Adult Protective Services Curriculum Training Manual

Part I: Foundations of Adult Protective Services

Part II: Collaborating for Best Practice

Part III: Intervention Strategies in APS

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Under contract through

Office of Continuing Education and Community Outreach

Curriculum developed with funding by the

Wisconsin Department of Health Services

Adult Protective Services Division

October, 2018

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Acknowledgements

Content recommendation for this training was created through the Adult Protective Services Workgroups convened by the Wisconsin Department of Health Services.

Members participating in the workgroups included:

Ongoing consultation for curriculum development was provided by the Adult Protective Services Workgroup Curriculum Committee:

In addition to those who provided assistance with insuring content was accurate, special thanks to Teri Zuege-Halversen from the University of Wisconsin- Green Bay Office of Outreach and Community Engagement. Teri provided essential guidance in the logistical implementation of the materials for training.

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Joan Groessl, MSW, PhD, LCSW earned her master's degree in Social Work from UW-Milwaukee and PhD from Marian University in Fond du Lac, WI. Joan's research interests center around interprofessional practice and social work ethics and ethical decision-making. Joan has been faculty at University of Wisconsin Green Bay since 2008 teaching a range of courses including *Ethical Issues in Contemporary Social Work*. Joan has extensive experience training in ethics and boundaries for a range of providers. Joan began her social work career as a nursing home social worker and then spent twenty years in the County Mental Health Services as both direct and administrative staff prior to her position with UW-Green Bay. Joan has been an active member of NASW-Wisconsin and is Chair of the Continuing Education Committee. She was selected as a 2017 Path to Licensure scholar through the Association of Social Work Boards. As one of her volunteer activities, Joan also served as a guardian of person and estate for several individuals over a ten-year period.

Brief Training Outline

Day 1: Foundations of Adult Protective Services

Training Objectives

    (1) Describe key statutes and terminology used in the WI Adult Protective Services System.
    (2) Identify types of situations requiring Adult Protective Services involvement.
    (3) Articulate the mission and values of the WI Adult Protective Services System.
    (4) Outline process, forms, and requirements surrounding Adult Protective Services involvement.
    (5) Explain Adult Protective Service's role and interface with other systems
    (6) Examine key ethical issues within Adult Protective Services.
    (7) Assess professional development needs for practice.

Outline

I.   Introduction and Overview of Training

    I.   Mission and Values

    II.   Wisconsin Aging Statistics

    III.   Prevalence of APS Involvement

II.   Nuts and Bolts of Adult Protective Services

    I.   Adult Protective Services System

    II.   APS Terminology

    III.   Identifying Abuse Neglect, Self-Neglect & Financial Exploitation

    IV.   Processes for involvement and service

III.   Statutory Guidelines

    I.   Parameters for Practice
    II.   Key Statutes
    III.   Guardianship & Protective Placement

IV.   Interfacing with other systems

V.   Strategies for Ethical Practice

VI.   Closing

Day 2: Collaborating for Best Practice

Training Objectives

(1) Examine best practice in Adult Protective Services
(2) Outline statutes and administrative codes that intersect with Adult Protective Services practice.
(3) Describe systems of care for vulnerable adults in WI.
(4) Evaluate the impact of cultural differences on practice.
(5) Apply decision-making to challenging situations and ethical dilemmas that arise in Adult Protective Services.
(6) Highlight opportunities for collaboration across systems.
(7) Outline strategies for safety and self-care in practice.

Outline

I.   Overview, Introductions and Brief Review of Prior Training

II.   Collaboration across Systems

III.   Expanding statutory awareness

IV.   Wisconsin's System of Care for Adult Protective Services

V.   Ethical Imperatives

        a. Best Practice in Adult Protective Services
        b. Cultural Competency in Practice
        c. Boundaries for Practice
        d. Safety and Self-Care

VI.   Wrap-up

Day 3: Intervention Strategies in APS

Training Objectives

(1) Complete risk assessments using sample case scenarios.
(2) Identify key components of case planning.
(3) Highlight basic interviewing skills.
(4) Outline documentation requirements and additional reporting.
(5) Apply ethical principles to intervention.

(6) Examine professional development needs for future practice.

Outline

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

Notes to Trainer

Training time

Each training session is designed to be provided in a one-day format. A guideline for scheduling is to plan a 5.5-hour day. Each of the trainings allow for a ten-minute break in the morning and another after lunch. This manual outlines the timing of content to effectively cover the material. Notes are included within the manual for adjustments or timing based on the needs of those receiving the training. Larger groups require additional time when processing the activities.

Target Audience

This training is specifically designed for new Adult Protective Services Staff. County or Tribal agency staff members, or those working closely with the Adult Protective Services System and who provide ongoing case management responsibilities or are responsible for working with older adults or those with disabling conditions may also benefit from the training.

When training is done within a single unit, modifications may be necessary since timing was established for large trainings with multiple county participation. When groups are smaller, the time needed to process an activity is less. The optional activities included in the training can be used to further develop the topics if there is time to include them.

Focus of the Curriculum

This series of training days was developed after consultation with the Adult Protective Services Workgroup and Curriculum Committee created by the Wisconsin Department of Health Services. All material within the curriculum must be included in a training series to ensure that the recommended content is included.

Content is designed to train newly hired Adult Protective Service (APS) workers in a sequential fashion. In other words, day two builds on material covered on day one and day three on that learned in day two.

Training content includes training on ethics and boundaries and will meet the criteria as outlined in MPSW 19 for individuals credentialed as Social Workers, Professional Counselors or Marriage and Family Therapists in Wisconsin. To meet the certification and licensing criteria of four hours of ethics and boundaries, the ethics content within the first two days of the training must be included.

Transfer of Learning

This training aims to introduce participant's to concepts, legal parameters, best practice and ethical skill development for APS workers. The framework for training includes incorporation of the NASW *Code of Ethics*, MPSW 20, and an ethical decision-making model. Activities are designed to assist participants to create a sense of who they are as competent and ethical practitioners.

Trainers

This curriculum can be trained by one trainer. Trainers should have extensive knowledge of APS regulations and practice. Trainers must be comfortable facilitating discussions and demonstrate strengths in identifying ethical issues and resolving ethical dilemmas in practice.

Continuing Education Training Hours

When presented in agency settings, these training session hours would be considered in–house training and development. In order to allow applicability of continuing education hours for practitioner credentials, it is recommended that application be made for approval through the National Association of Social Workers. (According to MPSW 19, only 15 of 30 hours each biennium may be in-house training.)

Training logistics

Timing

This training is scheduled as a 5.5 -hour session (generally 9:00 A.M. – 3:30 P.M.) with two 15-minute breaks and a break for lunch. As this training is designed to fulfill certification/licensing requirements, it is essential to ensure that the allotted hours are provided and that the material is covered.

Participant Numbers

Number of participants to include for the training session is dependent on the comfort level of the trainer as well as space available for training. Since this is a full-day training, it is important that environment be conducive to learning. It is recommended that any agency-based training be held in a location free from the typical work distractions.

Room Requirements

Trainers will need to adapt to various training environments, which are arranged by the agency. Seating should accommodate all participants and at a minimum provide space for trainer/equipment and allow small group interaction. Ideally, tables would be arranged in groups of 4-6 to allow small group activities. See section below for details.

Materials and Equipment Requirements

Specific materials for each of the training days are identified in subsequent sections of this manual. For all trainings, the following are required:

- Laptop and LCD projector for the trainer.
- Speakers
- Table for trainer's materials and media equipment in front of the room.
- Screen
- Extension cords/ power strip
- Podium (if possible)
- Registration table near the door

Trainings do include videos which can be obtained via You Tube or other sources as identified in the manual. If broadcasting directly from You Tube, internet access is required.

Handouts and Materials

Participants should be given a folder with handouts. The specific contents to be included for each training day are outlined within the section explaining each day of training.

It is recommended that multiple colors be used when printing off handouts. Although all handouts are numbered, navigation within the training occurs more easily with various colors for those handouts that participants will use for group discussions within the training. Trainer can then hold-up the colored handout as a demonstration of the handout to be used as the time of the group activity.

Optional Material

This curriculum was piloted during in 2018. Changes in content which resulted during that series of trainings have been integrated into this manual. There are activities which were removed or substituted. Within this manual, you will find that material identified in the manual. Either activity will meet the learning objectives for the training and allows for some flexibility in content.

Day 1: Foundations of Adult Protective Services Curriculum Overview

Curriculum Timing (330 minutes)

Module 1- Introduction to Training .... 35 minutes

Module 2- Nuts and Bolts of Adult Protective Services .... 60 minutes

Module 3- Statutory Guidelines .... 110 minutes

Module 4- Interfacing with other systems .... 25 minutes

Module 5- Strategies for Ethical Practice .... 90 minutes

Module 6- Closing .... 10 minutes

*Break (2-10 minute) .... 20 minutes

Learning objectives

Module 1- Introduction to Training

- Articulate the mission and values of the WI Adult Protective Services System.
- Assess professional development needs for practice.

Module 2- Nuts and Bolts of Adult Protective Services

- Identify types of situations requiring Adult Protective Services involvement.
- Outline process, forms, and requirements surrounding Adult Protective Services involvement.

Module 3- Statutory Guidelines

- Describe key statutes and terminology used in the WI Adult Protective Services System.
- Identify types of situations requiring Adult Protective Services involvement.
- Outline process, forms, and requirements surrounding Adult Protective Services involvement.

Module 4- Interfacing with other systems

- Explain Adult Protective Service's role and interface with other systems.

Module 5- Strategies for Ethical Practice

- Examine key ethical issues within Adult Protective Services.
- Explain Adult Protective Service's role and interface with other systems.
- Identify types of situations requiring Adult Protective Services involvement.

Module 6- Closing

- Assess professional development needs for practice.

List of handouts

Module 1- Introduction to Training

- Handout Packet
- Handout 1.1: Agenda and Learning Objectives

Module 2- Nuts and Bolts of Adult Protective Services

- Handout 1.2: Indicators of Elder and Adults at Risk Abuse, Neglect, and Self-Neglect
- Handout 1.3: Case Study: Mr. Adams
- Handout 1.4: Getting the STORY

Module 3- Statutory Guidelines

- Resource: CH 46.90 Elder Abuse Reporting System

Module 4- Interfacing with other systems

- Handout 1.5: Community Partners

Module 5- Strategies for Ethical Practice

- Resource: Code of Ethics
- Resource: MPSW 20

Module 6- Closing

- Handout 1.6: Evaluation

Advanced Preparation
- Copies of *Current Challenges in Practice Worksheet* should be placed in the center of the tables prior to beginning training

Daily Timing

Day 1: Foundations of Adult Protective Services

This is based on a 9:00 AM – 3:30 PM training day with two 10-minute breaks and one 45 minute lunch break. Timing is approximate.

9:00 am – 9:40 am……………….. Introduction to Training (Module 1)

9:40 am – 10:40 am………………Nuts and Bolts of APS (Module 2)

10:40 am – 10:50 am…………….. Break

10:50 am – 12:00 pm……………. Statutory Guidelines (Module 3)

12:00 pm - 12:45 pm…………….Lunch

12:45 pm – 1:05 pm………………Statutory Guidelines (continued)

1:05 pm – 1:45 pm……………….. Interfacing with other systems (Module 4)

1:45 pm – 3:15 pm……………….. Strategies for Ethical Practice Module 5)

[We will break for ten minutes during this portion of the training.]

3:15 pm – 3:30 pm………………. Closing (Module 6)

Module 1 – Introduction to Training Overview

Timing (40 minutes max.)

Learning objectives

- Articulate the mission and values of the WI Adult Protective Services System.

Advance preparation

- Copies of *Current Challenges in Practice Worksheet* should be placed in the center of the tables prior to beginning training.

Handouts

- Handout 1.1: Agenda and Learning Objectives

PowerPoint slides

- Slides 1 - 16

Module 1 – Introduction to Training

- Slides: 1 – 16

- Handouts: Handout 1.1 Learning Objectives and Agenda

A. Introduction

Display **Cover Slide** (Slide 1).

Explain that this is day one of three days of APS curriculum. Each day will build upon each other.

Display **Overview and Foundation of Training** (Slide 2).

Explain the development of the training:

The Department of Health Services pulled together a dedicated group of APS professionals who identified curriculum needs for APS training. Joan Groessl, a professor of Social Work at the University of Wisconsin-Green Bay developed the training using content identified by the APS workgroup. Some components of the training were drawn from already existing materials through the National Adult Protective Services Association. Grant funding for curriculum development was awarded to the Office of Continuing Education and Community Engagement at the University of Wisconsin- Green Bay by the Department of Health Services.

This training is designed to provide foundational knowledge of systems for practice by Adult Protective Services professionals in Wisconsin. Each county or

tribe may have variations in process, but the general concepts as presented meet best practice standards in WI.

Display **Sponsorship & CEH** (Slide 3).

Slide explains that curriculum was developed through the University of Wisconsin-Green Bay.

Note: If approval for the training was not obtained through the National Association of Social Workers, explain that the training is considered "agency-based training". MPSW 19 allows 15 of the 30 required continuing education hours through in-house training and development programs [See MPSW 19.03(1)(f).]

Explain total hours of training for the day (5.5). Today's training will provide 1.5 hours training in ethics and boundaries. Wisconsin MPSW 19 requires a total of four hours of ethics and boundaries in each certification/licensure biennium. Attending the first two days of training will insure the individual has participated in the four hours required ethics and boundaries.

Discuss requirements for keeping training materials in the event of an audit. Professionals have failed certification/licensing audits because they have not received or documented four hours of training—to obtain the total four hours, must attend Day 1 and Day 2 of the trainings.

B. Trainer Introductions

Briefly introduce self to the training participants. Emphasize your background and relevant experience.

C. Housekeeping

Review any housekeeping reminders specific to the training site (locations of rest rooms, how to request temperature changes).

Provide any housekeeping information specific to the training. For example, technology policy, evaluations, emergency contact information, etc.

D. Agenda and Learning Objectives

Display **Learning Objectives Slide** (Slide 4).

Review objectives using slide and participant handout packet.

The Learning Objectives are listed below:

- Describe key statutes and terminology used in the WI Adult Protective Services System.

- Articulate the mission and values of the WI Adult Protective Services System.

- Identify types of situations requiring Adult Protective Services involvement.

- Explain Adult Protective Service's role and interface with other systems.

- Outline process, forms, and requirements surrounding Adult Protective Services involvement.

- Examine key ethical issues within Adult Protective Services.

- Assess professional development needs for practice.

Display **Training Agenda Slide** (Slide 5).

Explain that there will be two breaks and lunch. There is some flexibility in the timeline within the agenda. Morning break will occur around 10:40.

E. Participant Introductions

Display **Introductions Slide** (Slide 6).

Ask participants to introduce selves to each other. Ask to start that introduction with explaining the numbers of years each has worked in APS. After we have finished the introductions and the activity, we will tally the years of experience for the participants of the training.

[Note to trainer: These tallies can be used when dividing up case studies to ensure that those tables with higher levels of experience are provided the more difficult case studies for discussion.]

Note: When training involves smaller numbers (30 or less), introductions by going around the room may be preferred since people tend to sit with those they know. Slide may be modified according to the form introductions will take.

Small Group Activity:

Using the worksheet, *Current Challenges in Practice Worksheet,* discuss areas of practice that you find challenging. After about 5 minutes, trainer will collect the worksheets. They will be reviewed so that participant interests/concerns are addressed within the course of this training or the subsequent two days of training if the topics are not covered today, if possible.

F. Mission and Values of Adult Protective Services

Display **Values and Principles Outlined by the National APS Association** (Slide 7).

Review the material on the slide.

All actions of APS balance the right to self-determination with the duty to protect. These two issues can create dilemmas in practice. We will examine these later today in the training.

A secondary value relates to the integrity with which we approach those we serve—honesty, caring, and respect are central characteristics we bring to the helping relationship.

We apply guiding principles to our practice that recognizes the interests of the adult are the first concern of any intervention.

Through all steps in the helping process, we apply these principles through the commitment to our clients. Respect includes recognizing individual differences such as cultural, historical, and personal values. As part of this respect we avoid imposing our personal values on others. If the individual is not able to voice his or her wishes, casework actions are supported that are in the adult's best interest. Substituted judgment by others who know the client's wishes and history is used when needed to insure the values are reinforced.

As key to respect of clients, we seek informed consent from the adult before providing services, respect the right to keep personal information confidential, and honor the right to receive information about their choices and options in a form or manner that they can understand.

We focus case planning on strategies that maximize the vulnerable adult's independence and choice to the extent possible based on the adult's capacity, including using the least restrictive services first whenever possible—community-based services rather than institutionally-based services. We use family and informal support systems first as long as this is in the best interest of the adult but to the best of one's ability, the client is involved as much as possible in developing the service plan.

In all interactions, we maintain clear and appropriate professional boundaries. The underlying premise of "Do no harm" is at the core of the helping relationship and any interventions selected.

Display **National Prevalence of Elder Abuse** (Slide 8)

According to the most recent figures from the National Coalition on Aging, approximately 1 in 10 Americans aged 60 or older—the statutory reporting requirement— have experienced some form of elder abuse. Some estimates range as high as 5 million elders who are abused each year. One study estimated that only 1 in 14 cases of abuse are reported to authorities.

Abusers are both women and men. In almost 60% of elder abuse and neglect incidents, the perpetrator is a family member. Two thirds of perpetrators are adult children or spouses.

Elders who have been abused have a 300% higher risk of death when compared to those who have not been mistreated. While likely underreported, elder financial abuse and fraud costs older Americans $36.5 billion per year. Yet, financial exploitation is self-reported at rates higher than emotional, physical, and sexual abuse, or neglect.

<u>Ask</u>: ***What factors do you think are contributing to these numbers?***

Solicit answers such as (1) Growing numbers of older adults, (2) The stress of work-family obligations, (3) Some because of the limited training and recognition of paid caregivers, (4) Family distance-mobility of people in global economy, (5) Growing technological advances and limited knowledge by a population not raised with technology

<u>Ask:</u> ***Why might so few report?***

Answers may be: (1) Fear of retribution, (2) Isolation, (3) Lack of awareness of options, (4) Value base (self-determination, independence, how see seeking help), and (5) cultural factors.

 We will talk more about this topic later.

G. Picture of APS in WI

Note slides in this section should be modified as more recent numbers are available.

Display **Picture of APS Services in WI** (Slide 9).

So let's talk about APS in Wisconsin. This slide outlines the statistics of the most recent year available. As you can see, reports of abuse are increasing, and over half are people new to the system. Serious injury and death occur in a significant number of referrals. The next slide explains the nature of the 8874 reports investigated.

Display **By the Numbers Statewide** (Slide 10).

This slide shows that almost one-quarter of the total reports were adults aged 18 -59. The vast majority were for self-neglect. We will talk about the types of APS referrals as we progress through this training.

The next several slides are added to give a picture of what is happening demographically in WI. We know that these demographics will impact how we provide services in the upcoming years.

Display **Percent of Population 65 or Older** (Slide 11).

This slide shows population over age 65 by county.

Can you find your county? As you can see, some counties are currently at up to 43% and the county with the fewest is St. Croix County at 11% of individuals over age 65.

Display **Projections by 2020** (Slide 12).

This slide shows the percent of the population that was age 65 or older in 2015. You can see that the majority of counties range from 12-21% although the percentage in the northern counties of Wisconsin is higher. The darkest blue is 27% to a high of 43%. (Remember, reporting requirements begin at age 60).

Note: Slides 11 and 12 can be combined to "Current Population" as 2020 numbers are released

Display **Projections by 2040** (Slide 13).

And this slide shows projections—almost all counties will have at least 21% of the population age 65 or older.

Ask: ***What do you think that means for the county or tribal system you work in? What kind of adjustments do you think will need to occur to the APS system?***

The flip-side of these numbers are that if almost half are age 65 or older, only slightly over half are aged birth to age 65! I guess this is one reason that we will be expected to retire at older ages—there will definitely be a workforce shortage.

Display **Wisconsin Dementia Population Projection** (Slide 14).

The Department of Health Services has evaluated dementia care services in WI. This slide looks at the proportion of those with dementia in Wisconsin in 2015 who rely on public funding. One-quarter of the 115,000 people use Medicaid to meet their care needs. It is important to note that these statistics refer only to those individuals who have diagnosed, we expect the numbers to be much higher than presented here.

We know that poverty is connected to higher health care needs. With increasing numbers of people over age 65, we can also anticipate more individuals needing public assistance. Since non-institutional care is more cost

effective, we will need to develop strategies to support those who are providing care to insure the safety and protection of these vulnerable elders.

Display **Projection of WI Population with Dementia** (Slide 15).

This slide highlights the estimated numbers from 2015 to 2040 in five-year increments. (The lightest blue is the number who will need Medicaid).

Of course, APS does not serve only those who are aged—individuals who are disabled at younger ages are also under the auspices of the Adult Protective Services System.

Display **Disability Numbers for WI** (Slide 16).

This slide shows the types of disability statuses for individuals under age 65 that were reported by the Wisconsin Department of Health in 2016. Almost 10% of the population has a disability with the most common being ambulation and cognitive difficulties.

We cannot assume that all individuals with disabilities are in need of protective services, but these conditions can increase the vulnerability of individuals. When we combine disability issues, poverty, and stress of caregiving, we increase the risk of neglect or abuse.

So, with this overview of the numbers, we can start to talk about the nuts and bolts of APS.

[End of Module]

Module 2 - Nuts and Bolts of Adult Protective Services Overview

Timing (60 minutes max.)

Nuts and Bolts .... …....60 minutes total

      Adult Protective Services System …………………………………………….5 min

      APS Terminology …………………………………………………………… 15 min

      Identifying Abuse Neglect, Self-Neglect & Financial Exploitation……30 min

      Processes for involvement and service…………………………………<u>10 min</u>

                                                  60 min

Learning objectives

- Identify types of situations requiring Adult Protective Services involvement.
- Outline process, forms, and requirements surrounding Adult Protective Services involvement.

Handouts

- Handout 1.2: Indicators of Elder and Adult-at-Risk Abuse, Neglect, and Self-Neglect
- Handout 1.3: Case Study: Mr. Adams
- Handout 1.4: Getting the STORY

PowerPoint slides

- Slides 17 – 28

Other

- Flipchart and easel is needed

Timing (60 minutes max.)

A. Adult Protective Services System ……………………………………………….5 min

B. APS Terminology …………………………………………………………… 15 min

C. Identifying Abuse Neglect, Self-Neglect & Financial Exploitation……30 min

D. Processes for involvement and service……………………………………10 min

60 min

Handouts

- Handout 1.2: Indicators of Elder and Adult-at0Risk Abuse, Neglect, and Self-Neglect
- Handout 1.3: Case Study: Mr. Adams
- Handout 1.4: Getting the STORY

PowerPoint slides

- Slides 17 – 28

Display **Nuts & Bolts** (Slide 17. [This is a transition slide.]

This training cannot provide full skill development for APS workers; many states require a minimum of 40 hours of training. We will touch on significant functions of adult protective services. This module highlights the core elements—language we use, how to identify those in need of service, and a brief overview of the processes we use.

A. Adult Protective Services System

Display **Adult Protective Services System** (Slide 18).

In Wisconsin, the Wisconsin Department of Health Services is ultimately responsible for oversight of the adult-at-risk system. DHS assures the availability to all individuals when in need of them, and to place the least possible restriction on personal liberty and exercise of constitutional rights consistent with due process and protection from abuse, financial exploitation, neglect, and self-neglect (55.001).

We are a county-operated state which means that each county develops a system in accordance with the needs of the county. In addition, tribes may have their own established systems by contract for some services through counties.

CH 55 creates the requirement for County Boards to designate an Adult-at-Risk Agency to receive, respond to, and investigate reports of abuse, neglect, self-neglect, and financial exploitation.

CH 55 outlines due process rights for protective services and works in concert with CH 54 (which governs guardianships).

Of course, for any system to work effectively, there also must be funding appropriated. Under CH 46, the language states: "The department shall ensure that each aging unit receives funds and shall take into account the proportion of the state's population of low–income older individuals who reside in a county" (CH 46, p 72).

Display **APS Goals/ Responsibilities** (Slide 19)

The National Association of Adult Protective Services' mission and principles highlighted earlier lead us to understand the goals and responsibilities of APS.

Following the practice principles, APS workers seek to achieve multiple goals:

(1) Ensure safety- this can be done by strengthening care giving systems, ensure that elders who are unable to make critical decisions have trustworthy surrogates.

(2) Promoting self-determination- which includes maximizing independence, empowering, and supporting victims and their decision-making.

(3) Intervention on behalf of clients who cannot protect themselves- resolving crises, preserving, protecting and recovering assets, ensuring justice and hold perpetrators accountable. Perhaps, a most important responsibility includes provision of resources to treat the physical, financial, and emotional effects of abuse as well as reducing the risk of abuse and neglect.

Display **Roles within APS in WI** (Slide 20).

Wisconsin statutes outline what "protective services" are. (CH 55)

Ask: ***What are the items listed by statute as protective services?***

Write down responses on flip chart.

6r) "Protective services" includes any of the following:

(a) Outreach.

(b) Identification of individuals in need of services.

(c) Counseling and referral for services.

(d) Coordination of services for individuals.

(e) Tracking and follow–up.

(f) Social services.

(g) Case management.

(h) Legal counseling or referral.

(i) Guardianship referral.

(j) Diagnostic evaluation.

(k) Any services that, when provided to an individual with developmental disabilities, degenerative brain disorder, serious and persistent mental illness, or other like incapacity, keep the individual safe from abuse, financial exploitation, neglect, or self–neglect or prevent the individual from experiencing deterioration or from inflicting harm on himself or herself or another person.

This slide also outlines three key roles for APS in Wisconsin—investigation and intervention in cases of abuse or neglect, guardianship activities, and case management to adults-at risk.

B. APS Terminology

Display **Definition for Practice** (Slide 21)**.**

These are key terms used in Adult Protective Services. I would like you to pull out your copy of CH 46.90.

<u>Ask:</u> _Who can read me the definition of adult at risk?_

This is a trick question! Note that the statute refers to elder-adult-at risk. When initially created, services were designed for those ages 60 or older.

"Elder adult at risk" means any person age 60 or older who has experienced, is currently experiencing, or is at risk of experiencing abuse, neglect, self–neglect, or financial exploitation.

Adult-at-risk is defined in CH 55:

> "Adult at risk" means any adult who has a physical or mental condition that substantially impairs his or her ability to care for his or her needs and who has experienced, is currently experiencing, or is at risk of experiencing abuse, neglect, self–neglect, or financial exploitation.

Ask: *What is a key feature when we are defining physical abuse?*

> (fg) "Physical abuse" means the intentional or reckless infliction of bodily harm. "Bodily harm" means physical pain or injury, illness, or any impairment of physical condition

Ask: *How about the definition for neglect?*

> (f) "Neglect" means the failure of a caregiver, as evidenced by an act, omission, or course of conduct, to endeavor to secure or maintain adequate care, services, or supervision for an individual, including food, clothing, shelter, or physical or mental health care, and creating significant risk or danger to the individual's physical or mental health. "Neglect" does not include a decision that is made to not seek medical care for an individual, if that decision is consistent with the individual's previously executed declaration or do–not–resuscitate order under CH. 154, a power of attorney for health care under CH. 155, or as otherwise authorized by law

What do you think are the key words or phrases to remember in that definition?

Failure to act—can be through omission. Adequate care and supervision. Significant risk or danger.

Note*: It is likely that the ambiguity of the underlined words also relates to some of the challenges that are identified by attendees. If so, refer to those challenges for further discussion.*

Remember from our earlier statistics, self-neglect is the most common reason for APS intervention in Wisconsin.

Ask: *Who can read the definition for self-neglect?*

> (g) "Self–neglect" means a significant danger to an individual's physical or mental health because the individual is responsible for his or her own care but fails to obtain adequate care, including food, shelter, clothing, or medical or dental care.

Ask: *When you think of situations you have investigated, in what ways has self-neglect been demonstrated?*

Attendees might answer—some combination of poor hygiene, squalor in and outside their dwellings, a lack of utilities, an excess number of pets, and inadequate food. Hoarding?

Ask: *What kind of factors can play into whether self-neglect is or is not substantiated when you investigate these cases?*

Look for answers such as:

- Medical problems (dehydration, undiagnosed or difficult to manage health conditions, or conditions that have resulted in significant levels of impairment).
- Mental health or substance Use issues.
- Diminished capacity such as dementias. (Depression can mask as dementia and should be assessed thoroughly since depression is treatable).
- Problems with medications and their administration—often linked to dementia symptoms.
- Environmental problems—unsafe or unhealthy living arrangements.
- Social or cultural considerations—when the individual is neglecting self to benefit other family members. This may have a cultural foundation and may also have financial implications.
- Lack of caregivers.

Both neglect and self-neglect are the absence or the breakdown of care giving systems. This may be because the caregiver is overwhelmed, or the family system is not functioning properly, or other caregivers are more concerned with self-interest. (I think we see this in cases of financial exploitation). Self-neglect is most often an individual who is alone without support and unable to meet his or her own needs, or one who refuses care.

Level of social support is a critical determinant in self neglect—even with significant impairments, people can function well if they have support; and minor challenges may have significant consequences for someone who does not have support.

This slide also highlights financial exploitation as another area where intervention is needed. As you can see by the definition in CH 46, there are a range of activities that are included in the definition.

> "Financial exploitation" means any of the following:
> 1. Obtaining an individual's money or property by deceiving or enticing the individual, or by forcing, compelling, or coercing the individual to give, sell at less than fair market value, or in other ways convey money or property against his or her will without his or her informed consent.
> 2. Theft, as prohibited in s. 943.20.
> 3. The substantial failure or neglect of a fiscal agent to fulfill his or her responsibilities.
> 4. Unauthorized use of an individual's personal identifying information or documents, as prohibited in s.943.201.
> 5. Unauthorized use of an entity's identifying information or documents, as prohibited in s. 943.203.
> 6. Forgery, as prohibited in s. 943.38.
> 7. Financial transaction card crimes, as prohibited in s. 943.41.

CH 943 refers to the broad category of "Misappropriation"—this is a good term to remember when thinking of financial abuse.

C. Identifying Abuse Neglect, Self-Neglect & Financial Exploitation

Display **Case Examples** (Slide 22).

Self-neglect cases encompass a wide range of situations. Here are some examples:

As you read each case example, ask how it connects back to the definition of abuse.

- Mr. Saunders is alert and oriented but suffers from short-term memory loss. He has neglected to pay his bills.
   [Does not meet criteria, intervention could be to assist in developing memory aids, referral to assistance in doing so.]

- Mrs. Anderson suffers from alcohol related dementia, which is mild when she is sober and extreme when she is intoxicated. She knows she has heart problems but denies the seriousness of her condition and refuses to go to a doctor.
   [Self-neglect, failure to treat medical condition.]

- Mr. and Mrs. Hubbard both suffer from dementia. Both are disheveled, thin, and dirty. They are refusing APS.
   [Self-neglect; meets criteria for intervention]

- Mrs. Jones' phone, gas, and electricity have been turned off because she hasn't been paying her bills. She has become increasingly isolated. She smokes and sometimes forgets that she's left a cigarette burning in the ashtray.

    [Potentially meets criteria, needs further investigation]

- Robert Stevens is 53 years old and suffers from a dementia due to a brain injury. He also has cancer. He is not able to follow instructions or cook for himself. He recently was hospitalized for dehydration. The discharge planner did not want to let him go home alone without help, but he refused services.

    [Signs of self-neglect: cognitive issues, dehydration. Need further evaluation regarding dementia (health factors may be causing.]

- Mrs. Graves lives with her son who abuses substance and has schizophrenia. He refuses to allow visitors into the home and has had the phone disconnected. Mrs. Graves is afraid of her son, but refuses help because she feels that he is her responsibility.

    [Abuse suspected as is isolating her. Involving mental health professionals will help in meeting his needs as well]

When looking at financial abuse and exploitation, there are several profiles that can lead to an individual being exploited:

- The adult who is physically or emotionally dependent on a family member, friend, or caregiver may become a "financial prisoner."

- An adult may find it increasingly difficult to manage finances and will turn for help to someone they trust. This adult recognizes there is a change and seeks help while they still have some ability to manage financial matters.

- The adult who is clearly confused before family or friends become involved. This adult may not recognize changes have occurred and a problem exists.

- Some cases develop after death of a spouse; these cases involve persons of long marriages whose spouses ran the family finances. This adult may be experiencing profound loss, loneliness and depression

You have a handout, *Handout 1.2: Indicators of Elder and Adult at Risk Abuse, Neglect, and Self-Neglect*. It outlines things to look for when assessing client situations. It will also be helpful as we work through the next activity. We will refer back to this throughout the day's training.

So, let's take a few minutes to talk about another case study.

Pull out the *Handout 1.3: <u>Case-Study Mr. Adams</u>*.

In your small groups, I would like you to read the case study together. Then, identify the types of abuse you suspect.

The table below the scenario contains Wisconsin's definitions. Together, discuss indicators for the types of abuse you suspect—we will come back together to discuss once you have had an opportunity to work this one through.

You have 10 minutes.

Once groups have worked out their answers, discuss as a group.

Answer key:

<u>Physical abuse:</u> Mr. Adams is being deprived of water. Mr. Adams is being physically restrained. Mr. Adams is not getting enough to eat.

Concerns:

Prolonged or continual deprivation of food or water is part of the definition of physical abuse. However, there may be other reasons that Mr. Adams drank so much water when his neighbor visited.

- *Diabetics drink more than others.*
- *It may have been a very hot day.*
- *Failing to leave him water may have been a one-time omission.*
- *Besides the fact that Mr. Adams has limited mobility due to his wheelchair, there is no indication that his daughters are intentionally limiting his physical activity.*
- *Failure to provide adequate food falls under both physical abuse and neglect. Mr. Adams may be losing weight because he is not eating enough. However, this could be because:*
- *He has been ill and has no appetite.*
- *The family income is limited and no one in the family is getting enough to eat.*
- *The daughters are not giving him enough food.*

<u>Financial Abuse</u>: there are no indicators, but you may want to ask whether the daughters are being paid to provide care, whether Mr. Adams is brining money into the household or whether the daughters are expecting and inheritance.

Neglect: On the face of the allegations, neglect is the most obvious type of abuse that Mr. Adams is experiencing. Mr. Adams has lost weight. Mr. Adams is sleeping on the couch. Mr. Adams is left sitting, without care, for long periods. Mr. Adams' hygiene is not being attended to.

Concerns:

Failure to provide adequate food falls under both physical abuse and neglect. Mr. Adams may be losing weight because he is not eating enough. However, this could be because:
• He has been ill and has no appetite.
• The family income is limited and no one in the family is getting enough to eat.
• The daughters are not giving him enough food.
- Because of Mr. Adams age and health problems, sleeping on the couch is not a good long-term plan. This, taken by itself, is not neglect but is a warning sign and more questions need to be asked.
- Left sitting without care for long periods is definitely an indicator of neglect and a concern due to Mr. Adams health problems and his inability to provide his own care. This could have serious consequences, however, keep in mind that Mr. Adams may be refusing care.
- Failure to provide needed help with hygiene is neglect. And, given Mr. Adams' diabetes, skin breakdown is a serious concern.

Display **Neglect and Self-Neglect…Systems** (Slide 23).

Neglect, particularly self-neglect, is the most common reason for referrals to Adult Protective Services. Early research into elder abuse concluded that caregiver stress was the primary cause of the problem. It suggested that an overwhelmed, stressed caregiver providing assistance to a frail older person might sometimes unintentionally "snap" and become abusive or neglectful. More recent and reliable research found that abuse is more closely related to the characteristics of the abuser than to the care needs of the victim. While caregiving is often stressful, most caregivers do not abuse the care receivers. Instead, they provide loving and lifesaving care, often for many years, and frequently with significant costs to their own health and wellbeing.

When we are examining neglect by a caregiver, this neglect may occur because the caregiver lacks understanding of the victim's needs or is not trained. The caregiver may be physically, mentally, or emotionally incapable of adequate providing care or does not have a clear understanding of or agreement about the victim's expectations. Often the caregiver lacks resources and/or social supports. (These are reflected by the first two bullets on the slide).

Caregivers with good intentions may neglect their loved one due to a range of conditions. These may include caregiver's own frailty, physical Illness, dementia, mental Illness, substance use, or disability. Services provided then must address both the victim and the one who was caring for him or her.

The self-interested caregiver may use rationales and excuses such as caregiver stress to deflect responsibility from themselves, and to convince investigators not to hold them accountable for their actions. The abusers may be willing to talk about their behavior believing that if they explain it, others will buy into their reasons for why the abuse was unavoidable.

Criminal Neglect=Serious Bodily Injury.

Social Service professionals assess for the necessary services that need to be put in place. Criminal Justice System assesses the possibility of a crime and prosecutes criminal actions.

Wisconsin does have a **criminal statute** for caregiver neglect.
Neglect that results in serious harm or death to the victim may be chargeable under criminal law. A conviction of a charge of serious bodily injury may result in criminal penalties.

Wisconsin Statutes 940.285(2)(a)3. Refers to Negligent Maltreatment of a Vulnerable Adult- resulting in Bodily Harm, a class A misdemeanor. The first time this was charged in Wisconsin was in Brown County Court in 2003 [State of WI vs. Dean Krause].

In that case, the caregiver had repeatedly refused interventions on behalf of the vulnerable elder. He also took possession of his home by having him change his will to transfer the assets to him. Authorities were alerted to a need for intervention by the Electric and Water Company representative who was concerned with the lack of usage as the winter months were upcoming. The victim died in the home and only after death did the caregiver call for assistance. Court ruled he should have known to seek help based on the emaciated condition of the victim. He was ordered to 200 hours community service in lieu of $2000. Due to failures to complete the hours timely, he eventually completed 400 hours of community service, and paid $6675 in court fees. The case was closed six years after initial appearance. (The DA prosecuting the case is now a federal judge).

Display **Types of Neglect** (Slide 24).

When intervening in cases of caregiver neglect, emergency intervention is warranted when there is: Unsafe living environment, malnutrition; dehydration; lack of medical care—untreated medical conditions, over or under medication, abandonment, skin breakdown/decubitus ulcers.

Other indicators of neglect (either caregiver or self-neglect) can include poor personal hygiene, inappropriate clothing; or isolation.

Ask: *What do you see in your practice as the most common indicators of neglect or self-neglect?*

D. Processes for involvement and service

Display **Process** (Slide 25).

Let's quickly go through the process of APS intake, investigation, and service planning.

Intake is the gathering of sufficient information to determine if an investigation is required including: locating the identified individual and indicating how emergent the needs may be.

Intake sets the tone for an introduction to the agency and program. It serves to obtain the most relevant information on the situation and to determine if the situation meets the criteria for APS investigation. As part of the intake, it is important to provide clear explanations to the reporting party.

Educate the referrer about:
- confidentiality,
- anonymity,
- response time,
- what constitutes APS,
- what the process is,
- whether case will or won't be evaluated and why,
- other agencies that might be more appropriate to answer their concerns.

It is important that you don't take attacks personally.

Intake process requires workers to use:
- empathy
- demonstrate patience and perseverance
- listening skills
- questioning skills
- clear, non-threatening, non-lingo communication.

Investigation

What do you sense about the case? More experience, leads to more instincts.
Call back referrer for clarification if necessary - especially if you did not take the
report.

Prepare in advance when possible. Find out as much information as possible
given the referral information -Where could you go to get info on services,
financial status, and medical insurance? Has anyone else ever worked with
client or family? How much checking with collaterals do you do before the visit?

Given the information, what possible service needs are there? Fill your bag of
tricks with possibilities - although these could change as soon as you see client.
If client is described as developmentally disabled, check with Developmental
Disability Services to see if they have an active case. A joint visit may be helpful.

If you feel anxious about the visit, discuss it with your supervisor.

Joint initial visits with other agencies or family members may be frowned upon.
Worker needs to make his or her own assessment and not be influenced.

Decide type of visit:
      (1) Announced or unannounced
      (2) Alone or in team
      (3) Visit with other person (home health aid, neighbor, family member)
      (4) In client's home or somewhere else.

Prior history of abuse—Prior knowledge to APS—Prior/present law enforcement
involvement—Existing court orders—Public records.

Service Planning
Services previously used: outcomes, issues—Potential services based on income
and described need—Cultural issues and availability of interpreter—Possible
access issues.

Display **Getting the S.T.O.R.Y** (Slide 26).

The NAPSA core curriculum used this pneumonic when discussing what
information needs to be gathered.

The STORY approach is one way to remember the most important information to
obtain from the reporting party. Every reporter has a unique relationship with
the person being referred. Some know the victim well, some hardly at all. There

are many reasons for reporting a case to APS, most very legitimate, some questionable. Therefore, the information available will vary greatly and the worker's expectations should not be too high. Using the STORY approach will help intake workers as well as front line APS workers preparing for the initial visit to focus and make the most out of the interview with the reporter. There may be only one chance to obtain information, so it is crucial that those speaking to reporters make the most out of the call. "STORY," serves as a guide and also reminds workers to listen patiently, communicate clearly, and try to get the big picture along with as many details as are available.

Specifics: Identifying info, directions to the house, where the entrance is, are there animals, does anyone else live in the house?

Tale: What happened? How long has it been going on? Why are they referring it now? What efforts have been made to address the problem? Details of allegations: who, what when, how? Witnesses, Description of client (physical, mental, past psychiatric history, substance abuse history), client's ability to care for self, defend self. Information about perpetrator. How much at risk is client? Is this an emergency? Why?

Others: Environment and Support System - condition of home, income, doctor, hospitalization, pharmacy, meds, other agencies involved, family members involvement, how client gets food, transportation, manages money.

Referral source: relation to client or perpetrator, identifying information, ask about need for anonymity, explain that even though you will not reveal referrer's name, client may suspect. Discuss expectations - what does referrer want to happen - is this realistic? Would referrer be available for helping gain access if necessary?

Yes or No: Does case meet criteria for an APS evaluation? If so, explain what will happen. If not, explain why and what you suggest (other referral, police,)

You have a handout (*Handout 1.4*) in your packet that spells out the components of STORY. This is a nice reminder for those of you who are fairly new to APS.

