Adult Maltreatment And Adult Protective Services in Central California

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in Central California

Prepared for
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Central California Social Welfare Evaluation, Research and Training Center

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Executive Summary

The purpose of this policy brief, commissioned by the Central California Area Social Services Consortium (CCASSC), was to research and report on adult maltreatment and Adult Protective Services (APS). Although the focus of this report is Central California, it presents and discusses national and state conditions related to adult maltreatment and Adult Protective Services programs.

Adult maltreatment is a complex social problem which, in comparison to other social issues, is relatively new to the public consciousness. This report, Adult Maltreatment and Adult Protective Services in Central California, was prepared with the intent and expectation that it will provide increased understanding of and enhanced ability to respond to this little understood social problem, which may have far-reaching consequences as older populations in CCASSC counties and the state continue to grow.

The methodology for this brief include literature review, secondary analysis of state APS data, interviews and consultations with key informants, and a survey of counties on key features of their APS systems. The framework for the policy brief includes:

- Adult maltreatment as a social problem
- Literature review
- National and state responses to adult maltreatment (historical and legislative)
- Population trends and APS workloads in Central California
- CCASSC county survey on APS
- Promising practices
- Recommendations

Findings for this report include:

- Adult maltreatment is often associated with other social problems, such as domestic violence, substance abuse and mental illness.
- Several theories exist that attempt to explain adult maltreatment, including the theory of caregiver stress/excessive demands. However, several studies do not support caregiver stress/excessive demands as a primary cause.
- A 2004 national study found most alleged perpetrators were adult children (32.6%), other family members (21.5%) and spouse's intimate partners (11.3%).
- Findings from the literature suggest that women comprise a majority of elder physicalabuse victims and are most likely to be victims of neglect; men are more likely to be victims of abandonment.
- Findings from the literature suggest that key features of the relationship between perpetrator and victim, perpetrator and victim characteristics, and APS worker decision-making processes are important elements to understand in developing responses to adult maltreatment.
- There is no federal legislation or oversight of APS programs and no federal agency responsible for collecting data, establishing outcomes, and issuing reports. State APS programs originate from state legislation and vary according to state resources, values, and perspectives concerning adult maltreatment.
- California currently has the largest elder population nationally, with at least 3.6 million adults over age 65. California's elder population is expected to double to 6.5 million by the year 2020, making up 14% of the state's population.
- Between 2005 and 2020, the elderly population in CCASSC counties is expected to increase between 50% to 70%.
- For calendar year 2007, CCASSC counties represented about 12% (14,002) of all cases reported statewide (113,066).
- In Central California many APS programs utilize best practices and ethical principles in providing protective services, some of which have been recognized by the National Center on Elder Abuse and include practices in Kern, Fresno and Stanislaus Counties.

Introduction

This policy brief, developed at the request of the CCASSC, explores the nature, extent, and response to adult maltreatment in the nation, the state of California, and the eleven CCASSC member counties – Calaveras, Fresno, Kern, Kings, Madera, Mariposa, Merced, San Joaquin, San Luis Obispo, Santa Barbara, and Stanislaus. Using existing publicly available data and information gathered from participating counties, it provides a historical perspective, discusses relevant policy

and legislation, and describes current local, state, and national conditions related to adult maltreatment and APS programs.

For purposes of this report, the term adult maltreatment refers to multiple forms of abuse affecting two groups of adults: the elderly, generally defined as persons 65 years of age or older, and dependent adults, generally defined as disabled persons between the ages of 18 and 64. However, readers should be aware that adult maltreatment laws and the professional and academic literature often reference only elder abuse in their presentation of adult maltreatment. In both law and literature, types of maltreatment are commonly categorized as physical abuse, sexual abuse, emotional abuse, financial exploitation, neglect, and self-neglect.

The Social Problem

Adult maltreatment first drew prominence in the literature in the 1970s, then referred to as "granny battering" and "battered older person syndrome" (Choi & Mayer, 2000). The National Center on Elder Abuse (NCEA) 2004 Survey of State Adult Protective Services reports APS received a total of 565,747 reports of adult maltreatment, an increase of 19.7 % from the national survey done in 2000 (Teaster, et al., 2007). However, many experts believe that state variations in reporting and the lack of a national database mask the true extent of the problem (Beaulieu & Leclerc, 2006; Brandl, et al., 2007). Other researchers estimate prevalence, especially among elders, to be much higher (Beaulieu & Leclerc, 2006; Bergeron, 2001; Wolf, 2000). It is believed that continued development and refinement of adult maltreatment reporting systems will provide more accurate estimates of the scope of the problem in the future.

Adult maltreatment is a complex social problem that does not possess a single chief source of causation and continues to progress in prevalence. Adult maltreatment is often associated with other social problems, such as domestic violence, substance abuse and mental illness. Adult maltreatment involves precarious social relationships and interactions between victims and perpetrators. Reports of adult maltreatment often point to perpetrators being spouse/partners, adult children, other family members or caregivers. Furthermore, persons identified as victims of abuse can sometimes be responsible for their own maltreatment, as may be the case in instances of self-neglect (Brandl et al., 2007).

In the most extreme cases, adult maltreatment can result in death (Brandl et al., 2007; Nerenberg, 2006). In a 1998 study, elders identified as neglected, including self-neglect, were two to three times more likely to die than those who were not mistreated (Dyer et al., 2005). Not all consequences of adult maltreatment are this severe, however; other consequences include: cognitive impairment, depression, learned helplessness, alienation, post-traumatic stress disorder, physical disabilities and lingering guilt, shame and fear (Choi & Mayer, 2000).

Societal Morals and Values

The United States has a highly idealized notion of family life and the role of the elderly within the family fabric. Perceptions about the elderly extend to American society, where they are generally valued, respected, and perceived as important to its general welfare. The contributions of elderly adults are many, including transmitting to younger generations societal morals and values, their wisdom, and their lifetime of experiences. Elder individuals represent mothers and fathers, sisters and brothers and other members of the family unit that deserve love and care.

Similarly, American society believes that dependent adults should be cared for and provided basic human necessities, protections, and rights. As a decent and humane society, America holds to the principle that elderly and dependent adults are entitled to live in safe environments and to be treated with dignity and respect (Bergeron, 2006; Oetjen & Oetjen, 2006). The acceptance of adult maltreatment runs contrary to this principle and challenges the moral and ethical underpinnings of American society. When family or caregivers perpetrate abuse against elders or dependent adults, they reveal values and perceptions that are not shared by most in society. In this respect, APS programs challenge the negative perceptions and distortions of elder/dependent adults that foster abuse.

Literature Review

The academic literature addressing adult maltreatment primarily discusses elder abuse and is largely silent concerning dependent adult abuse, except as an eligible group for APS. The attention to elder abuse is perhaps due to societal perceptions of elder vulnerability and greater mental and physical incapability due to the aging process (Wolf, 2000). Bergeron (2001) argues that adult maltreatment laws are largely drafted on the premise of elder incapacity and vulnerability and largely ignore well or less frail elders and non-elder adults as potential victims. Nonetheless, academics and researchers are making important contributions to understanding of and responses to adult maltreatment. Although academic literature is broad, six prominent themes relevant to APS are presented here. They are: elder abuse causal theories and consequences, the lack of uniform definitions for adult maltreatment and its types, perpetrator characteristics, victim characteristics, decision-making in APS and APS practice principles.

Elder Abuse: Causal Theories and Consequences

Several theories and hypotheses attempt to explain why adult maltreatment occurs, such as caregiver stress/excessive demands, intergenerational or transgenerational issues, social exchange theory, or power and control dynamics (Brandl et al., 2007; Wolf, 2000). Others view adult maltreatment as an extension of domestic violence, citing perpetrator power and control and victim learned helplessness found in domestic violence theory to explain the abuse (Bergeron, 2001). Additionally, there are explanations for financial exploitation of elders and adults.

Caregiver stress/excessive demands have been suggested by many as a primary factor contributing to adult maltreatment; however, a number of studies suggest that caregiver stress is not the primary factor (Bergeron, 2001; Brandl et al., 2007; Wolf, 2000). Studies indicate that caregiver stress can contribute to abuse, but in a limited number of cases. Although most researchers now agree that it may be a contributing factor, the causes of adult maltreatment are viewed as more complex and multifaceted and are more associated with the type of abuse and the nature of the victim-perpetrator relationship (Anetzberger, 2000).

The role of intergenerational or transgenerational violence posits that adults who were abused as children retaliate against their aging parents. It is held that an adult's experiences during an abusive childhood teach the adult to be abusive. Another feature of this theory is that the abuse is committed as an act of revenge for actual or fancied childhood abuse by the elderly person (Brandl et al., 2007). Although many researchers do subscribe to this theory, not enough empirical studies have been conducted to test it (Choi & Mayer, 2000).

The social exchange theory is based on the exchange of rewards and punishments between persons (Robbins, Chatterjee, & Canda, 2006). In adult maltreatment, the victim is often dependent on the perpetrator for care, which is a reward. The perpetrator perceives the victim as not giving equal rewards in relation to the care provided, which causes the perpetrator to administer punishment because no further rewards are forthcoming. This uneven exchange also leads to perpetrator power over the victim (Robbins, Chatterjee, & Canda, 2006). Furthermore, the perpetrator can administer punishment with little consequence by controlling the contact and exposure the victim has with persons outside the home. In instances when perpetrators are dependent on their victims, perpetrators administer punishment out of resentment of their own powerlessness (Brandl et al., 2007).

Domestic violence theory suggests that violence occurs over a continuum of time and, in some cases, into a victim's elder years. The theory also suggests that family violence is normative and over time the perpetrator gains more power and control as the victim grows older (Bergeron, 2001). Power and control dynamics suggest that a perpetrator exhibits emotionally and/or physically forceful behavior to control, dominate, or punish the victim. The perpetrator feels entitled to be in charge and will meet this need by any means necessary (Brandl, 2000). An example of this could be

a perpetrator that views himself or herself as the head of household who deserves unquestioned obedience from the victim and has been using such abusive behaviors for years to keep family members under control (Brandl et al., 2007).

Elderly persons are also targeted for financial abuse. Several factors contribute to elder financial abuse - persons over the age of 50 own 70% of the nation's private wealth, and persons age 65 or older control about 70% of funds deposited in financial institutions. It is believed that "undue influence" plays a major role in financial abuse (Brandl et al., 2007). "Undue influence refers to the psychological control that stronger people exert over weaker people to get them to do things that they would not have done otherwise." (Nerenberg, 2006, p. 21) In these instances, victims are unaware they are being financially manipulated. Other perpetrators use more direct methods to exploit elder and dependent adults, such as gaining control of their decision making, isolating them, creating dependency, or inducing fear and mistrust of others.

Lack of Uniform Definitions and Indicators of Adult Maltreatment in APS

There is no standard definition of elder abuse used by researchers, practitioners and policymakers (Choi & Mayer, 2000; Daly & Jogerst, 2005; Fryling, Summer & Hoffman, 2006). Brandl et al. (2007) and her colleagues point out that legal definitions of abuse and age classifications of victims vary from state to state. Also, professionals and communities have different perceptions of what constitutes abuse. Research studies use varying definitions based on what is being studied, time and location. Two studies examined variations in elder abuse definitions. Daly and Jogerst (2005) surveyed 351 national APS research network participants to respond to various definitions of abuse. The results were five operational definitions and perceived indicators for emotional abuse, exploitation of finances and/or property, neglect, physical abuse and sexual abuse. This study was an initial step in developing instruments and measurements that APS workers and researchers can utilize in practice and for examining elder abuse. In another study, Dyer et al. (2005), researchers examined key elements of neglect in elder maltreatment to develop a more uniform definition. The most commonly cited factor characterizing neglect was derangement of the client's environment. Derangement included external features such as the amount, type, smell and condition of junk in the yard; internal features identified included excessive clutter, dirty floors, the odor of feces or urine, unkempt pets and paths through trash and clutter.

