

Intervention Strategies in Adult Protective Services

Third in a Three-Part Series of Training for Adult Protective Services Professionals
Developed through a grant from the WI Department of Health Services

This training was developed by the University of Wisconsin Green Bay
Office of Continuing Education and Community Outreach
Participants will earn 5.5 Continuing Education Hours.



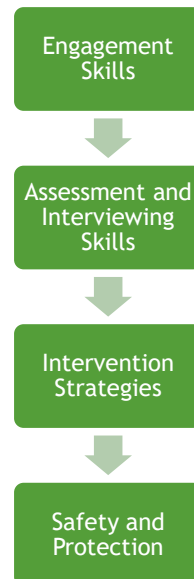
Training Objectives

- ▶ Complete risk assessments using sample case scenarios.
- ▶ Identify key components of case planning.
- ▶ Highlight basic interviewing skills.
- ▶ Utilize assessment tools for practice situations.
- ▶ Outline documentation requirements and additional reporting.
- ▶ Apply ethical principles to intervention.
- ▶ Examine professional development needs for future practice.

Agenda

- I. Overview, Introductions, and Follow-Up
- II. Effective Case Management Strategies
- III. Assessment
- IV. Planning
- V. Documentation within Adult Protective Services
- VI. Professional Development Planning

Effective Case Management Strategies



Best Practice

- ▶ Trauma Informed Approaches
- ▶ Person-Centered
- ▶ Use of Supported Decision-Making when Possible
- ▶ Clear, Concise, and Accurate Documentation

Safety Planning

Prevention

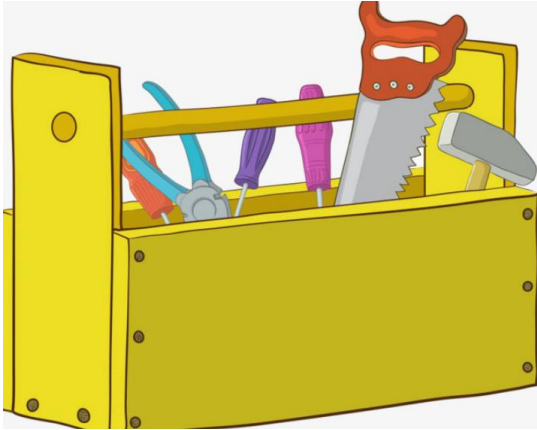
Protection

Notification

Referral

Emotional
Support

Assessment



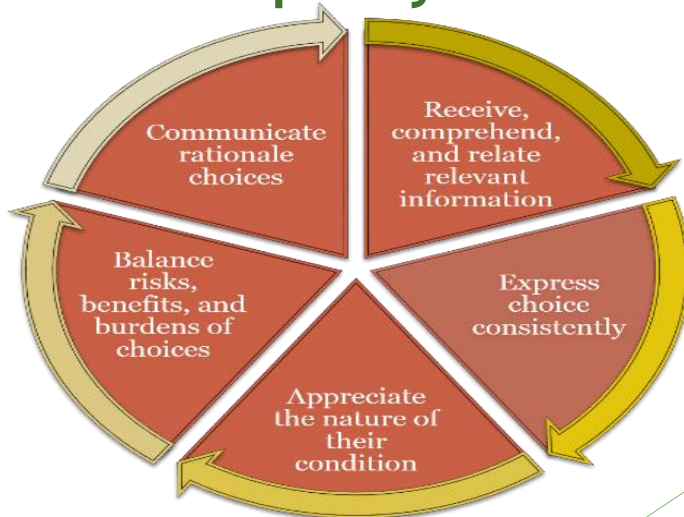
Capacity Assessment Skills

- ▶ Do your homework: know your client
 - ▶ Educational level
 - ▶ Language issues
 - ▶ Cultural factors
- ▶ Set the stage
- ▶ Join with client
- ▶ Be prepared for responses



SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

Attributes of Capacity



Capacity Evaluation

A complete capacity evaluation usually includes:

- ▶ A physical examination
- ▶ A neurological examination
- ▶ Short and long term memory assessment
- ▶ Assessment of executive function
- ▶ Exam for existing psychological disorders
- ▶ Diagnosis of any existing addictive syndromes.

Source: Oklahoma APS 2005

The Three D's

Dementia

Delirium

Depression

ACTIVITY: Differentiating the Three D's

Question 1	Question 2	Question 3
What are the indicators that client may have a mental status problem?	Does the client appear to have dementia, delirium or depression?	What more information do you need and how would you get it?

SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

Dementia Defined

- ▶ It is a descriptive term for a collection of symptoms that can be caused by a number of disorders that affect the brain. It includes a memory deficit *plus* a deficit in at least one other cognitive domain.
- ▶ Final common “behavioral pathway” for many diseases/etiologies that affect the brain.

Dementia



SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

Irreversible Dementias

- ▶ Alzheimer's Disease
- ▶ Vascular Dementia
- ▶ Parkinson's Disease
- ▶ Frontal-Temporal Dementia
- ▶ Dementia with Lewy Bodies
- ▶ Alcohol-related Dementia



Image from Daily Times

SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

Causes of Reversible Dementias

Drugs, dehydration, depression
Electrolyte imbalances
Mental health or metabolic disorders
Endocrine disorders
Nutritional Deficiencies
Trauma, tumor
Infections (urinary tract)
Acute illness, arteriosclerosis complications
Seizures, strokes, sensory deprivation

SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

Delirium

- ▶ Disturbance in alertness, consciousness, perception, and thinking
- ▶ Sudden onset
- ▶ Caused by infection, dehydration, changes in chemical balance, head trauma, post surgical recovery
- ▶ Medical emergency
- ▶ Treatable and reversible

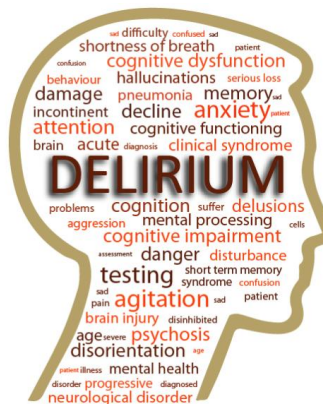


Image: Toronto Transplant Inst.

Symptoms of Depression

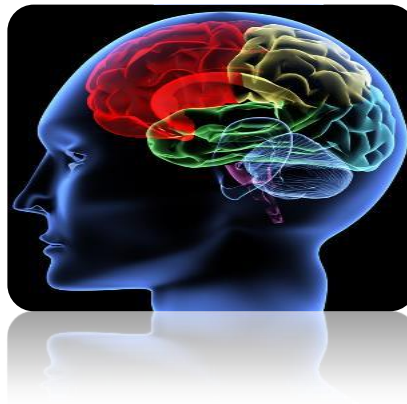
- ▶ Sleep Disturbance
- ▶ Loss of Energy/ Libido
- ▶ Change in Appetite/ Weight
- ▶ Psychomotor Retardation/ Agitation
- ▶ Poor Concentration/ Attention
- ▶ Anhedonia - Loss of Interest in Usual Activities
- ▶ Somatic Complaints
- ▶ Dysphoria - Flat Affect
- ▶ Sense of Hopelessness/ Worthlessness
- ▶ Suicidal Ideation



SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

Cognitive Domains

- ▶ Orientation
- ▶ Attention
- ▶ Memory
- ▶ Language
- ▶ Visual-Spatial Organization
- ▶ Executive Functioning



SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

Cognitive Domains: Orientation

- ▶ Person, Place, Time, Situation
- ▶ Tests of recent and longer-term memory
- ▶ Response is also influenced by level of alertness, attentiveness, and language capabilities.
- ▶ If there has been a precipitous change in orientation, this could signal a critical medical condition such as delirium.
- ▶ **Screens: MMSE, MoCA, SLUMS**

SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

MMSE (Mini Mental State Exam)

A 30-item test

Mini-Mental State Examination (MMSE)

Patient's Name: _____ Date: _____

Instructions: Ask the questions in the order listed. Score one point for each correct response within each question or activity.

Maximum Score	Patient's Score	Questions
5		"What is the year? Season? Date? Day of the week? Month?"
5		"Where are we now: State? County? Town/city? Hospital? Floor?"
3		The examiner names three unrelated objects clearly and slowly, then asks the patient to name all three of them. The patient's response is used for scoring. The examiner repeats them until patient learns all of them, if possible. Number of trials: _____
5		"I would like you to count backward from 100 by sevens." (93, 86, 79, 72, 65, ...) Stop after five answers. Alternative: "Spell WORLD backwards." (D-L-R-O-W)

"Spell world
Backwards"



SOURCE: https://www.uml.edu/docs/Mini%20Mental%20State%20Exam_tcm18-169319.pdf

Cognitive Domains: Attention

- ▶ Nonspecific abnormalities that can occur in
 - ▶ Focal brain lesions,
 - ▶ Diffuse abnormalities such as dementia, encephalitis, and in behavioral or mood disorders.
- ▶ Impaired attention is also one of the hallmarks of delirium.

SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

MoCA (Montreal Cognitive Assessment)

		2nd trial							
ATTENTION	Read list of digits (1 digit/ sec.).	Subject has to repeat them in the forward order		[]	2	1	8	5	4
		Subject has to repeat them in the backward order		[]	7	4	2		
								___/2	
	Read list of letters. The subject must tap with his hand at each letter A. No points if ≥ 2 errors			[]	F	B	A	C	M
				[]	N	A	A	J	K
				[]	L	B	A	F	A
				[]	K	D	E	A	A
				[]	J	A	M	O	F
				[]	A	A	B		
									___/1
	Serial 7 subtraction starting at 100	[]	93	[]	86	[]	79	[]	72
		[]	65						
				4 or 5 correct subtractions: 3 pts, 2 or 3 correct: 2 pts, 1 correct: 1 pt, 0 correct: 0 pt					___/3
LANGUAGE									

“Name the animals”



Cognitive Domains: Memory

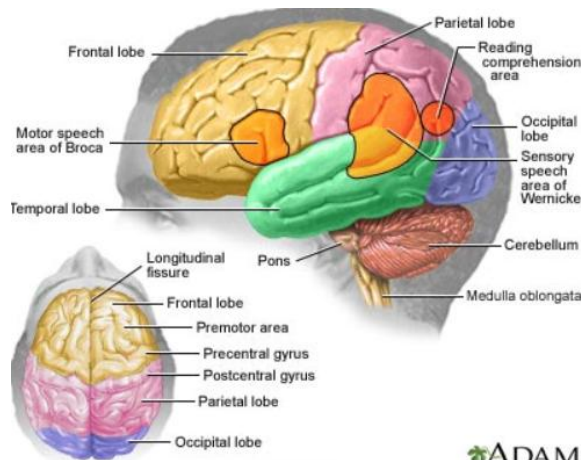
- ▶ **Immediate memory:** recall of a memory trace after an interval of a few seconds, as in repetition of a series of digits.
- ▶ **Recent memory:** ability to learn new material and to retrieve that material after an interval of minutes, hours or days. (e.g. word lists)
- ▶ **Remote memory:** recall of events that occurred prior to the onset of the recent memory defect. Note: this cannot be reliably tested unless you have verifiable information.
- ▶ **Screens:** MMSE- registration, 3-item delayed recall; MoCA- registration, 3-item delayed recall etc.

SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

Cognitive Domains: Language

- ▶ **Verbal Fluency.**
- ▶ **Speech**
 - ▶ Expressive Language
 - ▶ Receptive Language
- ▶ **Comprehension**

(Highlighted areas of the brain are impacted)



ADAM

SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

SLUMS

(St. Louis University Mental Status Examination)

Saint Louis University Mental Status (SLUMS) Examination

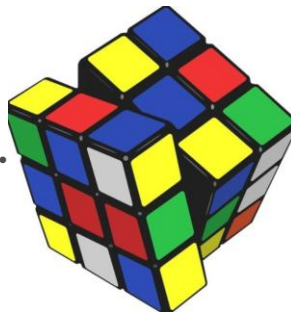
Name _____ Age _____
Is patient alert? _____ Level of education _____

1. What day of the week is it?
2. What is the year?
3. What state are we in?
4. Please remember these five objects. I will ask you what they are later.
Apple Pen Tie House Car
5. You have \$100 and you go to the store and buy a dozen apples for \$3 and a tricycle for \$20.
How much did you spend?
How much do you have left?
6. Please name as many animals as you can in one minute.
0-5 animals 1 5-10 animals 2 10-15 animals 3 15+ animals
7. What were the 5 objects I asked you to remember? 1 point for each one correct.
8. I am going to give you a series of numbers and I would like you to give them to me backwards.
For example, if I say 42, you would say 24.
87 1 649 2 8537
9. This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.
Hour markers okay
Time correct
10. Please place an X in the triangle. ☐ ☐ ☐

Cognitive Domains: Visual-Spatial Organization

- ▶ Very sensitive to brain dysfunction- can pick up mild delirium and otherwise silent lesions.
- ▶ In a person's history, listen for getting lost in previously familiar environments, difficulty estimating distance or difficulty orienting objects to complete a task.
- ▶ A sensitive indicator of delirium and can occur in any dementia syndrome; it often occurs early in the course of Alzheimer's disease.

▶ **Screens:** Clock drawing;
overlapping pentagons(from MMSE).



SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

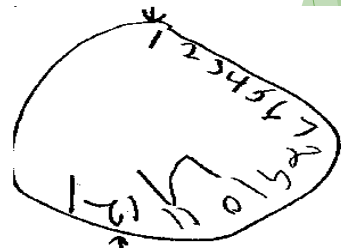
Clock Drawing

► The Clock Drawing Test

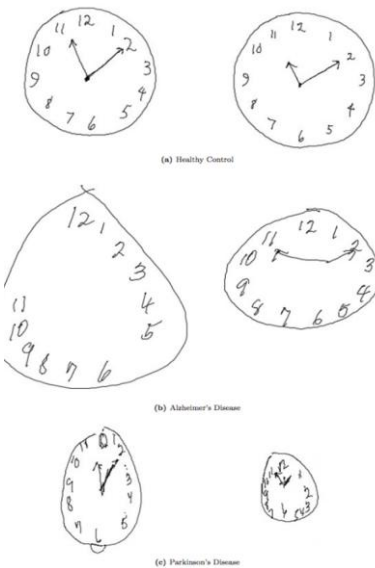
Have the person draw a clock by hand on a large piece of paper.

Have the person draw the face of a clock and put the numbers in the correct positions.

Then have them draw the hands to indicate the time like 3:40 - one hand of the clock on 3 and the other on the 8.



Clock Drawing



- To score, assign the following points for each part of the drawing:
- 1 point for a closed circle
- 1 point for properly placed numbers
- 1 point for including all twelve numbers
- 1 point for properly placed hands

Source of Image: MIT Tech

Cognitive Domains: Executive Functioning

- ▶ Constellation of cognitive skills necessary for complex goal-directed behavior and adaptation to a range of environmental changes and demands.
- ▶ Includes planning strategies to accomplish tasks, implementing and adjusting strategies, monitoring performance, recognizing patterns, and appreciating time sequences.
- ▶ Deficits associated with disruptive behaviors and self-care limitations among patients with Alzheimer's disease.

SOURCE: Advanced Biopsychosocial Assessment: Navigating the Grey Areas

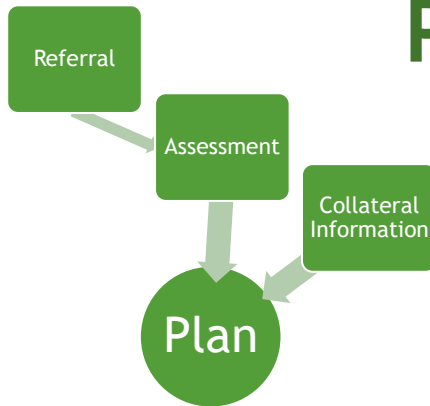
Cross Cultural Assessment

- ▶ Learn as much as you can beforehand about cultural beliefs that affect:
 - ▶ Values
 - ▶ Attitudes
 - ▶ Customs
 - ▶ Faith/religious beliefs
 - ▶ Family structure
 - ▶ Marriage
 - ▶ Roles



Source: Texas Department of Family and Protective Services 2004

Planning



Case Planning: Step by Step Decision making

- ▶ Assess risk
- ▶ Assess ability to consent
- ▶ Determine urgency
- ▶ Do it ethically
- ▶ Use least restrictive alternative



Weighing the Options



“Failure to intervene may result in injury, decline, financial loss, or even death. Workers and agencies may be accused of negligence or incompetence.

On the other hand, when workers initiate involuntary protective interventions, they may be accused of paternalism or authoritarianism.”