Display **Screen in or Out** (Slide 27).

One of the reasons it is important to know the statutes is to determine if a situation meets the criteria to proceed.

According to NAPSA, in the APS Jurisdictional Survey, vignettes were shared with many APS programs to determine when a case would be screened in or

screened out. Results showed a wide variation among programs and confirmed that different programs were using different criteria to make the decision if a case should be screened in. There seems to be a lot of room for interpretation, so it is important for assigned APS workers not to argue with the intake worker who may not know all the nuances of APS work or with the supervisor who may have a different interpretation of the intake information. The supervisor also may be pressured by the nature of the referral source: there may be influence from "above." It is best to discuss the information with the supervisor to obtain his/her "take" on it.

Display **Consultation/Support/Back-Up** (Slide 28).

As part of any investigation for adult-at-risk, we solicit input from those who may have information to "fill in the gaps" and give us a better picture about the individual's functioning, risk, and actions we can take.

Ask: *Can you think of anyone besides those listed on this slide that you typically would consult in the process?*

This is all we are going to talk about the process for now. In future trainings, we will talk more and go through some examples as we move from intake to investigation and service provision.
Of course, case investigation is only one piece of APS work. As we talk more about the statutes themselves we will discuss guardianship and protective placements.

[End of Module]

Module 3: Statutory Guidelines Overview

Timing (90 minutes max.)

Parameters for Practice……………………………………………………50 min
Key Statutes Overview …………………………………………………...30 min
Guardianship & Protective Placement …………………………………10 min

90 min

Learning objectives

- Describe key statutes and terminology used in the Adult Protective Services System in WI.
- Identify types of situations requiring Adult Protective Services involvement.
- Outline process, forms, and requirements surrounding Adult Protective Services involvement.

Advance preparation

- Each table should have Match Game sheets and envelopes with options, statutory code; scotch tape for attaching to the sheets.
- Capacity Case Study- Create packets with one Leader Case Study and one of the Capacity Case Study Handouts (6A-6E) to be handed to the groups when the activity is conducted.

Handouts

- Handout 1.5: Case Scenarios
- Handout 1.6A- 1.6E: Capacity Case Study [Not in participant packet]
- Handout 1.7: Interviewing for Capacity
- Handout 1.8: Due Process

PowerPoint slides

- Slides 29- 49

Other

- Flipchart is needed

Module 3: Statutory Guidelines

- Slides 29-49
- Handouts:
    - Handout 1.5: Case Scenarios
    - Handout 1.6A – 1.6E: Capacity Case Study [Not in participant packet]
    - Handout 1.7: Interviewing for Capacity
    - Handout 1.8: Due Process

A. Transition

Display **Statutes** (Slide 29).

We have talked about definitions that are outlined by statutes. For the next ninety minutes or so we will talk about components of the statutes that govern Adult Protective Services Practice.

Before we go further, though, we have a short video that highlights the value of APS

Display **Protection of Vulnerable Adults** (Slide 30).

Video can be obtained from: https://www.youtube.com/watch?v=2Kj4l_6oyZM [5:30]

This video was selected as it represents how a situation affects an adult-at-risk (to reinforce the fact that APS in WI also serves those below age 60). The need for others to intervene when an individual is unable to do so for him or herself, or who may not have any awareness that the abuse is not "normal", requires courage to "get involved".

In situations of elder abuse, allowances are made for family members who abuse, who take money from them, or act disrespectfully to them. They may refuse help out of fear—fear of escalating abuse or abandonment. They may be attempting to protect someone who they love, or their religious convictions or cultural upbringing might reinforce not getting others involved in family problems. If the abuse is lifelong, they may see it as fairly "normal" and not seek

help because of that. They may be isolated and reliant on the abuser for transportation or care. Without the abuser, they may see themselves entering into a nursing home—unaware of resources that can help them to live independently, safely, and free from abuse.

B. Parameters for Practice

Display **Parameters for Practice** (Slide 31).

Adult Protective Services in Wisconsin involves three primary statutes as listed on this slide. Wisconsin Administrative Code Chapter 46 is the global rule of social services in Wisconsin. It is in this chapter that adult protective services are outlined. Then we have Chapter 55 which further outlines protective services and Chapter 54 which outlines guardianship and protective placement procedures.

In addition, we can examine statutes related to parts of Chapter 50, which governs assisted living facilities and some hospice admissions. APS work also interfaces with Chapter 51-the rules for developmental disabilities, mental health and substance abuse services in Wisconsin. (We will not talk about that chapter during this training. The second day will examine the interface and coordination with Community Programs.)

Understanding of the rules surrounding advanced directives, powers of attorney for health care and finances are all within the skill set for APS workers.

Complicated statutory guidelines need to be interpreted across a range of situations. Let's take some time to work through some case studies to begin to talk about situations that APS workers get involved in. We are going to begin by talking about CH 55, the Protective Services Chapter and will apply the definitions we talked about earlier. You will also need Chapter 46.90.

Display **Case Scenarios: Part 1** (Slide 32).

Pull out Handout 1.5: Case scenarios

[This activity was developed from the Dynamics of Abuse NAPSA Core Competency Training]

There are three scenarios we will use as the basis for our discussions right now. Each table will take a different case scenario and as a group, discuss three key items: (1) Decide what role APS has in that situation; (2) What definitions under CH 55 allow APS workers to intervene; (3) What factors in the case lead us to determine APS should be involved.

Trainer: *Assign the three cases across participant groups in the room.*

You will have 10 minutes to discuss your scenario and then we will come back together and discuss what we have found.

Note Alternative Training Option: Instead of dividing into the small groups, full group can discuss the scenarios. Alternatively, discuss Tony and Josephina together and then move to small group discussions. (This option can allow for "catch up" should the training be behind schedule.]

Give 10 minutes. When come back together, discuss the scenarios. Answer Key is below:

TONY AND JOSEPHINA

Tony and Josephina have been married for almost 60 years. He is 80 and she is 77. Two years ago, Josephina was diagnosed with Alzheimer's disease. The disease progressed very quickly. Their son, Henry, told the residential care home director that Tony and Josephina's marriage had been tumultuous. During all of their married life, Tony had been verbally and physically abusive to Josephine. For years he told her that she was stupid and ugly, that no other man would want her, and that she was lucky he put up with her, though he might leave her at any time. He threw things at her, slapped her in the face, threatened to kill her, and once, pushed her down the stairs. On several occasions, Josephina left Tony. When Henry offered to help her move in with his family, she refused and went back to her husband. Since then, Henry has tried to talk to his mother about her relationship with Tony, but she always shut him off, saying that a wife had her duties, and it was none of his business.

Three months ago, Tony was diagnosed with liver cancer. His prognosis is not good. Recently, the aide who assists Josephina with her toileting and bathing noticed bruises on her breasts and inner thighs. When asked about the bruises, Josephina shook her head and cried, but did not answer. The aide suspected that Tony was having intercourse with his wife, and that she was unable to resist. When Tony was confronted, he became angry, saying, "It's nobody's business but ours! She's my wife and I can have sex with her whenever I want. I've done it for 60 years. Besides, I don't have long to live, and I deserve to have some pleasure before I die."

APS Role: Investigation of multiple types of abuse (history of physical and verbal abuse; domestic violence by Tony against Josephina; possible sexual abuse).

- Develop case plan with the client to the extent she can participate, and with the client's representatives (son, residential care setting) to reduce risk and to improve her safety.
- Offer information and referrals.

<u>Statutory Definitions</u>:

"Abuse" has the meaning given in s. 46.90 (1) (a).

> 46.90 (1) DEFINITIONS. In this section: (a) "Abuse" means any of the following: 1. Physical abuse. 2. Emotional abuse. 3. Sexual abuse. 4. Treatment without consent. 5. Unreasonable confinement or restraint.

"Bodily harm" has the meaning given in s. 46.90 (1) (aj). (possibly: "Great bodily harm" has the meaning given in s. 939.22(14).

> 46.90 (1) (aj) "Bodily harm" means physical pain or injury, illness, or any impairment of physical condition.

> 939.22 (14) "Great bodily harm" means bodily injury which creates a substantial risk of death, or which causes serious permanent disfigurement, or which causes a permanent or protracted loss or impairment of the function of any bodily member or organ or other serious bodily injury.

"Degenerative brain disorder" means the loss or dysfunction of brain cells to the extent that the individual is substantially impaired in his or her ability to provide adequately for his or her own care or custody or to manage adequately his or her property or financial affairs.

"Sexual abuse" means a violation of s. 940.225 (1), (2), (3), or (3m).

> [Full definition is in the resources section of the training manual]

<u>Indicators for Involvement</u>:

- Son's report that father told mother "she was stupid and ugly," "no other man would want her," and "she was lucky he put up with her"
- Threatened to leave
- Threw things at her
- Slapped her face
- Threatened to kill her
- Pushed her down the stairs
- Bruises on breasts and inner thighs
- Josephina cries when asked about the injuries
- Tony reports "It's nobody's business but ours. She's my wife and I can make love to her whenever I want.

ROSIE AND HER PARENTS

Rosie is a 47-year-old woman with Down Syndrome. When she was born, her parents vowed never to place her in an institution, as was often done in those days. As a result, she has lived with her father and mother her whole life and has had little exposure to the outside world. As her parents have aged, Rosie has taken on more and more of the household work and personal care for her parents. Although Rosie is relatively high functioning, she struggles to help her father, Frank, age 79, who has severe Parkinson's disease, and her mother, Betsy, age 72, who is legally blind and increasingly frail. The family has a limited income and barely makes ends meet. They do have a home health aide paid through Medicaid twice a week, as well as Meals on Wheels and senior transportation. Due to his Parkinson's disease, Frank is unable to feed himself. Rosie tries to help him, but often gets frustrated and roughly jams the spoon into his mouth. On one occasion, she broke his front tooth. She blamed Frank, because, "He jiggles around too much."

Returning after a long weekend, the in-home aide found Betsy unresponsive and lying on the floor between the bed and the doorway of the adjoining bathroom. She had several pressure ulcers on her left hip and left leg, apparently the result of her lying on that side for an extended period of time. The home aide called an ambulance, and the paramedics reported the carpeting beneath Betsy's body was badly soiled.

Rosie and Frank said that they found Betsy lying on the floor in her present location several days earlier. Rosie said she tried to help her up, but her mother cried out in pain and told her to leave her alone. After that, they left her lying on the floor, bringing her food and water and giving her medications. Frank said that Rosie put a pillow under her head and tried to care for her. When asked why he did not call for medical assistance, Frank told the paramedics that his wife said not to call anyone. The paramedics reported the case to APS.

APS Role: Investigation of possible neglect, possible physical abuse and possibly initiation of guardianship proceedings.

- *Develop case plan with the clients to the extent they can participate to reduce risk and to improve safety*
- *Offer information and referrals*

Statutory Definitions:

"Abuse" has the meaning given in s. 46.90 (1) (a).

46.90 (1) DEFINITIONS. In this section: (a) "Abuse" means any of the following: 1. Physical abuse. 2. Emotional abuse. 3. Sexual abuse. 4. Treatment without consent. 5. Unreasonable confinement or restraint.

"Adult at risk" means any adult who has a physical or mental condition that substantially impairs his or her ability to care for his or her needs and who has experienced, is currently experiencing, or is at risk of experiencing abuse, neglect, self−neglect, or financial exploitation.

"Caregiver" means a person who has assumed responsibility for all or a portion of an individual's care voluntarily, by contract, or by agreement, including a person acting or claiming to act as a legal guardian.

"Developmental disability" means a disability attributable to intellectual disability, cerebral palsy, epilepsy, autism or another neurological condition closely related to an intellectual disability or requiring treatment similar to that required for individuals with an intellectual disability, which has continued or can be expected to continue indefinitely, substantially impairs an individual from adequately providing for his or her own care or custody, and constitutes a substantial handicap to the afflicted individual. The term does not include dementia that is primarily caused by degenerative brain disorder.

"Neglect" means the failure of a caregiver, as evidenced by an act, omission, or course of conduct, to endeavor to secure or maintain adequate care, services, or supervision for an individual, including food, clothing, shelter, or physical or mental health care, and creating significant risk or danger to the individual's physical or mental health. "Neglect" does not include a decision that is made to not seek medical care for an individual, if that decision is consistent with the individual's previously executed declaration or do−not−resuscitate order under CH 154, a power of attorney for health care under CH. 155, or as otherwise authorized by law.

Under CH 54:

(14) "Impairment" means a developmental disability, serious and persistent mental illness, degenerative brain disorder, or other like incapacities.
(15) "Incapacity" means the inability of an individual effectively to receive and evaluate information or to make or communicate a decision with respect to the exercise of a right or power.
(19) "Meet the essential requirements for physical health or safety" means perform those actions necessary to provide the health care, food, shelter, clothes, personal hygiene, and other care without which serious physical injury or illness will likely occur.

Indicators for Involvement:

- *Roughly jams spoon into father's mouth*
- *Broke her father's tooth*
- *Mother found on floor unresponsive,*
- *Mother has several ulcers on her left hip and left leg*
- *Carpeting beneath Betsy' body was badly soiled*

JAKE AND REGINA

For years, Jake, who is 56, has been struggling to make a living as an artist, with little success. Sometimes he does house painting. But because he is an alcoholic, he doesn't hold onto a job for long. So, he turns to his mother, Regina, for financial help. In the beginning, Jake claimed that the money Regina gave him was loans, and that he would pay her back as soon as he "got on his feet." But the loans were never repaid. Now Jake is saying that if only he could take another art course, his paintings would finally begin to sell. He wants Regina to take out a reverse mortgage on her house, so he can have $10,000 for his art studies.

Regina, who is 75 years old, has advanced macular degeneration and relies on a private pay aide to help her with housework and to drive her to appointments. She is reluctant to mortgage her home. As an immigrant woman, she is very proud that she owns her own home free and clear. Also, her mother lived to be 101, and Regina is worried that if she cashes in on her home now, she will outlive the income provided by the reverse mortgage. She is also concerned that she will be unable to continue to pay for the increasingly levels of assistance she will need to cope with her vision loss. But she also wants to support Jake's dream of being a painter. He has sold an occasional picture, and she believes that he has real talent.

Jake is getting impatient with his mother. He claims that if she really loved him, she would help him out. Yesterday he barged into her house and kicked Bootsy, Regina's small dog. Regina started to cry, and begged Jake not to hurt the dog. She promised him that she would find the money "somehow." Jake replied, "You better find it." Before he left, Jake took the ATM card from Regina's wallet without her knowledge. He had helped her use it previously as her sight was failing, so he knew the PIN. That day and the next he made two withdrawals totaling $1,000.

APS Role: Investigate possible financial exploitation; emotional abuse

- *Develop case plan with the client to reduce risk and to improve safety.*

- *Offer information and referrals.*

Statutory Definitions:

(2s) "Financial exploitation" has the meaning given in s.46.90 (1) (ed).

> *(ed) "Financial exploitation" means any of the following:*
> *1. Obtaining an individual's money or property by deceiving or enticing the individual, or by forcing, compelling, or coercing the individual to give, sell at less than fair market value, or in other ways convey money or property against his or her will without his or her informed consent.*
> *2. Theft, as prohibited in s. 943.20.*
> *3. The substantial failure or neglect of a fiscal agent to fulfill his or her responsibilities.*
> *4. Unauthorized use of an individual's personal identifying information or documents, as prohibited in s.943.201.*
> *5. Unauthorized use of an entity's identifying information or documents, as prohibited in s. 943.203.*
> *6. Forgery, as prohibited in s. 943.38.*
> *7. Financial transaction card crimes, as prohibited in s. 943.41.*
>
> *[See resources for CH 943 sections]*

Indicators for Involvement:

- *Kicked and threatened her dog to get her to give him money*
- *Accepted loans from his mother that he never paid back*
- *Took and used her ATC card without her permission*

After discussion of these prompts:

APS caseworkers have a primary responsibility to respond to reports of adult-at-risk abuse, exploitation and neglect; to investigate the allegations and to work with the client to address their needs and to prevent further abuse.

Sometimes, APS responsibilities or interventions may overlap or conflict with the roles of other first-responders, such as law enforcement and the long-term care ombudsman. Knowing your professional role, and working collaboratively with others, will greatly enhance the safety of the victims you serve. Ongoing multi-disciplinary efforts help to resolve these issues.

Alternative training option: Combine slides 32 and 33 and use Handout A which has space for participants to write down the answers to the scenario prompts that are identified on the two slides.

If using handout 1.5 running behind and do not have time to process the activity fully, skip Slide 33 and its activities.

Display **Case Scenarios Part II** (Slide 33).

Using the same scenarios, I would now like you to answer the two questions on the slide: (1) what steps should the APS investigator take initially to promote the victim's safety and to begin the investigation? And (2) what other agencies should APS collaborate with?

You will have 5 minutes to discuss this piece of the scenario exercise.

Give 5 minutes

Points for discussion as part of the follow-up discussion:

<u>TONY AND JOSEPHINA</u>

Initial steps:

- *Talk to the victim alone – without alleged abuser present*
- *Ask questions and listen*
- *Learn what victim wants to have happen if she is able to communicate*
- *Offer information and referrals*
- *Work with the victim, the home and her son to create a safety plan*
- *Collect the evidence needed, including information from other people and record reviews, to support the substantiation decision*
- *Document what is learned through the investigation*
- *Collaborate with other professionals as appropriate*

Agencies to collaborate with:

- *Sexual assault program,*
- *Domestic violence program*
- *Law enforcement*
- *Restraining order*
- *Health care*

<u>ROSIE & HER PARENTS</u>

Initial steps:

- *Talk to all the parties alone*
- *Ask questions and listen*
- *Learn what Frank and Betsy want to have happen (if Betsy is able to communicate)*
- *Work with the victims, Rosie, the in-home aide and others to create a safety plan to provide protection and assistance to the parents and support services and education to Rosie*
- *Collect the evidence needed, including information from other people and record reviews, to support the substantiation decision*
- *Document what is learned through the investigation*
- *Offer information and referrals*
- *Collaborate with other professionals as appropriate*

Agencies to collaborate with:

- *Home health agency which provides aide*
- *Aging network services providers*
- *Physicians, therapists, etc.*
- *Disability agencies for the developmentally disabled, for the blind, etc. to help*

JAKE & REGINA

Initial steps:

- *Talk to the victim alone – without alleged abuser present*
- *Ask questions and listen*
- *Learn what victim wants to have happen*
- *Work with the victim to create a safety plan*
- *Collect the evidence needed, including information from other people and record reviews, to support the substantiation decision*
- *Document what is learned through the investigation*
- *Collaborate with other professionals as appropriate*
- *Provide information and referrals; help client determine if she is eligible for services (e.g. senior transportation; in-home help)*

Agencies to collaborate with:

- *Aging network services providers*
- *Disability and assistive devices agencies for the visually impaired*
- *Bank/money management service /financial advisor to protect Regina's assets*

- *Legal system – law enforcement and/or an attorney to seek a restraining order*

Display **Safety First** (Slide 34).

Assuring the immediate safety of the victim is the APS worker's first responsibility. While protecting the victim, the worker must also consider the victim's right to self-determination. Finding a balance between victim safety and self-determination is the most difficult challenge faced by APS professionals. Any intervention needs to take both of these issues into consideration. The client's cognitive capacity must be addressed in this process.

Keeping the victim safe and protected from immediate harm may involve temporarily removing the victim from the dangerous situation if necessary with, of course, his or her permission; or if the person lacks capacity, following the guidelines in CH 55. It may also mean requesting assistance from law enforcement to deal with the alleged perpetrator.

We will talk more in-depth about conducting an investigation a little later. The APS worker investigates what happened, who is involved, and how and why the abuse occurred. During this process, the focus must remain on the alleged victim's safety. APS should always collaborate with other community agencies to bring the most resources and alternatives to the victim.

C. Statutes in Practice

Display **Group Activity: Statute Sort Game** (Slide 35).

Our earlier slide showed the three main statutes involved for those in Adult Protective Services. Now, we are going to play a game to see just how well you all know your statutes.

Each group (3 – 5 individuals) will be given an envelope with a series of statutory references. You will also be given pages with the three chapters heading them. You will need to sort the references by statute. Tape the reference to the appropriate sheet. Once you have completed that, I will give you part 2 and the instructions for that. The group that most accurately finishes the task first will win a prize. I have allocated 20 minutes for this activity.

Ready… Set…. Go!

[See answer key in appendices]

After the first group has completed Part I of this activity.

Display **Statute Sort: Part II** (Slide 36).

Once the group tells you they have finished, provide them with the envelope with the statutory codes in them and the brief instruction sheet.

(They can use their resources but cannot move any that they have placed under the inaccurate statute.)

Alternative training option: If dividing the training into multiple sessions, more time could be allocated for the matching to allow completion of the task. Trainer could then go through the answers for those matched to each of the statutes. If doing this option, give an additional 30 – 45 minutes for the activity. Answers for the activity are included in the trainer resources.

Display **Additional Statutory Considerations** (Slide 37).

The game you just completed included some references from CH 50. This slide shows you another definition to consider when an individual requires supervision and care and placement in assisted living is necessary. The person must still meet the standards for protective services, but CH 50 allows placement by individuals other than a guardian when needed.

Display **2017 WI Act 187: CH 53** (Slide 38).

In late 2017, the State passed Wisconsin Act 187. The key topic areas of the law are identified on this slide. The focus is on creating uniformity across state lines (international transfers are included as "state"). At the time this curriculum was prepared, the actual implementation date was uncertain. We won't go into the law more fully but want you to be aware of these new requirements should you be involved in any proceedings where multiple states are involved.

D. Guardianship and Protective Placements

Display **Determining Competency** (Slide 39).

These references define competency as outlined in CH 54. In Wisconsin, a psychologist or psychologist makes the determination if an individual meets the standards for incompetence under CH 54 but the initial assessment referring the individual for guardianship (through the petition) is completed by the APS worker. We are going to once again use some case studies in small groups to discuss the concept.

Organizing groups (minimum of 6 members): Ask the person with the most APS experience at each table to come forward as the Leader of the group. Give the leaders both their handout with information about the client and worksheets for the group members.

Trainer Note*: The case studies to be used in this activity are labeled 1.6A- 1.6E. The Leader Information is titled 1.6A-Leader to 1.6E-Leader. (There should be copies of the small group answer sheet [1.6A-1/6E Small Group] for each group member).*

Display **Assessing Capacity Group Activity** (Slide 40).

These are the instructions:

Assume that you have received an intake call and have a very limited amount of information about the client.

The group leader in this exercise represents the people who have more information about the client.

In this exercise, each group will ask information of the Group Leader to get the information needed to make a decision about whether the client has capacity to make informed decisions. Think about the questions you should ask the Leader in order to get the information you need.

You will have 10 minutes to ask questions. Someone should write the answers to the worksheet down, so we can review them as a group after you have finished.

After the 10 minutes have expired, the Group leader will fill in the holes of the information about the client.

I will call us back together to report back after fifteen minutes.

Slides 41 – 45 include the information from the leader copy of each of the case studies. These should be used as discussion when processing the activity.

Alternative training option: Use only one of the case studies and have the entire group complete the one case study. This would be particularly relevant if there is a trend toward referrals that is identified in one of the case studies.

When 15 minutes is up, lead discussion by asking:

1. ***Which factors did you miss?***

2. ***How might you have questioned me more specifically to get the missing information***?

Display **Capacity Matrix** (Slide 46).

When assessing a client's capacity to make informed decisions there are four key questions that we consider:

1. Can the client understand relevant information?

    Can anyone give me an example of this type of question?

    • *Do you know that you have a serious cut on your leg?*

    With this question, we are testing out orientation, ability to attend to the conversation, and memory

2. What is the quality of the client's thinking process?

    What are some questions that assess the quality of someone's thinking process?

    • *How can you get treatment for your wound?*

    This is one way of asking about executive function—goal directed or planning abilities

3. Is the client able to demonstrate and communicate a choice?

    • *Do you want to get treatment for your wound?*

    We examine the individual's ability to understand what we have asked, communication of his or her thoughts and fluency of speech.

4. Does the client appreciate the nature of his/her own situation?

    • For example: *What will happen if you don't get your wound treated?*

Appreciation includes a process of reasoning: comparing alternatives in light of consequences by integrating, analyzing, and manipulating information. It involves the ability to provide rational reasons for a decision, to manipulate information rationally, generate consequences of decisions for one's life, and to compare those consequences in light of one's values

The word "appreciate" is a legal term. NAPSA identified four components from statutes developed across the country.

The meaning of "appreciate" is therefore defined by law.
It can mean: have understanding, an emotional response, generally understand risks and benefits and to understand his/her own situation

When "appreciate" is **not** defined in a statute, it generally means "understanding." However, "appreciate" has had many, different definitions depending not only on statutes but also on the specific attorney's and courtroom's usage.

Therefore, it is important to get this clearly **defined** with your legal advisors.

Then you need to make your **definition explicit** when working with others.

Display **Interfacing with Other Systems** (Slide 47). [This is a transition slide.]

Once capacity assessment demonstrates a possibility of incompetence, and safety requires action, guardianship and protective services or protective placement processes can be initiated.

Recent best practice developments include consideration of the concept of supported decision making. Instead of proceeding with establishing a guardian, assessment determines to what extent an individual needs assistance with decision making and services arranges to assist the client though advocacy, relationships and other services. We do not have time to go into this concept in today's training but will address it with the next session.

Display **Competency Assessments** (Slide 48).

A future training will focus on the actual assessment process and tools that can be used to enhance the assessment process. You have a handout in your packet that can be used for reference. See *Handout 1.7: Interviewing for Capacity*.

Dementia is the most common reason for competency determination. Whenever possible, the wishes of the person with dementia should be respected until safety becomes the issue.

When we are investigating whether to refer an individual for a competency evaluation, we can use the reasonable person standard as one consideration in our decision making. The reasonable person standard is both a legal and a medical term and denotes the standard of behavior that is appropriate and expected for a mentally stable or 'reasonable' person under a particular circumstance.

The reasonable person standard alone is not enough in our assessment, though, as people may have cultural factors to be considered in their response to

situations. I can also recall incidences when someone who I had felt needed intervention was described as "eccentric" and the risks minimized.

The laws and practices established under CH 55 and 54 protect the rights of the individuals who are subject to the proceedings. The administrative rules insure that the person has right to adequate notice, to an attorney, a trial by jury and right to cross examine witnesses, right to an independent evaluation. The person must meet proof of incompetence in order to be ordered to receive protective services or protective placement.

The earlier slide with definitions noted the need for the individual to meet the standards identified in CH 54.10 (3)—clear and convincing evidence that the individuals is at least 17 years + 9 months of age and because of the impairment, is unable to effectively receive and evaluate information or make or communicate decisions to such an extent that the individual is unable to meet essential requirements for physical health and safety.

As we talk about ethical issues later today, we can address the issue of right to refuse. Even though a court finds an individual incompetent, self-determination should be encouraged when possible.

Protective services or protective placement must be provided in the least restrictive manner that meets the needs of the individual. This, too, may be an area of contention. When working with adults at risk who have developmental disabilities, services must also meet the standard for most integrated.

Display **Due Process: Guardianship** (Slide 49).

You have in your packets a diagram of the process for guardianship appointment and protective services or placement orders. (*Handout 1.8: Due Process)*

The process begins with an investigation into the ability to make decisions.
To some extent, we need to know the history of the client's decision making and this process will insure that the client is capable of giving informed consent or refusal.

[End of Module]

Module 4: Interfacing with Other Systems Overview

Timing (25 minutes max.)

 Collaboration…………………………………………………………………. 25 min

Learning objectives

- Explain Adult Protective Service's role and interface with other systems

Advance preparation

- Flip Chart paper should be prepared- One sheet that says "Benefits" and one that says "Barriers". Post paper in a location where it is easily accessible.

Handouts

- Handout 1.9: Community Partners

PowerPoint slides

- Slides 50 - 55

Other

- Sticky Notes are needed for the brainstorm activity

25 Minutes total

  A. Transition Video …………………………………………………………...11 min.
  B. Collaboration …………………………………………………….… <u>14 min</u>.
                                                                                      25 min.

- Slides 50 - 55
- Handouts:
  - Handout 1.9: Community Partners

A. Transition

Display **Collaboration** (Slide 50).

A key competency for APS workers is working effectively with others.

Collaborative, multidisciplinary work in the field of aging is not new. The field of gerontology – and elder abuse – includes researchers and practitioners from diverse fields. In the last several decades, increased specialization has led to a deep knowledge base, but also, overlap in professional roles with, at times, accompanying services, inappropriate or inadequate referrals, lack of accountability and fragmentation or redundancy of services. The shared desire for optimal service provision to clients is what motivates professionals from different disciplines to collaborate.

We are going to show a brief video that highlights the role of APS Workers as a foundation for talking about interface across disciplines. (10:38). This video focuses on referral but as we all know, that is only the start of the process!

Display **Adults-at-Risk: Protection is a Team Effort** (Slide 51)

https://www.youtube.com/watch?v=0XPqhKKXLrI

B. Collaboration

Display **What is Collaboration?** (Slide 52).

Collaboration implies a process of shared planning, decision making, responsibility, and accountability in the care of the client. In collaborative practice, providers work well together through effective communication, trust,

mutual respect, and understanding of each other's skills. While some skills and services appear to overlap, most skills and services are complementary and reinforce each other.

Display **Collaboration Brainstorm** (Slide 53).

Collaboration can be hard work –there are barriers that can make it difficult. But collaboration also can have many benefits for our practice.

I would like two tables to work together for this exercise. I would like you to brainstorm on the topic of collaboration: (a) benefits (direct the appropriate groups) or (b) barriers (remaining groups). You can go stand by the flip chart paper that has the title of your brainstorm topic. Write your brainstorms on sticky notes and then transfer to the flip chart paper. You have about 5 minutes for brainstorms and then we will report-back to the larger group.

[If you have a large session, divide into four groups, round-robin the two groups on Benefits and the two groups on Barriers during the report-back.]

After 5 minutes, ask someone from the group to read off what they wrote on their sticky notes.

Trainer: Add to list if you believe an area of importance was missed. Ideas follow-In the BARRIERS report-backs, look for answers such as:

- *Lack of knowledge about other professions' roles, cultures and systems*
- *Confusion about goals/lack of consensus regarding the reasons for the collaboration*
- *Lack of a common stake/common mission that binds the different professions together in their task*
- *Territorialism or historical suspicion of other disciplines (e.g. social work and law enforcement)*
- *Desire to protect own professional domain*
- *Apathy/lack of participation by needed disciplines*
- *Individuals involved are not team players*
- *Time*
- *Confidentiality concerns*
- *Funding*
- *Lack of direction/focus of individuals or teams*
- *Historical conflict between disciplines (for example, between APS and law enforcement)*

- *Individual professionals who need to collaborate don't have the skills to do so*

In the BENEFITS report-backs, look for answers such as:

- *Shared expertise and cross-training/education*
- *Builds trust between agencies and individuals engaged in similar work*
- *Builds relationships*
- *Promotes networking*
- *More effective outcomes/action taken on behalf of clients*
- *Larger power base/advocacy efforts*
- *Feeling of larger support system for achieving goals*
- *Improved outcomes for clients through coordinated investigations and interventions*
- *Able to identify community's service gaps and system problems*
- *No one program, or agency, can meet complex needs*
- *Reduced duplication of efforts/improve efficiency in service delivery*
- *Resources are shared during hard economic times*
- *More holistic approach to problem-solving/case management/services*
- *Ensuring that all members of the multidisciplinary team are used in a way that is maximally effective*
- *Cross-fertilization of knowledge and skills between professions*
- *Supervisors become invested and continue staffing MDTs*
- *Administration will be less suspicious as their line workers pass on their comfort level after collaboration*
- *All disciplines come in on the ground floor and don't need to be convinced later of the relevance of collaboration*

Display **Differing Focuses** (Slide 54).

A thorough APS investigation should always explore all the possible causes of the neglect for insuring safety for the client. A focus on education and support is central to the role of APS.

Law enforcement is also concerned about safety; however, officers also have the focus of ensuring someone is held accountable for the crime committed when elder abuse occurs. Law enforcement is point in time—once the safety is insured; their interface with the client is finished.

While we are both working for the same things, we can often seem at opposite ends of the spectrum. There are many areas of practice where law enforcement and APS interface, however. These include:

- Wellbeing or welfare checks
- As safety backup for APS
- Obtain information in advance of conducting an intake home visit about prior calls and the parties from law enforcement
- If a criminal case, to gather information, identify sources of evidence and information, documentation in the APS file
- Testify in court as a witness
- Arranging for mental capacity evaluation of the victim if needed
- Arranging for services to meet victim's ongoing needs for services, assistance, housing, etc.
- Provide information regarding the suspect including relationship, role, strength of ties to victim, underlying problems such as substance abuse, mental health problems, employment history to assist prosecution and the court in making pretrial release decisions, issuance of protective orders, sentencing recommendations, and terms of probation

Display **Completed Puzzle** (Slide 55).

Handout 1.9 shows some of the community partners that APS Interfaces with and how they can be helpful.

Many disciples work together as a team to create a safety net of services as a wraparound service approach for victims of elder/dependent abuse. Older adults, particularly victims of abuse, confront biopsychosocial problems that are often too complex for one discipline (APS) to handle alone. Working with other professionals/disciplines is often needed in order to develop a comprehensive and integrated care and protection plan

[End of Module]

Module 5: Strategies for Ethical Practice Overview

Timing: 90 minutes max.

     Key Ethical Issues and Practice……………………………………… 10 min

     Ethical Decision-Making ……………………………………………… 35 min

     Scenario Practice ……………………………………………………… 40 min

     Best Practice …………………………………………………………... 5 min

Learning Objectives:

- Examine key ethical issues within Adult Protective Services.
- Explain Adult Protective Service's role and interface with other systems.
- Identify types of situations requiring Adult Protective Services involvement.

Advanced Preparation

     None

Slides: 56-65

Handouts:

- NASW *Code of Ethics*
- MPSW 20
- Handout 1.10: Ethical Principles
- Handout 1.11: Name the Dilemma
- Handout 1.12: Influence on Decision Making
- Handout 1.13: Ethical Decision-Making Worksheet

90 minutes

    A. Key Ethical Issues and Practice …………………………………10 min.
    B. Ethical Decision-Making ………………………………………….35 min.
    C. Scenario Practice…………………………………………………...40 min.
    D. Best Practice …………………………………………………….. 5 min.
                                                                    90 min.

Slides: 56 - 65

Handouts:

- NASW *Code of Ethics*
- MPSW 20
- Handout 1.10: Ethical Principles
- Handout 1.11: Name the Dilemma
- Handout 1.12: Influence on Decision Making
- Handout 1.13: Ethical Decision-Making Worksheet

A. Ethical Issues in Practice

Display **Ethics** (Slide 56).

Adult Protective Services, as with all social work practice, requires workers to be self-aware of their own values and of the impact those values have on practice. The National Association of Social Workers has developed a *Code of Ethics* which is used as a guideline for decision-making. Our certification and licensure regulations in Wisconsin requires that we maintain consistency with the dictates of the *Code* as a consumer protection measure. This is spelled out in our Code of Conduct, *MPSW 20*. Both documents—the *Code of Ethics* and *MPSW 20*—are in your packet. We will refer to them throughout the final ninety minutes of today's training. As an aside, social workers are required to complete four hours of interactive ethics and boundaries training every two years as part of credentialing. When you attend this and the next training, you will meet that obligation.

As discussed earlier, the National Association of Adult Protection Workers also has a *Code of Ethics* which represents best practice within APS work. The guiding values fit well with those identified in the NASW *Code of Ethics*. NAPSA's guiding value that "Every action taken by Adult Protective Services must

balance the duty to protect the safety of the vulnerable adult with the adult's right to self-determination." Highlights the right to self-determination which is a key value embodied by the commitment to clients articulated in the NASW *Code of Ethics*. NAPSA's guiding principles include the right to be safe and the right to accept or refuse services. These principles are also an area of focus through the statutes which govern APS.

The secondary value, "Older persons and persons with disabilities who are victims of mistreatment should be treated with honesty, caring, and respect" parallel's NASW's values of dignity and worth of individuals. Respect and authentic helping are values embedded within the *Code* as well. Social workers act within their areas of competence and with integrity in practice.

Social work practice is based on a foundation of social justice. NAPSA's guiding principles represent a focus on civil rights of those served, including a right to be safe. Actions identified through the statutes insure that justice is reinforced.

Display **Key Ethical Issues** (Slide 57).

The primary focus of our interventions is the commitment to our client's safety and wellbeing. A cornerstone is the right to self-determination that is reinforced not only within our ethical guidelines but within the statutes themselves.

Victims with the capacity to do so may refuse services. A challenge in practice is the determination at times of that capacity. Through the appointment of a guardian, individuals lose that right to self-determination. Once legal proceedings are invoked, the individual's right to self-determine ceases and mediation among family members may be impaired.

Even with appointment of a guardian, though, the ability to make some life decisions should be retained. The wishes of family—often spurred by the desire to keep their loved one safe—may limit some of that ability. We help to navigate the challenges that arise within these situations.

A fundamental obligation of workers is to assist clients in the process of providing informed consent. Informing of the risks and benefits of a choice and respecting that choice can be difficult in these situations when choices result in unsafe situations. For those with capacity to make their own decisions, clients' right to exercise self-determination outweighs their safety. People have a right to take risks.

Workers must determine if the individual is able to knowingly make the choice — and that are not pressured into doing do. When clients do not understand risks

AND the risks or dangers are substantial, involuntary measures may be warranted. Criminal acts may be pursued without the consent of victims.

We do reinforce self-determination by insuring the least restrictive option to meet their needs comes into being. Supported decision making may be one of those strategies. Insuring that individuals have as much choice as possible is key. This may mean educating families, service providers and others because it can be **easier** to direct behavior and activities, but the ultimate outcome of making decisions for others is a reduction in their own sense of control and value as an individual.

When people get involved with human services systems, particularly when it is involuntary, privacy is severely impacted. Parts of their lives are under the scrutiny of others that would normally be private. The United States considers privacy a primary right of all people. We make choices in practice as to how to communicate the correct amount of this private information to protect both the individual and their dignity. CH 54 and 55 are very clear on privacy of records.

Cultural differences are another key ethical consideration. I mentioned earlier the need to be self-aware of our own values. We must also be self-aware of our own culture and how that influences our decision making—the values passed on and lived by our parents and grandparents. Different cultures may have practices that need to be considered when evaluating safety. Help seeking behavior and discussing situations with those outside of the culture are also influenced by cultural. (We will spend time next training focusing on cultural competence).

Ethically, our goal is to do good for those we serve. As minimum, our commitment to clients means we do no harm.

Display **Ethical Principles for Decision-Making** (Slide 58).

NAPSA outlines these principles as key in decision making—also called the bioethical principles; these are the ethical foundations used in medical practice and are consistent with the standards and ethics of the social work profession.

Autonomy: People living in free societies have the right to make decisions for themselves that are voluntary and free from interference by others. The closely related concept of self-determination refers to people's ability to manage their own affairs, make their own judgments, and provide for themselves. Applying these principles to elder abuse prevention requires workers to abide by clients' wishes with respect to intervening or not intervening, and their choices with respect to services. Workers can help enhance their clients' autonomy by providing them with tools, information, and assistance and removing threats to

autonomy and self-determination such as coercion, duress, and undue influence. The requirement to consider the **Least Restrictive Alternatives** is consistent with the principle of autonomy. APS workers and others also operate on the principle that priority should be given to interventions that least restrict clients' autonomy, independence, and freedom of choice—respect the client's self- determination.

 Beneficence is the obligation to do good and assist others further their interests. Isn't this what we try to do every day in practice? When we maintain healthy boundaries, focusing on client needs and examine our motivations for the choices we make, we reinforce this principle.

Nonmaleficence is the sibling of beneficence is it the right to expect others to "do no harm" in the maintenance or enhancement of the client's welfare. Because helping others often consists in the infliction of a lesser harm in order to avoid a major imminent harm, nonmaleficence is generally taken to mean "Do not cause other persons to die, suffer pain or disability, or deprive them of their most important interests, unless you have a good reason." APS workers weigh out all of the consequences of their actions when making decisions in practice.

Justice refers to the fair and equitable distribution of benefits and burdens. For protective and social service workers, it entails an obligation to ensure that their clients have equitable access to service resources.

Fidelity refers to our consistency, reliability, and professionalism in practice. This means keeping our actions consistent with agency policy, social work standards, and respecting all with whom we interface in practice. This includes respecting the ideas of family members and significant others when intervening on behalf of their loved ones. In practice, this means being accountable and responsible for your actions and expecting others to do the same.

Veracity means truthfulness. Individuals have the right to expect others to tell the truth and be responsible for their actions, following through, effective communication and insuring that we are following through with the guidelines of **informed consent**, dealing with conflicting situations as openly and truthfully as possible. As part of veracity in practice, we may also expose deception and irresponsibility of others when it impacts the safety and wellbeing of those we serve or the functioning of our agencies.

Handout 1.10 provides a summary of these principles for you.

Not identified on this slide but equally important principles to follow include the primary principles of:

Privacy- supporting the right of individuals to keep their lives and personal affairs out of public view, or to control information about themselves.

Informed consent- reinforcing informed choice by outlining risks and benefits of options. Accepting those decisions once made, even if we don't think this is the best option. (This goes back to that 'right to take risks' we discussed earlier.)

Display **Ethical Practice** (Slide 59).

This slide is a nice outline of primary considerations for ethical practice—points to remember which will be helpful in all APS work, especially in the initial stages of case investigation/assessment. The work is very challenging and very personal, so it is important to get feedback and support from supervisors and coworkers. Often, we get so enmeshed in a case situation that we may lose perspective. Having regular supervisory sessions and spontaneous discussions with peers can help keep us grounded; help us see the forest from the trees. Ongoing training provides the opportunity to practice new skills, refresh old ones, and see what research is going on.

B. Ethical Decision Making

Display **Ethical Dilemmas** (Slide 60).