Nerenberg (2000) argues that the lack of consensus and consistency in defining elder abuse has made comparison of research findings difficult and slowed advances in the field. Without a broad national consensus on a definition of elder abuse, states have drafted their own definitions, resulting in wide variance in the purpose and scope of state APS programs. As incidences of elder abuse continue to grow, the lack of uniformity in definitions and reporting requirements has made measuring results and collecting meaningful data from the various state programs an arduous task (Bergeron, 1999; Otto, 2000).

Although definitions and types of elder abuse are numerous, many professionals and researchers defer to the definitions and types adopted by the National Center on Elder Abuse (NCEA). The NCEA defines three broad categories of elder abuse: domestic elder abuse, institutional elder abuse, and self-neglect or self-abuse. APS programs generally investigate cases that reflect NCEA's definition of elder domestic abuse and self-neglect. The NCEA defines domestic elder abuse as:

> …any of several forms of maltreatment of an older person by someone who has a special relationship with the elder (a spouse, a sibling, a child, a friend, or a caregiver), that occur in the elder's home, or in the home of a caregiver (NCEA, 2007, Elder Abuse/Maltreatment Defined section, para.5).

Different forms of maltreatment and their definitions are specified by NCEA. The definitions for forms of maltreatment are too lengthy to include here, but can be found at the NCEA website located at http://www.ncea.aoa.gov. The forms of maltreatment identified by NCEA are: physical abuse, sexual abuse, emotional or psychological

abuse, neglect, abandonment, and financial or material exploitation.

The NCEA defines domestic self-neglect: Self-neglect is characterized as the behavior of an elderly person that threatens his/her own health or safety. Self-neglect generally manifests itself in an older person as a refusal or failure to provide himself/herself with adequate food, water, clothing, shelter, personal hygiene, medication (when indicated), and safety precautions. The definition of self-neglect excludes a situation in which a mentally competent older person, who understands the consequences of his/her decisions, makes a conscious and voluntary decision to engage in acts that threaten his/her health or safety as a matter of personal choice (NCEA, 2007, Major Types of Elder Abuse section, para. 9).

The Victim and Perpetrator Relationship

In the 2004 national study conducted by the National Committee for the Prevention of Elder Abuse (NCPEA) and the National Adult Protective Services Association (NAPSA) for the NCEA, it was found that victims live in close proximity or with their abusers. The victim usually has a personal relationship with the perpetrator and the victim is often dependent on the perpetrator. The study also found that most alleged perpetrators were adult children (32.6%), other family members (21.5%) and spouse/intimate (11.3%). Choi and Mayer (2000) state that victim dependency on the perpetrator is a predictor of elder abuse.

In a victim and perpetrator relationship, the victim may desire to stop the abuse, but also wants to maintain the relationship with the perpetrator under safe and non-threatening conditions. Maintaining the relationship carries benefits such as allowing the victim to engage in familial activities or in other social relationships, such as with friends, neighbors or social clubs (Brandl et al., 2007). In situations involving a spouse, the victim may value the longevity of the relationship, and/or cultural, spiritual or generational values make divorce or separation inconceivable. The high value placed on the relationship may prevent the victim from seeking help, believing he or she can change the perpetrator and avoid the possibility of the perpetrator being arrested, or the victim becoming institutionalized or homeless (Nerenberg, 2006).

The consequences of disclosing abuse can influence the victim's willingness to report or cooperate in maltreatment investigations. A victim might be unwilling to utilize protective services due to fear of retaliation, being left alone or experiencing further isolation, having to seek out a new caregiver, separation from family and home, or becoming institutionalized (Bergeron, 2006). Sometimes the victim may not be in a position to report the abuse. The victim could be physically or mentally incapacitated, with the perpetrator controlling the victim's exposure to mandated reporters. For example, the perpetrator may not take the victim to medical appointments or allow the victim to leave the home (Fryling, Summers & Hoffman, 2006).

In situations in which victims are financially dependent on their perpetrators, victims have to carefully consider their options, since reporting a perpetrator may severely strain a victim's financial resources and may force a victim into a life of poverty. Religious and cultural norms also influence the decisions victims make regarding leaving their perpetrators or the services they will accept to remediate the abuse (Newman, 2006). For example, some cultures teach women to depend on family members and departure from an abusive relationship means being ostracized by their communities (Brandl et al., 2007). For these reasons and others, many believe that adult maltreatment is underreported (Teaster et al., 2006, 2006).

Victim and Perpetrator Characteristics

Some data suggest commonalities amongst victims (Brandl et al., 2007; Frying, Summer, & Hoffman, 2006). Women are the majority of elder abuse victims, with some estimates indicating that they comprise about two-thirds of all victims in reported cases of elder abuse. Risk factors associated with victimization include: mental or physical illness, social isolation, minority status, low financial resources and little social support (Choi & Mayer, 2006). Women are also most likely to be victims of neglect, or emotional, physical, sexual, and financial abuse. Men are more likely

to be victims of abandonment. Overall, victims experience common reactions to abuse, such as depression, shame or guilt. In contrast, it has also been found that victims acquire survival skills by adopting coping mechanisms that allow them to live in abusive situations.

Ramsey-Klawsnik (2000) developed a typology of elder abuse perpetrators based on her years of experience with elder abuse forensic investigations. Her five classifications included: 1) perpetrators who were overwhelmed caregivers, 2) impaired offenders due to advanced age and frailty, physical and /or mental illness, and developmental disabilities, 3) narcissistic offenders motivated by personal gain, 4) domineering or bullying offenders motivated by power and authority, and 5) sadistic offenders who take pleasure in humiliating, terrifying and harming victims. Other characteristics mentioned by researchers (Brandl et al., 2007; Fryling, Summer, & Hoffman, 2006) include perpetrators who are dependent on their victims' resources for housing, transportation, or addictions. Other perpetrators possess poor interpersonal skills, have few social relationships, and generally lack other social supports. They isolate themselves and victims from outsiders and other social interactions. Lastly, a majority of perpetrators are male and are most associated with physical and emotional abuse, financial exploitation and abandonment. Women perpetrators are most associated with reports of neglect.

Examining Factors of the Decision-Making Process in Investigations

An important area under examination in the research literature is the characteristics of decision-making processes used to investigate and intervene with victims of elder abuse. A study was conducted by Bergeron (1999) in which she examined factors that influence decision-making by APS workers in substantiated cases of elder physical abuse in New Hampshire. Bergeron constructed four primary categories of decision-making which she identified as personal factors, intra-office factors, community support, and professional creativity.

The personal factors included workers' gender, age, experience, education and attitudes about the elderly. The study concluded that workers placed a high value on field experience and gut feelings, rather than education. Bergeron (1999) cautions that this high value on experience and intuition might be overrated as it devalues the importance of formal education and could allow flawed decision-making processes to be passed from experienced workers to inexperienced workers. A finding by Jogerst et al. (2004) may support Bergeron's concern in that they found academic preparation, as well as more professional training, impacted APS investigators' efficiency to substantiate abuse in adult maltreatment cases.

Intra-office factors refer to work processes and norms promoted by the agency and utilized by workers. The ability to collaborate with colleagues was cited as an essential component of decision-making abilities because it allowed immediate feedback from colleagues and additional insights to cases. Dubble (2006) and Nerenburg (2006) broaden this theme to include collaboration with others outside the agency as influencing decision-making by APS workers. Ramsey-Klawsnik (1995) suggests that agencies and systems adopt more structured and comprehensive investigations and assessments procedures to adequately assess elder maltreatment and subsequent decisions.

Community support refers to the political and community resource system of the state. Bergeron (1999) found that the availability of community resources influenced the workers' decisional process, especially in situations where resources were more available; workers tried harder to open cases and influence the length of time cases were kept open. Daly, Jogerst and Schmuch (2007) and Beaulieu and Leclerc (2006) reached similar conclusions. These researchers state that the availability of agency resources influences the decision on whether or not a practitioner should intervene and the quality of services provided to victims of maltreatment.

Lastly, professional creativity is the use of professional self and perceptions of roles that influence decision-making. For example, some workers may possess perceptions of being family workers or promoters of client self-determination.

Although APS laws and regulations tend to focus on elder abuse victims, APS workers generally recognize the necessity of family members as part of the intervention. In some cases, this could include a family member identified as the perpetrator. In some jurisdictions where these workers perceptions are shared, communities have incorporated a restorative justice approach through the use of family group conferencing to involve families in solutions to their problems (Nerenberg, 2006).

A concern expressed by Bergeron (1999) in her study was the difficulty for workers to understand and reconcile the value of client self-determination. It was found that workers tended to focus on clients' right to refuse services and did not include other important concepts associated with self-determination, such as learned helplessness, extreme dependency, unconscious motivations, and the ability of the worker to adequately evaluate competency. Similarly, Beaulieu and Leclerc (2006) concluded that a number of ethical questions are faced by practitioners during decision-making, such as client autonomy, beneficence and non-malfeasance, practitioner attitude and competence, and family versus social responsibility.

The State of Elder Abuse Research

Erlingsson (2007) conducted an analysis of trends and patterns in elder abuse literature and research to assess current knowledge and direction for future research and understanding. She found that a majority of references in the databases reviewed "…were non-research review articles, most frequently of a very general character" (p. 71). These references point to only a few concentrated areas of study, such as investigating prevalence, typology, and definitions issues of elder abuse. She describes these concentrated areas as the steady state of elder abuse research, reflecting the continuing search for the nature of elder abuse and an inclusive, comprehensive definition. Erlingsson also expresses concern about the lack of qualitative studies and the lack of utilization of older person and family members as research participants. Lastly, Erlingsson notes the decrease in dissertations in the field of elder abuse, the lack of funding for elder abuse research, and the lack of graduate education programs that provide content on this subject, which complicates recruitment of new researchers to the field.

APS Practice Principles

The NAPSA has issued a consensus statement enumerating best practice principles for providing protective services that enhance elements of APS program service delivery from intake to investigation to case disposition. The principles NAPSA sets forth encapsulate specific features of protective services, such as the client's right to self-determination, utilizing the least restrictive level of service and being aware of personal bias (NCEA, 2007a).

The NAPSA indicates that it is of importance when performing best practice for an APS worker to distinguish the client's interest as the primary concern when providing any intervention and no personal values should be imposed upon a client. The APS worker should first seek informed consent and respect the client's right to confidentiality, and should provide information about choices and options in a manner the client can understand. During the course of providing services the APS worker should observe the client's cultural, historical and personal values (NCEA, 2007a).

The NCEA (2007a) notes that service plans should include the client as much as possible, and should promote the client's independence and ability to make choices. In the planned client service component, the least restrictive services should be utilized first, such as community services versus institutional services, and when appropriate family and informal support systems are included (NCEA, 2007a).

Ethical Principles. The NAPSA has also developed guidelines regarding basic ethical principles. The principles feature the client's right to be safe, retention of all civil and constitutional rights unless restricted by court action and the right to not conform to societal norms as long as no harm is inflicted on others. The presumption is always that a client possesses the capacity to make decisions unless a court adjudicates otherwise, and the client has the right to accept or refuse services (NCEA, 2007a).

Multidisciplinary Approaches for Addressing Adult Maltreatment. Nerenberg (2006) states in relationship to adult maltreatment that "The diversity and complexity of abuse cases makes it unlikely that any single agency has all the resources, services, or expertise needed to handle all types." (p. 15) Many communities have developed multidisciplinary teams to "…discuss difficult cases; learn what services, approaches and resources are available from other agencies and disciplines; share information and expertise; identify and respond to systemic problems; and insure offender accountability." (Nerenberg, 2006, p. 15) Many communities have developed responses to adult maltreatment that include: physicians and other health care providers, mental health providers, law enforcement, district attorneys, public guardians, community advocates, and more recently financial institutions. These multidisciplinary approaches are a major feature of best practices to address adult maltreatment.

