



**Strategies to Improve the Safety, Financial Stability, and
Well-being of Adults with Disabilities and Older Adults
throughout the Commonwealth**

**Report to
Delegate Orrock, Chair
House Committee on Health, Welfare and Institutions**

**Virginia Department for Aging
and Rehabilitative Services**

**Commonwealth of Virginia
Richmond
December 31, 2014**



COMMONWEALTH OF VIRGINIA
DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES

JAMES A. ROTHROCK
Commissioner

8004 Franklin Farms Drive
Henrico, VA 23229

Office (804) 662-7000
Toll free (800) 552-5019
TTY Toll free (800) 464-9950
Fax (804) 662-9532

December 16, 2014

The Honorable Robert D. "Bobby" Orrock, Sr.
Chair, House Committee on Health, Welfare and Institutions
General Assembly Building
Post Office Box 406
Richmond, VA 23218

Dear Delegate Orrock:

It is my pleasure as Commissioner of the Virginia Department for Aging and Rehabilitative Services (DARS) to present to this report in response to your letter dated February 26, 2014. At your request, DARS has completed a study regarding strategies and programs to improve the safety, financial stability, and overall well-being of elderly individuals and adults with disabilities throughout the Commonwealth. The importance of this issue cannot be overstated. More than 21,000 reports of adult abuse, neglect, exploitation were made to Virginia Adult Protective Services (APS) in state fiscal year 2014. Yet research indicates that for each report made, nearly 24 go unreported to authorities. In Virginia there may be hundreds of thousands of older adults and individuals with disabilities suffering in silence.

In preparing this report and its findings, DARS staff held two listening sessions for stakeholders, reviewed several years' worth of APS and Adult Services program data, and developed a survey that was completed by local departments of social services APS workers and supervisors.

Upon careful review and consideration, DARS developed 15 report recommendations, including encouraging the development of local multidisciplinary teams to better respond to adult abuse, neglect and exploitation, improving training for APS workers who are the first responders to protective services reports and increasing funding to provide services to victims of abuse. DARS looks forward to convening stakeholder workgroups to address the recommendations outlined in the report.

If you have any questions, please do not hesitate to contact me.

With best regards, I am

Sincerely,

James A. Rothrock

A handwritten signature in black ink, appearing to read "James A. Rothrock", written over a circular stamp or seal.

JAR/pm

TABLE OF CONTENTS

EXECUTIVE SUMMARY	2
THE VICTIMS	3
BACKGROUND	4
Study Request	4
Listening Sessions, Survey and Additional Research	4
APS Structure Nationally.....	5
Virginia’s State and Local APS System	8
APS Statistics in Virginia	9
Previous Legislative Changes to Virginia APS	10
REPORT RECOMMENDATIONS.....	15
CONTINUING EFFORTS	28
ACKNOWLEDGEMENTS.....	29
Appendix A: Letter Requesting the Study	30
Appendix B: Listening Session Participants.....	31
Appendix C: LDSS Survey Participants.....	33
Appendix D: APS Definitions	34
Appendix E: Case Examples submitted by Virginia APS workers.....	36
Appendix F: APS Mandated Reporters.....	40
Appendix G: Additional Recommendation and Strategies	42

EXECUTIVE SUMMARY

In March 2014, Commissioner James A. Rothrock with the Virginia Department for Aging and Rehabilitative Services (DARS) received a letter from Delegate Robert D. “Bobby” Orrock requesting DARS secure input from stakeholders and offer recommendations regarding strategies and programs to improve the safety, financial stability, and overall well-being of elderly individuals and adults with disabilities throughout the Commonwealth. After receiving the letter, DARS held stakeholder listening sessions in Virginia Beach and Fishersville, initiated an Adult Abuse Report survey with local department of social services (LDSS) Adult Protective Services (APS) units and requested that LDSS submit examples of APS cases. Additionally, DARS APS Division staff members reviewed five years worth of APS statistical data in Virginia and explored other states’ efforts to address concerns with the human services system that is responsible for protecting vulnerable adults.

The listening sessions and the LDSS survey yielded few surprises. For many years, APS staff and community partners have voiced concerns about an increasing number of APS reports, the lack of funding for services, and whether human services organizations, including LDSS, are able to respond to the needs of a growing aging population as well as to support adults with disabilities to live safely in the community. These longstanding concerns, as well as issues and themes that emerged from the listening sessions and survey, informed many of the recommendations in this report.

Fifteen recommendations are included in the report. The recommendations are straightforward and address various parts of a system that works to prevent the abuse, neglect, and exploitation of older adults and individuals with disabilities and as well to protect them from further maltreatment. Some recommendations, such as the call to restore or increase funding for services to protect and support adults, will require action of policy makers. Other recommendations, however, can be accomplished through collaborative efforts of state and local APS staff, stakeholders, and community partners to make a lasting impact on the lives of Virginia’s vulnerable adults. Collaboration among state and local agencies is critical as working together ensures the best outcomes for adults who have multiple needs across the human service spectrum. There is no one solution or program that will prevent adult abuse or stop future abuse. Rather, a variety of actions and efforts on the part of policy makers, state and local government leaders, service providers, healthcare professionals, and community members will ensure that older adults and individuals with disabilities have the highest quality of life and are free from abuse, neglect, and exploitation.

THE VICTIMS

She is in her mid-30s. Her primary caregiver was found dead in the home. The home was in deplorable condition--the floors were covered with animal feces and urine. The APS worker put on protective gear to enter the home with the police. The client, who had many medical and mental health diagnoses, was transported to the hospital for a physical and mental health assessment. The medical team felt she required 24-hour supervision and help with bathing, dressing and preparing meals. She was also determined to be unable to make decisions regarding her health care and financial matters. No family members were willing to be guardians or to help locate a place for her to live. She was eligible for a public guardianship program slot; however, no public guardianship slot was available.

She lives in a private pay assisted living facility and has Alzheimer's Dementia and hypertension. Her dementia prevents her from being able to live alone or make sound decisions. She has been financially exploited by her son who spent over \$170,000 of her money in 10 months on items such as internet purchases, restaurants, home renovations, a car, and his own household expenses including utilities.

These two cases are representative of the more than 8,000 adults who are known to have been abused, neglected, or exploited in Virginia each year.

BACKGROUND

Study Request

During the 2014 Session of the Virginia General Assembly, Delegate Michael J. Weibert sponsored House Joint Resolution (HJ) 39, which requested a study of adult abuse in the Commonwealth. The legislation was left in the Committee on Rules. However, Delegate Robert D. “Bobby” Orrock, Chairperson of Health, Welfare and Institutions wrote a letter (Appendix A) to James Rothrock, Commissioner of the Department for Aging and Rehabilitative Services (DARS) requesting that DARS secure input from stakeholders and offer recommendations regarding strategies and programs to improve the safety, financial stability, and overall well-being of elderly individuals and adults with disabilities throughout the Commonwealth.

Listening Sessions, Survey and Additional Research

In May and October 2014, DARS convened listening sessions with stakeholders to discuss ideas and strategies to improve the safety and well-being of older adults and adults with disabilities in the Commonwealth. A list of stakeholders who attended the listening sessions is in Appendix B. In August 2014, DARS also asked local departments of social services (LDSS) Adult Protective Services (APS) units to complete an Adult Abuse Report survey that included questions developed from the comments received during the first listening session. Seventy-eight out of 120 LDSS completed the survey. A list of LDSS that completed the Adult Abuse Report survey is found in Appendix C. DARS APS Division staff also reviewed five years of APS statistical data in Virginia and reviewed some states’ efforts to address concerns with the human services system that is responsible for protecting vulnerable adults.¹

The listening sessions and LDSS survey yielded few surprises. APS staff and community partners have voiced concerns for many years about the increasing number of APS reports, the lack of funding for services, and whether human services organizations, including LDSS, are able to respond to the needs of a growing aging population and safely support adults with disabilities in the community. These longstanding concerns, as well as the issues and themes that emerged from the listening sessions and survey informed many of the 15 recommendations found in this report.

The recommendations are straightforward and address various parts of the system that works to prevent abuse, neglect, and exploitation of older adults and individuals with disabilities and as well as protects them from further maltreatment. Some recommendations, which can be

¹ All Virginia APS and home-based care statistics in this report are derived from the State Fiscal Year (SFY) APS Division Annual Reports, located at <http://www.dss.virginia.gov/geninfo/reports/adults/as.cgi>. Statistics used in the annual Division Report are from the ASAPS database, the statewide APS case management system and LASER, the Department of Social Services financial system.

accomplished through collaborative efforts of state and local APS staff, stakeholders, and community partners, have the potential to make a lasting impact on the lives of vulnerable adults. No one solution or program will prevent adult abuse or stop future abuse. In fact, there is little available research on how effective APS interventions are in assisting vulnerable adults.² Rather, a variety of actions and efforts on the part of policy makers, state and local government leaders, service providers, healthcare professionals and community members will ensure that older adults and individuals with disabilities have the highest quality of life and are free from abuse, neglect, and exploitation.

APS Structure Nationally

In order to fully appreciate the challenges facing Virginia APS, it is important to understand the structure of APS across the nation. Unlike state child welfare and domestic violence (DV) programs, no federal oversight of or funding for state APS programs exists. Each state has developed its own system for APS intervention and service delivery and has significant programmatic variations. State APS programs differ by the populations served, locations in which investigations are conducted, report response times, and post-investigation service delivery responsibilities. APS workers are typically the first responders to reports of adult abuse, neglect, and exploitation, though response mandates differ. In all states, APS programs conduct investigations in community settings, such as the adult's own home, while fewer than 50% are responsible for investigations in nursing facilities or state facilities for individuals with mental illness or developmental disabilities.³ In some states, local ombudsmen or other state program staff members are responsible for APS investigations in facility settings.

Additionally, the types of professionals and other individuals who are mandated to report suspicions of adult abuse, neglect, or exploitation to APS vary from state to state. New York has no mandated reporting requirements at all. At least 15 states require professionals as well as ordinary citizens to report suspected abuse. Twelve states have specific laws that require financial institutions to report allegations of financial exploitation to APS.⁴

Recent studies and reports of APS Programs across the country illustrate some troubling trends. The U.S. Government Accountability Office (GAO) report, *Stronger Federal Leadership Could Enhance National Response to Elder Abuse*, determined that “according to program officials elder abuse caseloads are growing nationwide, and cases are increasingly complex and difficult

² Ernst, J., Ramsey-Klawnsnik, H., Schillerstrom, J., Dayton, C., Mixson, P., & Counihan, M. (2013). Informing evidence based practice: a review of research analyzing adult protective service data. *Journal of Elder Abuse & Neglect*, 24(5), 458-494.

³ National Adult Protective Services Association (2012). *Adult protective services in 2012: increasingly vulnerable*. Retrieved from <http://www.napsa-now.org/wp-content/uploads/2012/06/BaselineSurveyFinal.pdf>

⁴ New York County District Attorney/NAPSA Elder Financial Exploitation Advisory Board (2013). *Nationwide survey of mandatory reporting requirements for elderly and/or vulnerable persons*. Retrieved from <http://www.napsa-now.org/wp-content/uploads/2012/04/Mandatory-Reporting-Chart.pdf>

to resolve. However, APS program resources are not keeping pace with these changes. As a result, program officials noted that it is difficult to maintain adequate staffing levels and training.”⁵

The National Elder Abuse Incidence Study, one of the first studies to examine the scope of elder abuse, determined that for every one case reported, five more go unreported.⁶ Though this figure is still quoted today, other and more recent studies and surveys have revealed that elder and adult abuse is more prevalent than previously thought.