Ethical issues are everywhere in practice, particularly as we work with those who are involuntarily involved with us. The choice becomes a dilemma when conflict between these four areas:

(1)   Values—personal—professional—organization—client. In a study of dilemmas in practice, 77% of social workers outlined that a key source of dilemmas was different personal and client values; 82% said that often personal and organizational value challenges occurred. (perform tasks consistently with standards).

(2)   Situations can apply to more than one standard in the code. These include the issue of privacy and confidentiality vs. need to intervene due to risk of harm.

(3)   Our obligations may conflict. Obligations to our client, agencies we work for, courts and society, or even to ourselves. These dilemmas include how to protect client interests with other demands. They may involve questions as to who the client is.

(4)   Our roles—we are client advocates but also employees. We perform roles often described as "Social control agents" because of our responsibility to protect when unsafe situations are within our control.

At issue with ethical dilemmas are relationships. These may be formal or informal. These competing values require self-awareness and reflection to resolve. Concentration can be on making decisions that provide the least harm/greater good.

Of course, there are a lot of influences on our decision making: client wishes, professional obligations, personal values, community pressure. We consider our decisions in terms of context at the time. Context can center around funding, demands (both personal and professional), and the accountability inherent with our positions.

We are going to take some time in small groups to outline some ethical dilemmas in practice. Please pull out *Handout 1.11: Name the Dilemma*. Groups should outline the dilemma for each of the situations. You may not agree on what the dilemma is-that's okay since we may describe the issues differently. Key is being able to see the issues in practice.

You will have 10 minutes to work through this exercise and then we will come back together and discuss them.

Trainer note*- below are some suggested dilemma descriptions:*

*Scenario #1: The conflict is **autonomy (***Mrs. D has a right to refuse medication) and **beneficence** (her right to be safe/APS responsibility to protect her). Although Mrs. D has capacity, it does not necessarily mean that APS walks away… but it does mean that the worker must try to build a trusting relationship with her, provide information and education to help her make an informed choice, and discuss the medical consequences if she does not take insulin.*

*Scenario #2: The conflict is **loyalty/filial piety** (Mr. F feels loyalty to his son) but the son is not returning that loyalty/filial piety because he is not providing for his father's needs. Also, there is beneficence (Mr. F's right to be safe). When APS gets involved in a situation like this, care must be taken to consider the consequences of any action (**nonmaleficence**). If worker alienates the son or criticizes the son to the client, Mr. F. may close the door on the worker. If worker has son removed, there may be insufficient services available to meet client's needs. On the other hand, making no changes leaves Mr. F. at risk.*

*Scenario #3: The conflict is between **autonomy** (Mrs. S's independence, living in same home for 50 years) and **beneficence** (worker's pushing to have her placed elsewhere to keep her safe). Other issues include **nonmaleficence** (would moving her away from her home to a facility or to another state be in her best interest?) and who is this nephew and what is his interest in her money?*

What do we know about him? How do we know he will provide for her in California?).

*Scenario #4: The issues are **privacy** (Mrs. C's right not to disclose personal financial information) and **beneficence** (her right to services and to be safe). This is a situation where APS would need to use the relationship and perhaps some reality testing to explain the need for the information in order for Mrs. C to receive help. Mrs. C's assertion of her entitlement is one that may "push the worker's buttons" so worker must be careful not to let personal values get in the way.*

*Scenario #5: The issues are **loyalty/filial piety** (Mrs. B expects her daughter Ruth to provide care for her) and **justice** (Ruth has physical and medical problems and cannot provide the kind of assistance her mother needs). In this case, the APS worker has two clients and must build relationships and trust with both of them. In this case, APS may have two separate cases. The worker must discuss this situation with the supervisor in order to avoid a conflict of interest. It may be that two workers need to be assigned to the family and coordinate their work so that the needs of both clients are met.*

Display **Ethical Principles Screen** (Slide 61.)

Dolgoff, Loewenberg and Harrington developed a means of examining ethical issues in practice when the *Code of Ethics* does not provide sufficient direction in working through a dilemma in practice. What they recommend first is to look through the NASW *Code of Ethics* and to see if there is a standard that applies to the situation. If we find a standard, we can make a decision based on that standard.

If there is insufficient guidance in the Code or we see two equally important standards impacted in our decision, Dolgoff and colleagues say that we use this screen to prioritize our choices. Selecting that which is at a higher priority over those lower in the pyramid, privacy and confidentiality should supersede truthfulness and full disclosure. Protection of life is more important than quality of life. Self-determination is chosen over least harm.

We can see these priorities reflected in the APS standards.

Ask: *Can you think of situations which would apply?*

Example: Decision to end life-saving treatment may be self-determination over least harm. In some situation, maintaining consistency with the pyramid may not be consistent, though. For example, one may choose to remove life support may be quality of life over protection of life.

Display **Influences on Decision Making** (Slide 62).

As mentioned earlier, there are four areas that influence the decision-making process. Pull out *Handout 1.12: influences on Decision Making*. We are going to work through each of these issues in small groups and together.

Let's talk through the client wishes section.

Client wishes: What the client wants to do. The client wants to make his/her own choices even if he/she is old, eccentric, mentally ill, involuntarily committed, dying -- whether or not we, family, physician concur -- as long as those choices do not infringe on rights of others.

There are times when a client who has capacity is making a decision we feel is harmful.

Ask: *How do we determine if a client understands the consequences of choice?*

Ask: *What techniques might be helpful to engage a client who is making a choice, which puts him/her at risk?*

The key is to make sure that the client understands the consequences of the decisions and has the capacity to make that particular decision.

Let's move on to professional obligations.

Professional Obligations: Our role/responsibility on the job. It involves state statute(s), regulations and policies, the personnel manual, applicable code of ethics and what is expected of us from supervisor and administrator. Instances may arise when APS workers' ethical obligations conflict with agency policies or relevant laws or regulations. When such conflicts occur, workers must make a responsible effort to resolve the conflict in a manner that is consistent with the values, principles, and standards of the profession.

There may be times when your ethical assessment and plan of action comes into conflict with that of your supervisor, administrator, or legal directive.

Ask: *What strategies can you use to deal with the differences between your view and that of your supervisor or administrator?*

Ask: *How do you support your assessment? When/how do you compromise?*

If a reasonable resolution of the conflict does not appear possible, workers should seek proper consultation before making a decision.

Perhaps one of the most difficult considerations is our personal values and boundary preferences for practice.

<u>Personal Values:</u> What are our beliefs about what is good and what is right? What is it about this client that pushes our buttons? Do we like the client because she reminds us of our mother? Do we feel guilty about our own behavior in our own family and try to compensate with clients? How do we feel about the abusive acts committed? Are we angry at clients/ abusers because of characteristics that we are not comfortable with: drug use, HIV, demanding behavior, etc.? Are there cultural, racial, religious values that are interfering with the process? Are there cultural, ethnic, or religious stereotypes that are interfering with our ability to service this client?

There are times when certain clients, family members, or situations push your buttons and may interfere with your ability make ethical judgments regarding the situation at hand. There also may be times when your boundaries become too loose or too rigid.

<u>Ask:</u> *How do you know when your values (cultural, religious, ethnic) or gut reactions are getting in the way of your work with/on behalf of your client?*

<u>Ask:</u> *What strategies can you use to maintain objectivity and clear boundaries?*

APS workers should be aware of the impact on ethical decision making of their clients' and their own personal values and cultural and religious beliefs and practices. They should be aware of any conflicts between personal and professional values and deal with them responsibly. For additional guidance workers should consult the relevant literature on professional ethics and ethical decision making and seek appropriate consultation when faced with ethical dilemmas. This may involve consultation with an agency-based organization's ethics committee, a regulatory body, knowledgeable colleagues, supervisors, or legal counsel.

We must be sure to attend to counter-transference issues: Who does the client remind you of? If we like someone more, we may work harder and be more flexible. If we like someone less, we may apply the rules more rigidly. There is a need for self awareness, for looking inside ourselves to see if the situation is really an ethical dilemma or a self-imposed barrier.

<u>Community pressure:</u> What others think we should do or act in this situation. What are the values of other professions? What are the motives for the pressure? What is the public good? How do we explain our position? How do we justify our actions or inactions? Is that necessary?

Often times outsiders, community agencies, and family members feel that they know the best decision to be made for your client.

<u>Ask:</u> *What positive strategies can you use to deal with other agencies?*

Ask: *What strategies can you use to deal with family members? What action can you take when family members disagree with each other regarding the plan of action for your client?*

Any closing thoughts before we move on? This worksheet is one that I would like you to go back to after this training is finished. Think more on the questions and when a situation evolves, refer to the worksheet so that you can use those strategies that will help to maintain ethical practice.

C. Scenario Practice

Display **DO ETHICS** (Slide 30).

There are many different ethical decision-making models. This is one that the curriculum developer uses when providing ethics and boundaries trainings across the state. It selected it for two reasons. The first is that the pneumonic is easy to remember when we are pressured with ethical issues in practice. Second is the "C"—consultation is crucial when we are working through ethics situations. Dr. Groessl has modified Congress' model to add the "DO" and the "S".

DO = without conflicting obligations, values, roles or standards—there is no dilemma. You may have an ethical issue, but not a dilemma. An example of this may be values conflicts between what you personally value and the profession's values. Not really a dilemma when the professional stance is clear.

E = Examine values—all parties: client, self, agency, professional, and sometimes societal.

T = Think about (Apply) ethical standards, laws, policies and procedures

H = Hypothesize courses of action. What are the options in the situation?

I= Using those options, identify consequences—who will be harmed, who will be helped? Any long term issues?

C = Consult with supervisor or colleagues. Consulting with someone else can help you see beyond your own reactions—the forest for the trees, if you will.

S = Scribe (If it isn't written down, not done. This is a step that can be helpful in instances of possible litigation—never know when that might be! Informal notes if not in the record—should document supervision consultation in the record.

Also, in this S is sequel. Sequel means going back later and reassessing the situation. Would you do the same thing again? What might you change? Are there strategies that could prevent the dilemma from happening again?

I have added another S, Self-Care, in this discussion. Ethics work is hard and typically triggers emotions, sometimes regrets and the outcomes may not be

what we want them to be. Reviewing your process, making plans for future situations and forgiving yourself if mistakes were made is crucial to our own well-being for practice.

Let's do an exercise in our small groups.

Displace **Applying DO ETHICS** (Slide 64).

Pull out *Handout 1.13: Ethical Decision-Making Worksheet*. You will also need the *NASW Code of Ethics* (Under the "T" I want you to note the specific ethical standards from the Code that fit this scenario), *MPSW 20*, and *Handout 1.10-The Ethical Principles*.

In your small groups, you will work through the scenario outlined up to consultation—you are each serving as your own consultants!

You have 15 minutes, and then we will come back to discuss.

Trainer: After the 15 minutes, work through each of the components (DO, E, T, H, and I).

D. Best Practice

Display **Best Practices in EDM** (Slide 65).

This slide outlines key areas of best practice when we think about ethical decision making.

We can look to the:

Guiding APS Principles and Values

- Balance safety concerns and right to self-determination
- Treat people with honesty, care and respect
- Retention of civil and constitutional rights
- Assumed decision-making capacity unless a court adjudicates otherwise
- The right to be safe
- The right to accept or refuse services

APS Promising Practices Guidelines

- Practice self-awareness and professional use of self
- Understand importance and support appropriate casework relationship
- Act as client advocate
- Avoid imposing personal values
- Seek informed consent
- Respect confidentiality
- Recognize individual differences
- Focus on client strengths and empowerment
- Involve the vulnerable adult in the service plan
- Maximizes the vulnerable adult's independence and self-determination

- Use the least restrictive services first
- Use family and informal support systems as possible
- Maintain clear and appropriate professional boundaries
- Avoid inadequate or inappropriate intervention
- Practice conflict resolution vs. confrontation
- Seek supervision and expert collaboration
- Provide integrated care management
- Don't abandon clients who are difficult or unlikable
- Prevent further abuse, exploitation and neglect

Understanding Diversity

- Cultural competence
- Communicating cultural values
- Ageism awareness
- Disabilities awareness

[End of Module]

Module 6: Closing Overview

10 minutes maximum

Closing……………………………………………………………………………………10 min.

Advanced Preparation:

> None

Slides: 66

Handout:

> Handout 1.14: Evaluation

[Note: Reference list is included in the training resources.]

Module 6: Closing

Display **Wrap-Up** (Slide 66)

Today we have covered some heavy topics—the statutes related to APS as well as ethical dilemmas in practice. We will continue on with our discussion of these issues as we progress with the remaining training.

If attending subsequent sessions, please bring these materials with you again. We will continue to connect our learning to the statutes in the next training. We will also be using the *Code of Ethics* and MPSW 20 and the DO ETHICS model for the discussions of ethical decision making in the next training.

Before leaving, it is time to complete the evaluation materials.

Thank you for your participation today—I look forward to seeing you at the next training!

Day 2: Collaborating for Best Practice

Curriculum Timing (330 minutes)

Module 1: Overview, Introductions and Brief Review of Prior Training…30 minutes

Module 2: Collaboration across Systems.……………………………… 60 minutes

Module 3: Expanding Statutory Awareness …………………………….30 minutes

Module 4: Wisconsin's System of Care for Adult Protective Services…. 20 minutes

Module 5: Ethical Imperatives ...………………………………………150 minutes

Module 6: Wrap- Up ...……………………………………………………10 minutes

*Break (2- 10 minute) ……………………………………………………20 minutes

Learning Objectives

Module 1

- Highlight opportunities for collaboration across systems.

Module 2

- Highlight opportunities for collaboration across systems.
- Outline strategies for safety [and self-care] in practice.
- Apply decision-making to challenging situations and ethical dilemmas that arise in Adult Protective Services.

Module 3

- Outline statutes and administrative codes that intersect with Adult Protective Services practice.

Module 4

- Describe systems of care for individuals-at-risk in WI.

Module 5:

- Examine best practice in Adult Protective Services.
- Evaluate the impact of cultural differences on practice.
- Apply decision-making to challenging situations and ethical dilemmas that arise in Adult Protective Services.

- Outline strategies for [safety and] self-care in practice.

Module 6

- None

List of Handouts

Module 1

- Handout 2.1: Agenda and Learning Objectives)

Module 2

- Handout 2.2: Interdisciplinary Team Exercise (including Who did it scenarios)
- Handout 2.3: Collaboration Learning Inventory

Module 3

- Handout 2.4: Statutory Parallels

Module 4

- Handout 2.5: APS Partners
- Handout 2.6: Safety Planning Tips for Home Visits

Module 5

- Handout 2.7: Cultural Interface with Ethical Principles
- Handout 2.8: Conflict of Interest Standard
- Handout 2.9: Boundary Challenges
- Handout 2.10: Key Standards Connected to Self-Care
- Handout 2.11: Dilemmas in Practice
- Handout 2.12: DO ETHICS Worksheet

Module 6

- Handout 2.13: Evaluation

Advanced Preparation

- Envelope of Puzzle section and one-piece cardstock paper in center of table before workshop begins. [Need prize for winning team.]

- After lunch break, *Boundary Challenges* (Handout 2.9) should be placed in center of each table.

Daily Timing

Day 2: Collaborating for Best Practice

This is based on a 9:00 AM – 3:30 PM training day with two 10-minute breaks and one 45-minute lunch break. Timing is approximate.

9:00 am – 9:35 am……….. Overview, Introductions and Brief Review (Module 1)

9:35 am – 10:40 am………Collaboration across Systems (Module 2)

10:40 am – 10:50 am……. Break

10:50 am – 11:40 am……. Expanding Statutory Awareness (Module 3)

11:40 am – 12:00 am…… Wisconsin's System of Care for Adult Protective Services
(Module 4)

12:00 pm - 12:45 pm……...Lunch

12:45 pm – 3:20 pm………Ethical Imperatives (Module 5)

12:45 pm – 1:10 pm………Best practices

1:10 pm – 1:50 pm……….. Cultural Competence

1:50 pm – 2:00 pm……….. Break

2:00 pm – 2:25 pm……….. Boundaries

2:25 pm – 3:20 pm……….. Self-Care

3:20 pm – 3:30 pm……….. Closing (Module 6)

Module 1 – Overview, Introductions and Brief Review of Prior Training

Timing (35 minutes max.)

Introduction to Training .... 30 minutes total

    A. Introduction..3 min

    B. Participant Introductions. ....2 min

    C. Puzzle Exercise and Debrief...25 min

    D. Agenda and Learning Objectives ....<u>5 min</u>

                                                         35 min

Learning objectives

- Highlight opportunities for collaboration across systems.

Advance preparation

- Puzzle divided into envelopes [300-piece puzzle] (Need to put the puzzle together first so can put a section into each envelope).
- Place one envelope on the center of each table before the training begins.
- Cardstock paper to place completed puzzle section.
- Need prize for winning team.

Handouts

- Handout 2.1: Agenda and Learning Objectives

PowerPoint slides

- Slides 1 - 5

Module 1: Overview, Introductions, and Brief Review of the training.

A. Introduction

Display **Title (**Slide 1).

Welcome back to this second of the three-part APS training. In our last training, we reviewed the primary statutes that are applied to APS practice. Today, we are going to expand our discussion to include additional statutes and administrative processes that impact APS practice. We discussed the key ethical issues of self-determination and privacy, and applying the ethical principles of justice, autonomy, beneficence and nonmaleficence, in our interactions with clients. We also discussed agencies that APS interfaces with. Today, we are going to expand on all of those issues. We will apply best practice concepts in social work to APS work as well.

B. Participant Introductions

Display **Development Information (**Slide 2).

Before we begin again, let's take a few minutes to introduce ourselves.

Together with the first day's training, you will have completed the required four hours of ethics and boundaries training. We will spend the last portion of our day expanding our understanding of ethics in APS but first, we are going to talk about other systems issues.

Note: Training is considered agency-based training unless it goes through the acceptable approval process to meet the criteria for continuing education hours as outlined in MPSW 19. [See trainer notes.]

C. Puzzle Exercise and Debrief

Display **Life is a Puzzle (**Slide 3).

Instruct the tables to select the envelope of puzzle pieces that is on their table. The task is to quickly put the puzzle section together. Use the cardstock paper as a base. Once the section is complete, the section should be handed off to another group so that the section can be assembled into the larger puzzle. The team who completes their puzzle first will win a prize. We will wait until all sections are done before putting the puzzle sections together. You should take less than 10 minutes to complete your section.

After the groups have completed the activity:

The nature of our work requires us to work together in teams—often with people of different disciplines and with different styles, ethics, and individual characteristics. We can be surprised by unexpected challenges along the way.

Let's talk about this exercise of completing the puzzle with these thoughts in mind.

What were some of the dynamics of your team as they worked together to complete the puzzle? *[Elicit responses related to personal style, any "conflicts" in styles, or related to the time crunch in completing the project.]*

How about the nature of the assignment? *[Elicit responses related to the ambiguity—not seeing the big picture.]*

We will come back to this shortly, but let's review our schedule for the day.

 In our work, often, the terms multidisciplinary and interdisciplinary are used interchangeably, we will use interdisciplinary in this training. In Wisconsin, counties have established "I-Teams" (Interdisciplinary Team). A general definition of interdisciplinary is "*members of different professions working together.*"

A team is defined as, ""*a group of people with complementary skills who are committed to a common purpose, performance goals, and approach, for which they hold themselves mutually accountable.*" Teams need to have shared goals and values, and effective teams have members who understand and respect the competencies of other team members. An elder care/elder abuse interdisciplinary team is generally made up of representatives from several different disciplines who each interface with elderly/dependent, or at-risk adult clients. A common goal is established, and each discipline works to achieve that goal, assigning tasks to members based on their particular specialties and expertise.

In this training, we will use the terms "collaborator" and "team member" interchangeably.

Note: Insert a slide that contains a picture of the completed puzzle, so participants can see how their section related to the full picture.

D. Learning Objectives and Agenda

Display **Training Objectives** (Slide 4).

By the end of the day, all of you will have experience in these seven training objectives.

Display **Agenda** (Slide 5).

Here is our agenda for today. Today's training will provide 2 ½ hours of training on ethics and boundaries; if you attended Day 1, after today you will have the required four hours for certification and licensure. We have planned for one break in the morning and another in the afternoon. Much of our work today will be done in small groups—after all, we learn best when learning from each other.

[End of Module]

Module 2 – Collaboration across Systems Overview

Timing (65 minutes max.)

Collaboration across Systems... …65 minutes total

    A. Collaboration across Systems……………………………………………10 min

    B. Competencies in Interdisciplinary Teamwork……………………………… 16 min

    C. Communication Skills…………………………………………………….6 min

    D. Handling Conflict …………………………………………………….10 min

    E. Interdisciplinary Exercise……………………………………………..<u>23 min</u>

                                                                 65 min

Learning objectives

- Highlight opportunities for collaboration across systems.
- Outline strategies for safety [and self-care] in practice.
- Apply decision-making to challenging situations and ethical dilemmas that arise in Adult Protective Services.

Advance preparation

- Set up packets of handouts for the Interdisciplinary Teamwork Activity; use handouts 2.2A – 2.2D.

List of Handouts

- Handouts 2.2 & 2.2A – 2.2D [Handouts 2.2A-2.2D are not in participant packets]
- Handout 2.3

PowerPoint slides

- Slides 6 – 15

Other

- Flipchart and easel are needed

A. Collaboration across Systems

Display **Collaboration across Systems** (Slide 6).

Collaborative, interdisciplinary work in the field of aging is not new. The field of gerontology – and elder abuse – includes researchers and practitioners from diverse fields. In the last several decades, increased specialization has led to a deep knowledge base, but also, to overlap in professional roles with, at times, accompanying services, inappropriate or inadequate referrals, lack of accountability and fragmentation, or redundancy of services. The shared desire for optimal service provision to clients is what motivates professionals from different disciplines to collaborate.

Collaboration implies a process of shared planning, decision-making, responsibility, and accountability in the care of the client. Ideally, in collaborative practice providers work well together through effective communication, trust, mutual respect, and understanding of each other's skills. While some skills and services appear to overlap, most skills and services are complementary and reinforce each other.

When working in teams, there are a range of factors that impact successful teamwork

Each discipline involved in the task comes to the team with perspectives related to professional obligations, ethics, and standards.

In the APS process, as with other legal proceedings, there are different focuses.

> The APS worker's aim is to insure the safety of the individual-at-risk and will work to establish the least restrictive means for meeting that aim.

> Law enforcement focuses on accountability of the perpetrator when there is crime involved. Reliance is on the APS worker to address the needs of the individual-at risk. Court proceedings then focus on evidence and burdens of proof.

> There is also the interface with attorneys—dependent on which 'side' is being represented. Guardian ad liteum works toward the best interest of the person who is subject to the proceedings whereas other attorneys involved have an interest in the outcome—either supporting the petition or in the case of opposing counsel, defending the petition.

In addition to disciplinary differences, each party in team-based efforts generally has different roles and responsibilities. Within APS services, these are often statutorily designated; but if we think more broadly in organizations and systems, differences may be determined by position. Within organizations, supervisors, and managers have different responsibilities than line staff and will often approach a situation based on area of responsibility. Responsibilities differ by type of service as well—mental health workers, child protection workers, staff who work in systems addressing developmental disability or substance use-- see their functions differently. We can also look at roles and responsibilities across agencies whose purposes are different.

Because teams are centered in and across agencies, policies and guidelines may differ. How deadlines are approached and maintained may also differ by service provided as well as dynamics of the situation. It is often in this area that conflicts can arise when there are differing priorities or styles of completing the team task.

At the center of this interactive "puzzle" are the skills each team member brings to the table.

Ask the group: *What are some of the benefits and barriers that are related to interprofessional collaboration?*

[Write answers on flip charts as called out.]

Benefits	Barriers
- Shared expertise and cross-training/education - Builds trust between agencies and individuals engaged in similar work - Builds relationships - Promotes networking - More effective outcomes/action taken on behalf of clients - Larger power base/advocacy efforts - Feeling of larger support system for achieving goals - Improved outcomes for clients through coordinated investigations and interventions	- Lack of knowledge about other professions' roles, cultures and systems - Confusion about goals/lack of consensus regarding the reasons for the collaboration - Lack of a common stake/common mission that binds the different professions together in their task - Territorialism or historical suspicion of other disciplines (e.g. social work and law enforcement) - Desire to protect own professional domain - Apathy/lack of participation by needed disciplines

- Able to identify community's service gaps and system problems - No one program, or agency, can meet complex needs - Reduced duplication of efforts/improve efficiency in service delivery - Resources are shared during hard economic times - More holistic approach to problem-solving/case management/services - Ensuring that all members of the interdisciplinary team are used in a way that is maximally effective - Cross-fertilization of knowledge and skills between professions - Supervisors become invested and continue staffing I-teams - Administration will be less suspicious as their line workers pass on their comfort level after collaboration - All disciplines come in on the ground floor and don't need to be convinced later of the relevance of collaboration	- Individuals involved are not team players - Time - Confidentiality concerns - Funding - Lack of direction/focus of individuals or teams - Historical conflict between disciplines (for example, between APS and law enforcement) - Individual professionals who need to collaborate don't have the skills to do so

Let's talk a little about skills needed for effective team work.

B. Competencies in Interdisciplinary Team Work

Display **Competencies** (Slide 7).

<u>Knowledge</u> - Everyone on an interdisciplinary team brings to their work particular skills associated with their specific profession or discipline. In APS work, discipline-specific knowledge and expertise means: Are you knowledgeable about your role and the function of APS? Do you have content knowledge about the aging process, assessment, and interviewing skills, family and abuse dynamics, resources/referrals, etc.?

<u>Skills</u> – Each team member is a unique individual with individual interpersonal style or characteristics. Working on a team requires being able to communicate your knowledge and ideas to others in ways that can be "heard" by others in a variety of dynamic situations. It is these elements which may in fact have the greatest influence on how people function as team members and collaborators. Skills include interpersonal, communication, and conflict resolution skills.

<u>Attitudes</u> – One's attitudes and values have a significant bearing on behavior when working in a group. Attitudes and values mean that the individual holds a belief that collaboration with other disciplines/ partners maximizes outcomes for clients. This was covered in our "benefits to collaboration" exercise; it does minimize the challenge to collaboration, but fundamental to effective collaboration is a belief that overcoming obstacles to work together maximizes outcomes for clients.

Also, when thinking about attitudes/values is the willingness to accept feedback, self-awareness, and our commitment to ongoing growth.

<u>Structural</u> –Each team member is also required to work within the framework provided by their agencies. They have to follow that organization's policies and procedures which may act as either a barrier or a support to their collaborative efforts. Possible sources of support may include MOUs with other agencies, legal statutes that address cross discipline collaboration, written policies that outline specific methods of making referrals and working joint cases, etc.

Agency/institutional support for collaboration is another key need for competency in collaboration—providing the time and resources to successfully work through team issues. The attitudes and beliefs can be applied here on an individual or organizational level.

Practitioners require more than a prescribed set of competencies to perform their role. It means using those knowledge and skills effectively. Being able to accept feedback and understand others' perspectives and working through some of the conflict that is inevitable when different perspectives and disciplines work together. Being capable means responding professionally, respecting the other—including their time and expertise—as you work together.

Display **Team Member Skills** (Slide 8).

This set of trainings is created to increase APS competencies. In addition, you have competencies that are determined by your professional discipline—social workers must demonstrate competency in select areas to earn their degrees; certification and licensure is the test for minimum standards of competence.

Practitioners require more than a prescribed set of competencies to perform their roles, though. This is where capabilities come in.

We just talked briefly about attitudes and values. Many of the barriers to collaboration can be tied into this dimension.

Display **Small Group Discussion** (Slide 9).

Take a few minutes at your tables to brainstorm what interpersonal skills and communication characteristics you feel are essential for collaborative team efforts. Someone at the table should be a recorder so that we can be sure not to miss any of your ideas when we come back together. **You have five minutes for this activity.**

After the five minutes, use a round-robin framework to discuss what the participants believe are the most essential skills and communication characteristics for effective teamwork. Reponses can be written on the flip chart. [At the next group activity, trainer can put the list in a visible place in the room.]

C. Communication Skills

Display **Effective Communication** (Slide 10).

We have to be aware of several variables in communication, both when we are sending as well as receiving communications. You came up with a nice list in the brainstorming you just completed!

Important considerations include:

Clarity of our verbal communication: Are we abundantly clear in what we are saying/writing? Is there any way for what we said to be misinterpreted?

Non-verbal communication: It is commonly reported that more communication is done through non-verbal over verbal means.

Attitudes: One's generalized tendencies/feelings which get applied to the collaborative communication. For example, do I often wonder, "Is this person judging me?" "Does this person even want to know what I think?" If this unconscious inner dialogue is not addressed, it can impede communication.

Knowledge level: If we are knowledgeable and confident in our knowledge, then we convey our message differently than if we don't know or don't feel confident.

Position: Does my collaborative partner/team value my role? If the listener views the sender as a valuable partner, then he/she will listen more earnestly.

<u>Soliciting information</u>: It is recommended that we use <u>what</u> and <u>how</u> over <u>who</u> and <u>why</u>. "Why" questions – no matter how nicely phrased – are almost always blaming. When we ask "who" questions, what we're often really doing is looking for scapegoats (i.e. someone else to blame). Asking questions that focus our efforts and energy on what we can do makes us significantly more effective, happier, and less frustrated.

<u>Feedback</u>: Finally, we must be open to feedback, both as the speaker and as the listener.

<u>Culture</u>: Different cultures foster different communication styles. Culture also informs non-verbal communication factors such as making eye contact, sitting vs. standing, as well as cultural norms such as deference based on age or gender. There is no "right" or "wrong" in terms of cultural communication styles, but we must recognize there are differences. We also have to acknowledge professional cultures which differ; for example, law enforcement personnel have different communication norms/language than APS. Providers may use different terms to mean the same thing and can have very different focuses in the work within the same situation. Developing group agreements about the rules for communication within the group can be helpful.

And finally, key in effective communication is <u>working through conflicts</u> as they arise.

Conflict on teams is inevitable. Team members need to be able to express opinions and disagree with each other. It is important to recognize that most people would rather avoid conflict, but healthy partnering and teaming encourage open discussion of differing views.

Conflict is healthy—generates discussion and can be a catalyst for positive outcomes

Confrontation is not the same as conflict—being direct versus having a chip on your shoulder. The chip on my shoulder represents an attitude. If I respectfully and directly approach a colleague about a disagreement, I am doing appropriate confrontation.

The only way to discover and resolve differences is to open up, acknowledge the disagreement and negotiate a solution.

D. Handling Conflict

Display **Framework for Discussion of a Conflict** (Slide 11).

As social workers, we are trained in active listening and questioning. These skills are critical to working through conflicts. This framework focuses on those skills when in conflict situations.

- Actively Listen: Rephrase the issue and repeat the statement.
- Define the Problem: Emphasize the areas of agreement and frame the area of disagreement. Attack the problem; do not blame the person.
- Open-ended questions: Ask questions that encourage discussion and permit disagreement. "Tell me more about that…" "What else do we need to consider?"
- Clarify Responses: Help others recognize members' attitudes and feelings.
- Paraphrase and Reframe: Summarize discussion to ensure that the disagreement is understood. Explore group problem solving and encourage solutions that have not been considered before.

Tune in to your attitude and body language:

- Be aware of your personal reactions.
- Display courtesy and politeness.
- Remain impartial.
- Accept person, not behavior.
- Be open-minded to problem solving.
- Remain calm and confident.
- Respect personal space.
- Model relaxed and controlled stance.

Display **Proactive Responses to Conflict** (Slide 12).

When people are in conflict, emotions tend to be high.

It is generally helpful to be proactive and prevent conflicts before they occur. This slide shows responses that either escalate or diffuse conflict. As you can see, many of them relate to our attitudes more than what we say.

<u>*Ask*</u><i>: Do any of these resonate with you?</i>

In general, to manage conflicts, we should:

- Identify issues causing a conflict before there is an explosion.
- Choose an appropriate time and place for the discussion.
- Focus on what can be done, not on what can't be done and leave "old stuff" behind.
- Accept ownership for your part of the problem.

- Encourage differing points of view and honest dialogue.
- Demonstrate understanding of the other person's point of view before giving your own.
- Keep the focus on how resolution of the issue will advance your shared mission!

Display **Resolving Conflict** (Slide 13).

This step is important because there may be an assumption that everyone is working towards the same goal when, in fact, they are working towards opposing goals. For example, APS may be working with a son to help him quit misusing mom's money and become a better care provider for his mother while law enforcement may be working to arrest him. Because their goals are in conflict, the two agencies may actually undermine each other's attempts to be successful.

The first requirement of conflict resolution is to make sure you have the right people at the table. For example: If a team member says that he can't do X because of an agency policy, you will need to get that agency's decision maker at the table if you feel that X is something that the agency can or should do or that an exception can be made.

Develop an action plan with 'who', 'what', 'when', 'where' and 'how' detailed and put in writing.

Has anyone ever gotten upset with you because you didn't do something but the reason you didn't do it was because you didn't know they were expecting you to do it? In any kind of group work, it is important to clearly delineate who will do what (in detail) and when they are expected to do it. And, putting it in writing makes it clear to everyone on the team what is expected.

Checking in with partners at the agreed upon times also helps reduce confusion and keeps everyone on the same page as to what is happening on the case/project. If there has been any confusion, the sooner you are aware of it, the sooner you can resolve it.

Obviously, if you want to fix a situation, you have to set an example and do your part. Partnerships are based on trust and you will lose much of that trust if you don't either complete your part or, at the very least, communicate why you can't complete your part in a timely manner.

Trainer note: *You should be prepared with an example from your own experience to illustrate how you were part of the problem, took responsibility*

and help resolve the problem. Role modeling the ability to admit mistakes in public is an especially powerful teaching tool.

If the issue can't be resolved through this process or things get personal, step back and invite another player to the table.

E. Interdisciplinary Exercise

Display **Interdisciplinary Exercise** (Slide 14).

Divide the class into small groups of four participants. Ask participants to pull out Handout 2.2. Read the Interdisciplinary Team Exercise Instructions to the class. Give each member of the small group a single Fact Sheet (one for APS, one for Law Enforcement, one for Ombudsman, and one for Licensing [These are labeled Handout 2.2A-2.2D])- point out that their role for the exercise is that which is identified on the sheet.

Review the suspect list on the back page of Handout 2.1. Monitor the groups' progress, watching for signs of conflict, collaboration and "ah ha" moments. Give the groups 15 minutes to complete the tasks.

 NOTE: The Fact Sheets have the specific facts unique to each agency. The answer key below outlines the different cues that are in each of the four options.

Specific facts unique to each agency	
APS	Strong spent the night in Linda's room and only left the room when he got up in the morning to go to work.
Law Enforcement	Her assailant has type B+ blood. A brown pubic hair, as well as an unidentified animal hair, were recovered from her clothing.
Licensing	Jeff Green called in sick to work on Tuesday and Wednesday two weeks ago and a temporary worker, Janice Tibbs took his place.
Ombudsman	Mike Rogge was hired last week as a substitute worker. Jeff Green called in sick to work on Tuesday and Wednesday two weeks ago and a temporary worker, Janice Tibbs took his place.
Outcomes Based on Combined Information	
	Resolution for Trainer

Bill McHann	eliminated by blood type (Law Enforcement)
Paul Strong	no opportunity to commit crime (APS)
Jeff Green	no opportunity to commit crime (Licensing)
Mike Eagleheart	eliminated by hair color (Law Enforcement)
Rex McHann	eliminated by hair color (Law Enforcement)
Mike Rogge	no access to victim at time of crime (Ombudsman)
Pete Podgerski	Suspect

After small group work, ask the following questions:

What did you learn from this exercise?

Was there consensus that a crime was committed?

How long did it take for your group to realize that you had different facts?

What would have happened if one of the agencies was not present at this "meeting"?

How would this incident be communicated internally? Would they report it as a crime? Does the incident raise additional issues for an agency (Adult Protective Services, Law Enforcement, Licensing, and Ombudsman)? What would the agency investigators focus on?

What evidence would law enforcement focus on? What witnesses would they want to interview? What should they do before interviewing the victim? What other materials would they seek to obtain?

Are there any other service providers or assistance agencies/programs that could provide assistance to the client-victim or the mentioned responders? How could they be brought into the interdisciplinary response in this situation?

NOTE: If the participants are from a variety of agencies, ask each agency's personnel how their agency would handle this victim/perpetrator.

 Display **Know Your Strengths** (Slide 15).

In your packet, you have a handout titled, "Collaboration Learning Inventory" (Handout 2.3). Take a few minutes to complete the inventory. It provides an opportunity for you to assess your own strengths and challenges related to collaboration. This is not a shared activity. You will not be required to reveal your answers or score to anyone.

When completing the inventory, the ratings are NOT whether someone thinks the item is important or not; it asks the respondent to rate whether the skill is still developing for them, or whether they feel confident about this skill and able to teach/model for others. The exercise is intended to make the participant more aware of his/her strengths and areas needing improvement. There is no composite score.

After the training, use the scores to focus on areas for further development. Reassess your progress in strengthening the areas in need of development or other factors at regular intervals.

[End of module]

Module 3: Expanding Statutory Awareness Overview

Timing (30 minutes max.)

  Expanding Statutory Awareness ....30 minutes total

    A. Review…… .... 5 min

    B. Understanding Differences CH 54 & 55 and CH 51………………………… <u>25 min</u>

                                                                                           30 min

Learning objectives

- Outline statutes and administrative codes that intersect with Adult Protective Services practice.

Advance preparation

- None

List of Handouts

- Handout 2.4: Statutory Parallels

PowerPoint slides

- Slides 16 – 18

Other

- None

A. Review

Display **Review: Parameters for Practice** (Slide 16).

On the first day of training, we discussed the primary rules that govern APS practice.

Section 46.90 outlines the role of Elder Adult-at-Risk Reporting within the social services delivery system.

Chapters 54 outlined the rules for guardianships and CH 55 for adult at risk agency, protective services and protective placements. We also noted the interface with CH 50 when placing in residential care facilities.

> Note: This training was not designed to provide intensive statute training. Statute specific training should be sought from attorneys familiar with the statutes governing APS activities.

We also briefly referenced those statutes that outlined the opportunities for creation of powers of attorney for health care and finance (CH 155 and CH 244).

As APS workers, it is also not uncommon to provide clients with information about Advanced Directives as is outlined in CH 154—these include the creation of a "living will" and do-not resuscitate orders.

We also know that APS work interfaces with criminal statutes including CH 940 which relates to sexual assault. With the development of the internet, exposure to financial abuse and exploitation is increasing as well. CH 943 is referenced when challenges occur.

We know that we do not practice in a vacuum. A basic understanding of these statutory guidelines is important so that we can be competent APS workers and active members of the team.

Today, we are going to add to our statutory discussions to include the chapter used by the Community Programs system of care that interfaces with APS—CH 51. DHS 34 is the program for Crisis Services in WI.

B. Understanding Differences CH 54 & 55 and CH 51

Display **Expanding Statutory Awareness** (Slide 17).

CH 51: State Alcohol, Drug Abuse, Developmental Disabilities and Mental Health Act

Within this set of guidelines are the rules related to emergency detentions (51.15), and involuntary commitments (51.20, 51.22). Also included is what determines residency and how to handle the issue with mental health services (51.40).

Another important administrative code is DHS 34; this is administrative code that articulates Emergency Mental Health Service Programs. Counties may offer a certified crisis program which means that they follow the regulations under DHS 34. This rule outlines, among other items, acceptable staff credentials, timelines for completion of initial assessments.

DHS 34 allows counties to create certified programs of response for emergency mental health services. When participating in this program, adherences to clinical guidelines are required.

Under the emergency mental health services, DHS 34, credentials and training requirements are outlined for individuals eligible to provide crisis services, clinical supervision requirements, and related programmatic requirements. Individuals are eligible for services if in a mental health crisis or a situation which is likely to develop into a crisis if supports are not provided. An initial assessment is completed, and a response plan established. These plans must be co-signed by a psychiatrist or psychologist within five days after services are delivered. Proactive planning also can be completed for individuals who are at-risk of crises. These allow the individual's wishes to be respected should a crisis develop.

Ask students to refer to Handout 2.4. This handout outlines the standards for commitment under Chapter 51. Let's take a few minutes to compare them to what is required under the rules that govern APS.

Go through the handout with the participants. **Ask for responses related to APS for each of the items noted on the handout.** [Answers for CH 54 & 55 are noted in the section below as are the statutory connections for CH 51.]