Nerenberg (2008)

Case Planning: Involuntary Step by Step Decision making

- ▶ Assess risk
- ▶ Assess ability to consent
- ▶ Determine urgency
- ▶ Do it ethically
- ▶ Use least restrictive alternative



Involuntary Interventions

- ▶ Emergency Hospitalization
- ▶ Law Enforcement Assist: Gaining Access to Victim
- ▶ Freeze Bank Accounts
- ▶ Guardianship and Protective Services
- ▶ Emergency Detention



Case Planning Essentials

The Case Plan Should Be:

- ▶ Collaborative
- ▶ Problem oriented
- ▶ Appropriate to client's functional level and dependency needs
- ▶ Consistent with culture and lifestyle
- ▶ Realistic, time-limited, and concrete
- ▶ Dynamic and renegotiable
- ▶ Inclusive of follow up



Marie Rodriguez

Marie Rodriguez, who is a very frail elderly woman, lives with her 58 year old son Javier who has a developmental disability. Javier has never left home, has always been cared for by his mother, and has been in many day programs. He can get out of hand and has pushed his mother a few times. Mrs. Rodriguez now is unsteady on her feet and can't protect herself from Javier's outbursts like she used to. The worker arranges for Javier to be placed in a facility.

Hidden consequences? Ethical considerations?

Workability? Outcomes? Plan B?

Joe Jones

Joe Jones resides in an apartment in an unsafe neighborhood. He has a heart condition and diabetes. He has had four toes amputated, uses a wheelchair, and is housebound. His unemployed son, George, lives with him. It was reported by the client's daughter that her brother is a drug addict, takes her father's money, and threatens him. The daughter tells the APS worker that her brother is known to the police and asks the APS worker to have George removed from the home. When the APS worker meets with Joe Jones, he says that he understands his son and doesn't wish to take an action against George since the son helps him out. The APS worker says that there are many agencies that can provide the services he needs and convinces client to file a restraining order.

Realistic plan? Outcomes? Client feelings? Plan B?

Documentation



Documentation in APS

“The test of a good APS Case Record is when any reasonable and prudent person can read and review the record and draw his/her own conclusion as to what occurred, based on interview statements and supportive evidence.”

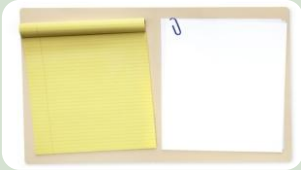
- CWDA APS Guidelines to Supplement Regulations, 2.7: Guiding Principles for APS Case Documentation

Purpose of Documentation

- ▶ Detailed and reliable case history, baseline data
- ▶ Evidence for involvement - APS and/or legal
- ▶ Accountability and liability
- ▶ Professionalism
- ▶ Consistency
- ▶ Justification for staff and funding for program
- ▶ Other?



Standards for Documentation



Accurate/
Factual



Complete



Timely

Activity: Critique Documentation

- ▶ **5/15/18 - Initial Assessment/Home Visit** Conducted visit at hospital. Client's daughter, M, was with client when SW arrived. Client is being treated for a heel ulcer and she reportedly had an operation yesterday. SW attempted to speak with client but she did not respond. Client was curled-up in the fetal position. She reportedly has pulled out her IV, so something is wrapped on both her hands to keep this from happening. Daughter also reported brother medicated client's sores with over the counter medication after consulting with her primary physician. Primary physician reportedly told brother that he can't treat something he hasn't seen. Daughter indicated that son was being stubborn and insisted on treating sores himself.

Just the facts...

- ▶ Direct and systematic observations
 - ▶ What you saw, heard, smelled
- ▶ Information obtained by other professionals
 - ▶ Medical diagnosis and prognosis
 - ▶ Bank statements
 - ▶ Legal documents
- ▶ Direct quotes
- ▶ Clear language
 - ▶ Understood by any reader
 - ▶ Acronyms and lingo beware

Subjective vs. Objective Descriptions

Subjective

- Gives an interpretation of an observation. Two people seeing the same event might be likely to give different *subjective descriptions*.

Objective

- Tells what was observed. Two people observing the same thing would probably give very similar *objective descriptions*.

“The kitchen smelled like it had not been clean for a month.”

Or

“When I entered the home, I smelled a foul odor. On entering the kitchen, I saw what appeared to be spoiled meat in the kitchen sink. The meat had turned pale green.”

- ▶ Be aware of your own values
 - ▶ What pushes your buttons?
- ▶ Watch your language
 - ▶ No judgmental, inflammatory, loaded words
- ▶ Use words like “seems” and “appears”
 - ▶ Describe what led you to that conclusion

Concise

- ▶ Get to the point
- ▶ Answer: who, what, where, when, why, and how
- ▶ Avoid unnecessary and extraneous words
- ▶ Make sure info is relevant to the case



Memory Improvement Tricks

- ▶ Brain Exercises
- ▶ General Guidelines and Mnemonics: Memory Tools (Handout 3.12)
 - ▶ Imagination
 - ▶ Association
 - ▶ Location
- ▶ Healthy Habits
 - ▶ Exercise
 - ▶ Manage stress
 - ▶ Get enough rest
 - ▶ Eat right
 - ▶ Do not smoke



Writing for Court: Rules of Evidence



- ▶ Admissible Evidence Criteria
 - ▶ Relevant: proves or disproves a disputed fact
 - ▶ Competent: legally obtained and receivable in court
- ▶ Exclusion of Evidence: Reasons
 - ▶ Reduce violations of constitutional protections
 - ▶ Avoid undue prejudice
 - ▶ Prohibit unreliable evidence (e.g. hearsay)
 - ▶ Protect valued interests and relationships (e.g. attorney-client privilege)

Victim/Witness Statements

- ▶ Document when statement was made and situation under which statement was made
 - ▶ Excited utterances/spontaneous statements - valuable form of evidence
- ▶ Strengthen veracity of statements
 - ▶ Witnessed by coworker
 - ▶ Documentation taken at the time statement provided
 - ▶ Documentation
 - ▶ Timely
 - ▶ Accurate
 - ▶ Dated

Language for Court Reports



DO:

- * Use “victim states” rather than “victim alleges”
- * Build case on fact not opinion
- * Write in a way that can refresh your memory and bring you back to the situation

AVOID:

- * The word “story”
- * Labeling : no opinions or biased language

Mrs. Gunther Activity

Mrs. Gunther is a 78 year old woman whose son, Dave, hit her in the face with the telephone when she threatened to call the police on him. He had been threatening her with violence if she did not give him her car keys. Because Dave was drunk, Mrs. Gunther did not want him to drive.

You are the APS worker called to interview Mrs. Gunther and you were first on the scene with the police. The police have now arrested Dave Gunther and you know that you may have to testify in court.

Professional Development Planning

- ▶ When thinking about your work in Adult Protection:
- ▶ What training do you need that was not covered fully enough in this three-day sequence?
- ▶ What advanced levels of training would be helpful?
- ▶ What would you like to learn more about?



Final Step:

Complete post-test
evaluation survey



Adult Protective Services Training Day 3

Intervention Strategies in Adult Protective Services

Participants will earn 5.5 Continuing Education Hours.

Agenda

- 9:00 – 9:15 Overview, Introductions, and Follow-Up
- 9:15 – 9:45 Effective Case Management Strategies
- 9:45 – 10:50 Assessment
- 10: 50 – 11:00 Break
- 11:00 – 12:15 Planning
- 12:15 – 1:00 Lunch
- 1:00 – 1:45 Planning
- 1:45 – 3:00 Documentation within Adult Protective Services
[Includes 10 minute break]
- 3:00 – 3:30 Professional Development Planning

[Timing is approximate.]

Learning Objectives

- Complete risk assessments using sample case scenarios.
- Identify key components of case planning.
- Highlight basic interviewing skills.
- Utilize assessment tools for practice situations.
- Outline documentation requirements and additional reporting.
- Apply ethical principles to intervention.
- Examine professional development needs for future practice.

Safety Planning and Violence against People with Disabilities

Safety plans include:

Prevention Strategies

Preventing future incidents of abuse (e.g. going to a shelter or moving to another residence, obtaining a restraining/protective order, hiding/disarming weapons, or changing schedules and routes to avoid being found).

Protection Strategies

Discussing methods victims can use to protect themselves during an abusive or violent incident (e.g. having an escape route or having victim seek shelter in a room where a door can be locked with a working phone available and/or where weapons are not present).

Notification Strategies

Developing methods for seeking help in a crisis situation (e.g. cell phones; emergency numbers readily available; life lines; security systems; towel in the window; code words with friends/family/neighbors).

Referral/Services

Recognizing and utilizing services that can offer assistance (e.g. domestic violence, sexual assault, adult protective services, criminal justice, aging and disability network, faith and community organizations, etc.).

Emotional Support

Considering methods of emotional support and ways to become less isolated (e.g. music, exercise, yoga, reading positive or spiritual materials, hobbies, art, friends, support groups, and other community activities).

Safety planning is NOT:

- Telling the victim what to do. (e.g. "I think you should go to a shelter.")
- Helping a victim accomplish your goals for his or her safety. (e.g. "Let's call the police and make a report.")
- Simply referring the victim to local agencies. (e.g. "Here's a list of agencies you can call. Let me know if you need other help.")
- Ignoring cultural, spiritual or generational values that influence the options the victim sees as available. (e.g., "I think your only choice here is to divorce him.")
- Recommending strategies that could increase the risk for the victim. (e.g. purchasing a gun or weapon, attending couples counseling, "just standing up to him.")
- Blaming the victim if he or she does not follow the safety plan and experiences further abuse.