National and State Responses to Adult Maltreatment

Historical Underpinnings

APS origins in the U.S. began in 1958 when the National Council on the Aging created an ad hoc committee of social workers to study the potential need for some form of a nationwide protective service response for elderly persons (Mixson, 1995). In 1960, Virginia Lehmann conducted the earliest formal study on the need for adult protective services for the National Council on the Aging. In 1961, the White House Conference on Aging encouraged social agencies, the medical profession, and legal aid and bar associations to collaborate and continue studying ways to provide protective services to the elderly (Otto, 2000). Throughout the 1960s, the Administration on Aging funded several demonstration projects to study the effects of service delivery systems on certain groups of elderly persons that were recognized as needing protective services. Despite these efforts on behalf of the vulnerable elderly population, by 1968 there were less than twenty community protective service programs in the nation.

In 1974, the catalyst for states to provide adult protective services came in the form of the Title XX amendment to the Social Security Act (Nerenberg, 2006). This Act allowed states to use Social Services Block Grant (SSBG) funds for the protection of adults as well as children. Approximately four years after the passage of the amendment, almost twenty states had enacted legislation requiring social service agencies to afford protective services to adults. In response to the lack of national legislation, states took the initiative to legislate statutes to provide adult protective services through state or local social service agencies. By 1981, all states had some form of agency responsible for providing protective services to adults (Mixson, 1995; Staudt, 1985).

In the late 1980s, a group of APS professionals formed the National Association of Adult Protective Services Administrators (NAAPSA), now called the National Adult Protective Services Association. An early official action taken by NAAPSA was to engage the American Public Welfare Association (APWA), now called the American Public Human Services Association. The NAAPSA was successful in creating awareness among APWA members on issues related to adult maltreatment and recognition of protective service programs as a solution to combat abuse against elders and dependent adults. The NAAPSA also advanced protective services by collaborating with other organizations such as the NCEA, funded by the Administration on Aging (Otto, 2000). By the mid to late 1990s, state protective service programs were empowered through state laws, had increased funding for staff, developed training, provided public education, and established offender registries and emergency client services. In addition to these gains, protective service programs developed closer working relationships with law enforcement, mental health providers, domestic violence programs, and financial institutions. Adult Protective Service programs also forged relationships with other professional groups at the local, state and national level (Otto, 2000).

Adult Protective Services agencies are the principal public response to reports and cases of adult maltreatment. They are assigned by their respective state and local communities to inves-

tigate reports of adult maltreatment. Currently there is no federal statute regulating the service delivery systems of APS agencies, and no federal agency has the responsibility to collect data and issue reports. Furthermore, no discrete funds are provided to states to support and/or enhance APS services (Otto, 2002). In California, the enabling legislation for APS programs is SB 2199, and counties operate their respective APS programs. Each local APS program is responsible for investigating allegations of adult maltreatment. If the individual resides in a long-term care facility, those investigations are conducted by the state's Ombudsman's Office within the Department of Aging (Research and Development Division, Adult Programs Analysis Team [RDD-APAT], 2000).

National

Despite each state having its own laws for adult protective services, most states share commonalities, such as shared principles for carrying out adult protective services that include client autonomy and self determination, least restrictive services and placement, maintaining the family unit, utilizing community-based services instead of institutions, and avoiding the ascription of blame (Bergeron, 2006; Otto, 2000). States also share similarities of APS models based on problem-solving, social casework, and systems approaches, which provide elder abuse victims with coordinated, interdisciplinary systems of social and health services. In addition to serving the elderly, the majority of states also provide services to dependent adults. The types of abuse codified are physical, sexual, and emotional abuse; financial exploitation; neglect; and self-neglect. The exact definition of each form of abuse varies from state to state; however, the descriptions are fairly similar (Teaster, 2007). State APS programs generally receive referrals, conduct investigations, evaluate risk to clients, assess clients' capacity, develop and implement case plans, counsel clients, arrange for services and benefits, and monitor ongoing service delivery. A study from a 1997 national survey found that less than 10 percent of clients received involuntary services (Duke, 1997).

Adult Protective Service programs nationally face a number of challenges, such as the costs of providing services, establishing trust with clients, inconsistencies in policy from state to state, available community resources and measuring outcomes. Establishing measureable outcomes is difficult due to the lack of uniform definitions across states. For example, some states define elder populations as those individuals age 60 years of age or older, some states use 65 years of age or older and another uses 55 years of age or older (Jogerst, et al., 2004). Additionally, there is criticism of the expensive social-casework model used in light of the popular managed care approach that is built on cost-effective outcomes. Lastly, few states have adequate or modern data management systems for APS, making accurate estimates of the scope of the problem difficult and labor intensive. This often has negative implications for funding and other resource request (Otto, 2000, 2002).

Since 2002, elder abuse legislation has been introduced in the U.S. Congress to establish a national response to elder abuse, including additional resources to state and local adult protective services agencies. The latest incarnation of elder abuse legislation is S. 1070 and H. R. 1783, which are commonly referred to as the Elder Justice Act, introduced on March 29, 2007. The Act amends the Social Security Act to establish an Elder Justice program under Title XX. The Elder Justice Act would coordinate efforts and develop leadership at the national level by establishing an Elder Justice Coordinating Council within the Office of the Secretary of Health and Human Services (HHS). The Act would also establish the Advisory Board on Elder Abuse, Neglect, and Exploitation (The Library of Congress, Thomas, 2007a; The Library of Congress, Thomas, 2007b).

An important feature of the Elder Justice Act is that it directs the Secretary of HHS to ensure funding to state and local adult protective services agencies that investigate reports of elder abuse, neglect and exploitation. Additionally, it would establish several national provisions that would directly affect state operated APS programs. It would also provide directives for collection and dissemination of related data in coordination with the Department of Justice. Lastly, the Act would create the Elder Justice Research Center and Library to educate the public, fund research,

provide information on prevention of elder abuse and evaluate for best practices in providing prevention, victim services and prosecution (The Library of Congress, Thomas, 2007a; The Library of Congress, Thomas, 2007b).

California

In 1999, SB 2199 became the enabling state legislation that created minimum APS program standards for California counties. Prior to SB 2199, APS agencies were authorized, but not mandated, to provide protective activities, such as investigations and assessments (RDD-APAT, 2000). APS programs provide services to any elder person or dependent adult. Elder adults are any persons 65 years of age or older and dependent adults are any persons between the ages of 18 and 64 who have physical or mental limitations which restrict their ability to carry out normal activities or to protect their rights (RDD-APAT, 2000).

Senate Bill 2199 created many systemic changes to APS, such as defining the scope of program activity and expanding the definition of a mandated reporter. It broadened categories of adult abuse to include financial abuse, neglect, self-neglect, abandonment, isolation, and abduction. SB 2199 also mandated APS agencies to provide certain services, such as abuse investigations, assessment of individual limitations, strategies for stabilization, short-term case management services, linkage to community services and monitoring and reassessment. Lastly, it required APS agencies to operate a 24-hour emergency response system, including an in-person response when necessary. Subsequent changes to SB 2199 have focused on broadening categories of mandated reporters, clarifying and defining abuse and neglect, establishing task forces, modifying procedures for the provision of services, and increased fines and jail terms for perpetrators (RDD-APAT, 2000).

Funding

In 1980, states used approximately about $83.3 million in SSBG funds for APS expenditures. By 1985, with the absence of national legislation and despite forty-six states providing adult protective services, the amount of SSBG funds for APS decreased to $48.1 million. By 1993, the amount decreased even further to $39.3 million. One explanation for this trend was increased pressures from state-mandated child welfare services (Otto,2000). From 1986 to 1991, the average amount of state SSBG used for adult protective services comprised approximately 4 % of SSBG funding (Otto, 2000, 2002). Teaster et al. (2007) reports from the NCEA's 2004 national survey that a large variance in states' APS expenditures exists, with California at $72 million, followed by New York at $65 million and Texas at $35 million.

In California, APS programs are partially funded from the County Services Block Grant (CSBG) Program. CSBG is derived from several federal sources, including SSBG, and state general fund. CSBG also funds additional services such as Out-of-Home Care for Adults, the Optional Services program, and Information and Referral. Since the passage of SB 2199, APS programs are funded by an APS state appropriation and CSBG (RDD-APAT, 2000). For 2007/2008, APS programs were funded at approximately $61.2 million dollars. As of this writing, Governor Schwarzenegger's proposed budget for 2008/2009 includes a decrease of 10% in APS funding or approximately at $55 .1 million dollars (CDSS, 2008).

The Elderly Population in California and Central California

Estimates indicate that the population of people age 65 and over will significantly increase in the coming years. California currently has the largest elder population nationally, with at least 3.6 million adults (California State Assembly, Committee on Aging & Long-Term Care [CSA-CALTC], 2006). Between 1950 and 2000, California's elder population increased from 1.6 million to 4.7 million, an increase of 194 % (California Department of Aging, 2005). California's elder population is expected to double to 6.5 million by the year 2020, reaching 14% of the state's population. The greatest increase is anticipated between 2010 and 2030, reflecting the aging of "Baby Boomers." By 2030, the oldest Californians, those that are age 85 or older, will represent 1 in 5 of the state's elder residents (CSA-CALTC, 2006). Table 1 illustrates the projected growth for persons age 60 and over in CCASSC counties, based on California's projected growth between 2005 and 2020.

At the national level, estimates of elder population increases are also significantly higher. The most recent figures from the Center for Disease Control and Prevention (CDC) indicate there were 36.8 million persons age 65 or older in the U.S. in 2005 (CDC, 2007). As of July 1, 2004, adults age 60 or older made up 12 % of the population. According to the U.S. Census Bureau, the elder population will comprise 21 % of the U. S. population by 2050 (McCauley, 2006).

Table 1

Elderly Population Estimates
Growth Age 60+, 2005 to 2020
CCASSC Counties

County	2005 60+ Population	2020 60+ Population	+% Change
Calaveras	12,259	19,884	62%
Fresno	115,060	181,451	58%
Kern	108,223	178,940	65%
Kings	15,522	27,276	76%
Madera	21,708	33,200	53%
Mariposa	4,627	6,341	37%
Merced	29,886	49,099	64%
San Joaquin	87,033	148,661	71%
San Luis Obispo	52,638	88,895	69%
Santa Barbara	67,795	88,895	32%
Stanislaus	70,227	114,227	63%
Tulare	50,65	79,080	56%

Source: California Department of Aging (2005)

APS Workload in Central California

Counties report workload and type of abuse data monthly to the state using State of California (SOC) form 242, the source of the data presented in the following sections. SOC 242 data is publicly available through the California Department of Social Services at www.dss.cahwnet.gov.
During calendar year 2007, a total 113,066 reports were made for all types of abuse to all APS programs in California. According to national figures obtained through the 2004 NCEA survey of all states, Washington D.C. and Guam, 565,747 reports were made to APS agencies nationally. Differences in state-to-state data collection methods, reporting requirements, and availability of resources may undercount incidents of adult maltreatment. However, available data, illustrated in Chart 1, indicate that CCASSC counties represented about 12% (14,002) of all reports made. CCASSC counties also represented about 12% (9,273) of the 74,860 reports made regarding suspected elder abuse and 12% of dependent adult abuse reports (4,729).