	Adult Protective Statutes: CH 54 & 55	Mental Health, Developmental Disabilities and Alcohol and other Drug Abuse under CH 51
Referral for services under CH 54/55 and	*CH 55* *Report is made to APS if:* *[55.043(1m)(b)]*	Must meet all criteria: [*51.20]*

emergency detention under CH 51.20	*1. The adult at risk is at imminent risk of serious bodily harm, death, sexual assault, or significant property loss and is unable to make an informed judgment about whether to report the risk.* *2. An adult at risk other than the subject of the report is at risk of serious bodily harm, death, sexual assault, or significant property loss inflicted by a suspected perpetrator.* *-shall refer the report within 24 hours after the report is received to the department for investigation. [55.043(1r)(a)(1g)]* *-Response to another investigative agency's report commence within 24 hours after report received (excl. Sat, Sun, Holidays)* *-May apply for a restraining order is a person interferes with investigation. [55.043(3)]* *-After receipt of report, believe abuse/neglect/self-neglect or exploitation, initiate services. [55.043(4)(b)(1)]* *CH 55.13 emergency protective services or CH 55.135 emergency and temporary protective placement initiated.*	-Mentally ill, drug dependent, or developmentally disabled [51.20(1)(a)] - Detention is least restrictive alternative appropriate Meets one of the following: [51.20(2)] (a) Substantial probability of physical harm to self (recent threats/attempts of suicide or serious bodily harm) (b)harm to others-evidence of homicidal or other violent behavior, reasonable fear of harm by other, recent acts, attempt, or threat (c) probability of impairment or injury due to Impaired judgment as manifested by act or omission; unable to protect in the community (d) Due to mental illness, unable to satisfy basic needs/treatment; will not avail of services Alternative standard: (e) Recent acts or omissions indicate unable to satisfy basic needs without prompts & adequate treatment. Person unwilling to use available services. Death, serious physical harm, debilitation, or disease if does not receive services.
Timeline for Hearings	*When detained under emergency protective placement, preliminary*	Petition filed within 24 hours of detention.

hearing held within 72 hours to establish probable cause. (a)Least restrictive conditions necessary to meet objective. [55.135(4)] *Emergency time of detention—* *-Notice of hearing (written and orally) at least 10 days before hearing. [54.38(2)(a)]* *-If not under guardianship, petition for guardianship accompanies protective placement petition.* *-Temporary protective placement order may be extended for 90 days if necessary so plan can be developed. [55.135(5)] [Initial = 30 days]* *Non- emergent:* *Court hearing within 60 days of petition filing; extension of up to 45 days allowed.* *-Right to jury trial (12 person) [55.42(2) & 55.10(4)(c)]* *Modification of order: [55.16(3)(a)]* *Hearing held within 21 days* *-If court finds still meet the criteria, continuation* *-Meets standards but not least restrictive, orders transfer to least restrictive within 60 days.* *-If does not meet the standards, protective placement terminated. [55.15(8)(b) & 55.16(4)]*	-State public defender's office informed of detention and represents all indigent. -Individual informed of rights at detention. -Superintendent of facility may release if find no cause before the probable cause hearing occurs. Probable cause hearing held within 72 hours of detention. (At request of subject, may delay 7 days from date of detention) [51.20(7)(a)] (a) Settlement-agrees to probable cause and agrees to treatment for 90 days [51.20(8)(bg)] OR (b) Final hearing held within 14 days of detention. If not detained, hearing scheduled within 30 days, if fails to appear, orders detention & hearing within 48 hours. Petition includes planned treatment plan. Commitment for up to six months must be re-evaluated for extension. [51.20(13)(g)] -Right to jury trial 5 of 6 jurors must agree. [51.20(11)(a)] -Extensions must be requested at least 21 days before commitment expires; Commitments can be extended up to one year (consecutive order allowed) [51.20(13)(2r)]

	[55.15(9)(c)] *Termination of order:* *Anyone can file petition for* *termination. Hearing held* *within 21 days; follows* *modification criteria. [55.17]* *Hearings are open unless* *request by subject to be* *closed. [55.10(3)]*	Hearings are open unless request by subject to be closed. [51.20(12)]
Guardianship Appointment	*When protective services or* *protective placement is* *ordered on an involuntary* *basis, guardianship* *proceedings must be* *concurrently initiated.* *[55.10(4)(d)]*	Court may determine need for guardian at probable cause hearing & appoint temporary guardian for period of 30 days. Petition for guardianship and protective services follows. [51.20(7)(d)(1)]
Medication Orders	*May be ordered as a* *protective service. Must* *have had two episodes in* *last 24 months that resulted* *in CH 51 action and must* *meet dangerousness criteria* *from CH 51.20* *[55.14(3)(e)1)]*	Probable cause hearing determines if competent to refuse medications. [51.20(8)(c)]
Examination	*Comprehensive evaluation* *required, medical* *examination by physician* *can be ordered by the* *court (CH 55).* *Incompetency* *determination by physician* *or psychologist (CH 54);* *recommendations of which* *rights to retain. [54.36]* *Has right to secure an* *independent evaluation at* *expense of the county* *where petition is filed.* *[55.10(4)(e)]*	By psychiatrist or psychologist appointed by the court before final hearing. Determines if proper subject for treatment and ability to understand re: medications [51.20(9)]
Fees/Costs	*Court may order the* *individual to reimburse the* *state for costs of*	Witnesses reimbursed in accordance with other cases when subpoenaed

	representation; payments made to clerk of courts for county where proceedings took place. [55.04(5) & 55.46(3)(a)&(b)	Expenses are the responsibility of the county from which the subject resides; reimbursement to the county in which was detained.
Records	*Records are confidential and may not be released unless under specific circumstances. [55.22& 55.043(6)]*	Records are confidential and privileged. Informed written consent of the subject individual is required to release to anyone. (Exceptions for continuity of care). [51.30(4)(a)] Additional limitations for AODA records. [51.30(20)]*
Residence	*County where residing; residence determination under CH 51.40, no prior services or terminated and has established alternate residence, court may determine county of responsibility. Entire record forwarded to another county. [54.30(2)]*	Intent to reside or return to prior county within one year. Must have fixed habitation [51.40(2)& 51.40(2)(g)] Guardian may declare county of residence. [51.40(2)(f)]
Other important considerations	*Annual review of status required. [55.18(1)] -by 1st day of the 11th month and annual thereafter*	If has a guardian, both guardian and individual must consent to admission to a mental health facility. *[51.12(5)(8)]* Commitment proceedings may occur while the person is incarcerated; does not expunge responsibility unless determined within the criminal court process. A petition for detention may be made by three adults when able to present evidence that lacks self-control due to alcohol/drugs to extent of substantial impairment and endangered.

__Note to Trainer__: If you are ahead of schedule for the training, initiate a discussion about any experiences with the interface of the APS and the mental health systems. Be prepared to provide personal experiences that can outline some challenges and successes.

Display **Slide 18**. This is simply a transition slide.

Just as completing your puzzle in our opening exercise required teamwork and communication to complete successfully, meeting the needs of individuals at risk involves careful collaboration among all partners. Challenges can occur when those we are working with have complicated situations. Understanding the roles and parameters of each party in the process can help us to effectively manage those complicated issues.

[End of Module]

Module 4: WI System of Care for APS Overview

Timing (20 minutes max.)

WI System of Care for APS .... 20 minutes total

    A. Review ....10 min

    B. Safety…………………………………………………………………….10 min

Learning objectives

- Describe systems of care for individuals-at-risk in Wisconsin.

Advance preparation

- None

List of Handouts

- Handout 2.5 APS Partners
- Handout 2.6 Safety Planning Tips for Home Visits

PowerPoint slides

- Slides 19 – 24

Other

- Need Flip Chart

A. WI System of Care for APS

Display **Slide 19.**

As you will recall from our first training, services to individuals-at-risk in Wisconsin are county and tribally centered but are under the oversight of the Wisconsin Department of Health Services.

APS interfaces regularly with other agencies and providers.

Ask: Who are some of the professionals you work with regularly in your work?

Trainer writes the agencies identified on a flip chart as they are called out.

- *Public Health*
- *Housing Inspectors and other Code enforcement*
- *Victim-Witness/Crime Victim Assistance*
- *Rape Crisis*
- *Law Enforcement and the Courts*
- *Other County or Tribal Human Services Departments*
- *Animal Control*
- *ADRC and other aging services*
- *Cultural/Ethnic/Faith Community Organizations*
- *Advocacy Groups*
- *Professional Guardianship Services*
- *Managed Care providers*

Handout 2.5 provides a list of agencies which partner with APS. As with any time we work with agencies whose primary focus is different than our own, there may be challenges that can evolve.

Take a few minutes to review the handout. **Ask participants if there is any agency they have worked with that is missing? Any barriers they often come up against in practice? Any strategies they have found helpful in navigating agency differences.**

Display ***Guidelines for Interdisciplinary Collaboration*** (Slide 20).

NASW has developed some *Guidelines for Interdisciplinary Collaboration*. The guidelines contain some essential themes:

- Self-awareness so you know how you are presenting self, body language and messages, limitations in your knowledge.

- Confidence in your position. Knowing your function, strengths, ethics and how you can contribute to the team.
- Using social work knowledge, ethics, and research to explain to those who might not understand your perspective. Be able to highlight differences and similarities.
- Ask questions to show a desire to understand and affirm the strengths of that discipline.
- Explore differences in goals and outcomes. [For example: safety].
- Find areas of overlap and reframe colleague's responses– keeping in mind common goals.
- Seek others' perspectives and negotiate.
- Find commonalities but be patient. Developing trust and reciprocity takes time.

B. Safety

 Display **Safety** (Slide 21). [This is a transition slide.]

We have one more topic I would like to cover before we break for lunch.

APS work can involve personal risk to the worker. This problem can have a marked impact on the ability of APS systems to provide services to the adults who need them most.

The 2004, a National Association of Social Workers (NASW) survey examined a variety of topics related to licensed social workers. In response to the question, "Are you faced with personal safety issues in your primary employment practice?"; 44% of respondents answered affirmatively. Thirty percent of them also stated that they did not think that their employers adequately addressed the safety issues. According to the NASW published results, social workers facing safety issues were more likely to:

- Be in the first five years of their social work practice (26%).
- Work in private, non-profit (37%) and state government settings (23%).
- Work in social services agencies (17%) and
- Describe their primary area of practice as mental health (35%) or child welfare/family (16%).

(Whitaker, Weismiller, & Clarke, 2006)

NASW has developed standards for worker safety. These standards outline strategies organizations can do to ensure worker safety and also outline risk assessment considerations when going out into the field. These include having a complete and exact address for the visit, considering neighborhood factors and

time of day, and cellular reception so the worker can call for assist if needed. Safety should also be assessed for the residence— Are there stairs? Well-lit common areas? Exits easily accessible if needed? Who is likely to be present at time of visit?

While agencies have a responsibility to insure worker safety and to evaluate settings' responsiveness to the needs of their employees, we too have a responsibility to practice safely.

Display **Worker Safety and Well-Being** (Slide 22).

Federal Voluntary Consensus Guidelines recommend that these items be considered as part of formal policies and procedures related to worker safety.

Resources regarding safety hazards include access to information related to criminal and civil legal proceedings, the ability to request law enforcement accompaniment for home visits, and worker safety training.

Be aware of your on-line presence, be aware of safety when in the field… it can happen to you.

Display **Planning for Safety** (Slide 23).

There is no single plan that can eliminate risk nor is there any one "right" way to deescalate tense situations. Guidelines are offered with the recognition that workers must assess the validity of a particular suggestion based on the individual circumstance they are dealing with. Workers must use their clinical and intuitive judgment to determine the best course of action in any given situation. If instinct or professional judgment indicates that a particular strategy will increase the possibility of harm, then the worker should discard that option.

Handout 2.6 provides a list of items for consideration when you are going out for an initial investigation.

Ask: *Is there anything on that list that you have found helpful when you found yourself in a potentially unsafe situation?*

Display **Involving Law enforcement at Initial Visit** (Slide 24).

Making an initial visit accompanied by law enforcement may be necessary if there is information to substantiate weapons in the home, active violent behavior, or acute mental illness where there is danger to self or others. It is important that the worker feel safe in the job. At the same time, there is a downside to involving law enforcement on the first visit.

Ask: *Can you think of some unintended negative results when bringing law enforcement to the initial visit?*

Make sure the following points are covered with the responses to the question: The initial visit is one that should build trust with the client. A police presence may induce fear and suspicion. It may make it difficult to explain the helping nature of the APS relationship. One way to mitigate the disadvantages of having law enforcement along for the first visit is to meet with the officer beforehand to get on the same page regarding who is leading the investigation and what outcomes are expected.

It is important to think through the reasons and to discuss the options with your supervisor first. There may be a less intrusive and aggressive way to approach the situation.

Ask: *What might some alternatives be?*

Meet client at a different, safer location, visit when alleged perpetrator is known not to be home, go with another worker, go when the home health aide or another service provider is present.

Display **Lunch Time** (Slide 25).

We covered quite a bit of material this morning. When we come back, we will build on the concepts of last training around ethical practice and apply the principles we have covered thus far.

We will reconvene in 45 minutes.

[End of Module]

Module 5: Ethical Imperatives Overview

Timing (157 minutes max.)

Learning objectives

- Examine best practice in Adult Protective Services.
- Evaluate the impact of cultural differences on practice.
- Apply decision-making to challenging situations and ethical dilemmas that arise in Adult Protective Services.

Advance preparation

- Handout 2.9 should be placed in the center of each table during the lunch break.

Handouts

- Handout 2.7: Cultural Interface with Ethical Principles
- Handout 2.8: Conflict of Interest Standard
- Handout 2.9: Boundary Challenges [Not in participant packets]
- Handout 2.10: Key Standards Connected to Self-Care
- Handout 2.11: Dilemmas in Practice
- Handout 2.12: Ethical Decision-Making Worksheet

PowerPoint slides

- Slides 26 - 53

A. Ethics

Display **Ethics** (Slide 26).

When we met on Day 1, we talked about the key ethical issues in APS—self-determination, privacy, confidentiality, and commitment to client. We discussed the principles used for ethical decision making—autonomy, beneficence, nonmaleficence, justice, fidelity, and integrity. We also learned a decision-making model when dilemmas occur. We are going to build on that discussion today with a deeper dive into the areas of cultural awareness, boundaries, and safety in the field.

Display **Ethical Imperatives** (Slide 27).

As a core component of ethical practice, we need to understand diversity and its impact on our practice. The NASW *Code of Ethics* defines attention to the needs of vulnerable and oppressed populations as central to our mission—this includes being sensitive to how individual difference has been impacted both historically and in the present moment. Diversity takes many forms: age, ability, ethnicity, race, social class, gender, sexual orientation, gender expression and gender identity. In APS we deal with ageism, racism, and discrimination against the elderly and people with disabilities. Often, we see an unmet need and look for creative ways to meet the need – or we put pressure on other entities (community agencies, government programs, for example) to meet the need.

Each culture values different things and it is important that we can communicate our own cultural values as well as understanding the values of different cultures we interface with. We can't generalize that just because someone is of a particular ethnic group that they will hold the values of that group but understanding them can serve as recognition of the need to think about our own stereotypes, biases, and assumptions about the population which the individual is a part of.

When working with cultural competence, the APS worker flexibly and skillfully responds and adapts when in a different cultural situation than his or her own. And, the APS worker understands and uses his or her own skills and knowledge in culturally congruent ways.

Central in APS is an awareness that many we work with face oppression due to ageism and able-ism. Often, those who are older or experiencing a disability

are treated as less than—we need to reinforce their self-determination, basic rights, and use an empowering approach to insure their voices are heard.

All of these factors contribute to best practice for Adult Protective Services. Let's start our discussion of ethics with a discussion of best practice in Adult Protective Services.

B. Best Practices in APS

Display **Best Practice in APS** (Slide 28).

The National Adult Protective Services Association has established recommended minimum program standards. While it is not possible to go through all the components identified by NAPSA within this training, if we adhere to the philosophies outlined here, we can be assured that we are attending to the standards for adult protection.

Key practice guidelines outlined include the need to:

- Recognize that the interests of the adult are the first concern of any intervention. This is consistent with the NASW *Code of Ethics* which outlines our ethical responsibilities as centering on our commitment to clients.
- Avoid imposing personal values on others. We need to be aware of biases we have in order to make decisions that focus on best interests of the clients we serve. In our assessment and intervention, we must recognize client differences -- cultural, historical and personal values—and their influence on choices, lifestyle and response to intervention.
- Respect the adult's right to keep personal information confidential. Honor the right of adults to receive information about their choices and options in a form or manner that they can understand. This can be reinforced through obtaining informed consent
- To the best of our ability, involve the adult as much as possible in developing the service plan. We are working in a practice area that requires us to intervene with people whose decisional capacity is impaired. If we focus on case planning that maximizes the vulnerable adult's independence and choice to the extent possible based on the adult's capacity, we will be providing best practice
- Best practice includes using the least restrictive services first and community-based services rather than institutionally based services whenever possible, using family and informal support systems first as long as this is in the best interest of the adult.
- In the absence of an adult's expressed wishes, we must support casework actions that are in the adult's best interest and use substituted judgment

in case planning when historical knowledge of the adult's values is available.

- We maintain professional boundaries while maintaining an ethics of care. We focus our activities on the intent to do no harm. Inadequate or inappropriate intervention may be worse than no intervention at all.

Display **Guidelines for Best Practice** (Slide 29).

The *National Consensus Guidelines* were developed as a result of a comprehensive literature review and a process of surveys, focus groups, and input from APS stakeholders across the country.

As we have been discussing thus far in these two trainings, best practice has been defined as providing person-centered services in the least restrictive environment. Use of supported decision-making is being used more often—we will discuss that further in the next training. We will also discuss what it means to take a trauma informed approach.

As we know, Wisconsin passed a supported decision-making law in 2018. The law allows an individual with a functional impairment to enter a formal agreement with a supporter who will assist the individual in decision-making. The adult retains all decision-making rights and authority. Judges will now consider whether supported decision making has been attempted prior to granting guardianship.

The *National Consensus Guidelines* highlight recommendations across the range of service dimensions. The need to maintain program integrity is one area I wanted to focus on in terms of this training. This focus includes avoiding conflicts of interest, protecting client rights, and avoiding dual relationships. Additionally, we protect program integrity by handling complaints appropriately, providing consistent practice and ensuring the workforce is well-trained, and those hired hold views congruent with the ethical guidelines.

The guidelines also provide recommendations for the remaining focuses listed on this slide. We are not going to go more specifically into the guidelines themselves, but we wanted you to be aware of them and to know that this set of trainings is designed in accordance with those recommendations.

Display **Best Practice as Ethical Imperative** (Slide 30).

The FrameWorks Institute is a nonprofit think tank that focused on framing the public discourse about social problems. One of the initiatives by that entity is research around ageism and attitudes toward elder abuse and neglect.

Frameworks supports the idea that we can explore community values to institute positive change for the affected populations—recommending that we foster a "confronting injustice" narrative in our communities. We do so by leading with justice—addressing ways we are marginalizing older adults and minimizing their contributions. We can extend this thinking to those with disabilities as well. Frameworks' philosophy fits in very well with the mission and values of social work.

The NASW *Code of Ethics* outlines social justice as an ethical principle guiding our practice. In our roles as social workers, and I would extend this to all APS workers whether a professional social worker or not, is to promote the wellbeing and social welfare of vulnerable and oppressed populations.

This involves not only our own approach to working with older adults or people with disabilities but also advocating for these groups. We need to promote inclusion of older people and those with disabling conditions so not seen as "other".

This involves reinforcing the concept of abuse and mistreatment as a community problem (not an individual one).

A consistent dilemma that occurs in practice is coming up against those beliefs about older people and aging that remove self-determination, restrict opportunities, and undermine wellbeing.

Stereotypes about those with disabilities also create limitations. As APS workers, you confront these often and combat them by reinforcing the least restrictive options and promoting self-determination and choice as much as possible.

Display **NASW Standards for Best Practice** (Slide 31).

While NASW has not articulated standards specific to APS Practice, we can look to several guidelines that can help up to ethically practice using best practice.

When we adhere to the *Code of Ethics* we are promoting social justice and addressing the issues we have been talking about throughout this training.

NASW's case management standards reinforce person-centered services—tailoring services to the client's needs, preferences, and goals. We use the person-in-environment framework—recognizing that everyone is influenced by their physical and social environments. Behavior cannot be understood, and strategies developed outside of that context. These standards reinforce what we have been discussing much of today—the collaborative teamwork for good service. We recognize that we do not work in isolation.

APS gets involved when situations arise that emphasize problems. We can focus our interventions on eliciting, supporting, and building on the resilience and potential for growth and development inherent in everyone—regardless of age or ability.

We also look beyond the individual to the families involved in our interventions. Barring abusive situations, we recognize the uniqueness of each family and work to ensure safe family relations for those we work with.

We recognize family caregivers' central role in the network of supports for individuals. We also recognize and attempt to impact the physical, emotional, and financial challenges associated with family caregiving.

One of the areas we need to continually address when examining our practice is that of our cultural competence.

C. Cultural Awareness

Display **Cultural Intelligence** (Slide 32).

The NAPSA training on culture uses the term cultural intelligence. They define cultural intelligence as the "ability to successfully function in environments where individuals have experienced cultural training". (Offermann & Phan, 2002). Cultural intelligence allows us to transcend our own cultural training and function more effectively in cross-cultural situations.

To be culturally intelligent, requires knowledge of the other and knowledge of the self. This allows us to be flexible and adapt to the "other". We develop this knowledge through research, conversations, and other informed communications. Use our knowledge, to act flexibly and in culturally appropriate ways is cultural competence.

Cultural competence has also been defined in the terms of knowledge, values, and skills. We first learn about the other culture, we must place value in their being and then apply this knowledge and respect in our interactions.

Display **Cultural Pyramid** (Slide 33).

As individuals and professionals, we move can progress through stages until we become proficient in our interactions with individuals of other cultures. Self-knowledge and reflection will help us become less culturally blind. Knowledge helps us to tune into similarities and differences.

We are sensitive when we demonstrate non-judgmental respect and acceptance of others' viewpoints. Empathy then follows. When we are proficient, we can flexibly and skillfully adapt in different cultural situations.

While demonstrated with a pyramid on this slide, we can think of our cultural competence on a continuum—we are continually learning and refining our knowledge and skills. Each new community of people we interface with requires us to again reflect on our knowledge and adapt our communications accordingly.

Display **Inclusive Practice** (Slide 34).

TAs individuals and professionals, we move can progress through stages until we become proficient in our interactions with individuals of other cultures. Self-knowledge and reflection will help us become less culturally blind. Knowledge helps us to tune into similarities and differences.

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[Source: https://www.nij.gov/topics/crime/elder-abuse/pages/financial-exploitation.aspx]

Some older adults with less comfort with technology are at risk of telemarketing threats, false charity requests, and home repair scams. Also common are grandparent scams where a grandchild is reportedly in trouble and needs money, or a relative is stranded and needs money to come home.

We now know that there is no end-point—we are never fully culturally competent. We can incorporate our cultural intelligence, our awareness, and approach with humility to continually learn and grown toward our inclusive practice.

Display Cultural Humility **(Slide 35).**

We need to be self-aware of our own biases and limitation in knowledge when we work with others. The term Cultural Humility was coined by Tervalon & Murray-Garcia in 1998 for physician training and this has been expanded to

social work. Cultural humility requires use to approach clients humbly and as collaborators in the process. We are going to watch a brief TED Talk by David Mosher that discusses the concept.

Watch first 5:23 of the You Tube: https://www.youtube.com/watch?v=DbrH-a1bbAg

While Mr. Mosher discussed his reaction to an individual who was homeless, we can apply the same issues to work with individuals with disabilities, older adults, and the unique cultural differences of individuals we serve. Our biases influence how we provide services. As we practice in human services, those biases can be reinforced. After all, we are called in when people are at their most needy.

I like the concept of cultural humility over other terms because it highlights an approach that I think demonstrates respect and one in which it is difficult to be insensitive—if we approach from a non-knowing stance, the client is the expert. This empowering perspective insures that we are addressing the issue from the perspective of the other and use that as we arrange services for individuals-at risk.

Display **Ethical Approaches and Culture** (Slide 36).

Ethical multiculturalism is a middle ground between absolutism and relativism. Ethical multiculturalism takes fundamental ethical principles and applies them in a culturally relevant manner.

- Absolutism, or the "fundamentalist" approach, claims that ethical principles are universally applicable. People holding this approach believe there are clear rights and wrongs. This often comes from doctrine, religion, or training.

- Relativism claims that ethical principles are culturally bound and context dependent. Social norms influence the "rightness" of a response.

Skills needed to apply ethical multicultural to each of the principles means we need to understand the underlying intent of the principle and then be able to analyze how that intent can be integrated with a specific culture.

Display **Small Group Activity** (Slide 37).

Let's take a few minutes and apply the ethical principles we learned last session to the idea of culture. Please pull out **Handout 2.7**. In small groups at your table, I would like you to review the principles, and then to highlight ways that culture may play a part. How might APS workers apply their cultural intelligence? What

types of situations might trigger a need to the principle in practice? What questions do we need to ask ourselves when thinking of the principle and cultural differences?

We will give you <u>10</u> minutes to discuss and then will come back as a group.

Points for discussion when re-unite:

Principle	Possible answers
Autonomy	*Who is the fundamental decision-making unit in the culture? To whom are they accountable?* *The APS worker understands that the fundamental decision-making unit varies in different cultures. Sometimes the elders in an extended family are recognized as the basic decision-making unit. In other cases, it is the community itself.*
Beneficence & Nonmaleficence	*Whose welfare is being promoted in this cultural situation?* *This principle recognizes that some cultural traditions can be harmful to individuals. Beneficence analysis takes this into account in decision-making.* *It also recognizes that beneficence (e.g. doing good) and nonmaleficence (e.g. doing no harm) often need to be weighed against each other within the specific culture.*
Justice	*This principle recognizes that there are both planned and unplanned consequences of services that affect others beyond the individual client.* *Potential impacts can spread from an individual, through extended family members, to whole communities within a specific culture*
Fidelity	*What is experienced as caring in this cultural situation? What norms guide interpersonal interactions?* *Can be considered the need to honor cultural behaviors and attitudes guiding interpersonal relationships.* *Key cultural questions: what interpersonal behaviors and attitudes are experienced as "caring" within this cultural context? How does this vary with different types of relationships? How should the APS worker respond to pain?*
Veracity	*Different cultures have different norms for admitting that problems exist, the willingness to talk about them is affected.*

	Role of the APS worker as "authority" determines how much information is shared—historical trauma is communicated across generations in perception of and response to authority.
	The role of elders in communication of information is an additional consideration.

You have roles and responsibilities within your agencies with defined sets of behaviors. We have boundaries established by policy as well as practice.

When thinking of boundaries in regard to the self, there are a range of dimensions to consider: What we wear, how we dress and even how we talk discloses things about ourselves.

Display **Break Time** (Slide 38).

This is a transition slide for the 10-minute break.

D. Boundaries

Display **Boundaries** (Slide 39).

How we apply our professional boundaries is influenced by our own beliefs and values, cultural considerations, as well as professional obligations. We have been taught for years about boundary crossings—when there is incidental contact with clients outside of the professional relationship. In smaller or specialized communities, boundary crossings are inevitable, and it is up to the professional to ensure that risks of exploitation or harm are minimized and privacy and confidentiality maintained.

Boundary violations occur when the crossing does harm the client, or the motivations of the worker are in question, or could appear to be in conflict. Sexual contact is a clear violation as is use of clients for personal gain.

A key area of boundaries to consider is the idea of self-disclosure. Self-disclosure is often employed to assist in developing rapport—finding common ground or helping to reinforce a point for a client. Zur defined five types of self-disclosure. In addition to deliberate self- disclosure, there is non-deliberate, accidental, inappropriate or client initiated self-disclosure.

Any deliberate self-disclosure should be purposeful, clinically driven, and appropriate.

Non-deliberate self-disclosure includes those things that are a part of us that we just are-- distinctive physical attributes, such as gender, age, visible tattoos,

piercings, pregnancy, disability, or injury. The way we dress, the style of our hair, use of make-up, and adorning jewelry are all forms of self-disclosure. Many clients pick up on these attributes, making assumptions of their own. Even, an announcement of a vacation can constitute as non-deliberate self-disclosure

Accidental self-disclosure occurs when there is a spontaneous verbal or non-verbal reaction (the raise of an eyebrow, a slight frown or an accidental yawn). Sometimes we are unaware of these reactions or they are outside of our control. A worker may have an unplanned negative response to a client's statement. Accidental self-disclosure may happen when a client and worker run into each other outside of the office.

Inappropriate self-disclosure is disclosure done for the benefit of the worker and not for the client. This type of self-disclosure can be a slippery slope as it can often burden the client with unnecessary information or create a role reversal where the client feels that she must take care of the worker's needs.

Clients can use the Internet to search a professional via websites and blogs, educational and training information, professional experiences, orientations to treatment, but also personal information such as private social media pages, legal records, political affiliations, community and recreational involvement. Zur refers to this as client-initiated self-disclosure. Some clients may have a strong reaction to information about their worker that they discover via the web.

Self-disclosure tends to be a therapeutic gray area and social workers often disagree on what amount of disclosure is appropriate. Too much self-disclosure may risk the client viewing the therapist as a friend rather than a professional helper. Further poorly executed self-disclosure, can be harmful to the client-worker relationship as the client may feel the worker is more focused on their own issues.

When we work with involuntary clients or adversarial systems (like the courts), we must be especially careful in considering our levels of self-disclosure and the impacts self-disclosure creates as boundary consideration.

Display **Boundaries for Practice** (Slide 40).

As professionals, we have the obligation to preserve and protect the emotional safety of the clients we work with—this includes confidentiality. Earlier, we indicated that best practice includes avoiding dual relationships and conflict of interest.

This slide outlines the key standards from the NASW *Code of Ethics* that discuss boundaries in our work with clients. Standard 1.06 outlines those situations which impair our ability to be impartial in our judgment—this includes dual relationships.

The need to keep clients' interests as primary is reinforced. **Handout 2.8** contains Standard 1.06-take a few minutes to read it now. Standards (e) – (h) are new to the 2017 revision.

We can also think of conflict of interest in relationship to colleagues –boundary challenges can occur at every level of practice.

Display **Dual Relationships** (Slide 41).

This slide contains the definition of dual relationships as outlined in MPSW 20—the Code of Conduct for social workers.

In an analysis of social work violations nationally, Boland Prom and colleagues found that in WI, adjudicated dual relationships violations are the most common violation reported.

Display **Boundaries Discussion** (Slide 42).

At your tables, I would like you to talk about challenges you have around boundaries in your practice. There is a sheet in the center of your table that you can use to record your answers. [This is *Handout 2.9*]

When we come back together, we will discuss strategies to work through those challenges.

Trainer should monitor discussions, give 5- 8 minutes to work in small groups. Once this initial discussion is complete, use a round-robin process of outlining common boundary challenges and write them on the flip-chart.

Display **DSPS Actions** (Slide 43).

I thought I would go through a few of the violations that have been adjudicated by the Department of Safety and Professional Services in the two years from July 2015 through June 2017. Some of these refer to professional boundaries but others to other practice facets.

Trainer: Present the finding and then ask what might be inappropriate about the situation. Suggested replies are included below. [Plan up to 10 minutes for this discussion.]

- A worker texted confidential information (received from a confidential database) to a friend who was also a social worker but was not involved in the situation
    - o *Violations: 20.02 (10) & (22)—Revealed confidential information and gross negligence.*

- *Right to privacy; need release of information. Issue of texting—if phone is not encrypted, may be seen by others.*
- In another situation, an employee claimed another worker asked her to disclose information. She later admitted this was untrue. The same worker posted a picture of a client on Snapchat-deleted within seconds.
    - *MPSW 20.02 (2) & (10)-Violating a law and revealing confidential information.*
    - *How might you respond if you were the colleague implicated? Why do you think someone would do that? It is possible the two had a friendship outside of work-the first thought the other would cover for her.*
- A person in an administrative position ended a sexual relationship with a client who subsequently became suicidal.
    - *20.02 (11) & (13) Sexual Conduct and Dual Relationships. The guideline according to the DSPS is four-year post termination of the relationship. NASW outlines a lifetime ban.*
- In another incident a worker would transport a client to a group, continued friendship after the group was finished, loaned the client money. Did not tell the supervisor
    - *20.02 (13)-Dual relationship.*
    - *Responsibility of the worker to maintain the boundaries. The worker likely did not tell the supervisor because she knew it was not acceptable to maintain the connection.*
    - *Another violation involved maintaining a relationship supposedly for helpful reasons—to assist in a transition but contact included disclosure of personal cell phone number, disclosure of personal information and communication via e-mail. The client disclosed the relationship to DSPS when was feeling conflicted about the level of involvement. With the 2017 revisions, standards are now specified more clearly within the Code of Ethics.*
- In terms of documentation issues, one social worker falsified payroll records and another insufficiently documented contacts and did not properly assess safety. Another individual destroyed records when leaving the job.
    - *Falsifying records is covered under 20.02 (06), Insufficient documentation fits under gross negligence and destroying records – unprofessional conduct*
    - *The individual who destroyed records also committed a HIPPA violation and could be charged for that offense as well.*

- Other violations centered around (1) inappropriate handling of clients' money and inability to account for the funds. (2) Negligent practice- not making contacts as required, failing to document accurately, and lack of organization skills necessary to do the job.
  - *In the second case, the employee discussed the stress and pace of the workplace as a reason. The Board did not accept this justification.*
- Impairment is another cause for discipline (1) Employee related inability of employee to focus on simple tasks, missed sessions with clients and come obsessive behaviors (2) A worker was stopped for DUI and told the officer she was a social worker and that she worked for a County and if arrested there she would have gone free.
  - *As social workers, we need to be aware of how our personal behavior may impact the work.*
  - *In the first case: employers are required to report terminations linked to poor practice to DSPS. In this instance, the individual had been terminated from a job several times prior and had not disclosed this to the new employer.*
  - *If arrested for a crime, you must report it to the DSPS. When an issue of impairment, a monitoring plan is created to insure no future violations occur for an extended period.*

Note: Trainer should review the DSPS violations to see if pertinent situations have been adjudicated beyond those outlined in this training. The notations in this section were through July 2015. Violations can be accessed at: https://dsps.wi.gov/Pages/SelfService/OrdersDisciplinaryActions.aspx

E. Self-Care

Display **Self-Care-Influential Factors** (Slide 44).

The *Code of Ethics* is clear about social work's mission to help the vulnerable and oppressed and always in practice our commitment is to the client. To commit to clients, we must also commit to ourselves. It is hard to commit to others when you need the lifesaver for yourself!

The remainder of our time together today will focus on the ethical imperatives to self-care—how it relates to our professional codes and the need for each of us to be tuned into ourselves to stay on the ethical side of practice situations.

We can examine self-care by looking at three key factors: the nature of the work, the organizations we work in, and out personal coping and style.

Display **Nature of the Work** (Slide 45).

As we have talked about in these first two days of training—APS work is complicated! We need to know quite a range of laws, work with a range of professionals—many of whom come from a different perspective and all with approaches that meet their job roles and functions.

Steiner and Cox defined social work as "emotional labor". It requires us to understand our own emotions, be able to set them aside to help others but also elicits an emotional response.

Our emotions are triggered often in APS practice. From the crisis orientation of the work to exposure to trauma of those who have been victimized by abuse, the work can influence how we view the world.

Professional obligations include all those responsibilities designed to meet the needs of at-risk adults as well as meet the legal and ethical requirements of the job.

Display **Professional Ethical Obligations** (Slide 46).

This slide highlights standards identified in the *Code of Ethics* of NASW, The *Code* tells us in 4.05 that we should not allow one's own personal problems, psychosocial distress, legal problems, substance abuse, or mental health difficulties to interfere with professional judgment and performance or to jeopardize the best interests of people for whom the worker has a professional responsibility. When risk is there, seek consultation and act to protect clients and others.

Standard 2 identifies our relationships with colleagues and how to handle it when we observe unethical practice in others—this involves consulting with that colleague and assisting them to take steps to remedy the situation. **Handout 2.10** in your packets spells out the related standards of both the Code and MPSW as they relate to self-care. We can look at the entirely of those documents to outline what is expected of us professionally in practice.

While the *Code* is our guide— *MPSW 20* mandates that we act according to the *Code*. It does outline two standards that can specifically be cited when focusing on situations that evolve due to poor self-care.

This includes standard 20.02(9) which states "Practicing or attempting to practice while the credential holder is impaired due to the utilization of alcohol or other drugs, or as a result of an illness which impairs the credential holder's ability to appropriately carry out the functions delineated under the credential in a manner consistent with the safety of a client, patient, or the public."

Key as well is the standard relating to dual relationships. [20.02 (13)] "Failing to avoid dual relationships or relationships that may impair the credentialed person's objectivity or create a conflict of interest. Dual relationships prohibited to credentialed persons include the credentialed person treating the credentialed person's employers, employees, supervisors, supervisees, close friends or relatives, and any other person with whom the credentialed person shares any important continuing relationship".

As you can recall from the earlier review of adjudicated violations, often those involving dual relationships occur when the social worker is herself vulnerable—having gone through an emotional hardship. Dual relationships require us to look at our motivations for entering those relationships. Self-awareness is key to determining when a relationship is impacting our objectivity or causing harm to a client.

Display **Organizational Factors** (Slide 47).

This slide highlights factors that research has described as impacting employee well-being.

Organizational culture is a concept that refers to how organizations act out their mission, what is acceptable and how others are treated within the organization.

This includes expectations—what is expected within the organization in terms of structuring time, being able to say 'no', chain of command, and how decisions are made. All of these influence relationships.

If the supervisor stays until the job is done, does it become expectation that all will? What behaviors get rewarded? Does self-protection (in the form of self-care) get punished or is it acknowledged as necessary? Does the way the organization functions fit well with social work's value stance? With changing work environments, these kinds of considerations play a large factor in the stress experienced by employees.

Workload has increased across the board—people are expected to do more with less. Organizational approaches may focus more on the task and less on the person doing the task. Many human service agencies focus business over service. How the work is distributed or managed can lead to burnout or compassion fatigue—we will talk about that in a minute.

Large caseloads, feelings of isolation, and stressful workplaces can lead to burnout. When our role at work is ever-changing or expectations are unclear, we may lose that sense of being able to help or control our practice. Effective supervision and organizational culture that is conducive to support of

employees, dialogue and discussion about ethical issues, can help to mediate burnout and compassion fatigue. The number one factor (as evidenced in the research) is an effective supervisory relationship.

Employees who feel supported by their supervisor, trust that the supervisor has their backs, can discuss challenges in the workplace without expectation of repercussions do better in coping with workplace stress.

Display **Implications-Compassion Fatigue and Burnout** (Slide 48).

So let's talk about burnout and compassion fatigue. (I use the term compassion fatigue interchangeably with secondary trauma as the literature hasn't clearly defined differences between the two.)

Key distinctions between the two are not the symptoms—they may be the same—but rather how the symptoms come about.

Burnout is more gradual—as the person feels less able to manage work load issues, perhaps feeling unappreciated. An analogy of burnout identified by Cox and Steiner is that it is like a smoldering fire—drains energy that occurred for a social worker who was once on fire. Burnout is rooted in the organizational environment—high work demands, low personal rewards, and minimal support.

Often, we can link compassion fatigue to a common set of helping situations. Interfacing regularly with vulnerable individuals who have been traumatized—abused children and adults is a key example. Another example is beginning to feel helpless in the face of so many needing help—seeing few results of your work. The person experiencing compassion fatigue may feel very isolated and begin to "shut down" to cope with experiences in practice.

Both impact the ability to experience empathy.

As humans, we are relational—it is this feeling of connection to others, what is identified as relational supports on this slide, that help us to cope with difficulties as they arise

Display **Personal Coping and Style** (Slide 49).

This slide highlights four concepts we can look at when discussing self-care and practice.

The first, emotional intelligence was coined by Daniel Gollman. He notes that our emotional intelligence is composed of our relationship skills, degree of self-awareness, motivation, and empathy. Part of competence involves those components of emotional intelligence linked to self-regulation, adeptness in relationships and our self-awareness.

The next slide will examine risk and resiliency factors. How we cope is influenced by both our emotional intelligence—how much we are able to effectively cope with our and others' emotions, as well as those factors in our personal history that influence our coping.

Optimism is one personal coping style that can influence how well we handle the challenges in the workplace. A study of case workers found that those who were optimistic about clients' abilities to recover and their own ability to help fared better. When working with individuals who's functioning may be permanently impaired, we must find other ways of looking at the work.

The final characteristic we will consider here is boundaries—again—and professional identity. These two are closely linked.

Doel and colleagues examined professional boundaries and dilemmas that occur in light of them. The context of our workplaces influences the development of our professional identity. How the organization functions and the expectations for us within the organization play a role in our identity as APS Professionals. Each organization also has subcultures—whether it be a department, group of colleagues, or whatever—each of those have a set of expectations for our behavior. How the supervisor's role is defined is also a factor—is the supervisor seen as one who reports problems and disciplines or is the relationship more supportive and allowing for dialogue. Our identity is formed by these factors.

Display **Risk and Resiliency** (Slide 50).

A key consideration in self-care is our resiliency to withstand challenges—both personally and in the workplace.

A 2015 study of social workers examined wellness across a range of factors. The study found that one quarter of social workers had experienced depression prior to becoming a social worker, 30% during their career. Fourteen percent of the over 6000 respondents were experiencing depression at the time of the study. By comparison, the National Institutes of Mental Health notes only 7% in the US population as depressed at any given time.

ASK: Does that surprise you?

Often, social workers enter the field because of their lived experiences and to help others through similar situations. As we look at risk and resiliency, we will see how this might impact practice.

Display **Boundaries** (Slide 51).

This slide reflects the work of Doel and colleagues –it shows the many areas of influence when we think about our professional boundaries.

Our role as helper and perspectives on how we tailor it are modified by the relationships with the various entities as outlined on this slide. In addition, we are influenced by cultural contexts, the laws that govern our work, and the prevailing ideologies related to them.

Display **Small Group Activity** (Slide 52).

Let's apply what we have talked about today to some dilemmas that occur in practice.

Ask participants to refer to **Handout 2.11**. Using the worksheet as a basis for discussion, outline strategies for ethically managing the situation. This means choosing an option that meets professional standards, considering the dilemma from multiple perspectives and evaluating what the outcomes might be.

[Give participants 10 minutes.]

Briefly discuss what participants outlined as responses.

Below are potential responses. The related NASW Codes are noted (these would be used when applying the DO ETHICS framework.

Dilemma	Strategies for Ethical Management
Lori is a white social worker employed by adult protective services and provides welfare checks on senior citizens when family, friends, or neighbors call with concerns about a senior's care, safety or accommodation. Lori is dispatched to a run-down neighborhood with a high rate of drug dealing, prostitution, robbery and murder to the house of an isolated 72-year old man who has not been seen by neighbors for two weeks. When she knocks on the door, a very large man in his twenties tells her to get lost (but in more colorful language) before she can get a word in edge-wise. *[1.01 Commitment to Clients, 1.17(b) Abandonment, 5.01(a)- Integrity]*	***Factors to Consider*** -Unsafe neighborhood - Man who answers the door does not allow her entry. -She may be uncomfortable based on the appearance and manner of the male who answers the door. - The man has not been seen in two weeks. Unsure if he lives alone.
	Potential Consequences *-if she does not gain entrance (a) status of the man may not become known and potential multiple abuses may be occurring (b) neighbors may not call with future issues, (c) she would be liable if leaves and does nothing more* *- Remedy: go back with officer.*

Essie (73) is an African American woman whose role in life was to take care of everyone else. Ever since she had a stroke and became non-ambulatory, she has had to relinquish this role and is dependent on her children for her care. Her children have been neglecting many of her needs. One son recently moved away, and her two daughters are working double shifts just to try to make ends meet. As a result, Essie is left alone for long periods of time, unable to feed herself or go to the bathroom. As her social worker, you offer help. Essie refuses help saying she has managed her whole life living at home and she plans on continuing here until she dies. [1.02 Self-determination]	***Factors to Consider*** *-Essie values her independence* *-family member time constraints limit their ability to provide the necessary assistance* *-Does she have capacity?* *-Culture* *- She will need convincing over time to accept assistance* ***Potential Consequences*** *-respect of self-determination but may result in negative outcomes for Essie (physical health issues)* *Solution: Work with Essie and daughters to develop a plan that will provide a safer option*
A hospital social worker provided services to a 52-year old woman who was recovering from hip surgery. In addition to her physical problems, the patient also manifested some modest difficulty in learning new information and remembering learned information and performing motor functions. The client's sister who visited the patient regularly, insisted that the social worker attempt to place her sister in an assisted living arrangement. She was very concerned about her sister's health and the risks she faced if she returned to her home to live alone. The client, however, adamantly refused to go to an assisted living arrangement and insisted that the social worker arrange home health care, the client said she was willing to assume any risk associated with her living alone. [1.14 Lack of Decision-making Capacity, 1.02 Self-determination]	***Factors to Consider*** *-There are some apparent deficits (a) memory and learning (2) motor* *- Sister is the support but does not approve of return to home. (Would she be willing to visit frequently in the home?)* *-The woman is receptive to receiving in-home care* *-Assuming risk-does that clear the worker if a problem occurs?* ***Potential Consequences*** *-In-home care provider could assist in monitoring of status* *-potential to assess home for ways to assist in managing* *- If she had problems in the home, sister may complain.*

| Karen has worked in APS for a long time. She felt she had a talent for the work and had felt fulfilled. In recent months, Karen has noted that the clients she is working with have presented with more complex profiles and the work is becoming more difficult. The outcome was poor for one of the individuals she had worked with recently. She has begun to doubt her abilities and is contemplating taking some time off but knows that the others on her team are also very busy and would have a hard time absorbing her duties. She feels very ineffective and exhausted. She has felt that her efforts were not recognized by administration either. Karen has seen co-workers who dislike their jobs and let it be known to their co-workers and she is concerned she will become one of them.

[1.01 Commitment to clients; Standard 4-4.05 Impairment, 5.01 Integrity] | ***Factors to Consider***

-Doubting her abilities although worked APS for long time, feeling ineffective and exhausted
-Poor outcome of prior case but may perception may be worse than actual outcome (because of her emotional state).
-Work culture-busy, no recognition
-Others <u>are</u> burned out |
| | ***Potential Consequences***

-Burnout evident-she may leave, or not effectively serve the clients. Personal health and wellness issues
-Workplace culture will continue, causing turnover, poor work satisfaction, and burnout and wellness risk for all employees |

Display **Applied EDM** (Slide 53).

Let's use the dilemmas we just discussed and apply them to the ethical decision-making model we learned last training.

Review the key elements of the DO ETHICS model.

DO is the dilemma—what are the opposing challenges in the situation

E- Evaluate the values of all stakeholders—the client, family, agency, and the worker. Sometimes the broader community also has a stake.

T- Remember this relates to the Code of Ethics as well as the statutes and policies that we must follow in practice

H & I- Think of possible options and then consider what the impacts of those options are so that you can make the best choice using all of this information.

For this exercise, you are the consultants for each other! In other situations, you want to insure that you are seeking out others' views to do a check for your own motivations, biases, or "blindspots"

And of course, we must then document our decisions.

Pull out **Handout 2.12** which provides the framework. Select whichever dilemma from **Handout 2.11** that resonates with you. I will give you 10 minutes and then we will come back together again.

Note Alternative Training Option: Have the groups work on only the first three in the prior exercise and save the fourth scenario for this section of the workshop.

Trainer should be sure to discuss the scenario linked to self-care and highlight the connections to materials earlier in this module.

- Because she is feeling discouraged, she may not see the outcome as realistically as it had turned out.
- Meeting with supervisor to discuss a plan for revitalization, perhaps training or education in those areas where she feels she needs development, would be helpful to resolving her feelings.
- Discuss vacation as a vital practice and reinforce care for self as well as others
- Consider therapy.

As discussed with the DO ETHIC model, we add the idea of Sequel and Self-Care.   Going back later to evaluate what we might do differently reinforces self-awareness in practice. Self-care allows us to replenish our own reserves when these intense situations arise.

[End of module]

Module 6 – Wrap Up Overview

Timing (10 minutes max.)

Introduction to Training .... 3 minutes total

    A. Wrap-up...<u>3 min</u>

<div align="right">3 min</div>

Learning objectives

- None

Advance preparation

- None

Handouts

- Handout 2.13: Evaluation

PowerPoint slides

- Slides 54- 56

Module 6: Wrap Up

Display **Wrap-Up** (Slide 54).

We have covered a range of topics today, but a predominant theme is the relational aspect of our work.

We discussed

- The need to implement best practice strategies—including least restrictive alternatives, person centered, and trauma-informed approaches.
- The role of teamwork and collaboration – recognizing the different perspectives brought to the situation by differing disciplines.
- And ethical practice—including developing boundaries and developing strategies for self-care and work-life balance.

Display **Boundaries and Identity** (Slide 55).

When thinking about the demands of the work, balance is key.

It is important that we can separate work from personal life to help maintain resiliency. This separation will revive us so that we can best serve the clients we serve.

We need to:

Manage our multiple identities-- defining ourselves both in and outside of the workplace, acknowledging our strengths and limitations, and balance competing demands.

Strike a balance between helping and self- care. Taking that step back, a deep breath and being able to say no, or not now, to maintain control of your life. Yet primary to all is the commitment to clients. But like the airplane scenario, we must first put our own air mask on to be able to help others.

Display **Thank You** (Slide 56).

Remind to complete the end of workshop evaluation.

Hope to see you at the next training! Day three will emphasize interviewing, assessment, and intervention skills in APS work.

Day 3 Intervention Strategies in APS

Curriculum Timing (330 minutes)

Module 1: Overview, Introductions, and Follow-Up………………………15 minutes

Module 2: Effective Case Management Strategies………………………45 minutes

Module 3: Assessment…………………………………………………….50 minutes

Module 4: Planning………………………………………………………120 minutes

Module 5: Documentation within Adult Protective Services…… ………85 minutes

Module 6: Professional Development Planning……………………………15 minutes

*Break (2 – 10 minute) ………………………………………………….20 minutes

Learning Objectives

Module 1: Overview, Introductions, and Follow-Up

Module 2: Effective Case Management Strategies

- Highlight basic interviewing skills.
- Apply ethical principles to intervention.

Module 3: Assessment

- Complete risk assessments using sample case scenarios.
- Highlight basic interviewing skills.

Module 4: Planning

- Identify key components of case planning.

Module 5: Documentation within Adult Protective Services

- Outline documentation requirements and additional reporting.

Module 6: Professional Development Planning

- Examine professional development needs for future practice.

List of Handouts

Module 1: Overview, Introductions, and Follow-Up

- Handout 3.1: Agenda and Learning Objectives

Module 2: Effective Case Management Strategies

- Handout 3.2: Safety Planning

Module 3: Assessment

- Handout 3.3: Factors Affecting Decisional Impairment in APS Clients
- Handout 3.4: 3-D Case Studies
- Handout 3.5: Types of Dementia
- Assessment Packet (AP)
    - AP 1: Burns Depression Inventory
    - AP 2: Geriatric Depression Scale
    - AP 3: MMSE
    - AP 4: MoCA
    - AP 5: SLUMS
- Handouts 3.6A – 3.6E: Case Studies (Anna Kovacs, Juan Garcia, Mark Hudson, The Bensons, Sharon Delay)

Module 4: Planning

- Handout 3.7: Learning the Language
- Handout 3.8: Strengths Based Care Planning

Module 5: Documentation within Adult Protective Services

- Handout 3.9: Terminology
- Handout 3.10: Rat Feces Exercise
- Handout 3.11: Clarity in Documentation
- Handout 3.12: Memory Assistance
- Handout 3.13: Photographing Evidence
- Handout 3.14: Body Maps

Module 6: Professional Development Planning

- Handout 3.15: Professional Development Planning [This is not in the participant planning]
- Handout 3.16: Evaluation

Advanced Preparation

- Communication cards should be placed in center of tables prior to the beginning of training (one per person at table).
- The Professional Development Planning, Handout 3.15, (if using) should be placed on the tables at second break. The handout can also be placed on the tables at the start of the day, placed upside down.

Daily Timing

Day 3: Intervention Strategies in APS

This is based on a 9:00 AM – 3:30 PM training day with two 10-minute breaks and one 45 minutes lunch break. Timing is approximate.

9:00 am – 9:15 am.............Overview, Introductions, and Follow-Up (Module 1)

9:15 am – 10:00 am ………. Effective Case Management Strategies (Module 2)

10:00 am – 10:30 am………Assessment (Module 3)

10: 30 am – 10:40 am……. Break

10:40 am – 11:00 am …… Assessment (continued)

11:00 am – 12:00 pm……. Planning (Module 4)

12:00 pm – 12:45 pm… … Lunch

12:45 pm – 1:45 pm ………. Planning (Module 4-cont)

1:45 pm – 3:15 pm ………Documentation within Adult Protective Services

(Module 5)

[Includes 10-minute break]

3:15 pm – 3:30 pm ………Professional Development Planning (Module 6)

Module 1 - Overview, Introductions, and Follow-Up Overview

Timing (15 minutes max.)

Overview, Introductions, and Follow-up…………………………………… 15 minutes

    A. Introduction to training ………………………………………….3 minutes
    B. Participant Introductions ………………………………………9 minutes
    C. Agenda and Learning Objectives……………………………….3 minutes

Learning Objectives:

- None

Advance Preparation

- Communication cards should be placed in center of tables prior to the beginning of training (one per person at table)

PowerPoint slides

- Slides 1 – 5

Handouts

- Handout 3.1: Agenda and Learning Objectives

Module 1: Introductions, Overview and Follow-up

A. Introduction to training ……………………………………………………….3 min
B. Participant Introductions …………………………………………………9 min
C. Agenda and Learning Objectives……………………………………… <u>3 min</u>
                                                                                         15 min

- Slides 1 – 5

- Handouts:
    o Handout 3.1: Agenda & Learning Objectives

A. Introduction to Training

Display **Title Slide** (Slide 1).

Welcome back to our final day of APS worker training. Today we will focus on those skills and supports to help with effective assessment and management of responsibilities in adult protective services. Before we begin, let's take a few minutes to introduce our selves.

Display **Information on CEH** (Slide 2).

Slide explains the development of the full-day training.

B. Participant Introductions

Display **Introductory Conversations** (Slide 3).

Instruct participants to pick up one of the cards from the center of the table. Instruct participants to pair up with someone who is not known to them for this exercise. The activity centers on one individual talking first while the other listens, and then repeating this exercise with the other card for the second person in the dyad.

Trainer times 90 seconds and then informs pair that it is time to switch.

After completion, discuss how it felt to share personal information with someone they did not know. Ask question s such as:

- Did you find yourself measuring your words, being careful of what you disclosed?
- How did it feel to have someone just listen?
- How did it feel to be the person who just listened? Did you want to provide a solution?

Tell people to go back to their initial table.

Explain to participants that this activity symbolizes the initial intake process.

Ask: How can we relate this activity to the initial assessment process?

Look for answers such as: Engagement skills which set the foundation for the remainder of the relationship, active listening, "warming up" with conversation prior to getting to the serious discussion in the assessment.

This activity symbolizes one of the activities we do in our practice—with initial assessments, we ask the clients to share intensely personal information about themselves. This can be very uncomfortable, and people will respond differently. In social work, we identify the first stage in the change process as engagement—how we do this when we must complete our assessments quickly requires skill. We will discuss that further as we move through today's training.

C. Agenda and Learning Objectives

Display **Training Objectives** (Slide 4).

This slide outlines our training objectives for today. We are building on the foundation of the other two trainings. Today, we will talk about the skills and tools needed in order to effectively do adult protective services work. The training objectives and agenda are included as Handout 1. If you are audited by the DSPS for continuing education, you would need to submit this as verification of content of the training. Keep all of your materials for at least two years should an audit occur; the state can go back to a previous cycle if you would be found to be in noncompliance with the current cycle.

Display **Agenda** (Slide 5).

Here is our abbreviated outline. We will take a break in the morning, for lunch, and again this afternoon.

[End of Module]

Module 2 - Effective Case Management Strategies Overview

Timing (60 minutes max.)

 Effective Case Management Strategies……………………………60 minutes total

> A. Skills for Case Management.……………….…………………… 6 minutes
> B. Initial Home Visit videos and discussion……………………..……30 minutes
> C. Best Practice.………………….……………………………….…...9 minutes
> D. Scenario: Domestic Abuse …..…………………………………… 15 minutes

Learning Objectives:

- Highlight basic interviewing skills
- Apply ethical principles to intervention

Advance Preparation

- None

Handouts:

- Handout 3.2: Safety Planning

PowerPoint slides

- Slides 6 - 10

Module 2 - Effective Case Management Strategies

A. Skills for Case Management ……………………………………… ….. 6 min
B. Initial Home Visit……………………………………………………… 30 min.
C. Best Practice…………………………………………………………..9 min
D. Scenario: Domestic Abuse …...………………………………………… <u>15 min</u>
                                                                            60 min

- Slides: 6 – 10

- Handouts:
  - Handout 3.2: Safety Planning

A. Skills for Case Management

Display **Effective Case Management Strategies** (Slide 6).

When we think of assisting the individuals we are working with, we can think of the skills we need for effective practice leading toward an effective intervention strategy and ultimately safety for the adult at risk.

Engagement skills- these include truly listening to the person you are speaking with, demonstrating empathy for their situation, and tuning in to cultural difference. We need to be aware what we are communicating non-verbally as well as what we say.

Most people feel respected, appreciated, and comforted when others take note and attend to them. Empathetic presence can be demonstrated through sensitive questions that help the client to express the situation from his or her own point of view. When we are able to do this effectively, we can then turn to assessment skills.

Assessment skills refer to those behaviors—including engagement skills—that lead toward understanding the client's story. Assessment is an exploration of the problem through active listening, asking open, non-leading questions, and seeking clarification about what led to the situation, and the client's perception of it. This means attending to the facts but also recognizing the feelings of the person you are working with. As we assess the situation, we are organizing the information in our heads in order to insure we are obtaining as complete a picture as we can.

Interviewing skills are those techniques we use to further our assessment. These include seeking clarification, and reflection of what you think you are hearing as well as the meaning of what the individual is telling you. We make connections between what we hear and our knowledge of abuse and neglect, aging and disability. We tune in to our own thoughts to ensure that we are interpreting what the client tells us objectively. We use silence effectively and tune in to body language to insure we maintain that connection with the client and are truly assessing the situation accurately.

In APS we do all these skills with the purpose of safety foremost in our mind. It is only through accurate and empathetic assessments that we can best serve the adult at risk and assure safety and protection as best we can.

B. Initial Home Visit

Display **Initial Home Visit: Self-Neglect** (Slide 7)

Explain the we are going to watch a video prepared for Adult Protective Services workers and outlines an initial visit with for a self-neglect investigation. We will discuss the video after watching it.

Play Part 1 link (4:15 minutes)

https://www.youtube.com/watch?v=lJ46wWBESoY&feature=youtu.be

After watching the video, solicit responses as to what went wrong in the interview.

Points to include in the debriefing: (1) Violation of confidentiality (calling the client by the wrong name and also disclosing she is going there next), (2) Attitude was judgmental (when kicks aside the newspapers and when referencing the wine bottles), (3) Phone, (4) Lack of preparedness (did not know his story, remarks about wife), (5) Wasn't "present" (does not appear to be caring nor show empathy for the client), (6) Safety (she sat in a way that the client was between her and the door).

After debriefing, show the Part 2 video (15:45) and then debrief observations of participants.

https://www.youtube.com/watch?v=nuxV1Z51YPI&feature=youtu.be

Points to include in the debriefing: (1) Engagement demonstrated by being allowed to continue the assessment. She was "softer" and more welcoming, less pushy in her approach. Made obvious attempts to engage (remarking on the quilt, being helpful); (2) Showed empathy and caring; (3) Explained the process with less emphasis on "protective services" (this may trigger a negative response

*from the individual); (4) Much more tentative in her assessment—"maybe",
willing to let things he couldn't agree to (the healthy diet) go without a
commitment to change); (5) Interviewing best practice-memory testing,
depression assessment with frank discussion of suicide, over-estimating drinking
in order to be less likely have client minimize use; (6) Came prepared with
resources; (7) Change in seating assured safety of exit*

C. Best Practice

Display **Best Practice** (Slide 8).

Wisconsin is one of the leaders in the implementation of trauma informed
approaches to intervention. A trauma informed approach means that we
consider the possibility that behaviors may develop as a response to previous
trauma. We recognize that no one is immune to the impact of trauma and
many concerns in later life can also be traced to adverse experiences earlier in
life. When we approach services through a trauma informed lens, we
acknowledge losses, transitions, and emotional adjustments faced by the adult-
at-risk. We recognize that everyone one experiences difficulties and it is
adversity that shapes how we react and behave. We recognize the individual's
resilience in working through past challenges as well as coping with the situation
that brings the person to our attention as this time. Asking, "What happened to
you?" is a way to allow the individual to talk about the trauma experienced and
can lead to deeper understanding of the current situation as well. APS as a
service is designed to provide the safety needed for individuals in abusive
situations—a safe environment is key to providing trauma informed care.

Past trauma responses can include things like memory problems, hyperarousal,
deficits in information processing, impaired ability to regulate emotions,
avoidance, and maladaptive coping. While this set of trainings is not designed
to fully discuss trauma and its responses, basic recognition that people's coping
is impacted by trauma can set the stage for more effective helping.

A second form of best practice is person-centered care. While this may be
more commonly connected to a longer-term intervention than that typically
provided by APS, a key component of person-centered care is the recognition
that each person demonstrates needs differently and we must also adjust our
approaches in response to the individual's way of communicating, coping, and
problem solving. This means not using a cookie-cutter approach and critically
thinking through our assessment information. It also means that the person we
are working with should be given as much choice as is possible within the
individual's level of capacity; their goals should be considered in the planning
and intervention process.

This leads to the idea of supported decision making. The Wisconsin Board for People with Developmental Disabilities has created a guide for use in examining supported decision making that can be a useful resource. This strategy allows for as much self-determination as is possible and can involve use of informal supports rather than removal of rights, as occurs with full guardianships. Providing the opportunity for as much choice as possible is a factor that can help the individual to avoid or reduce the risk of abuse. We can see how well this best practice also fits with person centered care!

WI Act 345 was passed into law in 2017. "Supported decision–making", according to this new law, means a process of supporting and accommodating an adult with a functional impairment to enable the adult to make life decisions, including decisions related to where the adult wants to live, the services, supports, and medical care the adult wants to receive, whom the adult wants to live with, and where the adult wants to work, without impeding the self–determination of the adult. Similar to advanced directives, the law further created a voluntary supported decision-making process and authorizes the individual to assign someone to assist with decision making as a supporter on the person's behalf.

The law is included in your binder as a resource. At the time of this curriculum development, however, implementation was not finalized but additional information will be forthcoming.

Finally, a best practice we will discuss later in the training is that of clear, concise, and accurate documentation. Our recording must be completed timely to ensure that it is as accurate as is possible. In review of credential violations for those licensed or certified as social workers through the Department of Safety and Professional Services, the accepted standard of practice is that all information should be documented within two days of a session. (Credential holders have been disciplined for documentation not completed within those parameters).

D. Scenario: Domestic Abuse

Display **Domestic Abuse** (Slide 9).

Before we go on to discussion of assessment and planning, we wanted to include some discussion of domestic abuse. For the purposes of this training, I will refer to domestic abuse in terms of someone who is competent to make the decisions surrounding the outcome of any intervention. The definition of domestic abuse is broader under adult protective services than is typically

considered. Beyond an intimate relationship, APS considers DV as including <u>any</u> family relationship.

Here is a brief video of a man discussing the process of leaving an abusive situation. There is no distinction between domestic abuse and abuse of adults-at-risk but Peter in this story talks about some of the dynamics of domestic violence that can be helpful to understand.

Safeguarding Adults: Peter's Story video
https://www.youtube.com/watch?v=2zcux_iluOI

Power and control is an underlying dynamic of domestic abuse. Abuse of persons in ongoing, familiar relationships often involves a pattern of coercive tactics used to gain and maintain power and control.

While physical and/or sexual violence may be present, some victims are controlled through intimidation, threats, emotional and psychological abuse, neglect, and isolation – no physical abuse is necessary.

In an abusive relationship, one party fears the other and attempts to comply with the other's wishes to avoid harm. APS workers should be familiar with these tactics and alert to the possibility that they may be at work in *any* case. Investigators should determine if power and control tactics are being used manipulate and/or coerce the victim.

Optional content:

An often-frustrating dimension of domestic abuse is the individual's return to the situation. Domestic abuse happens at any age.

This brief video clip discusses domestic abuse and a tragedy that resulted: https://www.youtube.com/watch?v=yF5CP70yXg4 [3 Minutes]

When working with domestic abuse situations, it is important for us to focus on safety planning.

Display **Safety Planning** (Slide 10)

Prevention of future incidents of abuse can include going to a shelter or moving to another residence, obtaining a restraining/protective order, hiding or disarming weapons, or changing schedules and routes to avoid being found.

Protection strategies include discussing methods victims can use to protect themselves during an abusive or violent incident. This includes things like 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.

Planning for notification involves developing methods for seeking help in a crisis. Making sure the individual has a cell phone, emergency numbers readily available, life lines, or security systems. Perhaps includes code words with friends, family, or neighbors that can be used when help is sought.

We refer to appropriate services that can offer assistance. These include helping the person to know of domestic violence, sexual assault, or adult protective services, the aging and disability network, or accessing faith and community organizations.

Most of all, people in domestically violent situations need emotional support. We can encourage involvement in activities to become less isolated-- music, exercise, yoga, reading positive or spiritual materials, hobbies, art, friends, support groups, and other community activities.

Recognize that the victim may want to stay with the abuser or may be in the process of leaving or returning to the abuser, or may have left and ended the relationship. In each of these situations, the five components of safety planning listed above are crucial.

We need to be sure to develop follow-up plans that are centered on the individual—consider safety in the home, other options available, desires of the person, and financial needs. Insuring the person has needed medications and other health related supplies. In some cases, respite or other in-home services can be helpful as a means of having ongoing "eyes" on the situation.

If the person who was abusing the individual was arrested, there are additional needs to consider—pets, or others living in the home, for example. The person may need assistance in obtaining a restraining order or working through other legal issues. If an immigrant and not yet a citizen, how to insure the person's needs are met can be assessed with services aimed at assisting that population.

 Most of all, we use our skills to build rapport, so the person is willing to open up. This includes a nonjudgmental manner, learning the fears of the person as a result of reporting or intervention. This includes fears about the actions the abuser might take as well as the consequences of their decisions. Consequences of leaving the abuser might include loss of financial security, loss of housing security, new and unfamiliar responsibilities, or the insecurity about the future.

Ask what the victim wants to do. The victim may be hesitant to take steps to ensure their safety for any number of reasons. Understanding the motivation behind their decisions can help the worker understand the victim's goals.

Remember, that the victim is the person who must live with the consequences of the decisions. Together you should problem solve in advance what a victim can do during and after a crisis situation.

Handout 3.2 in your packet reviews this information on safety planning that can be helpful in future when you assist individuals involved in domestic abuse situations.

[End of Module]

Module 3: Assessment Overview

Timing (50 minutes max)

Assessment……………………………………….……………………50 minutes total
    A. Introduction to Module…………………..…………………….……..………1 min
    B. Capacity Assessment……………………………………….…………11 min
    C. Dementia, Delirium, Depression.……………………………………15 min
    D. Cognitive Domains and Assessment ……………….……………. ….15 min
    E. Cross Cultural Assessment………………………………………………3 min
    F. Scenario Practice……………………………………………………… 5 min

Learning objectives

- Complete risk assessments using sample case scenarios.
- Highlight basic interviewing skills.

Advance Preparation

- Module 3 Case studies (3.6A-3.6E) should be divided to allow distribution of the 5 case studies for each table of participants

Handouts

- Handout 3.3: Factors Affecting Decisional Impairment
- Handout 3.4: 3D Case Studies
- Handout 3.5: Types of Dementia
- Handout 3.6A- 3.6E: Case Studies [These are not in participant packets]
- Assessment Packet (Includes 5 Assessment Scales)

PowerPoint Slides

- Slides 11 – 36

Module 3 Assessment

A. Introduction to Module…...…………………………………………………………1 min
B. Capacity Assessment…………………………………………………………………11 min
C. Dementia, Delirium, Depression…………………………………………………15 min
D. Cognitive Domains and Assessment ……………………………...……………20 min
E. Cross Cultural Assessment…………………………………………………………..3 min
                                                                                                    50 min

- Slides 11 – 36

- Handouts
    - Handout 3.3: Factors Affecting Decisional Impairment
    - Handout 3.4: 3D Case Studies
    - Handout 3.5: Types of Dementia
    - Assessment Packet (Includes 5 Assessment Scales)

A. Introduction to Module

Display **Assessment** (Slide 11). [This is a transition slide]

Engagement and interviewing skills we discussed are a foundation in your social work training—you already have them in your toolbox—so we will not be having you practice them today. Case management includes those components but also accurate assessments, case planning, and referrals as appropriate. (Although APS is sometimes not interpreted as "case management", the service includes all of the facets of case management-just in an abbreviated, crisis fashion.) We thought it would be more beneficial to have you leave the training with a toolbox of assessment tools that you can use in your practice.

APS workers may not use the full tool in practice. Being aware of them and the material covered can help to read reports as well as know what types of questions or prompts can be used to test the cognitive status of clients.

We do want to point out, though, that while these tools are helpful in both assessment and with monitoring of client status, most APS workers are advised by corporation counsel not to bring them up in court unless you can document expertise and training on the assessment tool. You should check with your corporation counsel when you have used the assessment tools we are including here.

B. Capacity Assessment

Display **Capacity Assessment Skills** (Slide 12).

This slide highlights basic skills needed for capacity assessment. Knowing clients' educational levels as well as language ability is important because these factors can influence the results of any assessment tools you use.

ASK: How do you think educational level or language issues can impact assessment?

> *Possible answers can include education level can impact the degree of understanding more technical elements. We may need to watch the terminology that we use. There may be barriers based on language and an interpreter might be needed.*

> *Trainer can follow-up with challenges of use of an interpreter—need to find one who speaks the same dialect, is trained so that accurate information is relayed.*

Cultural diversity was talked about it in earlier trainings. What is important is to be sensitive, to ask questions, not to jump to conclusions, not to impose your own cultural values on to the client.

Cultural factors can be difficult to describe. We may be told how certain cultures react under certain circumstances, but that may lead to stereotyping. We can learn generalities, but there are differences within cultures that have to do with level of acculturation, language, or racism.

Family values add another dimension. The challenge for intervention is when the client is at severe risk due to a cultural belief: How far do we address it? How far do we go? This will be covered in the coming modules.

If we can learn the client's value framework and usual standards of behavior, this will help determine if the individual is acting out of character or if the behavior is consistent with past history.

ASK: What do we mean when we say we "set the stage" for an interview?

> *Possible answers can include:*
> *(1) Setting the stage for the interview is important so that the client feels safe and comfortable. A quiet place with good lighting, avoiding glare, is recommended. It is important to be sensitive to any hearing or vision impairments.*
> *(2) Tuning in to the emotional state of the client (or alleged abuser) so we can respectfully address the issues.*
> *(3) Knowing the client helps to set the stage. Breaking down questions or concepts, using large print, using simple language are all helpful in doing*

the assessment interview with individuals who are disabled or have cognitive limitations.
(4) Think of the location for the interview and who might be present in the home. How can you assure that the adult-at-risk will have privacy in talking with you?
(5) Time of day can play a factor as well. Perhaps plan for short visits to prevent the person from getting tired and allowing for building of rapport.

This process takes patience and perseverance as client may have difficulty concentrating or become anxious. More than one visit will probably be necessary. Starting with general topics and weaving questions into a conversation is less threatening. This is what we mean when we say we are joining with the client.

We take the time to think about the significance of this first contact—the results can be life changing.

We need to be prepared for responses.

When talking to a cognitively impaired client, there may be additional challenges. The NAPSA training this is drawn from highlights that sometimes cognitively impaired clients will respond by confabulating (making up stories to cover up memory deficits), changing the subject, using charm as a diversion, ignoring the question, telling the same story over and over, or even refusing to answer, becoming angry, and terminating the interview.

Display **Attributes of Capacity** (Slide 13).

Decisional capacity is a complex concept. Kemp (2005) described decisional capacity as the ability to adequately process information to make a decision based on that information.

This definition has been chosen because it is simple, comprehensive and easy to remember. All of the facets on this slide are pieces of the capacity pie.

Decisions include choices related to medical or personal care, sexual or other relationships, contractual arrangements; testamentary proceedings (for example, creating a will), and research participation.

With decisional capacity, the person can communicate why choices are made, and do so using sound information. They can comprehend and relate relevant information about a situation. The person is able to express choice and is able to explain how that choice impacts the outcome. As social workers, we can

apply the concept of informed consent to decisional capacity. This means the ability to balance risks, benefits, and consequences of choices made.

Here are four basic questions to consider when assessing a client's capacity to make informed decisions
1) Can the client understand relevant information?
> For example: *Do you know that you have a serious cut on your leg?*
2) What is the quality of the client's thinking process?
> Continuing with our example, *How can you get treatment for your wound?*
3) Is the client able to demonstrate and communicate a choice?
> *Do you want to get treatment for your wound?*
4) Does the client appreciate the nature of his/her own situation?
> *What will happen if you don't get your wound treated?*

When an individual knowingly—with capacity-- refuses assistance and remains in what we see as "unsafe", it can be difficult for us to accept the decision. This is where our commitment to self-determination comes in. We may be able to anticipate future hardship, such as might be the case with a domestic violence situation; but our respect for the client means we provide resources and are prepared to repeat the process should an event occur again.

Display **Capacity Evaluation** (Slide 14).

To fully evaluate capacity, all of the following should be included:

- A physical examination— capacity can be influenced by medication and medication side effects, nutrition, and often physical conditions can impact mental functioning and with treatment, the decisional capacity can improve.
- A neurological examination—this can help in determining the actual depth of impairment as well as areas where functioning can be enhanced to improve independence and options for the adult at risk. Sensory deficits can influence perceptions of capacity.
- Short- and long-term memory assessment—we know that short term memory deficits can cause some safety concerns in the home.
- Assessment of executive function --Executive function describes a set of abilities that control and regulate someone's ability to anticipate outcomes and to adapt behavior to changing situations.
- Examination for any existing psychological disorders—again, this can determine the degree to which recovery is possible. Situational factors such as social isolation or depression can be treatable and improve decisional capacity.

- Diagnosis of any existing addictive conditions that influence abilities and functioning.

All these components may not be available to clients in your area. Resources are limited. It is very important that your client have the most comprehensive evaluation possible.

Incapacity is related to decisional capacity. It is the inability to receive and evaluate information, or to make or communicate decisions to such an extent that an individual is unable to meet essential requirements related to physical health, safety, or self-care, or even with the appropriate technological assistance.

There are two basic types of incapacity judgments. The first, legal incompetence is a judgment about one's legal rights and responsibilities. The second is clinical incapacity, a judgment about one's functional abilities.

The implications of a judgment of incompetence are life changing. Individuals may have many of their most basic rights curtailed. This is a very serious decision. Requesting a judgment of incompetency from a court should be the very last resort for APS workers. Clients may lose the right to make decisions about medical treatment and personal care, marry, enter into contracts, testify in courts, vote, participate in research, or choose where to live.

Think about some of your clients who received judgment of incompetence.

ASK: What were the results for them?

Trainer: *Be prepared to present a personal example related to an individual have worked with who was found incompetent.*
[Author's scenario could be used for discussion- Medical decision-making rights are curtailed with guardianship, an individual who was diagnosed with probable ovarian cancer and was refusing treatment. As guardian, the challenge was to follow the wishes of the client vs. medical treatment.]

Incapacity is not easily determined. The assessment is influenced by both the experience of the interviewer as well as the tests that are used. Age, eccentricity, poverty, or medical diagnoses alone do not justify a finding of incompetence. Physicians, lawyers, social workers, and judges all struggle with the concept. There is no gold standard for determining incapacity or incompetence.

There are many factors that affect a person's decision-making capacity including medical conditions, some which are listed on the slide.

In **Handout 3.3**, you will find several physical, psychological, and situational factors which may cause a person to appear to lack capacity. When these situations are successfully addressed, there may be a dramatic improvement in the person's ability to make informed decisions.

ASK: *What are some examples of situations from your own experiences in which medical, psychological and/or situational factors diminished the client's decision-making ability and resulted in the adult's inability to make informed decisions?*

[For example, a woman I worked with who had both a developmental disability (low IQ) and schizophrenia would often become increasingly psychotic when she had a urinary tract infection. We learned to have that assessment completed before other management strategies. Her placement was able to be maintained when we could determine this as a cause of her aggressive behavior and inability to communicate it to us.]

I would like to point out the issue of medication mismanagement listed on the handout. Seniors represent just over 13% of the population but consume 30-40% of prescription drugs and 35% of all over-the- counter drugs. On average, individuals 65 to 69 years old take nearly 14 prescriptions per year, individuals aged 80 to 84 take an average of 18 prescriptions per year. It has been concluded that 15% to 25% of drug use in seniors is considered unnecessary or otherwise inappropriate. Adverse drug reactions and noncompliance are responsible for 28% of hospitalizations of the elderly and 36% of all reported adverse drug reactions involve an elderly individual. And these statistics don't consider over-the-counter medications!

Given these statistics, knowledge of medications is crucial. It is important to obtain a list of medications from clients, observe medications in the home (including over the counter remedies and herbal supplements), and ask the client what she/he is taking, for what, and how often. This will give insight into the client's understanding of the drug, the illness, relationship with the prescribing physician, or how many physicians may be prescribing.

You may suggest that clients use the Physician's Desk Reference (PDR) which gives information on all prescription medications including photos, descriptions, uses, and interactions. Suggest that they have a good medical dictionary available – this will help when they speak to physicians and nurses.

Medications work through absorption (getting into the body), distribution (where it goes in the body), metabolism (how it is handled in the body) and excretion (how it is eliminated from the body). If a client is taking four (4) medications or more, it is likely that there are serious interactions. In addition, all medications have side effects. Some are minor, but some can be very serious.

The impact of medications leads us to think of the "Three D's".

C. Dementia, Delirium and Depression

Display **The Three D's** (Slide 15).

Differentiating between Dementia, Depression, and Delirium can be difficult.

__ASK__ participants about their experience in sorting out these three issues: What have their challenges been?
> Have they ever discovered a client who had delirium?
> How did they know?
> What did they do?
> Experiences with suicidal clients?

Before discussing Dementia, Delirium and Depression, we are going to discuss some case studies as a large group. Pull out **Handout 3.4**.

Display **Activity: Differentiating the Three D's** (Slide 16).

Read aloud (or ask a volunteer) the case of Mrs. Cellini aloud and process the following questions considering all client issues (culture, education, language) when deciding how to conduct your assessment.

> 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?

Answers:

Mrs. Cellini (1) doesn't recognize own house, appears confused and disoriented, referring to distant past as present (mom went to store). (2) Dementia or Depression (3) Physical—is she dehydrated? Examine onset.

Repeat with Cases #2 (Mr. Dixit) and #3 (Mrs. Jackson).

Answers:

Mr. Dixit (1) Nods even when doesn't understand, doesn't "see" the issues in the home (2) Dementia [May be further development of Parkinson's Disease] (3) May have cultural considerations (e.g. first name is unusual and may link to culture); (4) Collateral contact with son, medical evaluation.

Mr. Jackson (1) Difficulty focusing, needs you to repeat with delayed response. Lack of concern about limited food, concerns (2) Dementia or depression (3) Need physical evaluation, see if problem remedies with adequate food (possible connect to meals on wheels).

Let's look deeper into the "3 D's".

Display **Dementia Defined** (Slide 17).

Dementia 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.

Dementia is a final common behavioral pathway for many diseases/etiologies that affect the brain. We will not have time to go through all of the different types of dementia but have a handout that explains them.

Refer participants to **Handout 3.5,** a resource drawn from the American Bar Association and American Psychological Association Commission on Law and Aging, for more specific information on types of dementia and other issues that affect capacity. These were reorganized on the handout according to type of dementia—from the progressive to those associated with other disease states to developmental and mental illnesses concluding with substance use related.

[Review allowing time for comments]

Display **Irreversible Dementias** (Slide 18).

This slide highlights the irreversible dementias. **Handout 3.5** explains more about etiology and related symptoms.

We will develop different safety plans when the dementia is reversible versus unlikely to respond to treatment.

Display **Causes of Reversible Dementias** (Slide 19).

Using the mnemonic DEMENTIAS, we can outline what can cause dementia that is reversible.

- Drugs, dehydration, depression. We can consider either drugs of abuse of prescription medication side effects. Some cardiac medications, for example, may promote symptoms of depression in some individuals.
- Electrolyte imbalances-- The most serious electrolyte disturbances involve abnormalities in the levels of sodium, potassium, and/or calcium. Other electrolyte imbalances are less common, and often occur in conjunction with major electrolyte changes. Chronic laxative abuse or severe diarrhea or vomiting can lead to electrolyte disturbances along with dehydration.
- Mental health disorders such as bipolar disorder, or depression. Severe anxiety may also present with confusion.
- Metabolic disorders: Metabolism is the process your body uses to get or make energy from the food you eat. Your body can use this fuel right away, or it can store the energy in your body tissues, such as your liver, muscles and body fat. A metabolic disorder occurs when abnormal chemical reactions in your body disrupt this process. When this happens, you might have too much of some substances or too little of other ones that you need to stay healthy. You can develop a metabolic disorder when some organs, such as your liver or pancreas, become diseased or do not function normally. Diabetes is an example.
- Endocrine disorders: Includes Adrenal Disease, Diabetes, Hypoglycemia, and Osteoporosis. When determining depression, for example, thyroid levels need to be assessed since when out of the normal range, may present as depression.
- Nutritional Deficiencies
- Trauma, tumor
- Infections (urinary tract)
- Acute illness, arteriosclerosis complications
- Seizures, strokes, sensory deprivation

Display **Delirium** (Slide 20).

Delirium is characterized as an acute confused state, disturbance in alertness, consciousness, perception, and thinking.

Onset is sudden and can be caused by infection, dehydration, chemical imbalance, head trauma, or anesthesia, among others.

Delirium can be a medical emergency, a life and death situation so emergent medical evaluation is needed. Delirium is treatable and reversible. Once resolved, the individual resumes prior level of cognitive functioning.

Ask: ***Has anyone had experience intervening when an individual has either experienced a reversible dementia or delirium as discussed in the last two slides?***

Note: Trainer should be prepared with an example.
From author's practice—a resident in a nursing home became suddenly psychotic. Once potassium levels were brought back to normal, the psychosis cleared. The levels were disrupted by the treatments the individual was receiving for another chronic condition.]

Display **Symptoms of Depression** (Slide 21).

Depression in the elderly is often undiagnosed or under-diagnosed. This slide highlights the symptoms that are used in the diagnosis of depression and apply not only to those who are elderly but also represent symptoms for adults-at-risk who might be impacted by depression.

Many symptoms of depression can affect a client's decision-making capacity such as:

    Sleep disturbances which can affect concentration and attention
    Loss of energy and/or loss of interest in usual activities
    Sense of hopelessness, worthlessness, or suicidal ideation

Capacity issues caused by depression may fluctuate and be reversible with appropriate treatment.

The first handout (**Handout AP 1**) in your assessment packet is Burns Depression checklist. The second handout (**Handout AP 2**) in your assessment packet is Geriatric Depression Scale – Short Form which can be used in practice. Both are forms which can be completed without specialized training.

D. Cognitive Domains and Assessment

Display **Cognitive Domains** (Slide 22).

As we review the remainder of the tools, we will do so by discussing the cognitive domains they assess. Generally, there are six domains that are considered when discussing cognition:
- Orientation
- Attention

- Memory
- Language
- Visual-Spatial Organization
- Executive Functioning

We will discuss the assessment of each of these domains using the tools in your assessment packet.

Display **Screening for Dementia** (Slide 23)

Before beginning, we have a brief video that demonstrates the components of the cognitive screening we will be discussing. This video shows a psychologist doing an evaluation of a woman with dementia. While this is much more extensive than we would do, it is the type of assessment completed at memory clinics or in similar situations.

Show Screening example: https://www.youtube.com/watch?v=_hRBPrfDQVI [9:46 minutes—you do not have to show the entire video, general screen is complete around minute 6. Stop the video after the woman attempts to identify the pen.]

After video section is shown, ask participants for comments. Note his "2-hour" battery—something that APS is not likely to do. Participants have also noted his questioning (multiple questions, speed). Her memory deficits have him working to get verbalizations from her.

Of note is that we often emphasize deficits but also need to tune into the strengths of individuals, even with significant impairment. For example, in the video, the woman is quite pleasant and her demeanor is likely to have a positive impact on how her care is managed.

Display **Cognitive Domains: Orientation** (Slide 24).

[As you go through the remaining assessment slides, refer back to the videos shown thus far in the day's training to illustrate points]

Orientation refers to the ability of a person to know person, place, time, and situation. Assessing orientation is a standard procedure when working with older adults, may not be as fully implemented when working with individuals with disabilities.

When assessing orientation, we are mostly testing recent and longer-term memory.

[In the video, he asked about her children. It is important when asking these questions that we know what the correct response should be.]

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.

The three screens used for assessment of orientation include the MMSE, MoCA, and the SLUMS.

Display **Mini Mental Status Exam** (Slide 22).