Violence against People with Disabilities

Abuse against people with disabilities is a serious problem that we all must acknowledge, including health care providers, disability agencies, abuse investigators, domestic violence and sexual advocates, police, criminal justice personnel, crime victims' advocates, and personal attendants.

- People with disabilities experience common forms of violence and abuse, including physical and sexual assault, financial exploitation and verbal abuse.
- People with disabilities also face unique forms of abuse, such as neglect, refusal to provide essential care, manipulation of medications, and withholding or destruction of equipment. These forms of abuse can be life threatening by causing health deterioration or leaving people with disabilities unable to get away or call for help.
- Compared to nondisabled people, people with disabilities are more vulnerable to abuse by health providers and personal assistants or caregivers, who may be family members, friends or formal providers.
- People with disabilities often face barriers to stopping or preventing abuse, including: lack of knowledge of abuse resources, social isolation; lack of emergency back-up support needed to get away from a caregiver who is the perpetrator; fear of being institutionalized or losing their children if they acknowledge being victimized, and cognitive or physical inaccessibility of domestic violence services.
- It is critical to screen people with disabilities. This requires asking questions about all of these forms of abuse and being sensitive to the unique risks and barriers individuals with disabilities may face in managing the problem.

For example, ask the person if anyone has refused or neglected to help them with an important personal need, such as using the bathroom, eating or drinking. If they say “yes”, ask if the abuser is someone the person with a disability depends on for care and if there is a back-up caregiver. Consider what are the potential risks involved in the situation? And how are these risks linked to the disabilities experienced by the person?

- Many people with disabilities are afraid that if they disclose abuse, they won't be believed or that professionals will take control rather than supporting them to deal with the abuse.
- It is very important to validate that the abuse is wrong and the victims / survivors shouldn't have to live with it. Reassure the survivor that you will support them as they decide the best way to manage the problem. Help them identify their strengths and the resources they need.
- Creating a work / advocacy environment that is accessible and one that illustrates positive messages about disability may make people with disabilities more comfortable about disclosing abuse.

- Use appropriate language and structure the physical environment so people with disabilities can use it.

For example, use people-first language, such as “person with a physical or cognitive disability” rather than “handicapped, wheelchair bound or retarded”. Make sure your waiting room, restroom, exam tables and diagnostic equipment are accessible and your forms can be understood by people with learning or cognitive disabilities.

- Find out what disability and domestic violence community resources are available for referral regarding abuse.
- The Centers for Independent Living, ARCs, developmental disability, disability and aging agencies, or domestic violence / crisis lines in your area may be available to assist or to provide referral information.

Source: Arthur and Oschwald. 2006

Factors Affecting Decisional Impairment in APS Clients

Chronic Pain	May become the focus of attention and inhibit the ability to listen. A recent study found a relationship between untreated pain and increased depression among the elderly.
Dehydration	Can cause altered mental status, agitation or lethargy, lightheadedness and confusion. Speech difficulty, sunken eyes, weakness and lethargy are often attributed to other conditions. Chronic and acute-medical conditions, malnutrition and severe hot and humid weather can all cause dehydration.
Delirium	An acute, <u>reversible</u> disorder. It occurs suddenly, over a short period of time and fluctuates during the day. It may be caused by existing cognitive impairment, severe physical illness, stroke, Parkinson's disease or dehydration, and can be aggravated by acute pain. Symptoms include changes in the way the patient uses information and makes decisions, inability to focus, and uncharacteristic behavior. The patient reports feeling "mixed up."
Dementia	Involves a significant, persistent decline in functioning over a period of time. Depending on the type of dementia, the patient may lose memory as well as some or all of cognitive functions such as language, motor activities, ability to recognize familiar stimuli, and/or executive functioning. Accurate diagnosis requires a detailed history as well as physical and neurological examinations. Some dementias are reversible.
Depression	The patient reports feeling sadness, emptiness, detachment, loss of interest in usual activities, sleep disturbances, and/or weight loss. Speech is slowed, diminished or repetitive. Patient may show anxiety or panic. Condition persists for more than two weeks and is not related to situational loss.
Disease	Thyroid, diabetes, cancer, Parkinson's, heart disease, stroke and AIDS may cause diminished capacity as the diseases progress.
Grief	Intense grief reaction may result in temporary confusion, dependency, exhaustion and inability to make decisions.
Hearing/Vision Loss	Can mimic or exacerbate cognitive impairment. Communication difficulties due to sensory or physical impairments are often mistaken for confusion.
Low Blood Pressure	Can be due to side effect of medication or medication error, causing dizziness, weakness and falling which could result in head injury.
Low IQ	May affect patient's understanding of choices, risks and benefits.
Malnutrition	Protein energy malnutrition and low levels of vitamin D lead to weakness and diminished ability to provide self-care and ultimately to decreased cognition.
Medication Mismanagement	Drug interactions and adverse reactions are common and can be serious. May be due to patient's visual or cognitive impairment, inability to afford prescriptions, or functional illiteracy. Medication misuse frequently causes mental impairment. Antibiotics and cardiovascular drugs are the most frequent causes of adverse effects.
Physical Illness	May result in electrolyte imbalances that cause confusion and prevent rational decision making.
Psychosis	Difficult to detect. Symptoms include delusions, hallucination, and agitation.
Substance Abuse	Older adults become inebriated with lower levels of alcohol consumption—leads to malnutrition and alcohol dementia. Also, alcohol intake in conjunction with certain medications can have a greater impact on older individuals than younger individuals.
Stress/Anxiety	Anxiety disorder is more prevalent than depression among the elderly. Older women are more at risk than men. May be the result of family violence or Post Traumatic Stress Disorder.
Traumatic Brain Injury	May be the result of physical abuse or a fall. Falls are the most common injury in the elderly due to weakness, environmental hazards, dizziness, alcohol, medications or stroke. A patient with sudden changes in mental status after a fall may have subdural hematoma.
Urinary Tract Infection	Most common infection in the elderly. Can present as acute change in cognitive status. May result in delirium.

3 D's CASE STUDIES

Case Study #1 – Rosemary Cellini

Mrs. Cellini, age 83, was referred to APS because she was found outside mumbling to herself. When her neighbor approached her, she quieted down but didn't make any sense. She appeared to have lost weight as well. The neighbor stated that she talked to Mrs. Cellini last week when Mrs. Cellini returned from a brief hospitalization and she seemed ok at that time. Now, Mrs. Cellini doesn't even recognize her own house.

When you visit, she appears confused and disoriented. She is quite thin and has a bruise on her forehead, but cannot explain what happened. She talks about her mother and how she just went to the store and how much she loves her. (You had heard from the neighbor that client's mother lived in Italy and died 10 years before). It is difficult to follow her conversation as she often stops in mid- sentence and she seems distracted. The house is in good repair but is untidy.

There is very little food in the refrigerator and there is about a week's worth of dirty clothing on the floors. Mrs. Cellini has current medication in her house for hypertension and diabetes.

1. What are the indicators that client may have a mental status problem?
2. Does the client appear to have dementia, delirium or depression?
3. What more information do you need and how would you get it?

Case Study #2 - Proful Dixit

Mr. Dixit, age 77, was referred to APS by the Health Department because they had received complaints about the environmental conditions in the home which have deteriorated over the last year. Although there were some minor violations, the concern was that the client who was found dirty and disheveled. The officer stated that Mr. Dixit seemed embarrassed and nervous. When the officer told him about the violations, he seemed not to understand what the issues were, but smiled and said his son would take care of everything.

When you visit, Mr. Dixit greets you pleasantly but does not volunteer information. The house appears to be in the same condition as described by the Health Officer. Mr. Dixit is surrounded by newspapers, magazines, and take-out food containers. His clothing is urine stained, but he does not appear to notice it.

There are several cats in the home. Mr. Dixit seems to have difficulty understanding what you are saying, but nods his head politely. Mr. Dixit has medication for arthritis, high cholesterol, and Parkinson's.

1. What are the indicators that client may have a mental status problem?
2. Does the client appear to have dementia, delirium or depression?
3. What more information do you need and how would you get it?

Case Study #3 – Mary Jo Jackson

Mrs. Jackson, age 73, was referred to APS after the police did a welfare check requested by Mrs. Jackson's daughter who lives out of state. Initially, Mrs. Jackson failed to answer the door for the police. Then, she appeared to be confused about why the police were there and refused any assistance.