Chart 1

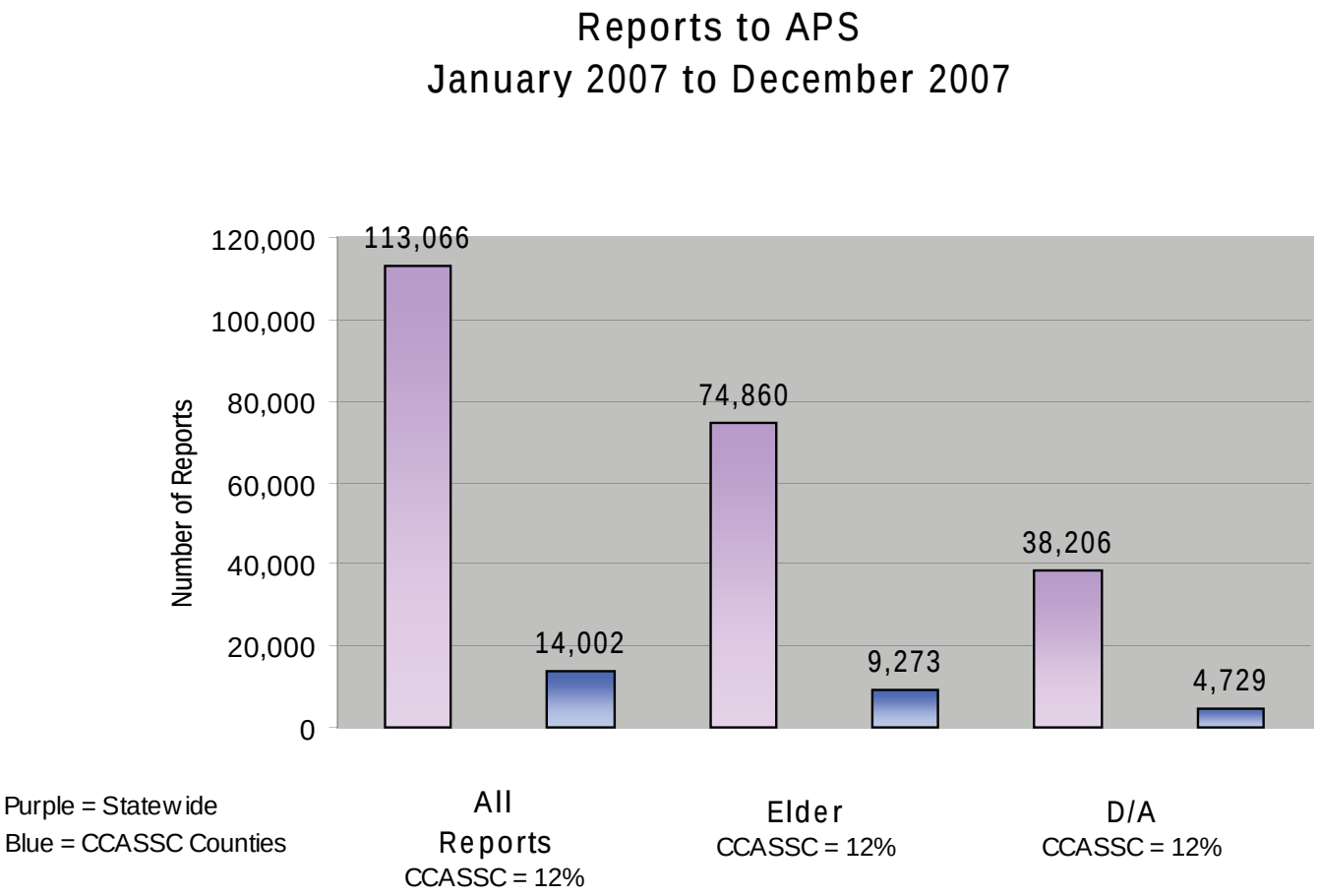
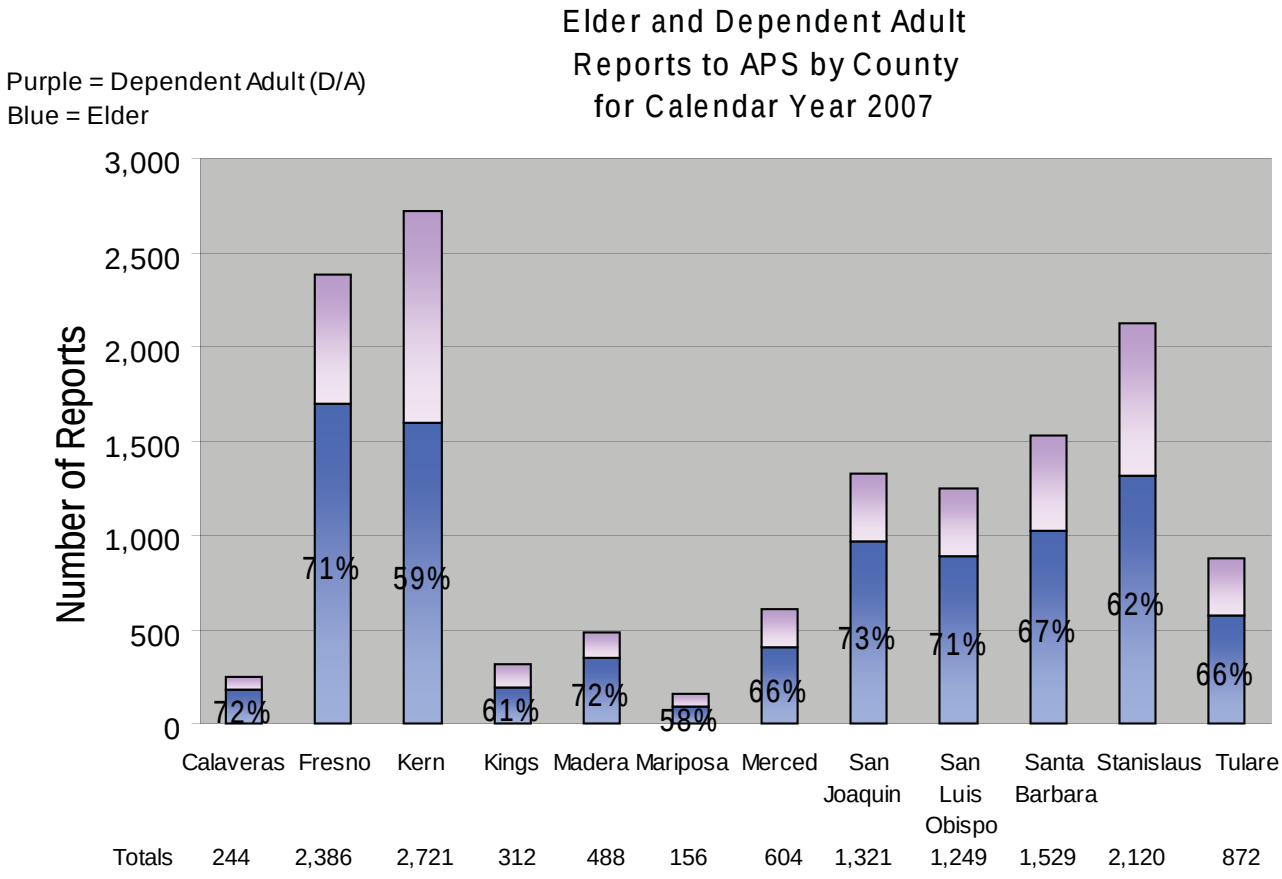


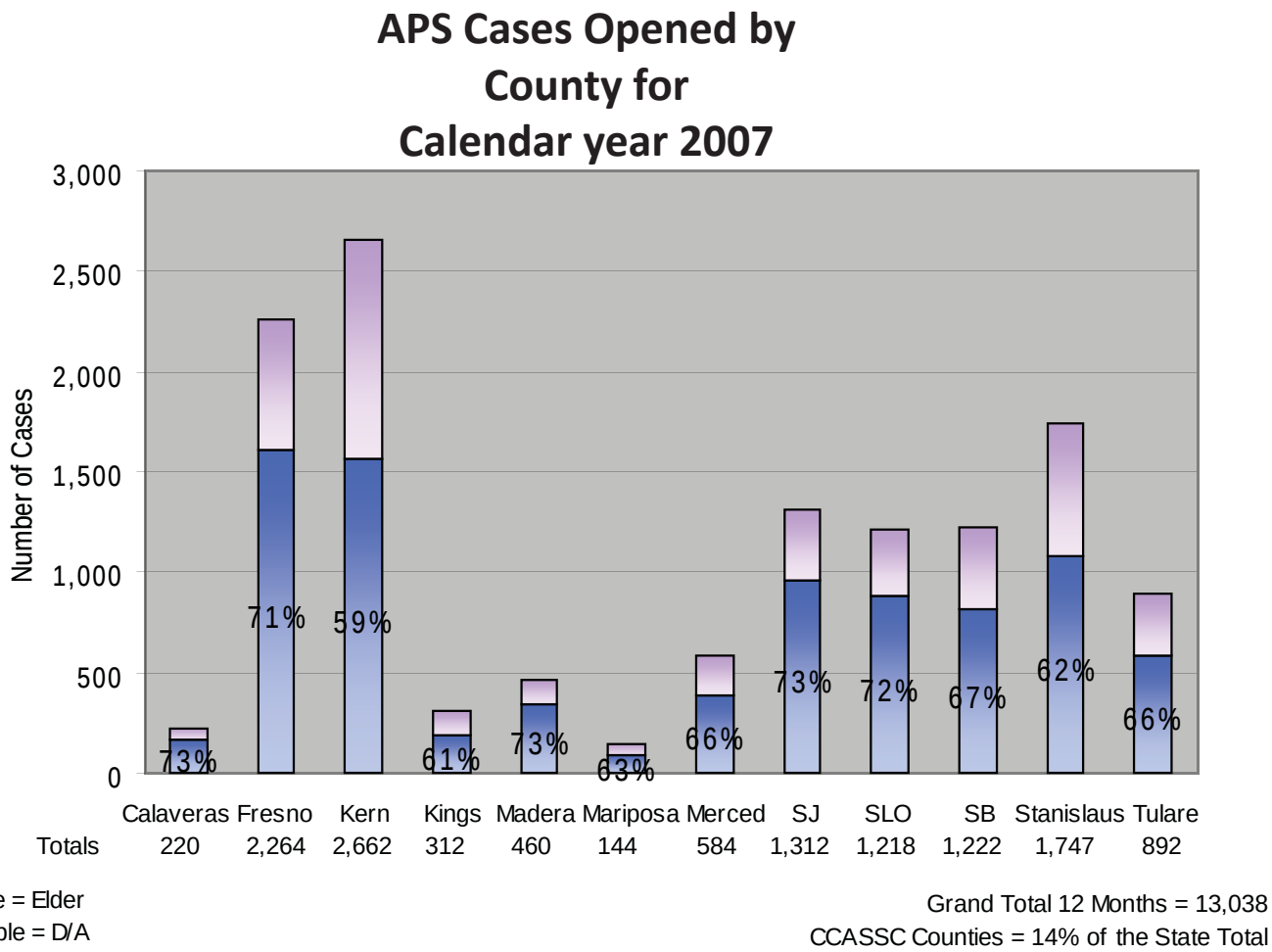
Chart 2 reflects reports of suspected elder abuse made by the public to CCASSC counties. The number of reports received for this category constitutes between 60% and 70% of all reports received, except in Kern and Mariposa counties. Kern County indicates 59% of all reports received are of suspected elder abuse, while Mariposa County indicates 58% in that category. These lower percentages may suggest local organizational structures, resources, and practices that allow more responses and services to dependent adults. The rate of reports to APS programs in CCASSC counties is similar to the statewide figures in which the elderly represent about 66% (74,860) of all reports made to APS programs.

Chart 2



Not all reports of abuse result in cases being opened. This chart represents cases opened by CCASSC county APS programs for calendar year 2007. Of 94,331 cases opened statewide for the same reporting period, 66% (62,275) were elder abuse and 34% (32,056) were dependent adult abuse. According to CDSS, statewide data indicate that, from January 2007 to January 2008, there was a 2.1% increase in cases opened for elder abuse and a 1.6% decrease in dependent adult abuse.

Chart 3

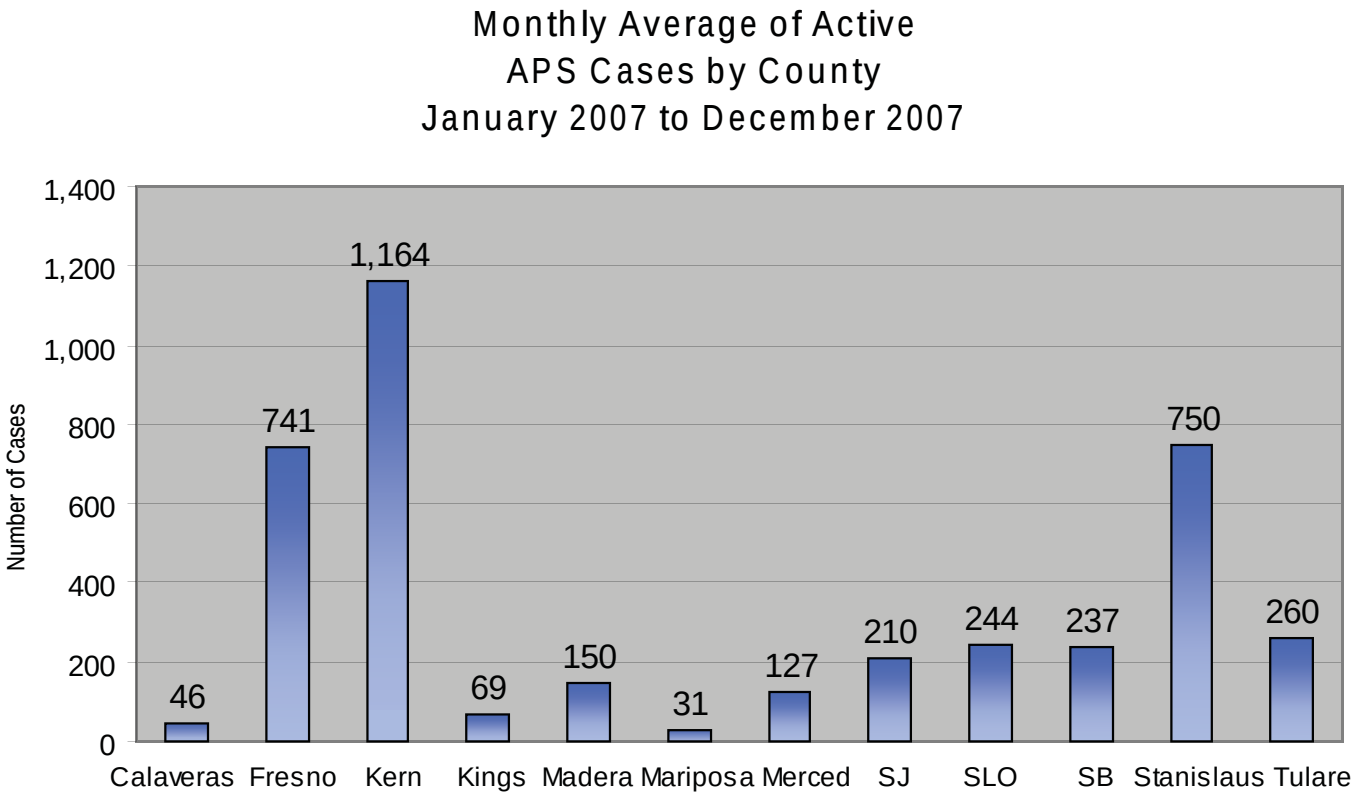


Blue = Elder
Purple = D/A

Grand Total 12 Months = 13,038
CCASSC Counties = 14% of the State Total

Statewide, the monthly average number of active cases for the same reporting period was 20,862; this represents a 3.3% increase from fiscal year 2005/2006, when the number was 20,173. In terms of county populations and the monthly average of active cases, distinct differences were observed between counties with similar populations, shown in Chart 4. According to the California Department of Finance population estimates for 2008, Kern and Fresno county populations totaled 817,517 and 931,098 respectively; Stanislaus and San Joaquin counties were 525,903 and 685,660. Despite similarities in population, Kern and Stanislaus counties experienced higher averages for active cases, which may suggest differences in practices, services and resources.

Chart 4

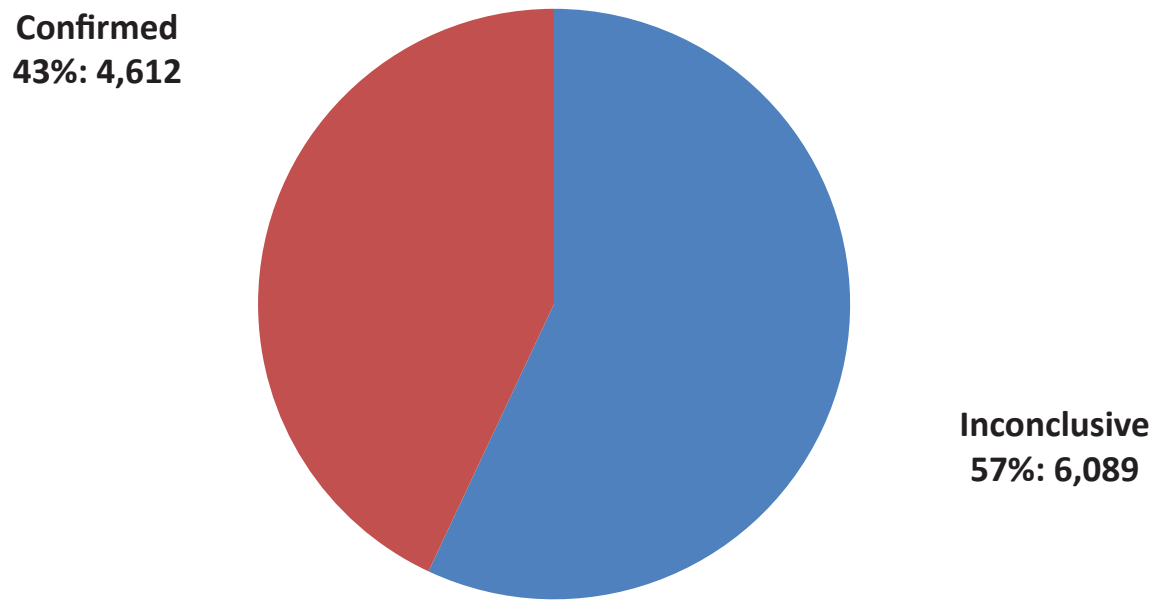


When a report of abuse or neglect is investigated in California it can be determined confirmed (abuse or neglect occurred or most likely occurred), or found to be inconclusive (insufficient evidence that abuse or neglect occurred, but not an unfounded report). The chart above shows a comparison of investigation results in 2007 between CCASSC counties and the state as a whole. Statewide, 37,158 (48%) investigated reports were confirmed and 40,657 (52%) were deemed inconclusive. CCASSC counties data reflect similar results at 43% confirmed and 67% inconclusive.

Chart 5

CCASSC Counties Unduplicated APS Investigations: Findings for Calendar Year 2007

All Groups: Elder and D/A

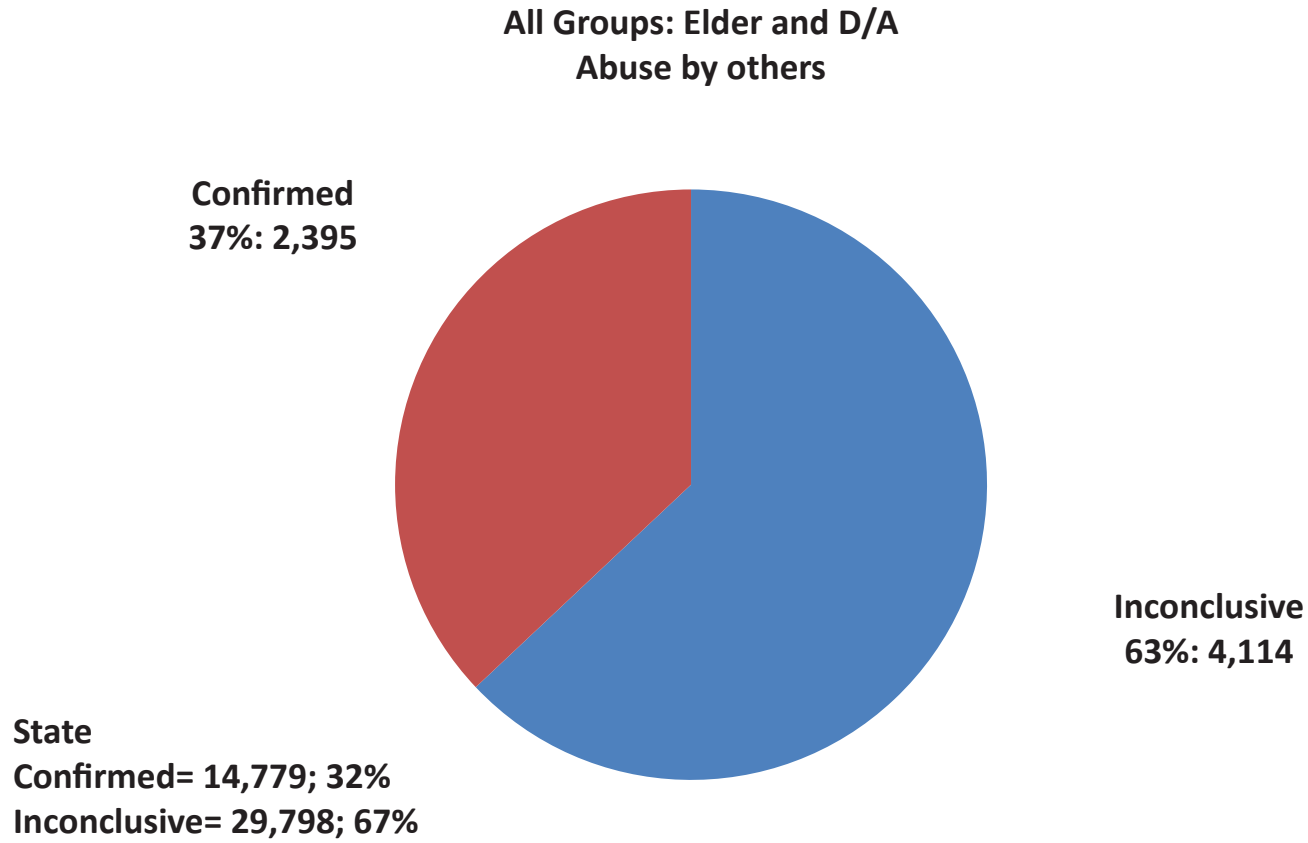


State
Confirmed= 37,158; 48%
Inconclusive= 40,657; 52%

Statewide data for 2007 reflect 14,779 (32%) confirmed investigations of abuse perpetrated by others; CCASSC counties, shown in Chart 6, reported 37% confirmed investigations in this category, 16% of the statewide total. Statewide, 29,798 (67%) of the investigated reports of abuse by others were deemed inconclusive; CCASC counties reported 63% inconclusive, approximately 14% of inconclusive reports statewide. According to a CDSS report, statewide confirmed reports of abuse perpetrated by others increased 8.9% between January 2007 and January 2008. A factor that may be associated with higher percentages of inconclusive determinations is victim reluctance to identify relatives or caregivers as abusers for fear of retaliation, being alone, or being institutionalized. In some instances, family members or caregivers may effectively "shield" communication and information between the victim and the APS investigation.

Chart 6

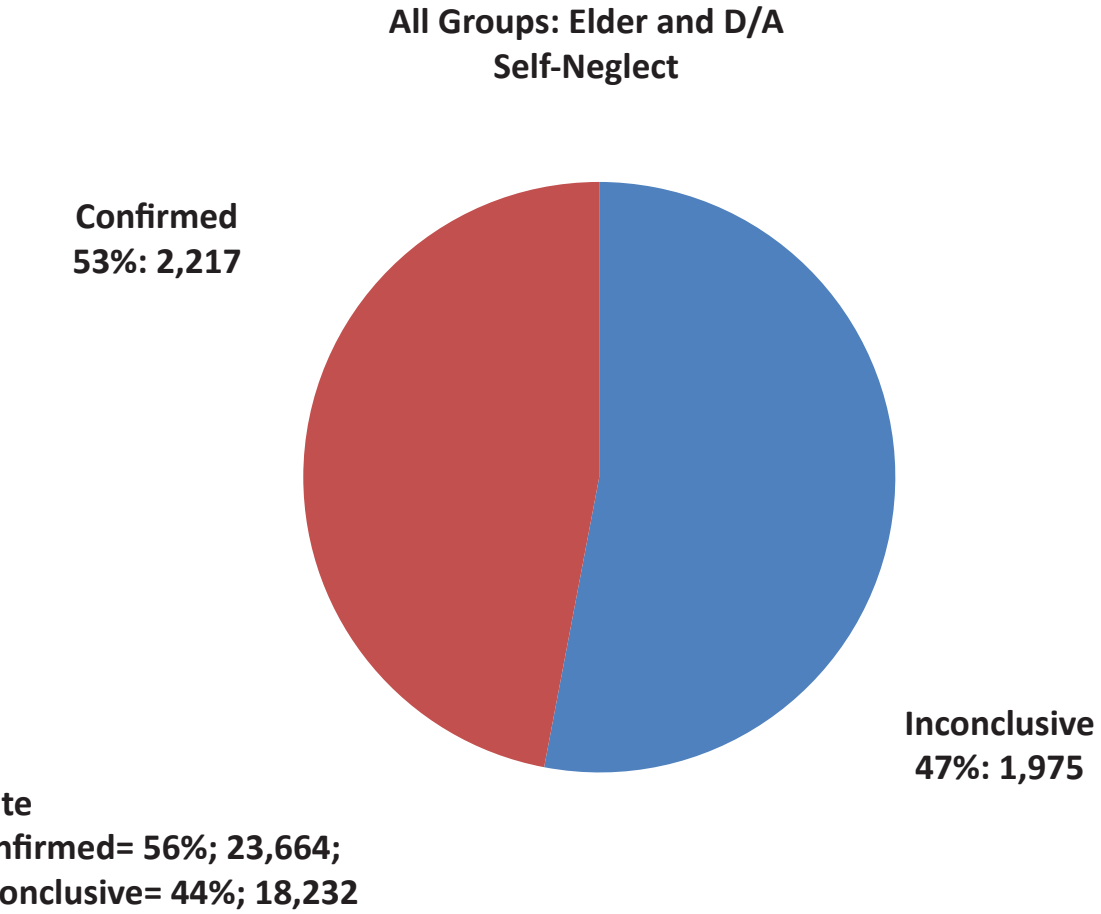
CCASSC Counties Unduplicated APS Investigations: Findings for Calendar Year 2007



Statewide, the 2007 data indicate proportionately similar rates for investigations of self-neglect with 23,664 (56%) confirmed and 18,232 (44%) inconclusive. As illustrated in Chart 7, CCASSC counties reported 53% confirmed investigations and 47% inconclusive investigations in this category, 9.4% and approximately 11% of the statewide totals respectively. According to a CDSS report, there was a 6.1% increase in statewide confirmed self-neglect cases between January 2007 and January 2008. A factor that may be associated with a higher percentage of conclusive determinations is the readily visible nature of physical, medical, and environmental deterioration experienced by persons unable to adequately care for themselves (see Chart 8).

Chart 7

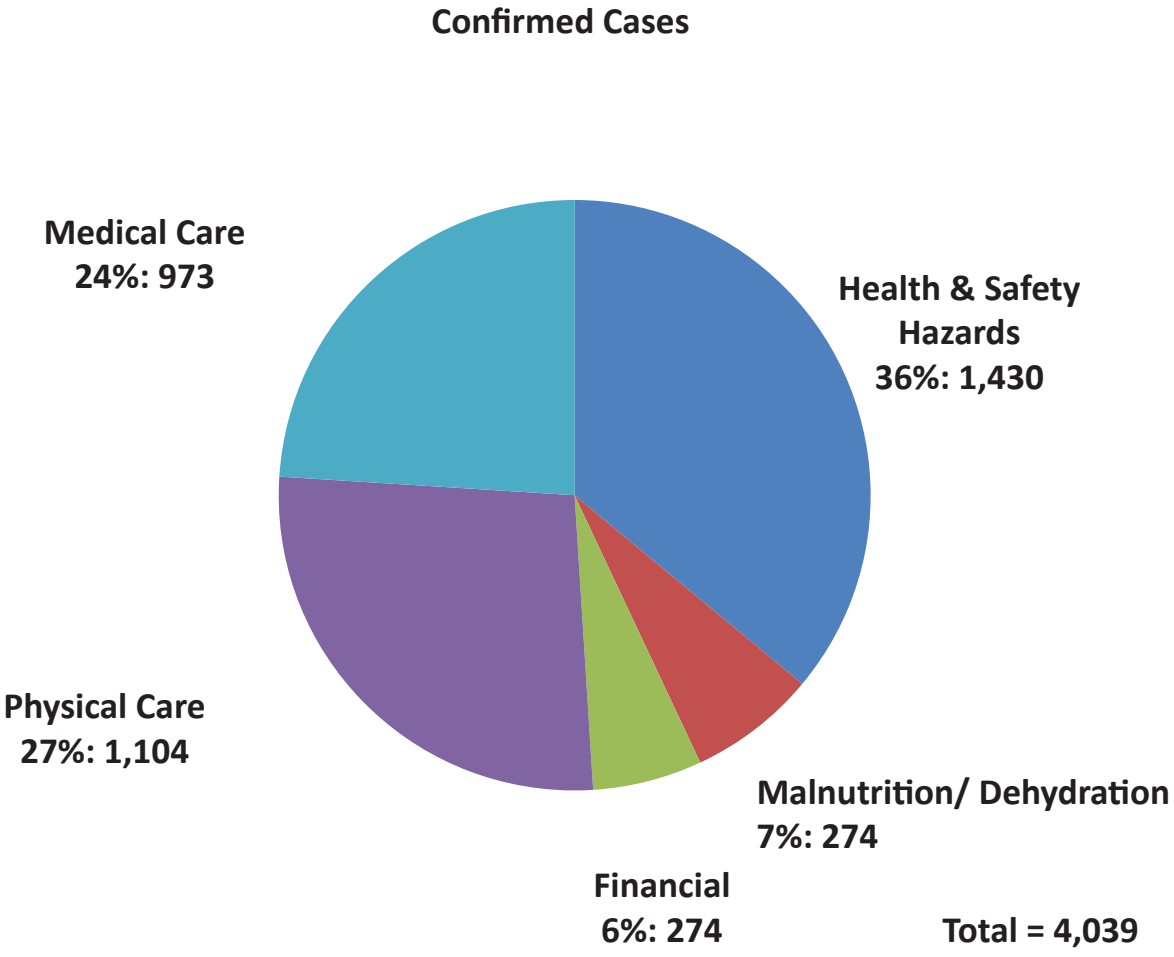
CCASSC Counties Unduplicated APS Investigations: Findings for Calendar Year 2007



CCASSC counties' percentage of all confirmed cases in the categories of Physical Care and Malnutrition/Dehydration self-neglect are proportionately similar to statewide figures of 28% (9,493) and Malnutrition/Dehydration 5% (1,841) respectively. For the category of financial self-neglect, the CCASSC counties' percentage of confirmed cases is significantly lower than the statewide figure of 17% (5,706). CCASSC counties report slightly higher percentages of confirmed Health/Safety Hazards and Medical Care self-neglect cases when compared to statewide data of 30% (9,936) and 20% (6,606) respectively.

Chart 8

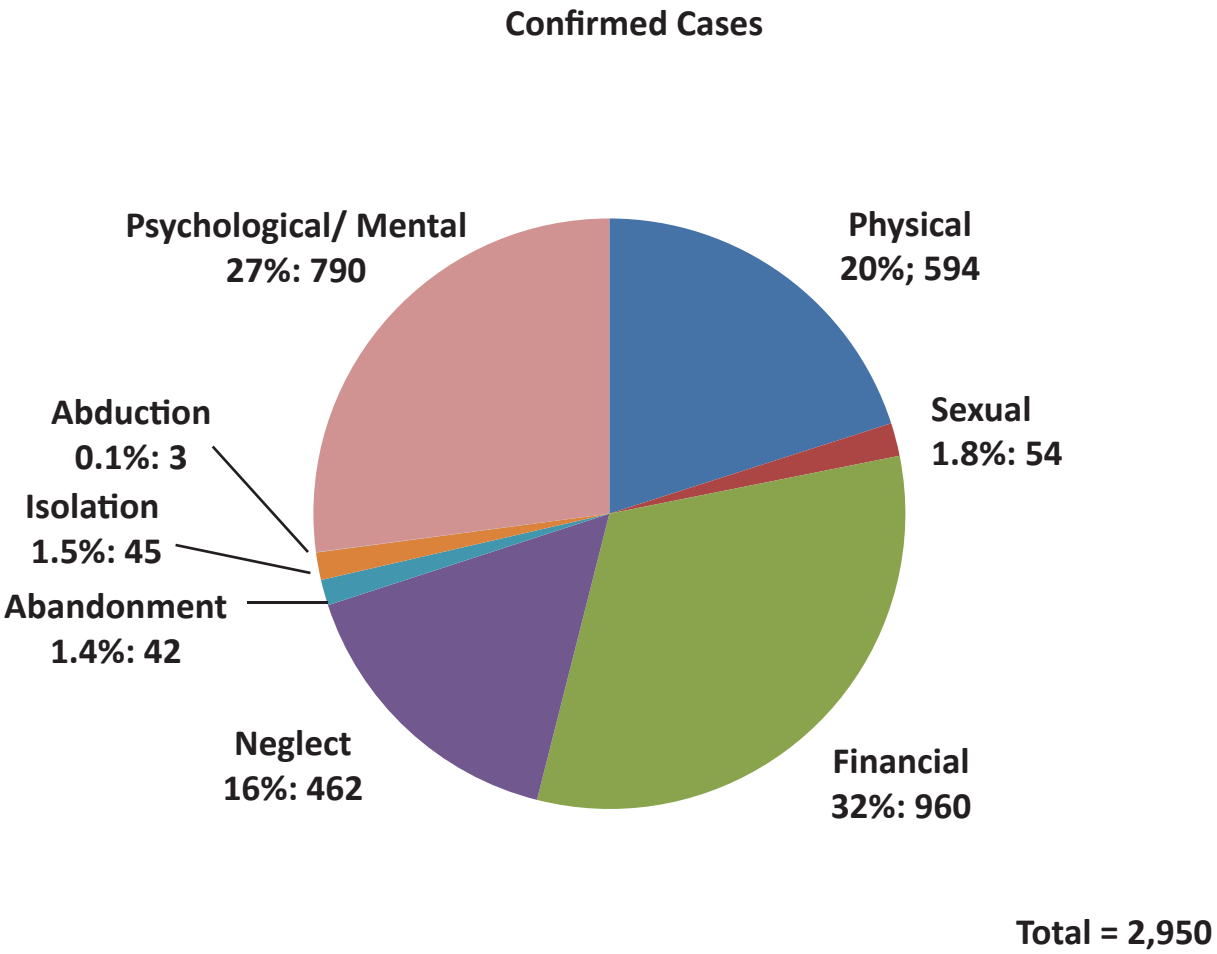
CCASSC Counties Types of Self-Neglect
All Groups: Elder & D/A



CCASSC counties' percentages of all confirmed cases for the same reporting period are proportionately similar to statewide percentages. The statewide percentages are as follows: Financial 31% (5,492); Psychological/Mental 29% (5,171); Physical 19% (3,454); Neglect 16% (2,892); Sexual 2% (324); Isolation 2% (284); Abandonment 1% (239); and Abduction .1% (24).

Chart 9

CCASSC Counties Types of Abuse Perpetrated by Others: All Groups for Calender Year 2007



APS Worker Characteristics from the Statewide APS Training: Central California

Implementation of Statewide APS training in California began in 2005. These data were collected by the Central California Training Academy for the Statewide APS Training Project held during December 2006 and May 2007. Of 76 participants, 72 identified themselves as working in APS programs in California; 65 participants identified themselves as line-workers, 4 as supervisors and 3 as administrators. Table 2 shows he numbers of training participants from counties located in and near Central California.

Table 2

Statewide Adult Protective Services Training
Central California Training Academy
APS Program Participants, December 2006 and May 2007, N = 72

County	Frequency	County	Frequency
Alpine	1	Merced	1
Fresno	14	Monterey	3
Kern	12	San Benito	1
Kings	8	Santa Barbara	4
Madera	6	Stanislaus	13
Mariposa	3	Tulare	6

Note: Alpine San Benito, and Monterey counties are not affiliated with the CCASSC.
Source: Central California Training Academy, 2008.

Participants were asked to indicate their level of education; forty-seven (47) possessed a four year degree and 18 possessed a Master's degree. The remainder indicated having high school diplomas (3), Associates degrees (3), and a PhD (1). Table 3 identifies training participants by college major; 27 majored in Social Work, 12 in Behavioral Science/Psychology. The category of "Other" is comprised of a single response for majors in: Gerontology, Human/Child Development, Interdisciplinary Studies and English Literature. There were 8 non-responses to this item.

Table 3

Statewide Adult Protective Services Training
Central California Training Academy
December 2006 and May 2007, N = 69
College Majors of Training Participants

College Major	Frequency	College Major	Frequency
Social Work	27	Counseling	2
Behavioral Science/ Psychology	12	Political Science/ Government	2
Sociology	5	Nursing	2
Criminal Justice/ Law	4	Other	4
Education	3	Missing Data	8

Source: Central California Training Academy, 2008

Participants were asked to indicate years of experience in their current adult services program. A majority indicated 10 or more years (26), followed by 5 to 10 years (17), and 3 to 5 years (15). The remaining participants reported 2 to 3 years (6), 1 to 2 years (6) and less than a year (2). Table 4 displays participants' employment experience prior to employment with their current programs. The top three experience areas were In-Home Supportive Services (12), Child Protective Services (10), and Caregiving/Nursing Home (7). The category of "Other" comprises single responses given for work experience in Disability Education, Financial Services, Medical Social Work, Probation, Domestic Violence and Advocate/Legal Services.

Table 4

Statewide Adult Protective Services Training
Central California Training Academy
December 2006 and May 2007, N = 72
Participants Previous Employment Experience

Field	Frequency	Field	Frequency
IHSS	12	Detox/ Substance Abuse	3
CPS	10	Clinical/ Mental Health	3
Caregiving/ Nursing Home	7	Nursing	2
Hospice	3	Other	6

Source: Central California Training Academy, 2008

CCASSC County Survey Results

The surveys were conducted by SWERT Center staff via telephone, e-mail, or in person during the months of April, May and June 2008. All CCASSC member counties were invited to participate; interviews were done with APS program staff in Fresno, Kings, Madera, San Luis Obispo, Stanislaus, and Tulare counties. The survey items (Appendix B) related to APS service delivery, administrative data management, worker characteristics and financial resources.

APS Service Delivery. All APS programs were described as being placed organizationally within an adult social services division or department. All APS programs reported utilizing the best practice approach of having multi-agency councils and multi-disciplinary teams. The councils discuss community issues concerning adult maltreatment and the multi-disciplinary teams provide case-specific review and service planning. In addition to councils, two counties reported having committees focused on specific issues, such as financial abuse, mental health services, and safety systems for adults at risk of wandering and getting lost. APS programs surveyed varied in how they collaborate with other local agencies. Many counties reported joint responses with law enforcement and public health as necessary. One APS program indicated co-location with law enforcement, public health and mental health personnel. Two APS programs reported having district attorney investigators on site either full time or part time. One APS program reported having a public health nurse with case-carrying responsibilities. Another APS program reported that referrals concerning In-Home Supportive Services (IHSS) recipients were first investigated by IHSS staff and could, in some instances, be followed entirely by IHSS. Another county also indicated using IHSS social workers to manage the after hours hotline. One county utilizes a case assignment system based on clients' geographic area of residence.

All counties categorized incoming referrals as immediate, 10-day, or No Initial Face to Face Investigation (NIFFI) response. One county reported utilization of an additional category of 5-day response. All counties surveyed maintain a 24-hour response system. The most commonly cited reporting sources were relatives, medical and health care providers, social service agencies and law enforcement. Although most referrals originate from urban areas, one county cited one of its rural communities as a major source of referrals due to its large senior housing development and the use of methamphetamine by in-home care providers and elder persons.

Most APS programs surveyed use an assessment tool to determine risk. Some counties incorporate mini-mental exams to assess risk. Several counties use the systematic assessment tool in Aging and Adult Client Tracking System (AACTS), a case management and reporting application designed for APS. Two counties utilize internally developed assessment tools. All APS programs reported providing investigation, assessment, case management, advocacy and developing service plans. Community services utilized by APS programs included Meals on Wheels, IHSS, emergency housing, legal aid, conservatorship, obtaining a payee, emergency funds for home repairs/clean up, clothing, pest control, and purchases of home appliances. One county issues credit cards to social workers for the purchase of items for clients to address elements of risk, such as food, transportation, or emergency housing.

Several counties reported having cases kept open an average 30 days or less and all reported having cases being open 30 to 45 days One county reported a small number of cases remaining active as long as a year. Appendix C provides additional detail about case status averages during the first quarter of calendar year 2008. The number of cases carried by individual workers ranged from 20 to 45.

Most APS programs reported they did not feel their community's APS system was adequate. Frequently-given explanations were related to funding to support internal resources and systems. A majority of those surveyed stressed the need for additional workers to respond to increases in APS cases and for further training for social workers to address complex cases. One APS program reported that the melding of APS and child welfare staff negatively affected service delivery. Another concern was the limited availability of community resources and services, which reduced APS programs' ability to suffi-

ciently address clients' needs. Specific community services described as inadequate were transportation, access to mental health services, and senior housing. One county also noted inadequate communication and cooperation with other agencies as contributing to poor service delivery.

Data Management Systems and Reporting. All APS programs reported some capacity to capture administrative data in addition to information reported on the State form SOC 242. Some counties utilize specifically designed case management software; AACTS counties use that system to capture additional administrative data. One county uses the Supervision and Management Automated Record Tracking to obtain additional client demographic data.

Suggestions for improving the SOC 242 focused primarily on two areas: the need to capture more relevant information and concern about the reliability of information reported on the SOC 242. APS programs also cited the need for the SOC 242 to capture demographic data and more information surrounding the complexity of cases and adult maltreatment. Several counties had concerns about inconsistent information reported due to the subjective interpretation of terminology and the lack of uniform definitions. Two programs indicated awareness of the State's SOC 242 workgroup currently addressing these issues; however, two counties stated they did not have any particular concerns about the SOC 242 as a reporting tool.

Worker Characteristics. APS programs workforce of social workers in counties surveyed ranged from 2 in smaller counties to 16 in larger counties. Depending on county size, some APS supervisors and administrators may also manage and supervise additional programs, such as IHSS. All programs reported low turnover and that APS positions are highly coveted. APS social workers were typically recruited from other county departments, more often from CWS. A frequent benefit of accepting CWS transfers was their greater level of experience in assessing risk. However, one county reported difficulties with APS retention because of salary differences in which CWS social workers receive substantial pay differentials.

Desired education and experience were similar among all reporting counties, with a four-year degree, preferably in Social Work, being the goal. One APS program indicated a preference for candidates with MSWs, but these candidates were not readily available. Most APS programs regarded previous work experience in adult programs or other social service agencies as equally important as educational experience. Most APS programs reported no formal internal training for social workers, although all utilize the Statewide APS training. However, some programs conduct additional trainings on county policies and procedures, collaborative partners, and focused topics. Several also reported that social workers attend UC Davis classes and local conferences. Two APS programs also cited on-the-job training.

Financial Sources. Funding information was obtained from county and state sources for counties participating in the survey. Funding for APS programs is allocated through County Services Block Grant, derived from federal and state funding sources and the state APS appropriation. One APS program reported receiving a small private donation, shared with IHSS. Counties are required to share in the cost of operating APS programs, known as APS Maintenance of Effort (MOE), drawn from county general funds and based on FY 1996-97 CSBG funding levels. In

Table 5

APS Program's Reported Budgetary Data

	Total APS Budget	CSBG	State APS Appropriation	County MOE
Range	$207,623-$2,063,763	$27,756-$409,836	$163,668-$1,325,424	$16,199-$247,503
Average	$806,209	$147,786	$575,164	$83,260

FY 2007-08, County MOE contributions for counties surveyed ranged from 6% to 12 % of the total allocated APS budget. Table 5 illustrates the range and average of funding amounts reported by APS programs surveyed for FY 2007-08:

Promising Practices

The National Center on Elder Abuse (2007d) provides an online database of best practice program models and information resources in relation to prevention, intervention and public education of elder and dependent adult abuse throughout the U.S. Several programs and information resources in California have been included. In addition to the information gathered from this database, information has been obtained from county websites that also illustrates the use of best practice principles.

Fresno County

Fresno County has been recognized for its Elder Abuse Unit, a collaboration of city and county law enforcement agencies, APS, home health services, mental health, and Victim Witness Services. Through this collaboration, the Elder Abuse Unit has been able to provide a variety of services in one central location to the elder and dependent adult communities (NCEA, 2007d). For more information e-mail inquiries can be submitted to Detective David Case on the Fresno-Madera Area Agency on Aging website at http://fmaaa.org/ or he can be contacted via telephone at (559) 253-7863.

Stanislaus County

A program model that has been recognized in Stanislaus County is the Stanislaus Elder Abuse Prevention Alliance, comprised of agencies such as APS, banks, churches, the District Attorney's office, hospitals, law enforcement, the Public Guardian's office, the Aging Services Division and the American Association of Retired Persons. This collaboration addresses the needs of abused elders and elders vulnerable to abuse by raising public awareness of elder abuse dynamics through outreach, advocacy, education, and prosecution (NCEA, 2007d). For additional information please see: http://web.csustan.edu/ppa/llg/padm5400/SEAPA.htm

Kern County

In Kern County, a program model that has been recognized by NCEA is The Gift of Safety. A Community Relations Specialist provides presentations on personal security, identification theft, violence in the work place, robbery prevention, bank teller training and senior safety. The contact person listed for this program is Sandy Morris at (661) 397-3907 (NCEA, 2007d). Another program model Kern County features is the Senior Outreach Assessment Response (SOAR) program. SOAR essentially is an outreach and prevention program that targets the isolated elderly. SOAR provides assessment services to determine individuals' needs and connects them with community resources with the goal of reducing isolation factors. Specific services include mental status assessments, safety assessments, plans for intervention actions, referrals to resources, socialization contacts, temporary case management and therapy, volunteer outreach via peer counseling, family guidance, crisis intervention services and multi-agency collaboration (Kern County Aging and Adult Services, 2008). For more information on the SOAR program please see www.co.kern.ca.us/aas/soar.asp

Santa Clara County

Recognized program models in other California counties include Santa Clara County's Financial Abuse Specialist Team (FAST). FAST is comprised of various organizations such as APS, the District Attorney's office, law enforcement agencies, the U. S. Department of Justice, the County Counsel office, the Public Guardian's Office, and Santa Clara County's Department of Aging and Adult Services. FAST was created in response to a mandate that APS respond to elder abuse charges within 10 days; FAST focuses on identification, investigation, and prevention of financial abuse of elders and dependent adults (NCEA, 2007d). For additional information please see: http://www.sccgov.org/portal/site/scc and type in search word "FAST."

Sonoma County

The Sonoma County Human Services Elder Abuse Prevention Council is also a recognized program model. This collaboration includes such

agencies as Meals on Wheels volunteers, Brown Bag Volunteers, Human Services Department and non-professional transit drivers. The Council's goal is to increase public awareness by training Meals on Wheels volunteers and Brown Bag volunteers as sentinels of elder and dependent adult abuse. For more information on the program contact Shari Robinson at (707) 565-5991 (NCEA, 2007d).

Orange County

In Orange County the Vulnerable Adult Specialist Team is comprised of agencies such as APS, the District Attorney's office, law enforcement, Ombudsman and the University of California. This collaboration also includes an interdisciplinary medical team consisting of geriatricians, a psychologist, a researcher and a gerontologist. This team provides assistance with mental status examinations and medical assessments. Orange County also has collaborations that utilize multidisciplinary approaches. The Elder Abuse Forensic Center uses the multidisciplinary approach to understand, identify and treat elder abuse, and determine more efficient ways to prosecute cases and promote prevention through education. The Elder Abuse Prevention Council consists of over 80 public and private agency representatives that meet to prevent and combat elder abuse. The Elder Death Review Team's goal is to prevent death due to elder abuse by educating the community and appropriate agencies (Center of Excellence in Elder Abuse & Neglect, 2008; NCEA, 2007d). For more information please see: http://www.centeronelderabuse.org/page.cfm?pgid=3

Recommendations

California has the largest population nationally and is expected to double by the year 2020. A majority of counties in Central California will experience more than a 50% increase in their elderly population by the year 2020. Fortunately the vast majority of elders and dependent adults receive adequate and loving care from their families or caregivers. However, adult maltreatment is a serious problem and the psychological, physical and financial consequences to the victim are cause for societal concern. No doubt, APS programs will continue to be an important resource as communities experience growth in their elderly populations. To prepare for the future, the following recommendations are offered to better prepare communities to respond to adult maltreatment.

Support Statewide and Regional APS Professional Training Efforts.

Adult maltreatment and all of its subtypes is a multifaceted and difficult social issue, yet professional APS training is relatively new in California. Continued support and expansion of professional training efforts, such as the Statewide Adult Protective Services Training Project, will be critical to ensure that the APS workforce possesses the necessary skills and expertise to respond to adult maltreatment and the general needs of the aged and disabled. The Statewide Adult Protective Services Training Project continues to advance its training series and the development of core curricula for new APS workers. Expansion of this training project should include more training offerings and coverage of the many complex topics associated with aging, disabilities and adult maltreatment. An adequate and stable funding source for APS training programs, similar to the support available for child welfare staff and supervisors, is a critical component of any effort to increase the scope and quality of services offered by APS programs.

Expand Aging and Disability Context in Curricula in Schools of Social Work.

Similar to the recommendation above, aged population trends suggest that a competent and diverse workforce is necessary to serve the state's increasingly elder and disabled population. A 2005-06 survey by CalSWEC's Aging Initiative (2008) found that California Schools of Social Work have limited capacity to delivery content on aging, generally limited to some content in generalist courses or offered as an elective. Future workforce needs will require more aging and disability content in social work curricula, including context on adult maltreatment. Recent efforts to shape the future workforce include the Geriatric and Gerontology Workforce Expansion Act (AB 2543) introduced in the California Assembly (2007-2008) and supported by the California

Chapter of the National Association of Social Work. This Act seeks to recruit and train professionals to care for the state's aging population by providing student loan assistance across a variety of disciplines, including social work.

Community Collaboration and Multidisciplinary Teams Responses to Adult Maltreatment.

Many communities throughout the nation and California have well developed community collaborations that discuss adult maltreatment in their communities, promote community awareness of the problem, coordinate responses and resources, and seek solutions to the problem. All communities should evaluate whether the necessary agencies needed to address adult maltreatment are engaged and are part of the community response to adult maltreatment. This often includes law enforcement, district attorneys, ombudsman, medical and health personnel, mental health clinicians, social workers, and public guardians, to name a few. Evaluation should also include whether coordination and communication among agencies is adequate. Some new treads in community collaborations directed at adult maltreatment include Financial Abuse Specialist Teams (FASTs) which include members with expertise in real estate, banking, insurance, trusts, financial planning and other financial matters (Nerenberg, 2006). Elder Fatality Review Teams include coroners/medical examiners, law enforcement, prosecutors, APS social workers, doctors and mental health professionals who evaluate injuries and causes of death in suspected adult maltreatment cases.

Conclusion

The problem of adult maltreatment is still largely a hidden problem, typically committed in the victim's home by persons having a close relationship to the victim. Public awareness of the problem is fairly recent and many communities still struggle with the vexing problems associated with state intervention to adult maltreatment, such as the family's right to privacy, personal life style choices and self-determination, a person's right to refuse services even if risk exists, limited resources, and too few research supported interventions and treatments. These are challenges yet to be overcome; however, many would agree that substantial gains have been made in highlighting and addressing the problem of adult maltreatment. Nonetheless, our understanding and the development of effective solutions to this problem is still in its infancy. Much work lies ahead which will require sustained commitment by a broad representation of constituents to remove the scourge of adult maltreatment from society.

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Appendix A

Internet Resources

Administration on Aging (AoA). The AoA is the federal focal point and advocate agency for the elderly and their concerns. The AoA heightens awareness among other federal agencies, organizations, groups and the public about the valuable contributions of the elderly and draws attention to the needs of the vulnerable elderly. Further information on the AoA can be located at http://www.aoa.gov/index.asp

American Bar Association's Commission on Law & Aging. The Commission purpose is to strengthen and secure legal rights, dignity, autonomy, quality of life, and quality of care of elders through research, policy development, technical assistance, advocacy, education, and training. The Commission is made up of a 15-member interdisciplinary body of experts in aging and law, including lawyers, judges, health and social services professionals, academics, and advocates. The Commission examines the wide range of law-related issues such as legal services to older persons, health and long-term care, housing needs, elder abuse and court-related needs of older persons with disabilities. For more information please see http://www.abanet.org/aging/

California Courts Self-Help Center. The California Courts online self-help center provides assistance and information to the public in regard to elder and dependent adult abuse. It provides forms and a list of frequently asked questions in regard to elder and dependent adult abuse. It also provides information in working with attorneys and in self-representation in some legal matters. Further information on California's Courts Self-Help Center can be located at http://www.courtinfo.ca.gov/selfhelp/protection/elder.htm

California Commission on Aging (CCoA). The CCoA is comprised of 25 commissioners; 19 appointed by the Governor, 3 appointed by the Speaker of the Assembly, and 3 by the Senate Rules Committee. The CCoA serves as the principal advocate in the state on behalf of older individuals by providing advisory considerations on all legislation and regulations made by state and federal departments and agencies relating to programs and services that affect older individuals. For more information please see http://www.ccoa.ca.gov/

Institute on Aging (IOA). The IOA is a community-based, not-for-profit organization that serves the San Francisco, Marin and Peninsula region. Since it's beginnings in 1975, the IOA has become one of the largest providers of community-based services for seniors. The IOA develops and provides community programs in health, social services, creative arts, spiritual support, and education. The IOA also offers professional training, education and research. Student and graduate training is provided through internships and fellowships. Continuing education for professionals is given via education seminars and professional trainings. Research is conducted by the IOA Research Center in collaboration with the University of California San Francisco and other institutions. A major focus of the IOA's research is on objectively assessing outcomes of new community based approaches to health and social services for older adults. The IOA is also active with both clinical trials and funded research investigating treatments and therapies for illnesses affecting older adults. For more information on the IOA, please see http://www.ioaging.org/

National Adult Protective Service Association (NAPSA). NAPSA is a national non-profit organization. NAPSA was formed in 1989 to provide state Adult Protective Services (APS) program administrators and staff with a forum for sharing information, solving problems, and improving the quality of service for victims of elder and vulnerable adult abuse. NAPSA conducts annual national training events, research and innovation in the field of APS. The organization publishes a twice-yearly newsletter and is actively involved in conducting ongoing national research activities on topics such as APS training activities, services to self-neglecting adults and national APS data collection. Further information on NAPSA can be located at http://www.apsnetwork.org/

National Center on Elder Abuse (NCEA). The NCEA is directed by the U.S. Administration on Aging; it is committed to assisting national, state, and local partners in the field in being fully prepared to en-

sure that the elderly will live with dignity, integrity, independence, and without abuse, neglect, and exploitation. The NCEA is regularly utilized as a resource for policy makers, social services and health care practitioners, the justice system, researchers, advocates, and families. For more information please see http://www.ncea.aoa.gov/ncearoot/Main_Site/index.aspx

National Clearinghouse on Abuse in Later Life (NCALL). NCALL is a nationally recognized leader on program development, policy and technical assistance and training that addresses the nexus between domestic violence, sexual assault and elder abuse/neglect. NCALL's mission is to eliminate abuse in later life by challenging beliefs, policies, practices and systems that allow abuse to occur and continue and to improve safety, services and support to victims through advocacy and education. Further information on NCALL can located at http://ncall.us/index.php

National Committee for the Prevention of Elder Abuse (NCPEA). The NCPEA is an association of researchers, practitioners, educators, and advocates dedicated to protecting the safety, security, and dignity of the most vulnerable citizens. It was established in 1988 to achieve a clearer understanding of abuse and provide direction and leadership to prevent it. The NCPEA is one of six partners that make up the National Center on Elder Abuse, which serves as the nation's clearinghouse on information and materials on abuse and neglect. The mission of NCPEA is to prevent abuse, neglect, and exploitation of older persons and dependent adults through research, advocacy, public and professional awareness, interdisciplinary exchange, and coalition building. For more information please see http://www.preventelderabuse.org/

Appendix B

CCASSC APS
Survey Instrument

The interview will take about a half hour to complete. These questions request information regarding your county's APS program, such as service delivery, administrative data management, worker characteristics and the financial sources of your system.

I would like to begin with covering general characteristics of your APS service delivery.

1. Please describe your County APS system. (For example does your APS system response often include law enforcement, the DA and/or the Public Guardian).

2. Is there a community collaborative in your community respective to elder or dependent adult maltreatment? Who are its members?

3. In regard to APS referrals, who are your primary reporting entities?
Of these entities, what are the top three referral sources?

4. Does a majority of your referrals initiate from urban or rural areas?
Can you estimate a percentage?

5. Do you respond to all APS referrals?

6. Do you use an assessment tool at investigation? Please describe.

7. What services does your APS system provide?

8. When a referral is promoted to a case, how long is it typically kept open?

9. On average, what is the size of a worker's caseload?

10. Do you feel that your community's APS system is adequate? Why or Why not?

Now I would like to ask some questions regarding the data management system for your APS program.

11. In addition to the SOC 242, does your agency collect other administrative data for APS, for example gender, ethnicity and/or other demographic information?

12. Do you feel the SOC 242 is an adequate reporting tool?
What improvements do you consider necessary?

The next topic I would like to address is the characteristics of social workers in your APS agency.

13. How are APS social workers, recruited?
a. What education and/or training do you believe an APS social worker should possess?

b. In addition to the APS Academy training, do you have your own internal training for APS?

14. What is the size of your APS workforce?
a. Social workers & Direct Supervisors
b. Support Staff

The last question I have relates to the financial sources of your APS system.

15. Please tell me about your APS system's funding sources for FY 2007.
a. Local funding $?
b. State funding $?
c. County Service Block Grant (CSBG) $?
d. Social Services Block Grants (XX) $?
e. Older American Act $?
f. Private grants/donations $?
g. Other sources$?

Again allow me to thank you for your time and participation in completing this survey, but before we conclude is there anything that I might have missed that you would like to add?