An adaptation of the MMSE is in your packets. The original, developed by Folstein is copyright protected. We included this tool so you can see what types of indicators are linked to mental status. In your assessments, asking general questions that lead to understanding of each of the items included in the scale can help in determining whether referral for a more comprehensive assessment is needed.

The MMSE is probably the most well-known test of mental status. Because it has been in use since 1987, the creators have a large normative data base for age and education level. It is quick and easy to administer.

Some of the disadvantages of the tool include that is does not address the client's decision-making skills for specific tasks. Knowing the date or how to count backwards from 100 is not relevant when the client needs to make a decision regarding medical treatment.

It also does not elicit the person's desires, wishes, or fears. It does not detect mild dementia or degrees of far advanced cognitive disorders. The results are influenced by the client's personal characteristics and experiences such as educational background, occupational status, cultural background, and other variables. It can be incorrectly administered and interpreted, particularly if cutoff scores are used and particularly if person has low literacy etc.

Finally, the original is copyrighted - if using official form and buying in bulk, each protocol would cost $1.62. Copy right is owned by Psychological Assessment Resources (PAR)

ASK: *if participants use the mini mental on a regular basis and their experience using it.*

The Montreal Cognitive Assessment is a second screening tool that is helpful for examining orientation as well as other cognitive domains. This assessment tool is free and is seen to be more sensitive than the MMSE.   We will talk more about that tool shortly.

Display **Cognitive Domains: Attention** (Slide 26).

Attention can be influenced by nonspecific abnormalities that can occur in
* Focal brain lesions,
* Diffuse abnormalities such as dementia or encephalitis, and in behavioral or mood disorders.
* Impaired attention is also one of the hallmarks of delirium.

On the Mini-Mental Status Exam, we examine concentration and attention based on attention to your questions, serial 7's or 3's in which they count backwards from 100 to 50 by 7s or 3s, naming the days of the week or months of the year in reverse order, spelling the word "world", their own last name, or the ABC's backwards.

[Thinking back to the brief video, we can see how he applied the serial sevens.]

On the MoCA, there are several questions that relate to attention.

Display **Montreal Cognitive Assessment** (Slide 27).

This tool is **Handout AP 3** in your assessment packet.

The section displayed in this slide is specific to attention.

This tool has been adopted by Kaiser, a large health provider which conducts health related research.

The MoCA takes longer and is a little more complicated to administer than the MMSE. As you can see on the slide, some directions are not printed on the form and this could lead to more administration errors.

Currently, there is relatively small normative data and no clear age or education corrected norms. Because this tool has not been as well known, providers may not be familiar with it.

You can get versions of this tool online at moca.org as well as earn certification in its use. (The use of the tool is free once certified but certification costs a fee). An app has been designed for the tool which can make administration mobile.

The MoCA was one of the screens given to Donald Trump with his medical assessment, as a result there has been much more interest in the tool—you now need to register for access rather than the tool being readily available.

Display **Cognitive Domains: Memory** (Slide 28).

When talking about memory, we assess the three different forms.

First, is immediate memory: recall of a memory trace after an interval of a few seconds, as in repetition of a series of digits. The first impairment for individuals with Alzheimer's disease is immediate memory.

Recent memory relates to the ability to learn new material and to retrieve that material after an interval of minutes, hours, or days. An example used in assessment is a list of words. Another example might the individual remembering your name at the end of the interview, even when you emphasized it and had them repeat it at introduction.

Remote memory is recall of events that occurred prior to the onset of the recent memory defect. "Sundowner" syndrome often present with Alzheimer's or other dementias is linked to remote memory. The individual remembers things from distant past and thinks they are occurring in the present. Remote memory cannot be reliably tested unless you have verifiable information.

Memory testing can vary day to day based on a range of factors including sleep, emotional state, and distractions. The best test is repetition over time.

[In the video, he was testing memory when discussing the television shows she watched. In the initial intake self-neglect video, she asked him about his hospital stay, reason for medications.]

To screen memory, we can complete the registration portion of the MMSE and MoCA or 3-item delayed recall on either test.

Display **Cognitive Domains: Language** (Slide 30).

The fourth area of cognitive functioning refers to the use of language.

We measure verbal fluency. This refers to the ability to produce spontaneous speech fluently without undue word finding pauses or failures in word searching.

Normal speech requires verbal fluency in the production of responses and the formulation of spontaneous conversational speech.

We note whether speech is at a normal rate and volume, pressured, slow, accent, enunciation quality, loud, quiet, or impoverished (meaning answers are minimal or unable to find the correct words).

Receptive language refers to the ability to comprehend questions, or the difficulty understanding questions.

Expressive language can range from no problems expressing self, to circumstantial and tangential responses, anomia (the inability to name common objects), difficulties finding words, misuse of words in a low-vocabulary-skills way, misuse of words in a bizarre-thinking-processes way, echolalia or perseveration, mumbling.

Naming, repetition, and reading or writing a sentence are all examples of tests that can be used in examining language.

Display **SLUMS** (Slide 30).

SLUMS refers to the St. Louis University Mental Status Examination. Developed by the Veteran's Administration, this is the assessment tool that is used in nursing homes as part of the MDS assessment process. It tests all of the domains discussed thus far.

Like the MoCA it is free, but SLUMS is easier to administer than the MoCA. As you can see by the instrument, norms are corrected by education level. This tool also incorporates clock drawing, a test which we will discuss shortly.

The SLUMS is **Handout AP 5** in your assessment packet. (Not the original which is inserted in this slide but a transcribed version is in your packet).

It is important to refresh yourself regularly when using this screen to insure you are asking all of the questions. A disadvantage is that is it not translated into other languages. Because this is commonly used in nursing homes, with repeated measures required early in the move to the nursing home, I have seen individuals without cognitive deficits "memorize" what they will be asked!

Display **Visual-Spatial Organization** (Slide 31).

This domain is very sensitive to brain dysfunction- can pick up mild delirium and otherwise silent lesions. It refers to the ability to visually place items. It is important in the ability to describe the meaning of items in our environment.

In a person's history, listen for getting lost in previously familiar environments, difficulty estimating distance, or difficulty orienting objects to complete a task.

Visual-spatial disturbance is a sensitive indicator of delirium and can occur in any dementia syndrome; it often occurs early in the course of Alzheimer's disease

[In the video, the pentagon drawings was visual-spatial assessment.]

Examples of screens include the clock drawing, and the cube drawing on the MoCA.

How many of you do well with the completion of a Rubik's Cube? This is an activity that requires good visual-spatial skills.

Display **Clock Drawing** (Slide 32).

The clock has been proposed as a quick screening test for cognitive dysfunction secondary to dementia, delirium, or a range of neurological and psychiatric illnesses.

Clock errors may be divided into categories including visuo-spatial, perseveration, and grossly disorganized.

Common errors in Alzheimer's disease include perseveration, counter-clockwise numbering, absence of numbers and irrelevant spatial arrangement.

Test results can provide information on general cognitive functioning such as memory, information processing, and vision. It can also offer clues about the area of change or damage (for example, brain change and/or damage).

Display **Clock Drawing Test in Action** (Slide 33)

Here is an example of someone completing the clock test---as you can see, it does not take much time to complete!

https://www.youtube.com/watch?v=qp2i0NNDxCg [1:46]

Display **Clock Drawing** (Slide 34).

Scoring of the clock test is relatively easy:
  – *1 point for the clock circle*
  – *1 point for all the numbers being in the correct order*
  – *1 point for the numbers being in the proper special order 1 point for the two hands of the clock*

- *1 point for the correct time.*

A normal score is four or five points.

How the clock is drawn has significance for the type of disorder an individual has as is outlined on this slide. The middle set of clocks was drawn by individuals with Alzheimer's disease and the bottom by someone with Parkinson's disease.

MIT is examining the Clock drawing further with a digital pen that will look at nuances based on hesitation in drawing and other factors that might also help with diagnoses accuracy, perhaps earlier in the process.

Display **Cognitive Domains: Executive Function** (Slide 35).

The final cognitive domain is that of executive function. This refers to the constellation of cognitive skills necessary for complex goal-directed behavior and adaptation to a range of environmental changes and demands.

Executive function includes planning strategies to accomplish tasks, implementing and adjusting strategies, monitoring performance, recognizing patterns, and appreciating time sequences.

Deficits in executive function are associated with disruptive behaviors and self-care limitations among patients with Alzheimer's disease.

The Clock drawing examines executive function as does the abstraction section of the MoCA.

There are many other tools available for use and many are being developed that will allow ongoing self-monitoring. As the population ages, this may be useful to insure advanced planning!

E. Cross Cultural Skills

Display **Cross Cultural Assessment** (Slide 36).

As a final point of discussion before we leave the topic of assessment tools is the discussion of cross-cultural assessment. The tools we have discussed can be used across cultures although there may be differences in interpretation.

When approaching assessment of individuals who are culturally different than you are, you need to keep in mind the norms of that culture, be aware of what the differences are.

Asking questions to determine the client's ability to make informed decisions is a complex task even when you are working with adults who share your culture.

The complexity increases tremendously when working with those who are from another culture. Then cultural awareness must become a more conscious part of the interview.

For the purpose of this training, "Cultural awareness means openness to learning about other persons' beliefs, attitudes, values and customs. It includes awareness about the cultures of physically and mentally challenged persons, as well as of persons from other ethnic groups, and countries."

The focus of this definition is on being open to other people's ways of living in the world, whether the differences are related to disabilities, social class, religion, or gender issues.

Of course, no one knows all there is to know, even about his or her own culture.

And it would be impossible to be an expert about every culture.

What is important is to approach people of other cultures with respect and with a willingness to learn what is most important to them. This means paying attention to subtle cues during the interview process.

Culturally effective interviewing takes time and practice to develop. But the investment pays off by:
- helping to develop rapport more quickly,
- getting more accurate information, and
- providing a context for accurate analysis.

Since accurately assessing decisional capacity is such an important issue, improved cultural awareness is essential.

When interviewing someone from another culture, learn as much as you can beforehand about cultural beliefs that affect values—especially when they differ from the primary culture of the area. The attitudes people have about helping, helpers, aging, and disability are also impacted by culture. The customs, faith, religious beliefs all are influenced by culture. The rules about family roles and gender, family structure are also determined by culture.

Cross-cultural skills include being aware that strangers are perceived as "outsiders", taking time to establish rapport, speaking clearly, avoiding idioms and slang. Mirroring the interviewee in tone of voice, eye contact, directness of speech, and being respectful are all keys to cross-cultural assessment.

[End of Module]

Module 4 Overview: Planning

Timing (120 minutes max.)

Planning……………………………………………………………………120 minutes total

 A. Case planning with Involuntary Individuals………………………… 40 min
 B. Involuntary Interventions……...…………………………………………30 min
 C. Essentials………………...……………………..………………………… 20 min
 D. Case Planning …………………………………………………………… 30 min

Learning Objectives

- Identify key components of case planning.

Advanced Preparation

- Place piece of Flip Chart Paper and Marker on table during lunch break

Handouts

- Handout 3.6: Anna Kovacs
- Handout 3.7: Learning the Language
- Handout 3.8: Strengths Based Care Planning

PowerPoint Slides

- Slides 37 - 46

Other:

- Need Flip Chart

Module 4: Planning

105 min

- Slides 37 – 46

- Handouts

    o Handout 3.6: Case Study Anna Kovacs
    o Handout 3.7: Learning the Language
    o Handout 3.8: Strengths Based Care Planning

Note for trainer: Typically, part of this module will be completed before lunch and part after lunch. Depending on progress through the unit, break for lunch could occur before beginning this module. In the pilot trainings, the break occurred both ways. Much depends on the amount of discussion in the modules.

A. Case Planning with Involuntary Individuals

Display **Planning** (Slide 37). [This is a transition slide]

We have gotten the referral, completed an assessment, spoken with collateral contacts. The next steps are developing a plan and documenting that plan. Preparing for court proceedings when necessary includes documenting injury and justifying the least restrictive option.

We are going to address planning from two different perspectives—working with involuntary clients and working with those who voluntarily accept services.

Display **Case Planning: Step-by-Step Decision Making** (Slide 38).

The steps outlined on this slide are part of any APS case plan. We will discuss them in relation to providing involuntary interventions. Before the break we will discuss assessing risk, assessing the ability to consent, and determining urgency.

We have devoted quite a bit of today to discussion of capacity assessment—a key consideration to risk assessment. We must define the risk to the client. What

would be the consequences to this individual if no action is taken? Has it happened before, and what were the results? What makes it different this time?

As part of assessing risk, we examine lethality.

Although many involuntary interventions come because of self-neglect, there is also the need to examine the consequences of perpetrator abuse on adults at risk.

Lethality Assessment includes considering if there is
- Access to/ownership of guns
- Use of weapon in prior incidents
- Threats with weapons
- Serious injury in prior abusive incidents
- Threats of suicide
- Drug or alcohol abuse
- Forced sex
- Obsessive or extreme jealousy or dominance

These are red flags that your client may be at serious risk of harm or even death. There are many reasons that victims of domestic violence do not take action or refuse help.

As we saw in the earlier, people stay in relationships for many reasons, some of them for practical reasons related to finances. Other reasons can include learned helplessness, depression, fear of the unknown, shame, loyalty. Often times, the victim may seem like she is making an informed choice, but she is not. We must be sensitive to these emotional factors and be prepared to take necessary action to protect the victim. This means developing a trusting relationship and negotiating consent whenever possible.

Assessing ability to consent is a crucial factor in the decision whether or not to take involuntary action. It is not a simple process because there are many variables.

If an individual is determined to lack capacity, it does not always mean that involuntary interventions have to be used. The individual may have a strong support system or there may be voluntary services (home health care, visiting nurses, home-delivered meals, and bill-paying) in place that keep the individual safe. If the individual is isolated and at extreme and urgent risk, involuntary intervention should be considered.

Sometimes, even when an individual seems to have the capacity to understand the dangers of the situation, undue influence by family members, exploiters or

abusers may be contributing to the denial or refusal of services. Evaluation of financial issues needs to be considered to insure there is no exploitation.

There are medical conditions that cause temporary capacity issues and require emergency attention. These may include delirium, medication interactions, diabetic coma, and gangrene.

Mental illness alone is not a reason for involuntary intervention. Many individuals manage to get through life with mental diagnoses. When an untreated or mistreated mental illness results in an individual threatening himself (suicide/suicidal ideation) or threatening others (violence/homicidal ideation), involuntary intervention may be indicated.

As we mentioned earlier, people who have lived with domestic violence may not be able to see their lives any differently. They have been conditioned to believe that they deserve the situation they are in and feel helpless to change it/hopeless that anything can make it better (this is what we call learned helplessness). Depression can result. Of course, depression can manifest itself for other reasons including developing multiple disabling conditions along with aging or suffering many losses that cause them extended grief reactions which cloud their ability to consent to services.

Finally, in terms of assessing capacity, we can examine substance use or abuse. This can affect the individual's ability to evaluate the risks facing them as well as their decision to accept services. Whether an individual has had a long history of substance abuse or has begun drinking more recently perhaps because of depression, loneliness, and isolation, APS workers must be aware of the effects of substance abuse on the mental and physical functioning of the adult-at-risk.

We can also examine consent through the idea of differing levels of consent There are different categories that characterize the client's willingness and ability to accept help. These can be described as:

➤ Capable and consenting: if the client is in this category, the worker's job is to give information, help client evaluate options, and respect the decisions the client makes.

➤ Capable and non-consenting: if the client is in this category, the worker still must respect the client's wishes. Rather than give up immediately though, the worker still can try to "negotiate consent" (Harry Moody, 1998) with the client. This is done through building of a trusting relationship and provision of acceptable options.

➢ Incapable and consenting: this may raise some ethical questions so make sure documentation is clear.

➢ Incapable and non-consenting: this would indicate the need for involuntary interventions, especially if the risk is very high.

It is important to remember that the client's capacity may fluctuate.

ASK: **Based on what we have talked about today, what may influence this fluctuation?**
Poor nutrition, medication interactions, time of the day, depression, infections, sleep issues, state of inebriation, etc.

It is always important to realize that your relationship to the client is a crucial piece of consent.

ASK: **what situations would make involuntary intervention more urgent***?*

Possible answers: confused client living alone with no support system, mentally ill client who is threatening herself or other people, client in a medical emergency refusing to go to the hospital, unsafe living environment, lack of supervision due to loss of caregiver (hospitalization, arrest), imminent danger of violence or physical injury by others, imminent homelessness (condemnation, foreclosure), imminent risk of severe financial losses.

Trainer's note*: As participants volunteer situations, write them on a flipchart. This will be a reference for what follows.*

Display **Group Activity-Case Planning: Anna K** (Slide 39).

Let's use a case example to discuss a situation where we can look at urgency and discuss case planning. Pull out **Handout 3.6 Case Study Anna Kovacs**. This should look somewhat familiar. We used this case study at an earlier training. (So some of this is refresher).

In small groups, answer the prompts on the handout. We will come back together in about 10 minutes to discuss your findings.

Debrief after small group activity.

Factors for discussion of urgency: (1) Her diabetes-gangrene indicates quite advanced. Does this increase the urgency? (2) Recent hospitalization and use of a wheelchair. Can she even navigate around her house (e.g. the clutter)? (3)

Lives alone. Are there other supports available to her? (4) What is her usual pattern? (5) level of understanding- English is limited. Does she even understand her medical condition?

Key in planning is collateral contacts and urgent medical monitoring—physical examination to determine blood sugars. This was not a "good discharge" from the hospital!

Alternate or Additional activity (depending on time):

Display **Small Group Activity: Most Urgent Situations** (Slide 40).

Look at the list of urgent situations on the flip chart and pick 5 of the most typical situations.

Divide the class into 5 groups and assign one situation to each group.

Have them discuss it and answer the following questions:
• How would you assess the risk?
• How would you assess the capacity of the victim?
• How would you assess the urgency?

Give them 10 minutes to do this and then process the 5 situations in a large group. Ask the spokesperson to present it or just have them share their answers, asking for additions from the large group.

Display **Weighing the Options** (Slide 41).

This, again, is the dilemma of APS workers and the reason that we discuss this so often. Our decisions are very important – so we must make sure we have a solid foundation on which to make them. In some controversial cases, you may be called upon to defend your actions to other professionals, victim's families, courts, professional boards, or the media. You may be putting your own reputation as well as your agency's reputation on the line.

These 4 factors can have an influence on your decision-making process.

- Client wishes: Client's action or inaction/ refusal of voluntary services is putting her/him at severe risk of harm. ***Ask for examples.***

- Professional Obligations: There are times when your ethical assessment and proposed decision on an APS situation comes in conflict with that of your supervisor, administrator, and state statute. ***Ask for examples.***

- Personal Values: There are times when certain clients, family members, or situations push your buttons and may interfere with your ability to make a sound decision. These may be cultural values or family values. There also may be times when your boundaries become too loose or too rigid. *Ask for examples*.

- Community Pressure: Often outsiders, community agencies, and family members feel that they know the best decision to be made for your client.

Display **Case Planning Involuntary** (Slide 42). [This is a similar to the prior slide]

When we think of ethically working through the dynamics of involuntary treatment, we need to be in tune with our own values. Self-awareness of your values, motivations, and needs is imperative in APS work, especially when you are making decisions of life and death, freedom and restrictions.

Beware of approaching situations with:
- Dogmatism: "I am the savior of victims"
- Rationalizations: "Since nobody else will help, I will do it (even if it is unethical)"
- Passivity: Not taking action, excusing behavior, blaming the victim
- Passion: Crusading for what you believe is the "right thing" to do
- Arrogance: No need for supervision, above it all

In making ethical decisions, we honor the client:

• **Honor preferences** victim has expressed before incapacity. You may be able to obtain that information by consulting past case records or discussing the situation with people who know the client.

• **Use substituted judgment**. If the client's preferences are not known, the surrogate's decision should be based on what the client would have wanted or preferred. In order to use this approach, there must be substantial information about the client's views and wishes.

• **Use "best interest."** When there is insufficient information on which to base substituted judgment, decisions should be made on what would be in the "best interest' of the client. Judgments are not based on the surrogate decision-makers preference, but on what a "rational normal person" would prefer. (Nerenberg, 2008)

• **Allow for exchange of views**. When the individuals involved (family members, physicians, surrogates, and service providers) disagree on what is in the client's best interest, all parties should be encouraged and provided with opportunities to meet and exchange information and views. Seek consultation through supervision or multidisciplinary teams, and even the courts.

An important tenet of APS work is that priority should be given to interventions that least restrict the client's autonomy, independence, and freedom of choice. We can look at continuums of home-based care, of money management services, of limited rather than total guardianships, having animals neutered rather than destroyed, etc.

Now let's look at a few situations to try and determine if the worker went too far or not far enough.

__Trainer's note__: Read these vignettes and ask for a show of hands… how many think the worker went too far? How many think she did not go far enough? Ask for reasons.

1. Client lives in an apartment which is full of clutter and collectables. There is a path from the bedroom to the kitchen. Client has difficulty with her ambulation and has fallen a few times. Client says all the items in the apartment have sentimental value and he does not want to throw anything out. You call the Mental Health Screeners and ask to have him evaluated.
   __Too far__: Is he a danger to himself or others? Does he have a mental health history?

2. Client is bedbound and dependent on her mother for care. Her mother has a substance abuse problem and has not been providing supervision and meals. Client is losing weight and seems a little fearful of her mother but doesn't want you to do anything about the situation. You do a mini mental and client scores 27 points. You leave and close the case, since client has capacity, even though she has a disability.
   __Not far enough__: scoring high on a MMSE is not enough to close the case.

3. Client is an 89-year-old man who has been a widower for 25 years. He recently met a 32-year-old woman and has fallen in love. He informs his adult children that he will marry this woman. He has changed his will, leaving all his substantial assets to her. The children inform APS and the worker puts a freeze on client's bank account.

Too far: not enough info on the client's capacity to make choices (even if they are choices we do not approve of), questionable motivation of the adult children.

Note: This third scenario is approached differently by some. Because of the risk to finances (easy removal), some would freeze and then assess. There are ethical considerations should this occur. It can also be noted that banks do have the power to freeze accounts should they have concern, then will refer to APS.

B. Involuntary Interventions

Display **Involuntary Interventions** (Slide 43).

These are some of the interventions that can be used in providing services. Although APS workers often feel as though they are a lone soldier fighting an uphill battle, when we make the decision that an involuntary intervention is warranted we need the help of others. Look at this list and think about which agencies or individuals might be able to assist you.

ASK: *Who are the players that can best assist and under what circumstances.*

Possible answers include: [Trainer can write these on flipchart, if desired]

Law enforcement: access to client living alone if report indicates extreme self- neglect (medical, mental illness, environmental), access to client when a caregiver or perp is denying access, response to a crime

EMT: if client is in extreme medical distress or unconscious. EMT cannot transport client against his/her will, so casework is still needed.
Mental Health System: if client or perpetrator/caregiver is a danger to self or others due to mental illness

Corporation Counsel: Cognitive impairment causing risk: emergency placement via protective order, guardianship

Bank or financial institution: freezing bank account, providing documentation to build a case for financial exploitation.

Most often APS workers cannot take an involuntary action alone. We spoke about the other individuals, disciplines, agencies that must be "on board" to make intervention happen. Working with other agencies or disciplines can present some challenges. Frequently APS is misunderstood and mysterious to the outside world. This could be due to confidentiality rules as well as to unrealistic expectations.

Referring to the list, **_ASK: What is your experience getting cooperation with these individuals? What worked? What didn't?_**

Sometimes there is a history of mistrust perhaps due to the misconceptions about the responsibilities and limitations of APS, about the definitions of abuse and neglect, about the issue of self-determination. There may be turf issues or a conflict of roles – who is to do what in what kind of case. Just as other agencies/disciplines may not fully understand APS, APS also needs to make the effort to understand the responsibilities and limitations of those from whom they are requesting assistance.

In addition, each discipline has its own "language" –the lingo it uses as well as the professional terminology and definitions used to guide their practice. To enhance your ability to access the people you need, you must learn their language.

ASK _if any have dealt with law enforcement or mental health crisis teams? Were they aware of any "language barrier" regarding the lingo?_

Law enforcement works in "black and white", so the "language" deals with facts.

Mental Health defines a crisis as "danger to self or others", so you need to understand what that means.

Learning the "language" does not imply that you manipulate/fabricate the story in order to get the attention of another agency. (We know that other agencies do that when referring to APS, and we are not happy about that.) It means that you understand and respect the mandate of the other and that you speak clearly are assertive (but not aggressive). **Handout 3.7**- Learning the Language, can give you helpful hints in working across disciplines.

Because the decision to force intervention is such a delicate and difficult one, it is important that workers have "all their ducks in a row." In the next part of this training we will cover these issues (listed on slide). Learning to do this step by step will give you more confidence in your decision and increase your comfort level with your decision. You will need to "make a case" for your decision – with your supervisor, agency attorney, prosecutor, judge, etc. Making sure your plan is legal, ethical, and meets the "least restrictive alternative" criteria are crucial. Gathering facts and documentation will make your case solid. Examining all the possible consequences will help you sleep better at night.

If the involuntary intervention you plan to implement is governed by statute, you need to be familiar with that statute. If a crime has been committed, you may be required to contact law enforcement and provide information to assist.

When taking a legal action against a client/victim's wishes, it is important to examine the consequences of that action both to the client and to the alleged perpetrator if there is one. Example: if the victim lives with her abusive son but does not want to "get him in trouble," there may be a time that you observe the abuse and need to report it. Is arrest mandatory? If so, how long will the abuser be out of the house? Who signs the restraining order? How will the restraining order be enforced? Will the victim allow the abuser to return to the home in spite of the restraining order? What are the rights of the abuser?

<u>ASK</u> for other examples.

Remember, just because a situation seems unfair or abusive does not mean that it is illegal.

Now that we have determined what is legal and who can help you achieve your goal of involuntary intervention, we need to be aware of the social consequences of this action.

Trainer's note*: as you go through these items, ask participants for their own examples. We want them to evaluate the potential consequences of their actions very carefully, so they can prepare for them as much as possible.*

Display **Marie Rodriguez** (Slide 44)

Case information: 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.

Prompts on the slide ask the essential questions: What might be the hidden consequences of intervention? What ethical considerations are there? Is the plan workable, or should other options be considered? What are the outcomes? Do we have a Plan B?

Ask the group:
- What may be the emotional consequences for both client and son due to placement?

- How might the case plan affect the bond between Javier and client?
- How might the plan affect the client's role and dedication to her son?
- Did Javier provide any services for his mother that are now an unmet need?
- Did the client want Javier placed? If not, what are the ethical issues around placing the client's safety before her wishes?
- What might be a good plan B?
- Are there other family members that can help out?
- What about the local agency that provides services to the developmentally disabled community –what services might they be able to provide?

Display **Joe Jones** (Slide 42).

Case information: 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.

Prompts ask if the plan is realistic? What might the outcomes be? How might client feelings influence the outcomes? Do you have Plan B?

Ask the group:
- *Consider whether the plan is realistic (are services really available to replace whatever son did)?*
- *Will the client be left with unmet needs?*
- *Might the daughter have hidden motives? Could this be sibling rivalry rather than a real problem for the client?*
- *What might happen as a result of the restraining order?*
- *How does the client feel about the possibility of his son being incarcerated? Might the son return home and threaten the client? Might the client allow the son back in despite the restraining order?*
- *Should you be "convincing" the client to do something he doesn't want to do? How might he react if this plan backfires?*
- *What might be a good plan B in this case? How might you follow-up to make sure that this plan is working? What might be an alternate way to handle this situation, rather than getting a restraining order? Could a*

representative payee handle the client's money so the son doesn't have access to the client's money? Might a family conference to clear-up the issues work in this case?

Ask participants the prompts on the slide, leaving time for calling out.

Other aspects to discuss with these case scenarios (Marie Rodriquez and Joe Jones):

What will happen to client/victim?

- Will this action remove her from her home? If so, for how long? Where will she go? Who will be "in charge" while she is out of the home?
- If she is transported to a mental health facility, how long can they hold her? What kind of medication will she be on? Who will follow up when she is released?
- If the action removes the perpetrator who has been providing care or supervision, who will continue to provide care or supervision? If client was against the removal of the perpetrator due to loyalty or love, what will be done to fill the emotional gap? Will the victim feel obliged to take perpetrator back? Does victim have other supports? Can APS cultivate them?

What will happen to perpetrator? Where will he/she go?
- To jail: for how long? What will the conditions of his/her release be? Does perpetrator have income? How will he support himself if he is not with the victim?
- To a hospital for mental health/substance abuse treatment? For how long? Who will follow up? Where will he go upon discharge?

What will be the effect on family members?
- If a guardianship is being pursued, who will be named guardian? Will any family members contest the appointment? Will they secure their own attorney? Are there any financial or property issues that we should be aware of?
- If a spouse is arrested for domestic violence, will there be repercussions from adult children or other relatives? How will that affect the victim?

How will you respond to the larger community?
- What are the chances of this action hitting the newspapers? According to APS confidentiality rules, what can/should and cannot/should not be shared?

As we have been saying all day, you must build a case for any involuntary action you plan to do. We have to then assemble all the facts. These include:

Who: witnesses, victims, complainants, reporting parties
What: happened, what is the evidence
Where: did it happen, are the persons involved
When: did it happen, was it reported
Why: did it happen, was it reported.

We also need to include our observations and gather all information from other sources that will support our case. Those sources should be reliable and credible.

Remember that your documents may wind up in a court of law, so be factual, objective, and concise. Make sure you have as much supporting documentation as possible. We will be talking about documentation shortly.

Involuntary actions are not designed to help the worker sleep at night. They are done only after the most careful deliberation, following ethical standards, trying all other options first, and using the least restrictive intervention that will meet the APS mandate. We need to maintain flexibility in the case planning process. When we receive information that may change the needs or the proposed plan, we may need to alter the plan. Maybe a distant nephew will appear and be able to take on some of the supervision responsibilities. Maybe, the cognitive impairment that seems like advanced dementia is due to a urinary tract infection and can be cleared up without filing for guardianship.

C. Essentials

Display **Case Planning Essentials** (Slide 46).

Of course, not all involvement with clients will be on an involuntary basis. We can work with those who might be reluctant to develop plans that can increase their safety and retain their independence as much as possible.

The case plan is developed on the basis of specific issues identified and their priority of resolution, of identified strengths and perceptions, and of the internal psychological resources and external support systems. Ideally the case plan should meet the criteria outlined on the slide and expanded upon in the handout.

A good case plan should be:

Collaborative: it should be developed mutually. If it is imposed by the worker and the client does not "buy in" or participate in the process, the plan is likely to be sabotaged.

Problem Oriented: the plan should be focused on problem resolution, with the problem/issue being defined and shared by worker and client.

Appropriate to client's functional level and dependency needs: it should be based on an accurate assessment of the client's abilities and needs.

Consistent with culture and lifestyle: it should not cause conflict with the client's beliefs or values.

Realistic, time-limited, and concrete: the case plan must be doable. Setting expectations too high will disappoint the client and may result in a negative experience that the client will not repeat. It will also frustrate the worker. The case plan may need to happen in small increments, with trial periods, and check-ups.

Dynamic and renegotiable: in APS work, we never know what new information will become available, what friend or relative will appear/disappear, what medical or psychiatric condition will change. Therefore the plan (and the worker) must be flexible and willing to renegotiate depending on the circumstances.

Inclusive of follow up: it is important to follow up with the client as well as with the service providers, family members, and others who are a part of the plan.

In APS case planning, there are general goals to which our interventions lead.

- Maximizing independence: Since most victims would prefer to remain at home as long as possible, the services offered should provide options towards this end. These may include visiting nurse services, home health care, reassuring calling, and home delivered meals.
- Resolving crises and emergencies: short term placement in a facility or motel, order of protection against perpetrator, law enforcement intervention, mental health crisis services, emergency medical treatment, or hospitalization.
- Healing, empowering, supporting victims: mental health services, medication, counseling, or support groups.
- Cultivating new resources: involvement in senior programs, reconnection with family members, or physical therapy.
- Preserving, protecting, recovering assets: direct deposit of SS checks, freezing bank accounts, or changing POA.

- Ensuring safety/risk reduction: safety planning, home repairs, or cleaning service.

The worker must take into consideration the client's preferences and values when considering any intervention. For example, if placement is the least restrictive and only option, the client may have some input as to the type of facility, the location, etc.

We must be careful to examine our recommended case plan for the following:

- Hidden/unintended consequences: Will the intervention put the client at more risk? Will the client be able to follow through when the worker is not available?
- Ethical dilemmas: If the client has capacity, are we respecting the right to self-determination?
- Workability: Are the services we propose available when we need them? How do we know if the perpetrator will follow through on promises?
- Whose needs are being served: Are we responding to community pressure ("How can you let a person live like that?) Or to our own value system ("I would never treat my mother that way." "That son is a scum-bag and shouldn't be allowed anywhere in the house.")
- Plan B: Do we have another plan in case Plan A falls short? How do we plan to follow up?

Now that you know the essentials of good case planning, let's evaluate the following vignettes.

D. Case Planning [Optional Activity. Handout 3.6 is the Anna Kovacs case study. If completing that activity, would not use that handout here. These are the case studies which were used in the earlier training.]

We are revisiting the case studies of Anna Kovacs, Juan Garcia, Mark Hudson, Rob & Wilma Benson, and Sharon Delay that we worked with on the first day of training. [These are **Handouts 3.6A – 3.6E**. Trainer should hand the different case studies to the groups.]

In your groups, I would like you to discuss the questions on this slide:

With the information you have explaining the case study, discuss what outstanding questions you have, and how you would go about obtaining that information.

What assessment tool would be the best to utilize?

Are there any cultural considerations that should be taken with this client?

You have ten minutes to discuss and then we will come back together and discuss the outcome of your discussion.

Decide what is the most appropriate, immediate next step in the case planning process for this client. Don't try to resolve all the client's issues, just focus on what needs to happen next, based on this client's current situation and decisional capacity.

You have 15 minutes to determine an intervention plan. Use **Handout 3.8** as a guideline for the strengths-based plan.

After the 15 minutes, ask a representative from the groups to come forward for the discussion. [Depending on size of the group, you will likely have more than one group reporting for each of the case studies; ask each group to share in the reporting.]

TRAINER NOTE: *As each group completes its report, encourage the members of the large group to ask questions and comment on each small group's assessment and case plan.*

Review of answers should not take more than 10 minutes.

As a wrap-up for this module, standardized tools give another dimension and help you decide when it is important to get further assistance – from a physician, psychiatrist, or attorney. Scores may fluctuate depending on the time of day, emotional state of the client, and the comfort level of the worker administering the scale. Assessment scales and tools should always be part of a package. An effective way to use a tool is to weave questions in the interview. Tools are just that, tools, and each has strengths and limitations.

The most important tool is the worker: skills and use of self. For this reason, APS caseworkers should not rely solely on one assessment tool to determine whether a client needs a professional capacity evaluation. Weaving questions into your conversation that examine capacity is a strategy that allows for assessment while not requiring the structure of some of these assessment tools.

NOTE: If there is time, have the large group brainstorm about lessons learned from this activity. Otherwise, individuals can quickly call out, in a sentence or two, key things they learned.

[End of Module]

Module 5 Documentation in APS Overview

Timing (75 minutes max)

Documentation in APS……………………………………………………………….75 minutes

    A. Standards for Documentation.…………………………………………...20 min
    B. Documentation Skills……………………………………………………… 35 min
    C. Documentation for Court…..………………………………………………20 min

Learning Objective

- Outline documentation requirements and additional reporting.

Handouts

- Handout 3.9: Terminology
- Handout 3.10: Rat Feces Exercise
- Handout 3.11: Clarity in Documentation
- Handout 3.12: Memory Assistance
- Handout 3.13: Photographing Evidence
- Handout 3.14: Body Maps

PowerPoint Slides

- Slides 47 – 62

Advanced Preparation [Optional]

- If desired, create a poster-board/flip chart sized copy of the documentation for critique (slide 51).

Module 5: Documentation within APS

- Slides 47- 62

- Handouts
    o Handout 3.9: Terminology
    o Handout 3.10: Rat Feces Exercise
    o Handout 3.11: Clarity in Documentation
    o Handout 3.12: Memory Assistance
    o Handout 3.13: Photographing Evidence
    o Handout 3.14: Body Maps

A. Standards for Documentation

Display **Documentation** (Slide 47). [This is a transition slide]

Developing the plan is a key result of assessment. As with all client contact, documentation is the key for insuring that we are reporting accurately and are able to support our conclusions, particularly when the court system is involved. We will spend the remainder of today talking about documentation.

Display **Documentation in APS** (Slide 48).

As APS workers you will find that there is a lot of documentation required, forms for this, forms for that, forms go to different entities, sometimes they are used at the moment, sometimes they show up years later.

So, you will be writing… and writing. Some of you may not like that. Some may not have experience doing it. For some of you English may be your second language. Some will think that their time is more valuably spent in direct service to clients.

The quote on this slide highlights a guiding principle for APS documentation.

Case records should include:

- **Required Forms** as per your jurisdiction

- **Progress notes** should be well written and clear, including what we discussed before – dates, times, places, phone numbers, stakeholders, other agencies.

- **Medical information,** including documents received from physicians, nurses, hospitals… and any evaluations and affidavits should also be included.

- **Legal Information -** Records from law enforcement are important. If you don't have the documents, make sure you have the dates of restraining orders, protective orders, etc with all the information included.

- **Financial Information -** Banking information is especially important when investigating financial exploitation, but can also be helpful evidence when dealing with a self-neglecting client who has begun sending their money to charities seen on TV

ASK: *What other banking info should be in the record*?

- Possible answers: monthly statements, unpaid bills, cancelled checks, etc

What should not be included in a case record:

[**Note**: If case records are all electronic, then some of the following will not be appropriate. You might want to ask the group if they use paper files.]

- **Personal notes -** if there is a paper file, these items do not belong in it (Personal notes, scraps of paper). If you take notes during an interview, they should be transcribed into progress notes and carefully written, documenting what you observed and what people said to you. We'll get to the specifics of that later.

- **Alterations -** Also be careful about changes you make into a paper case record…any alteration may be questioned in court.

- **Irrelevant information -** Also information in the case record should be relevant to the allegations and the investigation in question. We'll also talk more in depth about that later.

- **Judgmental or inflammatory statements** these type of statements do not belong in your case documentation. We will discuss this more in depth later as well.

Display **Purpose of Documentation** (Slide 49).

Workers often complain that they spend more time documenting than providing services to their clients. In our hearts, we know that there is a good reason to document and document well. Here are some of the reasons:

Establish a detailed and reliable case history and baseline data: Why is this important? This allows you to mark improvement or deterioration.

Evidence for involvement – APS and/or legal: Both justification for being involved and documents created during the assessment process can be the most damaging evidence in court. Documentary evidence is better than personal testimony. Worker testimony based on records is more strategic than eye witness testimony without records.

Accountability and liability - Shows case handled appropriately. Legal attacks on documentation are weak because an attorney would have to prove that the entire record was false. Legal experts indicate that good records presume good services are being provided, and bad records presume bad service.

Professionalism: A level of professional competence can be demonstrated by the written work.

Consistency: Demonstrates that the case was handled efficiently, and all relevant leads were followed up.

Justify the need for staff/funding: Numbers alone don't tell the story and numbers don't assure quality. Records serve to determine the complexity of the task as well as the quality of the services provided.

Other?

ASK: what other purposes does good documentation serve?

> *Some examples include: Communication within the agency, to assist with substantiation decision, identify service gaps; improve the quality of services to people in the community. Good documentation also helps when you are out of the office, whether in the field, out sick, or on vacation. If your coworkers and supervisor know what has been done on a case, it may prevent duplication of efforts when you are not in.*

The bottom line is that you went into this field to help clients. Many of us complained that documentation takes time away from the work we can do with clients. But in order to really help clients, we not only engage them, develop trusting relationships, do the "social workie" thing… but to really service them, we need to build their case. Those details that are recorded will help you help them get what they need. And that's what we want.

The important things to remember when considering the time and effort that you put into documentation:
- You never know who will read it… it could be your agency director, attorney, a prosecutor, a judge.
- You don't know where it will end up and how long it may take before it winds up in court – maybe 2 years?
- Your documentation helps you refresh your memory as a witness, helps you remember the details.
- The bottom line: yes, documentation helps you, your agency, the legal system… but it helps your client most.

The better job you do in documenting the situation, the better chance you have in getting your client the services and the justice she/he deserves. And that is what our jobs are about: helping and protecting vulnerable people.

Display **Standards of Documentation** (Slide 50).

When we document we need to make sure that we are documenting accurately and factually, completely, and in a timely fashion.

Let's discuss why we include these in our standards for documentation in APS and look at some examples.

It cannot be emphasized enough how important it is to make sure that your facts are accurate. Including these elements:

Dates & Time: These include all dates and times related to the case and the dates and times of any action taken on the case.
- When did you visit?
- Of course, you need to include where the visit took place as well – in the home, at a senior center, in the police station, at the home of a neighbor or relative.
- All phone calls made by you (and to whom) or received by you (from whom) should be included, as well as identifying the caller, his/her title/agency or relationship to client.

- You also need to record dates of any contact you had with anyone involved with the case as well as the dates of all referrals you make on behalf of the clients.

<u>ASK</u><i>: How can dates of referrals help you?</i>

It is easy to lose track of time when you make referrals, so having the dates will help you with follow up. Knowing how long programs take to respond will help you in the future when serving other clients.

Names, Relationships, Titles, and Ranks:

Again, make sure that the names are spelled correctly and keep an accurate listing of phone numbers of people related to the case. This will save you time in the future and help when you are out of the office and someone else needs to follow up on the case. When you list medical professionals, make sure you put their specialty and for legal/law enforcement professionals, the title/rank of the individual.

Language: Be careful of your word usage. We have professional slang and acronyms that we use on a daily basis. Some are unique to APS, some are medical, some are legal, and some refer to programs and services. Not everybody understands what they mean, so be careful that what you abbreviate can be understood by coworkers, managers, and attorneys.

Profession documentation is error free and clearly written, following rules of grammar. Please check your spelling… and remember, you can't always rely on spell-check.

Handout 3.9 is a list of commonly confused words and common APS and Adult Service abbreviations and acronyms. [*Briefly review a few examples from each handout.]* These are tools for participants to use in the field.