When you visit, Mrs. Jackson appears to have difficulty focusing on your conversation. You have to repeat your questions as she often doesn't respond immediately and then seems to lose the thread of the conversation. When you ask Mrs. Jackson about her family, Mrs. Jackson seems uninterested in discussing her past or her daughter's current concerns. She says she'll call her daughter "later", when she feels up to it. The house is in reasonable repair but is very untidy.

There is little food in the home and the client appears unconcerned about getting more food. She asks you to leave because she doesn't feel up to answering questions.

1. What are the indicators that client may have a mental status problem?
2. Does the client appear to have dementia, delirium or depression?
3. What more information do you need and how would you get it?

Assessment of Older Adults with Diminished Capacity

Dementia is a general term for a medical condition characterized by a loss of memory and functioning. Primary degenerative dementias are those with disease processes that result in a deteriorating course, including Alzheimer's Disease, Lewy Body Dementia, and Frontal Dementia (each associated with a type of abnormal brain cell).

Condition	Etiology	Symptoms	Treatability
Alzheimer's Disease (AD)	Most common type of dementia, caused by a progressive brain disease involving protein deposits in brain and disruption of neurotransmitter systems	Initial short-term memory loss, followed by problems in language and communication, orientation to time and place, everyday problem solving, and eventually recognition of people and everyday objects. In the early stages, an individual may retain some decisional and functional abilities.	Progressive and irreversible, resulting ultimately in a terminal state. Medications may improve symptoms and cause a temporary brightening of function in the earlier stages.
Frontal or Frontotemporal Dementia (Pick's disease is example)	Broad category of dementia caused by brain diseases or small strokes that affect the frontal lobes of the brain	Problems with personality and behavior are often the first changes, followed by problems in organization, judgment, insight, motivation, and the ability to engage in goal directed behavior.	Early in their disease, patients may have areas of retained functional ability, but as disease progresses they can rapidly lose all decisional capacity.
Diffuse Lewy Body Dementia (DLB)	A type of dementia on the Parkinson Disease spectrum	DLB involved mental changes that precede or co-occur with motor changes. Visual hallucinations are common, as are fluctuations in mental capacity	This disease is progressive and there are no known treatments. Parkinson medications are often of limited use.
Jacob-Creutzfeldt Disease	A rare type of progressive dementia affecting humans that is related to "mad cow" disease.	The disease usually has a rapid course, with death occurring within two years of initial symptoms. These include fatigue, mental slowing, depression, bizarre ideations, confusion, and motor disturbances, including muscular jerking, leading finally to a vegetative state.	There is no treatment currently and the disease is relentlessly progressive.
Delirium	A temporary confused state with a wide variety of causes, such as dehydration, poor nutrition, multiple medication use, medication reaction, anesthesia, metabolic imbalances, and infections.	Substantially impaired and attention and significant decisional and functional impairments across many domains. May be difficult to distinguish from the confusion and inattention characteristic of dementia.	Often temporary and treatable. If untreated, may progress to dementia. It is important to rule out delirium before diagnosing dementia. To do so, a good understanding of the history and course of functional decline, as well as a full medical work-up, are necessary.
Stroke or Cerebral Vascular Accident (CVA)	A significant bleeding in the brain, or a blockage of oxygen to the brain.	May affect just one part of the brain, so individuals should be carefully assessed to determine their functional and decisional abilities	Some level of recovery and improved function over the first year; thus, a temporary guardianship might be considered if the stroke is recent.

Condition	Source	Symptoms	Treatability
Parkinson's Disease (PD)	Progressive brain disease that initially affects motor function, but in many cases proceeds to dementia.	PD presents initially with problems with tremors and physical movement, followed with problems with expression and thinking, and leading sometimes to dementia after a number of years.	PD is progressive, but motor symptoms can be treated for many years. Eventually, the medications ineffective and most physical and mental capacities are lost. Evaluation of capacity must avoid confusion of physical for cognitive impairment.
Vascular Dementia	Multiple Strokes that accumulate and cause dementia	Functional strengths and weaknesses may vary, depending on the extent and location of the strokes	May worsen if cardiovascular disease continues to cause progressive impairment.
Vascular Cognitive Impairment	Multiple infarcts that cause cognitive impairment	Functional strengths and weaknesses may vary, depending on the extent and location of the strokes	May remain stable over time if underlying cardiovascular heart disease is successfully managed.
Coma	A state of temporary or permanent unconsciousness	Minimally responsive or unresponsive, unable to communicate decisions and needs substitute decision maker	Often temporary; regular re-evaluation required
Persistent Vegetative State (PSV)	A state of minimal or no responsiveness following emergence from a coma.	Patient is mute and immobile with absence of all higher mental activity. Cannot communicate decisions and requires a substitute decision maker for all areas	Cases of PSV usually lead to death within a year's time.
Developmental Disorders (DD), including mental retardation (MR)	Brain-related conditions that begin at birth or childhood (before age 18) and continue throughout adult life. MR concerns low-level intellectual functioning with functional deficits that can be found across many kinds of DD, including autism, Down syndrome, and cerebral palsy.	Functioning tends to be stable over time but lower than peers. MR is most commonly mild. Some conditions such as Down Syndrome may develop a supervening dementia later in life, cause a decline in already limited decisional and functional abilities.	Not reversible but everyday functioning can be improved with a wide range of supports, interventions, and less restrictive alternatives. Individuals with DD have a wide range of decisional and functional abilities and thus, require careful assessment by skilled clinicians.
Traumatic Brain Injury (TBI)	A blow to the head that usually involves loss of consciousness	Individuals with mild and moderate TBI may appear superficially the same as before the accident, but have persisting problems with motivation, judgment, and organization. Those with severe TBI may have profound problems with everyday functioning.	Usually show recovery of thinking and functional abilities over the first year, thus a temporary guardianship should be considered if the injury is recent.
Bipolar Disorder (often called manic depression)	A psychiatric illness characterized by alternating periods of mania and depression	May affect functional and decisional abilities in the manic stage or when the depressed stage is severe.	Can be treated with medication, but requires a strong commitment to treatment on the part of the individual. Varies over time; periodic re-evaluation needed.

Condition	Source	Symptoms	Treatability
Major Depression	A very common psychiatric illness	Sad or disinterested mood, poor appetite, energy, sleep and concentration, feelings of hopelessness, helplessness and suicidality. In severe cases, poor hygiene, hallucinations, delusions, and impaired decisional and functional abilities	Treatable and reversible, although in some resistant cases electroconvulsive therapy (ECT) is needed.
Schizophrenia	A chronic brain-based illness	Hallucinations and delusions, poor judgment, insight, planning, personal hygiene, interpersonal skills. May range from mild to severe. Impact on functional and decisional abilities is variable.	Many symptoms can be successfully treated with medication. Capacity loss may occur when patients go off their medication.
Alcoholic Dementia	A fairly common form of dementia, caused by long-term abuse of alcohol, usually for 20 years or more. Alcohol is a neurotoxin that passes the blood-brain barrier.	Memory loss, problem-solving difficulty, and impairments of visuospatial function are commonly found in patients with alcohol dementia.	Alcohol dementia is partially reversible, if there is long-term sobriety—cessation of use. There is evidence to suggest that some damaged brain tissue may regenerate following extended sobriety, leading to modest improvements in thinking and functioning.

Adapted from *Assessment of Older Adults with Diminished Capacity: A Handbook for Psychologists*. (Appendix G). Published by the American Bar Association Commission on Law and Aging and the American Psychological Association.

Case Study : Anna Kovacs

Reason for referral to APS: Possible self-neglect

Referral made by: Visiting Nurse

Psycho-social Factors Affecting Capacity: Anna is an 82 year old widow. She and her husband Miklos emigrated from Hungary 40 years ago. Anna's English is limited. Miklos died suddenly of a massive heart attack one year ago. He had worked his entire life and managed the financial affairs of the home. They had one daughter who died 10 years ago of cancer at the age of 38. Anna had cared for her daughter during her two-year illness. Anna seems confused about her medications. She does not seem to understand the importance of maintaining her diabetic diet. She eats a lot of rye bread and processed meats which are high in sugar.

Physical Factors Affecting Capacity: Anna was recently hospitalized due to complications of diabetes. Her sugar levels were out of control. She had developed gangrene in her left foot. Two of her toes had to be amputated. She is beginning to have problems with her vision. After rehab, she was sent home in a wheelchair. There is no one providing in-home care.

Environmental Factors Affecting Capacity: Anna lives alone. Reportedly, Anna was an excellent cook and housekeeper when she was younger. Now the home is very cluttered. It is difficult for her to maneuver around the home in her wheelchair.

Prognosis: If Anna does not follow her diabetic medication and dietary regimen, she will be at risk of a foot or full-leg amputation.

Exercise:

How would you assess the risk?