- A 2012 survey with over 7,000 participants including people with disabilities, family members of individuals with a disability, and disability advocates found only 37.3% of people with disabilities who were victims of abuse said they reported it to the authorities.⁷
- A 2011 report, *Under the Radar: New York State Elder Abuse Prevalence Study*, found an elder abuse incidence rate in New York State that was nearly 24 times greater than the number of cases referred to social service, law enforcement, or legal authorities who have the capacity as well as the responsibility to assist older adult victims.⁸

The GAO report acknowledged that many studies do not reveal the full extent of elder abuse, because researchers did not study all types of abuse, neglect, or exploitation or excluded older adults with cognitive issues from the study samples.⁹

The impact of abuse, neglect, and exploitation on adults is significant. A Utah study estimated that, as a result of financial exploitation, Utah seniors, businesses, and governments lost up to \$51,506,100 in 2009.¹⁰ This figure included more than just personal items or property that were

⁵ Government Accountability Office (2011). *Stronger federal leadership could enhance national response to elder abuse*. Retrieved from <http://www.gao.gov/assets/320/316224.pdf>

⁶ Tatara, T., Kusmeskus, L., & Duckhorn, E. (1998). *National Elder Abuse Incidence Study* (1998). Retrieved from http://aoa.gov/AoA_Programs/Elder_Rights/Elder_Abuse/docs/ABuseReport_Full.pdf

⁷ Baladerian, N., Coleman, T., Stream, J. (2013). *Abuse of people with disabilities: victims and their families speak out*. A Report on the 2012 National Survey on Abuse of People with Disabilities. Retrieved from <http://www.disabilityandabuse.org/survey/survey-report.pdf>

⁸ Lachs, M., Psaty, I. & I., & Berman, J. (2011). *Under the radar: New York State elder abuse prevalence study*, Retrieved from <http://www.ocfs.state.ny.us/main/reports/Under%20the%20Radar%2005%2012%2011%20final%20report.pdf>

⁹ Government Accountability Office (2011). *Stronger federal leadership could enhance national response to elder abuse*. Retrieved from <http://www.gao.gov/assets/320/316224.pdf>

¹⁰ Gunther, J. (2010). *The 2010 Utah Cost of Financial Exploitation*, Retrieved from http://www.nlrc.aoa.gov/NLRC/Docs/2010_Cost_of_FE_5_24_LE.pdf

stolen or misappropriated. It also accounted for the cost of older adults turning to Medicaid for long-term care services because their personal investments, which had been intended to support the adult in later life, had been wiped out. Other studies have indicated that older adults who had been verbally abused reported higher levels of depression than individuals who had not experienced verbal abuse, and that elder abuse and neglect significantly increased the risk of premature death of the victim.¹¹¹²

It is impossible for APS workers to tackle the tragedy of adult abuse alone. Workers often collaborate with numerous state and local agencies on investigations and service provision. However, the recent economic crisis, coupled with the rapidly increasing older adult population, has created an increasing demand for APS services as well as the services of partner agencies. As a Virginia APS worker stated, “APS is the community catch-all” for individuals over age 18, who are “impaired by reason of age, disability, medical, or mental health. This has become increasingly burdensome as the available funding for other community services continues to decline.”

Federal legislative efforts to support state APS programs and create a national APS structure have languished. The Elder Justice Act (EJA) passed by Congress and signed by President Obama in 2010 addressed several issues important to APS Programs such as:

- authorizing the first ever funding for state and local APS Programs;
- authorizing funding for APS demonstration projects;
- creating a new federal Elder Justice Coordinating Council and an Elder Abuse Advisory Committee;
- authorizing funding for new elder abuse forensic centers and for research; and
- enhancing long term care and ombudsman provisions, including a requirement that federally funded long term care facilities report any crimes committed against any of their residents to local law enforcement.

Unfortunately, funding for the federal EJA has never been approved, leaving state APS programs without designated federal support. President Obama’s 2015 budget called for \$25 million in funding. While the Senate included \$10 million in EJA funding in its budget, there has been no action taken in the House. Additionally, the EJA expired on September 30, 2014 though efforts are underway to reauthorize it.¹³ The minimal federal funding, such as the Social Services Block Grant (SSBG), that states use to provide services for elder abuse victims, pales in comparison to federal support for child protective services (CPS) or DV programs. The National Adult Protective Services Association (NAPSA) analyzed federal funding for adult victims and

¹¹ Lachs, M., Williams, C., O’ Brien, S., Pillemark, K., & Charlson, M., (1998). The mortality of elder mistreatment. *Journal of the American Medical Association*, 280 (5), 428-432.

¹² Fulmer, T., Rodgers, R., & Pelger, A. (2014). Verbal mistreatment of the elderly. *Journal of Elder Abuse & Neglect*, 26 (4), 351-364.

¹³ H.R. 5515 introduced on September 17, 2014. Retrieved from <https://www.govtrack.us/congress/bills/113/hr5515>

estimated that nearly \$6,000 is spent on each child victim, \$240 on each DV victim and less than a dollar (\$0.89) is spent on each elder abuse victim.¹⁴

Virginia's State and Local APS System

Pursuant to legislation that passed the 2012 Session of the General Assembly, the APS Division relocated from the Department of Social Services (DSS) to DARS on July 1, 2013. This realignment created better coordination of services for adults in Virginia, as DARS is also the home to the State Long-term Care Ombudsman Program, the Virginia Division for the Aging, the Community-Based Services Division, which includes Brain Injury Services Coordination and Personal Assistance Services Programs, and employment services for individuals with disabilities.

APS Division staff in Richmond and five regional offices develop policies, procedures, regulations, training, and standards for LDSS programs and are responsible for the monitoring and evaluation of those programs. The Commissioner and Division staff act as liaisons to federal and state legislative and executive agencies and to local boards of social services. The Division, in collaboration with the DSS allocates and manages funding for local LDSS APS units.

The Division Director, two Program Consultants and one administrative assistant are located in Richmond. Five regional Consultants are located in Abingdon, Henrico, Roanoke, Virginia Beach, and Warrenton. The regional consultants provide case consultation, technical assistance and training, and serve as resources in the areas of planning, organization and budgeting.

An APS report is an allegation made by any person to an LDSS or to the 24-hour toll-free APS Hotline **(1-888-832-3858)** if he or she suspects that an older adult or an incapacitated individual is being abused, neglected, or exploited. When the hotline staff receives an APS reports about adult abuse, neglect, or exploitation, hotline workers gather the relevant information and forward all reports to the appropriate LDSS. LDSS are responsible for receiving APS reports, conducting the investigations, and providing or arranging for needed services to stop or prevent further maltreatment. Appendix D lists Virginia APS definitions.

In Virginia, every APS report must meet certain criteria in order for it to be deemed a “valid” report. The term valid does not refer to accuracy of the report, but rather to specific elements that must be present to establish APS authority and jurisdiction:

- The adult must be at least 60 years or older or age 18 to 59 and incapacitated;
- The adult must be living and identifiable;
- Circumstances must allege abuse, neglect, or exploitation; and
- The local department must be the agency of jurisdiction.

¹⁴ Information presented at the 2011 Virginia Coalition for the Prevention of Elder Abuse conference and provided through email correspondence with Kathleen Quinn, NAPSA Executive Director, October 28, 2013

APS has its own statutory definition of an incapacitated person. For purposes of validating an APS report, “incapacitated” does not mean that the adult has been found incompetent by a court, but rather that the adult is impaired due to physical disability, mental health condition, intellectual disability or other causes and is unable to make, communicate, or carry out responsible decisions concerning his or her well-being. The APS worker makes a determination as to whether the adult meets the definition of an incapacitated person. Additionally, APS does not have the authority to investigate allegations when the subject of the report has died. The individual in the report must be living and enough information must be provided so the APS worker is able to locate the person who is the subject of the allegation.

Pursuant to § 63.2-1605 of the Code of Virginia, Virginia APS investigates valid reports in all settings including community-based (i.e. the adult’s home) and institutional (i.e. nursing facilities, hospitals, or assisted living facilities (ALF)) with the exception of state correctional facilities.

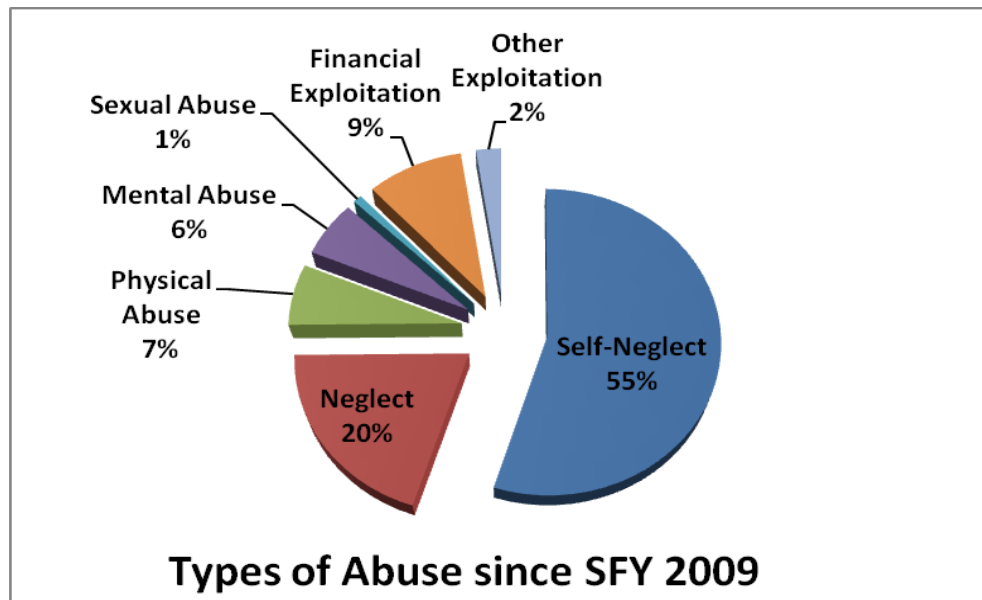
If APS validity criteria are not met, the LDSS may refer the reporter to other LDSS programs, another human service agency, or other service provider. If the report is valid, the investigation is initiated within 24 hours. APS workers have 45 days to conclude an investigation from the date a valid report is received at the LDSS. Upon the conclusion of an investigation, the APS worker makes one of the following investigation dispositions:

- Adult needs and accepts protective services;
- Adult needs and refuses protective services;
- Adult needed protective services but the need for protective services no longer exists;
- Unfounded (the allegation of abuse, neglect, or exploitation was not substantiated);
- Invalid (the report was initially thought to meet validity criteria but later it was determined it did not).

APS Statistics in Virginia

As described in Table 1, neglect and self-neglect are the most common forms of abuse, neglect or exploitation in APS investigations. Since 2009, self-neglect has been consistently identified in 55% of APS investigations, while neglect by another person, such as a caregiver, is found in about 20% of the investigations. Financial exploitation occurs in 9% of investigations. Since 2009 the total number of incidents of abuse, neglect, or exploitation in Virginia has exceed total substantiated reports, as some adults experience two or three forms of polyvictimization, such as physical abuse and financial exploitation, at the same time.

Table 1: Types of Abuse since 2009



Because self-neglect is the most common type of abuse, it is not surprising that the adult's own home is most frequently the location of the abuse, neglect, or exploitation (70% of APS cases). Additionally since 2009, approximately 70% of the subjects of APS reports have been age 60 or older.