We already talked about the importance of including the date and time for all your entries. This helps trace the chronology of the case, what happened and when.

Also, all reports should be signed by the author.

It may also help to enter the start and end time of a visit; this can help establish that the visit, observation, or interview was long enough for the worker to understand what was happening.

Remember, if it is NOT documented in your case record, it is fiction… it did not happen.

ASK: how soon do you document what you have seen? How do you do it?

The issue is the longer you wait, the more likely it is that you will forget an important detail. Some workers take notes in front of the client. Some workers don't feel comfortable; others ask permission and explain that writing things down will help them to get the client needed services. Others may wait until they get into their car, away from the client's home.

Best practice tip – Document quotes and observations immediately – you don't have to use them all in your documentation, but you have them if you need them.

Now we get into the heart of today's discussion. What are the necessary and essential components of effective documentation?

We'll be talking in depth about how to make documentation clear and factual, how to make sure you are using objective language, and how you can make sure you have included the most essential information without being too wordy.

We will discuss these components and you will have the opportunity to practice them as well.

B. Documentation Skills

Display **Activity- Critique Documentation** (Slide 51).

In a large group format, ask them for their feedback on this sample and chart answers on flip chart.

Optional variation: In the pilot trainings, the example was copied unto a flip chart and a highlighter of a different color was used to point out the areas where there were issues with the 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 an insisted on treating sores himself.

Discussion: *Points to consider: Lack of clarity; Report observations specifically without "reportedly". Unclear of reason for being in hospital or reason for referral—significance of comments related to brother. During the discussion, participants note essential components when documenting. These include names of those who were contacted (M—may have more than one daughter with the first initial M). Missing time of day in the note as well as the initial reason for the visit. (Some counties would have a separate document for this, however).*

Display **Just the Facts** (Slide 52).

To repeat what we have discussed thus far: We want to be sure that our documentation reflects direct observations—what saw, heard, smelled.

Report specific information obtained from others—physician reports, finances, and legal documents.

Use direct quotes of those you interview.

And be sure your writing is clear and easily understood by non-APS professionals.

Best Practice Tip – Document client medications including name of drug, strength/dosage, and prescribing doctor, expiration date – it can't be emphasized enough how important this is considering the issues many clients have with their medications.

Display **Activity** (Slide 53).

As they say on police show, just the facts, ma'am.

Please take out **Handout 3.10**: Rat Feces Exercise. This exercise was adapted by Paul Needham, an APS trainer colleague from the Oklahoma Department of Human Services (who probably borrowed it from another APS program… we all share good things with each other, and what better thing to share with APS workers than rat feces?).

Activity: This exercise is done in 3 stages. Read the instructions and clarify the meaning of T (true), F (false) and Q (questionable).

Part 1: Ask participants to read the narrative and answer the questions individually. Give them about 5 minutes for this.

Part 2: Then break the class into small groups and ask them to come to a consensus as to the correct answer and tell them they must be ready or able to justify that answer as a group. Give them 8-10 minutes to do this.

Part 3: Then have a shout out session and brief discussion about each question. This should be very lively, bringing out worker's assumptions, conclusions and opinions about the situation presented.

Answer Key:

1: F	2: F	3: F	4: Q	5: Q	6: T
7: Q	8: Q	9: Q	10: Q	11: T	12: Q
13: Q	14: T	15: T	16: Q	17: Q	

Although Mr., Needham noted the answers, there is disagreement amongst people who have participated in this activity in regard to the "False" for questions 1 – 3. The consensus is that this should be "questionable" as we cannot rule it out.

Trainer Note: The narrative appears relatively straightforward when in reality it presents little if any clear information. Large group discussion may reveal how workers make assumptions, draw conclusions, and form opinions when they do not have sufficient clear information. For example, they may say that #13 is true… because many feel that feces on the floor mean that the house is dirty. This comes from their own value system and from an assumption they make. Nothing is indicated in the narrative about the rest of the house, just as it isn't clear what kind of feces is on the floor. Processing this activity is an opportunity to discuss both clear and objective writing.

[Take a 10 minute break after this activity]

Display **Subjective vs. Objective Descriptions** (Slide 54).

Review the definitions of subjective and objective descriptions as is outlined on the slide.

When we think of objective descriptions, we think of <u>Facts</u> –Information that can be verified. Example – The client just had open heart-surgery.

<u>Observations</u> - The act of careful watching and listening; the activity of paying close attention to someone of something in order to get information (Merriam-Webster). Things the worker may see, hear, or smell.

Subjective Description can be referred to as inferences or interpretations.

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<u>Inferences</u> – The act of passing from one proposition, statement or judgment. Considered true to another whose truth is believed to follow from that of the former (*Merriam-Webster*). Inferences beyond what is directly observed, conclusions which entail some degree of risk or uncertainty

<u>Interpretations</u> – The act or result of explaining or interpreting something; the way something is explained or understood (*Merriam-Webster*). Combination of facts, observations and inferences and what this means to the worker, i.e., a professional opinion.

Display **Documentation Choices** (Slide 55).

How can we make sure that our descriptions and our language are objective? First we need to be aware of our own values and opinions. We must remember that every individual has a lifetime of experiences and relationships – that we are all different. This depends on our family structure, our cultural identity, and religious background, our parents' own experiences and how they passed their own values on to us. It depends on our experience in society, relationship with peers, our ideas about different issues, such as substance abuse, homosexuality, smoking, swearing, and yelling. What is "right" for you may not be "right" for someone else. What is "inappropriate behavior" to you may seem very appropriate to others.

We also must pay attention to situations that "push our buttons." In psychological terms, we call this countertransference. Countertransference is defined as redirection of a worker's feelings toward a client, or more generally as a worker's emotional entanglement with a client. That can mean that we may interpret someone's actions in a particular way, maybe even leading to not providing service or providing too much service, depending on our feelings. Does this client, caregiver, service provider remind us of someone in our lives that brings negative or positive feelings? We need to become attuned and aware of these feelings so they do not get in the way of our work. T his issue of values is not only important in documentation but in all aspects of human services work.

Watch your language; do not use judgmental, inflammatory or "loaded" words. Certain words like "charity," "government", "welfare", "services" might be unclear and scary to clients and turn them off as well.

Using the words "seems" and "appears" can be helpful... you are describing what "appears to be" – but at the same time you should describe what lead you to that "conclusion." It is not correct to say "the client is depressed" because you cannot make that diagnosis. If you say "the client seemed

depressed," that is not enough, because depressed behavior means different things to different people. Therefore you need to describe what you observed to make you believe that client seemed depressed.

Display **Objective Writing Activity** (Slide 56).

This exercise uses **Handout 3.11**: Clarity in Documentation and can be done individually or in pairs.

Instruct participants:

First identify what is wrong with the original statement. Then rewrite the description using clear, objective, and descriptive language.

[Give 10 minutes. Participants may need more time.]

Go through these as a large group. Solicit any challenges participants had in the writing exercise.

Display **Concise** (Slide 57).

Now we have arrived at concise recording.

We need to get to the point, by answering who, what, where, when, why and how questions that are pertinent to the assessment, investigation, substantiation, and termination of the case.

Many workers think that the more they write the better. We are not writing a novel, we are documenting what is necessary to explain our case plan.

It is important to write down our observations as soon as possible after the visit, particularly with quotes said.

Display **Memory Improvement Tricks** (Slide 58).

Memory, like muscular strength, is a "use it or lose it" proposition. The more you work out your brain, the better you'll be able to process and remember information. Novelty and sensory stimulation are the foundation of brain exercise. If you break your routine in a challenging way, you're using brain pathways you weren't using before.

Handout 3.12 outlines some helpful strategies for improving memory for those times we can't document right away. You can read this on your own but in looking at the Mnemonics, you might remember some that we used in this

course—DO ETHICS, and DEMENTIAS capitalize on this way of remembering key points to remember.

Maintaining the healthy habits outlined on this slide can help memory by effectively managing our physical health, and handling stress. Concentration improves when we are taking care of ourselves. Remember our earlier discussion related to self-care. This is one more reason to take care of ourselves—improving our memory performance!

C. Documentation for Court

Display **Writing for Court: Rules of Evidence** (Slide 59).

Documentation is key when we anticipate having to go to court to protect the safety of the adult at risk—either for criminal proceedings of the perpetrator or for guardianship and protective services.

As we prepare evidence for court, we have to consider the points on this slide.

One way of being able to support our observation of abuse, document a risky situation, is by taking pictures. As they say, a picture is worth a thousand words. This can be extremely helpful when you are documenting the condition of a client's home or to indicate physical abuse. It is important to ask permission from the client when you wish to photograph her/him or his environment. If you have a short, written permission form, that may be helpful as well.

Handout 3.13 outlines best practice strategies in taking photographs. One of the areas to clarify with your agency is policy related to cell phone pictures. Personal cell phones are not encrypted, and we need to insure that any photographs taken are protected in terms of confidentiality.

The body map can be used to note any bruising, scars, injuries, red marks or the like, giving as much detail as possible under the prevailing circumstances as to size, color, and so on.

The body map is especially useful when you don't have access to a camera or if the client refused to allow you to take photos.

Only complete these if the injuries are clearly visible or shown to you freely. **Handout 3.14** has some diagrams that can be used should you need to draw a body map.

Regarding court writing and testimony, the first issue has to do with rules of evidence, what is admissible and what can be excluded. To be admissible in court, evidence must past the tests of relevancy and competency. That means that it has to prove or disprove a disputed fact and it must have been legally obtained.

Sometimes evidence will be excluded, usually for reasons of unconstitutionality, unreliability, to protect against prejudice, and privileged relationships.

Display **Victim/Witness Statements** (Slide 60).

In APS work, clients or perpetrators may tell us something very meaningful that will influence the case in court. We must document those statements carefully - including when and under what circumstances the statements were made. Statements have more weight if they are witnessed.

Most statements made to an APS worker are not admissible with one exception – Excited Utterances/Spontaneous Statements which need to be carefully documented.

A spontaneous statement is a statement made by a witness, including a victim, while under the stress of excitement caused by witnessing a startling event. It is considered truthful because little time has passed to allow the witness to "make-up" a story.

Special considerations when documenting spontaneous statements:

A spontaneous statement can only come from a first-hand witness, such as the victim.
- Document the witness' physical and emotional demeanor, for example behaviors that show the stress level when making the statement.
- Document the victim's physical and emotional demeanor, including sounds and gestures, especially when the victim is non-verbal

Save written interviews with non-verbal victims when done on paper.
- Document the name of the person who heard the spontaneous statement.
- Document what that person heard from the victim (in quotes), when they heard it, the circumstances in which they heard it.
- Document spontaneous statements even when made by a person who may be found to be legally incompetent to testify or lack decision making capacity.

And, as we have said repeatedly today, make sure statements are documented in a timely fashion, are accurate, and dated.

Display **Language for Court Reports** (Slide 61).

We spoke about the use of language and this is especially important when documenting for court. Focus on facts, not opinions - what the individual states rather than your interpretation of what he/she means. Also sometimes it takes a year, maybe two for a case to go to court. Make sure you write in such a way that brings you back to the situation. Practice some of those memory tricks!

NAPSA's legal consultant advised us that the word "story" should not be used in a document going to court. Story implies fiction. Fiction is not what you are documenting… fiction is what happens when you fail to document. Also she emphasized that biased language should not be used…that means you want to report the facts and not your opinion about them. And, as we said earlier today, avoid using slang, lingo, and inflammatory language.

Display **Mrs. Gunther Activity** (Slide 62).

Trainer: Read the scenario to participants and have them answer the following questions as a large group. Answers are included below in bold italics.

Scenario: 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.

Let's consider what you would need to document. Applying the rules of evidence and witness statements, choose which statements you would include in Mrs. Gunther's case record and which you would trash. All statements were taken on December 12, 2017.

1. The police officer and I heard Dave shout at his mother, "I should have knocked you out cold." *File*

2. Upon opening the door, Mrs. Gunther cried, "He tried to kill me. I am so happy you are here, can you help me?" Her hands were visibly shaking, her skin was ashen and there was a wound above her left eye that was bleeding. She stated she felt light-headed and I helped her to the nearest chair. Once seated, Mrs. Gunther began to cry and mutter to herself, "What did I do wrong? I raised him right." *File – this is a spontaneous statement*

3. Dave was practically falling down drunk. ***Trash***

4. Dave shouted at the police officer and me, "You have no business being here and you need to leave immediately." He was red in the face and his hands were clenched into fists. In my opinion, I was in serious danger. ***File***

5. Mrs. Gunther alleged that Dave had threatened to hit her if she didn't give him the car keys. ***Trash – hearsay. Avoid the using "alleged"***

6. Mrs. Gunther's doctor stated she has arthritis and urinary incontinence. ***File***

7. Dave was angry enough to seriously hurt his mother. ***Trash***

8. Officer Brown stated that Dave's blood alcohol level was 2.5 when Dave was arrested. ***File***

9. Mrs. Perry, the next door neighbor said, "I overheard Mrs. Gunther and her son shouting at each other at 7:30pm this evening." ***File, but could be thrown out as hearsay.***

These statements would be used in criminal court for the prosecution of abuse. We also need to document for guardianship proceedings. As we discussed the first day of training, a comprehensive assessment is completed by the social worker which is used as a foundation for the court proceedings and is shared with all parties.

Essential elements must be documented:

Inability to manage finances or health care:
This needs to be attributed to a medical condition that is not likely to be reversed, such as irreversible dementia. (This is NOT due to a client's conscious decision not to pay bills or an informed decision not to continue some form of medical treatment.)

Assets/income that can't be managed without a legal arrangement:
Legal arrangements consist of durable power of attorney for finances/health, or a trust. If neither is in place when the adult-at-risk loses the ability to give informed consent (due to irreversible medical condition such as dementia), AND there are assets/income that cannot be managed without a DPOA or successor trustee AND/OR the adult-at-risk is in an unsafe environment but refuses to move or can't give informed consent to move to higher level of care, a guardianship is the only remedy.

No legal arrangement:

Such as a durable power of attorney for finances or a trust, is in place

Present legal arrangement is not working:
POA or trustee is unwilling to act, is not available to act, or is unsuitable (for instance, is the perpetrator)

Dangerous environment:
If the environment poses a clear and present danger to the elder or adult at risk and that adult is refusing to make a change or is unable to consent to being moved AND no legal arrangement has been made by which a third party can act on the client's behalf.

We could spend a lot more time on documentation. It can be helpful to have your supervisor review your documentation and provide feedback to you. One of the main areas agencies often cite the need for additional training is in writing, something that may not have been covered in your undergraduate education. Consciously monitoring for readability, grammar, and spelling can help to improve documentation. As noted in our earlier example, pretend the person reading it has no knowledge of the situation. How clearly did you record the events and your assessment?

[End of Module]

Module 6 Professional Development Planning Overview

Timing (15 minutes max.)

Professional Development Planning……………………………………15 minutes total

    A. Future training Needs ……………………………………………………….5 min
    B. Evaluation ……………………………………………………………………10 min

Learning Objective

- Examine professional development needs for future practice

Advance Preparation

- One copy of the Handout Professional Development Planning should be placed in the center of each table

Handout

- Handout 3.15: Professional Development Planning
- Handout 3.16: Evaluation

PowerPoint Slides

- Slides 63 – 64

A. Future training Needs .... 5 min
B. Post test and Evaluation ....<u>10 min</u>
                                                                                                        15 min

- Slides 63 -64

- Handouts:
    - Handout 3.15: Professional Development Planning
    - Handout 3.16: Evaluation

A. Future Training Needs

Display **Professional Development Planning** (Slide 63).

We have covered quite a bit of material today. As we look to the future, we recognize that additional training is needed.

These past three trainings have been an attempt to cover key aspects related to the services provided by APS staff. The job is very complex! We know we have not identified all the areas where training is needed or provided the level of depth some of you may want.

On your tables, there is one final handout titles "Future Training". We would like you to take a few minutes to discuss what you think you need for further training or want you want to learn more about.

[Give 5 minutes to complete]

Alternate: In small agency-based trainings, participants could be asked to complete the handout individually, asking them to write down questions they have that could be addressed in supervision. If enough time remaining, the group could review the topics and discuss the best ways to learn the topics (e.g. any webinars available, strategies the trainer found helpful, etc.). This activity would take more processing time so would alter the timing of the workshop slightly.

B. Post Test and Evaluation

Display **Thank You** (Slide 64).

Before you go for the day, please take a few minutes to complete your evaluation.

Thank the participants for their attendance and active participation in the training.

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Creating Trainings using Adult Learning Principles

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This training is sponsored by the

University of Wisconsin Green Bay

Office of Continuing Education and Community Outreach

Participants will earn 4 Continuing Education Hours.

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Agenda

I. Principles of Adult Education
II. Characteristics of the Learner
III. Training Logistics
IV. Training Development

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Training Objectives

At the end of this training, participants will:

- Understand the principles of adult learning
- Recognize how learning styles may affect trainings
- Understand how generations learn, interact, and function in the workplace
- Discover practical approaches to become a more effective instructor/trainer
- Learn basic planning and preparation techniques to insure quality trainings

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The Learner

We are Individuals

Learning is a process, not a thing that can be seen. It is individual and personal.

Introduction to Terms

- **Pedagogy**
  - The science and art of education
    - Strategies that are used to improve learning outcomes
- **Andragogy**
  - Method and practice of teaching adult learning

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Assumptions about Adult Learners

Adult learners:
- Experience is a resource for learning
- Self-directed and readiness to learn
- Focus on problem centeredness rather than subject focus.
- Internal motivation to learn

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Basic Principles of Adult Education

Adult education requires learner-centered methods and a cooperative learning environment.

Adults learn best when:
1. They understand why they need to learn something
2. They have the freedom to learn in their own way
3. Learning is experiential or hands-on
4. The time is right for them to learn
5. The process is positive and encouraging

(Knowles, Holton,& Swanson, 2015)

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Considerations for Trainings

Adult Learners

- Have life experiences and knowledge
- Are relevancy oriented
- Are goal-oriented
- Are practical
- Require respectful dialogue
- Are independent and self directed
- Participatory approach
- We are all learners and we are all educators

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Sources of Motivation for Adult Learners

- Social relationships
- External expectations
- Social welfare
- Personal advancement
- Escape/Stimulation
- Cognitive interest

(Lieb,1991)

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Participatory Learning

Training based around adult learning principles looks more like this:

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Principles of Adult Learning

According to a study conducted by North Central Regional Education Lab,

"Adults will commit to learning when the goals and objectives are considered realistic and important to them."

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Training Process

1. Tell participants what you plan to tell them (explain subject material and learning objectives)

2. Tell them

3. Tell them what you told them (review learning objectives, activities, etc.)

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Translating Theory into Practice

"Have some respect for my learning style."

B. Smaller
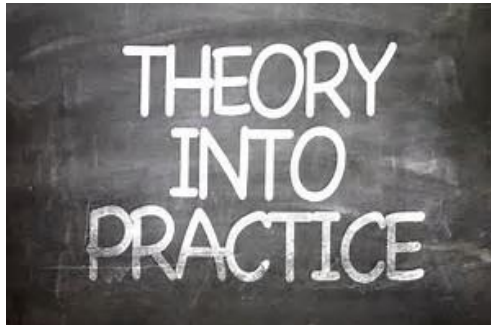
What's Your Learning Style?

- Knowing your learning style can help you become a more reflective learner

- You can help those you are teaching by providing them with the opportunity to assess their learning style

- Learning Style Inventory

See it *Visual*

Say it *Auditory*

Do it *Kinesthetic*

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Learning Styles

Learning Style	Preference for information acquisition
Visual / Verbal or Nonverbal	Prefers to read information Uses graphics or diagrams to represent information This includes looking, seeing, viewing and watching
Auditory / Verbal	Prefers to listen to information. This includes listening, hearing, and speaking.
Kinesthetic/Tactile	Prefers physical hands-on experiences. This includes moving, doing and experiencing.

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Multimodal Learning

Visual

Auditory

Kinesthetic

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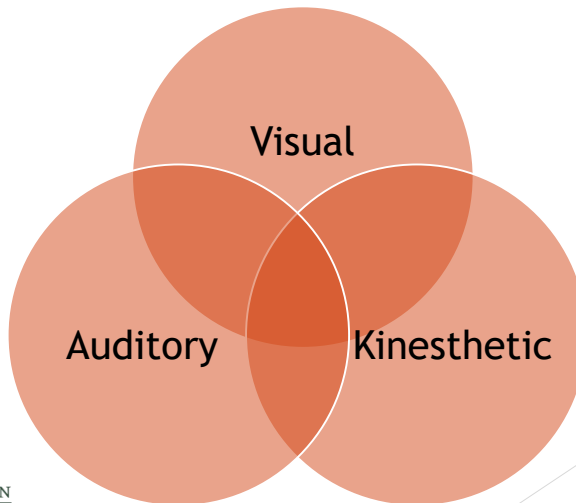
Visual Learners

- Visual learners want to "see" it to learn it.

- Prefer instructors who use visual aids

- Learn well from written text or notes and like things organized in outline form.

- Tend prefer to work alone in quiet environments

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Visual Learners

- Visualize information in their "minds' eye" in order to remember something
- Relate well to information obtained from images and charts
- May be artistic and enjoys visual art and design

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Visual Learning Strategies

- Illustrations
- Graphs/Chart
- Displays
- Photographs
- Slide Shows
- Posters

- Crossword & Word Find Puzzles
- Diagrams
- Power Point
- Videos or Movies
- Articles (pre-work)
- Worksheets

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Auditory / Verbal Learners

- Learn best when information is presented to them through sound
- Remember what others say, benefit from hearing things multiple times and by saying things aloud
- Benefit from podcasts, reading aloud, group discussions, obtaining information from audio sources
- Remember verbal instructions well
- When trying to remember something, they often repeat it out loud and can mentally "hear" the way the information was explained to them

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Auditory / Verbal Learners

- Learn best when interacting with others in a listening/speaking activity
- Enjoy the chance to present information in role play or speeches
- Appreciate the use of music in teaching
- Prefer to discuss ideas they do not immediately understand
- Find it difficult to work quietly for long periods of time

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Auditory Learning Strategies

- Presentations or oral summaries
- Panel discussion
- Group discussions
- Debate
- Audio recordings – podcasts, videos, etc.
- Read material aloud
- Use music in presentations or activities

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Kinesthetic/Tactile Learners

- Learn best when doing a physical "hands-on" activity
- Prefer to learn new materials in a setting where they can touch and manipulate materials
- Learn best in physically active situations
- Benefit from instructors/trainers who use in-class demonstrations, hands-on learning experiences, etc.

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Kinesthetic/Tactile Learners

Enjoy hands-on activities. They retain more information when it is provided in a tactile manner. These learners benefit from simulations, role playing, making and creating, etc.

- May take notes to keep busy but often will not use them
- Enjoys using computers or fiddling with small objects while in the learning environment
- Wants to eat while studying or being able to move around while learning

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Kinesthetic Learning Strategies

- Case Scenarios
- Role Plays
- Small Group Discussions
- Games and Simulations
- Projects
- Writing Tasks
- Self Study
- Body movement while reciting information

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Experience

Experiential Learning Model

Apply

Reflect

Envision/Conceptualize

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Kolb, 1984
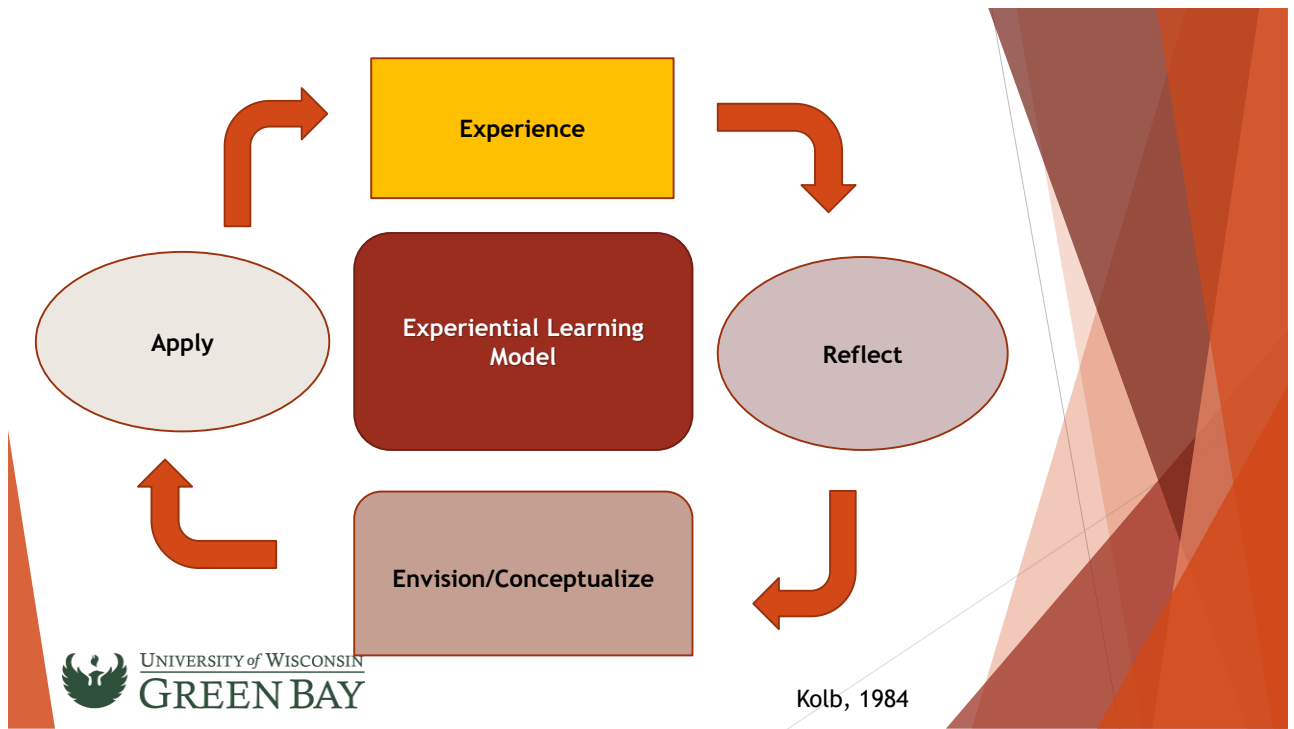
Learner Differences

Millennials

Gen Z/Centennials

Silents

Baby Boomers

Gen Xers

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Generations

Learning about generational differences will help you enhance your understanding of how generational differences can affect how you train and interact with participants and it gives you insight on how they prefer to learn.

Millennials

Gen Z/Centennials

Silents

Baby Boomers

Gen Xers

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Generation Timeline and Cohorts

Silent Generation (1924 – 1944)

Baby Boomers (1945 – 1964)

Gen Xers (1964 – 1980)

Millennials (1981 – 2000)

Gen Z/Centennials (2001 – present)

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Silent Generation

Less than 1% of the workforce

Core Values:
- Rules
- Duty
- Patience
- Dedication
- Sacrifice
- Conformity
- Hard Work
- Law & Order
- Respect
- Delayed Reward

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Baby Boomers

26% of the workforce/ this will decrease to ~6% by 2025

Core Values:
- Youth
- Work
- Personal growth
- Team orientation
- Optimism
- Health & wellness
- Personal gratification

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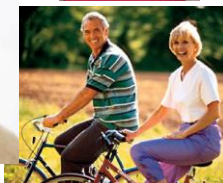
Gen Xers

30% of the workforce

Core Values:
- Balance
- Fun
- Informality
- Self-reliance
- Think globally
- Pragmatism
- Techno-literacy
- Diversity
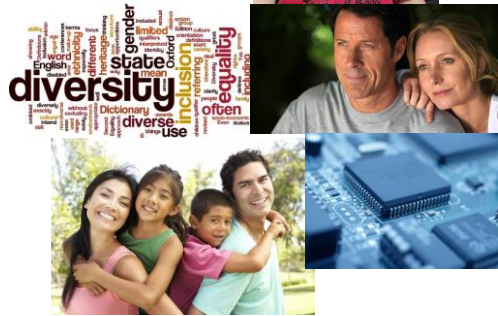
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Millennials

▶ 42% of the workforce

▶ *Core Values:*
- Civic Duty
- Confidence
- Sociability
- Morality
- Optimism
- Achievement
- Street smarts
- Diversity

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Gen Z / Centennials

1% of the workforce

Core Values:
- Safety from violence
- Equity
- Access
- Inclusion & elimination of oppression
- Champion of modern day issues
- Mental health advocate
- Social change
- Expansion of services for others

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Generations

The key is to include multiple methods and techniques in order to address the wide variety of preferences.

Group Discussion questions:
What is your generation expecting or looking for when the come to a training?

How will your generation interact or look at the other generations in the training?

What does your group think the challenges or opportunities will be when teaching a class of mixed generations?

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Learning is not a spectator sport……..

They must *talk* *about what they are learning,* *write* *about it,* *relate it to past experiences,* *and* *apply it* *to their daily lives. They must* *make what they learn part of themselves.*

Taken from the article written by: Arthur W. Chickering and Zelda F. Gamson, "Seven Principles for Good Practice"

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Training Logistics

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Sample Timeline for Training Preparation

Before Your Training	
One week before your training	1. Practice your session 2. Know your subject matter very well 3. Make a list 4. Confirm all arrangements and materials
One day before your training	1. Practice the entire session with the visuals. 2. If possible, view the room set up and the room mechanicals. 3. Test your equipment (if possible). 4. Get a good night's sleep.
One hour before your training	1. Arrive 40 to 60 minutes before training is to begin. 2. Make sure equipment is set up and it all works. 3. Organize your space and make sure all of your notes are ready. 4. Have a contingency plan (more activities) just in case you get through content quickly.
One minute(or a few) before your training	1. Last peek at introduction. 2. Breathe. 3. Smile and begin session.

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Preparation and Delivery Skills

- Recognize your strengths and weaknesses and don't pretend to know all the answers
- Dress appropriately
- Watch your body language
- Be responsive and flexible
- Be sensitive to learners
- Use your sense of humor

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Trainer Preparation

▶ Room Arrangement
▶ Slide Preparation
    ▶ Discussion Points
▶ Structuring Activities
    ▶ Ice-breaker
    ▶ Multiple learning styles

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At the start of every training…

▶ Housekeeping Issues
    ▶ Session Start and Stop Times
    ▶ Breaks and Lunch
    ▶ Location of Restrooms
▶ Electronic Devices – please silence
▶ Participation & Questions
▶ Review Training Objectives

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During the Training

▶ Engagement & Interaction of Participants
  ▶ Discussion
  ▶ Responding to Challenges
▶ Communicating to the Room
▶ Pacing and Breaks

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Answering Questions

- Repeat the question
  - Answer now/later
  - Redirect –parking lot
  - Discussion
- Don't bluff
  - You know
  - You don't know

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Communications Skills for Facilitators

- Paraphrasing
- Questioning
- Reflection
- Communication
- Summarizing
- Clarifying
- Validating
- Encouraging

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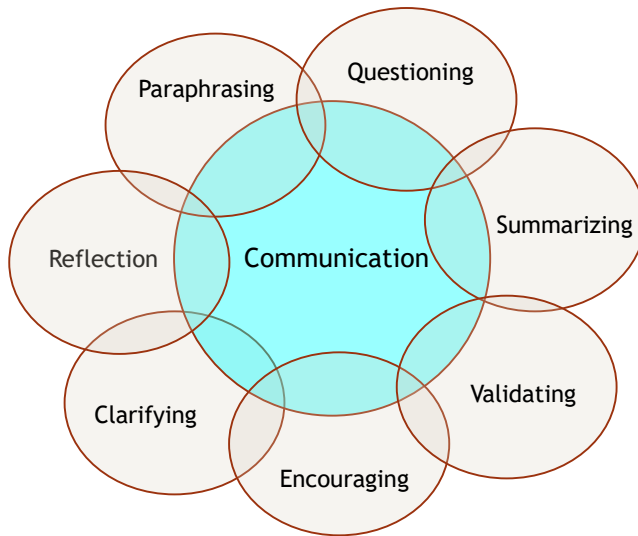
Avoid these pitfalls...............

- Poor first impression
- No sharing of objectives
- Dull, dry and boring
- Frozen in one spot or sitting the whole time
- Weak or no eye contact
- Poor visual aids
- No humor

- Poor preparation
- No audience involvement
- No enthusiasm or conviction
- Being too formal
- Being a know it all or talking down to learners
- Using profanity
- Having distracting mannerisms

I smile because I have no idea what's going on

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Challenging Situations

- Argumentative individual

- Loaded questions

- Long-winded

- Rude to others

- Student not understanding materials

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Developing Training

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Creating Trainings

▶ Start with the Purpose
  ▶ Learning Objectives
▶ Outline key content
▶ Plan activities
  ▶ Blended/ Multiple modes (Think: Adult learning principles!)
  ▶ Knowledge-Skills-Attitudes
  ▶ "Chunk" Learning
▶ Create training materials
▶ Timing and Rehearsal

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Learning Objectives

Create

Evaluate

Analyze

Apply

Understand

Remember

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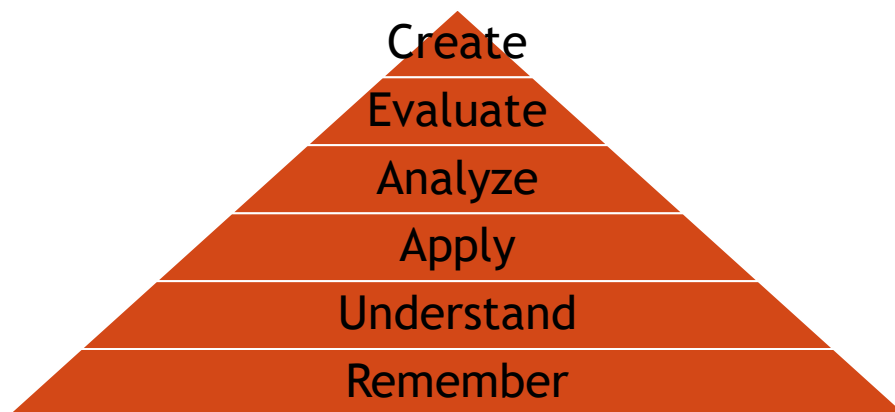
Preparing Your Toolbox

Closing Thoughts

▶ Training Conclusions
  ▶ Review
  ▶ Evaluation
  ▶ Thank-you to attendees

"I never teach my pupils; I only attempt to provide the conditions in which they can learn."

- Albert Einstein

"The art of teaching is the art of assisting discovery."
- Mark van Doren

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THANK YOU!

You got this!

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Translating Theory Into Practice	
Theory	**Practice**
Adults remember 10% of what they hear, 65% of what they hear and see, and 80% of what they hear, see and do.	To increase retention, provide both auditory and visual stimulation and allow for practice.
Adults bring a great deal of life experiences and knowledge into to training.	Connect life experiences and prior learning to new information. Capitalize on the experiences by facilitating discussions.
Adults are autonomous and self-directed.	Involve participants in the learning process, serving as facilitator rather than as supplier of facts.
Adults learn best when they are active participants in the learning process.	Limit lecturing and provide opportunities for sharing of experiences, questions and exercises that require participants to practice a skill or apply knowledge.
The greater the degree of concrete relevance to the individual, the greater is the degree of learning.	Help learners see a reason for learning something by making it applicable to their work or other responsibilities of value to them.
Adults need to be able to integrate new ideas into what they already know if they are going to be able to retain the information.	Capitalize on the experiences of the audience to build new concepts; structure lessons to move from the known to the unknown.
Adults prefer self- directed and self- paced instruction to group learning led by an instructor.	If the training is done in a group led by the instructor, build in independent activities; consider trainee-focused approaches to training.
Adults learn more effectively when given timely and appropriate feedback and reinforcement of learning.	Provide opportunity for feedback from self, peers and trainer.
Adults learn better in an environment that is informal and personal.	Promote open group interaction.
Not all adults learn the same way.	Accommodate different learning styles by offering a variety of training methods and by using visual, auditory and kinesthetic techniques.

(Source: adapted from Penny LIttner & Alex F. Douds (1988): Train the Trainer. Practical Skills that Work; Janet Collins (2004): Education Techniques for Lifelong Learning)

Learning Styles Inventory

Answer the questions to the best of your ability. Mark a **YES** *or* **NO** *response.*

1. I prefer watching a video to reading.	YES	NO
2. When I sing along with my CDs or the radio, I know the words to the songs.	YES	NO
3. I have athletic ability.	YES	NO
4. I can picture the setting of a story I am reading.	YES	NO
5. I study better with music in the background.	YES	NO
6. I enjoy hands-on learning.	YES	NO
7. I'd rather play sports than watch someone play them.	YES	NO
8. Reading aloud helps me remember.	YES	NO
9. I prefer watching someone perform a skill or a task before I actually try it.	YES	NO
10. I color-coordinate my clothes.	YES	NO
11. I'm good at rhyming and rapping.	YES	NO
12. Use phrases like: "I've got a handle on it," "I'm up against the wall," or "I have a feeling that . .	YES	NO
13. I need to look at something several times before I understand it.	YES	NO
14. I prefer having instructors give oral directions than written ones.	YES	NO
15. I have difficulty being still for long periods of time.	YES	NO
16. I use phrases like "I see what you're saying," "That looks good," or "That's clear to me."	YES	NO
17. I'm good at figuring out how something works.	YES	NO
18. I can understand a taped lecture.	YES	NO
19. It's easy for me to replay scenes from movies in my head.	YES	NO
20. I enjoy studying foreign languages.	YES	NO
21. I would rather conduct my own science experiment than watch someone else do it.	YES	NO
22. I would rather paint a house than a picture.	YES	NO
23. I enjoy studying in groups.	YES	NO
24. I prefer to have written directions to someone's home.	YES	NO
25. I can look at an object and remember it when I close my eyes.	YES	NO
26. I have musical ability.	YES	NO
27. When I study new vocabulary, writing the words several times helps me learn.	YES	NO
28. I can imagine myself doing something before I actually do it.	YES	NO
29. I use phrases like "That rings a bell," "I hear you," or "That sounds good."	YES	NO
30. I enjoy building things and working with tools.	YES	NO

Scoring Your Inventory

Tally your responses by adding up only the YES answers. Put the number of the question in the appropriate box. For example, if you answered questions number nine with a yes, write nine in the **VISUAL** box. If you answered number 11 with a yes, write number 11 in the **AUDITORY** box. If you answered number seven with a yes, write seven in the **KINESTHETIC** box. Add up the number of questions in each box and write a total for each one. This will determine your *preferred learning style*. Don't worry if a dominant mode doesn't emerge. You are a versatile learner! Use the knowledge you gain to create excellent study tools, the ones that are right for you. Chart your answers below.

Visual Style: Questions 1, 4, 9, 10, 13, 16, 19, 24, 25, 28
Auditory Style: Questions 2, 5, 8, 11, 14, 18, 20, 23, 26, 29
Kinesthetic Style: Questions 3, 6, 7, 12, 15, 17, 21, 22, 27, 30

Visual	Auditory	Kinesthetic
Total:	Total:	Total:

The highest score indicates your *preferred learning style*. If you have a high score in more than one area, you are using additional modalities. Remember that there are no wrong answers to this inventory.
Everyone is an individual and has her own style of learning.

Characteristics of Visual, Auditory, and Kinesthetic Modes

- **Visual learners need to see information.** If your preferred style is visual, you have strong visualization skills and can remember objects, shapes, and pictures. You learn by reading, and by watching films, videos, and demonstrations. You can see pictures in your mind.

- **Auditory learners need to hear information.** If your preferred style is auditory, you have a "good ear" and can hear differences in tones and rhythm. Reading out loud will be beneficial. You can remember what you hear in a lecture.

- **Kinesthetic learners need to be physically active and doing things.** If your preferred style is kinesthetic, you are a hands-on learner. You have good coordination and learn by doing. You generally have an active approach to learning.

Excerpted from: Leonard, Enid. College Success Simplified, 2005.

Communication Skills

Communication is essential for all interactions between people. It is a two-way process of sending and receiving signals and information. For communication to work effectively, both sender and receiver need to be aware of and understand the method of communication. However, communication can be both intended and unintended. Communication can fail if sender and receiver interpret messages in different ways, leading to misunderstandings or conflict.

Communication Skills for Facilitators		
Skill	Use of Skill	How to Use
Reflective Listening/Feelings	• To diffuse the situation • To reflect feelings back to person • To show understanding	Listen to tone of voice. Observe body language. Acknowledge feelings and reflect them back. "You sound disappointed…"
Paraphrasing	• Indicates you are listening • Lets you check for understanding	Say back your understanding of what they said, in your own words. "You thought the resident would fall down…"
Questioning	• To gather information • To focus discussion • To expand understanding	Use open ended questions – beginning with what, how, when, where. "How did the activity surprise you?"
Summarizing	• To bring important points out • To review progress • To bring closure to move on	Restate the main points of the discussion, facts and feelings. "Your main priorities were…"
Validating	• To show what people say is important	Acknowledge issues and feelings as valuable. Appreciate efforts. "Thanks for explaining the impact on the residents…
Encouraging	• To show interest • To encourage discussion	Body language, nodding. Ask probing questions. Avoid agree/disagreeing. "And then what happened?"
Clarifying	• To ensure you understand • To clear confusion	Ask questions. Ask if interpretation is on track. "By impacts, you mean…"
(Source: Colma Keating (2003): Facilitation Toolkit, (pp.74-75)		

Chapter MPSW 19

CONTINUING EDUCATION

Note: Chapter SFC 19 was renumbered ch. MPSW 19 under s. 13.93 (2m) (b) 1., Stats., and corrections made under s. 13.93 (2m) (b) 7., Stats., Register October 2002 No. 562. **Chapter MPSW 19 was repealed and recreated, Register February 2015 No. 710, eff. 3−1−15.**

MPSW 19.01   Definitions. In this chapter:

(1) "Board" means the marriage and family therapy, professional counseling, and social work examining board.

(2) "Interactive learning format" means a live, synchronous presentation with discussion or an asynchronous educational program by a provider under s. MPSW 19.03 (1) (a) or (f).

(3) "Section" means any of the following:

(a) Marriage and family therapy section.

(b) Professional counseling section.

(c) Social worker section.

History: CR 13−117: cr. Register February 2015 No. 710, eff. 3−1−15.

MPSW 19.02   Continuing education requirements.
(1) Unless granted a postponement or waiver of the continuing education requirement under s. 19.04, Stats., every marriage and family therapist, professional counselor, social worker, advanced practice social worker, independent social worker, and clinical social worker shall complete at least 30 continuing education credit hours in approved continuing education programs during each 2 year credential period and certify on the application for renewal that all required education was completed. Unless granted a postponement or waiver of the continuing education requirement, a credential holder who fails to meet the continuing education requirements by the renewal deadline must discontinue the use of the title.

(2) A minimum of 4 continuing education credit hours, of the required 30 continuing education credit hours, shall be in the area of professional ethics and boundaries related to the practice of marriage and family therapy, professional counseling, or social work.

(a) A person holding multiple credentials granted by the board shall complete only a minimum of 4 continuing education credit hours in the area of professional ethics and boundaries.

(b) Social work credential holders shall complete their ethics continuing education credit hours in an interactive learning format.

(3) During the time between receiving the initial credential and commencement of a full 2 year credentialing period, a new credential holder is not required to meet continuing education requirements for the first renewal of the credential.

(4) Continuing education credit hours shall apply only to the 2 year credential period in which the credit hours are completed, unless either of the following applies:

(a) Continuing education credit hours required as a consequence of a disciplinary proceeding may not be counted towards the fulfillment of generally applicable continuing education requirements.

(b) If the credential holder fails to meet the continuing education requirement during a 2 year credential period, any additional continuing education credit hours completed on or after the renewal date to satisfy the requirement of the preceding period will not apply to the period in which they are earned.

History: CR 13−117: cr. Register February 2015 No. 710, eff. 3−1−15.

MPSW 19.03   Approved continuing education.
(1) Continuing education programs, if relevant to the professional practice of marriage and family therapy, professional counseling, or social work, are approved as follows:

(a) Any continuing education program approved, sponsored, provided, endorsed, or authorized by:

1. American Association for Marriage and Family Therapy (AAMFT) or affiliated divisions.

2. Wisconsin Association for Marriage and Family Therapy (WAMFT).

3. National Rehabilitation Counseling Association (NRCA).

4. American Rehabilitation Counseling Association (ARCA).

5. Wisconsin Rehabilitation Counseling Association (WRCA).

6. National Board for Certified Counselors (NBCC).

7. American Counseling Association (ACA).

8. Wisconsin Counseling Association (WCA).

9. National Board for Certified Counselors (NBCC).

10. Commission on Rehabilitation Counselor Certification (CRCC).

11. Association of Social Work Boards (ASWB).

12. National Association of Social Workers (NASW) or affiliated chapters.

13. Association of Baccalaureate Program Directors (BPD).

14. Council on Social Work Education (CSWE).

15. National Association of Alcohol and Drug Abuse Counseling (NAADAC) or affiliated divisions.

(b) Any continuing education program or course offered by a training program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE).

(c) Any continuing education program approved, sponsored, or co−sponsored by a presenter approved by the Committee for the Approval of Continuing Education Sponsors of the American Psychological Association.

(d) Any educational programs, recognized as approved at the time of attendance as "Category I" continuing medical education programs by the Council on Medical Education of the American Medical Association or the American Osteopathic Association.

(e) Any course or continuing education program offered by an accredited college or university.

(f) Public and private agencies that provide in−house training and development programs. Only 15 of the required 30 continuing education credit hours shall be met through in−house training and development programs which are not approved by an organization identified in pars. (a) to (e).

(2) Continuing education hours may be awarded for the following professional activities, if relevant to the professional practice of marriage and family therapy, professional counseling, or social work:

(a) A presenter of professional material shall receive 1 continuing education credit hour per hour of continuing education. A developer of professional material shall receive 1 continuing education credit hour per hour of development of continuing education. A presenter of a semester education course shall receive 20 continuing education credit hours. No additional continuing education credit hours will be granted for subsequent presentations of the same material. A presenter of professional material at any of the following qualifies for continuing education:

1. Seminars, workshops, programs, or institutions approved in sub. (1) (a) to (f).

2. University, college, or vocational technical adult education courses.

(b) Authorship of a published textbook or professional resource book. Authors of a book shall receive 20 continuing education credit hours.

(c) Authorship of a published chapter in a textbook or professional resource book, or a professional journal article. Authors of chapters or articles shall receive 8 continuing education credit hours. No more than 16 continuing education hours may be obtained for authorship of chapters or articles.

(d) Authorship of alternative or electronic media or computer software. Authorship of these materials shall receive 8 continuing education credit hours. No more than 16 continuing education hours may be obtained for authorship of alternative or electronic media or computer software.

History: CR 13−117: cr. Register February 2015 No. 710, eff. 3−1−15; corrections in (1) (f), (2) (a) 1. made under s. 35.17, Stats., Register February 2015 No. 710.

MPSW 19.04 Postponement, waiver, and exemption. (1) A credential holder may apply to the section for a postponement or waiver of the requirements of this chapter on grounds of prolonged illness, disability, or other grounds constituting extreme hardship. The section shall consider each application individually on its merits, and the section may grant a postponement, partial waiver or total waiver as deemed appropriate in the circumstances.

(2) The section may grant an exemption from the requirements of this chapter to a credential holder who certifies to the section that the credential holder has retired and no longer uses the title "marriage and family therapist," "professional counselor," "social worker," "advanced practice social worker," "independent social worker," or "clinical social worker," and no longer practices marriage and family therapy, professional counseling, or social work. The credential holder's status will change to non−practicing.

(3) A credential holder who has been granted an exemption due to retirement may not return to the active practice or use the title without submitting evidence satisfactory to the section that the credential holder has completed at least 30 continuing education credit hours for each of the biennia during which the credential holder was granted an exemption.

History: CR 13−117: cr. Register February 2015 No. 710, eff. 3−1−15.

MPSW 19.05 Record retention and audits. (1) A credential holder shall retain for a minimum period of 4 years and shall make available to the board, or its agent upon request, documentation of publication or certificates of attendance issued by the program sponsor for all continuing education programs for which the credential holder claims credit for purposes of renewal of the credential. The certificate shall include the name of credential holder, date, provider name, hours, and title of program.

(2) The section may conduct audits or investigations, including random audits, to determine compliance by credential holders with this chapter.

History: CR 13−117: cr. Register February 2015 No. 710, eff. 3−1−15.

Bloom's Taxonomy, Revised for 21st-Century Learners
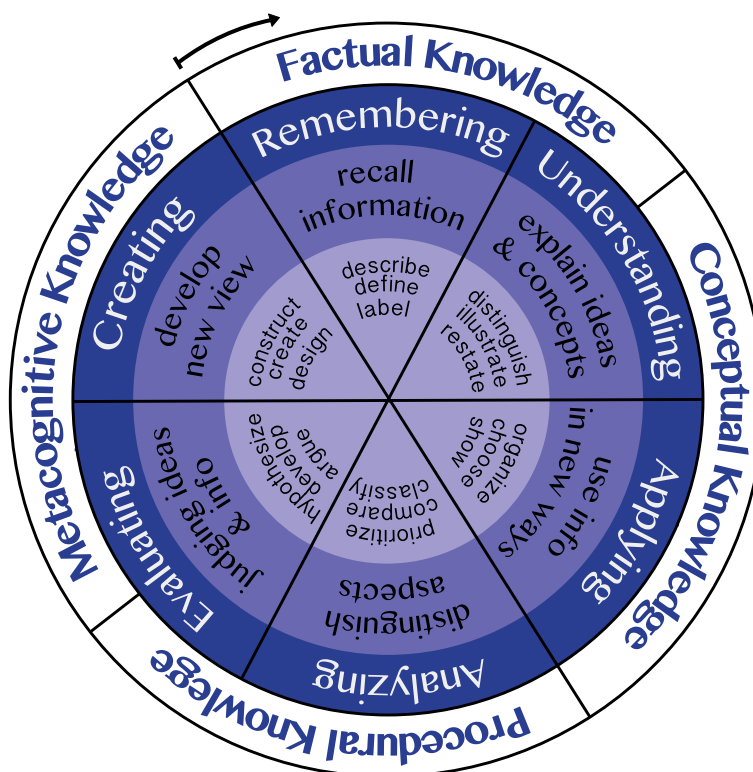
Benjamin Bloom led a team of researchers in the 1950s to establish behaviors associated with learning; the outcome of this study was Bloom's Taxonomy of Learning (1956). Forty years later, one of his students, Lorin Anderson, revised the taxonomy to accommodate progressions in pedagogy. The revised taxonomy has altered categories and now includes verbs associated with each of the six aspects of cognition.

The graph demonstrates the six aspects of learning, **Remembering, Understanding, Applying, Analyzing, Evaluating,** and **Creating,** in combination with a brief explanation of the process, and verbs teachers can use to get students to think on these levels. Here, Bloom's Taxonomy is situated in the four types of knowledge, **Factual Knowledge** of terminology and details, **Conceptual Knowledge** of relationships among pieces of concepts or theories, **Procedural Knowledge** of processes and methods of theories and problems, and **Metacognitive Knowledge** of learning strategies and processes. This chart starts with factual knowledge and remembering and builds in complexity as it moves clockwise. A comprehensive lesson will require students to apply multiple types of knowledge and cognitive skills.

BLOOM'S REVISED TAXONOMY

Level	Verbs & Sample Objectives	Discussion Questions
Remember Be able to recall information such as dates, events, places, ideas, definitions, formulas, and theories.	Arrange, Define, Describe, Detail, Draw, Duplicate, Identify, Indicate, Inventory, Label, List, Locate, Match, Name, Outline, Pick, Point, Pronounce, Quote, Recall, Recite, Recognize, Record, Relate, Repeat, Reproduce, Restate, State, Underline • Label the parts of the heart. • Outline the steps in the writing process. • Recite the Gettysburg Address.	• Who was…? • What is…? • When was…?
Understand Be able to grasp the meaning of the information, express it in own words, and/or cite examples.	Classify, Confirm, Contrast, Convert, Decipher, Defend, Designate, Differentiate, Equate, Estimate, Examine, Express, Extend, Extrapolate, Generalize, Give Examples, Group, Infer, Interpret, Order, Paraphrase, Predict, Rephrase, Rewrite, Sort, Specify, Substitute, Tell, Translate • Defend your position about flat taxes. • Give an example of an adjective. • Specify the role of project management in an organization.	• Can you name…? • What is an example of…? • Where does…differ from…?
Apply Be able to apply knowledge or skills to new situations. Use information and knowledge to solve a problem, answer a question, or perform another task.	Add, Allocate, Alter, Apply, Calculate, Change, Choose, Complete, Compute, Conduct, Coordinate, Demonstrate, Determine, Direct, Discover, Divide, Dramatize, Draw, Employ, Formulate, Gather, Graph, Make, Manipulate, Model, Multiply, Operate, Perform, Present, Provide, Recount, Report, Schedule, Show, Sketch, Subtract, Use, Utilize • Choose criteria to assess change readiness. • Demonstrate the proper technique for drawing blood. • Graph the results of the market analysis.	• How does…explain…? • Examine the graph and tell me…? • Which events led to…?
Analyze Be able to break down knowledge into parts and show and explain the relationships among the parts.	Analyze, Appraise, Associate, Break Down, Criticize, Discern, Diagram, Discriminate, Dissect, Distinguish, Elect, Establish, Explain, Expound, Illustrate, Inspect, Profile, Question, Refute, Separate, Simplify, Subdivide, Summarize, Test • Explain the ramifications of sexual harassment in the workplace. • Appraise potential suppliers according to organizational needs. • Distinguish between ethical & unethical behavior.	• What is the relationship between…and…? • What caused…? • How does…apply to…? • Why does…work? • How does…relate to…? • What distinctions can be made about…and…?
Evaluate Be able to judge or assess the value of material and methods for a given purpose.	Argue, Assess, Attack, Compare and Contrast, Conclude, Critique, Debate, Decide, Deduce, Diagnose, Evaluate, Forecast, Improve, Judge, Justify, Measure, Prioritize, Prove, Rank, Rate, Recommend, Resolve, Revise, Select, Solve, Support, Value, Verify, Weigh • Support the value of diversity in a project team. • Recommend course of action for comprehensive organizational change. • Resolve ethical issues that plague researchers conducting experiments on animals.	• How does…meet criteria for…? • What judgments can you make about…? • Can you compare and contrast…criteria for…? • Is there a better solution to…?
Create Be able to pull together parts of knowledge to form a new whole and build relationships for new situations.	Assemble, Assimilate, Categorize, Collect, Combine, Compile, Compose, Condense, Construct, Create, Design, Derive, Develop, Devise, Elaborate, Expand, Generate, Guide, Hypothesize, Integrate, Invent, Manage, Modify, Organize, Plan, Prepare, Prescribe, Produce, Propose, Rearrange, Reconstruct, Reorganize, Rework, Set Up, Synthesize, Theorize, Transform, Write • Devise a plan to deal with violence in your community. • Design an instructional unit to meet the needs of online students. • Modify the training process for a business or organization.	• What would happen if…? • Can you compile the data to…? • How can we solve…? • How many ways can you…? • What hypotheses can you make? • Why?

Reference:
Table adapted from: Anderson, L.W., & Krathwohl, D.R. (2001). *A taxonomy for learning, teaching, and assessing, abridged edition.*
Boston: Allyn & Bacon.
Wheel adapted from: *Edutechalogy*. Retrieved from http://eductechalogy.org/swfapp/blooms/wheel/engage.swf

Techniques for Your Toolbox

USING VARIOUS LEARNING STYLES

Techniques for Your Toolbox
Using various learning styles

1. Brainstorming
Steps:
- Present an open-ended question for participants to discuss or solve.
- Students can work individually, in pairs or small groups, or as a class (or combination of these).
- Have students share ideas with class, making notes on the board, flipchart or piece of paper.
- Have each group report out. Discuss and share any information needed. At the end, correct any misconceptions, note opposing points of view, and summarize main points.

Value: promotes critical and creative thinking and imagination.
Learning Style: Visual, Auditory, Kinesthetic

2. Decision Making
Steps:
- Provide participants with a problem that they need to work on for example "Imagine you have a participant in class who is monopolizing the conversation…"
- Ask participants to work in groups (2-4 students) to develop a plan to deal with the situation.
- Have participants share ideas with class, track all suggestions from each group.
- Discuss. Determine any challenges or issues with any of the suggestions. Eliminate ones that the group determines aren't the best choices. Create the list of the best practices.

Value: promotes integration of ideas, critical, creative thinking, provides immediate feedback about student understanding.
Learning Style: Visual, Auditory

3. Group Graphic
Steps:
- Have participants get in pairs or small groups.
- Ask the pairs or groups to illustrate curriculum content by constructing a picture, diagram, flowchart, concept map, or some other visual illustration that represents their understanding of the content.
- Have participants report on their group graphic to the rest of the class, explaining what is represented and why (their representation might also include questions, unknowns, etc.).
- Have other groups respond with questions, feedback or suggestions, and you can also provide feedback to help clarify questions, point out misconceptions or oversimplifications, or correct errors. You can also have groups turn in their illustrations for you to scrutinize after class and later hand back with feedback.

Variation for Large Classes: Have small groups assign roles such as recorder (person drawing), facilitator (ensures everyone participates), reporter (will report on illustration), and participants (contribute to discussion). Once the graphic complete, have the reporters from each group go to a different group and report on the illustration, receiving feedback from the other group. Some instructors provide markers and large post---it notes or pieces of paper and tape to adhere illustrations to a wall.

Value: promotes integration of ideas and thinking, facilitates attention on the "big picture" and relationships among ideas, and allows for creativity in thinking and expression
Learning Style: Visual, Auditory

4. One Minute Paper
Steps:
- Have participants take out a blank sheet of paper,
- Pose a question/issue/problem to them.
- Give them one or two minutes to write something down.
- Have the group come back together and do round robin sharing.

Value: Shows how participants are viewing the material and what you might need to focus on next. Gives participants a chance to review what they have learned and helps them determine if they have questions about the content.
Learning Style: Visual

5. Muddiest Point
Steps:
- Have two participants pair up together.
- Have them determine "the muddiest" point/concept/topic so far in the session.
- Ask them to determine questions to ask so they can become clear on the point/concept/topic.
- Come back together as a large group, have each dyad share their "muddiest" point and share their questions.
- The instructor/trainer can then answer the questions or open to class discussion.

Value: Promotes problem solving, examining issues from all perspectives and teamwork.
Learning Style: Visual, Auditory

6. Yes/No/Unsure
Steps:
- Create three signs – one with the word Yes, one with the word No and one with the word Unsure.
- Hang each of them on a separate wall in the room where the session takes place.
- You will have questions created from the course material that can be answered with a yes/no/unsure. You will be using this as a way to review material you have already covered.
- Ask one of the questions and ask the participants to move to the correct answer – Yes or No. Or to go to Unsure if they really cannot decide.
- Once everyone has chosen an answer, ask those in each area why they picked the answer they picked.
- Once that is completed, share the correct answer. Have further discussion if needed.

Value: A great review technique that gets participants moving. Easy energizer.
Learning Style: Visual, Auditory and Kinesthetic

7. Fishbowl
Steps:
- This activity can be used to do review or try to help their fellow participants solve issues that have taken place at work. Ensure no names are used to insure confidentiality.
- Each participant is given an index card on which they list the review question or share their work issue.
- The instructor/trainer collects all of the cards and puts them into a fishbowl or basket.

- The instructor/trainer proceeds to draw an index card and share the question (if it is a review) and ask for responses. Or read the work issue (if more in-depth) and ask for solutions.
- It provides participants with the chance to share what they know and for the instructor/trainer to address incorrect assumptions or share the course approved response/materials.

Value: Provides a chance for participants to share their expertise, promotes problem solving.
Learning Style: Visual, Auditory

8. Finger Signals
Steps:
- Participants are asked questions on the materials content and instructed to signal their answers by holding up the appropriate number of fingers immediately in front of their torsos (this makes it impossible for students to "copy", thus committing them to answer each question on their own).
- The instructor/trainer might say "one finger for 'yes', two for 'no".
- Helps the instructor/trainer assess how well the students know the content. Requires that the instructor/trainer have the questions prepared in a yes – no format.
- This can also be accomplished with flashcards – Yes or No

Value: Provides immediate feedback on participant understanding of the materials, easy to implement and to use with large groups.
Learning Style: Auditory and Kinesthetic

9. Role Playing
Steps:
- Warm up the group – This step involves presenting participants with a problem, providing examples, and having students predict what might happen.
- Select participants – In this step, the characters and their characteristics are identified and volunteers come forward.
- Set the stage – A line of action and the setting are established and the roles are restated.
- Prepare the observers – To make sure that the whole group stays involved; the instructor/trainer is encouraged to assign them tasks. For example, the observers could evaluate the realism of the role playing, respond to the effectiveness and sequences of the role players' behavior, and define the feeling and ways of thinking of the persons being portrayed.
- Enact – The players assume the roles and spontaneously "live" the situation from beginning to end of the situation.
- Discuss and Evaluate – In this step, the action of the role playing is reviewed, the focus is discussed. Are there more questions? Discuss if there are solutions/options/methods to use.

Value: Helps the participants understand the situation or issue.
Learning Style: Auditory and Kinesthetic

10. Case Study - Documented study of a specific real-life situation or imagined scenario, used as a training tool. Participants analyze the prescribed cases and present their interpretations or solutions.
Steps:

- Can be done individually or in small groups.
- Provide the case study to participants. Have them read it and try to determine the following:
  - What is the issue(s)?
  - What would be a good goal to strive for considering the situation? Some professions have mandates that need to be followed.
  - What are the key facts in the case study?
  - What options or alternatives are available in this situation?
  - What would you or your group recommend be done in this situation and why?
- Discuss or Reflect and write down the answers to the questions above.
- Return to the large group and discuss the issue in depth. Instructor trainer can provide more information or share solution used/results with the group (if a real-life situation).

Value: Promotes problem solving, increases proficiency with analytical tools, quantitative and/or qualitative, depending on the case, improves decision making in complex situations, helps participants learn to cope with ambiguities better.
Learning Styles: Visual, Auditory

11. Jigsaw - Jigsaw is a cooperative active learning exercise where students are grouped into teams to solve a problem or analyze a reading. An individual or small group of people complete a different portion of a larger assignment and then contribute their knowledge to the class as a whole. The jigsaw comes from the bringing together of the various ideas at the end of the activity to produce a solution to the problem.

Steps:
1) Share information about an overall large assignment that has many components or sections. Assign each individual or small group of people with a section or specific part of the overall assignment.
2) Provide time for participants to work on their section of the assignment. Determine whether they will need additional materials, access to resources or to just have discussion.
3). Have them document what their results are and have them present their section to all of the other participants.
4) Provide feedback to each person or small group on their section.
5) Review the main points of the overall assignment with the whole group.

Value: Increases the ability to explore substantive problems or readings, help with the engagement of all students with the material, improves how participants learn from each other and critical analysis of a diversity of ideas.
Learning Styles: Visual, Auditory and Kinesthetic (depends on participants approach)

12. Labeling a Diagram
Steps:
1) Each participants is given an unlabeled diagram or picture.
2) They must label it with the correct terminology in a specified amount of time. Instructor/trainer decides if notes can be used for the activity.
3) Once time has expired, review the correct answers for the diagram with participants.

Value: Great review activity to increase recall, helps participants visualize needed visual.
Learning Styles: Visual, Auditory

13. Terms and Examples
Steps:
1) Participants are given a term or terms for which they have to generate examples of given a concept, problem, situation, or principle (how it would be used, addressed, what it is connected with, etc.) For example – "Transdermal" Fentanyl is an example of a transdermal medication. A patch which has the medication in it, is placed on the skin so the medication can be absorbed through it. An example for this would be for them to define the term and then share how it is used– the CBRF worker washed his hands, opened the transdermal packet of Fentanyl and then placed the patch on the resident's arm.
2) Each participant or small group shares their example with the large group.

Value: Generating examples increases recall, helps visual learners "visualize" what the process is which increases their ability to do the task, easy review process.
Learning Styles: Auditory and visual

14. Three Point Summary
Steps:
1) After presenting a section of new information, call on a participant and ask them to pick out three points or three things to remember.
2) As they are sharing the three points, write them on a whiteboard or flipchart.
3) Ask the rest of the participants if they have anything to add.

Value: Helps participants review and improve their memory of the materials.
Learning Style: Visual, Auditory

15. Matrix
Steps:
1.) Participants should create a table with information to compare (i.e. pros/con, two different processes).
2) Ask students to work in groups (2---4 students) to fill out the table.
3) Have groups share their ideas with the class. Capture key ideas on whiteboard or flipchart.

Process	Value of Process	Limitations of Process	When would you use this process

Value: Promotes integration of ideas, allows participants to easily compare ideas and reduce complexity.
Learning Styles: Visual, auditory

16. Quick Thinks - For each of the following, use immediate material from lecture, and allow students a couple of minutes to reflect before surveying their responses (have students share aloud, and you can collect written responses for participation points)-
- Correct the Error: Present participants with a statement, equation, or visual that you have intentionally made incorrect and have them correct the error. The error may be an illogical or inaccurate statement, premise, inference, prediction, or implication.

- Complete a Sentence Stem: Present participants with a sentence starter and have them complete the sentence. The completed statement may be a definition, category, cause---and---effect relationship, rationale, controversy, etc. Try to avoid statements that ask for rote knowledge.
- Reorder the Steps: Present sequence items in the wrong order and have students re---order the sequence correctly. This might be a process, cycle, method, plan, technique, etc.
- Interpretation/Paraphrase: Let participants know that you will be calling on them at random during your sharing of the materials and asking them to interpret what you've said, putting the material in their own words. When you are ready, pause for a moment to signal that you are about to call on someone. Once a participant has shared, you can have another participant add more. You can also have participants work and share in pairs.
- What do You See? Present participants with an image, such as a picture, symbol, graphic, equation, etc., and ask them "what do you see?" The image can be something new or familiar to participants. The idea is to ascertain if they can identify noticeable patterns, discrepancies, unusual features, and so on. You can also present an intentionally altered image to determine if students can identify what is wrong or missing or suggest how to correct it.
- Reach a Conclusion: Present participants with some data, opinion, event, or solution and have them infer logically the implications of the facts, concepts or principles involved. Their conclusions can be probably results, probable causes or outcomes.

Value: these exercises foster attentiveness, provide immediate feedback about student understanding, and promote critical thinking skills.
Learning Styles: Visual, Auditory

17. Strip Sequence
Steps:
 1) Provide participants with an out of order list of step in a multi---stepped process (can be written on small strips of paper or on a PowerPoint slide).
2) In groups or individually, have participants put the "strips" into the correct order from beginning to end.
3) Have participant groups compare answers with another group.
4) Review order and answer questions (especially to clarify misconceptions) for the whole class.

Value: promotes critical thinking and collaborative learning.
Learning Styles: Visual

18. Think Aloud Inquiry
Steps:
1) Present a particular problem, ideally one that can be solved in a relatively short timeframe (or, for a more complex problem, the method of inquiry via which you would go about solving the problem can be presented).
2) Next, literally talk aloud in front of participants how you would go about engaging the problem. You might say, for example, "Okay, for this particular problem, first I need to clarify the nature of the problem. Do I understand what is at stake? From what is given here, I understand it to involve x,y,z. Given this, the next thing I need to do is consider…." And so on. The idea is to demonstrate explicitly your thinking process so that participants can literally observe/hear "thinking in action" as one moves through a basic process of problem---solving (e.g. identify the nature of the problem, analyze the

knowledge or skills required to engage it, identify potential solutions, choose the best solution, evaluate potential outcomes, report on findings, etc.).

3) Next, have participants form pairs and assume the roles of "problem---solver" and "listener." Then present a problem for them to solve. The "problem---solver" is to read the problem aloud and talk through the reasoning process in attempting to solve it. The role of the listener is to encourage the problem---solver to think aloud, describing the steps to solve the problem. The listener can also ask clarifying questions or offer suggestions but should not actually solve the problem.

4) Present yet another problem and have participants switch roles.

5) After an allotted amount of time, have participant pairs share their experience. Did they actually solve the problems? What obstacles or breakthroughs did they encounter? How did it feel to talk aloud or listen to "thinking in action"?

Value: promotes critical thinking and inquiry, attentiveness, and collaborative learning.
Learning Styles: Auditory

19. Reflect Activities Learning is enhanced if we are given a chance to reflect, review, and personally relate to the material and how we might apply it. Give participants a log or journal, then use a variety of ways to have participants stop and reflect periodically for a few minutes on what they've learned and how they might use it.

After the reflection time you can have them volunteer to share, share in small groups, or not share. Here are six examples:

1) Most Important: Write three things you just learned. Now put a star by the most important.
2) Three Applications: Write three ways you can use or apply what you've just learned. Circle the one you plan to do first.
3) One Sentence: Write one sentence explaining what you learned in the last _____ minutes.
4) One Question: Write one question that you have about what you've heard.
5) Wow / How About: On a sticky note, write a "WOW"—something you learned that was important to you. On another sticky note, write a "HOW ABOUT"? question or other idea you might have. Post your notes on the two flip charts (labeled WOW and HOW ABOUT). Build in some time to debrief the two charts.
6) Highlights: Spend the next four minutes reading and reviewing the notes and the other information in your packet. Highlight the important points. Write any questions you still have. Similar to three point summary.

Value: All of these activities help increase understanding of material, increase critical thinking and provide feedback to the instructor.
Learning Styles: Visual

20. Summarize
Having learners summarize, in a sentence or two, the most important things they have just learned is another powerful way to have them interact with the content and fix it in their minds. Here are 7 fun ways they can share their summaries with others.

1) Best Summaries: On an index card, each participant prepares a summary of the main points at the end of a segment or topic. On the other side of the card have them put a code or identifying PIN. Put participants into small groups, collect their cards and exchange them with another small group. Then

each small group selects the best summary from the set of cards they were given. Each small group reads the summary to the whole group. Also read the identifying PIN so the author can be congratulated.

2) <u>Important:</u> After a presentation, ask participants to identify the most important piece of information or concept that you presented. Give them time to think and jot an idea down. Ask for responses. Then ask them to share that with a partner. Take a few responses in the whole group.

Value: promotes critical thinking and collaborative learning.
Learning Styles: Visual, Auditory

21. Showtime
Steps:
1) Divide participants into small groups.
2) Assign small group with a portion of the material that was presented by the instructor.
3) Have each small group prepare and give a short, creative recycle presentation of the material.

Value: Great review activity to increase recall, promotes critical thinking and collaborative learning.
Learning Styles: Visual, Auditory and Kinesthetic

Compiled through the following sources:
- Angelo, Thomas A., and K. Patricia Cross. 1993. Classroom Assessment Techniques: A Handbook for College Teachers. 2nd Edition. San Francisco: Jossey Bass.
- Barkley, Elizabeth F. 2010. Student Engagement Techniques: A Handbook for College Faculty. San Francisco: Jossey---Bass.
- Davis, Barbara G. 1993. Tools for Teaching. 1st Edition. San Francisco: Jossey Bass. [see Chapter 16,
- "Supplements and Alternatives to Lecturing: Encouraging Student Participation," pp. 131---139]
- Handlesman, J., S. Miller, and C. Pfund. 2007. Chapter 2, Active Learning in Scientific Teaching. New York: W.H. Freeman and Co.
- McClanahan, E.B., and L.L. McClanahan. 2002. Active Learning in a Non---majors Biology Class: Lessons Learned. College Teaching 50(3): 92---96.
- Nilson, Linda B. 2010. Teaching At Its Best: A Research---Based Resource for College Instructors. 3rd Edition. San Francisco: Jossey---Bass. [see Chapter 12, "Making the Lecture a Learning Experience," esp. pp. 117---122]
- Thiagi's Interactive Lectures by Sivasailam Thiagarajan, 2005, and Presenting with Pizzazz by Sharon Bowman, 1997.

Additional examples and resources can be found at:
50 CATs by Angelo and Cross – Compiled by Cunningham and Moore
http://tep.uoregon.edu/resources/newteach/fifty_cats.pdf
Classroom Assessment Techniques (CATs) – UO Teaching Effectiveness Program
http://tep.uoregon.edu/resources/assessment/cats.html
Classroom Assessment Techniques (CATs) – Center for Teaching, Vanderbilt University,

You Tube Video Resources

Adult Protective Services & Elder and Dependent Adult Abuse (13:01)

     https://www.youtube.com/watch?v=wCFIsSS2wkc

Elderly Woman Speaks about Abuse by Grandson (2:32)

     https://www.youtube.com/watch?v=SE3u88_ScaE

Everyone's responsibility: Preventing Abuse Against People with Disabilities (39:02).

     https://www.youtube.com/watch?v=Ps0Rt9TU3ao

Aging and Exploitation: Aging Matter-NPT Reports (27:02).

     https://www.youtube.com/watch?v=P8lEOLAAU6U

SANE Series

     LuLa's Story (8:56)

     https://www.youtube.com/watch?v=cr7J64iqtz8

     Bert's Story (7:48)

     https://www.youtube.com/watch?v=yuEvFIIsm28

     Harvey's Story (6:48)

     https://www.youtube.com/watch?v=ZOxVTj1e9dI

     Martin's Story (6:30)

     https://www.youtube.com/watch?v=o2Ui1SrOd4I&t=50s

     Responders (10:34)

     https://www.youtube.com/watch?v=0XPqhKKXLrI

Elder Abuse ABC 730 [in NH] (8:32)

     https://www.youtube.com/watch?v=h8uxgyggY1Q&t=8s

Mickey Rooney Testimony (4:08)

     https://www.youtube.com/watch?v=s2r2uVOWee4

Abuse of Power: APS Guardian (2:37)

     https://www.youtube.com/watch?v=yQJlAZW4xVA

Elder Abuse News Segment (NCPC) (1:49)

     https://www.youtube.com/watch?v=n_nAkP2Q1T0

Open your eyes to Elder Abuse in Your Community (20:35)

     https://www.youtube.com/watch?v=t9CFcoJ5-cU

Elder Abuse Training Videos: Scenarios of Elder Abuse (14:06)

     https://www.youtube.com/watch?v=8Cc10ed3Vtc

Signs of Elder Abuse (15:34) [Beginning 7:34- case study/financial and again around minute 10.]

https://www.youtube.com/watch?v=lcIhN7dgvFI

Elder Abuse 5 Case Studies (3:01)—Norman [TNF Films]

https://www.youtube.com/watch?v=EYQVIwVC48s

TX DFPS Reporting Elderly Abuse "Donna" (5:42)-training on reporting

https://www.youtube.com/watch?v=3qXdyoS2Gvc

Violence Against Women with Disabilities (5:51)

https://www.youtube.com/watch?v=EovgP4YXjL8

Disabled Woman Abused (2:33)

https://www.youtube.com/watch?v=aop9DTgqKdU

Mentally Disabled Woman Found in Horrific Conditions-Kenneth Headrick

https://www.youtube.com/watch?v=lIWt852NWFE

Report: Woman Lived in Filth; Husband Did Not (2:07)

https://www.youtube.com/watch?v=b0TDld4Dbyk

Photos Show Squalor Inside Home Where Woman Died (1:41)

https://www.youtube.com/watch?v=l2rjkM-ucUk

Addressing Abuse of Disabled Adults (3:32)

https://www.youtube.com/watch?v=GFWXWFBt5B4

Safeguarding Adults-Annie's Story (3:57)

https://www.youtube.com/watch?v=nlVpR8_6CLk

Safeguarding Adults: Call Me Joe (3:21) [NH]

https://www.youtube.com/watch?v=Bd8dywHjwMQ

Safeguarding Adults: Peter's Story (4:22)

https://www.youtube.com/watch?v=2zcux_iIuOI

Safeguarding Vulnerable Adults Part 1 (3:35)

https://www.youtube.com/watch?v=auDScEgxc6o

Part 2 (1:17)

https://www.youtube.com/watch?v=XcteySQcsAc

House of Horrors (10:56)

https://www.youtube.com/watch?v=1yq5nydWK34

Safeguarding Adults: An Independent Life after Abuse (8:55)

https://www.youtube.com/watch?v=A419D-X09kQ

Mental Capacity Act: Respecting the Right to Make Unwise Decisions (7:01)

https://www.youtube.com/watch?v=WbZWRiU9BSc

Safeguarding Adults: Looking out for Each Other to Prevent Abuse (11:16)

> https://www.youtube.com/watch?v=uKnebFA1ahI

Abuse of People with Disabilities: A silent Epidemic (2:59)

> https://www.youtube.com/watch?v=yhLsATwO0o4

Recognizing and Preventing Abuse, Neglect, and Exploitation (11:31)

> https://www.youtube.com/watch?v=UU94N2yi294

Elder Abuse-Learn the Signs and Break the Silence (6:12)

> https://www.youtube.com/watch?v=OEGhbbpeI30

Elder Abuse Root Causes [Indigenous] (3:32)

> https://www.youtube.com/watch?v=rMFpS7-m3y8

Just to Live in Peace (3:11) video was from 2010

> https://www.youtube.com/watch?v=OzJx0Cynz9A&t=6s

Responding to Late Life Domestic Violence [Massachusetts Office of Elder Affairs]

> Part I (28:19)

> Part II: Interviewing Alleged Perpetrators (25:37)

> Part III: Responding to Late Life DV (47:34)- 2:43 victim report

> http://forprofessionals.800ageinfo.com/2015/09/responding-to-late-life-domestic-violence.html#more

An Age for Justice: Confronting Elder Abuse in America (16:03)

> https://www.youtube.com/watch?v=-eaJXBj87to

Break the Silence: Elder Abuse in America (5:46)

> https://www.youtube.com/watch?v=LoY7EI_qPQk

Forensic Markers of Elder Abuse (28:35)

> https://www.youtube.com/watch?v=oEutdrrp4XQ

Elder Abuse: The Crime of the 21st Century? Research on Aging (59:28)

> https://www.youtube.com/watch?v=1JoUapRfjZw

Protection of Vulnerable Adults (5:30)-example from Singapore (Impaired intellect)

> https://www.youtube.com/watch?v=2Kj4l_6oyZM

Everyone's Responsibility: Preventing Abuse Against People with Disabilities (38:02)-

> Client story at 12:00. [Nice discussion of systems issues]

> https://www.youtube.com/watch?v=Ps0Rt9TU3ao

Elder Rights Project (WI-1/11/2017)- Webinar (24:10)

> https://www.youtube.com/watch?v=u_i3ujIJZTE

Jerika Bolen Story [WI Public Radio] (31:04)

https://www.youtube.com/watch?v=uu0-QtUcl1c

Abuse and Exploitation Panel/11-18-2016 –TN (29:39)

https://www.youtube.com/watch?v=3NSl0aEdVqQ

TED Talks

BJ Miller-What really matters at the end of life (19:09)

https://www.ted.com/talks/bj_miller_what_really_matters_at_the_end_of_life

Laura Carstensen-Older People are Happier (11:38)

https://www.ted.com/talks/laura_carstensen_older_people_are_happier

Train-the-Trainer

Training Outlines from Participants

Use the Bloom's Taxonomy handout when developing learning objectives. Start with lower level (understanding, describing) and move to higher order (applying, creating). The back-side of the handout provides a range of verbs that can be used when creating learning objectives at the different levels within the hierarchy.

It can be helpful to begin a learning objectives discussion with the phrase "As a result of this training, participants will [be able to]" and then list the objectives.

[These training outlines are unedited from participant work.]

Topic	Diffusing Cries
Learning Objectives	- Define a crisis - Recognize a crisis - Diffuse a crisis - Self-awareness to a crisis
Activities	Personal plan to crisis response ("Check yourself" plan) Define a crisis from personal perspective and as agency Case scenarios Motivational interviewing role play Training soft skills—active listening, mediation confidence Self-care debriefing [Self-care toolbox]

Topic	Overlap od Depression and Dementia
Learning Objectives	- Definitions of each with symptoms/signs - Similarities/Differences - Use 3 D's - Assessment/tools - Safety planning/levels of restriction - Associated statutes - Client rights
Activities	Case studies (define, videos, use appropriate tools, which statute to use) De-escalation techniques (interviewing tips, collaboration/community partnering, Teepa Snow videos) Role Playing (which diagnosis, safety plan options, legal routes)

Topic	Giving Testimony
Learning Objectives	- Components of the courtroom - Role identification - Components of Testimony - Familiarization with state statutes/court documents/reports
Activities	Video introduction to courtroom activities [Law and Order video] Presentation on components of the courtroom Presentation on role identification—role match up activity Overview of state statutes/court documents/reports Role play activity using case scenarios

Topic	Safety Strategies for Workers

Learning Objectives	• Identify/understand risk factors in home visits
	• Learn new strategies to increase worker safety
	• Learn strategies to mitigate risk
	    ○ Geographical area (high crime)
	    ○ Hostile client/relatives
	    ○ Unsafe home conditions

Activities	Small group activity to show pictures and various home visits scenes with brainstorming to document identified risks Video vignette and group technique De-escalation techniques-role play Large group sharing of local resources each county uses/ideas for developing resources Create safety checklist to use for referral/data collection

Topic	Interview Skills
Learning Objectives	• Describe and demonstrate communication styles (#1) • Examine and illustrate effective listening (#2) • Critique and develop interview techniques (#3)
Activities	Lecture and Case scenarios (#1) Role plays and discussion (#2) Video and Reflection (#3)

Topic	Criteria for Emergency Protective Placements (EPP)
Learning Objectives	• Understand WI Statute 55.135 • Recognize adult-at-risk situations that meet criteria • Identify appropriate persons/agencies who can initiate an EPP
Activities	Matching game criteria from statute (Provide handout of statute) Case scenarios to assess if they met legal criteria Role play EPP's being done or show video(s).

Topic	Screening In and Out
Learning Objectives	• Understand the statutes that may apply • Understand the County's current process • Recognize implications of decision • Learn appropriate documentation
Activities	Case scenarios and documentation Flow Chart Table used to compare statutes Video of interviewing skills to gain appropriate information Parking lot—What do other counties do?

Topic	Hoarding: When is Too Much Too Much?
Learning Objectives	- What is hoarding? Understanding the reasons why. - Lifestyle vs. safety concern-recognize what to look for in APS - Is it dirty or is it hoarding? Apply knowledge to decisions - Who else needs to be involved? - Learn resources and next steps
Activities	Round table discussion-Case scenario Video: Hoarders- Medical Emergency-Good Outcomes Get up and Move! Interactive activity with non-judgmental What do I do if I need more help? Next steps of interventions; checklist. Handouts with resources Chocolate and coffee breaks.

Note: The Behavioral Health Training Partnership housed at the University of Wisconsin-Green Bay has a training developed on hoarding. [These trainings are created for County workers.] Access their listing of trainings at:

https://www.uwgb.edu/behavioral-health-training-partnership/

Topic	WATTS Reviews
Learning Objectives	- Purpose of WATTS review (#1) - Content of WATTS review (#2) - Process of WATTS review (#3) - Interpreting information (#4)
Activities	Role playing of interviewing skills (#2) Labeling a diagram (#3) Case study/case example (#4) Strip sequence of WATTS process (#3) Summarize (#1) Muddiest Point (All)

Topic	Conducting Investigations
Learning Objectives	Understand the elements of a thorough investigation according to statutes
Activities	Case scenarios Referral example—then what? Data collection Video—Good vs Bad General Questions (risk) Substantiates/unsubstantiated/Not able to complete WITTS

Train the Trainer

Training/Trainer Brainstorm

Good Training

Well organized materials

Real life examples

Personal knowledge (real, practice)

Engaging

Tailor to audience

Trainer—humor

Multiple ways of training

Tolls to utilize after the training

Usable material

Interaction

Pacing—Important areas

Timely

Refreshments

Group work instructions clear

Cost-location-time—balance with value for the participant

Good Trainer

Passion—desire to share

Confidence-Competence

Credibility—experience

Energetic

Humor

Role play—strengths/weaknesses

"Cares" about learner

Uses a variety of techniques

At/level with learners

Moves about the room