How would you assess the capacity of the victim?

How would you assess the urgency?

What is next step in the planning process?

What interventions might you initiate?

Learning the Language

Helpful Hints to Access the Help of Other Agencies/Disciplines

Mental Health

- Educate yourself on the legal mandates, responsibilities and limitations of the agency
- Approach with an open mind rather than being set on a particular outcome
- Provide a baseline by describing:
 - Client's typical behavior and how current behavior differs from it
 - Changes in sleep pattern, appetite, activity level, mood, or behavior
- Review factors leading up to the problem and inform them of any factors that might be relevant
- Inform them of any medical problems and all medications, including dose and frequency
- Find out if there is a family history of mental illness or previous diagnosis of mental illness

Law Enforcement

- Understand the laws, what the officer is mandated to do, what the officer cannot do
- Focus on the facts, avoid gray areas
- Gather documentation which would support the case
- Discuss crimes and penal code violations, not social problems

Emergency Medical Services/Transport

- Provide all medical and medication history that is available to you
- If client is resistant or fearful of hospitalization, use your social work skills to find out what the source of the fear is.
 - Was it a previous negative experience or perhaps a feeling of shame due to her present hygiene?
 - Validating client's feelings and understanding the resistance may help you eliminate the barriers.

Financial Institution

- Understand your state statutes regarding fraud and financial exploitation
- Provide the institution with your suspicions and reason for investigation.
- Provide documentation if available.

Strengths-Based Care Planning and Goal Setting

Traditional care planning: Social worker identifies resources; decides who will provide them; and arranges type and frequency of services.

Client-driven care planning, strengths model: takes into account client preferences and interests; client's participation in developing the care plan; clients need for personal planning and goal-setting; and the client's ability to incorporate his/her strengths into planning process.

Process:

Engagement

- Know client in holistic way
- Begin where client is physically and emotionally and move with him/her towards higher participation Capitalize on strengths
- Assess: current status (identified problem), client's desires, and client's personal/social resources (what he/she has used in the past)
- Consider life domains
 - Daily living situation
 - Health
 - Finances
 - Social supports
 - Spirituality/religion
 - Leisure/recreational interests

Expand client's confidence in making choices and selecting options

Payoff:

- Better outcomes, more chance for compliance.
- Less anxiety for worker, less poor decisions.

Personal Goal Plan:

Blends client's needs with desires.

Generated from client's perception of problem.

Break broad goals into manageable parts.

Strengthens client-worker relationship.

Key considerations in selecting intervention activities include:

- Pick the least drastic and most gradual available.
- Insure deliberation and agreement with the adult.
- Be certain about the adult's knowledge and ability to follow through.
- Include all steps.
- Break complex activities into parts.
- Have reasonable time frames.
- Provide reciprocal accountability.

APS plan implementation activities include:

- Identifying available and appropriate providers.
- Making referrals to identified providers.
- Preparing providers for handling the referrals by providing necessary information about the victim or perpetrator and that person's situation.
- Following up to make sure the resources are provided and used.
- Communicating with providers regularly to evaluate progress and reassess need.

Often Misused Terms

Device (contrivance)	Principal (chief)	Compliment (flattering remark)
Devise (invent)	Principle (tenet)	Complement (goes well together)
Precedence (priority)	Raise (transitive)	
Precedents (examples)	Rise (intransitive)	
Disburse (pay)	Rationale (reason)	
Disperse (scatter)	Rational (reasonable)	
Emersion (act of appearing)	Sewage (waste)	
Immersion (act of dipping)	Sewerage (drain system)	
Eminent (distinguished)	Spacious (full of room)	
Imminent (about to happen)	Specious (misleading)	
	Species (classification)	
Some time (period of time)	Personal (individual)	
Sometime (point of time)	Personnel (staff)	
Sometimes (at times)		
Stationary (not moving)	Track (course, path)	
Stationery (writing paper)	Tract (region)	
New (recent)	Than (compares)	
Novel (unusual)	Then (refers to time)	
Leave (go away)	Fortunate (lucky)	
Let (permit)	Fortuitous (accidental)	
Flaunt (display boastfully)	Lie/lay/lain (intransitive)	
Flout (scoff at)	Lay/laid/laid (transitive)	
Perquisite (privilege)	There (place)	
Prerequisite (requirement)	Their (possessive "they")	
Practical (useful)	Perspective (view)	
Practicable (able to be used)	Prospective (expectant)	
Complacent (self-satisfied)	Effective (producing desired effect)	
Complaisant (eager to please)	Affective (arousing emotions)	
Imply (hint)		
Infer (take a hint)		

COMMON APS ABBREVIATIONS and ACRONYMS

Keep this hand out in your field book – there is room to add additional words.

A:)

AAA – Area Agency on Aging
AD – Alzheimer's Disease
ADD – Attention Deficit Disorder
ADA – Americans with Disabilities Act
ADC – Adult Day Care
ADHC – Adult Day Health Care
ADL – Activities of Daily Living
AIDS – Acquired Immune Deficiency Syndrome
ALANON – Alcoholics Anonymous Support for Families/Friends
ALS – Amyotrophic Lateral Sclerosis
AMA – Against Medical Advice
AP – Alleged Perpetrator
Approx. – Approximately
APS – Adult Protective Services
ASHD – Arteriosclerotic Heart Disease

B:)

B&C – Board & Care
BDI – Beck Depression Instrument
BP – Blood Pressure
BRO – Brother
bid/b.i.d – Twice Daily/Two Times a Day
bx – Behavior

C:)

CA – Cancer
CAD – Coronary Artery Disease
CNA – Certified Nursing Assistant
CCL – Community Care Licensing
CG – Care Giver

CHF – Congestive Heart Failure
CI – Court Investigator
COPD – Chronic Obstructive Pulmonary Disease
CVA – Cerebrovascular Accident (stroke)
CL – Client
CM – Case Manager/Case Management

D:)

DA – District Attorney
d/c – Discontinued
DD – Developmentally Disabled
DIL – Daughter-in-law
DJD – Degenerative Joint Disease
DM – Diabetes Mellitus
DNR – Do Not Resuscitate
DOB – Date of Birth
DPOA/HC – Durable Power of Attorney/Health Care
DSG – Dressing
DTR – Daughter
DV – Domestic Violence
DX or dx – Diagnosed/Diagnosis

E:)

EDRT – Elder Death Review Team
EMT – Emergency Medical Team
ESRD/ERD – Endstage Renal disease
ETOH – Alcohol

F:)

FA – Father
F.A.S.T. – Financial Abuse Specialist Team
FD – Fire Department
f/f – Face to Face
f/u – Follow Up

G:)

GDS – Geriatric Depression Scale
GI – Gastrointestinal

GP – General Practitioner
GSW – Gun Shot Wound
GRDDTR – Granddaughter
GRDS – Grandson
GYN – Gynecology

H:)

HA – Housing Authority
HBP – High Blood Pressure
HH – Home Health
HIPAA – Health Insurance Portability and Accountability Act
HIV – Human Immune Virus
HUSB – Husband
HOH – Hard of Hearing
HTN – Hypertension (High Blood Pressure)
HV – Home Visit
H&W – Health & Welfare
Hx – History

I:)

IADL – Instrumental Activity of Daily Living
IDDM – Insulin Dependent Diabetes Mellitus
IHSS – In-home Supportive Services
ILP – Independent Living Program
IM – Intramuscular
IV – Intravenous
IR – Incident Report
I&R – Information and Referral
IQ – Intelligence Quotient
INCL – Include/Including/Inclusive
INEL – Ineligible
INFO – Information
INIT – Initial
L:)
L – Left
LPS – Lanterman, Petris, Short
LTC – Long-Term Care
M:)
MA – Medicaid

COMMON APS ABBREVIATIONS and ACRONYMS

MC – Medicare
MCT – Mobil Crisis Team
MDT – Multi Disciplinary Team
meds – Medications
MH – Mental Health
MI – Myocardial Infarction
MMSE – Mini Mental Status Exam
MO – Mother
MOCA – Montreal Cognitive Assessment
MOW – Meals-on-Wheels
MR – Mentally Retarded
MS – Multiple Sclerosis
MSSP – Multi-purpose Senior Services Program
MVA – Motor Vehicle Accident
N:)
n/a – Not Applicable
NIDDM – Non-Insulin Dependent Diabetes Mellitus
NIFFI – No Initial Face-to-Face Investigation
NOS – Not Otherwise Specified
nv – Non-Verbal
O:)
O2 – Oxygen
OT –Occupational Therapy/Occupational Therapist
P:)
PA – Physician’s Assistant
Para – Paraplegia
PCP – Primary Care Provider
PD – Police Department
PG – Public Guardian
PH –Public Health
PHN – Public Health Nurse
POA – Power of Attorney
PT – Physical Therapy/Physical Therapist
PTSD – Post Traumatic Stress Disorder

