines, p. 29). The NAPSA Recommended Minimum Program Standards (NAPSA, 2013) define a protective services investigation as, "A systematic, methodical, detailed inquiry and examination of all components, circumstances, and relationships pertaining to a reported situation" (p.9). These standards call for APS programs to: make a determination of the accuracy of the report, including whether maltreatment has occurred; have a systematic method for making that determination and recording findings; and substantiate the report or not based upon careful evaluation of all investigation findings.

There are critical distinctions between APS and criminal justice (CJ) or police investigations which are designed to determine if crimes have been committed and arrests are warranted. APS is designed to protect victim safety rather than punish perpetrators. In some cases, concurrent or collaborated APS and CJ investigations occur. For a discussion of APS/CJ differences and potential collaborations, see: **http://www.napsa-now.org/wp-content/uploads/2016/04/TA-Brief-Working-with-Prosecutors.pdf**.

The primary APS investigative goal is to determine if reported allegations are valid. Ascertaining that ANE did not occur is equally as important as confirming actual ANE. Additional goals are to determine unmet needs for care, assistance, and protective and other services. If maltreatment has occurred, APS will attempt to: identify the perpetrator(s); determine ANE specifics (type of abuse, severity, extent, and impact of abuse); and assess the current level and sources of risk. During the investigation, immediate intervention is offered if imminent threat to victim safety is discovered. Otherwise, thorough assessment is necessary to plan appropriate intervention. The process of a full APS investigation is discussed at: **http://www.napsa-now.org/wp-content/uploads/2015/03/TA-Brief-Invesitgation-Protocols.pdf**.

A key APS investigation issue is the capacity of the alleged victim to understand and grant informed consent, including consent to services from APS and collaborating organizations. Those who have capacity retain the right to refuse any proposed service, treatment, or intervention. The complex issue of capacity and consent is discussed at: **http://www.napsa-now.org/wp-content/uploads/2015/06/TA-Brief-Mental-Capacity-FINAL.pdf**. Alleged victims also have other important rights, including the rights to confidentiality and least intrusive intervention. APS programs and staff are guided by a Code of Ethics and Practice Guidelines which can be found at: **http://www.napsa-now.org/wp-content/uploads/2014/04/Recommended-Program-Standards.pdf** (p. 6-7). During an investigation, reporters and concerned others may be tempted to contact APS to inquire about work being done on behalf of an alleged victim. Ethics prevent sharing information without the expressed informed consent of that person. There is a role for APS collaborators, however, during investigations. In many cases collateral professionals and/or significant others are needed to provide victim assistance and services. With that person's informed consent, or with other official approval such as a court order, APS is empowered to both share victim information and request victim assistance from concerned and capable others.

REFERENCES

Administration for Community Living. (2016). *Final Voluntary Consensus Guidelines for State Adult Protective Service*. Washington, DC: US Department of Health and Human Services Administration for Community Living.

NAPSA. (2013). *Adult Protective Services Recommended Minimum Program Standards*. Washington, DC: Author.

This material was completed for the National Center on Elder Abuse situated at Keck School of Medicine at the University of Southern California in Collaboration with the National Adult Protective Services Association and is supported in part by a grant (No. 90ABRC000101-02) from the Administration for Community Living, U.S. Department of Health and Human Services (DHHS). 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 ACL or DHHS policy.

NATIONAL ADULT PROTECTIVE SERVICES ASSOCIATION & NATIONAL CENTER ON ELDER ABUSE

Understanding and Working with Adult Protective Services (APS)

Part III: Intervention Collaboration

By: Holly Ramsey-Klawsnik, PhD, LCSW, LMFT, NAPSA Director of Research

With contributions from:
Carol Dayton, ACSW, LISW, Retired APS Chief, Cuyahoga County, Ohio
Trudy Gregorie, NAPSA Executive Director
B. Lynn Koontz, APS Administrator, Retired, State of New Hampshire

ABSTRACT

Part I of this brief (released May 2018) describes APS program functions, responsibilities, policies, practices, clients served, and constraints. It is available at: **http://eldermistreatment.usc.edu/wp-content/uploads/2018/05/Understanding-and-Working-with-APS_May2018.pdf**. Part II addresses collaborating with APS during the reporting and investigation of alleged abuse, neglect, and exploitation (ANE) of older adults and adults with disabilities adults. Part III addresses collaborating with APS to remediate substantiated ANE.

INTRODUCTION

Victimization of older adults and adults with disabilities is a complex public health, justice, social, family, and financial problem typically requiring multi-faceted efforts to successfully resolve. APS is legislatively mandated to respond to ANE, however, collaboration with important and multiple others is essential to fulfill this mandate.

FEDERAL GUIDELINES

As described in the *Final Voluntary Consensus Guidelines for State Adult Protective Service* (ACL, 2016, p. 4):

> *APS programs are often the gateway for adult maltreatment victims who need additional community, social, health, behavioral health, and legal services to maintain independence in the settings in which they prefer to live, as well as the avenue through which their maltreatment is reported to police or other agencies of the criminal justice system. APS receives and responds to reports of adult maltreatment, and works closely with clients and a wide variety of allied professionals to maximize safety and independence.*

These guidelines recommend that APS programs collaborate with, among others: local, state and federal law enforcement; medical, behavioral and social service providers; disability and aging services organizations; domestic violence, sexual assault and victim services; financial services providers, and animal welfare organizations. Furthermore, APS programs are guided to participate in formal interdisciplinary adult maltreatment teams in order to promote needed collaborations on behalf of those who have experienced ANE.

APS GOALS

APS is designed as an emergency and short-term service to receive and investigate ANE reports, establish needed intervention plans for victims using existing resources to remediate maltreatment, and close the case. The *Adult Protective Services Recommended Minimum Program Standards* (NAPSA, 2013) cite intervention goals, "to make the client safer, prevent continued abuse, and improve (victim) quality of life," (p. 11). Intervention is also designed to promote victim healing from the impact of ANE experienced.

APS LIMITATIONS

APS programs handle a large volume of cases, typically on quite limited budgets. They are not funded or designed to provide ongoing or long-term services and there are important limits to APS authority. Without their consent, APS cannot take action on behalf of adults who have cognitive capacity to make informed decisions. Well-intended family and community members and professionals want older adults and adults with disabilities to live free from ANE and are frustrated when this does not occur. For example, APS does not, because it cannot, coerce a victim into evicting from his or her home a drug-addicted, abusive, exploitative adult child as a prevention from continued abuse. **Victims who have capacity retain the legal right to refuse any service, treatment, intervention, or referral offered or suggested by APS.** Furthermore, even when assisting victims lacking cognitive capacity to understand, evaluate, and choose ANE interventions, APS cannot act unilaterally. Authorization is required, either in the form of a court order, or the approval of a duly-appointed surrogate decision-maker, such as a guardian. Regardless of the level of danger or ANE harm inflicted, APS cannot intervene without proper authorization from a victim with capacity to consent, a court order, or surrogate approval. This includes interventions such as removing victims from dangerous homes or abusers and placing victims into care facilities or any other form of treatment. APS, like other helping organizations, cannot force victims to terminate relationships or contact with abusive spouse/partners, family members, or others. Additionally, there are important ANE-related functions that come under the jurisdiction of other entities including investigating facility licensing violations and criminal conduct, arresting and prosecuting perpetrator(s), and achieving restitution of exploited assets.

An understanding of APS functions and limits clearly reveals the need for interdisciplinary collaboration. Coordinated work with multiple parties is often needed in a single case, including probate and family courts, police and prosecutors; medical, social services, and domestic violence and sexual assault programs and personnel. Collaboration with mental health professionals may also be needed to obtain victim diagnosis and treatment, including cognitive capacity evaluations.

INTERVENTION CONSIDERATIONS

Professional ethics are essential in all helping professions. APS is guided by a Code of Ethics and Practice Guidelines available at: **http://www.napsa-now.org/wp-content/uploads/2014/04/Recommended-Program-Standards.pdf** (p. 6-7). Key ethics include: "Use family and informal support systems first as long as this is in the best interest of the adult," and "Do no harm. Inadequate or inappropriate intervention may be worse than no intervention."

Securing needed intervention services for APS clients can be very challenging, particularly in rural and underserved areas and when payment mechanisms are lacking. Additionally, APS clients often face challenges using community services designed for people who are disability-free, such as domestic violence, sexual assault, and mental health services, due to factors such as lack of transportation, and health and disability limitations.

Even when accessible services are available, multiple factors can impede APS clients from using them, including loyalty to perpetrators (especially when they are loved ones); fear of medical, mental health and other forms of treatment; concern about loss of independence and autonomy; and fear of facility placement.

STRATEGIES FOR OFFERING ANE INTERVENTION

The following tips are offered to those attempting to assist older adults and adults with disabilities experiencing ANE to achieve safety and healing:

- Build rapport with victims, then use active listening to learn their needs and wishes.
- Offer services that meet the victim's needs, rather than the needs of others.
- Offer services in the victim's environment if possible.
- Offer "tolerable harm-reduction strategies," that is, services that are acceptable to the victim.
- Do not expect or pressure victims to make significant life changes quickly.
- Provide "trauma-informed care" (see Ramsey-Klawsnik & Miller, 2017).
- Refrain from pushing victims to accept multiple services simultaneously.

It is also essential to make culturally-relevant services available. For example, in some APS/American Indian Tribal collaborations, ANE interventions offered to victims include tribal healers and medicine persons, healing ceremonies, talking circles, and sweat lodges.

A CLOSING CONSIDERATION

Research is urgently needed to illuminate and inform our understanding of ANE victims, perpetrators, maltreatment impact, and effective prevention and intervention methods, with a particular focus on APS interventions. To this end, collaborations between researchers and APS professionals are encouraged by the ACL Guidelines (2016) as well as by NAPSA. Guidance regarding APS/researcher collaboration can be found at: **http://www.napsa-now.org/wp-content/uploads/2018/03/Guiding_Principles_2018.pdf**.

REFERENCES

Administration for Community Living. (2016). *Final Voluntary Consensus Guidelines for State Adult Protective Service*. Washington, DC: US Department of Health and Human Services Administration for Community Living.

NAPSA. (2013). *Adult Protective Services Recommended Minimum Program Standards*. Washington, DC: Author.

Ramsey-Klawsnik, H. & Miller, E., (2017). Polyvictimization in later life: Trauma-informed best practices. *Journal of Elder Abuse & Neglect*, 29(5), 339 – 350. https://doi.org/10.1080/08946566.2017.1388017.

NCEA National Center on Elder Abuse

Keck School of Medicine of USC

NAPSA National Adult Protective Services Association

This material was completed for the National Center on Elder Abuse situated at Keck School of Medicine at the University of Southern California in Collaboration with the National Adult Protective Services Association and is supported in part by a grant (No. 90ABRC000101-02) from the Administration for Community Living, U.S. Department of Health and Human Services (DHHS). 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 ACL or DHHS policy.

FACT SHEET

Adult Protective Services, What You Must Know

What is APS?

Adult Protective Services (APS) programs promote the safety, independence, and quality-of-life for vulnerable adults who are, or are in danger of, being abused, neglected by self or others, or financially exploited, and who are unable to protect themselves. APS is a social service program authorized by law in every state to receive and investigate reports of elder or vulnerable adult maltreatment and to intervene to protect the victims to the extent possible.

APS can differ from state to state and even from county to county in terms of definitions, client eligibility requirements and standards of practice. In the vast majority of states, APS clients are "vulnerable adults", or adults 18 and older with a significant physical and/or mental impairment. In a few states APS serves only older persons (usually age 60 and above), while in a few other states older persons can be served based on age alone; i.e. they do not have to have a disability. APS responds to reports of elder/vulnerable adult abuse in private homes in every state; in about half the states they also investigate reports in nursing homes and other long-term care facilities.

REPORTING ELDER/VULNERABLE ADULT ABUSE

In nearly every state there are certain professions that are required by law to report concerns of maltreatment (called "**mandatory reporting**"). Some states require all citizens to report concerns. All states accept voluntary reports, allow for anonymous reports, and provide good-faith reporters with legal protections.

Reports to APS are often made by phone, although some states have web-based methods of accepting reports. For a list of state reporting information, please visit **www.napsa-now.org/report**.

When a report is made, the program must determine if the victim and the allegations meet state definitions/criteria. Reports that do not are referred to other agencies for assistance.

APS must always balance the duty to protect the safety of the vulnerable adult with the adult's right to self-determination. All vulnerable adults should be treated with honesty, caring, and respect.

WHAT DOES APS DO?

- Receives reports of alleged abuse, neglect, self-neglect or financial exploitation and determines if the client is eligible.
- Investigates the allegations through interviewing the client, collateral contacts, alleged abuser(s) and through examining evidence such as medical and bank records.
- Addresses emergency needs for food, shelter or law enforcement protection
- Determines whether abuse is occurring or not. *If it is not*, the case is closed.
- *If it is*, develops a case plan, with the client, to stop the abuse, and to address the client's health and safety needs through services such as medical or mental health treatment, housing assistance, legal assistance, financial assistance, personal care, and home delivered meals.

CLIENT PROTECTIONS

- As is the case with any adult, victims have the right to decline protective services unless a qualified professional determines they are unable to make decisions for themselves. In these cases, APS may need to petition the legal system to appoint a guardian or conservator, or seek a court order for involuntary protective services. It is the duty of the APS professional to exhaust all other measures before seeking involuntary protective services.
- All client information is held in strict confidence by APS and generally may not be disclosed without a court order or a release of information signed by the client.
- APS professionals work collaboratively with other professionals to ensure the safety of vulnerable adults. This collaboration often takes the form of multidisciplinary teams consisting of professionals from social services, criminal and civil justice, mental health, medicine, finance, public health and other services.

Keck School of Medicine of USC

NCEA
National Center on Elder Abuse

NAPSA

Frequently Asked Questions (FAQ)

I've witnessed vulnerable adult maltreatment and wish to make a report. Can I make an anonymous report to Adult Protective Services? If I disclose my identity, how will that information be used?

Yes, any person making a report to APS can do so anonymously. Please visit **www.napsa-now.org/report** for more information on how to make a report in your area. Providing your information will allow the APS investigator to contact you in order to request additional details about your concerns. While some state laws protect the identity of the person making the report, others do not. It is important for you to understand that, depending on state law, the vulnerable adult who is the subject of the report may discover that you made the report to APS.

I made a report to Adult Protective Services, but have not heard back from the program about the status of the allegations I reported. Why is this?

Despite being a government record, APS records and the findings in any case are not public record. All documentation completed for an APS case must be kept confidential and can only be released to the vulnerable adult or persons designated by the vulnerable adult to receive the information, much like medical records, or by court order.

A close relative of mine was reported to Adult Protective Services. What should I do?

The single most important action you can take is to cooperate fully with the investigation and provide any information you can if contacted by the investigator. Many reports to APS are found to be unsubstantiated and the case is closed when this is determined. If maltreatment has taken place, you may be asked to assist with whatever action is necessary to keep the vulnerable adult safe.

Someone made a report to Adult Protective Services that I was being mistreated. What are my rights?

It is the duty of the APS investigator to inform you of your rights at the beginning of the investigation. You will have the right to determine what happens with your situation and what assistance you will receive unless a psychologist or physician evaluates you and reports that you are unable to make your own decisions and a judge concurs. It is important that you cooperate with APS as they determine if maltreatment has occurred. You may read about the APS Code of Ethics at **www.napsa-now.org/ethics**. Remember, APS' only goal is to help you be safe.

I made a report to Adult Protective Services and know that maltreatment occurred, but the case was closed. Why did this happen?

There could be several reasons as to why the case was closed without intervention. The APS investigator may have determined that the maltreatment did not meet the legal, APS definition of such. The vulnerable adult may have declined protective services, despite maltreatment occurring. Perpetrators of vulnerable adult abuse are often adult children (20%) or other family members (19%) whom the vulnerable adult may wish to protect despite the maltreatment[1].

Someone made a report to Adult Protective Services that I was being mistreated. Will I be placed in a nursing facility if the maltreatment is confirmed?

The majority of APS investigations do not involve involuntary intervention. It is very unlikely that you would be placed into a nursing facility without your consent. APS professionals can only seek involuntary intervention when a judge orders the involuntary intervention. It is the responsibility of the APS professional to use the least restrictive services first whenever possible—community-based services rather than institutionally-based services[2].

I made a report to Adult Protective Services and the allegations were deemed substantiated. The victim appears confused and forgetful, but APS still took no action. Why is that?

There could be several reasons for this outcome. Despite exhibiting some confusion or memory loss, the impairment may not be significant enough for a psychologist/physician to recommend involuntary intervention. Involuntary intervention may not be warranted given the extent of the maltreatment.

[1](Teaster, et al., 2007)
[2](National Adult Protective Services Association, n.d.)

About the National Adult Protective Services Resource Center (NAPSRC) The National Adult Protective Services Resource Center (NAPSRC) is a project (No. 90ER0003) 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.

This document was completed in association with the National Adult Protective Services Resource Center (NAPSRC) for the National Center on Elder Abuse situated at Keck School of Medicine of USC and is supported in part by a grant (No. 90AB0003-01-01) from the Administration on Aging (AOA), U.S. Department of Health and Human Services (DHHS). 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.

NATIONAL CENTER ON ELDER ABUSE

Red Flags of Abuse

Our communities are like structures that support people's safety and wellbeing. One of the most important ways we can all contribute to this ongoing construction project is by looking out for warning signs of maltreatment. Does someone you know display any of these signs of abuse? If so, **TAKE ACTION IMMEDIATELY**. Everyone, at every age, deserves justice. **Report suspected abuse as soon as possible.**

Emotional & Behavioral Signs

- Unusual changes in behavior or sleep
- Fear or anxiety
- Isolated or not responsive
- Depression

Physical Signs

- Broken bones, bruises, and welts
- Cuts, sores or burns
- Untreated bed sores
- Torn, stained or bloody underclothing
- Unexplained sexually transmitted diseases
- Dirtiness, poor nutrition or dehydration
- Poor living conditions
- Lack of medical aids (glasses, walker, teeth, hearing aid, medications)

Financial Signs

- Unusual changes in bank account or money management
- Unusual or sudden changes in a will or other financial documents
- Fraudulent signatures on financial documents
- Unpaid bills

WHAT IS ELDER ABUSE?

Elder abuse is the mistreatment or harming of an older person. It can include physical, emotional, or sexual abuse, along with neglect and financial exploitation. Many social factors–for example, a lack of support services and community resources–can make conditions ripe for elder abuse. Ageism (biases against or stereotypes about older people that keep them from being fully a part of their community) also play a role in enabling elder abuse. By changing these contributing factors, we can prevent elder abuse and make sure everyone has the opportunity to thrive as we age.

TYPES OF ELDER ABUSE

- **Physical abuse:** Use of force to threaten or physically injure an older person
- **Emotional abuse:** Verbal attacks, threats, rejection, isolation, or belittling acts that cause or could cause mental anguish, pain, or distress to an older person
- **Sexual abuse:** Sexual contact that is forced, tricked, threatened, or otherwise coerced upon an older person, including anyone who is unable to grant consent
- **Exploitation:** Theft, fraud, misuse or neglect of authority, and use of undue influence as a lever to gain control over an older person's money or property
- **Neglect:** failure or refusal to provide for an older person's safety, physical, or emotional needs

HOW CAN WE PREVENT AND ADDRESS ELDER ABUSE?

We can lessen the risk of elder abuse by putting supports and foundations in place that make abuse difficult. If we think of society as a building that supports our wellbeing, then it makes sense to design the sturdiest building we can–one with the beams and load-bearing walls necessary to keep everyone safe and healthy as we age. For example, constructing community supports and human services for caregivers and older adults can alleviate risk factors tied to elder abuse. Increased funding can support efforts to train practitioners in aging-related care. Identifying ways to empower older adults will reduce the harmful effects of ageism. And leveraging expert knowledge can provide the tools needed to identify, address, and ultimately prevent abuse.

HOW CAN WE REPORT SUSPECTED ABUSE?

No matter how old we are, justice requires that we be treated as full members of our communities. If we notice some of these signs of abuse, it is our duty to report it to the proper authorities.

Programs such as **Adult Protective Services (APS)** and the **Long-Term Care Ombudsmen** are here to help. For reporting numbers, contact **Eldercare Locator** at 1-800-677-1116 (www.eldercare.acl.gov).

*If you or someone you know is in a life threatening situation or immediate danger, call **911** or the local police or sheriff.*

The National Center on Elder Abuse (NCEA) directed by the U.S. Administration on Aging, helps communities, agencies and organizations ensure that older people and adults with disabilities can live with dignity, and without abuse, neglect, and exploitation. We are based out of Keck School of Medicine of USC. NCEA is the place to turn for education, research, and promising practices in preventing abuse.

Visit us online for more resources!

ncea.acl.gov

NCEA
National Center on Elder Abuse

This material was completed for the National Center on Elder Abuse situated at Keck School of Medicine at the University of Southern California and is supported in part by a grant (No. 90ABRC000101-02) from the Administration for Community Living, U.S. Department of Health and Human Services (DHHS). 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 ACL or DHHS policy. LAST DOCUMENT REVISION: DECEMBER 2018

Keck School of Medicine of USC