

NATIONAL ADULT PROTECTIVE SERVICES ASSOCIATION & NATIONAL CENTER ON ELDER ABUSE

Understanding and Working with Adult Protective Services (APS)

Part III: Intervention Collaboration

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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-Klawnsnik & 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

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