Psy – Psychiatric
PUD – Peptic Ulcer Disease
PVD –Peripheral Vascular Disease
Q:)
Q – Every
QD – Everyday
QH – Every Hour
QHS – Every Night
QID – Four times a day
QOD – Every other day
Quad – Quadriplegia
R:)
R – Right
RC – Regional Center
RCF – Residential Care Facility
RCH – Residential Care Home
RCU – Restorative Care Unit
RN – Registered Nurse
Rx – Prescription
RO – Restraining Order
ROM – Range of Motion
RP – Reporting Party
r/o – Rule Out
S:)
SA – Substance Abuse
SC – Subcutaneous
SED – Severely Emotionally Disturbed
SI – Suicidal Ideation
SIS - Sister
SNF – Skilled Nursing Facility
SOB – Shortness of Breath
SOC – Share of Cost
SRO – Single Room Occupancy (Hotel)
SSA – Social Security Administration
SSI – Social Security Supplement Income
SSNR – Social Security Number
ST – Speech Therapy/Speech Therapist

SW – Social Worker
T:)
t/c – Telephone Call
TIA – Transient Ischemic Attack
Thx – Therapy/Therapist
Tx – Treatment
U:)
UTI – Urinary Tract Infection
unk – Unknown
V:)
VA – Veterans Administration
VNA – Visiting Nurses Association
VW – Victim Witness Program
W:)
W&I Code – Welfare & Institutions Code
w/ - With
w/out – Without
Y:)
yo – Year Old

This document was created by the APS Training Project - Bay Area Academy/SFSU for the APS Case Documentation & Report Writing training – June 2008.

Rat Feces Exercise

Read the following narrative information carefully:

The worker walked into the kitchen and observed rats scurrying under the cabinets when the light was turned on. Feces were all over the floor. The client's daughter said her mother liked rats but she didn't like people. Mrs. Jones said she was surprised that the rats stayed around with so little food in the house, then she walked out of the room.

Now read the following statements about the narrative. Circle "T" if the statement is true, "F" if the statement is false, and "Q" if you do not know if it's true or false.

- | | | | |
|---|---|---|---|
| T | F | Q | 1. Rat feces covered the kitchen floor. |
| T | F | Q | 2. The client's daughter didn't provide her mother with enough food. |
| T | F | Q | 3. It was reported that the client liked people. |
| T | F | Q | 4. The worker turned on the kitchen light. |
| T | F | Q | 5. Mrs. Jones liked rats. |
| T | F | Q | 6. Someone turned on a light. |
| T | F | Q | 7. Mrs. Jones doesn't like people. |
| T | F | Q | 8. There was not very much food in the kitchen. |
| T | F | Q | 9. The client is ambulatory. |
| T | F | Q | 10. Mrs. Jones went to another room after she talked to the worker. |
| T | F | Q | 11. Rats went under the cabinets when the light was turned on. |
| T | F | Q | 12. The worker interviewed the client and her daughter. |
| T | F | Q | 13. The client's house was not very clean. |
| T | F | Q | 14. The worker walked into the kitchen. |
| T | F | Q | 15. Age of the client was not revealed in this part of the narrative. |
| T | F | Q | 16. Mrs. Jones was hungry. |
| T | F | Q | 17. The narrative mentions three people: the worker, the client, and the client's daughter. |

Clear and Objective Language Exercise

Please read the following statements and rewrite them so they will be clear and objective. Be able to explain what was wrong with the original statement.

Example:

Client was filthy and disheveled. → Client's arms, legs, and face were caked with dirt. His shirt was stained and unbuttoned. His trousers hung down to his knees. There were urine stains on his pant legs. He had no socks on and only one shoe.

1. Visit to home of 55 year old double amputee, Mr. Williams. Neighbors complain that he has filled his home with trash which is attracting vermin. The client's behavior was inappropriate during the visit.

2. Client states her sister, who is her primary source of care, worries a lot about everything. After interviewing the sister, she is paranoid.

3. Case closure summary submitted by APS Social Worker: Despite all I have done for her over the months, the client is manipulative and is never satisfied.

4. After APS report from physician, visit to home of 92 year old woman who lives alone in the country. Client was inappropriately dressed.

5. Client states he gives his brother money since his brother was laid off six months ago. The brother appears to be a drunk.

6. Home visit with client, her adult son, and adult daughter. Both adult children reside with the client. This is a dysfunctional family.

General Guidelines to Improve Memory

In addition to exercising your brain, there are some basic things you can do to improve your ability to retain and retrieve memories:

- 1. Pay attention.** You can't remember something if you never learned it, and you can't learn something — that is, encode it into your brain — if you don't pay enough attention to it. It takes about eight seconds of intent focus to process a piece of information through your hippocampus and into the appropriate memory center. So, no multitasking when you need to concentrate! If you distract easily, try to receive information in a quiet place where you won't be interrupted.
- 2. Tailor information acquisition to your learning style and use as many senses as possible.** Most people are visual learners; they learn best by reading or otherwise seeing what it is they have to know. But some are auditory learners who learn better by listening. They might benefit by recording information they need and listening to it until they remember it. Even if you're a visual learner, read out loud what you want to remember. If you can recite it rhythmically, even better. Try to relate information to colors, textures, smells and tastes. The physical act of rewriting information can help imprint it onto your brain.
- 3. Relate information to what you already know.** Connect new data to information you already remember, whether it's new material that builds on previous knowledge, or something as simple as an address of someone who lives on a street where you already know someone.
- 4. Organize information.** Write things down in address books and datebooks and on calendars; take notes on more complex material and reorganize the notes into categories later. Use both words and pictures in learning information.
- 5. Understand and be able to interpret complex material.** For more complex material, focus on understanding basic ideas rather than memorizing isolated details. Be able to explain it to someone else in your own words.
- 6. Rehearse information frequently and “over-learn”.** Review what you've learned the same day you learn it, and at intervals thereafter. What researchers call “spaced rehearsal” is more effective than “cramming.” If you're able to “over-learn” information so that recalling it becomes second nature, so much the better.
- 7. Be motivated and keep a positive attitude.** Tell yourself that you *want* to learn what you need to remember, and that you *can* learn and remember it. Telling yourself you have a bad memory actually hampers the ability of your brain to remember, while positive mental feedback sets up an expectation of success.

Mnemonic Devices to Improve Memory

The three fundamental principles underlying the use of mnemonics are imagination, association and location. Working together, you can use these principles to generate powerful mnemonic systems.

Imagination: is what you use to create and strengthen the associations needed to create effective mnemonics. Your imagination is what you use to create mnemonics that are potent for you. The more strongly you imagine and visualize a situation, the more effectively it will stick in your mind for later recall. The imagery you use in your mnemonics can be as violent, vivid, or sensual as you like, as long as it helps you to remember.

Association: this is the method by which you link a thing to be remembered to a way of remembering it. You can create associations by:

- Placing things on top of each other
- Crashing things together
- Merging images together
- Wrapping them around each other
- Rotating them around each other or having them dancing together
- Linking them using the same color, smell, shape, or feeling

As an example, you might link the number 1 with a goldfish by visualizing a 1-shaped spear being used to spear it.

Location: gives you two things –

First, a coherent context into which you can place information so that it hangs together.

Second, a way of separating one mnemonic from another. By setting one mnemonic in a particular town, I can separate it from a similar mnemonic set in a city. For example, by setting one in Wimbledon and another similar mnemonic with images of Manhattan, we can separate them with no danger of confusion. You can build the flavors and atmosphere of these places into your mnemonics to strengthen the feeling of location.

Common types of mnemonic devices include:

1. **Visual images.**
2. **Sentences** in which the first letter of each word is part of or represents the initial of what you want to remember.
3. **Acronyms**, which are initials that creates pronounceable words.
4. **Rhymes and alliteration:**
5. **Jokes** or even off-color associations using facts, figures, and names you need to recall, because funny or peculiar things are easier to remember than mundane images.
6. **“Chunking” information;** arranging a long list in smaller units or categories that are easier to remember.
7. **“Method of loci”:** You associate each part of what you have to remember with a landmark in a route you know well, such as your commute to work.

Photographing Evidence

When to take photographs:

APS workers are encouraged to take photographs of their clients' injuries and adverse health conditions (e.g. severe weight loss due to malnourishment), or environmental conditions whenever:

- Photographs will help document the client's lack of ability to provide self care for a probate guardianship case.
- A photograph can more accurately depict the client's injury or situation than can be stated in a brief narrative.
- Requested to do so by law enforcement.
- There has been a violation that can be documented photographically.
- APS workers may also take baseline photographs, with the client's permission.