Previous Legislative Changes to Virginia APS

Over the past several years, legislative changes in Virginia have enhanced the safety and well-being of older adults and individuals with disabilities. These changes included:

- Expanding the list of professionals who are mandated to report suspected adult abuse, neglect, or exploitation.
- Requiring LDSS to refer relevant information to the appropriate licensing, regulatory, or legal authority for administrative action or criminal investigation.
- Authorizing LDSS, with informed consent, to take or request relevant photographs, video recordings, or medical imaging of the adult and his environment.
- Expanding the list of APS situations in which law enforcement must be notified.
- Requiring law-enforcement and other state and local departments, agencies, authorities, and institutions to cooperate with APS investigations and prevention activities.
- Adding accounting firms to the list of financial institutions that may report voluntarily.
- Adding criminal penalties for making a false report.

- Authorizing the Commissioner of the Department for Aging and Rehabilitative Services to impose civil penalties for cases of non-reporting by all mandated reporters with the exception of law-enforcement officers. (Civil penalties for law enforcement are the responsibility of the court system).
- Making it a Class 3 felony for the abuse or neglect of an incapacitated adult that resulted in death.
- Making financial exploitation of a mentally incapacitated person a criminal offense. Prior to 2013, Virginia's Commonwealth's Attorneys did not have a separate criminal offense under which to prosecute individuals who financially exploited adults with a mental incapacity.
- Establishing a civil remedy process for victims of financial exploitation.

Despite many positive efforts by the Virginia General Assembly to improve the well-being of older adults and adults with disabilities, Virginia's APS system and LDSS APS workers continue to face many challenges. Population figures alone present an overwhelming future for APS. Currently, more than 1.4 million individuals, or about 18% of Virginia's population is age 60 or over. By 2030, 24% of Virginia's population or approximately 2.3 million individuals will be age 60 or older---a 64% increase in two decades.¹⁵

According to the 2011 American Community Survey, nearly 470,000 Virginians age 16 to 64 reported having least one disability. Virginians with disabilities also are more likely to fall below the poverty line, rely on food stamps and have Medicare or Medicaid for health insurance.¹⁶

As illustrated in Tables 2 and 3, Virginia APS has seen nearly a 33% increase in reports since 2009. In 8,000-9,000 of these reports, the adult is determined to need protective services. Approximately 4,000-4,500 adults in need of protective services accept either some or all of the services offered by APS workers.

Table 2: Five Year Comparison of APS Reports

Year	Pending	Invalid	Unfounded	Substantiated	Total Reports
2009	157	1,839	5,553	8,076	15,625
2010	87	2,304	5,998	8,752	17,141
2011	73	2,653	6,269	8,941	17,936
2012	124	3,393	6,863	9,610	19,990
2013	87	3,985	7,557	9,075	20,704

¹⁵ Weldon Cooper Center for Public Service, Demographics and Workforce Group, Retrieved from www.coopercenter.org/demographics/

¹⁶ Weldon Cooper Center for Public Service, Retrieved from <http://www.coopercenter.org/demographics/publications/working-age-virginians-disabilities>

Table 3: Five Year Comparison of Substantiated APS Reports

Year	Substantiated	Needs & Accepts	Needs & Refuses	Need No Longer Exists
2009	8,076	4,440	1,314	2,322
2010	8,752	4,466	1,621	2,665
2011	8,941	4,274	1,623	3,044
2012	9,610	4,391	1,776	3,443
2013	9,075	4,048	1,766	3,261

The APS cases in Appendix D provide a representative sample of the challenging situations that APS workers face daily. APS workers emphasize that financial exploitation cases are particularly difficult to address. Older adults, who weathered the recent economic recession, fared better than other age groups did.¹⁷ Significant assets and resources combined with the adult's failing health or social isolation make older adults particularly attractive financial exploitation targets. Though financial exploitation alone is a complicated to remedy, it becomes even more difficult to resolve when the adult is being physically abused or neglected as well.

The fact that most perpetrators of adult abuse, neglect, or exploitation are family members, adds an additional layer of complexity to all APS investigations. A national study found that family members were frequently the perpetrators of adult emotional, physical, and sexual abuse, neglect, and financial exploitation.¹⁸ Despite the abuse, the adult victim may be reluctant to cooperate with an investigation for fear that the APS worker will place him or her in a nursing facility or that the family member, who is the only caregiver, will be removed from the home. Moreover, many adults are ashamed to acknowledge that a trusted family member is the perpetrator and may not even make the report.

A lack of community supports adds to the challenge of responding to adults who are victims of abuse, neglect, or exploitation. Accessible, affordable housing is a perpetually scarce resource for low-income elderly individuals and adults with disabilities. APS workers have raised significant concerns about the lack of emergency housing for clients who are facing eviction, living in substandard conditions, or trying to leave an abusive situation. Permanent, supportive housing options such as ALFs are often not an option for low-income individuals. The median monthly cost of an ALF in Virginia is \$3,990, which is out of the price range for many older

¹⁷ Pew Research, (2012). *The lost decade of the middle class*. Retrieved from <http://www.pewsocialtrends.org/2012/08/22/the-lost-decade-of-the-middle-class/>

¹⁸ Acierno, R., Hernandez, M., Amstadter, A., Resnick, H., Steve, K., Muzzy, W., & Kilpatrick, D. (2010). *Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the United States: National Elder Mistreatment Study*, US Department of Justice. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2804623/pdf/292.pdf>

adults and individuals with disabilities whose only source of income is Social Security.¹⁹ Many ALFs refuse to accept low-income individuals who receive an Auxiliary Grant (AG), the state supplement eligible individual access to pay for care in an ALF setting. ALF providers, who accept AG payments, cannot accept more than the state established January 2014 rate of \$1,207 per month.²⁰ Due to the low AG reimbursement, ALF providers have found it difficult to meet the level of care of clients who have significant needs and instead have decided to close their facilities. Since January 2014, 14 Virginia ALFs that accepted AG have closed.

APS workers not only face the challenges of complex cases but also in many instances battle the perception among family members and the community that they “do nothing” to stop the abuse, neglect, or exploitation. Unlike CPS, adults who have mental capacity may refuse APS interventions, even when the adult’s decision is in opposition to what relatives, neighbors, or other community members think best for the adult. This concept is sometimes referred to as the “dignity of risk.” Every year adults exercise their right to refuse services in approximately 1,700 or 19% of substantiated APS cases. Workers frequently feel caught between wanting to provide assistance to an adult while respecting the adult’s right to self determination and independence.

The worst case I ever saw was involving a bedridden female who had a terminal illness. She was in her early fifties. Her parents were caring for her. Her father verbally abused her in front of others calling her “worthless” and accusing her of faking her illness. He would bathe her in a lawn chair and with a garden hose. Healthcare professionals, friends, and neighbors made APS reports, hoping she would go to a skilled care facility to live out her last days. I interviewed her, and she confirmed everything but wanted to be at home with her parents. It was heart wrenching to allow her to remain in the home. She was oriented and had the capacity to make that decision. She died two weeks after I visited.

It is also not uncommon for APS workers to find themselves in unsafe situations during the course of the investigation. In many instances the individual who is perpetrating the abuse, neglect, or exploitation is present when the worker visits the home.

APS workers have very few protections. We have no idea what may be on the other side of that door. If there is any truth to the report we have received, the alleged perpetrator is put in a position to lose something such as money, housing, or the elderly client’s medications. I have had a gun drawn on me. I had a family member threaten to “stomp a hole in me” if they caught me out in the community.

During a home visit, the alleged perpetrator came bursting out of the screen door and pinned me against the porch railing while he screamed at me, “You get off my property, or I will pick you

¹⁹ Genworth. (2014). *Cost of care survey*. Retrieved from <https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/Virginia-040114.pdf>

²⁰ In Northern Virginia, the AG rate is \$1,388 per month

up and throw you off.” I did not retreat but informed him that I was calling the sheriff because the property was not actually his but his grandmother’s, who was the victim.

Sometimes the threat comes from the adult himself.

I visited a client who lived in an isolated area where "No Trespassing" signs were posted. The client had numerous guns and thought the signs entitled him to shoot those who came on his property. Luckily, he chose not to shoot on this date.

The man suffered from dementia and had a large dog and a loaded gun in the home and stated he needed both to protect himself.

The man was in his 70s, medically fragile, living alone, and unable to care for himself. His mental status fluctuated due to his pain medications and his medical condition. He would attempt to isolate me, refusing to allow other workers inside his home or throw other the workers out of his home and demand to speak alone with me. When I refused his requests to meet with him alone, he became increasingly angry with me. When an ambulance crew responded to his house after he fell, they discovered four handguns loaded within arm’s reach.

The background information presented above details the significant and daunting challenges of ensuring the safety and well-being of older adults and individuals with disabilities in the Commonwealth. This information provides an important backdrop against which to consider the following recommendations that emerged through conversations with stakeholders and survey responses from LDSS APS workers.

REPORT RECOMMENDATIONS

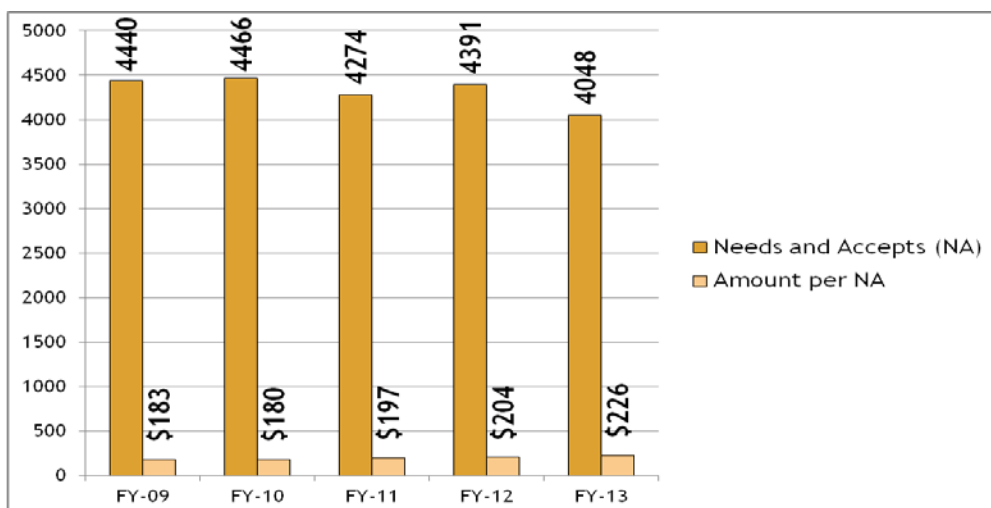
Recommendation #1: Increase funding to provide services to victims of adult abuse, neglect, or exploitation.

It is difficult for APS workers to provide protective services to adults who are abused, neglected, or exploited, when there is minimal and inadequate funding available for these services. Forty-six percent of 78 LDSS who participated in the Adult Abuse Report survey identified that increasing APS funding is a top priority. Despite rising APS reports and the multiple service needs of many victims, funding for APS has remained flat for the past five years. As detailed in the following charts, a review of APS expenditures from SFY 2009 through 2013 indicated that approximately \$180-\$225 was spent on each adult who needed and accepted (NA) protective services.

Table 4: Five Year Comparison of APS Expenditures

Year	APS Expenditures
2009	\$810,916
2010	\$804,628
2011	\$840,284
2012	\$896,396
2013	\$913,291

Table 5: Five Year Comparison of APS Funding per Client



APS workers express high levels of frustration with inadequate APS funding commitments to stop or prevent the abuse, neglect, or exploitation. In most cases that APS staff confront, two hundred dollars is too little an amount to pay for emergency housing, medical bills, clothing, food, or home repairs, or other types of assistance that workers provide to adult victims.

APS received a call from the Sheriff's office. They were ready to issue an eviction for a disabled, bedbound man, who was renting a room and had not paid his rent in several months. The Sheriff's office requested APS help to "find a place" for client who was obese, unable to walk, and required a hospital bed. APS stated finding placement on the day of the call would be nearly impossible as there was no emergency housing available that would meet the client's needs. The client had no family or support system. Sending individuals to hospitals has become a limited option for APS. The client was refusing nursing facility placement. Even if he was willing to be placed in a nursing home, finding an available Medicaid bed even with the luxury of time, is difficult. The Sheriff's office was willing to wait no later than the following morning to evict him. APS agreed to be on the scene at 10 am. APS began contacting every facility in the surrounding area for an available bariatric bed, which he needed due to his extreme obesity. Fortunately, one facility in the area had an available bed and was willing to accept him. After much persuasion and discussion of his options--either enter the facility or remain on the sidewalk in a hospital bed--he agreed to go, only if APS could guarantee that there was a TV in his room.

Understanding that state APS programs are facing dire circumstances, some states have found ways to increase funding for APS. The Ohio state legislature recently passed, and the Governor signed House Bill 483, which provided a unique approach to appropriating APS funding. The bill established an APS Funding Workgroup to study Ohio's APS system and make recommendations on how to distribute \$10 million in new APS funding.²¹ While Ohio's approach may or may not be a solution for Virginia, at a minimum it demonstrates a statewide commitment to shoring up the system that is responsible for protecting vulnerable adults.

Recommendation #2: Restore funding for Other Purchased Services.

Other Purchased Services funding which is used to prevent further maltreatment and protect adults from future abuse, neglect, or exploitation was eliminated in June 2011. APS workers used this funding to pay for services such as adult foster care for an individual who doesn't qualify for AG, congregate or home delivered meals, or extermination services for insect or animal infestation. Twenty-five of 78 LDSS identified restoration of Other Purchased Services funding as a priority for APS in the Adult Abuse Report survey.

²¹ Ohio Legislative Services Commission, Retrieved from <http://www.lsc.state.oh.us/analyses130/h0483-ps-130.pdf>

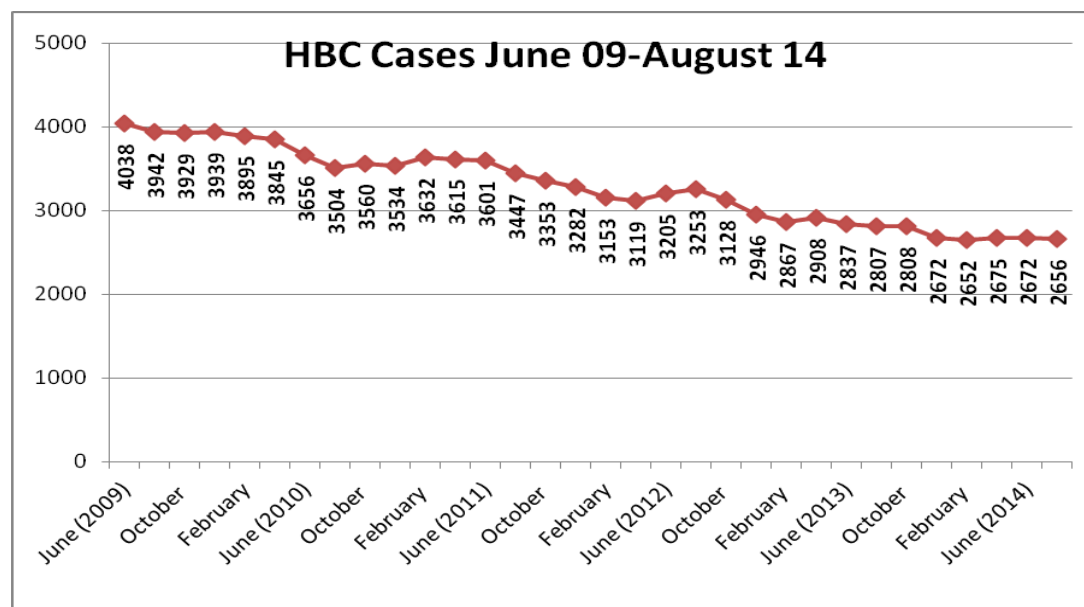
Recommendation #3: Increase funding for home-based care services.

As described in Table 6, funding for supportive home-based care (HBC) such as LDSS homemaker, chore, or companion services, has declined approximately 32% from SFY 2009 to SFY 2014. Funds are used to pay providers, either hired by the LDSS or from home care agencies, to help clients with activities of daily living such bathing and dressing, instrumental activities of daily living such as housekeeping and meal preparation, or minor house repairs, with the goal of keeping older adults and individuals with disabilities in their home. Many older adults indicate that they wish to remain in their home for as long as possible.²² However, as funding has decreased, LDSS have been forced to reduce HBC clients' hours, close less critical cases, and add clients to the waiting lists for services. Table 7 highlights the declining caseloads that have mirrored funding cuts.

Table 6: Home-based Services Cases 2009-2014

Year	HBC Allocations
2009	\$8,087,504
2010	\$7,379,840
2011	\$6,051,469
2012	\$6,054,107
2013	\$6,054,107
2014	\$5,536,481

Table 7: Decline in Home-based Care Cases



²² AARP (2011). *Aging in place: a state survey of livability policies and practices*. Retrieved from <http://assets.aarp.org/rgcenter/ppi/liv-com/aging-in-place-2011-full.pdf>

When home-based services funding is not available, adults who still need assistance turn to more costly interventions, including assisted living or nursing facility care. A 2011 analysis by the Department of Social Services, Office of Research & Planning determined that eliminating the home-based services programs (which are funded via the Social Services Block Grant) would increase State general fund costs by an estimated \$6.6 million as adults sought more costly supports.²³ Additionally home-based services often prevent vulnerable adults from descending into self-neglecting situations by helping these adults meet basic needs such as cooking meals, bathing, or minor house repairs. Restoring approximately \$3 million in funding cuts would return funding for HBC to SFY 2009 levels.

Recommendation #4: Increase funding for additional Public Guardianship slots.

Despite the APS philosophy that adults have the right to self determination, there are instances in which the only means to protect an incapacitated adult from abuse, neglect, or exploitation is to seek guardianship for him or her. In SFY 2013, local departments filed 301 guardianship petitions as a step to protect the adult from abuse, neglect, or exploitation.

Serving as a guardian represents a lifetime commitment, and APS workers experience the situation firsthand when relatives or friends are unwilling or unsuitable to assume the guardianship role. There are few options available when a guardian cannot be located. Virginia's Public Guardianship Program provides guardianship services to incapacitated, indigent adults for whom there is no person willing or suitable to serve as a guardian. The Program currently serves just over 600 adults and has a waitlist of over 900 individuals.

The significant lack of available guardians has a tremendous impact on Virginia's APS Programs. Virginia APS is in danger of becoming the unmonitored and unregulated substitute for Virginia's Public Guardianship Program. Some LDSS APS programs spend \$50,000 to \$100,000 in APS funding and local funding annually to pay local guardianship programs to assume the role of private guardian for a large number of incapacitated LDSS APS clients. Smaller agencies may pay between \$2,000 and \$5,000 annually for these services. All of these programs are depleting their annual APS budget or limited local money to pay the cost of guardianship services. This leaves little or no money for APS services for other clients. In the words of one APS worker, "a significant portion of our funds cover guardianships." Otherwise "we could put in place more services to keep the adult safe in the home."

In other parts of the state, where LDSS have fewer local resources and smaller APS budgets and are unable to pay agencies to provide guardianship services, local judges are appointing LDSS workers and directors as permanent guardians for incapacitated APS clients. A 2013 survey of 26 Southwestern region LDSS found that seven of them had LDSS employees who were serving as

²³ Results of analysis provided by DSS Office of Research & Planning via email to DSS Adult Protective Services staff, October 17, 2011

guardians for clients when no other guardians could be identified.²⁴ In one LDSS, workers were guardians for 11 clients while another was serving 19 clients. The personal toll is significant, as workers become accountable for these incapacitated individuals far beyond their normal job responsibilities. Also, LDSS workers acting as guardians creates a conflict of interest as these same LDSS, by law, are responsible for reviewing the annual guardian reports that all Virginia guardians are required to submit. In these instances, neighboring jurisdictions have assumed the review of the annual reporting, creating additional work for those LDSS.

Fifty-five percent of 78 LDSS completing the Adult Abuse Report survey selected the need for additional public guardianship slots as a top priority in Virginia. In addition, when asked on the survey to describe a strategy or program that would improve the safety, financial stability, and overall well-being of elderly individuals and adults with disabilities, 11 LDSS again stated the importance of increasing the number of public guardianship slots.

Recommendation #5: Fund the Adult Fatality Review Team.

Adult Fatality Review Teams (AFRT) can assist communities and state level organizations by indentifying interventions for preventing deaths of vulnerable adults. When people die, agencies are called to account to investigate and explain how the death occurred. AFRT take advantage of this information, using death investigation reports and health care and social services systems records to understand how and why people die. Fatality review asks what services providers or community programs were involved with the adult and if these providers had the tools and resources needed to assist the adult and keep him alive. Fatality review answers these questions and helps identify actions that contributed to the death and potential gaps in the response system. AFRT can also recommend strategies for intervention before an adult dies as well as strengthen the capacity of state and local government and other service providers to respond to older adults and adults with disabilities in crisis.²⁵ AFRT help focus attention on the signs of adult abuse, neglect, and exploitation, recommend ways to improve reporting to APS and highlight the need for additional services that could prevent untimely deaths of older adults and individuals with disabilities.

In 2008, the General Assembly passed legislation creating Virginia's AFRT. Pursuant to § 32.1-283.5 of the Code of Virginia, the AFRT is comprised of representatives from state agencies, providers, law enforcement, LDSS, and geriatric care specialists. Members review deaths of individuals age 60 or incapacitated adults age 18 or older who were the subjects of APS investigations, whose deaths were due to abuse or neglect or acts suggesting abuse or neglect, or whose death came under the jurisdiction of or was investigated by the Office of the Chief Medical examiner.

²⁴ Survey conducted in September 2013 by DARS Southwestern Region APS Consultant. Results provided by email to DARS APS Division.

²⁵ Stiegel, L. (2005). *Elder abuse fatality review teams: a replication manual*. Retrieved from <http://apps.americanbar.org/aging/publications/docs/fatalitymanual.pdf>

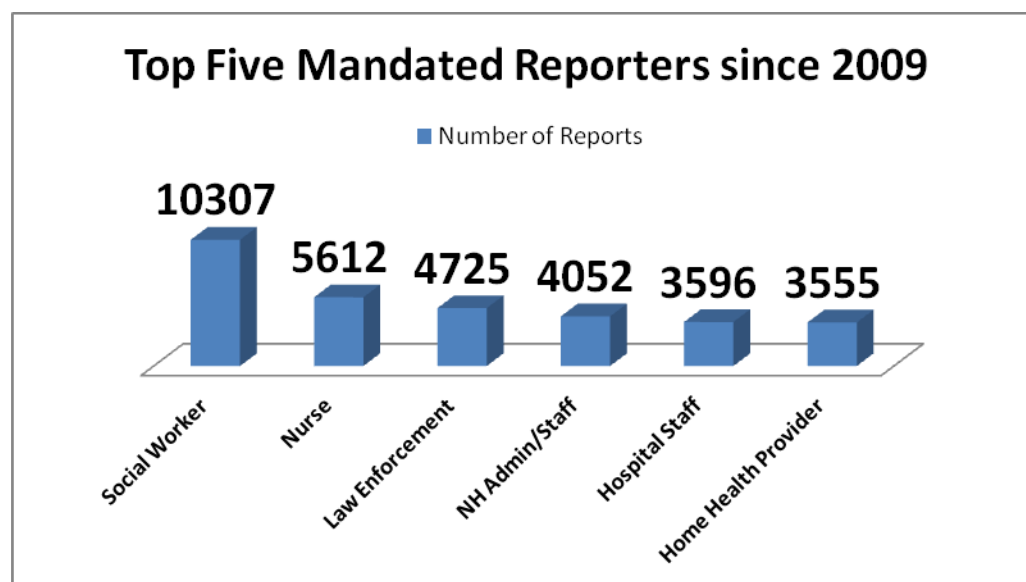
Though Virginia's AFRT is law, the AFRT has not yet reviewed any adult deaths since the law passed because no funding was appropriated upon passage nor has funding been appropriated since.

Recommendation #6: Convene a workgroup of professionals who are mandated to report adult abuse, neglect, and exploitation in Virginia to recommend improvements to mandated reporter training on adult abuse, neglect, and exploitation.

Appendix F lists Virginia's mandated reporters. Mandated reporters play an essential role in identifying suspected adult abuse, neglect, and exploitation and ensuring that such suspicions are reported to APS. However, there is no designated state or local funding for mandated reporter education or public awareness efforts in Virginia. Virginia is not the only state that lacks direct support for public awareness efforts. Despite recognizing the need for public awareness campaigns that focus on APS, most state APS programs indicate that they do not have adequate resources for these efforts.²⁶ The last significant campaign to educate mandated reporters in Virginia occurred after mandated reporter laws changed in 2004.

During the first listening sessions, several stakeholders indicated that physicians are hesitant to make APS reports. A review of APS reporter data since SFY 2009 provides valuable information as to who does and does not make APS reports. Since SFY 2009, the professions that most frequently report to APS have remained very consistent. These professions include social workers, nurses, and law enforcement as indicated in Table 8.

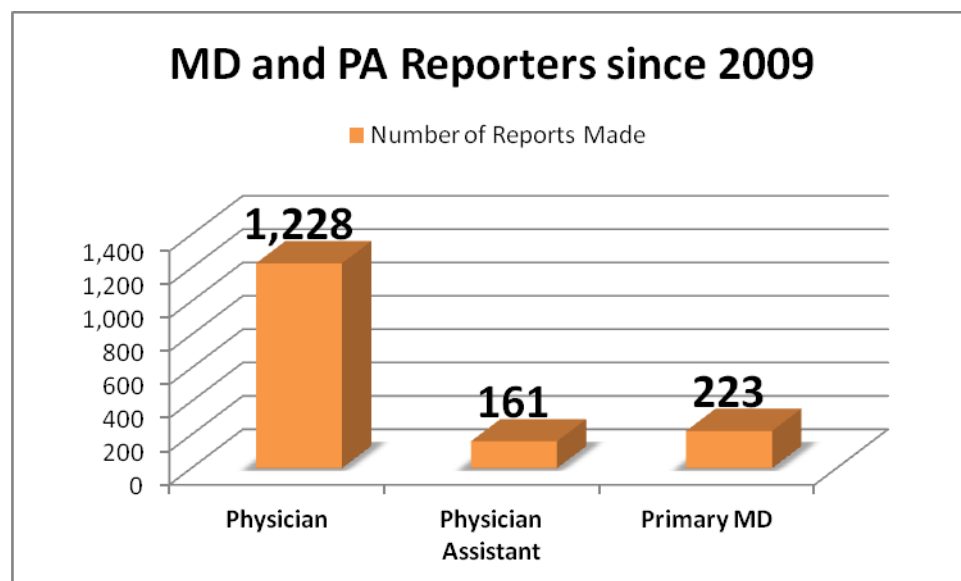
Table 8: Top Five Mandated Reporters since 2009



²⁶ National Adult Protective Services Association (2012). *Adult protective services in 2012: increasingly vulnerable*. Retrieved from <http://www.napsa-now.org/wp-content/uploads/2012/06/BaselineSurveyFinal.pdf>

Although physicians and other health care professionals such as physician’s assistants (PA) could be included in the totals for hospital staff, in general it appears that these particular health care professionals report less frequently than other types of mandated reporters (Table 9). Analyzing who reports less frequently to APS may provide the focus for a statewide mandated report campaign that reaches out to those professions that may benefit from more education on the topic of adult abuse, neglect, and exploitation and the responsibilities of mandated reporting.

Table 9: Medical Doctor (MD), Physician Assistant and Primary MD Reporting since 2009



Civil penalties, which the Commissioner of DARS may impose on mandated reporters for failure to report, may not encourage more reporting. Civil penalties became law in 2004, however, only a handful of LDSS have requested that a civil penalty be imposed. One limitation with civil penalties is that the “failure to report” is usually discovered during the course of an APS investigation. For example, during a nursing facility investigation, the APS worker may discover that a facility staff person failed to report suspected abuse. The worker is able to gather enough information to request that a penalty be imposed. Yet workers do not have the authority to investigate a mandated reporter’s failure to report, unless it is during the course of an APS investigation, making it impossible for the worker to obtain enough evidence to support a request for civil penalty.

Current mandated reporter training consists of a free, online mandated reporter training course. The DSS public website also hosts a webpage that contains information about adult abuse, neglect, and exploitation. Every May, during Virginia’s Adult Abuse Prevention Month, the APS Division, in collaboration with other community partners, attempts to raise awareness about adult abuse, neglect, and exploitation by posting fliers, fact sheets and other information on the DSS website. Though information for mandated reporters is accessible, another approach is obviously needed to reach some mandated reporters and encourage them to report.

Recommendation #7: Improve training for APS workers and other community partners.

Pursuant to § 51.5-148 of the Code of Virginia, the DARS APS Division has the authority to establish training requirements for APS workers. APS workers are required to complete four mandated courses within one year of their employment as an APS worker.

The four mandated courses are:

- New Worker Training
- Assessing Capacity
- Investigating Self-Neglect
- APS Facility Investigations

Previously, LDSS worker training was provided by the Virginia Institute for Social Service Training Activities (VISSTA) via a contract with DSS. In addition to the four mandated courses, other non-mandated courses such as Adult Sexual Abuse, Financial Exploitation, and Surrogate Decision Making were also available to workers. However, in October 2011, DSS assumed responsibility for all LDSS training. Available courses were then limited to the four mandated ones.

APS workers need comprehensive training and training updates to handle increasingly complex and challenging investigations. Workers who have appropriate assessment and investigation skills can respond to critical situations with the most effective interventions for vulnerable adults and their families. However, the limited course selection raises concerns as to whether workers, particularly new ones, have the knowledge base and capabilities to respond to the entire spectrum of abuse, neglect, and exploitation they encounter. Also without adequate training and recognizing this deficit, new staff members may resign with the first year of employment.

In addition to limited skilled based training, there is no state course that addresses APS worker safety. As criminal activities such as drug dealing, methamphetamine production, and dog fighting are increasingly found in the homes and surrounding properties of vulnerable adults, Virginia's APS workers have emphasized the need to learn more about staying safe during home visits. A study involving APS in Kentucky documents that APS cases are increasingly complex and dangerous.²⁷

Once workers complete the four state mandated courses, few opportunities exist for continuing education. Though workers are also required to obtain 20 hours of continuing education each year, state sponsored training beyond the established core courses is limited or non-existent. Furthermore LDSS have few or no resources to send APS workers to conferences or trainings in the community.

²⁷ Teaster, P.B., Roberto, K.A., & Dugar, T.D. (2006). Intimate partner violence of rural aging women. *Family Relations*, 55, 636-648.

Several APS workers articulated the following concerns about APS training in the Adult Abuse Report survey and during the listening sessions:

- *It is not provided. The vast majority of training is child welfare centered.*
- *Training opportunities in person are not adequate to meet the needs. Once workers have completed the trainings available there is never any new training to attend.*
- *The State does not provide appropriate training for staff to complete APS functions.*
- *Our agency refers APS workers to CPS training to gain further knowledge on investigative, assessment, and documentation skills.*
- *APS workers do not receive mental health training which is needed as the majority of APS clients encountered by APS workers are individuals with serious mental illness in self-neglecting situations.*

DARS, APS Division staff in collaboration with DSS needs to assume a more active role in reviewing the quality of the mandated course material to ensure that the courses are meeting the needs of workers and also explore ways to increase workers access to other training, particularly on topics such as mental health issues, investigation interview skills and worker safety.

Finally, DARS should explore developing trainings with state partners such as the Department of Behavioral Health and Developmental Services (DBHDS), the State Long-term Care Ombudsman and the Office of the Attorney General, which would help broaden training options outside of what is offered through the DARS/DSS partnership. Such trainings would also provide the opportunity to cross train community partners, such as local law enforcement and local ombudsmen, who frequently participate in investigations with APS workers.

Recommendation #8: Convene a workgroup of APS supervisors and workers to develop a guidance manual that addresses best practice tools, job aids, and promising initiatives.

Many APS programs report that their workers need access to information on interventions and practices that may help address adult abuse.²⁸ Currently, Virginia's APS guidance and policy manuals focus on mandated requirements for investigations and service provision. However, these manuals do not contain APS best practices information, investigation tools or job aid information that can assist the worker during investigations or during service delivery.

DARS, in collaboration with workgroup representatives, should develop guidance that highlights promising initiatives, practices, and tools used by local Virginia APS programs as well as APS programs in other states. Raising awareness of these promising initiatives may help Virginia's

²⁸ Government Accountability Office (2011). *Stronger federal leadership could enhance national response to elder abuse*. Retrieved from <http://www.gao.gov/assets/320/316224.pdf>

local APS programs implement effective strategies to improve the safety and well-being of older adults and adults with disabilities.

Recommendation #9: DARS will convene a workgroup of stakeholders to review implications of increasing or eliminating the age based criteria that currently determines eligibility for APS interventions.

In most state APS programs, individuals eligible for APS services are 18 or older and have a physical or mental condition that makes them unable to provide for their well-being or safety or to make or understand the consequences of decisions. Some states further describe eligible service populations as “vulnerable,” “frail,” “at-risk.” About a dozen states designate a specific age (i.e. age 60 or 65) as a sole factor in determining eligibility for APS services.

In Virginia, adults age 60 and older are eligible for APS services regardless of whether they are incapacitated. APS workers who attended the listening sessions and completed the Adult Abuse Report survey felt strongly that the concept of “age 60 or older” needed to be reevaluated. Instead of making decisions about a person’s needs based solely on age, the level of an adult’s incapacity or impairment and ability or inability to care for and self-protect are more relevant factors than age in determining whether or not an adult needs APS interventions. Raising the age to “70 or 75 and older” or eliminating the age requirement entirely may help focus limited financial and worker resources on individuals who are most in need of services. Changing or eliminating the age requirement may reduce what some individuals perceive as intrusive interventions in the lives of some adults who are capable of making and carrying out their own decisions, even if those decisions may not be in their best interest.

Recommendation #10: Create a workgroup of LDSS APS workers and supervisors and community partners including but not limited to ombudsman, law-enforcement, and service providers to explore the feasibility of implementing a two-track APS response system.

An APS investigation must be initiated when an APS report meets validity criteria regardless of the situation described in the report. For example, a report alleging sexual abuse by nursing facility worker requires the same investigation response as a report that alleges that an elderly husband who is unable to read and provide adequate wound care for his wife or a report of an adult with mental illness and is hoarding animals. Pursuant to § 63.2-1504 of the Code of Virginia, CPS workers are able to respond to CPS reports through a differential response system. Depending on the situation described in the complaint, CPS workers may conduct either an investigation or a family assessment. The development of a similar system in APS would afford workers the opportunity to tailor the response and service delivery depending on the circumstances of the case. An assessment, instead of an investigation, would permit staff members to address the adult’s situation and support system, without labeling the self-neglecting adult or caregiver, who lacks education or has a significant disability, as a perpetrator of abuse.

Recommendation #11: DARS will create a workgroup to study APS workers’ caseloads and recommend statewide standards for APS worker to case ratios.

No national caseload standards exist for APS workers and no recent national studies are available that recommend an acceptable worker to APS caseload ratio. The 2012 survey of state APS programs found that 36 states indicated that caseloads have increased.²⁹ A 1997 report for NAPSA suggested an acceptable APS worker to caseload ratio of 1 to 25.³⁰

Higher caseloads negatively impact a worker's ability to conduct a thorough APS investigation or provide effective post-investigation case management services. Increased caseloads may result in worker turnover thus jeopardizing the system that needs a stable and dependable workforce in order to protect and prevent adult abuse.³¹ According to data provided by DSS Office of Research and Planning, in 2009 Virginia APS workers carried an average caseload of 28 APS cases, 15 of which were ongoing investigations and 13 of which were ongoing APS cases.³² However, obtaining an accurate evaluation of worker caseloads is further complicated by the fact that many LDSS workers carry non-APS adult services, child foster care, and CPS cases in addition to APS cases.

North Carolina completed a caseload study in 2011 and recommended a standard of 15 APS cases per worker.³³ Establishing appropriate caseload standards would help LDSS supervisors better manage how cases are assigned to staff to ensure that complex and challenging cases are evenly distributed among workers and that workers are able focus attention on case management needs of each client. The establishment of a recommended Virginia caseload standard for APS would also provide bench marks for localities and the state to measure the impact of growth in numbers of APS cases and would provide a useful tool for setting staffing goals.

Recommendation #12: DARS will convene a workgroup of stakeholders to explore ways to improve information sharing between financial institutions and APS to facilitate financial exploitation investigations.

Financial institutions are not mandated to report to APS. However, pursuant to § 63.2-1606 of the Code of Virginia they may report to APS. Reports from financial institutions to Virginia APS have increased nearly 580% from SFY 2009 to 2013. Yet, despite increased reporting, workers indicate that it is difficult to obtain important financial records and documentation from financial

²⁹ National Adult Protective Services Association (2012). *Adult protective services in 2012: increasingly vulnerable*. Retrieved from <http://www.napsa-now.org/wp-content/uploads/2012/06/BaselineSurveyFinal.pdf>

³⁰ Otto, J. (2014). *Adult protective services caseload management*. NAPSA Technical Assistance brief 14-1. Retrieved from <http://www.napsa-now.org/resource-center/technical-assistance/>

³¹ Social Work Policy Institute. (2010). *High caseloads: how do they impact delivery of health and human services?* Research to Practice Brief. Retrieved from <http://www.socialworkpolicy.org/wp-content/uploads/2010/02/r2p-cw-caseload-swpi-1-10.pdf>

³² Email correspondence with Bill McMakin from DSS, Office of Research & Planning, January 20, 2010.

³³ Information provided NAPSA via email dated April 7, 2014.

institutions in order to substantiate an allegation of financial exploitation. A workgroup could explore the strategies that other state and local APS Programs have implemented to encourage financial institutions to share information and work in collaboration with APS workers.

Recommendation #13: DARS, in collaboration with LDSS representatives, will develop guidelines to encourage LDSS participation in local multi-disciplinary teams (MDT).

Collaboration and cooperation among APS, law-enforcement, service providers, community partners, and others is needed in order to address adult abuse effectively. MDTs, which often include representatives from APS, area agencies on aging, local ombudsman, medical professionals and community service providers, provide a forum to discuss solutions to address challenging or difficult APS cases. Team members review APS cases, including the needs of the individual, impediments to providing services for the client, and possible ways to meet the client's needs. MDTs that include representation of local law enforcement and Commonwealth's Attorneys have the potential to increase prosecution of adult abuse, neglect, and exploitation.

Despite the benefits of MDTs, 64% of 78 LDSS who completed the Adult Abuse Report survey stated that their APS workers did not participate in a local MDT.³⁴ LDSS, such as Henrico County DSS, that have established MDT, can attest to their effectiveness in enhancing collaboration among professionals who play a role in addressing adult abuse. Their efforts and others could serve as models for LDSS do not participate in MDT.

Henrico DSS's MDT, TEAM Henrico held its first meeting in September 1998. Early participants included representatives from the Commonwealth's Attorney's Office, APS, law enforcement including the Special Victims Unit and the Economic Crimes Unit, victim witness, Area Agency on Aging, hospice providers, the Central Virginia Legal Aid Society, forensic nursing, The Alzheimer's Association, domestic violence programs, parish nursing, mental health and a local assisted living providers. TEAM Henrico met monthly at various locations to learn what services each group contributed to the community. Selected cases were reviewed and group members discussed what each had to offer in a coordinated response to a citizen in crisis. APS, law enforcement and the Commonwealth's Attorney's Office also met separately to staff common cases and work on a coordinated response. The MDT has resulted in successful prosecutions, the strengthening of working relationships, and increased familiarity with providers and what they have to offer. Group members were able to help victims and families understand how to report concerns, make referrals, watch for trends and repeat offenders and better protect vulnerable citizens. TEAM Henrico has also provided regional training for law enforcement on the signs of elder abuse and financial exploitation.

Recommendation #14: DARS, in partnership with DBHDS, community services boards (CSB), and LDSS should explore strategies to address the community-based mental health needs of older adults.

³⁴ Navarro, A.E., Wilber, K.H., Yonashiro, J. & Homeier, D.C. (2010). Do we really need another meeting? Lessons from the Los Angeles County elder abuse forensic center. *The Gerontologist* 50(5), 702-771.

APS workers, family members and community partners express frustration at their inability to obtain mental health services for older adults. Twenty-four of 78 LDSS who completed the Adult Abuse Report survey identified increased funding for community-based mental health services as a top priority. One worker who participated in the survey stated, “We are in desperate need of more mental health options in assisting clients and their families.”

APS workers and their clients feel the impact of limited community-based mental health services. APS workers, who are not mental health professionals and do not have in-depth training on addressing mental health issues and behavioral or cognitive impairments, are left as the primary support to individuals with mental health diagnoses, dementia or behavioral challenges or a combination of these. According to the DBHDS SFY 2013 annual report, only 4% of the individuals who received CSB services were 65 or older.³⁵ The report also stated that “Addressing the needs of individuals with Alzheimer’s disease or related dementias is becoming increasingly important because of the significant growth in Virginia’s older adult population and in the numbers of individuals with these dementias.”

Recommendation #15: Establish a monitoring system for the Auxiliary Grant Program.

The AG Program provides financial assistance to nearly 6,000 low-income older adults and adults with disabilities who live in ALFs or adult foster care (AFC) homes. Approximately 280 ALFs statewide accept AG recipients. AFC is an optional program for LDSS. Approximately 17 LDSS operate an AFC program with a statewide total of 50 AFC providers.

Adults who are eligible for AG receive a supplement payment that is combined with their countable monthly income and is used to pay providers the established AG rate. AG payments are issued to the adult who is responsible for paying the provider. AG recipients are entitled to a monthly personal needs allowance (PNA) of \$82. The average monthly AG payment to an adult is over \$400, and in SFY 2013 AG Program expenditures totaled over \$27 million.

APS workers frequently respond to reports that AG recipients are in jeopardy of being discharged from the facility because their AG applications have not been processed by the LDSS or because AG checks have not been received by the AG recipient. Other complaints center on ALF providers not giving AG recipients their monthly PNA. There is no audit process in place to monitor LDSS AG eligibility determinations or to ensure that ALF providers comply with AG program regulations. Program oversight, accomplished by creating a dedicated monitoring position, would be a significant step toward ensuring that AG recipients are able to maintain their housing and that they receive the PNA to which they are entitled.

³⁵ Department of Behavioral Health and Developmental Services 2013 Fiscal Year Annual Report. Retrieved from [http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD702014/\\$file/RD70.pdf](http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD702014/$file/RD70.pdf)

CONTINUING EFFORTS

DARS APS Division is committed to collaborating with stakeholders to implement these report recommendations. The recommendations provide a starting point for making cutting edge improvements to the network of agencies and organizations such as APS, public guardianship programs and community mental health services that are responsible for the protection, support and security of a rising population of older adults and individuals with disabilities.

It is essential to acknowledge that the report's 15 recommendations do not represent every idea or strategy available to improve the safety, financial stability, and overall well-being of elderly individuals and adults with disabilities in Virginia. Stakeholders, who participated in the listening sessions and survey, provided several ideas and suggestions that were not included in the report's recommendations. DARS APS Division staff felt that these additional comments needed to be acknowledged and they are included in Appendix G. Service providers, human services organizations, and policy makers in Virginia may wish to explore and implement some of these ideas locally, regionally or statewide. It is only through a broad, ongoing effort that the Commonwealth will be able to meet the important needs of older adults and individuals with disabilities.

ACKNOWLEDGEMENTS

The following individuals are acknowledged for the assistance and expertise they provided during the development of this report:

Paige McCleary, Carey Raleigh, Andrea Jones, Angela Mountcastle, Carol McCray, Marjorie Marker, Tishaun Harris-Ugworji, and Venus Bryant, APS Division Staff; Ali Faruk, Special Assistant to the Commissioner; Amy Marschean, DARS Senior Policy Analyst; Barbara Burkett, DARS Policy Planning Specialist; Pamela Teaster, PhD, Associate Director for Research, Virginia Tech; Michael Bradshaw, DSS Senior Management Analyst; Mike Theis, DSS Senior Research Associate; Virginia Powell, PhD, Virginia Department of Health, Office of the Chief Medical Examiner; Barbara Antley, Division Director, Adult and Aging, Fairfax Department of Family Services; and Gail Nardi, APS Division Director (retired).

A special acknowledgement is extended to LDSS APS workers, supervisors, and directors; state agency representatives; community advocates; and service providers for sharing their stories about the challenges of providing preventative and protective services and supports to adults in Virginia and for their dedication to helping older adults and adults with disabilities live free of abuse, neglect, and exploitation.

Appendix A: Letter Requesting the Study



COMMONWEALTH OF VIRGINIA
HOUSE OF DELEGATES
RICHMOND

ROBERT D. "BOBBY" ORROCK
POST OFFICE BOX 458
THORNBURG, VIRGINIA 22565

FIFTY-FOURTH DISTRICT

COMMITTEE ASSIGNMENTS:
HEALTH, WELFARE AND INSTITUTIONS (CHAIRMAN)
FINANCE
AGRICULTURE, CHESAPEAKE AND
NATURAL RESOURCES
RULES

February 26, 2014

James A. Rothrock, Commissioner
Department for Aging and Rehabilitative Services
8004 Franklin Farms Drive
Henrico, VA 23229

Dear Commissioner Rothrock,

Del. Michael Weibert introduced House Joint Resolution No. 39 requesting the Department of Social Services to study adult abuse in the Commonwealth. Based on discussions with both the Department of Social Services and the Department for Aging and Rehabilitative Services, it was agreed that the Department for Aging and Rehabilitative Services was the appropriate agency to give consideration to this important issue.

As Chairman of the Health, Welfare and Institutions Committee, I respectfully request that you, as Commissioner of Aging and Rehabilitative Services, secure input from stakeholders and offer any recommendations regarding strategies and programs to improve the safety, financial stability, and overall well-being of elderly individuals and adults with disabilities throughout the Commonwealth.

I would further request to be apprised of any findings no later than the first day of the 2015 General Assembly session.

I thank you in advance for considering this request, and I will be happy to assist in any way.

Sincerely,

Robert D. "Bobby" Orrock, Sr.

cc: Delegate Michael Weibert
Delegate Steve Landes

DISTRICT: (540) 891-1322 * RICHMOND: (804) 698-1054 * E-MAIL: DELBORROCK@HOUSE.VIRGINIA.GOV

Appendix B: Listening Session Participants

AARP of Virginia

David DeBiasi

Albemarle DSS

Tricia Suszysnki

Kim Poole

Appalachia Agency for Senior Citizens

Beth Thompson

Bristol Victim Witness

Molly Harley

Carroll County DSS

Brita Groseclose

Commonwealth's Attorneys' Services Council

Jane Chambers

Shannon Weist

Crossroads to Brain Injury Recovery

Susan Hartzler

Delegate Webert's Representative

Melissa McManaway

District Three Governmental Cooperative

Chris Stone

Giles County DSS

Suzy Quillen

Greater Augusta Coalition Against Adult Abuse

Anne See

Fairfax County Government

Kemberly Thornton

Fauquier County DDS

Cindy Giles

Harrisonburg/Rockingham DSS

Jeanie Clark

Henrico County DSS

Michael Olin

Senior Services of Southeastern Virginia

Adrianne Rochelle-Jackson

Shenandoah County DSS

Nicole Medina

Spotsylvania County DSS

Samantha Stevens

Transportation RATS n RACC

Joan Manley

Union Bank

Pam Acton

Valley Associates for Independent Living

Gayl Brunk

Virginia Beach Department of Social Services

Wendy Swallow

Virginia Beach City Attorney

Christianna Cunningham

Virginia Board for People with Disabilities

Katherine Lawson

Virginia Coalition for the Prevention of Elder Abuse

Lisa Furr

Virginia Department of Criminal Justice Services

Julia Fuller-Wilson

Virginia Department of Health

Office of the Chief Medical Examiner

Ginny Powell

Virginia Department for Aging and Rehabilitative Services

James A. Rothrock, Commissioner

Gail Nardi, Director, APS Division

Ali Faruk, Special Assistant to the Commissioner

Joani Latimer, State Long-Term Care Ombudsman

Carey Raleigh, Eastern Region Program Consultant

Marjorie Marker, Eastern Region Program Consultant

Paige McCleary, DARS/APS Program Consultant

Rachel Maxey

Henry/Martinsville DSS

Rhonda Handy
Bonnie Pendleton

Montgomery County DSS

Joan Craft

Mountain Empire Older Citizens, Inc.

Rachel Helton
Angela Peterson

Norfolk Department of Human Services

Heather Crutchfield
Pam Cole

Office of the Attorney General

William Gentry
Howard J. Hicks, III
Mary Ware

Pittsylvania County DSS

Carrie Bennett
Peggy Helms

Pleasant View/Virginia Network of Private Providers

Nancy Hopkins-Garriss

Roanoke County DSS

Dawn Riddle

Scott County DSS

Maria Dorton
Sheila Jones

Tishaun Harris Ugworji, DARS/APS Program Consultant
Venus Bryant, DARS/APS Administrative Assistant

Virginia Department of Social Services

Sharon DeBoever

Virginia League of Social Service Executives

Catherine Pemberton
Susan Umidi

Virginia Poverty Law Center

Kathy Pryor

Virginia Tech

Nancy Brossioe
Pamela B. Teaster
Cristin Sprenger

Washington County DSS

Tammy Olivio

Waynesboro Senior Advocacy Commission

Dan Sullivan

York/Poquoson Department of Social Services

Kendall Ferguson

Appendix C: LDSS Survey Participants

Accomack	Louisa
Alleghany County-Covington	Lunenburg
Appomattox	Lynchburg
Arlington	Madison
Bath	Mathews
Bristol	Middlesex
Brunswick	Montgomery
Buchanan	New Kent
Buckingham	Newport News
Campbell	Norfolk
Caroline	Nottoway
Charlotte	Orange
Charlottesville	Patrick
Chesapeake	Petersburg
Fredericksburg	Pittsylvania
Williamsburg	Portsmouth
Craig	Prince Edward
Cumberland	Prince William
Danville	Rappahannock
Dickenson County	Richmond City
Fairfax	Roanoke City
Franklin City	Roanoke County
Franklin County	Rockbridge
Fredericksburg	Scott
Galax City	Shenandoah Valley
Gloucester	Smyth
Goochland	Southampton
Grayson	Spotsylvania
Greene	Suffolk
Greensville/Emporia	Surry
Halifax	Sussex
Hampton	Tazewell
Henrico County	Virginia Beach
Henry/Martinsville	Warren
Hopewell	Washington
Isle of Wight	Winchester
James City County	Wise
King & Queen	Wythe
Lee	York-Poquoson

Appendix D: APS Definitions

Abuse means the willful infliction of physical pain, injury or mental anguish or unreasonable confinement of an adult. (22VAC30-100-10)

Adult means any person 60 years of age or older, or any person 18 years of age or older who is incapacitated and who resides in the Commonwealth; provided, however, "adult" may include qualifying nonresidents who are temporarily in the Commonwealth and who are in need of temporary or emergency protective services. (§ 63.2-1603 of the Code of Virginia)

Adult protective services means the receipt, investigation and disposition of complaints and reports of adult abuse, neglect, and exploitation of adults 18 years of age and over who are incapacitated and adults 60 years of age and over by the local department of social services. Adult protective services also include the provision of casework and care management by the local department in order to stabilize the situation or to prevent further abuse, neglect, and exploitation of an adult at risk of abuse, neglect, and exploitation. If appropriate and available, adult protective services may include the direct provision of services by the local department or arranging for home-based care, transportation, adult day services, meal service, legal proceedings, alternative placements and other activities to protect the adult and restore self-sufficiency to the extent possible. (22VAC30-100-10)

Emergency means that an adult is living in conditions that present a clear and substantial risk of death or immediate and serious physical harm to himself or others. (§ 63.2-1603 of the Code of Virginia)

Exploitation means the illegal use of an incapacitated adult or his resources for another's profit or advantage. This includes acquiring an adult's resources through the use of the adult's mental or physical incapacity, the disposition of the incapacitated adult's property by a second party to the advantage of the second party and to the detriment of the incapacitated adult, misuse of funds, acquiring an advantage through threats to withhold needed support or care unless certain conditions are met, or persuading an incapacitated adult to perform services including sexual acts to which the adult lacks the capacity to consent. (22VAC30-100-10)

Incapacitated person means any adult who is impaired by reason of mental illness, intellectual disability, physical illness or disability, advanced age or other causes to the extent that the adult lacks sufficient understanding or capacity to make, communicate or carry out reasonable decisions concerning his or her well-being. This definition is for the purpose of establishing an adult's eligibility for adult protective services and such adult may or may not have been found incapacitated through court procedures. (22VAC30-100-10)

Mandated reporters means those persons who are required to report pursuant to § 63.2-1606 of the Code of Virginia when such persons have reason to suspect that an adult is abused, neglected, or exploited or is at risk of adult abuse, neglect, or exploitation. (22VAC30-100-10)

Neglect means that an adult is living under such circumstances that he is not able to provide for himself or is not being provided such services as are necessary to maintain his physical and mental health and that the failure to receive such necessary services impairs or threatens to impair his well-being. However, no adult shall be considered neglected solely on the basis that such adult is receiving religious nonmedical treatment or religious nonmedical nursing care in lieu of medical care, provided that such treatment or care is performed in good faith and in accordance with the religious practices of the adult and there is written or oral expression of consent by that adult. Neglect includes the failure of a caregiver or another responsible person to provide for basic needs to maintain the adult's physical and mental health and well-being, and it includes the adult's neglect of self. Neglect includes, but is not limited to:

1. The lack of clothing considered necessary to protect a person's health;
2. The lack of food necessary to prevent physical injury or to maintain life, including failure to receive appropriate food for adults with conditions requiring special diets;
3. Shelter that is not structurally safe; has rodents or other infestations which may result in serious health problems; or does not have a safe and accessible water supply, safe heat source or sewage disposal. Adequate shelter for an adult will depend on the impairments of an adult; however, the adult must be protected from the elements that would seriously endanger his health (e.g., rain, cold or heat) and could result in serious illness or debilitating conditions;
4. Inadequate supervision by a caregiver (paid or unpaid) who has been designated to provide the supervision necessary to protect the safety and well-being of an adult in his care;
5. The failure of persons who are responsible for caregiving to seek needed medical care or to follow medically prescribed treatment for an adult, or the adult has failed to obtain such care for himself. The needed medical care is believed to be of such a nature as to result in physical and/or mental injury or illness if it is not provided;
6. Medical neglect includes, but is not limited to, the withholding of medication or aids needed by the adult such as dentures, eye glasses, hearing aids, walker, etc. It also includes the unauthorized administration of prescription drugs, over-medicating or under-medicating, and the administration of drugs for other than bona fide medical reasons, as determined by a licensed health care professional; and
7. Self-neglect by an adult who is not meeting his own basic needs due to mental and/or physical impairments. Basic needs refer to such things as food, clothing, shelter, health or medical care. (22VAC30-100-10)

Appendix E: Case Examples submitted by Virginia APS workers

The following cases represent actual APS cases throughout Virginia. Client identifying information has been altered and identifiers de-identified.

Example 1

She was over 80 years old, disheveled and forgetful. A psychologist, who assessed her, determined that she was incapacitated and recommended that a guardian/conservator be appointed. During the summer months, the air conditioning unit in her home stopped working. Replacing the unit would cost several thousand dollars. APS provided her with fans, but she was confused and unplugged them. She said that she wasn't eating because she was so hot. She would drive to the local fast food business to cool off and get food. After determining that her home was no longer a safe place in which to live, the APS worker found an Adult Foster Care home for her to live. She was very reluctant to leave and was especially worried about her outdoor cat. She spent one night there but ran away in the morning. She walked home in 100 degree weather, although she was many miles away from her home. The APS worker spotted her and transported her for a mental health evaluation. She was taken to a psychiatric hospital but was discharged by the Special Justice after 48 hours. She was admitted to a secure unit in a local Assisted Living Facility. A guardian/conservator was identified and applied on her behalf for Medicaid. Once approved for Medicaid, the client moved to a local nursing facility.

Example 2

She was in her 80s, widowed, and was being financially exploited by a telephone scam artist who claimed that she had won the lottery. The woman made frequent withdrawals from her bank account to pay lottery "transfer fees." She has nearly depleted her savings account and mailed several payments that amounted to over \$100,000. She would not accept cautionary measures offered by her financial institution. She presented as a high functioning adult with no apparent cognitive deficits. She was isolated from family and friends and was adamant that APS should not contact them. At first she appeared to cooperate with APS; however, her fixation on collecting her "lottery winnings" left her vulnerable to ongoing contacts by the alleged perpetrator. During the investigation, APS was able to work in partnership with the client and her financial institution to put safeguards in place regarding her accounts. It was also discovered that one of the alleged perpetrators resided in another county in Virginia, and the police there was contacted. APS was able to collaborate with law enforcement in that city as well as with local law enforcement to pursue legal action. After the initial APS investigation, she agreed to ongoing APS services to ensure her safety and well-being. APS encouraged the client to seek psychological counseling as well as to involve her family in developing a safe plan to protect client against future exploitation.

Example 3

The APS report concerned a woman who had recently had a leg amputated due to diabetes. Her home was described as “deplorable.” The floors of her home were covered in black mud and extreme clutter. She permitted her cat to lick her leg wound, which then led to an infection. Due to her refusal to seek medical treatment after the infection was identified by the home health nurse, her leg required further amputation. APS assessed her and determined that she did have capacity to make decisions for herself. Doctors indicated that her infected leg would certainly cause death if she did not attend to treatment immediately and improve her living conditions that contributed to the infection. APS convinced her to seek treatment, but she refused to make changes to her living environment once she returned home from the rehabilitation facility. The APS worker observed men in the home who did not appear to be paying rent but who were living there in exchange for “caring for her.” She did not want APS to remove the men from her home, even though they were not paying rent, neglecting her care, and using her money to purchase food for themselves. APS had no choice other than to walk away from this situation due to her refusal of other services.

Example 4

She was in her 70s, single, and childless. She was receiving home-based services. She was bed-ridden and living in a hotel. She had a medical condition but had mental capacity. She had care for only 3 hours a day for 6 days a week. She remained alone in her hotel for 21 hours each day. She had a catheter and lay in her feces for long periods of time. Often her skin broke down, and she developed bed sores. She self-administered medicine and at times confused her medication dosages. She often argued about the care that was provided to her through she refused to be bathed and have her hair washed. She sought care from several community agencies, though she fired the caregivers or they resigned due to her behavior. Her home was condemned. She is unable to receive additional care because she did not qualify for Medicaid, as she was determined to be over resourced and refused to sell her home in order to qualify. She stated that she wants to live independently as long as she can. She lived in several different facilities, though she leaves and refuses to return. She has been living this way for many years.

Example 5

A female in her 30s with a mental health diagnosis was being evicted by public housing for non-payment of rent for several months. She was participating in mental health treatment and was isolated from her family. APS agreed to pay her overdue rent but the housing authority would not allow her to remain in the apartment and consequently evicted her. The client had delusions and believed that someone else was paying her rent and that God had told her she owned the building. She had been a resident of public housing for many years and had had no problems. The sheriff contacted police and a Temporary Detention Order was initiated. However, the magistrate stated that homelessness was not a reason for an emergency custody order, although she was aware of the client’s delusions. APS coordinated with the community services board

(CSB) and contacted the police to bring her to the CSB. She was screened and hospitalized for 10 days. Upon her discharge she was homeless with no support from family or other community services. APS continued to advocate for her with public housing and through Legal Aid. The housing authority continued to deny her housing even after being served and having a meeting with Legal Aid. The judge did order the housing authority to provide an apartment for her. However, she was not allowed to move back into her previous apartment where she had many friends and could walk to stores and had laundry facilities. She received another apartment but far from the city center and with no laundry facilities or known friends. She was linked to CSB services and continues to participate in case management, mental health support, and medication management services.

Example 6

APS served an elderly man with sufficient income and full capacity, who chose to live in substandard conditions. Previously he owned his home and property but lost it due to not paying taxes. However, he continued to live on the property even after law enforcement made him leave. He always returned. Although the conditions of the home could easily have met a criteria for condemnation, there was no municipal ordinance for such, and he did not want to make any change in his living circumstances. This situation made the APS worker's job increasingly difficult. The residence was in such poor shape that it was hazardous for the APS worker to enter it. The residence was located in a very secluded wooded area. Vehicles could not safely maneuver to the house due to high grass around the property. The residence had previously caught fire and the client was living in one side of the residence, which did not have appropriate covering for bad weather or protection from wildlife. Floors were not stable in all areas. There was no electricity because the man preferred not to have an electric bill and no indoor plumbing though he had a well from which he could pump water. He had a generator that he used to power a hot plate in order to cook, and he received home-delivered meals, which he picked up in a wagon using an elaborate roping system to navigate to the main road. He used a kerosene heater and layered himself in clothing. In the summer for the most part he wore little to no clothing. His hygiene was extremely poor and not a priority for him.

He was familiar with community resources, using only those services that he felt benefited him to remain in his home. He had income that could accommodate any living situation of his liking. He just did not want to spend any of his money on things that would have made life much easier according to the standards of others. He had some friends in the community but maintained no relationship with his only child and therefore had no dependable family support. Over many years of working with him off and on, as he would allow, the APS worker purchased hygiene accessories, clothing, kerosene, and food to help him have the basic necessities for his chosen lifestyle. The worker made referrals and arranged transportation to local physicians, though the client typically refused to go. Eventually his health failed and he was no longer able to care for himself physically. He entered a nursing facility when he was no longer able to walk. The APS worker visited him at the facility. He had the desire to return to his home, but it is unlikely he will ever do so.

Example 7

He had had an intellectual disability as well as a physical disability. When the perpetrator, who had been financial exploiting the man, learned that he had been identified as the alleged perpetrator, he went to the man's home and threatened him physically. This was witnessed by a caregiver. The police investigated and a temporary protective order (PO) was issued. When the temporary PO needed to be extended, the man had to appear in court. He could not afford an attorney and physically was unable to go to the courthouse. I did manage with difficulty to get him there, but when the perpetrator violated the PO my client had to return to court again.

Appendix F: APS Mandated Reporters

Virginia's mandatory reporting law (§ 63.2-1606 of the Code of Virginia) requires mandated reporters to report immediately to LDSS or to the 24 hour toll-free APS hotline upon suspecting abuse, neglect, or exploitation. Mandated reporters must report to both law enforcement and medical examiners any deaths arising from suspected abuse or neglect. A civil penalty of up to \$1,000 may be imposed for failure to report any suspected abuse, neglect, or exploitation. Individuals who make APS reports in good faith are protected from civil or criminal liability.

Mandated reporters of adult abuse, neglect, or exploitation include:

- Any person licensed, certified, or registered by health regulatory boards listed below:

Board of Nursing	Registered Nurse (RN); Licensed Nurse Practitioner (LNP); Licensed Practical Nurse (LPN); Clinical Nurse Specialist; Certified Massage Therapist; Certified Nurse Aide (CAN), Advanced Medication Aide, Medication Aide,
Board of Medicine	Doctor of Medicine and Surgery, Doctor of Osteopathic Medicine; Doctor of Podiatry; Doctor of Chiropractic; Interns and Residents; University Limited Licensee; Physician Assistant; Respiratory Therapist; Occupational Therapist; Radiological Technologist; Radiological Technologist Limited; Licensed Acupuncturists; Certified Athletic Trainers, Licensed Midwife, Behavioral Analysts, Assistant Behavioral Analysts
Board of Pharmacy	Pharmacists; Pharmacy Interns; Permitted Physicians; Medical Equipment Suppliers; Restricted Manufacturers; Humane Societies; Physicians Selling Controlled Substances; Wholesale Distributors; Warehousemen, Pharmacy Technicians
Board of Dentistry	Dentists and Dental Hygienists Holding a License, Certification, or Permit Issued by the Board
Board of Funeral Directors and Embalmers	Funeral Establishments; Funeral Services Licensees; Funeral Services Interns, Funeral Directors; Funeral Embalmers; Resident Trainees; Crematories; Surface Transportation and Removal Services; Courtesy Card Holders
Board of Optometry	Optometrist

Board of Counseling	Licensed Professional Counselors; Certified Substance Abuse Counselors; Certified Substance Abuse Counseling Assistants; Certified Rehabilitation Providers; Marriage and Family Therapists; Licensed Substance Abuse Treatment Practitioners
Board of Psychology	School Psychologist; Clinical Psychologist; Applied Psychologist; Sex Offender Treatment Provider; School Psychologist – Limited
Board of Social Work	Registered Social Worker; Associate Social Worker; Licensed Social Worker; Licensed Clinical Social Worker
Board of Long-Term Care Administrators	Nursing Home Administrator; Nursing Home Preceptors; Assisted Living Facility Administrators; Assisted Living Facility Preceptors
Board of Audiology and Speech Pathology	Audiologists; Speech-Language Pathologists; School Speech-language Pathologists
Board of Physical Therapy	Physical Therapist; Physical Therapist Assistant

- Any mental health services provider;
- Any emergency medical services personnel certified by the Board of Health pursuant to § 32.1-111.5, personnel immediately reports the suspected abuse, neglect or exploitation directly to the attending physician at the hospital to which the adult is transported, who shall make such report forthwith;
- Any guardian or conservator of an adult;
- Any person employed by or contracted with a public or private agency or facility and working with adults in an administrative, supportive or direct care capacity;
- Any person providing full, intermittent, or occasional care to an adult for compensation, including but not limited to companion, chore, homemaker, and personal care workers; and
- Any law-enforcement officer.

Appendix G: Additional Recommendation and Strategies

- Make financial institutions mandated reporters.
- Create affordable assisted living facilities.
- Wider availability of financial counseling for older adults to prevent financial exploitation.
- A home-based program similar to Programs for All Inclusive Care for the Elderly (PACE) to support elderly or disabled adults in their homes. A team would go to the home and make monthly visits to the client and caretaker. The team would consist of a doctor, nurse, rehabilitation services and mental health professional.
- Stricter sentences for perpetrators of adult abuse.
- Provide more training for Law Enforcement on investigating financial exploitation.
- Create a financial exploitation education campaign statewide.
- Provide home nursing services for older adults to assist with medications and chronic disease management.
- Make stiffer penalties and guidelines regarding financial abuse by Powers of Attorney so more cases could be prosecuted.
- Broaden the income guidelines for Medicaid, SNAP and cooling limits.
- Increase availability of more low-income and Section 8 housing for elderly individuals and adults with disabilities.
- Trained financial institutions on signs of financial exploitation and how to refer information.
- Implement an adult version of the Family Assessment and Planning Team process (which is used in child cases). The State should provide funding for the FAPT's recommended services.
- Implement Family Partnership Meetings (similar to those used in child welfare) at the local level. May help address family conflicts that result in multiple APS reports that are ultimately unfounded or invalid.
- Provide transportation for older adult to attend social support programs.
- Improve services for young adults with disabilities who are aging out of foster care.
- Provide more ID waiver slots.
- Implement Structured Decision Making (SDM) for APS statewide. It will provide consistency and equity of assessments to determine safety, risk and service needs.
- Create a central registry for APS perpetrators. It will reduce risk to others as well provide for accountability for actions and provide a societal shift in recognizing the seriousness of abuse and neglect of the elderly and impaired.
- Provide affordable housing that will accept elderly clients that committed a crime 20, 30, or 40 years ago.
- Implement a statewide program for installing ramps and accessible showers for older adults and individuals with disabilities.
- Fund facilities to provide safe housing for adults with mental health diagnoses, brain injury or dementia who have behavioral issues.
- Implement a Community Scholar program through schools. Volunteer hours used towards 2 free years at community college.

- Make the state do a better job of helping LDSS develop and implement Adult Foster Care programs.
- Provide education for community partners about what services APS does and does not provide.
- Provide written materials to individuals who are the subject of APS reports about the role of APS.
- Provide education to older adults about long-term care planning (i.e. advance directives, etc.). Would possibly reduce need for guardianship for the individual.
- Ask Marie-Therese Connolly, MacArthur Fellow, to address the General Assembly about elder abuse issues.
- Propose legislation requiring hospital emergency room staff to report serious bodily injuries to APS when the patient is unable to explain the cause of the injury.
- Increase the number of referrals from APS to the Office of the Attorney General, Medicaid Fraud Control Unit, Elder Abuse and Neglect Division.
- Make more reports and data on APS cases available to LDSS.
- Bring uniformity to how LDSS take APS reports.
- Improve availability of services (i.e. courts) that are not available during weekends/nights. Lack of availability limits APS workers ability to respond to some crisis situations.
- Stop the implementation of the right to review process for alleged perpetrators of adult abuse, neglect or exploitation.
- Educate prospective APS workers about what working in the field of APS entails. This may reduce worker turnover.