Always take an identifying shot:

Always take at least one photograph showing the whole person, the front of the home or an overview of the scene.

Rationale: Without an identifying shot, it is often difficult to determine who was injured and exactly what part of the body was injured. It is also important to show that the interior shots are of the client's home and not another residence.

Use the rule of thirds:

Using the identifying shot, move in by thirds to show the details of the injury or of an environmental condition (e.g. rat droppings, spoiled food, etc). [This allows clarity in understanding what one is looking at with the more close-up picture.]

Use a scale in photographs:

It is helpful to position an ordinary object of known size (e.g. a ruler, a coin or a pen) next to the object or injury being photograph to demonstrate the size of the item being photographed.

Photograph the injuring object:

If the object that is believed to have caused the injury is identified, it is helpful to photograph the object next to the injury. For example, photographing a 1 inch wide leather belt next to a one inch wide bruise may help to demonstrate that the belt was the cause of the injury. (Please note that in some cases the size of the injuring object will **not** match due to swelling, movement of the victim when struck or other factors.)

Take sharp pictures:

The following guidelines will help you produce sharp, detailed pictures:

1. Avoid backlighting the person or object as the resulting photograph will be a silhouette without any detail.
2. Use side lighting only if you need to show the texture or depth of a wound.

3. Almost all documentary photographs should be lit from the front if at all possible. However, it is advisable to take photographs in varying light levels.
4. Steady your camera against a table, the roof of a non-running car, etc. and squeeze the shutter slowly so as not to jerk the camera.
5. Make sure that your lens is clean, your batteries are charged and the camera has available memory.
6. Shoot most of your photographs from eye level as this makes it easier to judge the perspective of objects in the picture.

Downloading photographs:

Photographs are to be (1) downloaded to the worker's computer or a CD and (2) labeled as soon as is practical after being taken.

All photographs, electronic files, CD's or floppy discs must be labeled with, at a minimum, the client's name and the date the photographs were taken. In addition, it is desirable to include the name of the person taking the photographs and a description of what was photographed (e.g. the bruise on Mrs. M's left knee).

Only one client's photographs may be stored in any single electronic file.

All photographs should be stored in at least 2 places (e.g. CD and on paper, CD and in an electronic file on the worker's computer).

Maintain the original photograph:

In some cases, photographs may need to be enhanced in order to clearly see some details. Enhancements include changes in lightness/darkness, sharpening the focus, cropping the photograph, etc.

Do not enhance the "original" photograph. Make a copy and then make any necessary enhancements. The changed photograph needs to be labeled as having been enhanced with notations of what changes were made. The notation should reference the original photograph and both photographs (the original and the enhanced version) should be kept in the same electronic file.

Release of photographs:

Photographs are part of the APS case documentation and their release is regulated by the same policies as any other part of the case record.

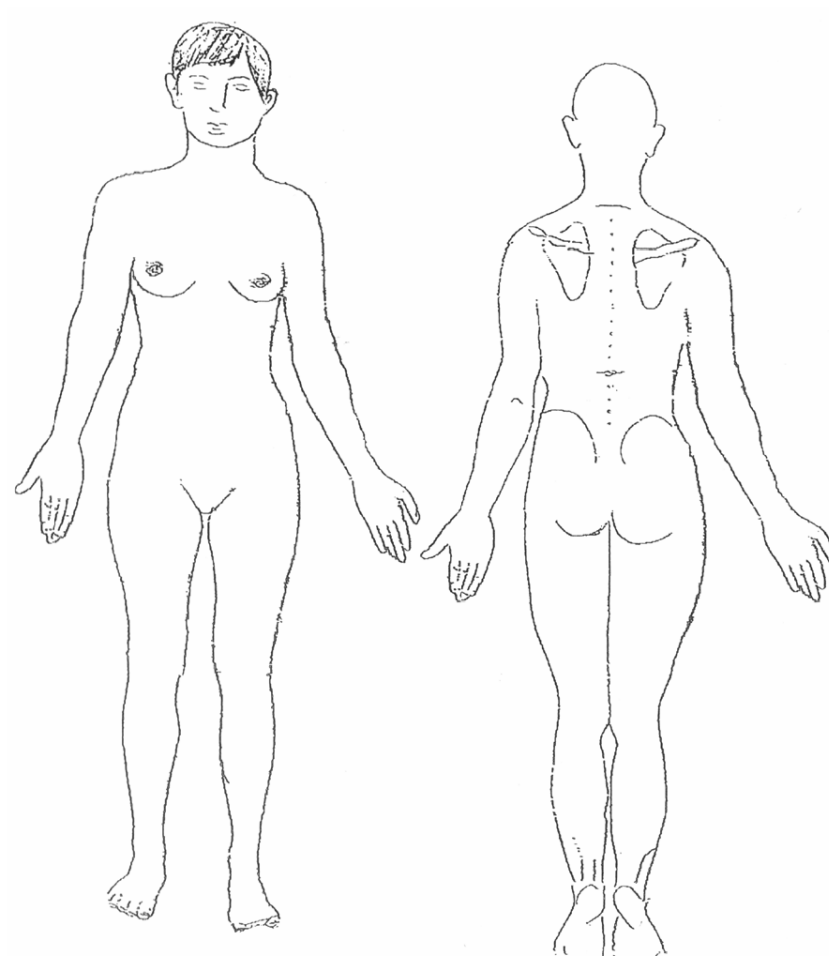
4.1 Front and Back Views – Female

Details of service user:

Name:

Address:

DOB:



Completed by

Name:

Designation:

Date:

Time:

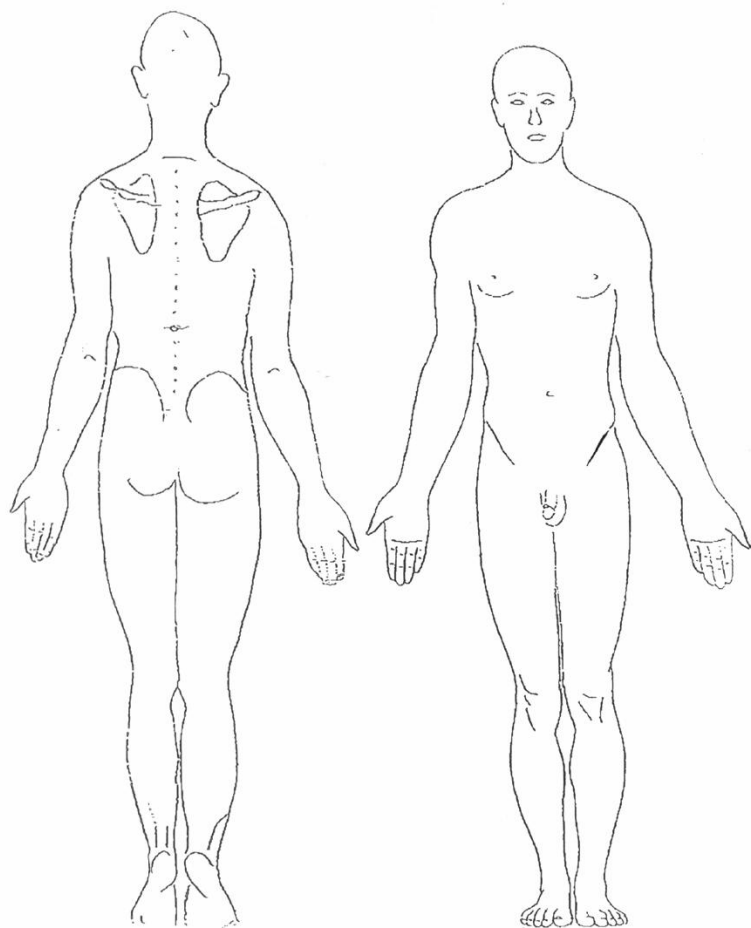
4.2 Front and Back Views - Male

Details of service user:

Name:

Address:

DOB:



Completed by

Name:

Designation:

Date:

Time:

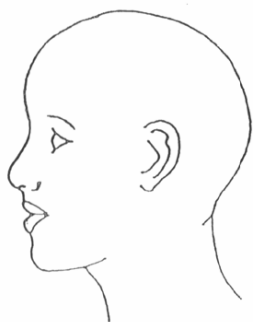
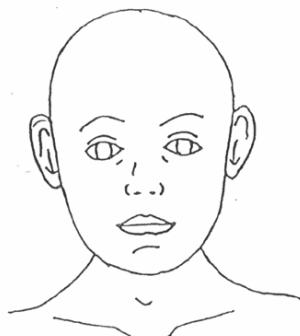
4.3 **Front and Side Views - Head**

Details of service user:

Name:

Address:

DOB:



Completed by

Name:

Designation:

Date:

Time: