Kentucky Can Improve the Coordination of Protective Services for Elderly and Other Vulnerable Adults

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Foreword

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Robert Sherman
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Contents

List of Tables

List of Figures

Summary

At its August 2003 meeting, the Program Review and Investigations Committee directed staff to determine how adult protective services could be better coordinated. The study was conducted in two phases. The report on phase one was approved by the committee on December 17, 2003, and was updated in phase two. This phase two report incorporates the updated Chapters 1 through 3 and a new Chapter 4 that includes additional data and conclusions on information systems and funding of adult protective services.

Major Conclusions

Kentucky's adult protective services process is well designed. Any person who suspects that an adult has suffered abuse, neglect, or exploitation is required by KRS Chapter 209 to report to the Department for Community Based Services (DCBS) in the Cabinet for Health and Family Services. DCBS is required to notify law enforcement and other applicable agencies and to investigate to determine whether an adult was abused, neglected, or exploited. For providers of health services regulated by other Cabinet for Health and Family Services agencies, the agencies are required to investigate whether the providers complied with laws and regulations for care and protection. Law enforcement agencies may investigate to determine whether a crime has been committed and a person should be charged with abuse, neglect, or exploitation. Prosecuting attorneys may attempt to obtain criminal convictions.

In practice, mismatched expectations, responsibilities, and capabilities hamper the process. The public is generally unaware of its responsibility to report suspected cases of adult abuse, neglect, and exploitation, and is unaware of the services available to victims. Professionals, such as bankers, who come in contact with vulnerable adults also are generally unaware of their responsibility to report. Inadequate communication among people and information systems and a lack of dedicated funding hamper the process from beginning to end. Little training on adult protective services is mandated for DCBS social workers, law enforcement officers, prosecutors, and judicial officials. Much free information is available on state agency Internet Web sites that would be useful in conducting training courses and public awareness campaigns.

Administrative regulations for adult protective services are not as specific as the regulations for child protective services. Terminology, such as the definition of a "substantiated" finding of adult abuse, is not included in administrative regulation. In addition, DCBS exercises little direct oversight of its regional offices. The 16 regional offices operate autonomously under standards of practice issued by the central office in Frankfort. Many operating procedures to implement the standards are determined by each regional office administrator. The lack of regulatory authority for substantiating abuse and the lack of central oversight can lead to differences among regions and counties in protecting vulnerable adults. Officials of other state agencies and local advocates perceive that investigations are conducted differently among regions and counties, using

different procedures. Program Review staff noted differences among counties but were unable to determine the reasons for the differences.

In some instances, DCBS does not investigate situations that other agencies believe satisfy the criteria for investigation. When DCBS does investigate, social workers sometimes provide too little information or irrelevant information. Law enforcement officers state that the information they receive often is too general to be used by officers. In other situations, DCBS provides irrelevant information by notifying police of social work activities that are not investigations. As a result, potentially dangerous situations can become lost in the numerous notifications faxed to the police station. A phone call from the social worker to a police officer would be more efficient and effective in an emergency.

Many law enforcement officials, prosecutors, and judges are unaware of the problem or extent of adult abuse, neglect, and exploitation, or of KRS Chapter 209 and its criminal penalties. When police do investigate, the alleged perpetrator may not be charged with a crime if the officer believes the prosecutor may not pursue prosecution. If the police charge a person, the case may or may not be prosecuted and come to trial if the prosecutor believes a conviction is unlikely. Only 34 persons were convicted of crimes under KRS Chapter 209 in fiscal years 2001 through 2004.

DCBS closes a case after all available protective and other social services have been provided. Law enforcement, prosecutors, and the courts are not required to notify DCBS of the disposition of findings that were substantiated by social workers as abuse, neglect, or exploitation. DCBS has no official way of knowing whether an alleged perpetrator was identified and charged with a crime, whether the case was prosecuted, and whether the prosecution resulted in a conviction. On the other hand, DCBS does not always notify other agencies of the outcomes of its investigations.

A lack of basic communication within and among state and local agencies sometimes undermines the goal of protecting vulnerable adults from abuse, neglect, and exploitation. Three weaknesses staff noted in this study are 1) inadequate communication among people who care for and protect vulnerable adults; 2) inadequate analysis and availability of information in computer systems on people, investigations, and outcomes; and 3) inadequate communication among those computer systems.

No dedicated federal funding is provided for adult protective services. However, numerous grants from the federal government and private foundations are available and should be pursued by the Commonwealth for state and local agencies involved in the care and protection of vulnerable adults.

Recommendations

Recommendations from phase one of the study are listed below.

2.1 The Department for Community Based Services should provide better oversight and coordination of the adult protective services investigations conducted by its social workers at the 16 regional offices. This coordination should include standardized procedures for notifying law enforcement and other agencies when the social workers start an investigation.

2.2 The Department for Community Based Services' standards of practice should be revised to identify specific conditions under which the social workers must call a specified law enforcement agency or a specified law enforcement officer to explain the situation, in addition to faxing a DSS-115 form.

2.3 The Department for Community Based Services should develop a standardized DSS-115 form that provides information on the potential crime. For example, abuse of an adult by a caretaker is a violation of KRS 209.020, which is a Class B misdemeanor.

2.4 The Department for Community Based Services should assign a social services priority code to each law enforcement referral. For example, in cases of a preponderance of evidence that abuse has occurred, the case would be assigned a high priority. In cases of self-neglect, to which police would not normally be required to respond, a lower priority would be assigned.

2.5 Training on adult abuse, neglect, and exploitation should be mandatory and timely for DCBS social workers, law enforcement officers, prosecutors, and judicial officials. Training and public awareness materials should be made available to other agencies at cost.

2.6 The Cabinet for Health and Family Services and other state agencies should establish new and renewed relationships among themselves to provide training about, share information on, and promote awareness of adult abuse, neglect, and exploitation. Various state agencies have information that could be shared with other agencies to better coordinate protective services to vulnerable adults. Much information is available from CHFS and the Administrative Office of the Courts that could be shared with other organizations, including the Kentucky Sheriffs Association, the Kentucky Association of Chiefs of Police, the Kentucky Medical Association, the Kentucky Nurses Association, the Kentucky Bankers Association, the Kentucky Department for Medicaid Services, and other groups.

2.7 The Cabinet for Health and Family Services and other state agencies should establish new and renewed relationships with local agencies and advocacy groups, such as the local long-term care ombudsmen, local law enforcement agencies, bankers, attorneys, providers of nonemergency transportation services, local health departments, and local charitable and faith-based organizations. The intention of these relationships should be to share information about, provide training on, and promote awareness of adult abuse, neglect, and exploitation. State agencies should offer to make presentations, answer questions, and assist in identifying available federal grants to enhance adult protective services and in writing grant proposals.

Additional recommendations from phase two of the study are listed below.

4.1 The Office of the Governor should consider creating a unit to oversee the coordination of adult protective services in the Commonwealth. The unit should be charged with 1) facilitating communication among people who care for and protect vulnerable adults; 2) facilitating interagency staff access to information in computer systems on people, investigations, and outcomes; 3) facilitating coordination among the various computer systems; 4) identifying federal grant opportunities and coordinating interagency applications; and 5) exploring ways by which social workers and law enforcement officers can obtain information from confidential sources when investigating potential abuse, neglect, and exploitation of vulnerable adults. The unit should address the needs of all vulnerable adults, both the elderly and nonelderly, in the community and in facilities.

4.2 The Governor's Office and the Administrative Office of the Courts should implement Recommendation 2.5 and expand it to include multidisciplinary training on each agency's roles, responsibilities, and constraints in adult protective services. The training should clarify where each agency's responsibility begins and ends and how agencies can help each other in the process of protecting vulnerable adults.

4.3 Central offices of the Department for Community Based Services, State Long Term Care Ombudsman, Mental Health and Mental Retardation Services, and the Office of Inspector General in the Cabinet for Health and Family Services should research, compile, and disseminate information on best practices of local offices. The best practices should be incorporated into agencies' policies and emphasized in interagency and multidisciplinary training.

4.4 In conjunction with implementing Recommendation 2.4 regarding the use of a high-priority code in cases of a preponderance of evidence that adult abuse has occurred, the Department for Community Based Services should consider amending 922 KAR 5:070 to provide definitions of "substantiated" and "unsubstantiated" that are similar to those in 922 KAR 1:330 for child abuse cases. If DCBS decides that such a change is not advisable, an explanation should

be provided to the Program Review and Investigations Committee, the Health and Welfare Committee, and the Judiciary Committee.

4.5 The Department for Community Based Services should compile statewide and county-level data on allegations accepted for investigation and the outcomes of those investigations by type: abuse, neglect, and exploitation. The statewide and county-level data should be shared with groups such as those noted in Recommendations 2.6 and 2.7 and other groups, such as local coordinating councils.

4.6 The Cabinet for Health and Family Services and the Justice and Public Safety Cabinet should work together, in consultation with the Administrative Office of the Courts, to design and implement information system interfaces among The Workers Information System, the ASPEN Complaints/Incidents Tracking System, other related CHFS systems, and the Unified Criminal Justice Information System. The objectives should include the ability of staff working on a case in an agency to find all related cases at other agencies, security so that staff at one agency may view only information at other agencies that is permitted for their role, automated exchange of data between systems where it is found to be appropriate and efficient, case cross-checks to find current and previous involvement of victims and perpetrators with all agencies, and automated notification of changes in perpetrator status and location.

4.7 The Department for Community Based Services should dedicate more social workers to adult protective services. In conjunction with implementing Recommendation 2.5, the dedicated Adult Protective Services workers should receive mandatory and timely training on conducting investigations of adult abuse, neglect, and exploitation.

4.8 In conjunction with implementing Recommendations 2.1, 2.2, 2.3, and 2.4 on improved procedures for notifying law enforcement of an investigation, DCBS should work with law enforcement officials to determine the specific information they need and to modify the DSS-115 form accordingly.

4.9 The Cabinet for Health and Family Services should fully fund a full-time long-term care ombudsman office in every area development district each year. In coordination with implementation of Recommendation 4.1, the Governor's Office and the cabinet should explore the use of federal grants and other dedicated state money to supplement the civil monetary penalties used to fund the offices.

Chapter 1

An Overview of Adult Protective Services and This Report

Legislative intent for the protection of vulnerable adults is stated in KRS 209.090:

Legislative intent is to establish a system of protective services for adults who are unable to manage their own affairs or to protect themselves from abuse, neglect, or exploitation. Legislative intent also is to provide the services in the least restrictive way.

> The General Assembly of the Commonwealth of Kentucky recognizes that some adults of the Commonwealth are unable to manage their own affairs or to protect themselves from abuse, neglect, or exploitation. Often such persons cannot find others able or willing to render assistance. The General Assembly intends, through this chapter, to establish a system of protective services designed to fill this need and to assure their availability to all adults. It is also the intent of the General Assembly to authorize only the least possible restriction on the exercise of personal and civil rights consistent with the person's need for services, and to require that due process be followed in imposing such restrictions.

Protective services are provided by the Cabinet for Health and Family Services.

The Cabinet for Health and Family Services provides Kentucky's adult protective services. KRS Chapter 209, the Kentucky Adult Protection Act, specifies the requirements. In this study, the definition of a "vulnerable adult" is the same as the definition of an "adult" in KRS 209.020: a mentally or physically dysfunctional person 18 years of age or older who cannot manage one's own resources, carry out daily activities, or protect oneself from neglect or abuse, and who may be in need of protective services. An adult also is a person without regard to age who is the victim of abuse and neglect inflicted by a spouse. The definition of adult in this study and in KRS Chapter 209 assumes that the individual is not capable of self-protection.

KRS 209.020 states that protective services include

- investigations of complaints of possible abuse, neglect, or exploitation to ascertain whether the situation and condition of the adult warrant further action;
- social services aimed at preventing and remedying abuse, neglect, and exploitation; and
- services directed toward seeking legal determination of whether the adult has been abused, neglected, or exploited and to ensure that suitable care is obtained in or out of the home.

This study was conducted in two phases. Phase one addressed the major issues in legislative intent by describing vulnerable adults and where they live, federal and state requirements for providing protective services, the investigative process in different settings, the availability of services throughout the state, the protection of an adult's personal and civil rights, and confidentiality. The phase one report also addressed awareness of the problem of adult abuse and whether service providers, including law enforcement, receive training on adult protective services. The Program Review and Investigations Committee approved phase one of the report, comprised of early versions of Chapters 1 through 3, on December 13, 2003. Phase two of the study updated the results of phase one, focused additional attention on funding for the care and protection of vulnerable adults, and considered whether state computer systems could be used to help coordinate services. This phase two report incorporates the updated Chapters 1 through 3 and a new Chapter 4 that includes additional data and conclusions on information systems and funding of adult protective services. The committee approved the final report on November 9, 2004.

Protective services are provided to vulnerable adults who are abused, neglected, or exploited.

The cabinet's Department for Community Based Services (DCBS) provides protective services to vulnerable adults who are being abused, neglected, or exploited, as defined in KRS 209.020.

- *Abuse* is the infliction of physical pain, mental injury, or injury of an adult. The definition includes sexual, physical, and mental or emotional abuse.

- *Neglect* is a situation in which an adult is unable to perform or obtain the services necessary to maintain health or welfare; or is the deprivation of services by a caretaker, including a spouse, that are necessary to maintain the health and welfare of an adult. The definition includes self-neglect and caretaker neglect.

- *Exploitation* means the improper use of an adult or an adult's resources by a caretaker or other person for the profit or advantage of the caretaker or other person. The definition includes improper use of an adult's money, property, and other resources. Exploitation often results from intimidation of a vulnerable adult.

Acceptance of Adult Protective Services Is Usually Voluntary

Acceptance of adult protective services is voluntary except in an emergency.

Adult protective services are voluntary in most circumstances. If the adult or guardian refuses the services, the DCBS social worker may close the case or may offer general adult or preventive services. These services include providing information on and referral to other agencies and organizations that may be of assistance.

A court may order emergency protective services, but the person's liberty and rights may not be overly restricted.

In an emergency, KRS 209.100 provides for court-ordered services. If an adult lacks the capacity to consent to receive protective services or the guardian refuses the services in an emergency, emergency protective services may be ordered by a court provided that certain conditions are satisfied. If those conditions are satisfied, according to KRS 209.100(2), the court may order only those protective services it finds to be "the least restrictive of the individual's liberty and rights while consistent with his welfare and safety."

Description of This Study

How This Study Was Conducted

The Program Review and Investigations Committee voted on August 22, 2003, to have staff determine how adult protective services could be better coordinated. In conducting the study, committee staff researched laws; regulations; agency manuals; other studies and reports; training materials; model protocols; Web sites; and other documentation obtained from federal, state, and local sources on the care and protection of vulnerable adults, including funding sources and information systems.

Interviews were conducted with staff of the Cabinet for Health and Family Services, the Attorney General's Office, the Administrative Office of the Courts, the Kentucky State Police, the Kentucky Department of Corrections, the Kentucky Domestic Violence Association, the Auditor of Public Accounts, the Justice and Public Safety Cabinet's Department of Criminal Justice Training, the University of Kentucky School of Public Health, the General Assembly's Health and Welfare Committee, and the Special Advisory Council of Senior Citizens. Interviews were also conducted with representatives of local law enforcement agencies, prosecutors, and advocacy groups. Staff attended meetings of the Interim Joint Committee on Health and Welfare and the Adult Protective Services Advisory Council, which was disbanded in October 2003.

Organization of the Report

This report is organized as follows:

The remainder of Chapter 1 summarizes major conclusions from the report; describes vulnerable adults and the agencies and persons who care for and protect them; lists signs of adult abuse, neglect, and exploitation; and identifies participants in an investigation.

Chapter 2 describes the laws, regulations, and policies for the care and protection of vulnerable adults. Requirements for adult protective services are compared to the requirements for domestic violence and child protective services. Problems in adult protective services investigations are summarized from previous studies. Chapter 2 also addresses public awareness of adult abuse, neglect, and exploitation and identifies the training opportunities for participants in protective services.

Chapter 3 describes the investigation processes used by the Cabinet for Health and Family Services and law enforcement in various settings in which vulnerable adults live. Examples of actual investigations obtained from state and local agencies are used to show how the protective process is well coordinated in some cases but not so well coordinated in other cases.

Chapter 4 describes populations of vulnerable adults, communications within and among agencies involved in the care and protection of vulnerable adults, and funding of adult services.

Major Conclusions

The adult protective services process is well designed. In practice, mismatched expectations, responsibilities, and capabilities hamper the process.

The adult protective services process is well designed. Any person who suspects that an adult has suffered abuse, neglect, or exploitation is required by KRS Chapter 209 to report to the Department for Community Based Services. DCBS is required to notify law enforcement and other applicable agencies and to investigate to determine whether an adult was abused, neglected, or exploited. For providers of health services regulated by other Cabinet for Health and Family Services agencies, the agencies are required to investigate whether the providers complied with laws and regulations for care and protection. Law enforcement agencies may investigate to determine whether a crime has been committed and a person should be charged with abuse, neglect, or exploitation. Prosecuting attorneys may attempt to obtain criminal convictions.

The public and professionals who come in contact with vulnerable adults are generally unaware of their responsibility to report abuse, neglect, or exploitation. Little training on adult protective services is mandated.

In practice, mismatched expectations, responsibilities, and capabilities hamper the process. The public and professionals, such as bankers, who come in contact with vulnerable adults are generally unaware of their legal responsibility to report suspected cases of adult abuse, neglect, and exploitation and the services that are available to victims. In addition, little training on adult protective services is mandated for social workers, law enforcement officers, prosecutors, and judicial officials. Much free information is available on state agency Internet Web sites that would be useful in training and in public awareness campaigns.

Administrative regulations for adult protective services are not as specific as the regulations for child protective services. Terminology, such as the definition of a "substantiated" finding of adult abuse, is not included in administrative regulations. In addition, DCBS exercises little direct oversight of its regional offices. The 16 regional offices operate autonomously under standards of practice issued by the central office in Frankfort. Many operating procedures to implement the standards are determined by each regional office's administrator. The lack of regulatory authority for substantiating abuse and the lack of central oversight can lead to differences among regions and counties in protecting vulnerable adults. Officials of other state agencies and local advocates perceive that investigations are conducted differently among regions and counties, using different procedures. Program Review staff noted differences among counties but were unable to determine the reasons for the differences.

The Department for Community Based Services (DCBS) does not always investigate situations that others believe should be investigated. When DCBS does investigate, social workers sometimes provide too little or irrelevant information to law enforcement officers.

In some instances, the department does not investigate situations that others believe satisfy the criteria for investigation. When DCBS does investigate, social workers sometimes provide too little information or irrelevant information to law enforcement. Officers state that the information they receive is often too general to be used. In other situations, DCBS provides irrelevant information by notifying police of social work activities that are not investigations. As a result, potentially dangerous situations can become lost in the numerous notifications faxed to the law enforcement agency. A phone call from the social worker to a police officer would be more efficient and effective in an emergency.

Only 34 persons have been convicted of crimes against vulnerable adults under KRS Chapter 209 in the last four fiscal years. DCBS has no way of knowing whether an alleged perpetrator was identified and charged with a crime, whether the case was prosecuted, and whether the prosecution resulted in a conviction.

Many law enforcement officials, prosecutors, and judges are unaware of the problem or extent of adult abuse, neglect, and exploitation. Many are also unaware of KRS Chapter 209 and its criminal penalties. When law enforcement does investigate, the alleged perpetrator may not be charged with a crime if the officer believes the prosecutor may not pursue prosecution. If a person is charged by law enforcement, the case may or may not be prosecuted and come to trial if the prosecutor believes a conviction is unlikely. Only 34 persons were convicted of such crimes under KRS Chapter 209 in fiscal years 2001 through 2004.

DCBS closes a case after all available protective and other social services have been provided. Law enforcement, prosecutors, and the courts are not required to notify DCBS of the disposition of findings that were substantiated by social workers as abuse, neglect, or exploitation. DCBS has no official way of knowing whether an alleged perpetrator was identified and charged with a crime, whether the case was prosecuted, or whether the prosecution resulted in a conviction. On the other hand, DCBS does not always notify other agencies of the outcomes of its investigations.

A lack of basic communication within and among state and local agencies sometimes undermines the goal of protecting vulnerable adults from abuse, neglect, and exploitation. Three weaknesses staff noted in this study are 1) inadequate communication among people who care for and protect vulnerable adults; 2) inadequate analysis and availability of information in computer systems on people, investigations, and outcomes; and 3) inadequate communication among those computer systems.

No dedicated federal funding is provided for adult protective services. However, numerous grants from the federal government and private foundations are available and should be pursued by the Commonwealth for state and local agencies involved in the care and protection of vulnerable adults.

Vulnerable Adults

An adult may be vulnerable because of illness, injury, developmental disability, or advanced age.

An adult may become vulnerable as the result of many conditions. For example, vulnerability can arise from mental retardation, cerebral palsy, epilepsy, autism, or physical injury. Organic brain damage may develop with advanced age, from an accidental cause, from mental or physical illness, or from continued consumption or absorption of substances.

Signs of Abuse, Neglect, and Exploitation

All persons who come into contact with vulnerable adults can recognize the signs of abuse, neglect, and exploitation.

The Cabinet for Health and Family Services (CHFS) Web site lists numerous signs of abuse, neglect, and exploitation. Many signs could be identified by family, friends, physicians, nurses, home health workers, bankers, attorneys, and providers of Medicaid's nonemergency transportation services, among others. The information from the CHFS Web site can be downloaded, printed, and used free of charge by any person or group with an interest in protecting vulnerable adults. Appendix A lists the signs of abuse, neglect, and exploitation.

The presence of one or more signs does not guarantee abuse, neglect, or exploitation but does increase the probability that the vulnerable adult is a victim.

Characteristics of Vulnerable Adults

Most victims are unable to take care of themselves.

CHFS reports that nearly 7 in 10 victims of abuse, neglect, or exploitation are either unable or marginally able to take care of themselves. Research compiled by CHFS indicates that the typical adult victim of abuse, neglect, or exploitation is likely to

- be female, isolated, dependent, and/or a substance abuser;
- have a mental or physical impairment;
- live with intergenerational conflict;
- internalize blame; and
- have excessive loyalty to the abusers.

The presence of one or more of these characteristics does not guarantee mistreatment but does increase the adult's vulnerability.

Advanced age can increase vulnerability.

Another factor that can increase vulnerability is advanced age. Many elderly Kentuckians are physically frail and many have mental dysfunction. They often are the targets of financial exploitation by family, friends, and strangers, often through intimidation by the perpetrator. As the elderly population increases, the vulnerable adult population will increase. In 2000, the U.S. Census Bureau reported that Kentucky had an estimated 509,000 adults 65 and older. By 2025, the Census Bureau estimates that the number will almost double, to 917,000 adults aged 65 and older.

DCBS's Requirement To Notify Other Agencies

DCBS is required by statute to notify the appropriate law enforcement agency of all investigations. DCBS also notifies other CHFS agencies if the allegation occurs in a setting regulated by another CHFS agency. These regulatory agencies include the Office of the Inspector General, the Department for Mental Health and Mental Retardation Services, the Office of Aging Services, and the Department for Public Health. The settings include, but are not limited to, nursing facilities, personal care homes, family care homes, intermediate care facilities for the mentally retarded and developmentally disabled, certified assisted living facilities, Supports for Community Living placements, and registered boarding homes. The settings and CHFS regulators are discussed in Chapters 2, 3, and 4.

Caretakers of Vulnerable Adults

Caretakers and family members are often alleged to have caused the abuse, neglect, or exploitation of vulnerable adults.

Persons who care for vulnerable adults include doctors, nurses, nurse aides, and other paid caretakers, and may include family members, depending on the setting in which the adult lives. Often, the caretakers and families are alleged to have caused the abuse, neglect, or exploitation. DCBS social workers in 16 regional offices receive referrals and provide protective services.

Advocates for Vulnerable Adults

Advocates for vulnerable adults include spouse abuse shelters, long-term care ombudsmen, and local coordinating councils.

Vulnerable adults are served by a variety of advocates including paid personnel and volunteers. For example, the state funds a spouse abuse center in each of 16 regions and a local long-term care ombudsman in each area development district. However, all local ombudsman offices have not been fully funded for fiscal year 2005. As of October 2003, there were 30 local coordinating councils on domestic violence. Volunteers provide assistance at the spouse abuse shelters and with the ombudsman services to residents of long-term care facilities. Family groups advocate for residents in various settings.

Twenty-five local coordinating councils on elder abuse are located throughout the state, and the number is increasing. Many local coordinating councils are in the organizational phase. Program Review staff learned of only one shelter for abused elders: ElderShelter in Jefferson County, which is funded by a federal grant.

Triads coordinate efforts to reduce criminal victimization of the elderly.

A community-based council, a triad, brings together law enforcement, senior volunteers, and senior service providers to reduce criminal victimization of the elderly. These local councils design and implement programs in accordance with each community's needs and resources. The National Sheriffs' Association sponsors a National Association of Triads to provide support and training to local triads across the country. The association reports that Kentucky has 23 county-level triads: Adair, Carroll, Daviess, Fayette, Floyd, Franklin, Graves, Grayson, Hancock, Hardin, Henderson, Jefferson, McCracken, McLean, Montgomery, Ohio, Oldham, Pulaski, Taylor, Union, Warren, Webster, and Woodford.

Charitable and Faith-based Organizations

DCBS officials have stated that the help of charitable and faith-based organizations is encouraged and welcomed in addressing the needs of vulnerable adults. Other Cabinet for Health and Family Services officials have stated that their focus on regulating providers of health services does not lend itself to engaging the help of charitable and faith-based organizations, but that their input is valued.

Charitable and faith-based organizations can provide assistance.

At the local level, charitable and faith-based organizations can monitor the health and welfare of vulnerable adults in the community and be alert for signs of abuse, neglect, and exploitation. Many can also provide or arrange temporary shelter for victims. These organizations seem particularly suited to promoting awareness of the problem and the available resources in the community. Charitable organizations and members of the clergy have been recommended as participants in the local coordinating councils on elder maltreatment. At the state level, a church representative was a member of the Adult Protective Services Advisory Council before it was disbanded in 2003.

Participants in an Investigation

The potential participants in an adult protective services investigation and its resolution include CHFS agencies, local long-term ombudsmen and other advocates, law enforcement, prosecutors, and judges. An overview of the role of each participant is provided below. Details of investigative procedures are described in Chapter 3.

The public is required to notify DCBS of suspected adult abuse, neglect, and exploitation.

In addition to the participants in an investigation, the public is required to play a role by contacting the DCBS office and/or local law enforcement agencies in instances of suspected adult abuse, neglect, or exploitation. Doctors, nurses, home health workers, bankers, providers of nonemergency transportation, and any other persons who know or suspect that a vulnerable adult is being abused, neglected, or exploited are required by law to report the situation to DCBS.

Department for Community Based Services

DCBS has 16 regional offices that provide frontline services to victims.

The Cabinet for Health and Family Services' social workers in 16 regional DCBS offices are responsible for providing frontline services to alleged victims of adult abuse, neglect, and exploitation. The social workers receive complaints, determine whether to provide protective or other services, notify law enforcement when beginning and completing an investigation, and notify other agencies, as appropriate.

Other CHFS Agencies

Other cabinet agencies license, regulate, and/or operate long-term care facilities and community residential settings.

Other cabinet agencies license, regulate, certify, and/or operate long-term care facilities and certain community residential settings.

- The Office of Inspector General licenses and regulates long-term care facilities and related health-services providers, such as hospitals. The Office of Inspector General is required to determine whether facilities and other providers are complying with laws and regulations on the care and protection of vulnerable adults.
- The Department for Mental Health and Mental Retardation Services operates certain long-term care facilities. The department also certifies and monitors Supports for Community Living providers that serve vulnerable adults who do not require the services of a long-term care facility.
- The Office of Aging Services certifies assisted-living facilities.
- The Department for Public Health registers boarding homes.

The State Long Term Care Ombudsman Program in CHFS provides policy assistance for the local ombudsman in the area agencies on aging, which are located in each area development district. The local ombudsmen are available to assist residents of long-term care facilities.

Law Enforcement

Law enforcement investigates allegations and determines whether charges will be filed.

Law enforcement officials investigate to determine whether there is evidence that the crime of adult abuse, neglect, or exploitation has been committed and, if so, whether there is enough evidence to charge an alleged perpetrator. Law enforcement has the flexibility to determine whether to investigate and file charges.

Prosecutors

Prosecuting officials determine whether a case will be prosecuted.

The Attorney General's Medicaid Fraud and Abuse Control Division and Consumer Protection Division, Commonwealth's attorneys, and county attorneys prosecute persons charged with adult abuse, neglect, and exploitation. These officials have the flexibility to determine whether a case should be prosecuted.

Chapter 2

Legal Requirements, Process Problems, Training Opportunities, and Public Awareness

Chapter 2 discusses statutes, regulations, and policies for the care and protection of vulnerable adults. Problems in adult protective services are summarized from previous studies. Cooperative efforts between the Department for Community Based Services, other Cabinet for Health and Family Services agencies, the Attorney General's Office, and law enforcement agencies are described. Requirements for adult protective services are compared to the requirements for child protective services and domestic violence situations. The chapter discusses the lack of public awareness of adult abuse, neglect, and exploitation and identifies the training opportunities for participants in protective services. The chapter also discusses the vast difference between the number of cases of abuse, neglect, and exploitation that are substantiated by social workers and the number of convictions obtained. Chapter 2 concludes with seven recommendations that are intended to improve the coordination of adult protective services.

Problems Noted in Other Studies

Numerous studies have identified problems in adult protective services.

Numerous studies have identified problems in adult protective services. Some studies focused on problems faced by the protective system and its workers. Other studies focused on the victims of adult abuse, neglect, and exploitation in long-term care facilities and in the community. The results of four of those studies are summarized below.

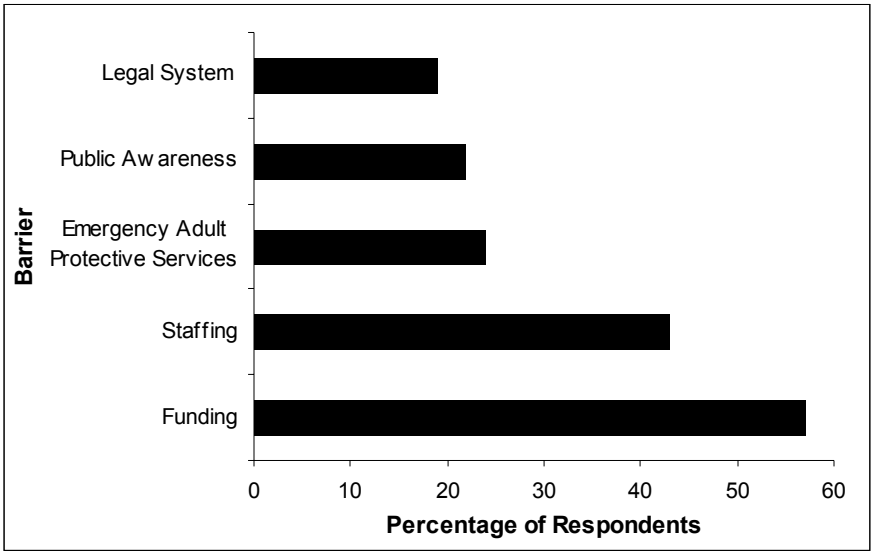
Problems Facing the Adult Protective Services System and Its Workers

In January 2003, the National Association of Adult Protective Service Administrators (NAAPSA) published the report *Problems Facing State Adult Protective Services Programs and the Resources Needed to Resolve Them.* In 2001, nine regional representatives of NAAPSA conducted a national telephone survey of the state adult protective services administrators to determine problems they were facing and the resources needed to address the problems. Forty-two states completed the survey. The report did not indicate which states responded, but a Department for

Community Based Services official said that Kentucky completed the survey.

The report identified several problems related to coordination of services. The problems are summarized below and the most frequent response categories are shown in Figure 2.A.

Figure 2.A
Barriers to Coordination of Adult Protective Services: Survey Responses From 42 State Adult Protective Services Administrators



Source: Prepared by Program Review staff from information obtained from the National Association of Adult Protective Services Administrators.

A survey of state adult protective services administrators identified several problems: a lack of funding, a lack of adequate staff, a lack of emergency resources and alternative placement resources, a lack of public awareness, and the legal system's barriers to service delivery.

- More than half the respondents identified insufficient funding at the state and federal levels as a problem. The lack of federal funds earmarked for adult protective services and the need to compete with child welfare services for reduced federal funding were cited specifically (3). KRS Chapter 209 requires the Cabinet for Health and Family Services to provide adult protective services within budgetary limitations.

- More than 40 percent of the respondents identified staffing issues as a problem. Problems included a lack of available funds for developing staff expertise in adult protective services, large caseloads, and low wages that resulted in high staff turnover (3). The DCBS central office reports that the average caseload per social worker in Kentucky is 15 cases.

- Almost a quarter of the respondents identified a lack of emergency and alternative placement resources as problems. Such resources are needed for vulnerable adults including people with physical disabilities, elderly victims of domestic violence, and people with mental health problems and developmental disabilities (4). Spouse abuse shelters that do not offer medical care may be inappropriate for elderly victims of domestic violence who have medical problems. An exception to the lack of alternative placement is the ElderShelter in Louisville.

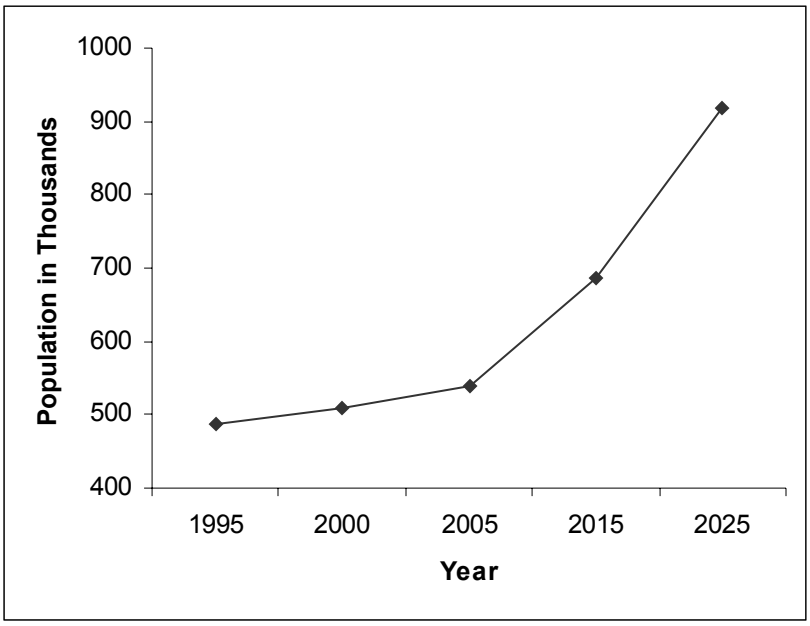
- More than 20 percent of respondents identified a lack of public awareness of adult protective services issues as a problem. Much of the general public does not understand adult abuse, neglect, and exploitation and does not know about the programs designed to address these (4). Kentucky's public awareness campaign is discussed later in this chapter.

- Approximately 20 percent of respondents stated that problems with the legal system were seen as barriers to service delivery. The problems noted in the NAAPSA study mirror issues that were noted in this study including lack of training for law enforcement staff, inadequate criminal investigations, low rates of prosecution, unwillingness of the courts to address adult protective services issues, and a lack of coordination and collaboration between adult protective services agencies and law enforcement (4).

Problems in Nursing Homes and Similar Facilities

Although there is no minimum age for admission to a nursing home, the 2002 Kentucky Annual Long-Term Care Services Report indicated that more than 90 percent of the residents in long-term care facilities in Kentucky were aged 65 and older (Commonwealth. Cabinet for Health Services. Department 171). The U.S. Census Bureau estimates that Kentucky's population 65 and older is expected to increase by 80 percent by 2025, from 509,000 in 2000 to 917,000. The growth is shown in Figure 2.B.

Figure 2.B
Projected Growth in Kentucky's
Population Aged 65 and Older



Source: Developed by Program Review staff from information obtained from the U.S. Census Bureau.

Poor quality of care in some nursing homes causes harm to residents.

According to a March 1999 U.S. Government Accountability Office (GAO) report, the poor quality of care at about one-fourth of the nation's more than 17,000 nursing homes has repeatedly caused harm to residents, such as worsening pressure sores, failure to prevent accidents, and failure to assess residents' needs and provide appropriate care (U.S. Government. *Nursing Homes* 3).

Office of Inspector General surveyors investigate quality-of-care complaints against nursing homes.

A 2003 GAO report provides more information on nursing home problems. Oversight of nursing homes is a shared federal-state responsibility. The U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services defines standards that nursing homes must meet to participate in the Medicare and Medicaid programs. The agency contracts with states to assess whether homes meet these standards through annual surveys and complaint investigations (U.S. Government. *Nursing Home Quality* 6). According to the GAO report, "Complaint investigations provide an opportunity for state surveyors to intervene promptly if quality-of-care problems arise between standard surveys" (7). Kentucky's surveys are conducted by the Cabinet for Health and Family Services' Office of Inspector General surveyors, who are nurses, dieticians, pharmacists, and social workers. These surveyors also investigate complaints of abuse, neglect, or exploitation against the facility. The Office of

Inspector General surveyor focuses on whether action needs to be taken against the facility. The Department for Community Based Services social worker, on the other hand, focuses on whether the victim needs protective or other services.

Some nursing homes cycle in and out of compliance with federal regulations.

Ensuring that documented deficiencies in nursing homes are corrected also is a shared federal-state responsibility. Based on referrals from the state, the federal Centers for Medicare and Medicaid Services imposes sanctions on homes with Medicare or dual Medicare and Medicaid certification. States are responsible for enforcing standards in homes with Medicaid-only certification. Sanctions can include requiring training for staff who provide care to residents, imposing monetary fines, denying the home Medicare and Medicaid payments for new admissions, and terminating the home from participation in these programs. Typically, federal policy allows a grace period of 30 to 60 days for a nursing home to correct an identified deficiency (U.S. Government. *Nursing Home Quality* 9). Despite the threat of federal sanctions, however, nursing homes cycled in and out of compliance and thus avoided sanctions by returning to compliance within the grace period, even when they had been cited for actual harm on successive surveys (U.S. Government. *Nursing Homes* 5).

Inexperienced surveyors can contribute to quality-of-care problems.

Inexperienced surveyors were cited as a factor that contributes to the understatement of serious quality-of-care problems. In July 2002, 51 percent of Kentucky's surveyors had two years or less of experience, and 17 percent of surveyor positions were vacant (U.S. Government. *Nursing Home Quality* 18,78). According to Kentucky's Office of Inspector General, 26 percent of surveyor positions were vacant as of September 2004.

Problems Associated With Financial Exploitation

In fiscal year 2003, DCBS investigated 1,155 cases of financial exploitation.

In July 2003, NAAPSA published the survey report *State Adult Protective Services Program Responses to Financial Exploitation of Vulnerable Adults.* The report is based on a written survey conducted in 2001. Kentucky responded to the survey. Of the 35 states that responded, 28 states said they received 38,015 reports of financial exploitation of vulnerable adults during their most recent reporting year (2). In response to an inquiry from Program Review staff, DCBS reported that in fiscal year 2003 it investigated 1,155 cases and substantiated exploitation in 150 of them.

The perpetrator's access to a victim often is the key factor in financial exploitation.

Perpetrators often obtain money from victims through intimidation, such as threatening physical harm if the person does not pay. However, perpetrators are not always after the victim's money;

property and resources are sometimes targeted. In fact, income may be less of a factor than the perpetrator's access to the vulnerable adult (National Association. *State* 7). Steps taken by responding states to address the issue of financial exploitation are described below.

Banks identify less than one-half of 1 percent of reported financial exploitation.

- Many states have multidisciplinary teams to specifically address issues of financial exploitation of vulnerable adults. These teams typically are made up of professionals in a community who review cases of alleged abuse, neglect, or exploitation and recommend solutions. Representatives of banks and other financial institutions would seem to be logical members of the teams. However, most responding states reported that banks were rarely or never represented (National Association. *State* 8). NAAPSA stated that banks reported less than one-half of 1 percent of cases of financial exploitation brought to the attention of the authorities. Kentucky's *Model Protocol for Local Coordinating Councils on Elder Maltreatment*, developed in 2002 by the Prevention, Intervention, and Coordination Subcommittee of the Elder Abuse Committee, does not include bankers on the proposed list of local council members. However, a cabinet official stated the councils have been encouraged to include local bankers as members.

Training is needed for Adult Protective Services workers and others who serve vulnerable adults.

- Adult protective services training often includes information on financial exploitation. However, the training often is provided by adult protective services workers who have little knowledge of, training in, or experience with financial exploitation (National Association. *State* 8). Of the 33 states responding to a question asking what actions would improve responses to financial exploitation, 32 stated that training for other agencies would do the most to improve exploitation investigations. The DCBS training for its social workers has not emphasized exploitation of vulnerable adults.

Problems in Supports for Community Living Settings

Lack of communication between state agencies can put vulnerable adults at risk.

The Kentucky Auditor of Public Accounts issued a performance audit report in 2002 on the Supports for Community Living (SCL) program. The report stated that a lack of communication between DCBS and other Cabinet for Health and Family Services agencies places SCL consumers at risk. SCL is a Medicaid waiver program that provides care and services to mentally retarded and developmentally disabled persons in community-based settings

rather than in institutions. Investigations in SCL settings and examples are discussed in Chapter 3.

Cooperative Efforts Among State Agencies

State agencies have entered into agreements to coordinate training and to clarify roles in an investigation.

State agencies involved in investigating allegations of adult abuse, neglect, and exploitation have entered into agreements to better coordinate their efforts. DCBS and the cabinet's Long Term Care Ombudsman have entered into a memorandum of agreement to provide training and to help ensure consistency between legal requirements and actions taken on allegations of abuse, neglect, and exploitation. DCBS and the Office of Inspector General have identified contact persons responsible for investigations.

DCBS and the Office of Inspector General have entered into a memorandum of agreement to clarify their roles in investigating and communicating about abuse, neglect, and misappropriation of resident property in nursing homes. Joint investigations are conducted when possible. In addition, quarterly meetings have been scheduled between managerial representatives from both offices to improve investigative processes and to ensure that allegations are forwarded to the appropriate agency. However, Office of Inspector General officials have stated that DCBS representatives are seldom represented at the meetings.

The Department for Mental Health and Mental Retardation Services (MHMR) has entered into an agreement with the Department for Medicaid Services and DCBS to clarify roles in investigating and communicating possible cases of abuse, neglect, and exploitation of persons in the Supports for Community Living program and programs in the Community Health Centers. DCBS workers regularly attend training offered by MHMR.

Joint training has been planned between DCBS and Office of Inspector General staff. Although DCBS stated that this training is mandatory for its staff, officials have estimated that it will take from three to five years to train all the social workers. Training is discussed in greater detail later in this chapter.

The Attorney General has entered into agreements with Cabinet for Health and Family Services agencies to clarify their roles in an investigation of adult abuse, neglect, and exploitation.

Laws, Regulations, and Policies

Many state and federal laws are relevant to adult protection.

Many state and federal laws impact elder abuse investigations, adult protective services, and coordination of services for adult victims. For example, laws govern the reporting and investigation of allegations of abuse and domestic violence; laws regulate facilities where disabled adults live; and criminal laws provide penalties for abuse, neglect, and exploitation of adults.

Federal Laws

No comprehensive federal law addresses adult protective services.

Although no comprehensive federal law addresses the provision of adult protective services, various federal laws address issues faced by vulnerable adults. The federal Older Americans Act, enacted in 1965 and reauthorized in 2000, created the federal Administration on Aging, authorizes grants for various state and community programs on aging, and funds nutrition and health promotion programs, among others (42 USC 3001-3056). The act also created the State Long Term Care Ombudsman Program and Programs for the Prevention of Abuse and Exploitation (42 USC 3058). Under KRS 205.204, Kentucky's Cabinet for Health and Family Services is designated as the state agency to administer the Older Americans Act.

Other relevant federal laws address funding of social services and protection of residents of long-term care facilities. Under 42 USC 1397, block grants to the states are authorized to provide social services aimed at "preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests." Federal regulations prescribe procedures for reporting and investigating allegations of abuse, neglect, and misappropriation of property in long-term care facilities and require states to maintain a nurse aide registry of all qualified nurse aides in the state (42 CFR §§483.13; 483.156). The state must include in the registry identifying information for each nurse aide and any state findings of abuse, neglect, or misappropriation against a nurse aide (42 CFR 483.156). KRS 216.936 expands Kentucky's registry to include home health aides. No similar registry is required for others with access to vulnerable adults, such as housekeepers and maintenance personnel employed in long-term care facilities. There is no similar registry for doctors and nurses; however, complaints can be filed with their licensing agencies.

The Elder Justice Act was introduced in the U.S. Congress in 2003 but was not enacted into law.

In 2003, the Elder Justice Act was introduced in both houses of the United States Congress (108th Congress: S. 333, H.R. 2490). The law would create Offices of Elder Justice in both the

Administration on Aging and the U.S. Department of Justice that would develop objectives, policy, and a long-term plan for elder justice programs. The Act would also establish a federal Office of Adult Protective Services and would award grants to improve training, investigation, and prosecution, as well as create "safe havens" or elder shelters for elderly victims. Neither bill was enacted into law.

Kentucky Laws

Kentucky's laws provide for the care and protection of vulnerable adults.

Kentucky has responded to the need for care and protection of vulnerable adults with specific state laws.

- KRS Chapter 209 requires any person having reasonable cause to suspect that an adult has suffered abuse, neglect, or exploitation to report or cause a report to be made to the Cabinet for Health and Family Services. Chapter 209 also requires the cabinet to investigate and to provide protective services to adults.

- KRS Chapter 403 creates protective orders and authorizes local domestic violence coordinating councils. It also requires domestic violence training for law enforcement officers and defines their duties in domestic violence situations.

- KRS Chapter 216 defines the rights of residents of long-term care facilities, including the right to be free from mental and physical abuse, and establishes requirements for the facilities and the Cabinet for Health and Family Services to protect those rights.

- KRS Chapter 216B places authority in the cabinet to license and regulate health care facilities, including long-term care facilities, hospitals, and community health facilities.

- KRS Chapter 205 requires that alleged fraud and abuse by recipients or providers in the Medical Assistance Program be reported to the Attorney General's Office. The Attorney General's Office is given authority to enforce the provisions of Chapter 205 and to prosecute all related criminal offenses.

The following section of the report discusses the requirements of KRS Chapter 209, the Kentucky Adult Protection Act, on reporting and investigating abuse, neglect, and exploitation of adults. This section also addresses some of laws relevant to domestic violence and child abuse—two societal problems that are similar to elder

abuse and that involve many comparable challenges, including raising public awareness, ensuring adequate training for providers, and coordinating services among many different agencies. Additionally, because of the many parallels between the regulatory schemes for protecting vulnerable adults and children, a review of child protective services laws and policies can provide instructive comparisons that may reveal weaknesses in adult protective services.

The Kentucky Adult Protection Act: Penalties

KRS 209.990 establishes the specific crimes and penalties for adult abuse, neglect, and exploitation. KRS 209.990 states that it is a crime for any caretaker to knowingly, wantonly, or recklessly abuse, neglect, or exploit an adult. The crimes are classified as a Class A misdemeanor or Class C or D felonies depending on the amount of money exploited or the level of intent associated with the abuse or neglect. As discussed in more detail below, any person who has reasonable cause to suspect abuse, neglect, or exploitation of an adult is required to report it. KRS 209.990 also states that it is a crime to knowingly or wantonly fail to report abuse, neglect, or exploitation of an adult as required by KRS 209.030(2).

The Kentucky Adult Protection Act: Reporting and Investigating

Kentucky law establishes requirements for reporting and investigating incidents of adult abuse, neglect, or exploitation.

Kentucky statutes establish certain requirements for reporting and investigating abuse, neglect, and exploitation of adults. KRS 209.030(2) mandates reporting of all suspected incidents of adult abuse, neglect, and exploitation to the Cabinet for Health and Family Services. The reporting requirement applies to everyone and is not limited to individuals who may encounter evidence of abuse in their professions. Under the statute, failure to report adult abuse as required is punishable as a Class B misdemeanor, which carries a penalty of imprisonment for no more than 90 days. According to the Administrative Office of the Courts, three convictions were obtained for failure to report in fiscal years 2001 through 2004.

KRS 209.030(4) requires the Cabinet for Health and Family Services to take action as soon as practical after receiving a report. The cabinet must

- notify the appropriate law enforcement agency;
- initiate an investigation of the complaint; and

- make a written report of the initial findings together with a recommendation for further action, if indicated.

KRS 209.020(9) requires the Cabinet for Health and Family Services to conduct a personal interview with the alleged victim or review the coroner's or doctor's report in cases involving a fatality as a part of any investigation. If the results of the investigation show that protective services are necessary, the law requires the cabinet to provide services within budgetary limitations unless the adult refuses them (KRS 209.030(7)).

DCBS workers report allegations to law enforcement and then initiate an investigation.

The regulations promulgated by the cabinet provide more detailed guidelines for the process (922 KAR 5:070, 922 KAR 5:090). Regulations require DCBS workers to obtain the relevant information and then prepare a written intake report on a form DSS-115. A copy of that report must then be sent to the appropriate law enforcement agency. If the reporting source claims the adult is in a state of emergency, the assigned social worker must initiate the investigation within one hour of receipt. If there is no indication of an emergency, the worker has 24 hours to initiate the investigation (922 KAR 5:070 §2). The regulations do not require a social worker to contact the alleged perpetrator and witnesses or to review relevant documents, such as police records, legal records, and financial records, but the social worker may do so (922 KAR 5:070 §3).

DCBS workers document investigative findings and may open a case if a need for services is indicated and the adult does not refuse them.

Upon conclusion of the investigation, the social worker must document the findings on a form DSS-292, maintain a written record of the investigation, and maintain any written statements or photographs. Based on the results of the investigation, a case may be opened if an adult is in need of services and does not refuse them. If a case is opened, the worker must develop a case plan and initiate it within 15 working days (922 KAR 5:070 §5, §6).

DCBS workers are required to report their findings to law enforcement and prosecutors, naming "a person with access to the victim," if applicable.

Although both the statute and regulations require social workers to notify law enforcement of initial reports of abuse, neither requires the findings to be sent to law enforcement at the conclusion of the investigation.[1] DCBS's standards of practice, however, do require social workers to provide notice of their findings to law enforcement. According to Standard of Practice 4.3.17, within 24 hours of completing an investigation, a social worker must send a Notification of Protective Services Investigative Findings

[1] 922 KAR 5:070 §7 provides that "substantiated reports of abuse, neglect, or exploitation *may* be referred for consideration for criminal prosecution." (Emphasis added.)

Reporting Form to law enforcement, the prosecutor's office, or any other regulatory agency with a legitimate interest in the case.

The same standard of practice requires that social workers provide the name, if known, "of any individual who had access to the victim at or around the time of the occurrence of adult abuse, neglect, or exploitation." Before August 2003, social workers did identify an alleged perpetrator in substantiated Adult Protective Services cases. Cabinet officials are considering a policy change to resume identifying alleged perpetrators.

Child Protective Services: Reporting and Investigating

Laws and policies on reporting and investigating allegations of child abuse provide a comparison for laws and services to protect adults.

KRS Chapter 620 governs reporting and investigating allegations of abuse, neglect, and dependency of children and provides a point of comparison for laws and services to protect adults.[2] Table 2.1 shows that the statutes and regulations for reporting and investigating allegations of child and adult abuse are similar. Both include reporting requirements applicable to everyone and make failure to report a crime. Both encourage coordination by requiring the relevant agencies to share information and provide similar guidelines for initiating investigations.

There are some differences. In child cases, DCBS must make a written report to law enforcement and the Commonwealth's or county attorney concerning the action that has been taken on an investigation within 72 hours of receipt of a report (KRS 620.040(1)(c)). In adult cases, DCBS is required to notify law enforcement of the initial report, but there is no other mandatory timeframe to make progress on an investigation, complete an investigation, or otherwise communicate with law enforcement until after an investigation is completed.

Also, child regulations require a 24-hour on-call response system and child abuse hotline. There is no similar requirement for adult abuse; however, DCBS provides the use of the 24-hour child abuse hotline for reporting allegations adult abuse. Information received from the hotline is forwarded to the appropriate county for response. Each DCBS county has a system of workers on call who can respond 24 hours a day. According to a DCBS official, if there is a report to the hotline involving an adult in an emergency situation, a social worker will respond within one hour.

[2] A dependent child is one who is under improper care, custody, control, or guardianship not due to an intentional act of the parent or guardian. KRS 600.020(16).

Table 2.1
Comparison of Selected Adult and Child Abuse Provisions

Adult	Child
Any person having reasonable cause to suspect an adult has suffered abuse, neglect, or exploitation shall report or cause oral or written reports to be made immediately to CHFS (KRS 209.030).	Any person who knows or has reasonable cause to believe a child is dependent, neglected, or abused shall immediately cause an oral or written report to be made to a local law enforcement agency or KSP, the cabinet or its representative, and the Commonwealth's or county attorney (KRS 620.030).
Failure to report is a Class B misdemeanor (KRS 209.990).	Failure to report is a Class B misdemeanor (KRS 620.990).
If the reporting source claims the adult is in a state of emergency, the investigation must be initiated within one hour. All other investigations must be initiated within 24 hours (922 KAR 5:070 §3).	If the report indicates imminent danger, the investigation shall be initiated within the hour. All other investigations must be initiated between 24 and 48 hours (922 KAR 1:330 §3).
Investigation must include personal interview (KRS 209.020(9)).	Investigation must include interview with the child (922 KAR 1:330 §3).
Allegations are substantiated if supported by a personal interview with the victim and strong evidentiary or supportive facts (Standard of Practice 4.3.14).	Allegations are substantiated if preponderance of evidence exists that abuse, neglect, or dependency was committed by the person alleged to be responsible (922 KAR 1:330).
If allegations are substantiated, notice sent to law enforcement, the Commonwealth's or county attorney's office, and other agencies with a legitimate interest (Standard of Practice 4.3.17).	If allegations are substantiated, notice of findings and a form to file an appeal are sent to the perpetrator (922 KAR 1:330 §8).

Source: Program Review staff's analysis of Kentucky Revised Statutes, Kentucky Administrative Regulations, and CHFS standards of practice.

Child abuse cases are substantiated using a "preponderance of evidence" standard. Adult cases require strong evidentiary or supportive facts to substantiate abuse.

Although child and adult abuse cases are handled similarly in the way they are reported and investigated, different standards apply for substantiating them. The child protective services regulations define "substantiated" to mean

- the perpetrator made an admission of abuse, neglect, or dependency;
- there was a judicial finding of abuse, neglect, or dependency; or
- a preponderance of evidence exists that abuse, neglect, or dependency was committed by the person alleged to be responsible (922 KAR 1:330 §1(11)).

A preponderance of evidence is evidence that is sufficient to allow a reasonable person to conclude it is more likely than not that the child was abused or neglected, or is dependent, and that the alleged perpetrator is responsible (922 KAR 1:330 §1(9)).

Adult abuse cases require strong evidentiary or supportive facts to substantiate abuse. The standard for substantiating allegations of adult abuse is set out in the cabinet's Standard of Practice 4.3.14. A substantiated finding is made as a result of one of the following conditions:

- An interview with the individual having access to the victim at or around the time of the alleged incident, if conducting the interview does not pose a threat to the victim, in which the individual admits to abusing, neglecting, or exploiting the victim; or
- A personal interview with the victim and the presence of strong evidentiary or supportive facts, such as medical evidence, observation of injuries, or witness testimony.

The adult substantiation standard is set forth in internal DCBS policy, which could be changed without notice.

The substantiation standard used in adult cases appears to require a higher standard of proof. A child case is substantiated if it is more likely than not that abuse occurred, but an adult case requires strong evidentiary or supportive facts. Additionally, because the adult substantiation standard is established in DCBS's internal policy, it could be modified without notice. Since the child substantiation standard is in administrative regulation, it could not be amended without a public hearing and a written comment period.

DCBS's procedures for adult and child cases also differ in their procedures after substantiation. As defined in the child protective services regulations, "substantiated" necessitates a finding that a particular perpetrator has committed child abuse or neglect. If an allegation of child abuse is substantiated, the worker must send notice of the findings and an appeals form to the victim's parent or guardian and to the identified perpetrator (922 KAR 1:330 §9). The alleged perpetrator may then request a hearing to appeal DCBS's findings. In an adult abuse case, there are no such provisions for identifying a perpetrator and providing a mechanism for an appeal. If abuse is substantiated in an adult case, the social worker names any individual with access to the victim at the relevant time and sends notification to law enforcement, the Commonwealth's or county attorney, and other agencies with a legitimate interest in the case.

Domestic Violence and Abuse

Domestic violence includes any violence between family members related by blood or marriage.

KRS Chapter 403 defines and addresses domestic violence—one particular type of abuse encountered by vulnerable adults. Domestic violence and abuse are defined as physical injury, sexual abuse, assault, or the infliction of fear of any of those between

family members or members of an unmarried couple (720(1)). Although domestic violence is usually thought of as violence between intimate partners, it includes violence between any family members related by blood or marriage within the second degree, including a spouse, parent, child, or stepchild (720(2)). An elderly woman who is abused by her daughter-in-law or an elderly man assaulted by his son would therefore fall within the definition of domestic violence, as would a disabled adult child injured by her mother. Domestic violence would not include residents of nursing homes assaulted by caretakers or employees in which there is no family relationship.

Adult victims of domestic violence have additional resources available to them, such as protective orders and shelter services.

Additional resources are available to assist adult victims who fall within the definition of domestic violence. KRS 403.740 states that a victim may petition the court for an emergency protective order to prohibit an abusive family member from making contact or committing further acts of abuse. The victim can also seek to have the abusive family member ordered to vacate their shared residence. KRS 403.735(3) requires that such emergency protective orders be available to victims 24 hours a day. After holding a hearing, the court can enter a more permanent domestic violence order, which can be effective for up to three years and is renewable. A violation of a protective order is a Class A misdemeanor punishable by up to 12 months in jail (KRS 403.750, 763).

Victims of domestic violence also have a safe place to go 24 hours a day. Kentucky has 16 regional domestic violence shelters and attendant programs that receive both state and federal funds. The shelters offer a secure environment for victims and have a capacity to shelter 419 persons across the state. The shelters also provide to residents and nonresidents a variety of support services, such as court advocacy, safety planning, housing assistance, support groups, and individual counseling. In addition to the 24-hour statewide abuse hotline provided by CHFS, a national toll-free domestic violence hotline also is accessible 24 hours a day with information about available shelter programs and services in each state.

Although domestic violence includes all types of family violence, domestic violence services are usually ill-suited for disabled or elderly victims.

Although domestic violence is defined to include family violence other than that between intimate partners, the additional resources available for domestic violence victims generally are ill-suited to meet the needs of disabled or frail elderly victims. Many vulnerable adults are dependent on family members for their care, may have nowhere to go, and fear placement in a nursing home. They may also be reluctant to do anything to hurt a family

member. In those situations, it is unlikely a victim would be willing to seek a protective order against the perpetrator. Even if the victim is willing, the logistical challenges of traveling to the circuit clerk's office to file the petition or traveling to court for the hearing may prove insurmountable for a disabled or frail adult.

Program Review staff talked to officials at the Kentucky Domestic Violence Association (KDVA), the statewide coalition of shelters. KDVA officials stated that, although all of the shelters are handicapped accessible, they do not have the resources to care for victims who are unable to care for themselves. Also, shelters can house a mix of residents of diverse ages and backgrounds, including young children, in a small space. Many older victims do not feel comfortable in this environment. The shelters provide counseling and advocacy for nonresidents, but most of the information and counseling provided are focused on the particular dynamics of intimate partner violence. KDVA officials noted that there has been little demand for their services from older adults. In fiscal year 2002, the shelters provided services to 14 victims older than 59 across the state. In fiscal year 2003, shelters served four victims older than 64 statewide (Kentucky. *Program Statistics 2003*, *2004*).

KRS 209.020 defines "adult" to include not only adults with a mental or physical dysfunction but also any person 18 or older who is the victim of abuse and neglect inflicted by a spouse. Therefore, the statutory reporting requirements apply regarding domestic violence victims who fall within that definition. KDVA officials stated that shelter program staff receive training on the statutory requirement to report adult abuse, neglect, and exploitation, and that they comply by reporting incidents of abuse to DCBS. KDVA statistics show that shelter programs across the state reported a total of 4,183 adults to DCBS as victims of abuse in fiscal year 2002, and 3,223 adults in fiscal year 2003 (Kentucky. *Program Statistics 2003*, *2004*). DCBS workers, likewise, can refer adult victims to shelter programs as appropriate; however, the limitations described above restrict the effectiveness of the area domestic violence programs in addressing the needs of elderly or disabled victims. DCBS workers must therefore look elsewhere for temporary housing for such victims. Kentucky has no temporary shelters for elderly or disabled victims apart from ElderServe in Jefferson County.

Domestic violence training and awareness campaigns tend to focus on intimate partner violence to the exclusion of other types of family violence.

Domestic violence training and awareness campaigns tend to focus on intimate partner violence to the exclusion of other types of family violence. For example, the certification program required

for shelter staff does not include any training specifically addressing elder abuse. Domestic violence training is statutorily required for law enforcement, prosecutors, social workers, circuit clerks, judges, nurses, primary care physicians, and other medical personnel. Interviews with the various agencies providing this training reveal that violence against elders is addressed tangentially, if at all, in domestic violence training.

Domestic violence and child abuse laws include provisions that promote awareness and coordination of services.

The child abuse and domestic violence laws include many additional statutory requirements for which there are no corresponding provisions in the adult protection statute. These provisions serve to promote awareness of child abuse and domestic violence and encourage coordination among service providers by creating entities for that purpose and by placing additional requirements on law enforcement agencies and prosecutors.

Coordination and Awareness

Kentucky has local domestic violence coordinating councils.

The Governor's Council on Domestic Violence and Sexual Assault was created to increase awareness and to plan and direct "legal, protection, and support services related to domestic violence" (KRS 403.700). KRS 403.705 authorizes the formation of local domestic violence coordinating councils to promote public awareness of domestic violence, facilitate interagency coordination, and assess service delivery. As of October 2004, there were 43 local domestic violence coordinating councils across the state. The same statute authorizes local fatality review teams to evaluate the effectiveness of local prevention efforts in the wake of a fatality.

Kentucky has local multidisciplinary teams that investigate child sexual abuse reports.

Similarly, child abuse statutes create the Kentucky Multidisciplinary Commission on Child Sexual Abuse and require that local specialized multidisciplinary teams investigate child sexual abuse reports (KRS 431.600). Commonwealth's and county attorneys are required by that statute to have a child sexual abuse specialist in their offices. Prosecutors also are required by KRS 15.727 to assist any multidisciplinary team in their jurisdictions.

A 1998 law, codified as KRS 209.005, requires the Cabinet for Health and Family Services to create an Elder Abuse Committee to develop a model protocol on elder abuse and neglect and to address issues of prevention, intervention, and agency coordination of services. The committee began meeting in December 1998. It developed a Model Protocol on Elder Maltreatment and a Model Protocol for Local Coordinating Councils on Elder Maltreatment that were completed in early 2002.

In 2002, Governor Paul Patton issued Executive Order 2002-785 and abolished the Elder Abuse Committee and created the Kentucky Commission on Elder Abuse to address many of the same issues. Under KRS 12.028, the governor may only temporarily change state government's organizational structure between sessions of the General Assembly. A temporary reorganization terminates 90 days after adjournment of the next regular session of the General Assembly.

The Elder Abuse Committee, the Kentucky Commission on Elder Abuse, and the Adult Protective Services Advisory Council no longer exist.

House Bill 242, introduced during the 2003 Session, would have amended KRS 209.005 to create the commission as outlined in the executive order. That bill did not pass and the executive order expired. Cabinet officials stated they did not reconvene the statutory committee but continued working toward similar goals with the Adult Protective Services Advisory Council, which met 10 times between July 2002 and October 2003. According to a cabinet official, the council was disbanded in October 2003 in anticipation of the election of the new administration and the reestablishment of the Elder Abuse Commission by legislation expected to pass during the 2004 Session. No such legislation was passed. Neither the commission nor the council continues to meet. Cabinet officials state they are meeting with stakeholders to discuss statutory and practice issues but no consensus has been reached as to how to proceed.

Although no statute addresses elder abuse coordinating councils, CHFS officials stated the advisory council recognized a need for them and councils began forming across the state in early 2003. There are currently 25 regional coordinating councils and more are being developed.

Law Enforcement Requirements

Kentucky's model domestic violence law enforcement policy contains little that is specific to the needs of elderly or disabled victims.

The domestic violence laws also impose additional requirements on law enforcement. KRS 403.783 requires the Justice and Public Safety Cabinet to develop a written model domestic violence policy and disseminate it to each law enforcement agency in the state. The policy must address 24-hour access to protective orders, reporting to DCBS, victim rights, and officers' assistance and service responsibilities. Each law enforcement agency must also adopt a written domestic violence policy and submit it to the Justice and Public Safety Cabinet for approval every two years. A review of the cabinet's *Model Domestic Violence Law Enforcement Policy* shows that it is broad enough in scope to apply to all types of family violence, but it contains little that is specific to the needs of elderly and disabled victims.

Law enforcement's responsibilities in domestic violence cases exceed the responsibilities in adult protection cases.

In addition to the reporting requirement discussed previously in KRS Chapter 209, KRS 403.785 sets forth an additional reporting requirement for law enforcement in domestic violence cases. The statute requires all law enforcement agencies to report "all incidents of actual or suspected domestic violence and abuse within their knowledge" to DCBS within 48 hours. The statute also specifically requires law enforcement officers who have reason to suspect domestic violence has occurred to "use all reasonable means" to prevent abuse, including remaining at the location, assisting the victim in obtaining medical treatment, and advising the victim of his or her rights.

Training

Elder abuse training is provided to some but not all service providers who play a role in the investigation and prosecution of adult abuse. DCBS social workers and the Office of Inspector General's surveyors receive training, but law enforcement officers, prosecutors, and judges typically do not.

Elder abuse training is available to some service providers but is not required for all who serve vulnerable adults and play a role in the investigation and prosecution of allegations of adult abuse.

The only service providers who receive training specifically addressing elder abuse are DCBS social workers and the Office of Inspector General's nursing home surveyors. Law enforcement officers, prosecutors, and judges do not. Below is a description of the training currently provided to the different professionals and whether the training is mandatory.

DCBS Social Workers

DCBS provides several different training courses relevant to adult abuse. The course Meeting Needs of Vulnerable Adults lasts three-and-a-half days and is required training for new social workers. The course covers both general adult services and protective services for victims of abuse, neglect, and exploitation. It is intended to prepare workers to provide services and appropriate case management and to utilize community resources. The course also includes information and advice about assessing and communicating with older adults.

Investigations in Alternate Care Settings is a one-and-a-half day training course DCBS requires for all workers who handle alternate care investigations and for staff responsible for intake referrals. Alternate care settings include nursing homes, intermediate care facilities for the mentally retarded, and personal care homes. The training is offered quarterly and is limited to 25 participants each time. The training is not well attended. DCBS officials stated they do not know how long it will take for all adult

protective services workers to receive this training since the available training slots are not being filled.

DCBS regional supervisors may delay sending social workers for mandatory training if adult abuse is not a priority in that service region.

Although DCBS describes these training courses as being mandatory, a DCBS official told Program Review staff that, in order for employees to receive training, the regional supervisors must make the decision to send their employees to the training. The official stated that there has been an uneven response to such required training. If a regional supervisor does not believe there is a problem with elder abuse in the service area, the supervisor may delay sending the employees for training. Because of DCBS's decentralized structure, regional service areas set their own priorities, and child protective services and domestic violence usually receive a higher priority than adult protective services. The region's priorities and scheduling concerns affect the regional supervisors' decisions about sending workers to training.

DCBS also offers the one-day training course Working With Adults Who Have Developmental Disabilities. This optional training is offered quarterly if enough employees enroll. According to the course description, it is intended to prepare workers to identify and assess the needs of adults with developmental disabilities; and it addresses protective services, general adult services, and alternate care services. Additionally, introductory domestic violence training courses are offered monthly and are required for all employees. According to a cabinet official, continuing domestic violence training is not currently offered.

Office of Inspector General Surveyors

Office of Inspector General surveyors must complete a federally required program that trains them to detect and prevent abuse and neglect.

Federal and state laws require periodic surveys of nursing facilities to ensure they comply with federal and state requirements. Federal regulations require the surveyors who conduct those surveys to successfully complete a training and testing program prescribed by the Centers for Medicare and Medicaid Services (CMS) (42 CFR §488.314). Office of Inspector General officials stated that Kentucky surveyors are trained through assignment to a mentor for the first six months of employment. They must also attend one week of training provided by CMS and must pass the Surveyor Minimum Qualifications Test. As part of that training, surveyors are trained to detect and prevent abuse and neglect of residents of long-term care facilities. The same federal regulation requires an individual to attend the CMS training and pass the test before serving as a survey team member.

Office of Inspector General officials stated that ongoing training is provided by central office staff to regional managers at monthly meetings and sometimes at regional training across the state. In the past, the office has provided annual training that brought together Inspector General staff, long-term care ombudsmen, long-term care facilities staff, and DCBS staff. As of October 2003, the office was unable to continue that training because of budget constraints.

Department for Mental Health and Mental Retardation surveyors attend a two-day orientation when hired and receive one-on-one training on the regulatory requirements and survey process for certifying providers of Supports for Community Living Services. The department's staff also attend joint training with DCBS and additional training on how to conduct investigations.

Law Enforcement Officers

In the past, law enforcement officers did not receive training in elder abuse.

Until 2004, no elder abuse training was available to Kentucky law enforcement officers. There are four primary sources of training for Kentucky law enforcement officers, and the content and location of that training vary somewhat depending on where the officers work. Lexington and Louisville provide independent training for their officers, as does the Kentucky State Police. All other law enforcement officers receive training from the Department of Criminal Justice Training (DOCJT), a division of the Justice and Public Safety Cabinet. Officers are required by statute to receive at least 640 hours of basic training and 40 hours of annual in-service training at a school certified by the Kentucky Law Enforcement Council.

An official with the Kentucky State Police Academy told Program Review staff that the State Police does not offer any training that specifically addresses elder abuse in basic training or in-service training. He stated that topic is addressed in more general training on sexual and physical abuse. Lexington and Louisville police officers told staff that elder abuse training is not provided to officers there but it is now offered by DOCJT as a separate topic.

Beginning in 2004, the Department of Criminal Justice Training offers a 16-hour course on elder abuse.

Beginning in 2004, DOCJT began offering a 16-hour course solely about elder abuse. According to a DOCJT official, the course was offered eight times as of October 2004, with one more course scheduled for December 2004. Although the training is not mandatory and is one of several courses from which officers may choose to fulfill their in-service training requirements, response to the training has been very positive. A DOCJT official stated that every time the course was offered in 2004 it was filled to capacity

and that approximately 250 officers will have attended the training by the end of 2004.

The training covers

- psychological and physical changes related to aging;
- communicating with older persons;
- types of abuse (physical, sexual, neglect, and exploitation);
- indicators of abuse and neglect, e.g., pattern injuries; and
- the aging services network.

DOCJT developed the curriculum with input from DCBS, and DCBS provided some materials for the training. The Bluegrass Nursing Home Ombudsman also provided information that has been incorporated into the training to teach officers about conducting investigations in a long-term care setting. The course will be offered again in 2005.

Prosecutors

Prosecutors do not routinely receive training on elder abuse.

Prosecutors receive training in several ways. The Prosecutors' Advisory Council provides training at its annual conference held each August. According to an official with the council, the two-and-a-half-day conference provides training on various topics required by statute, including child abuse and domestic violence. Specific training on elder abuse and KRS Chapter 209 is also being provided. A council official stated that elder abuse is an issue that is receiving more attention, and regular training is now being provided at the annual conference. A two-hour session on the topic is scheduled for the 2005 annual conference. Additional training on various topics is offered by the Commonwealth's and county attorney associations at their mid-winter meetings. In December 2003, the Commonwealth's Attorneys' Association offered training on elder abuse issues. Additionally, the national District Attorneys' Association recently mailed information about elder abuse to all prosecutors in the state.

Judges

Training for judges has not included elder abuse topics.

Supreme Court Rule 8.070 requires judges to attend a minimum of 25 hours of continuing judicial education courses every two years. Judges receive training from the Administrative Office of the Courts (AOC). According to an official with AOC, new judges attend a four- to five-day orientation during which the issues of guardianship and involuntary hospitalization are addressed, but the orientation includes nothing specific to elder abuse. Three-day annual training sessions for all judges also are provided. In the

past, AOC provided training on child protective services and juveniles but no specific training on elder abuse. Domestic violence training is required, but it tends to focus on other types of family violence rather than elder abuse. An official with the Cabinet for Health and Family Services stated that the cabinet has initiated discussions with the district judges' training committee about adding elder abuse training to the 2005 Judges' Conference.

A Comparison With Domestic Violence Training

In contrast to elder abuse training, domestic violence training is common.

In contrast to training on elder abuse, training on domestic violence is ubiquitous. Statutes require many different professionals to receive initial and ongoing domestic violence training. That training emphasizes intimate partner violence and includes little that specifically addresses abuse of elderly or disabled adults. Domestic violence training is statutorily required for law enforcement, prosecutors, social workers, shelter workers, circuit and deputy clerks, judges, nurses, primary care physicians, and other medical personnel (KRS 403.784; KRS 15.718; KRS 194B.530; 194B.535; KRS 30A.015; KRS 21A.170 and SCR 8.070; KRS 194A.540). Additionally, KRS 15.717 requires the Attorney General to develop a domestic violence manual for prosecutors that establishes policies and procedures for prosecuting domestic violence-related crime. According to an official with the Attorney General's Office, the manual has been developed and distributed, and it is updated every two years. A small section of the manual includes information about working with special populations, including elderly and disabled victims.

Other States

Laws that address abuse of the elderly vary among states.

All 50 states have laws that address abuse of the elderly, but they vary widely in their approaches. Some states, like Kentucky, use a single definition to cover all vulnerable adults who fall within statutory protections. Others use different terms and sometimes different protections for disabled adults 18 and older and for elders, defined as being 60 years old and older in some states and 65 and older in others.

In most states, only certain categories of professionals are required to report suspected abuse and neglect.

According to the National Center for Victims of Crime, most states require reporting of suspected abuse and neglect (National Center). In most states, only certain categories of professionals are required to report, but in several states, like Kentucky, any person who suspects abuse or neglect has a duty to report it (American Bar Association). Many states' statutes provide penalties for failure to

report and immunity from civil suits or prosecution for those who make reports "in good faith" (National Center). Kentucky's statute confers immunity from civil or criminal liability for "anyone acting upon reasonable cause" (KRS 209.050).

Some states use the age of an elderly victim as a criterion at sentencing.

States' criminal laws also vary greatly in their treatment of crimes against the elderly. Some states use special classifications for elderly victims in their general criminal codes (National Center). For example, Iowa and Oregon include age of the victim as one of the characteristics that can classify a crime as a hate crime. Kentucky's hate crime statute does not include age as a qualifying characteristic (KRS 532.031). Some states' statutes enhance the sentence imposed on an offender when the victim is elderly, and others consider a victim's advanced age as a factor to be considered at sentencing.

Judges and court staff in some states have been trained on elder abuse.

Some states have provided training on elder abuse to their judges and court staff. For example, the American Bar Association Commission on Legal Problems of the Elderly and the National Association of Women Judges created a curriculum for training judges and court staff on elder abuse; seven states have used it to train their judges and court staff (Stiegel 2000).

Charges and Convictions in Cases of Adult Abuse, Neglect, and Exploitation

The Administrative Office of the Courts reported charges, cases tried, and convictions obtained under KRS Chapter 209.

Program Review staff requested and received a report from AOC on the number of charges, cases tried, and convictions obtained under KRS Chapter 209 for fiscal years ending June 30, 2001, 2002, 2003, and 2004. AOC reports this information statewide and by county. The report can be used as a gauge of the extent of prosecution and conviction of alleged perpetrators of adult abuse, neglect, and exploitation. The report does not necessarily include all charges and convictions because some alleged perpetrators may be tried for another crime at the prosecutor's discretion, such as assault or theft by deception.

In the AOC report, *charges* consist of all original and amended charges within a case. A *case* may consist of one or multiple charges. For example, a case against one person may consist of a charge of abuse and two charges of exploitation. Table 2.2 summarizes the AOC report.

Table 2.2
Statewide Charges, Cases, and Convictions
Under KRS Chapter 209

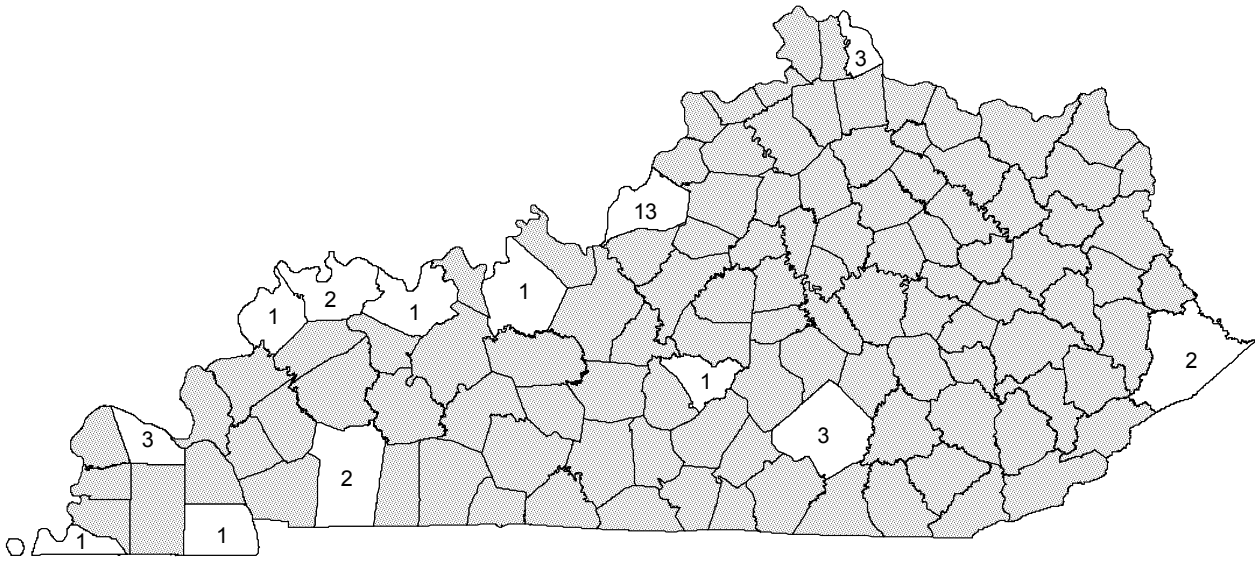
Fiscal Year	Charges	Cases	Case Convictions
2001	41	31	8
2002	130	69	12
2003	109	72	7
2004	171	113	7
Totals	451	285	34

Source: Developed by Program Review staff from information obtained from the Administrative Office of the Courts.

In the four-year period ending June 30, 2004, only 34 people were convicted of crimes under KRS Chapter 209.

In the four-year period ending June 30, 2004, only 34 people were convicted of crimes under KRS Chapter 209. Three of the convictions were for failure to report abuse, neglect, or exploitation. In fiscal year (FY) 2001, 8 of 31 people prosecuted were convicted. In FY 2002, 12 of 69 people prosecuted were convicted. In FY 2003, 7 of 72 people prosecuted were convicted. In FY 2004, 7 of 113 people prosecuted were convicted. The number of convictions by county over fiscal years 2001 to 2004 is shown in Figure 2.C.

Figure 2.C
Convictions of Adult Abuse, Neglect, and Exploitation by County,
Fiscal Years 2001 to 2004



Source: Prepared by Program Review staff from information obtained from the Administrative Office of the Courts.

Thirteen of the 34 convictions were obtained in Jefferson County.

Of the 34 convictions through FY 2004, 13 were in Jefferson County. The higher rate in Jefferson County could be attributed to a good working relationship between DCBS social workers, the police, and prosecutors, as indicated by interviews with DCBS staff, local police, and the prosecutor's office. The remaining 21 convictions occurred in 12 counties as shown in the figure.

In fiscal year 2003, DCBS substantiated 1,100 incidents of adult abuse, neglect, and exploitation.

The number of charges, cases, and convictions appears small in and of itself. The number appears extremely small in comparison to the number of instances substantiated by DCBS in a year. Program Review staff received a report from DCBS showing that almost 15,000 cases of adult abuse, neglect, and exploitation were investigated in FY 2003. This number does not include spouse abuse, partner abuse, and self-neglect. DCBS substantiated 1,100 of the incidents, for a substantiation rate of 7.5 percent. DCBS officials have stated that social workers do not substantiate enough allegations. If the actual number of instances of abuse, neglect, and exploitation exceeds 1,100 a year, the conviction rate would be even smaller.

The use of reports from the Administrative Office of the Courts, training programs, and public awareness campaigns could help increase the number of charges and convictions.

Reports from AOC could be used by law enforcement, prosecutors, and judges to identify potential problem areas. A lack of understanding of KRS Chapter 209 could contribute to the low number of charges and convictions. The 34 convictions were obtained in 13 counties, which means that about 10 percent of Kentucky's counties obtained convictions and 90 percent did not. Training for law enforcement officers, prosecutors, and judges may help address the issue. More public awareness of the problems of adult abuse, neglect, and exploitation would also alert Kentuckians to their legal responsibility to report and motivate them to report suspected problems.

Public Awareness

Cabinet for Health and Family Services agencies participate in a number of initiatives to promote public awareness of adult abuse, neglect, and exploitation. Examples include working better together within the cabinet and with local coordinating councils and triads.

The Kentucky Elder Abuse Awareness Campaign can promote awareness by all persons who come in contact with vulnerable adults.

An innovative and inexpensive initiative is the Kentucky Elder Abuse Awareness Campaign. The campaign makes use of cabinet funding and publicly and privately donated services.

Brochures, videotapes, television spots, radio spots, and other information have been obtained or developed. The estimated cost to the state through fiscal year 2003 was just more than $10,000. Donated costs were estimated at more than $180,000. The campaign has five stated goals, which are described below, with examples of the accomplishments for each goal.

Alerting Senior Citizens

A free brochure and poster are available on the Cabinet for Health and Family Service's Web site to alert senior citizens to their rights and roles.

The goal is to alert older Kentuckians to their rights and their roles in avoiding financial, physical, and emotional abuse. A brochure and poster for nursing home residents and their families have been developed. The estimated cost to the Cabinet for Health and Family Services to print and distribute the brochure and posters is about $7,000. These materials are free on the cabinet's Web site to any interested person or group. The brochures and posters could be widely used by local coordinating councils, triads, and charitable and faith-based organizations.

Informing the Public

The goal is to inform the public that elder abuse, exploitation, and neglect really do happen in Kentucky and that everyone has a legal obligation to report it if suspected. Examples of accomplishments, plans, and other potential uses are as follows:

Media attention to the problem of elder abuse has been provided free of charge.

- WAVE-TV in Louisville has produced and aired free of charge short spots on elder abuse. WAVE-TV also produced, at its own expense, videotapes and scripts that the Cabinet for Health and Family Services sent to additional television stations in each of the other Kentucky television markets to edit for their own use. Excluding the cost of air time, the cabinet estimated that the donated costs for the television spots were about $6,000. The cost to the cabinet was only $27. Officials stated that information on how to order the videos would be posted to the cabinet's Web site. The video can be viewed on the Web site, but there is no information for ordering it. If the videotape were available, local coordinating councils, triads, ombudsmen and other advocates, and charitable and faith-based organizations could encourage local television stations to air the information.

The Cabinet for Health and Family Services has obtained a videotape on elder abuse that could be distributed at cost.

- *Unheard Cries* is a 17-minute videotape that describes different types of elder abuse. Cabinet for Health and Family Services officials stated that the video would be distributed on request to Kentucky citizens and community groups, local coordinating

councils, each DCBS service region's training coordinator, and cable television and public access stations. The videotape was originally produced by the Tennessee Department of Human Services at a cost of $35,000. The cost to the cabinet to obtain, edit, and copy the tape has been less than $6,000. Cabinet officials stated that information on how to order the video would be posted to the Web site. The video can be viewed on the Web site, but there is no information for ordering it. If the videotape were available, local coordinating councils, triads, ombudsmen and other advocates, and charitable and faith-based organizations could use it as a training and public awareness aid. The cabinet could provide the videotape to these organizations at its cost.

A free brochure on how to identify abuse and neglect is available on the cabinet's Web site.

- A 16-page brochure, *20 ways YOU can help prevent elder abuse*, has been posted to the cabinet's Web site. The brochure focuses on, among other things, how to identify abuse and neglect, how to recognize the signs of abuse, how to be a good neighbor, and when suspicions should be reported. Cabinet officials estimated that printing costs for 150,000 copies would be almost $22,000. The cabinet is seeking funding. However, the brochure is available at no cost on the cabinet's Web site. Local coordinating councils, triads, ombudsmen and other advocates, and charitable and faith-based organizations could use this free brochure as a training and public awareness aid.

Training Other Professionals

The goal is to train medical, law enforcement, legal, and financial professionals to identify and report cases of abuse and neglect. Examples of accomplishments, plans, and other potential uses are as follows:

The Cabinet for Health and Family Services has obtained a videotape on police investigations of elder abuse. The tape could be distributed at cost.

- *Roll Call*, a 12-minute police education videotape on handling elder investigations and reports, has been mailed to 625 small local police and sheriff's departments. Cabinet for Health and Family Services officials reported that the Lexington Division of Police has begun using the videotape in its training program and that the Kentucky State Police domestic violence instructor is using the video in cadet training. Local coordinating councils, triads, ombudsmen and other advocates, and charitable and faith-based organizations could encourage local law enforcement agencies to order and use the videotape as required viewing for all officers. In addition, the videotape could be used by the Department of Criminal Justice Training.

The Cabinet for Health and Family Services could provide the videotape to these organizations at its cost.

The cabinet has obtained a videotape to train bank staff on financial exploitation. The tape could be distributed at cost.

- *Preventing Elder Financial Exploitation: How Banks Can Help* is a 24-minute videotape to train staff of financial institutions to spot and handle exploitation of the elderly. Cabinet officials stated that 365 copies would be made and sent to DCBS training coordinators, the Bluegrass Bankers Association, the Kentucky Bankers Association, local coordinating councils, and to local area agencies on aging on request. The video can be viewed on the Web site, but there is no information for ordering it. Local coordinating councils, triads, ombudsmen and other advocates, and charitable and faith-based organizations could encourage local bankers and other financial service professionals to order and use the tape as required viewing for their personnel. The cabinet could provide the videotape to these organizations at its cost.

Informing and Training Service Workers

The free brochure on identifying abuse and neglect could be used to train service workers, including providers of nonemergency transportation services.

The goal is to inform and train service workers, such as telephone and cable installation and repair employees, grocery and pharmacy employees, postal carriers, sanitation staff, meter readers, and cab drivers, to be alert to signs of abuse or neglect. This goal could be accomplished in part by incorporating the help of Medicaid's providers of nonemergency transportation services. Cabinet officials have stated that nothing had yet been done to accomplish this goal. However, distribution of the brochure *20 ways YOU can help prevent elder abuse* could alert drivers who have frequent contact with vulnerable adults to the signs of abuse, neglect, and exploitation. Local coordinating councils, triads, ombudsmen and other advocates, and charitable and faith-based organizations could encourage local employers to download the brochure and use it for training their personnel. The brochure is available free of charge on the cabinet's Web site.

Informing Young Kentuckians

A free coloring book is available on the Cabinet for Health and Family Service's Web site to teach children to protect elders.

The goal is to teach some of Kentucky's youngest citizens to treasure and protect their grandparents and other elders. The Cabinet for Health and Family Services designed a 20-page coloring book to accomplish this goal, and officials stated that a potential sponsor had been found to fund publication of 150,000 of the books. However, the pages of the coloring book are available free to any interested person or group on the cabinet's Web site. The coloring books could be widely used by local coordinating councils, triads, and charitable and faith-based organizations.

Recommendation 2.1

The Department for Community Based Services should provide better oversight and coordination of the adult protective services investigations conducted by its social workers at the 16 regional offices. This coordination should include standardized procedures for notifying law enforcement and other agencies when the social workers start an investigation.

Recommendation 2.2

The Department for Community Based Services' standards of practice should be revised to identify specific conditions under which the social workers must call a specified law enforcement agency or a specified law enforcement officer to explain the situation, in addition to faxing a DSS-115 form.

Recommendation 2.3

The Department for Community Based Services should develop a standardized DSS-115 form that provides information on the potential crime. For example, abuse of an adult by a caretaker is a violation of KRS 209.020, which is a Class B misdemeanor.

Recommendation 2.4

The Department for Community Based Services should assign a social services priority code to each law enforcement referral. For example, in cases of a preponderance of evidence that abuse has occurred, the case would be assigned a high priority. In cases of self-neglect, to which police would not normally be required to respond, a lower priority would be assigned.

Recommendation 2.5

Training on adult abuse, neglect, and exploitation should be mandatory and timely for DCBS social workers, law enforcement officers, prosecutors, and judicial officials. Training and public awareness materials should be made available to other agencies at cost.

Recommendation 2.6

The Cabinet for Health and Family Services and other state agencies should establish new and renewed relationships among themselves to provide training about, share information on, and promote awareness of adult abuse, neglect, and exploitation. Various state agencies have information that could be shared with other agencies to better coordinate protective services to vulnerable adults. Much information is available from the Cabinet for Health and Family Services and the Administrative Office of the Courts that could be shared with other organizations, including the Kentucky Sheriffs Association, the Kentucky Association of Chiefs of Police, the Kentucky Medical Association, the Kentucky Nurses Association, the Kentucky Bankers Association, the Kentucky Department for Medicaid Services, and other groups.

Recommendation 2.7

The Cabinet for Health and Family Services and other state agencies should establish new and renewed relationships with local agencies and advocacy groups, such as the local long-term care ombudsmen, local law enforcement agencies, bankers, attorneys, providers of nonemergency transportation services, local health departments, and local charitable and faith-based organizations. The intention of these relationships should be to share information about, provide training on, and promote awareness of adult abuse, neglect, and exploitation. State agencies should offer to make presentations, answer questions, and assist in identifying available federal grants to enhance adult protective services and in writing grant proposals.

Chapter 3

Investigations by State and Local Agencies

The Department for Community Based Services focuses on the victim. Law enforcement focuses on the alleged perpetrator. The Office of Inspector General and Department for Mental Health and Mental Retardation Services focus on facility and provider compliance.

KRS Chapter 209 requires the Cabinet for Health and Family Services and local law enforcement to be notified of all cases of suspected adult abuse, neglect, or exploitation. The cabinet's Department for Community Based Services focuses its investigation on the victim and offers services when abuse is substantiated. Local law enforcement determines whether a crime occurred and, if so, pursues arrest of the alleged perpetrator(s).

The roles of the cabinet's Office of Inspector General and Department for Mental Health and Mental Retardation Services are focused on facility and provider compliance. They determine whether facilities or providers, by not complying with certification or licensure regulations, contributed to suspected abuse, neglect, or exploitation. The Office of Inspector General also is responsible for reporting substantiated instances of abuse, neglect, and misappropriation of resident property by nurse aides to the federally required nurse aide registry.

The Role of the Department for Community Based Services in Adult Protective Services

DCBS leaves much discretion to its regional offices.

Figure 3.A shows that DCBS has 16 service regions, each with a regional office and county offices. The regional offices are decentralized from the DCBS office in Frankfort. Unlike other agencies, such as the Office of Inspector General, DCBS leaves much discretion to its regional and county offices.

Figure 3.A
Department for Community Based Services' Regions

Source: Created by LRC staff using information provided by the Cabinet for Health and Family Services.

DCBS's Investigative Process

Regional DCBS social workers perform the investigations of alleged abuse, neglect, and exploitation using standards of practice provided by the cabinet.

Regional DCBS social workers perform the investigations of alleged abuse, neglect, and exploitation using standards of practice provided by the cabinet. The standards state that the purposes of DCBS investigations are to

- determine through personal contact whether alleged abuse, neglect, or exploitation of an adult has occurred;
- assess the need for adult protective services;
- provide protective services upon request, acceptance, or court order; and
- distribute investigative findings that may help various state agencies in the performance of their duties and the protection of the alleged victim.

Acceptance Criteria for Investigation. Allegations of adult abuse, neglect, and exploitation come to DCBS from many sources, typically from family members, law enforcement personnel, and nursing home ombudsmen.

Social workers must determine whether an allegation meets the criteria for investigation.

After taking a report of an allegation, DCBS social workers must determine whether the allegation meets the criteria for investigation. Table 3.1 illustrates the conditions under which a social worker may reject a report for investigation.

Table 3.1
Conditions Under Which a Report of Adult Abuse, Neglect, or Exploitation May Be Rejected for Investigation by DCBS

- The alleged victim is younger than 18 and not married to the person having access to the victim at the time of the alleged abusive incident.
- The alleged victim is cohabiting and younger than 18.
- There is insufficient information to locate the adult.
- A specific act of abuse, neglect, or exploitation is not alleged.
- The referral source reports generalized feelings of concern regarding the welfare of the adult but does not state specific allegations that reflect abuse, neglect, or exploitation.
- The referral source reports that an adult is improperly dressed for some activities, but the clothing deficiency does not result in harm to the well-being of the adult.
- The referral source reports that the caretaker provides nutritious food irregularly or in insufficient amounts but there is not impairment in the health of the adult.
- The referral source reports inadequate hygiene conditions that, although not optimal, do not adversely affect the well-being of the adult.
- The referral consists of reports of threats or attempts to commit suicide.
- Adult's right to self-determination and lifestyle issues are compromised with no allegation of abuse, neglect, or exploitation.
- The report alleges only a "verbal argument" between married or cohabiting partners.
- The report concerns a situation or specific incident investigated in the past 30 days and no new or additional information or change in the adult's circumstances is communicated by the reporting source.

Source: Prepared by Program Review staff from information obtained from the Cabinet for Health and Family Services.

When a report does not meet the criteria for investigation, the social worker must give the person who made the report information on community resources that may be of assistance.

When a report does not meet the DCBS criteria for investigation, the social worker must give the person who made the report information on community resources that may be of assistance. For example, if a report was rejected because the caretaker is feeding the adult insufficient amounts of food due to a lack of money but this practice has not resulted in health impairment, the social worker may refer the individual to local food banks.

The social worker would then complete a referral-source screen in DCBS's database, The Worker's Information System. This database is discussed in Chapter 4 of this report.

The department is required to notify local law enforcement of any incident of suspected adult abuse, neglect, or exploitation.

Notification of Other State Agencies and Local Law Enforcement. When a report meets the criteria for investigation, social workers are required to notify law enforcement and other state agencies that have a legitimate investigative interest. KRS Chapter 209 requires the department to notify local law enforcement of any incident of suspected adult abuse, neglect, or exploitation. The standards of practice state that law enforcement and other agencies must be contacted by faxing a DSS-115 form. An example of a DSS-115 form provided to Program Review staff by the department is included as Appendix B.

Program Review staff found inconsistencies in the reporting forms sent to the Office of Inspector General from the regional DCBS offices.

Program Review staff reviewed a sample of the forms received by the Office of Inspector General's regional offices from DCBS's regional offices. Program Review staff noted inconsistencies in the reporting forms sent to the Office of Inspector General from the regional DCBS offices:

- DCBS regional offices were using forms with different formats;
- The Office of Inspector General received notification of reports that were general adult services rather than investigations; and
- The Office of Inspector General received notification of reports that did not occur in long-term care facilities.

The different types of forms and unrelated information sent to the Office of Inspector General by the department are indicative of the varying practices by regional offices. For instance, the Office of Inspector General received a reporting form from a DCBS office regarding a man who had been hospitalized four times in three weeks. He lived in the community and had asthma, bronchitis, diabetes, and alcoholism. An emergency room doctor had requested that social workers follow up with the patient at his home after release. According to the department's own standards of practice, the Office of Inspector General should not have been notified of this referral because it was not accepted by DCBS for investigation and the man did not live in a long-term care facility. Implementing Recommendation 2.1 would help alleviate this problem.

The social worker must initiate the investigation within one hour of receipt of the report when an individual is substantially at risk of death or immediate serious physical harm.

Components of a DCBS Investigation. Unlike other state agencies that investigate facility and provider compliance, DCBS has a shorter time frame to begin an investigation of alleged adult abuse, neglect, or exploitation. If a referral presents a substantial risk of death or immediate serious physical harm, the social worker must initiate the investigation within one hour of receipt of the report. Other investigations should be initiated within 24 hours.

When applicable, the social worker must interview the alleged victim or the alleged victim's guardian, family members and neighbors, witnesses, physicians and other medical personnel, residents in alternate care facilities, court personnel, law enforcement personnel, and individuals with access to the victim at or around the time of the alleged occurrence.

In 2003, the department ended the practice of naming an alleged perpetrator.

In August 2003, the department changed its standards of practice. Rather than naming an alleged perpetrator, the report names persons with access to the alleged victim. By contrast, state regulations require that a perpetrator be named in a child abuse investigation.

The social worker must also review records pertinent to the investigation, typically mental and physical health records, financial records, and law enforcement and court records.

To clarify how an investigation proceeds, an example of an actual case of exploitation and psychological abuse is described below. This example was provided to Program Review staff and is reprinted verbatim. The Department for Community Based Services considers it an investigation that was well coordinated with local law enforcement.

A Case of Exploitation and Psychological Abuse

In the fall of 2001, a woman called the Elder Abuse Hotline voicing concern that a construction company owner was exploiting her 80-year-old neighbor. The case was assigned to an Adult Protective Services (APS) worker in Warren County for investigation.

The APS worker, always accompanied by a law enforcement officer, made numerous nighttime visits to the 80-year-old to investigate the circumstances. She often seemed frightened and confused by their visits, but the presence of a uniformed officer seemed to calm her enough to tell her story.

The victim said she first met the perpetrator when he knocked on her door several months earlier and offered to tear down a small deteriorating out-building behind her house for a small fee. He tore down the building, but he didn't stop there.

Taking advantage of her confusion, he got her to sign over the deed to her house and to give him her Power of Attorney. With these two documents, he relegated her to three rooms at the back of the house, even blocked any entrance from her area to the front part of the house, which he remodeled into a fine office for his construction company. He put up a high fence, topped with barbed wire, around her back yard so he could store his equipment there, and charged a set of new tires and numerous other items to her credit cards.

The construction company owner was indicted in January 2002 and convicted three months later on two counts of felony theft by deception. He was given five years' conditional discharge and ordered to pay $39,543 in restitution and stay out of Warren County.

Because she had no family, the woman was placed in emergency state guardianship and her home and property were sold to pay off the thousands of dollars the man took from her. She was placed in a retirement home, then in a nursing home where she resides today.

Under the facts outlined above, the social worker should interview the woman who called in the referral, the alleged victim, the construction company owner, neighbors, witnesses, and bank officials. The social worker should also review the victim's health and financial records and the construction company owner's criminal history.

An allegation is substantiated or unsubstantiated based on an investigation.

In this example, exploitation and psychological abuse were substantiated by the social worker. An allegation is found to be substantiated or unsubstantiated as a result of the department's investigation. The definitions are as follows.

- *Substantiated*: A social worker has determined that an adult is the victim of abuse, neglect, or exploitation as a result of an individual with access admitting abusing,

neglecting, or exploiting the victim; or the presence of strong facts, such as medical evidence, observation of injuries, or witness testimony.

- *Unsubstantiated*: Contact with the alleged victim reveals no evidence or indicators to substantiate abuse, neglect, or exploitation, or the location of the adult is known but attempts at contacting or conducting a personal interview with the alleged victim have been unsuccessful.

The Department for Community Based Services sends a notification of investigative findings to law enforcement and various agencies upon the completion of an investigation.

Available Adult Protective Services

When an allegation is substantiated, social workers must offer the victim protective or preventive services.

When abuse, neglect, or exploitation is substantiated, the social worker must offer the victim necessary protective or preventive services. If the victim does not refuse services, the social worker must develop a case plan that has individual objectives for prevention and safety within 15 working days.

Sometimes the victim is placed in an alternate care setting.

In many cases, adult protective services include placement in alternate care settings, such as group homes, family care homes, and nursing homes. The social worker may provide family members with information on Supports for Community Living placements, nursing homes, and other care settings. The social worker may assist in placing an individual in an alternate care facility by identifying vacancies in facilities with the appropriate level of care and by suggesting pre-placement visits by the family to the facilities. Social workers may also arrange transportation for the victim to the alternate care facility.

The Role of Law Enforcement in Adult Protection

Law enforcement officials were interviewed about investigations and related issues.

Program Review staff interviewed several law enforcement officials representing police chiefs, local police officers, sheriffs, state police, state and local detectives, and the Justice Cabinet's Department of Criminal Justice Training. Staff asked law enforcement officials about their role in adult protective services investigations, the use of the DSS-115 forms sent to them by local DCBS offices, available training on adult abuse, relationships with prosecutors, and their opinions on deficiencies in the system.

The Relationship Between Law Enforcement and Adult Protective Services

If law enforcement gets the call first, officers investigate and notify the department, when appropriate.

When law enforcement receives a call of alleged abuse, neglect, or exploitation of a serious nature, officers are sent to the scene immediately. Officers interview the alleged victim, alleged perpetrator, and anyone else involved. The officers fill out a police report and forward it to their supervisor. The supervisor decides whether to approve the report and contact the local Department for Community Based Services office. The law enforcement officials interviewed by Program Review staff said that DCBS is contacted within 24 hours.

In Louisville and Georgetown, law enforcement and the local DCBS office communicate regularly by telephone.

The Louisville area is considered by some to be a model of cooperative effort between law enforcement and the Department for Community Based Services. Interviews by Program Review staff revealed a high level of cooperation in the Georgetown area, as well. In Louisville and Georgetown, law enforcement and the local DCBS office communicate regularly by telephone.

The Louisville Metro police department also has a Crimes Against Seniors Unit.

Unlike other parts of the state, Louisville Metro has a Crimes Against Seniors Unit in the police department, funded by a federal grant. The unit has five full-time detectives trained in and dedicated solely to crimes against seniors. Implementing Recommendation 2.7 would help other parts of the state establish similar crime units.

Officers in the Crimes Against Seniors Unit talk regularly with the DCBS social workers about cases of a criminal nature. The social workers call detectives immediately when they suspect a crime has been committed.

The Use of DSS-115 Forms by Law Enforcement

Social workers are required by department policy to fax a notification form to law enforcement.

KRS Chapter 209 requires the Cabinet for Health and Family Services to notify local law enforcement agencies of suspected adult abuse, neglect, or exploitation. The Department for Community Based Services' standards of practice require social workers to fax a DSS-115 form to local law enforcement notifying the police of reported allegations of adult abuse.

The law enforcement officials interviewed by Program Review staff did not find the DSS-115 forms to be very helpful. Two law enforcement officials told Program

Review staff that there was too much paperwork and many of the DSS-115 forms were just placed in file cabinets. This situation could be alleviated if Recommendations 2.2, 2.3, and 2.4 were implemented.

Several law enforcement officials stated that when a social worker felt a crime had been committed, a phone call would be much more effective than a faxed form.

Several law enforcement officials stated that when a DCBS social worker felt a crime had been committed, a phone call would be more effective than a faxed form. Some law enforcement officials in Louisville and Georgetown agreed that a phone call is more effective. A former Louisville Metro law enforcement officer also told Program Review staff that the Crimes Against Seniors Unit does not need to be informed of self-neglect because the unit does not investigate these cases.

Lack of Training and Awareness in Law Enforcement Agencies

Law enforcement officials believe major barriers to effective adult protection include a lack of awareness of the problem and a lack of training.

Law enforcement officials told Program Review staff that a lack of awareness of the problem of adult abuse, neglect, and exploitation, and a lack of related training programs are major barriers for law enforcement. The officials interviewed said that police officers receive a great deal of training on domestic abuse and child abuse but lack training on adult and elderly abuse.

A representative with the Justice and Public Safety Cabinet's Department of Criminal Justice Training said that the agency has worked with DCBS and the Nursing Home Ombudsman Agency of the Bluegrass to develop law enforcement training on elder abuse. The training is expected last approximately 16 hours and be offered eight times during 2004.

Training on elder abuse is not mandatory for police officers, but the training has been well attended.

The training on elder abuse is not mandatory for police officers. Police officers are required to have 40 hours of in-service training each year, and officers can choose 32 of the 40 hours of training they receive. Many law enforcement officials worried that officers would not take the elder abuse training because it may not be perceived to be as interesting as training on homicides or narcotics. However, the elder abuse training has been well attended by police officers so far.

Lack of Prosecution

Law enforcement officials are frustrated over the lack of prosecution in adult abuse, neglect, and exploitation cases.

Law enforcement officials expressed frustration over the lack of prosecution in adult abuse, neglect, and exploitation cases. Several officials interviewed by Program Review staff said they did not know of a single case of elder abuse in their areas of the state that had been prosecuted. Those interviewed said that the few cases that are pursued are often prosecuted under other offenses in the penal code, such as assault, criminal abuse, or theft by unlawful taking, rather than under the KRS Chapter 209 penalty section.

Proposed Solutions

Law enforcement officials said social workers should call when they think a crime has been committed.

Law enforcement officials offered ideas on how to improve coordination between local police and the Department for Community Based Services. First, a phone call rather than a fax from the social worker when a crime has allegedly been committed would expedite the process of getting law enforcement involved. This action would require all social workers to know what does and does not constitute a crime. Implementing Recommendation 2.2 would help accomplish this solution.

Awareness of and training on KRS Chapter 209 and how to recognize adult abuse, neglect, and exploitation were also frequently offered as ways to improve coordination between police and social workers. Many law enforcement personnel said that such training would be helpful to all police officers since it is the officer on patrol or the responding officer who may benefit the most from knowing the signs of elder abuse, neglect, and exploitation and the applicable law. Implementing Recommendation 2.5 would help accomplish this solution.

Law enforcement officials said officers specializing in adult abuse would be helpful.

Having officers who specialize in adult abuse, neglect, and exploitation was another proposed solution offered by law enforcement. For example, the Crimes Against Seniors Unit in Louisville Metro has five full-time detectives who are trained in and specialize in elder abuse. Law enforcement officials in other parts of the state believe that specialized officers would help in their jurisdictions also. Implementing Recommendation 2.6 would help accomplish this solution.

One law enforcement official suggested having one or two officers in each local agency who specialize in adult cases and rotating officers in and out of the position every six

months to a year. The official suggested that this rotation method would ensure that all officers in an agency would be capable of handling an adult abuse, neglect, or exploitation case. Such specialization could also improve coordination between law enforcement and social workers by fostering a relationship between them and providing social workers with a single point of contact within law enforcement. Implementing Recommendations 2.6 and 2.7 would help accomplish this solution.

The Role of the Office of Inspector General in Adult Protection

The Office of Inspector General is responsible for licensing, certifying, monitoring, and investigating long-term care facilities and other residential settings where vulnerable adults live.

The Cabinet for Health and Family Services' Office of Inspector General is responsible for licensing, certifying, and monitoring all long-term care facilities and certain other residential settings where vulnerable adults live. The Office of Inspector General is also responsible for the investigation of complaints made against long-term care facilities.

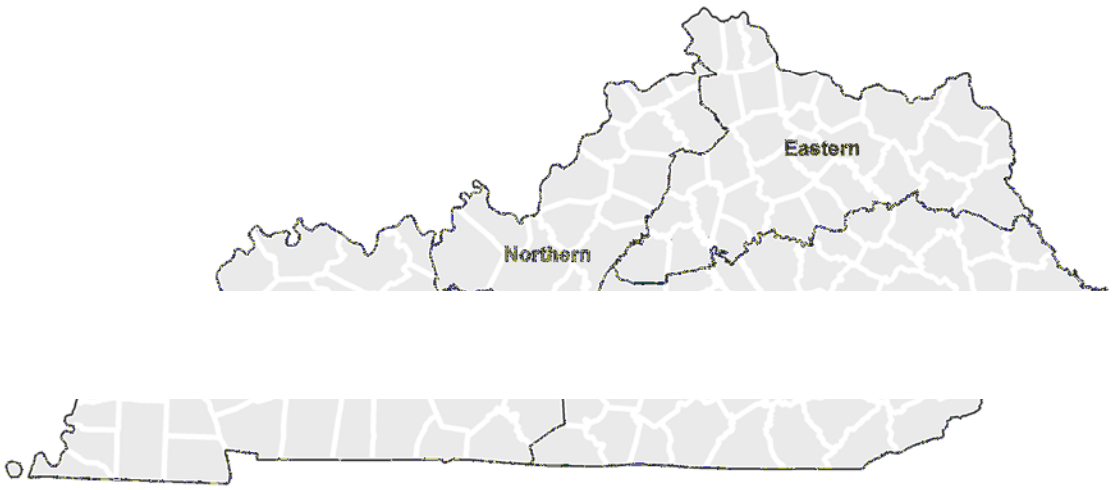
The facilities under the jurisdiction of the Office of Inspector General include

- nursing facilities;
- skilled nursing facilities;
- intermediate care facilities for the mentally retarded and developmentally disabled;
- other intermediate care facilities;
- nursing homes;
- free-standing personal care homes; and
- family care homes.

The remainder of this section focuses on long-term care facilities, such as nursing homes.

Four regional offices license, certify, monitor, and investigate the facilities and other residential settings in their respective jurisdictions. As illustrated in Figure 3.B, the Western Region office located in Hopkinsville monitors 32 counties, the Northern Region office located in Louisville monitors 16 counties, the Southern Region office located in London monitors 42 counties, and the Eastern Region office located in Lexington monitors 30 counties in central and northern Kentucky.

Figure 3.B
Office of Inspector General's Service Regions



Source: Office of Inspector General, Cabinet for Health and Family Services.

Licensure and Certification of Long-term Care Facilities

Facilities must satisfy state regulations to be licensed.

KRS 216B.010 requires that all long-term care facilities be licensed. Such facilities must satisfy minimum state regulations to be licensed. The licensure regulations address staffing, training, patient admittance, record keeping, medication administration, nursing services, social services, facility accommodations, and patient rights.

Facilities that request Medicare and Medicaid certification must also satisfy federal regulations.

Some facilities may also receive federal certification for participation in the Medicare and Medicaid programs. Facilities requesting Medicare and Medicaid certification must satisfy all applicable federal regulations in addition to the minimum state licensure regulations (42 CFR §483).

Monitoring Long-term Care Facilities

Long-term care facilities are surveyed regularly by the Office of Inspector General.

After initial licensure, a long-term care facility is surveyed regularly by the Office of Inspector General to determine continued compliance with state licensure and federal certification requirements. Federal law mandates that facilities certified by Medicare and Medicaid be surveyed once every 9 to 15 months, with a statewide average of 12 months between surveys. All long-term care facilities are surveyed annually for compliance with state licensure regulations.

Investigating Complaints Made Against Long-term Care Facilities

The Office of Inspector General staff also investigate complaints against the facilities.

Staff of the Office of Inspector General's regional offices investigate complaints against long-term care facilities. The timing, scope, duration, and conduct of an investigation are at the discretion of the Office of Inspector General, except when the complaint involves an allegation of immediate jeopardy to resident health and safety. An immediate jeopardy complaint must be investigated within two working days (Commonwealth. Office. *Survey* 51).

Each complaint is assigned a priority level based on urgency.

Each complaint is assigned a priority level based on urgency. The four levels of priority and timelines for the investigations are shown in Table 3.2.

Table 3.2
Office of Inspector General's Long Term Care Complaint Priority Levels

Priority Level	Definition	Investigative Time
I	Immediate Jeopardy—alleged noncompliance has caused or is likely to cause death or serious physical injury, harm, or impairment	Within 48 hours
II	Actual Harm—noncompliance that results in a negative outcome that has compromised resident's ability to maintain or reach his or her highest practicable physical, mental, and psychosocial well-being	Within 10 working days
III	No actual harm, potential for more than minimal harm	Within 45 days
IV	No actual harm, potential for only minimal harm	Within 120 days (can handle by phone)

Source: Office of Inspector General, Kentucky Long Term Care Complaint Investigation Guidelines.

DCBS and Office of Inspector General staff should conduct a joint investigation when possible.

Once a priority level has been assigned to a complaint, Office of Inspector General staff plan the facility investigation. Before planning the investigation, the assigned worker must contact the local Department for Community Based Services office. Agency investigation guidelines require Office of Inspector General workers to schedule a joint investigation with a DCBS worker, when possible. The two agencies focus on different issues in their investigations. The Office of Inspector General's investigation is focused on the facility and whether it failed to properly care for and protect the individual. The DCBS investigation is focused on the victim and whether he or she needs protective or other services.

There are four major steps of a long-term care investigation by the Office of Inspector General:

1. off-site preparation;
2. entrance conference;
3. information gathering; and
4. analysis of information and decision making.

A Hypothetical Example of a Long-term Care Investigation by the Office of Inspector General. A regional office receives a complaint that a physically disabled elderly woman residing in a nursing facility fell out of bed while sleeping and received an injury that resulted in hospitalization. The individual making the complaint is concerned that the incident might not have been an accident.

Step 1: Off-site Preparation

The complaint is taken and assigned a priority level. In this example, the complaint is assigned a priority level I based on the severity of the injuries that resulted in hospitalization of the resident.

The investigation is assigned to a worker based on specific professional knowledge. Since this complaint involves medical injuries, a nurse is assigned.

The investigator reviews current data on the facility and determines if there have been any recent changes in administrative or nursing staff. The worker reviews the history of the facility including any history of noncompliance with licensure requirements.

Step 2: Entrance Conference

The next step in the investigation is a meeting between the Office of Inspector General worker and the administration of the facility. This meeting is known as an entrance conference. The purpose of the entrance conference is to make the facility administration aware that an investigation is under way and to collect information.

The investigator makes an unannounced visit to the facility and lets administration officials know that he or she is investigating a complaint. The investigator protects the confidentiality of the complainant and the persons involved in the complaint.

The investigator may request staffing schedules and a list of transfers to the hospital from the facility. In this example, the investigator also goes to the hospital to speak with the alleged victim and medical staff to assess the extent of the injuries and the events leading up to the fall.

Step 3: Information Gathering

The information-gathering stage consists of observing, interviewing, and obtaining any type of critical information to determine if the facility was in compliance with regulations when the incident occurred. In this example, the nurse interviews the alleged victim at the hospital, any witnesses to the incident, and the facility staff who were directly involved with the resident's care at the time of the incident.

The investigator observes the physical environment, the facility's procedures, patterns of care, and delivery of services to the resident. The investigator also checks the condition of the resident's room and unit. In this case, the investigator determines if the resident was turned as scheduled, if the bed was specialized for the resident's unique needs due to her disability, and if staff were trained on how to properly care for the resident's unique needs.

Step 4: Analysis of Information and Decision Making

The final step in the investigation is to analyze the information and make a decision. In this step, the investigator reviews all notes and information obtained from interviews and observations at the facility. Based on this information, the worker substantiates or does not substantiate that the facility was out of compliance with regulations.

In this example, the investigator learned from interviews that there was only one staff person covering the unit at the time of the incident. This staff person was new to the job and not fully trained. The staff person told the investigator that she found the resident on the floor beside the bed during a nightly round. She said the bed rails were not put up before the resident fell asleep on the night of the incident. She further said that she did not know she was supposed to put up the bed rails because those instructions were not written in the resident's chart.

In this case, the investigator substantiates that the facility was out of compliance with staffing, training, and record-keeping regulations and writes up a final report. The investigator then informs the facility's administrator of the insufficient staffing, training, and record keeping.

The Office of Inspector General may revoke the license of facility.

Follow-up Actions. The facility must submit a plan of correction to the Office of Inspector General. The scope and severity determine if a follow-up visit will be conducted. Particular sanctions, such as a revocation of license, may be implemented depending on the history of compliance and severity of the deficient practice.

The Department of Mental Health and Mental Retardation Services' Role in Adult Protection

Background

Adults with mental retardation or developmental disabilities may qualify for the Supports for Community Living program, an alternative to facility care.

The Supports for Community Living (SCL) program provides community-based services for qualifying vulnerable adults. Medicaid-eligible individuals who meet requirements for residence in an intermediate care facility for persons with mental retardation and developmental disabilities are eligible for these services.

The program was created as an alternative to institutionalization under the Alternative Intermediate Services/Mental Retardation Medicaid Waiver program. SCL services allow these individuals to remain in or return to the community as an alternative to institutional care. In 1997, the day-to-day operations of the program were transferred from the Department for Medicaid Services to the Department for Mental Health and Mental Retardation Services in the Cabinet for Health and Family Services.

The SCL program offers an array of services that are coordinated by a support coordinator and are tailored to meet the individual's needs. Services include 24-hour residential support (family home, staffed residence, group home, or adult foster care home), helping individuals learn to live in the community, psychological services, occupational therapy, physical therapy, speech therapy, prevocational service, specialized medical equipment and supplies, and respite. Support coordination is a requirement and is also funded by the SCL program.

Providers of SCL services include the regional comprehensive care centers and public and private agencies across the state. Providers are reviewed annually by the Department for Mental Health and Mental Retardation Services (MHMR).

Incident Management

MHMR's investigations of Supports for Community Living providers and facilities focus on regulatory compliance. MHMR workers do not substantiate adult abuse, neglect, or exploitation. Instead, they focus on providers and determine if they create an environment that promotes the "safety, health, and well-being" of the individuals served. Substantiation is the responsibility of Department for Community Based Services social workers.

MHMR workers monitor the treatment of individuals in SCL settings through the use of incident management. An incident is any occurrence at an SCL setting that puts the safety, health, and well-being of individuals at risk. SCL providers classify the severity of incidents in the three levels shown in Table 3.3.

Class II21g iTJ-12.2258sdspaiTJ-12.2258bI013 Tw(iider)8.5(ps do not subst)4.4(i

Table 3.3
Supports for Community Living Incident Levels

Class	Definition	Examples
I	Minor in nature, do not create serious consequences, and may not require an investigation by the provider agency	Minor injuries that require only first aid, isolated behavior outbursts
II	Serious in nature and require an investigation that must be initiated by the provider agency within 24 hours of discovery	Injury or illness requiring medical treatment, suicide threats, peer-to-peer aggression
III	Grave in nature and require an investigation initiated immediately by the provider agency	Death, suspected abuse, neglect, exploitation, medication errors resulting in hospitalization

Source: Cabinet for Health and Family Services, Department for Mental Health and Mental Retardation Services, Division of Mental Retardation.

Some incidents are indicative of adult abuse, neglect, or exploitation. Others are not.

Not all Class III incidents are reportable to the Department for Community Based Services. Only when an SCL provider agency has reasonable cause to suspect that an adult has suffered abuse, neglect, or exploitation will the provider report the incident to DCBS. Examples of Class III incidents that the SCL provider agency must report to DCBS are

- an injury;
- a pattern of aggression between two involved individuals;
- unexplained bruising on the inner thigh, inside upper arm, stomach, or back, or bruises in a pattern; and
- a medication error occurring over several days or weeks, or resulting in serious health consequences.

MHMR's Investigative Role

MHMR performs an on-site review when the provider's investigation and action are determined to be insufficient.

Incident reporting requirements allow the SCL provider time to conduct its own internal investigation and take appropriate action. MHMR performs an on-site review of an incident only when the provider's investigation and action are determined to be insufficient.

MHMR conducted 69 on-site investigations from January 1 to November 1, 2003. Thirty-nine of those investigations were related to suspected abuse, neglect, or exploitation. The Division of Mental Retardation received confirmation from DCBS that 10 of the 39 were substantiated, 9 did not meet criteria for investigation, 6 were not substantiated, and 13 were still being investigated by DCBS.

MHMR can take action against a provider that is out of compliance.

When MHMR does perform an investigation and finds a provider out of compliance, the agency can take any of the following actions, depending upon the severity of the deficiencies:

- make a recommendation to the Department for Medicaid Services to terminate the certification and Medicaid participation of the provider;
- place a moratorium on new admissions to the provider;
- shorten the certification period and increase monitoring of the provider; and/or
- penalize the provider financially through recoupments of Medicaid payments made while the provider was out of compliance.

An SCL provider's action related to incidents is reviewed as part of its certification and will determine the length of certification and state oversight of the provider. For example, if a provider's actions on certain incidents are determined to be insufficient, MHMR has the authority to shorten its certification period, increasing state oversight of the provider.

MHMR reviews the provider's plan of correction.

If an SCL provider is found to be out of compliance during an MHMR on-site review, the provider must send a plan of correction to MHMR within 30 days addressing all the deficiencies found in the review. If the plan is accepted by MHMR, a follow-up visit will be performed by MHMR to ensure that the deficiencies have been corrected. If the plan is repeatedly denied, certification action is taken by MHMR.

Joint Investigations by MHMR and DCBS

MHMR's Division of Mental Retardation provided Program Review staff with examples of investigations in which its office worked well with DCBS and examples when coordination was lacking. Below are two verbatim examples provided by the division of actual cases illustrating each scenario. The first example shows coordination; the second indicates a lack of coordination.

An Example of Coordination Between MHMR and DCBS

Initial Referral. An incident report was received involving the presence of marijuana on an agency van, and an allegation of an individual supported and staff member having the appearance of "being high". As the collaborative investigation progressed, the following critical issues were identified:

1. Evidence of widespread use of illegal substances by staff members and individuals.
2. Failure to ensure the health, safety and welfare of individuals supported.
3. Violations of numerous SCL personnel and hiring requirements.
4. Demonstrated incompetence in the delivery of SCL supports.
5. Failure to cooperate with Division of Mental Retardation (DMR) investigations.
6. Failure to ensure timely corrective action.

Summary of Investigative Activities. During the course of the investigation, a number of collaborative efforts were employed to ensure that DMR and DCBS shared information with each other and appropriate agencies as required. Joint interviews were conducted by DCBS/DMR investigators involving individuals, staff members, families, community members, and law enforcement personnel. Due to the large scope of this investigation, it was frequently impractical to ensure that both agencies would conduct joint interviews; in these instances, information gleaned from separate interviews was shared among the Cabinet for Health Services staff and the Cabinet for Families and Children staff. The end result of these collaborative efforts included a cohesive and thorough investigative format, increased consistency between DCBS and DMR findings, and cooperation with law enforcement officials.

Summary of Resolution. In addition to numerous substantiated allegations of abuse (see below), DMR and DCBS officials worked together to ensure the smooth transition of individuals from the program into safer environments. The Division of Mental Retardation immediately made a recommendation to the Department for Medicaid Services to begin proceedings during the investigation to terminate the agency's provider agreement, with the end result being closure of the agency. Investigative reports were shared between CFC and CHS to ensure that all areas were addressed. The findings associated with DCBS investigations included:

1. A substantiated allegation of caretaker neglect when an individual was administered aspirin despite contraindications of such.
2. A finding of "Some indication" of sexual abuse involving staff and individuals.
3. A substantiated allegation of caretaker neglect for inappropriate supervision.

An Example of a Lack of Coordination Between MHMR and DCBS

Initial Referral. The Division of Mental Retardation received a complaint from a current employee who made several complaints regarding substandard conditions at the agency. The caller indicated that the owners of the company were asking staff to sign training and policy rosters without training and threatening action for not signing the documentation. She further indicated that there continued to be insufficient supplies of food in the homes. Finally, the caller indicated that there was an unexplained bruise for an individual that was not documented on an incident report. During the course of this investigation, DMR staff received an additional incident report that the agency was failing to provide an individual with adequate staffing per his individual service plan.

Summary of Investigative Activities. These allegations were reported to the Jefferson County DCBS office, which—according to the provider—did investigate the allegations. Each member of the investigative team attempted to contact the DCBS office and were unable to determine if the allegation had been received, whether it was investigated, or the results of the DCBS investigation. To date, these issues have not been resolved.

Summary of Resolution. Following the outcome of this investigation, a recommendation for termination of the provider agreement was made to DMS by the Division of Mental Retardation, resulting in the agency's closure on June 14, 2003. Individuals were transferred to other providers to ensure their immediate safety. As of October 1, 2004 partial findings from DCBS have been received.

Implementing Recommendations 2.6 and 2.7 would help alleviate such a lack of coordination.

Chapter 4

Populations, Communications, Funding, and Emerging Issues

Chapter 4 presents the results of phase two of the study. It focuses on populations of vulnerable adults, communications, and funding of protective services. The nine recommendations in this chapter should be implemented in coordination with the seven recommendations in Chapter 2 that were approved by the Program Review and Investigations Committee on December 17, 2003. Recommendations are made in Chapter 4 to 1) create a unit in the Governor's Office to oversee the coordination of adult protective services and their funding; 2) require multidisciplinary training on each agency's roles, responsibilities, and constraints in an investigation; 3) require the Cabinet for Health and Family Services central offices to research, compile, and disseminate information on best practices of local offices; 4) consider making the regulations for adult protective services similar to the regulations for child protective services; 5) compile and distribute statewide and county-level data on incidents accepted for investigation and the outcomes; 6) design and implement information system interfaces to enhance coordination of investigations; 7) dedicate more social workers to adult protective services; 8) modify the DSS-115 notification form to provide more specific information to law enforcement officials; and 9) enhance the funding for local long-term care ombudsmen.

Vulnerable Adult Populations

This study did not focus on victims of domestic violence. Instead, it focused on other vulnerable adults who have fewer resources available to them.

This study did not focus on victims of domestic violence. Program Review staff's research showed that victims of domestic violence have resources available to them that are not available to other vulnerable adults in community settings. Therefore, this study focused on other groups of vulnerable adults who live in the community. These groups include elderly and nonelderly adults who live at home, in Supports for Community Living placements for the mentally retarded and developmentally disabled, and in other settings, such as personal care homes and boarding homes.

This study also focused on vulnerable adults who require facility care. That population can be described as elderly adults who live in nursing facilities and primarily nonelderly adults who live in

intermediate care facilities, state psychiatric facilities, and other institutional settings.

The Department for Community Based Services social workers are required to participate in every protective service investigation.

Regardless of where vulnerable adults live, social workers in the Cabinet for Health and Family Services, Department for Community Based Services (DCBS) are required by statute to participate in every protective service investigation. Social workers also are required to notify law enforcement officials of each investigation. Depending on where vulnerable adults live, other Cabinet for Health and Family Services (CHFS) agencies may be involved, such as the Office of Inspector General, the Department for Mental Health and Mental Retardation Services, the Department for Public Health, the Office of Aging, and the State Long Term Care Ombudsman. In addition, the Office of Attorney General, local long-term care ombudsmen, and local charitable and faith-based organizations often are involved. The involvement of the many individuals and agencies is required because instances of adult abuse, neglect, and exploitation can be a combination of legal, medical, and social issues.

Inadequate Communication, Lack of Funding, and Confidentiality Requirements Hamper the Coordination of Adult Protective Services

Coordination of adult protective services is hampered by limited communication.

Coordination of adult protective services is hampered by inadequate communication. Three weaknesses staff noted in this study are 1) inadequate communication among people who care for and protect vulnerable adults; 2) inadequate analysis and availability of information in computer systems on people, investigations, and outcomes; and 3) inadequate communication among computer systems. The communication weaknesses occur within and among agencies charged with the care and protection of vulnerable adults, including the Cabinet for Health and Family Services, the Justice and Public Safety Cabinet, local law enforcement agencies, local advocacy groups, and others.

Coordination of services is hampered by a lack of funding.

Coordination of adult protective services is hampered by a lack of funding. The federal government provides dedicated funding for child protective services but not for adult protective services. Discretionary federal funding is used by the Commonwealth to provide services to both children and adults. Many federal grants are available to enhance adult protective services by state and local agencies. However, the Commonwealth has no central office with responsibility for identifying these grant opportunities and coordinating interagency applications.

Coordination of services is hampered by confidentiality requirements.

Finally, coordination of adult protective services is hampered by confidentiality requirements. The system that protects confidentiality between patient and psychotherapist often prevents social workers and law enforcement officers from obtaining the information they need to identify and protect a vulnerable adult.

Organizations should work together under a central coordinating authority.

Given that a major problem with adult protective services is a lack of coordination, the question is how to proceed. Increasing the available resources may help vulnerable populations, but the lack of coordination means that resources will not be used as efficiently as possible. Since existing organizations have different perspectives and roles, the approach most likely to get results is to bring the organizations together so they can learn from each other. However, a central authority must be in place to ensure that coordination is improved and adopted policies are implemented.

In attempting to address the problem of violence against vulnerable populations, the Commonwealth has previously adopted a team approach with high-level direction. For example, the Governor's Council on Domestic Violence and Sexual Assault was created to increase awareness and to direct services related to domestic violence. The Kentucky Multidisciplinary Commission on Child Sexual Abuse requires local specialized multidisciplinary teams to investigate child sexual abuse reports. From 1998 to 2002, the Elder Abuse Committee addressed prevention, intervention, and coordination of services. The committee was abolished in 2002, and the Kentucky Commission on Elder Abuse was created by executive order. The order expired in 2003.

Recommendation 4.1

The Office of the Governor should consider creating a unit to oversee the coordination of adult protective services in the Commonwealth. The unit should be charged with 1) facilitating communication among people who care for and protect vulnerable adults; 2) facilitating interagency staff access to information in computer systems on people, investigations, and outcomes; 3) facilitating coordination among the various computer systems; 4) identifying federal grant opportunities and coordinating interagency applications; and 5) exploring ways by which social workers and law enforcement officers can obtain information from confidential sources when investigating potential abuse, neglect, and exploitation of vulnerable adults. The unit should address the needs of all vulnerable adults, both the elderly and nonelderly, in the community and in facilities.

Inadequate Communication Among People

A basic communication problem in coordinating services is that people who care for and protect vulnerable adults interpret the definitions of abuse, neglect, and exploitation differently.

A basic communication problem in the coordination of adult protective services is that the people throughout the Commonwealth who care for and protect vulnerable adults interpret the definitions of abuse, neglect, and exploitation differently. The people include social workers, other state agency staff, law enforcement, prosecutors, judges, and advocates. They work in geographically diverse areas: cities, counties, regions (for example, area development districts, court districts, and DCBS service regions), and central offices in Frankfort. A related problem is that the people who care for and protect vulnerable adults do not adequately understand each other's roles, responsibilities, and constraints.

These problems can lead to differences in

- incidents accepted for investigation by social workers and law enforcement officers;
- incidents substantiated by social workers and charges filed by law enforcement officers; and
- prosecutions and convictions obtained.

The differences could be attributed to a lack of common understanding of the definitions among persons who conduct investigations. The lack of common understanding could explain why some DCBS offices routinely accept some kinds of referrals, such as medication errors reported by providers of Supports for Community Living services, while other offices routinely reject them unless actual harm to the resident is indicated.

One solution is to require training for all who are involved in investigations.

One solution is to require timely initial and ongoing training for all who are involved in adult protective services investigations. Implementation of Recommendation 2.5 as approved by the Program Review and Investigations Committee would help accomplish this solution.

The training should emphasize that violations of KRS Chapter 209 are crimes.

The required training should emphasize that violations of KRS Chapter 209 are crimes, not merely social work problems, and that the penalties may differ from those for similar crimes in the penal code. For example, an assault against a vulnerable adult may be a misdemeanor under the penal code but may be a felony under KRS Chapter 209. On-the-job training and supervision succeed only if the trainer and supervisor use the right definitions and correct knowledge of KRS Chapter 209.

Multidisciplinary training should address each agency's roles, responsibilities, and constraints.

Another solution is to require multidisciplinary training on each agency's roles, responsibilities, and constraints. The disciplines should include social workers, law enforcement officers, prosecutors, judges, advocates, and others, as appropriate. The training should clarify where each agency's responsibility starts and stops and how the agencies can help each other protect vulnerable adults. The training should use case studies in which a multidisciplinary team has to decide on the steps to take to resolve an allegation of adult abuse, neglect, or exploitation. Examples of such case studies used in actual training courses are provided in Appendix C. These examples can be adapted for use throughout the Commonwealth.

The training for executive branch agencies could be mandated and coordinated by the Governor's Office in conjunction with implementing Recommendations 2.5 and 4.1. The training for judicial officials could be mandated and coordinated by the Administrative Office of the Courts in conjunction with implementing Recommendation 2.5.

Recommendation 4.2

The Governor's Office and the Administrative Office of the Courts should implement Recommendation 2.5 and expand it to include multidisciplinary training on each agency's roles, responsibilities, and constraints in adult protective services. The training should clarify where each agency's responsibility begins and ends and how agencies can help each other in the process of protecting vulnerable adults.

Central offices should research the best practices of their local offices and help other offices implement the practices.

A third solution is to require Cabinet for Health and Family Services central offices (DCBS, State Long Term Care Ombudsman, Department for Mental Health and Mental Retardation Services, and Office of Inspector General) to research the best practices of local offices and help other local offices implement the practices. For example, the Louisville DCBS office and the area long-term care ombudsman have an informal agreement on the allegations each agency will investigate. The ombudsman investigates minor incidents in facilities, such as when a resident is missing a few dollars. If the ombudsman suspects that the problem is larger than it appeared from the initial allegation, the incident is referred back to DCBS.

Local office staff and other groups often have innovative ideas to improve coordination.

Regional administrators, local long-term care ombudsmen, local coordinating council members, and others have innovative ideas on how to improve coordination of services for the care and protection

of vulnerable adults. Often these ideas are shared within a region but not among regions. Within a region, innovative procedures used by one county may not be known and used by other counties. CHFS central offices should research the best practices of local offices and help other offices implement the practices.

Recommendation 4.3

Central offices of the Department for Community Based Services, State Long Term Care Ombudsman, Mental Health and Mental Retardation Services, and Office of Inspector General in the Cabinet for Health and Family Services should research, compile, and disseminate information on best practices of local offices. The best practices should be incorporated into agencies' policies and emphasized in interagency and multidisciplinary training.

Some law enforcement officers, prosecutors, and judges are reluctant to pursue adult abuse cases. Sheriffs, many prosecutors, and judges are locally elected officials and may be subject to local pressures. However, cases can be referred to the State Police for investigation, and cases can be tried in another county when officials are reluctant to pursue them locally.

Interagency Staff Access to Information in the DCBS Computer System

A second communication problem in the coordination of adult protective services is inadequate analysis and availability of information in the DCBS computer system on people, investigations, and outcomes. The DCBS information system is the central repository of information on adult protective services investigations.

Adult protective services data are stored in The Worker's Information System (TWIST).

Adult protective services data are recorded in The Worker's Information System (TWIST), which is a statewide client server system for social services in Kentucky. Unisys, Inc. completed the development of TWIST in October 1996. The Commonwealth Office of Technology maintains the system.

TWIST was created to store child protective services information. Information on adults was added in June 2001.

TWIST originally supported case management activities in the areas of child welfare, child abuse, foster care, and adoption. In June 2001, DCBS began automating adult protective services by placing case data into TWIST. This addition made it possible for

social workers to instantly access case information on adults and share it with other agencies involved in a case.

Program Review staff were granted access to TWIST for this study. The accuracy of the data is not known.

Program Review staff were granted access to TWIST for this study from November 2003 through February 2004. Program Review staff did not verify the accuracy of the TWIST data. In addition, CHFS staff cited the following gaps in the data:

- Adults have the right to refuse an investigation on their behalf. As a result, many allegations that may have started as potential investigations are classified as information and referral services.
- TWIST does not provide a reliable way to assign an incident to a county. The county associated with the referral is often the county of the worker who took the call, not the office that worked the referral. Workers often do not fill out the county in which an incident allegedly occurred. DCBS typically uses the assigned case manager to determine the county, but this forces all referrals and incidents in a case to show the same county, even if they occurred in and were handled in different counties.
- Workers are not required to complete as much information in TWIST for cases involving adults as they are for cases involving children.
- Because workers were not accustomed to using TWIST for adult protective services during this period, some information might not have been entered correctly or might not have been entered at all.

Analysis of TWIST Data

Program Review staff extracted data from TWIST to examine incident acceptance rates, incidents by type, and investigation outcomes.

Understanding the data limitations, Program Review staff extracted adult protective services data from TWIST from 2002 and part of 2003 to examine incident acceptance rates; incidents by type (abuse, neglect, or exploitation); and outcomes of investigations.

Domestic violence (spouse abuse) incidents were excluded from this analysis. Law enforcement officials normally respond to and investigate domestic violence allegations. The analysis focused on other vulnerable adults who may be the victims of abuse, caretaker neglect, and exploitation as defined in KRS Chapter 209.020(4)(a).

Self-neglect data were not examined because DCBS workers often cannot intervene in these incidents, and law enforcement officers are seldom involved. An adult has the right to refuse services unless he or she is determined by a court to be incompetent. When a competent adult decides to live in a manner that threatens his or her safety or well-being, DCBS workers can only offer information

and referrals to sources of assistance. As a result, DCBS workers and law enforcement officers are often prevented from providing protective services to people who neglect themselves.

Incident outcomes that indicated the victim could not be located were not included in the analysis. KRS Chapter 209.020(9) states that an investigation must include an interview with the victim, unless the victim is deceased.

Some state and local officials have expressed concern that incident acceptance and substantiation rates vary significantly among regions and counties. Potential reasons suggested by officials for the perceived variation include the use of different interpretations of the definitions of adult abuse, neglect, and exploitation and different interpretations of the circumstances that lead to a substantiated finding.

Information from TWIST might not be reliable. The analyses presented in this report are tentative and should be used only as a starting point for asking further questions.

Based only on the TWIST data, it was impossible for Program Review staff to determine why regions and counties differed. The TWIST information might not be reliable for the reasons given earlier. None of the staff analyses of TWIST data should be taken as final, but significant differences by region and county merit further study.

Incident Acceptance Rates

A DCBS social worker must determine if an incident meets the criteria for investigation.

When a referral is received, each allegation of adult maltreatment becomes a separate incident. The DCBS social worker must determine whether each incident meets criteria for investigation. As discussed in Chapter 3, certain conditions must exist for an incident *not* to be accepted for investigation. Some of the conditions are that the alleged victim is younger than 18, insufficient evidence is available to locate the adult, specific allegations are not stated by the referral source, and the referral consists of threats or attempts to commit suicide.

In TWIST, an incident may contain multiple types of maltreatment (abuse, neglect, or exploitation), multiple victims, and multiple perpetrators, but it is still a single incident. Program Review staff defined an incident differently. Within each TWIST incident, each type of alleged maltreatment was counted as a separate incident for each victim, regardless of how many perpetrators were involved. This may differ from the way DCBS counts referrals and incidents on TWIST reports.

From January 2002 through September 2003, 64 percent of incidents statewide were accepted for investigation by DCBS. The acceptance rate varied significantly by region and county.

From January 2002 through September 2003, 64 percent of incidents statewide were accepted for investigation by DCBS. More than 13,000 incidents were accepted for investigation out of approximately 20,500 total incidents.

Appendix D shows the incident acceptance rate for each Kentucky region and county.[1] The acceptance rate varied among DCBS service regions. Six of the 16 regions were below the rate of the rest of the state and the differences were statistically significant.[2] Of these, the regions with the lowest acceptance rates were Lincoln Trail (31 percent), Barren River (47 percent), and Big Sandy (49 percent). Four regions were significantly above the acceptance rate for the rest of the state.

There was even more variation among the counties. Twenty-five counties accepted a significantly lower percentage of incidents than the rest of the state. The counties with the lowest acceptance rates were Woodford, Logan, Bullitt, Casey, and Grant. In these five counties, less than 20 percent—less than a third of the statewide percentage—were accepted for investigation. Thirty-eight counties had significantly higher acceptance rates than for the rest of the state. Three of these counties (Fleming, Morgan, and Green) each accepted more than 95 percent of incidents for investigation.

Adult Protective Services Investigations by Type

Program Review staff extracted data from TWIST on the number of incidents accepted for investigation by the following types of allegations:

- *Abuse*: the infliction of physical pain, mental injury, or injury of an adult.
- *Caretaker neglect*: the deprivation of services by a caretaker, including a spouse, that are necessary to maintain the health and welfare of an adult.
- *Exploitation*: the improper use of an adult or an adult's resources by a caretaker or other person for the profit or advantage of the caretaker or other person.

[1] There were no cases for Robertson County in the TWIST database for 2002 or 2003. Program Review staff were unable to determine whether there were no actual cases or whether the cases were not input into TWIST properly.
[2] Regions and counties were compared to the rest of the state. Differences were defined as statistically significant or not based on the results of a two-sided Fisher's Exact Test or a Chi-Square test (at the 99 percent confidence level).

More than 85 percent of incidents accepted for investigation in 2002 and 2003 were abuse or caretaker neglect.

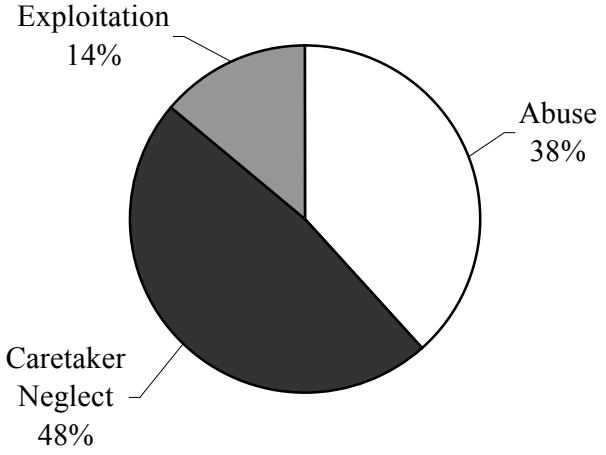
Excluding domestic violence and self-neglect incidents, more than 85 percent of the incidents accepted for investigation in 2003 were abuse (38 percent) and caretaker neglect (48 percent), as shown in Figure 4.A. The relatively small percentage (14 percent) of exploitation incidents taken by DCBS could in part be explained by the nature of the allegation. Exploitation is often viewed as a crime that should be investigated by law enforcement officers but not by social workers. Nevertheless, KRS Chapter 209 requires DCBS workers to investigate allegations of exploitation of vulnerable adults.

The percentage of incidents classified as abuse varied by region from 29 percent to 55 percent. In six counties, 25 percent or less of investigations were for abuse. In four counties, abuse incidents comprised at least 75 percent of the total.

The distribution of incidents by type among service regions varied. For example, the percentage of incidents that were abuse ranged from 29 percent to 55 percent. In four regions, the percentages of abuse incidents were significantly less than in the rest of the state. In another four regions, the share of incidents that were abuse was significantly higher than in the rest of the state.

Among counties, one-fifth had significantly higher (16 counties) or lower (10 counties) percentages of abuse incidents than elsewhere in the state. In six of these counties, 25 percent or less of investigated incidents were abuse. In four counties, 75 percent or more of the incidents were abuse. Regional- and county-level data on the types of incidents investigated are presented in Appendix E.

Figure 4.A
Types of Adult Protective Services Investigations
(January 2002 to September 2003)



Source: Compiled by Program Review staff from the TWIST database (13,181 incidents).

Outcomes of Investigations

An investigation results in a finding that the allegation was substantiated or unsubstantiated.

Upon the conclusion of an investigation, a DCBS social worker determines whether the alleged abuse, neglect, or exploitation has been substantiated or unsubstantiated. Guidance on determining substantiation is not provided in regulation. The only guidance to social workers is provided in the department's standards of practice. Standard of Practice 4.3.14 provides the following guidance on substantiated and unsubstantiated allegations.

An allegation is *substantiated* when the social worker has determined that an adult is the victim of abuse, neglect, or exploitation. A substantiated finding is made as a result of one of the following conditions:

a. An interview with the individual having access to the victim at or around the time of the alleged incident, if conducting the interview does not pose a threat to the victim, in which the individual admits to abusing, neglecting, or exploiting the victim; or
b. A personal interview with the victim and the presence of strong evidentiary or supportive facts, such as medical evidence, observation of injuries, or witness testimony.

An allegation is *unsubstantiated* when

a. contact with the alleged victim reveals no evidence, facts, indicators, or justification to substantiate abuse, neglect, or exploitation; or
b. the location of the adult is known and attempts at contacting or conducting a personal interview with the alleged victim have been unsuccessful, and there is a lack of supportive evidence to indicate abuse, neglect, or exploitation.

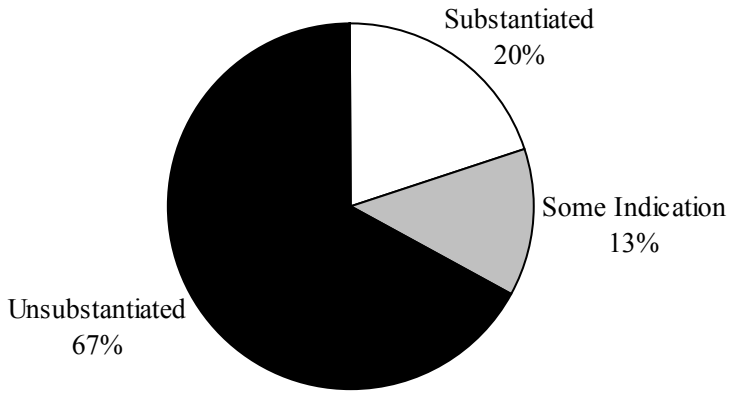
If the social worker cannot locate the alleged victim, the worker identifies the finding as "unable to locate." These incidents were not included in the data analysis because they do not qualify as investigations under statute.

Until August 2003, social workers could use another type of finding, "some indication," when the adult did not confirm that abuse, neglect, or exploitation occurred but circumstantial or other supportive facts of abuse existed.

Twenty percent of investigations resulted in a substantiated finding.

Figure 4.B shows that 20 percent of adult protective services investigations resulted in a substantiated finding from January 2002 through September 2003. Two-thirds of investigations resulted in an unsubstantiated finding.

Figure 4.B
Findings of Adult Protective Services Investigations
(January 2002 to September 2003)



Source: Compiled by Program Review staff from the TWIST database (13,091 incidents).

Six regions substantiated significantly higher percentages of incidents than the rest of the state.

The substantiation rates were significantly higher than the rest of the state in six regions, the highest being Gateway/Buffalo Trace and Cumberland Valley (both 27 percent). Five regions—with rates ranging from 13 to 17 percent—substantiated significantly lower percentages of incidents than the rest of the state.

In six counties, 10 percent or less of incidents were substantiated.

In 17 counties, substantiation rates were significantly higher than in the rest of the state. In three of those counties (Bullitt, Logan, and Hickman), more than half the incidents were substantiated. Eight counties had significantly lower percentages of substantiated incidents. Of these counties, six had substantiation rates of 10 percent or less. The substantiation rates for each Kentucky region and county are provided in Appendix F.

Cabinet for Health and Family Services officials have stated that social workers do not substantiate enough incidents of adult abuse, neglect, and exploitation. The standard for substantiation is higher for adult protection cases than for child protection cases. The higher standard could contribute to lower substantiation rates in adult cases. Substantiation for child cases is defined by 922 KAR 1:330 as a preponderance of the evidence. For adult cases, 922 KAR 5:070 does not define substantiation. The definition in the standard of practice, strong evidentiary or supportive facts, is the only guidance for social workers and is not based on regulatory authority.

Recommendation 4.4

In conjunction with implementing Recommendation 2.4 regarding the use of a high-priority code in cases of a preponderance of evidence that adult abuse has occurred, the Department for Community Based Services should consider amending 922 KAR 5:070 to provide definitions of "substantiated" and "unsubstantiated" that are similar to those in 922 KAR 1:330 for child abuse cases. If DCBS decides that such a change is not advisable, an explanation should be provided to the Program Review and Investigations Committee, the Health and Welfare Committee, and the Judiciary Committee.

Distribution of Individual Case Information From TWIST

Information on DCBS investigations often is not available to others who need it. Other agencies wait to learn the results of hundreds of referrals.

Over time, the quality of information in TWIST should improve. However, the usefulness of the information will improve only if it is available to other agencies and persons who need it. Staff did not find this to be the case.

In September 2004, Department for Mental Health and Mental Retardation Services staff who work with the Supports for Community Living program told Program Review staff that they were waiting to learn the results of more than 800 cases that had been referred to DCBS for investigation. The Nursing Home Ombudsman Agency of the Bluegrass was waiting on the results of more than 100 referrals to DCBS. The Bluegrass ombudsman had to ask for help from the State Long Term Care Ombudsman in Frankfort. The Attorney General's Office has requested access to TWIST to enable investigators to access information on investigations.

Distribution of Summary Information From TWIST

DCBS and other state and local agencies participate in investigating allegations of adult abuse, neglect, and exploitation. These other agencies need to know the results of each DCBS investigation in a timely manner. Professional associations, such as those of law enforcement and medical professionals, could use summary information to help better coordinate protective services.

Information on investigations should be shared among state and local agencies and other groups.

Recommendations 2.6 and 2.7 noted that information should be shared among state and local agencies. Much information is available in TWIST that could be summarized at the statewide level, by region, and by county, and shared with state and local organizations. For example, the Kentucky Sheriffs Association,

Kentucky Association of Chiefs of Police, Kentucky Medical Association, Kentucky Nurses Association, Kentucky Bankers Association, Kentucky Department for Medicaid Services, and other statewide organizations could use information from TWIST to better coordinate protective services to vulnerable adults. At the local level, long-term care ombudsmen, law enforcement agencies, bankers, attorneys, providers of nonemergency transportation services, and charitable and faith-based organizations could use TWIST information to better coordinate services.

Recommendation 4.5

The Department for Community Based Services should compile statewide and county-level data on allegations accepted for investigation and the outcomes of those investigations by type: abuse, neglect, and exploitation. The statewide and county-level data should be shared with groups such as those noted in Recommendations 2.6 and 2.7 and other groups, such as local coordinating councils.

Inadequate Communication Among Computer Systems

Safety, case oversight, and accountability are hindered when computer systems do not share information.

A third communication problem is inadequate communication among computer systems. The ability to connect investigations in one agency with those in another produces several important benefits. A top priority is to ensure the safety of victims, social workers, and law enforcement officers by knowing the history of the individuals involved in a case. If agencies working on the same case can share information easily, it improves cooperation and efficiency. Being able to follow the progress of a case through the many steps of adult protection and criminal justice facilitates better overall case management and oversight. For policy purposes, connecting information from all the many agencies would make it possible to measure the effectiveness of adult protection in ways that are not possible today.

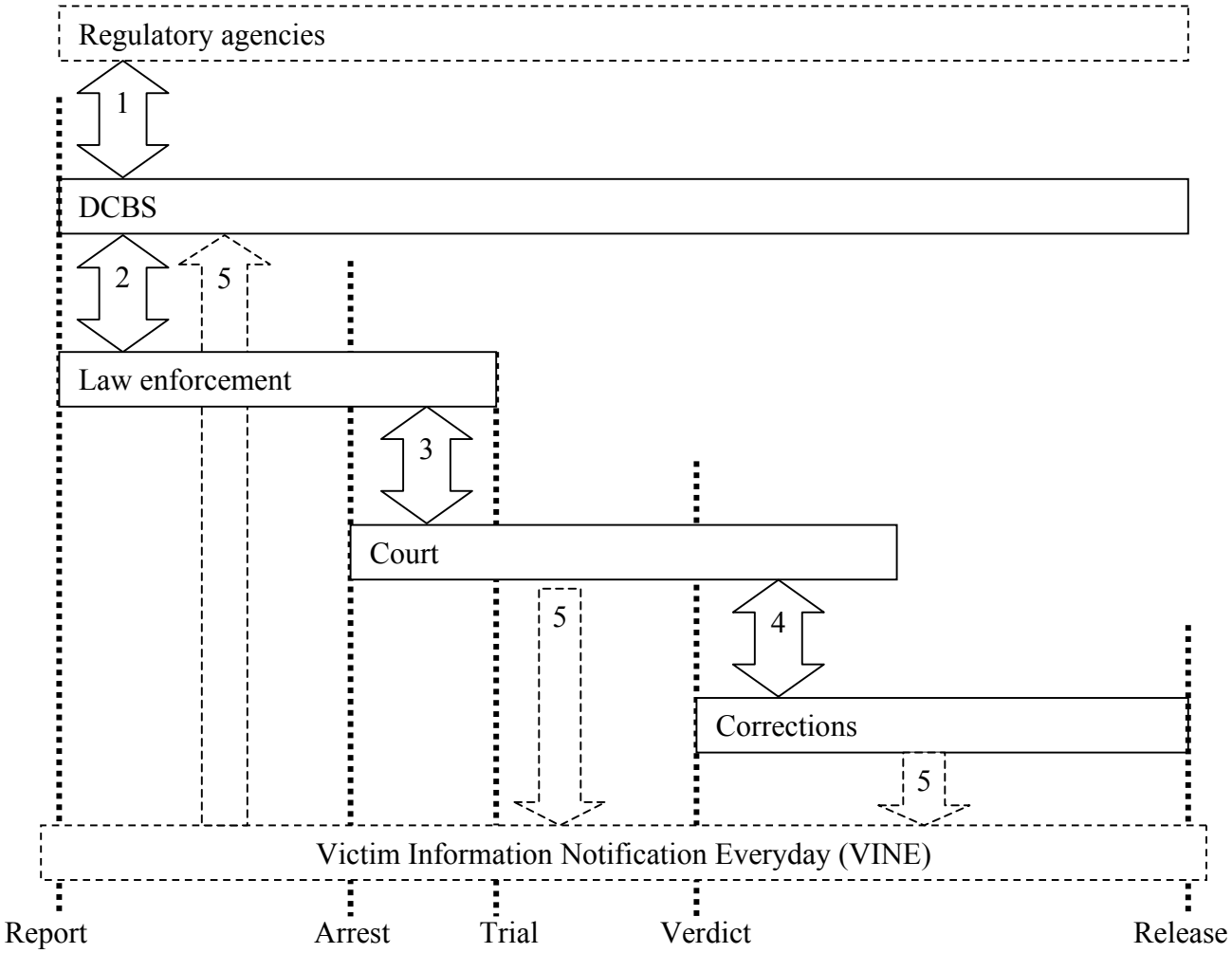
Staff learned of cases in which lives were saved because the agencies involved worked together and had good information available regarding criminal histories and related cases. In other cases, lives were lost or permanently damaged because key pieces of information fell through the cracks.

Regulatory Agencies and DCBS

Regulatory agencies investigate to determine whether an incident was caused by failure to follow regulations.

When an incident occurs in a facility, both DCBS and the agency that regulates the facility will investigate. In fact, the regulatory agency itself may have discovered the incident and reported it to DCBS. The agency investigates in order to determine whether the incident was caused by a facility's failure to follow regulations. Unlike DCBS, the relationship between the regulatory agency and the facility is ongoing. This is shown by the dashed box and arrow #1 in Figure 4.C.

Figure 4.C
Agencies and Interactions in Adult Protection Investigations



Source: Compiled by Program Review staff from agency interviews and written materials.

Regulators report adult protection cases to DCBS, and DCBS reports cases to facility regulators. Coordination would be enhanced if their computer systems shared information.

One such agency, the Cabinet for Health and Family Services' Office of Inspector General, can serve as an example of how information systems might work together. The Office of Inspector General regulates long-term care facilities and related providers, such as hospitals. The office maintains its complaint cases in a system called the ASPEN Complaint/Incident Tracking System (ACTS). When the Office of Inspector General receives a complaint, staff create a case in ACTS and the case is given a case number. If the case involves a reportable incident, the Office of Inspector General worker will send a report to DCBS that includes the ACTS case number.

Conversely, if someone else informs DCBS of an incident in a facility, DCBS staff create an incident record in TWIST and a case number is assigned. DCBS staff will send a DSS-115 form to the Office of Inspector General. When the DSS-115 form is generated from TWIST, it will contain the DCBS case number.

To work together, TWIST or ACTS or both must have access to the other system's case number. At this time, neither system has a data field that is designated for an outside case number. At best, the DCBS worker could type the ACTS case number into a TWIST comment field. Similarly, an Office of Inspector General worker could type the TWIST case number into an ACTS comment field. This would make it easier for staff to communicate about a case, but it still would not allow the two systems to send information back and forth.

Regulators within the Cabinet for Health and Family Services and in other agencies, as well as DCBS workers, would benefit from links among computer systems. The cost of such links could be shared.

To build communication between the two systems, the computer on each side must know where to look for the other system's case number. This would require some database and/or programming changes, involving some expense. Alternately, interface software could be built that knows how to access cases in both systems and keeps a list that shows both numbers for each case. This might be less expensive. Other regulatory agencies within the cabinet are involved in adult protection, and all of them would benefit from having the same kind of link as the Office of Inspector General. The overall effort of system integration could be combined and the cost could be spread among all of these projects.

In addition to regulators within the Cabinet for Health and Family Services, the Office of Attorney General houses the Medicaid Fraud and Abuse Control Division and the Consumer Protection Division. The office's staff have expressed a need to know the findings of DCBS case assessments. This could be accomplished by giving the Attorney General's staff access to TWIST or by

creating an interface between a case database at the Office of Attorney General and TWIST.

Criminal Justice and Adult Protection

The Unified Criminal Justice Information System (UCJIS) is an ongoing project to connect computer systems among all criminal justice agencies, including the courts.

In 1998, KRS 17.131 authorized the Unified Criminal Justice Information System (UCJIS). The ambitious goal of UCJIS is "[t]he ability to share critical information at key decision points throughout the justice enterprise," including all 400 law enforcement agencies, jails, prosecutors, Attorney General, the courts, and correctional facilities (Valicenti and Pedersen 7). KRS 17.150 gives the Justice and Public Safety Cabinet authority to obtain information from all agencies responsible for criminal justice, except the courts. The statute encourages the cabinet and the courts to develop an agreement regarding the exchange of information between them.

The statute places responsibility for UCJIS in the Commonwealth Office of Technology, but the current administration is moving the management of this project to the Justice and Public Safety Cabinet. Program Review staff were told that the administration plans to propose legislation to codify this management change.

Most UCJIS funding has come from federal grants. Funding has fallen in 2003 and 2004.

From 1998 to 2000, UCJIS received about $5 million in state general funds. In the past two budget proposals, no state funds were allocated. Since 2000, UCJIS has been funded exclusively through federal grants. According to SEARCH, the National Consortium for Justice Information and Statistics, Kentucky has succeeded in obtaining more overall funding for criminal justice information systems than have other states of comparable size. For instance, Kentucky and North Carolina had the same total funding, even though North Carolina has twice the population. The current amount of grant money is much lower than in previous years. Kentucky received $27 million from 1998 to 2002 but has grants for $648,000 in 2003 and $672,000 in 2004.

Unifying criminal justice information is a complex and difficult task. Early in the process, the Commonwealth Office of Technology commissioned a project plan and a series of position papers detailing the existing situation, system goals, and a plan to achieve them. So far, UCJIS has made progress on a number of fronts and is still keeping to the original roadmap.

There are 400 law enforcement agencies in Kentucky. After police action, an adult protection case may involve the courts and corrections.

Figure 4.C shows that when an adult protection case enters the criminal justice system, several agencies become involved. One or more of the Commonwealth's 400 law enforcement agencies

conduct an investigation and may arrest an alleged perpetrator. After arrest, the court system makes such decisions as releasing on bail or bond, pressing or dropping charges, finding guilt or innocence, and setting terms of a sentence. The Department of Corrections begins to act when there is a guilty verdict by providing presentence recommendations. If the sentence involves incarceration, the case moves to Corrections. The following sections of this report will go into more detail for each of the primary areas of criminal justice as they relate to adult protection.

DCBS and Law Enforcement

DCBS and law enforcement have paperwork to inform each other about cases.

As shown by arrow #2 in Figure 4.C, DCBS and law enforcement often work together. When DCBS accepts a report, the worker sends a DSS-115 form to local law enforcement. When someone reports an incident to law enforcement, the responding officer fills out a JC-3 form (Child Abuse, Adult Abuse, and Domestic Abuse Standard Report), which is sent to DCBS with information about the incident.

Within law enforcement, record management systems keep track of investigations until they are closed. Some agencies use paper and some use computers.

Information systems on the law enforcement side vary from paper-and-pencil record keeping to computerized dispatch and record management systems. Kentucky has about 400 distinct law enforcement agencies, and the task of computerizing and integrating their operations is difficult. There has been no standardized uniform crime reporting system. Staff from the Justice and Public Safety Cabinet described a model process toward which the state's law enforcement agencies are moving.

The key information system for law enforcement cases is the record management system. As soon as a call comes in or a DSS-115 form is received, officers respond and decide whether there is reasonable cause to believe that a crime has been committed. If so, an officer will write a report and assign a local case number to the case. If the law enforcement agency has its own record management system, the case will be entered into it. As soon as practical, the law enforcement agency will transmit the case information to the state's central record management system, which assigns a "master file number" to the case but also remembers the local agency case number.

Law enforcement agencies can use a computerized system to communicate with a statewide system. The State Police offer a free record management system to all law enforcement agencies.

The central system allows all law enforcement agencies to see what the others are working on. Justice and Public Safety Cabinet staff described many benefits, including the ability of detectives to see patterns of criminal activity across county lines. Taking advantage of information from all crime reports, law enforcement

agencies could work together to locate suspects who may have committed crimes in several jurisdictions. When all law enforcement agencies are linked to the system, every investigation in the state will have a case master file number that can be used to track it.

To encourage law enforcement agencies to participate, the Kentucky State Police has developed and is using the Kentucky Open Portal System, a record management system available at no cost to any law enforcement agency. It is readily accessible through the Internet and automatically works with Kentucky's central record management system.

Linking DCBS with law enforcement would require system changes and security measures to protect sensitive data.

At this time, there are no data fields in TWIST or in the current and planned law enforcement systems that allow them to share identifying numbers. As with the regulatory agencies, it would be possible to change these systems so that they can be linked, perhaps manually at first and then through an automated interface. Alternately, separate interface software could be built to contain the identifiers of both systems. The DCBS case identifier and the master file number are the essential elements needed to tie the cases together. Care would have to be taken to ensure that certain kinds of information are not transferred between the systems, particularly information that might compromise a law enforcement investigation.

Protective orders and warrants are recorded in the Law Information Network of Kentucky (LINK).

Another important tool in adult protection is the protective order. When a judge issues an emergency (temporary) protective order, law enforcement is asked to serve the order as soon as possible. When a person requests a domestic violence (permanent) order, the judge issues a summons to compel the respondent to attend a hearing, and law enforcement is asked to serve the summons as soon as possible. Similarly, when an investigation identifies an alleged perpetrator, officers may obtain a warrant for the suspect's arrest. As soon as a protective order or a warrant is issued, another information system comes into play. This is the Law Information Network of Kentucky (LINK), which can inform law enforcement agencies across the state about current and previous protective orders and arrest warrants.

LINK needs automated connections with law enforcement record management systems and with court systems.

Currently, LINK does not contain the court case number or law enforcement investigation number (master file number) that would allow the order or warrant to be matched automatically with the associated court case or investigation. The task is complicated by the fact that protective orders are connected to court cases, but

warrants are associated with investigations. Some sort of communication or interface among these systems is needed.

A goal of UCJIS is an electronic citation system that updates criminal histories.

An arrest may be made after an adult protection investigation or when someone violates a protective order. In either situation, the arrest results in a citation. Most law enforcement agencies still use paper citations, but UCJIS is working toward the use of an electronic citation system. E-Citations, using mobile workstations in officers' cruisers or computers at the local jails, can speed the process of updating the other criminal justice systems, including the Computerized Criminal History. The criminal history system is another important tool for law enforcement and DCBS that can enhance the safety of victims, social workers, and officers.

Coordination would be improved by linking TWIST, the central record management system, LINK, and criminal histories.

Creating links among TWIST, the central record management system, Law Information Network of Kentucky, and Computerized Criminal History would greatly enhance coordination of assessments and investigations. Tasks that now take considerable staff time and effort would be rapid and automatic. Such a goal, however, will require time and funding for computer hardware and software systems and the staff to operate them.

DCBS, Law Enforcement, and the Courts

Courts manage cases via a statewide, uniform case management system.

After an arrest is made and the citation is written, it is forwarded to the court and a court case is created. This is represented by arrow #3 in Figure 4.C. At the clerk's office, the citation is entered by hand into the court's case management system, KY Courts II.[3] The system keeps track of all court-related activity on a case, such as hearings, arraignments, trials, and sentences. Each day, all the new information from the system is sent to the statewide database, CourtNet.

Courts have cooperated with UCJIS to develop automated links between court and justice systems and with DCBS to provide information on request.

Although statute does not require the courts to participate in UCJIS, the Administrative Office of the Courts has engaged in discussions with the Justice and Public Safety Cabinet about information sharing. The cabinet and the court system are working on a protocol for sending e-Citations to the KY Courts system so that clerks could avoid entering arrest information by hand. Also, they are discussing ways that Computerized Criminal History could obtain case dispositions directly from CourtNet; currently, law enforcement must look these up by hand.

[3] Most clerks' offices are using KY Courts II, but some are still using KY Courts I. The Administrative Office of the Courts expects all offices to be upgraded by March 2005.

At the Department for Community Based Services, TWIST has a section designed to track warrants, charges, and court activity. This feature was created to support child protection cases but is available for adult cases. DCBS procedures do not require adult protection workers to use this feature, and Program Review staff were told that most workers do not use it. Through an agreement with DCBS, the Administrative Office of the Courts has provided workers with case progress and dispositions on request for the past several years. In FY 2003, the office filled 130,773 requests, including both child and adult protection cases. This information could be entered into TWIST by hand. In the future, an interface between UCJIS and TWIST could be developed so that such requests for information could be generated and filled automatically.

From an information systems perspective, connecting the case identifiers across the various systems is crucial. DCBS and law enforcement case numbers need to be tied directly or indirectly to citation numbers and court case numbers. This should be considered as UCJIS interfaces are built.

An automated connection between TWIST and court systems would enhance adult protection, if it could be funded.

Connecting TWIST with CourtNet would help the Department for Community Based Services provide services, ensure safety, and provide evidence in prosecutions. Such a goal, however, will require time and funding for computer hardware and software systems and the staff to operate them.

Courts and Corrections

The Department of Corrections does not always inform the courts about transfer, parole, and release of inmates.

When a suspect is convicted and sentenced to probation, probation violations are heard by the court and recorded in the KY Courts system. When a convict is sentenced to prison, the Department of Corrections takes over, as shown by arrow #4 in Figure 4.C. Corrections keeps track of incarceration, parole, parole violations, and release. Program Review staff were told that sometimes the court will receive information from Corrections, but much of the time the court system does not know what has happened to the convict.

Information about the status of convicts would aid in safety and planning for services. Program accountability would improve if cases could be tracked from referral to final disposition.

Convict location and release status is important to the victims, DCBS, and law enforcement. The paramount concern is the safety of the victim, social workers, and officers who were involved in the case. Beyond that, case disposition information alerts DCBS workers to plan with the victim for the perpetrator's return to the community. Program accountability and measurement would benefit from connecting the original case to the final outcome.

According to the Justice and Public Safety Cabinet, the information systems at the Department of Corrections are in the process of being replaced. The UCJIS plan includes an automated interface with CourtNet so the court systems can send information to Corrections with the transfer of a convict, and Corrections can send up-to-date inmate status information to the Administrative Office of the Courts. The interface would depend on connecting the court case number with a Corrections identification number. As with other information system enhancements, funding will be necessary to build and operate the system.

Victim Information Notification Everyday

The Victim Information Notification Everyday (VINE) system collects inmate status information from jails, prisons, juvenile facilities, and inpatient mental health sites. Victims and other parties can register to receive automatic status change notification by phone or e-mail.

In 1993, the case of 21-year-old Mary Byron shocked Kentucky into awareness of the dangers a victim can face when reporting a crime. Byron's ex-boyfriend had been arrested for raping her and was released without her knowledge. He found and killed her. After this murder in Jefferson County, local agencies created the Victim Information Notification Everyday (VINE) system to notify victims whenever an alleged or convicted perpetrator was released from custody. Today, the VINE system covers the entire state, and has served as a national model used in 36 other states. A victim or other interested party, such as a social worker or law enforcement officer, can register and receive notification by automated telephone or e-mail messages whenever an alleged perpetrator's status changes.

KRS 196.280 requires local detention centers and Corrections facilities to send VINE information about all persons incarcerated there. The statute similarly requires all juvenile detention centers to send VINE information about all juveniles who are charged with certain felony offenses. When a person charged with a violent crime is committed to a mental health facility, KRS 202A.410 requires the facility to send information to VINE. Law enforcement officers and Commonwealth's attorneys are required by KRS 421.500 to tell victims how to register with VINE.

The two arrows labeled 5 in Figure 4.C show how information flows in VINE. Systems are in place to update VINE from local jails and juvenile detention centers every 15 minutes. Corrections institutions update VINE twice a day, but Corrections has the ability to make a manual update any time it is needed for rapid notification. An official at the Department of Corrections stated that mental health facilities fax their information and that some facilities are not cooperative in sending information to VINE.

Connecting VINE with TWIST and including it in the Unified Criminal Justice Information System would enhance safety and expand the types of information that could be provided.

For the safety of DCBS social workers and their clients, VINE information can be crucial. Today, workers can register manually with the system, but it might be feasible to build an interface that automatically registers workers for certain cases in TWIST.

The VINE system was developed and is maintained by Appriss, Inc., in Louisville. Although VINE was not part of the original UCJIS roadmap, Justice and Public Safety Cabinet officials have said that it should be included in planning for the system. Extensions of VINE have been considered to connect with Law Information Network of Kentucky and the State Police's sexual offender registry. A LINK interface could provide notification when warrants have been issued or served and when protective orders have been served or expire. An interface to the sexual offender registry could notify victims whenever sexual offenders change residence. The future of VINE should be coordinated with UCJIS so that all the systems work well together. Adequate funding should be provided to build and operate the systems.

Coordination Between DCBS and Law Enforcement

Law enforcement across the state uses the JC-3 form to notify the Department for Community Based Services of adult protection cases.

A system has been developed that appears to work well to inform other agencies about law enforcement actions. Program Review staff were told that virtually all law enforcement agencies in the state use the cabinet's JC-3 form for calls involving "care, custody, and control." These calls typically include adult protection as well as other family issues. The JC-3 is a multipart form that contains copies for DCBS, detention, and the court. Officials at DCBS and at law enforcement agencies told staff that a copy of the JC-3 form routinely goes to the DCBS office. DCBS officials estimated that 99 percent of all reports from law enforcement come via the JC-3. This fulfils law enforcement's obligation under KRS 209.030, 620.040, and 403.785(1) to make reports to the Cabinet for Health and Family Services.

The JC-3 form should be used even when the report came from the Department for Community Based Services.

A possible gap in the process occurs when law enforcement is responding not to a citizen call but to a report from the Department for Community Based Services. A Justice and Public Safety Cabinet official told staff that the JC-3 might not be used when the report comes from DCBS. Program Review staff were unable to confirm this, but it should be verified. Because one purpose of the JC-3 is to collect information about law enforcement's response, the form should be used for all reports and sent to DCBS, even for cases that originated with DCBS.

The victim's rights section of the JC-3 tells victims about available services and protections.

Another benefit of the JC-3 is its victim information section, which explains the victim's rights and how to contact various agencies for services. The law enforcement officer is instructed to tear off the victim information section and give it to the victim at the scene of the incident. Besides being helpful to the victim, this form assists the officer in complying with KRS 403.785(2), the duty to inform victims of their rights.

The JC-3 was designed to report crime statistics, but no agency is required to collect the statistics.

Historically, the JC-3 was created in response to KRS 15A.190, titled "Uniform reporting forms to provide statistical information on crimes." It pertains to gathering statistical information about certain crimes, such as domestic violence and victimization of the elderly. So far, the objective of compiling statistical information on these crimes has not been met, partly because the statute does not make any agency responsible for doing so.

The JC-3 version in use contains some out-of-date information and does not mention VINE.

The version of the JC-3 currently in use was revised in June 1992. Most of the victim information on it is still correct, with the exception of agency name changes and a few phone numbers. A significant omission is the VINE system, which was not created until 1994. Putting this information on the form could save lives and help law enforcement officers comply with their duty to inform victims about the system (KRS 421.500).

The success of the JC-3 should be preserved if any changes are made to update it or to collect statistical information.

The JC-3 thus facilitates the requirements of several statutes and aids in the protection of victims. The dramatic success of the JC-3 should be recognized and preserved. Bringing the victim information on the form up to date would be helpful. Any action to further the goals of KRS 15A.190 should be carefully crafted to maintain the other benefits of the JC-3 and associated procedures.

Recommendation 4.6

The Cabinet for Health and Family Services and the Justice and Public Safety Cabinet should work together, in consultation with the Administrative Office of the Courts, to design and implement information system interfaces among The Worker's Information System, ASPEN Complaint/ Incident Tracking System, other related CHFS systems, and the Unified Criminal Justice Information System. Objectives should include the ability of staff working on a case in any agency to find all related cases at other agencies, security so that staff at one agency may view only information at other agencies that is permitted for their role, automated exchange of data between systems where that is found to be appropriate and efficient, case cross-checks to find current and previous

involvement of victims and perpetrators with all agencies, and automated notification of changes in perpetrator status and location.

Caseloads, Dedicated Adult Protective Services Workers, and Investigations

Some state and local officials involved in adult protection have suggested that high caseloads may make it difficult for social workers to conduct thorough investigations of some incidents and to substantiate adult abuse, neglect, or exploitation. However, DCBS did not provide evidence of oppressively high caseloads. Others have suggested that the process is hampered instead by a lack of dedicated adult protective services workers who understand the complexities of adult cases. Still others suggest that the process is hampered by a lack of knowledge by social workers about how to obtain evidence of adult abuse, neglect, and exploitation under KRS Chapter 209.

Jefferson County investigated 30 percent of the adult protective services cases in the state. Approximately 17 percent of the state's adults live in Jefferson County.

According to the data extracted from TWIST by Program Review staff, in 2003 Jefferson County investigated approximately 30 percent of the adult protection cases in the state (2,597 of 8,601). Jefferson County's adult population was only 17 percent of the state's population in 2002. Each of the other 15 service regions carried approximately 5 percent of the statewide caseload with an average of 382 cases per region.

Program Review staff requested the average caseload per worker from the Department for Community Based Services. According to a department official, in TWIST every referral is assigned a case number; the same case number is used if a second referral is received. A worker caseload is the total number of TWIST cases currently open for services assigned to a specific worker.

Given the small number of dedicated adult protection workers in the state, DCBS was unable to provide an average adult protective services caseload. Table 4.1 is the caseload data provided to Program Review staff by the department.

The average caseload of a social worker in the Commonwealth is 15.

The average caseload of a social worker who provides both adult and child protective services in the Commonwealth is 15, with a low of 12 cases in the Lake Cumberland region and a high of 19 cases in the FIVCO region. Caseload standards have been recommended for child protective services workers but not adult protective services workers. According to a 2004 U.S. Government Accountability Office report, the Child Welfare League of

America suggests a caseload ratio of 12 to 15 children per worker, and the Council of Accreditation suggests that caseloads not exceed 18 children per worker.

Kentucky has few dedicated adult protective services social workers.

Table 4.1 illustrates that Kentucky has very few social workers dedicated solely to adult protection. In fact, caseload ratios for dedicated adult protection workers could only be calculated for the Fayette, Jefferson, and Northern Kentucky service regions. Three service regions—Gateway/Buffalo Trace, Lake Cumberland, and Lincoln Trail—have no dedicated adult protection workers. Office of Inspector General officials, Jefferson County DCBS staff, and law enforcement officials told Program Review staff that workers dedicated exclusively to adult cases greatly enhance coordination of services. Cabinet officials have stated that they plan to include more dedicated adult protection workers among the regional office staff.

Table 4.1
Child Protective Services (CPS) and Adult Protective Services (APS)
Caseloads by Service Region (September 24, 2004)

Region	CPS Cases	APS Cases	Generic Workers	CPS Workers	APS Workers	Total Case/ Staff Ratio	CPS Ratio	APS Ratio
Barren River	1,439	136	43	40	5	18	N/A	N/A
Big Sandy	982	169	24	49	8	14	N/A	N/A
Bluegrass Fayette	1,190	115	0	66	7	18	18	16
Bluegrass Rural	1,715	187	23	86	17	15	N/A	N/A
Cumberland Valley	1,035	60	9	68	7	13	N/A	N/A
FIVCO	750	59	24	15	3	19	N/A	N/A
Gateway/Buffalo Trace	714	54	52	0	0	15	N/A	N/A
Green River	1,475	131	35	54	3	17	N/A	N/A
Kentucky River	1,091	88	19	61	7	14	N/A	N/A
KIPDA Jefferson	3,253	559	0	227	42	14	14	13
KIPDA Rural	576	24	4	29	4	16	N/A	N/A
Lake Cumberland	776	56	68	0	0	12	N/A	N/A
Lincoln Trail	1,252	88	63	12	0	18	N/A	N/A
Northern Kentucky	1,777	135	9	109	13	13	16	10
Pennyrile	753	83	40	22	2	16	N/A	N/A
Purchase	841	82	48	6	3	16	N/A	N/A
State Average	**19,637**	**2,026**	**461**	**844**	**121**	**15**	N/A	N/A

Source: Cabinet for Health and Family Services, Children and Family Services

Recommendation 4.7

The Department for Community Based Services should dedicate more social workers to adult protective services. In conjunction with implementing Recommendation 2.5, the dedicated adult protective services workers should receive mandatory and timely training on conducting investigations of adult abuse, neglect, and exploitation.

Law enforcement officers, including the Office of Attorney General, told Program Review staff that services could be better coordinated if DCBS social workers received training on conducting investigations, gathering evidence, and documenting the results. DCBS workers are not required to prove whether a crime has been committed under KRS Chapter 209. That responsibility falls to law enforcement and the courts. However, DCBS workers are required to determine whether enough evidence is available to substantiate adult abuse, neglect, or exploitation.

A substantiation is not a legal finding. However, in their crime investigations, many law enforcement officials use the information provided by DCBS on the DSS-115 form. An official with the Office of Attorney General suggested that the DSS-115 form should be modified to include more specific data elements and to exclude lengthy narrative explanations. A modified DSS-115 form could help law enforcement officers determine whether a crime may have been committed and an investigation should begin immediately.

Recommendation 4.8

In conjunction with implementing Recommendations 2.1, 2.2, 2.3, and 2.4 on improved procedures for notifying law enforcement of an investigation, the Department for Community Based Services should work with law enforcement officials to determine the specific information they need and to modify the DSS-115 form accordingly.

Lack of Funding

A shortage of funding has been cited by state officials as a hindrance to effective coordination of adult protective services investigations. This section describes some actual and potential uses of state, federal, and other funds for the care and protection of vulnerable adults.

DCBS Funding Sources for the Care and Protection of Vulnerable Adults

The federal government does not provide dedicated funding for adult protective services.

The federal government does not provide dedicated funding for adult protective services. The National Association of State Units on Aging found in its 2003 survey that states use various sources of funding for elder abuse prevention, including

- Social Services Block Grant,
- Community Services Block Grant,
- Older Americans Act Title VII,
- Violence Against Women Act,
- Victims of Crime Act,
- nursing home fines,
- state lottery funds,
- other state funds,
- foundation grant funds, and
- private grants by companies.

Federal funding sources includes the Community Services Block Grant and the Social Services Block Grant.

Two major funding sources for Kentucky's adult protective services are the Community Services Block Grant and the Social Services Block Grant. The U.S. Department of Health and Human Services, giving states flexibility to determine what services to provide, administers both block grants. Together the grants provided more than 40 percent of total funding for adult services in FY 2004.

The objective of the Community Services Block Grant is to provide assistance to community-based organizations for programs and services to reduce the causes and consequences of poverty and to revitalize low-income communities. In FY 2004, the grant provided nearly $11 million in federal dollars to Kentucky's adult services.

Services funded through the Social Services Block Grant must be directed at one or more of the statutory goals:

- Achieving or maintaining economic self-support and self-sufficiency to prevent, reduce, or eliminate dependency;
- Preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests;
- Preserving, rehabilitating, or reuniting families;
- Preventing or reducing inappropriate institutional care by providing community-based care; and
- Securing referral or admission for institutional care when other forms of care are not appropriate or providing services to individuals in institutions.

In FY 2004, the grant provided nearly $2.5 million in federal dollars to Kentucky's adult services.

In 2002, states spent more than twice as much funding from the Social Services Block Grant on child protective services than on adult protective services.

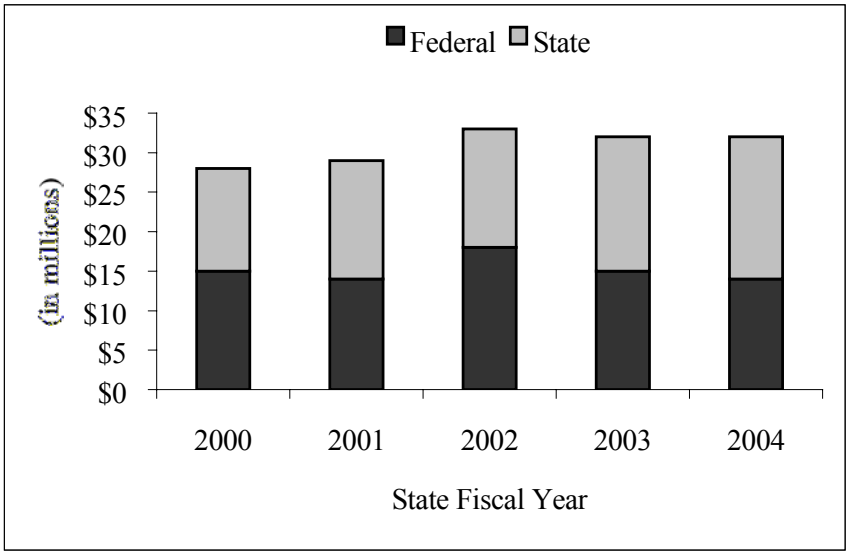
With discretion left to the states, adult protection competes for funding with other services, such as child protection. The U.S. Department of Health and Human services noted in its 2002 annual report on Social Service Block Grant expenditures that states spent more than twice as much money from the grant on child protective services than they spent on adult protective services.

Other sources of funding for Kentucky's adult protective services include the Family Violence Prevention and Services federal grant, the Clinical Research Project federal grant, Medicaid, and restricted funds from marriage license and guardianship fees.

Total federal and state funding has remained steady at approximately $30 million for each of the past five years.

Figure 4.D illustrates funding for DCBS adult services for FY 2000 through FY 2004. Total federal and state funding has remained steady at approximately $30 million for each of the past five years. Included in the funding are expenditures for adult/spouse protection, alternate care, clinical research, guardianship, homemaker services, preventive services for adults, spouse abuse shelters, and staff training.

Figure 4.D
Funding of DCBS Adult Services
(FY 2000 to FY 2004)



Source: Prepared by Program Review staff from information provided by the Cabinet for Health and Family Services.

MHMR Funding Sources for the Care and Protection of Vulnerable Adults

MHMR provides services to vulnerable adults through state-run residential facilities and the community-based Supports for Community Living program.

The Department of Mental Health and Mental Retardation Services (MHMR) provides services to vulnerable adults through state-run residential facilities and the community-based Supports for Community Living program that serves adults with mental retardation and developmental disabilities.

MHMR residential facilities include state-run psychiatric hospitals, nursing facilities, and intermediate care facilities for persons with mental retardation and developmental disabilities.

- Psychiatric hospitals provide acute, psychiatric care for adults with severe mental illness. These persons are admitted to the hospital when community-based services cannot meet their immediate needs. The state's four psychiatric hospitals served more than 8,000 individuals in FY 2003.

- Nursing facilities serve individuals who need long-term medical care and who are unable to find placement to meet their unique mental and physical needs. Kentucky's two state-run nursing facilities state served nearly 300 individuals in FY 2003.

- Intermediate care facilities for people with mental retardation provide specialized, intensive training and active treatment to reduce the debilitating effects of mental retardation and developmental disabilities through skill training and behavior management. The 10 such facilities in the state served more than 700 individuals in FY 2003.

Annual funding for MHMR residential facilities has increased from approximately $160 million to $200 million over the past five years.

Funding for MHMR state-run residential facilities increased in the past five years from approximately $160 million in FY 2000 to nearly $200 million in FY 2004, as illustrated in Table 4.2.

Table 4.2
Funding for MHMR State-run Residential Facilities
(FY 2000 to FY 2004)

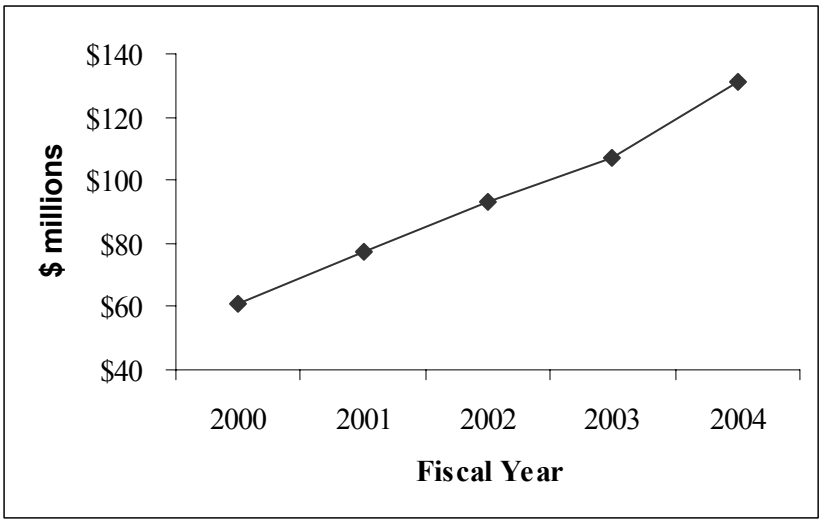
Type of Facility	Fiscal Year (funding in $ millions)				
	2000	2001	2002	2003	2004
Psychiatric Hospital	$86.3	$91.3	$92.7	$90.4	$89.6
Nursing	$10.1	$10.6	$11.4	$11.5	$11.8
Intermediate Care	$64.7	$80.5	$94.1	$94.3	$98.6
Total	$161.1	$182.5	$198.2	$196.2	$199.9

Source: Compiled by Program Review staff from information provided by the Department for Mental Health and Mental Retardation Services.

Supports for Community Living expenditures have more than doubled in the past five years.

MHMR administers the Supports for Community Living program; Medicaid funds the benefits. Figure 4.E illustrates that total program expenditures have more than doubled in the past five years from $61 million in FY 2000 to $131 million in FY 2004.

Figure 4.E
Supports for Community Living
Administrative and Benefit Expenditures
(FY 2000 to FY 2004)



Source: Compiled by Program Review staff from information provided by the Department for Mental Health and Mental Retardation Services and the Department for Medicaid Services.

Funding of Local Ombudsman Offices

Local ombudsman services are provided by area agencies on aging.

Area agencies on aging in area development district offices provide local long-term care ombudsman services. The local ombudsmen are advocates who assist residents of long-term care facilities in resolving complaints, including allegations of abuse, neglect, and exploitation. The local offices operate under policy

guidance from the State Long Term Care Ombudsman in the Cabinet for Health and Family Services.

Local ombudsman offices are funded in part by civil monetary penalties against long-term care facilities. The amount of penalties collected varies over time.

Part of the funding for local ombudsman offices has consisted of civil monetary penalties paid by long-term care facilities for violating federal laws and regulations for the care and protection of residents. The penalties are imposed by the federal Centers for Medicare and Medicaid Services based on the results of surveys and investigations of facilities conducted by the state Office of Inspector General.

The amount of penalties collected varies from year to year. The Office of Inspector General reported that $1.08 million was collected in FY 2003, and more than $450,000 was made available to local ombudsman offices. In FY 2004, less than $600,000 was collected, and $460,000 was made available to local ombudsman offices. No civil monetary penalties funding was made available to the offices under the Governor's spending plan for the first quarter of
FY 2005.

Some local ombudsmen have had to curtail services.

The lack of adequate funding in FY 2005 has caused some local ombudsmen to curtail services, which can increase the vulnerability of facility residents. Federal grants and other dedicated state money could be used to supplement funding to the offices.

Recommendation 4.9

The Cabinet for Health and Family Services should fully fund a full-time long-term care ombudsman office in every area development district each year. In coordination with implementation of Recommendation 4.1, the Governor's Office and the cabinet should explore the use of federal grants and other dedicated state money to supplement the civil monetary penalties used to fund the offices.

Federal Grant Opportunities

Federal grants are available for the care and protection of vulnerable adults.

Federal grants are available to state and local agencies, not-for-profit and faith-based organizations, and various associations and coalitions to help address the issue of adult abuse, neglect, and exploitation. Examples include:

- *Helping Outreach Programs to Expand Grant*: The U.S. Department of Justice's Office for Victims of Crime provides up to $5,000 in funding to grassroots community-based and

faith-based victim service organizations and coalitions to improve outreach and services to crime victims through support of program development, networking, coalition building, and service delivery. Funds may be used to develop program literature, train advocates, produce a newsletter, support victim outreach efforts, and recruit volunteers.

- *Programs for Prevention of Elder Abuse, Neglect, and Exploitation*: The U.S. Department of Health and Human Services appropriated approximately $5 million to provide formula grants to states to support activities to develop, strengthen, and carry out programs for the prevention and treatment of elder abuse, neglect, and exploitation. The funds may be used for activities such as providing for public education; ensuring the coordination of services provided by area agencies on aging; promoting the development of information and data systems; conducting training for individuals, professionals, and paraprofessionals in relevant fields; and providing technical assistance to programs that provide or have the potential to provide services for victims of elder abuse, neglect, and exploitation.

- *Training Grants to Stop Abuse and Sexual Assault Against Older Individuals or Individuals with Disabilities Program*: The U.S. Department of Justice appropriated approximately $5 million in 2003 to train law enforcement officers, prosecutors, and court personnel to recognize, address, investigate, and prosecute cases of elder abuse, neglect, and exploitation. The grants also include training about violence against individuals with disabilities and the elderly, including domestic violence and sexual assault. States agencies, local governments, not-for-profit organizations, and judicial organizations may apply.

Internet tools are available to help agencies find grant opportunities.

Many tools are available to help agencies find grant opportunities. A popular Internet tool is Grants.gov, which allows organizations to electronically find and apply for competitive grant opportunities from all federal grant-making agencies. The site contains more than 900 grant programs offered by 26 federal agencies. Grants.gov also provides mailing lists for certain types of grants.

Some grants require interagency cooperation and one application for the state.

Cooperation Among State Agencies Is Required. The nature of many federal grants requires state agencies in different cabinets and departments to work together. Grant applications require early collaboration by encouraging different agencies to submit one application for the state.

An example of such a federal grant opportunity is the 2004 Program for Background Checks for Employees with Direct Access to Individuals Who Require Long Term Care. The federal Centers for Medicare and Medicaid Services is inviting proposals from states to be considered for inclusion in the mandated Background Check Program. Up to 10 states will be allowed to participate. The amount of funds to be awarded to each state will be between $500,000 and $5 million, and states will be able to expend these funds through 2007. No state matching or cost-sharing funds are required.

Officials of the Cabinet for Health and Family Services and the Justice and Public Safety Cabinet told Program Review staff that the two cabinets have tried to develop a proposal but have not been able to agree on several important issues. As of October 11, 2004, no proposal from the Commonwealth had been finalized. The deadline to apply is October 15. The Commonwealth may lose the opportunity to obtain the grant money and help develop a program that will be implemented nationally in a few years.

Implementing Recommendation 4.1 will facilitate the identification of federal grant opportunities and interagency cooperation in obtaining the grants.

Other grants anticipate that work will be coordinated between levels of government and include nongovernmental entities.

Cooperation With Local Governments and Others Is Required. Some grants anticipate that work will be coordinated between state agencies, local governments, nonprofit organizations, and/or faith-based and charitable organizations. Implementing Recommendations 4.1 and 4.9 will facilitate cooperation among state and local entities that provide care for and protection of vulnerable adults.

Agencies in the Louisville Area Use Grants To Facilitate Coordination of Adult Protective Services

Agencies in the Louisville area rely on federal grant money for success.

As noted throughout this report, Louisville has been the leader in the state in tackling adult abuse, neglect, and exploitation. State and local agencies in the Louisville area have relied on federal grant money for some of their success.

In 2004, the Louisville Metro Office for Aging and Disabled Citizens was awarded nearly $250,000 from the U.S. Department of Justice's grant to Stop Abuse and Sexual Assault Against Older Individuals or Individuals with Disabilities. This grant program provides training for law enforcement officers, prosecutors, and court officers to enhance their ability to recognize, address,

investigate, and prosecute instances of elder abuse, neglect, and exploitation and violence against individuals with disabilities, including domestic violence and sexual assault against older or disabled individuals. Eligible recipients for this grant include state agencies, units of local government, not-for-profit organizations, advocacy organizations, national criminal justice constituency organizations, and judicial organizations.

This grant money was used to sponsor a multidisciplinary training session on September 9, 2004. Individuals from the local DCBS office, the Commonwealth's attorney's office, Louisville Metro Police Department, county coroner's office, Center for Women and Families, ElderServe, and GuardiaCare (a not-for-profit organization providing guardianship services) attended. Participants received training materials and other relevant information, such as a laminated card summarizing the different types of adult abuse and the relevant statutes and penalties. Case studies were used to help participants understand the different roles of the various community partners.

An example of what can be achieved with federal grant funds by not-for-profit organizations and church groups is ElderServe, Inc. The mission of ElderServe is to offer a range of supportive human services that enable older persons in the Louisville area to live secure, self-directed lives. ElderServe is the oldest and largest agency in Louisville that serves senior citizens. The agency offers a wide variety of services to the elderly who are homebound and frail as well as to persons who are well and active. Appendix G describes some of ElderServe's programs.

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Appendix A

Signs of Adult Abuse, Neglect, and Exploitation From the Department for Community Based Services' Web Site

Signs of physical abuse include

- frequent injuries, such as bruises, burns, and broken bones, especially when the explanation of the injury seems unrealistic;
- multiple bruises in various stages of healing, particularly bruises on inner arms or thighs;
- chronic or acute physical illness;
- pain on being touched;
- obvious malnutrition and/or dehydration;
- loss of bowel and/or bladder control;
- many medicine bottles in sight and/or the appearance of sleepiness or sedation;
- appearance of fright or withdrawal;
- never leaving the house and/or never allowed visitors;
- never mentioning family or friends;
- confinement to a chair or bed;
- being locked in a room or tied up; and
- clothing that is not appropriate for the weather.

Signs of sexual abuse include

- evidence of sexually transmitted disease;
- irritation or injuries to the mouth, genitals, or anus;
- upset when changed or bathed;
- fearful of a particular person; and
- loss of bowel and/or bladder control.

Signs of emotional or psychological abuse include

- isolation from family and friends;
- sudden dramatic change in behavior, for example, appears withdrawn, depressed, or hesitates to talk openly;
- caregiver will not let the victim speak for himself or herself;
- caregiver scolds, insults, or threatens the victim;
- trembling or clinging behavior;
- fearfulness, hopelessness, and anxiety;
- lack of eye contact;
- confusion or disorientation; and
- anger or agitation.

Signs of caretaker neglect or self-neglect include

- obvious malnutrition and/or dehydration;
- dirty, uncombed hair and offensive body odor;
- torn and dirty clothes that are not appropriate for the weather;
- being unshaven;
- lack of glasses, dentures, and/or hearing aid;
- lack of medical care;
- apparent weight loss;
- bedsores;
- recent loss of a spouse, family members, or close friends;
- exterior or interior of the home in poor repair;
- filthy living environment and/or strong odors;
- little or no food in the refrigerator or decayed and moldy food;
- many pets or animals that appear neglected;
- garbage or litter, including excessive alcohol containers;
- unkempt lawn or walks; and
- mail or newspapers not taken in.

Signs of financial exploitation include

- unusual activity in a bank account, sudden large withdrawals, and/or expenditures that are not consistent with past financial history;
- use of automated teller machines when the person has no history of using ATMs or cannot walk or otherwise get to an ATM;
- a recent will, when the person seems incapable of writing a will;
- rights signed away on legal papers without understanding what the papers mean;
- unpaid bills, such as house payment, rent, taxes, or utilities;
- lack of food, clothing, or personal supplies;
- title to home signed over in exchange for a promise of lifelong care; and
- missing personal belongings, such as art, silverware, jewelry, or television.

Source: http://chfs.ky.gov/dcbs/dpp/eaa/signsOfAbuse.htm

Appendix B

The DSS-115 Form

DSS Number:
DSS Name:

DSS-115
Rev.7/94

COMMONWEALTH OF KENTUCKY
CABINET FOR FAMILIES AND CHILDREN
DEPARTMENT FOR COMMUNITY BASED SERVICES

CONFIDENTIAL SUSPECTED ABUSE/NEGLECT, DEPENDENCY OR EXPLOITATION REPORTING FORM

TYPE REPORT: ☐Child ☐Adult ☐Spouse County of Report: Time Report Received:

Report Date: Incident Date(s):

Name(s)	Age	Sex	Nature of Report

2. Current Address:
   Telephone Number:

3. Directions:

4. Parent(s)/Guardian/Caretaker:
   Name Relationship

5. Other Known Household Members:

6. Describe nature/extent/causes of abuse/neglect/dependency, or exploitation. List witnesses and/or collateral contacts, previous incidents or reports. Describe behavior of adult victim and of alleged perpetrator (dangerous?)

7. Alleged Perpetrators:

Name	Relationship	Address	Telephone Number

8. Person Taking Report: Title:

9. Worker Assigned to Investigate: County: Telephone Number:
   by: Family Services Office Supervisor:

10. Law Enforcement Notification sent to:

_____
County Attorney/Commonwealth Agency

_____
Law Enforcement Agency

10a. Law Enforcement requested to do Criminal Records Check on:

☐ Alleged Perpetrator(s) ☐ Other (specify) _____
Name & Relationship

11. Notification of Initial Results of CPS Investigation: (72 Hour Status Report) Date_____

Appendix C

Examples of Multidisciplinary Problem-solving Exercises for Adult Protective Services Training

The following problem-solving exercises were provided to Program Review staff by Nikki Henderson. Before her recent retirement from the Louisville Metro Police Department, Henderson led the department's Crimes Against Seniors Unit. She now works for AARP and provides multidisciplinary training throughout the Commonwealth. The exercises focus on elderly persons living in the community but can be adapted for use by any group that wants to improve coordination of adult protective services.

Potential training partners include, but are not limited to, social workers, law enforcement officers, prosecutors, bankers, and providers of guardianship services. For each exercise, the large group is divided into smaller multidisciplinary teams. Each team is instructed to read and discuss a scenario and then determine the "ideal" community response to the incident. The team also is instructed to determine which agencies should or could be involved to protect the individual, as well as which service linkages should or could be made to enable the vulnerable adult to obtain other necessary assistance. The team is instructed to write its answers and be prepared to present its responses to the other teams.

Some of the following scenarios refer to ElderShelter and GuardiaCare. Both agencies operate in the Louisville area. ElderShelter provides temporary shelter to elderly victims of abuse, neglect, and exploitation. GuardiaCare provides guardianship services to vulnerable adults.

Problem-solving Exercise #1

Jane, a 79-year-old mother of three, lives in a house with her son Michael. She has two daughters who live out of state. Jane suffers from arthritis and hypertension for which she takes medication but otherwise is in good health and not in need of supervision. Although she has become somewhat forgetful over the past five years, she continues to have responsibility for her fiscal affairs.

Last week, after a reported fall in her kitchen, Jane broke her hip. After a thorough examination at the hospital, doctors noticed bruising on her arms and shoulders that appear to be unrelated to the fall.

Michael does not work and relies on his mother's pension for food, shelter, and money. He says that he is needed at home to "look after" his mother. He gets her checks, helps her pay her bills, goes to the grocery, and helps clean the house. Her daughters think their brother is taking advantage of their mother. Jane defends her son and even provides him with "spending money." Afraid to live alone, it is important to Jane that her son is there

for her. She reports that Michael can be a "handful" when he has had a few beers but that he cares about her.

Possible things to look for:

Report to DCBS Adult Protective Services
Police investigation, including thorough investigation of bank records
ElderShelter network use?
Prosecution (depends on police investigation)
Domestic dynamics (evidence of sexual assault?)
Son's alcohol use
Daughters' motives
Home health care availability

Problem-solving Exercise #2

After hearing repetitive cries, neighbors called the police to report problems with their neighbor. Dorothy was living in a small apartment at the rear of a very large complex. Many of the adjoining apartments were empty, and so there were few residents and very little traffic. Usually someone would come by once a day to bring food to Dorothy. When the police arrived, they found Dorothy lying on the living room sofa with her dog in her lap. She couldn't walk and was in a soiled diaper. There was some food in the refrigerator but Dorothy couldn't get to it. There were candy and sodas by her sofa. She ordered everyone out of the apartment and began to scream profanities. Kelly, Dorothy's power of attorney, arrived at the apartment shortly after the police. She stated that she checks in on Dorothy approximately 3 to 4 times a day to make sure she is all right.

Possible things to look for:

Report to DCBS Adult Protective Services
Call to emergency medical services (EMS)
Police investigation
ElderShelter network use?
GuardiaCare use?
Prosecution (depends on police investigation)
Change in power of attorney; disability proceedings
Home health care availability

Problem-solving Exercise #3

Edith has one son and two daughters, all of whom are married and living in town. Because she was becoming forgetful and needed some supervision, Edith's daughter Grace and her family moved into her home. Grace got Edith to name her as "power of attorney." Three months later, Edith deeded the house to Grace. Eventually, Edith became ill and was sent to a hospital and later placed in a nursing home. Grace and her family moved out of state. When the other siblings entered the house, they discovered

that Edith's accounts were empty, the house had been mortgaged, and no payments had ever been made toward the mortgage on the house.

Possible things to look for:

Report to DCBS Adult Protective Services; may need Medicaid bed; past reports?
Police investigation (possible physical and financial abuse)
Prosecution (depends on police investigation)
Change in power of attorney; disability proceedings

Problem-solving Exercise #4

At age 70, John lived alone. Over the past several years his health had been declining. His diabetes was becoming more difficult to manage. On a recent trip to the VA hospital, John met Gwen. She offered to help him by doing cooking and cleaning. John decided to purchase another house where he and Gwen could both live on the first floor. He has plans to rent out the second floor, or Gwen may start a boarding home to care for others. The additional tenant would cover the house payment on the new house. Gwen takes John's credit card and makes all the purchases, including numerous appliances and furniture items. They have also made several trips to the "gambling boat." When Gwen began to ask for large amounts of cash, John became concerned. A bank teller who has known John for years overheard one of these conversations and called APS to report that John's funds had dropped rapidly and his credit card bills were skyrocketing. The teller was concerned that John may not be aware of the bills being incurred on his account by Gwen.

Possible things to look for:

Report to DCBS Adult Protective Services
Police investigation (including possible misuse of veterans benefits?)
GuardiaCare use?
Prosecution (depends on police investigation)

Problem-solving Exercise #5

Sally is a 92-year-old woman with a military background and a history with Adult Protection dating back to 1996. She is blind due to glaucoma, is wheelchair bound, has a decubitus (bedsore) on her coccyx, and is incontinent. Although her home burned in 1997, she refused to be placed outside of her home. She stayed in several hotels but was asked to leave because of dog and cat feces everywhere and for trashing of the room. Sally then started staying in an abandoned car on the back of her property. She was able to get back into her home in 1998, but she continues to live alone. Her house is filthy with adult diapers strewn throughout and cat and dog feces everywhere. In 1998, she was found several times on the floor and eventually broke her hip. She has been uncooperative with therapy and refuses placement.

Over the past few years, Sally's medical condition had continued to get worse. She leaves her door open so that friends and care providers can come and go but, as a result, her home has been broken into. She sleeps in her wheelchair most nights because she is fearful and/or there isn't anyone to assist her into bed. She has had numerous agencies involved with her over the years and either she has fired them or they have pulled out because of the conditions of the home. All feel she is at risk because she does not have a 24-hour care provider. Sally is extremely independent but does not mind asking for help, often coming across as demanding. She is very guarded and does not like to be asked too many questions because she knows it is an attempt to question her competency and an attempt to get her out of her home.

Possible things to look for:

Report to DCBS Adult Protective Services
Call to emergency medical services (EMS)?
GuardiaCare use?
Disability proceedings, mental inquest?
Home health care availability

Appendix D

Adult Protective Services Incident Investigations by DCBS Region and County January 1, 2002, to September 30, 2003

(Excluding Domestic Violence and Self-Neglect)

In TWIST an incident could have multiple alleged victims and perpetrators. An incident was counted once for each alleged victim and type of allegation (abuse, neglect, exploitation), regardless of how many alleged perpetrators were involved. Investigations do not include incidents in which the victim could not be located or those for which "Accepted for Investigation" was the only outcome. Incidents were assigned to a county based on the referral county. This may differ from the DCBS office that worked the incident. See report text for details. Regions or counties are shown as "Below" or "Above" the rest of the state only when the difference is statistically significant ($p<0.01$ using chi-square test for KIPDA Jefferson region and Jefferson County, $p<0.01$ using two-sided Fisher's Exact Test for all other regions and counties). Localities with the same percentage may not have the same level of statistical significance.

Worker's DCBS Region/ County	Number of Incidents Referred	Number of Incidents Investigated	% of Incidents Investigated	Different from Rest of State
Barren River	1,343	634	47%	Below
Big Sandy	1,850	900	49%	Below
Bluegrass Fayette	1,533	947	62%	
Bluegrass Rural	1,384	849	61%	
Cumberland Valley	1,142	568	50%	Below
FIVCO	496	342	69%	
Gateway/Buffalo Trace	412	383	93%	Above
Green River	1,520	824	54%	Below
Kentucky River	1,005	671	67%	
KIPDA Jefferson	4,462	4,042	91%	Above
KIPDA Rural	194	111	57%	
Lake Cumberland	1,080	554	51%	Below
Lincoln Trail	1,472	458	31%	Below
Northern Kentucky	1,233	852	69%	Above
Pennyrile	886	599	68%	
Purchase	503	447	89%	Above

Worker's DCBS Region/ County	Number of Incidents Referred	Number of Incidents Investigated	% of Incidents Investigated	Different from Rest of State
Adair	45	35	78%	
Allen	46	28	61%	
Anderson	79	49	62%	
Ballard	11	11	100%	
Barren	30	23	77%	
Bath	40	34	85%	Above
Bell	243	127	52%	Below
Boone	20	18	90%	
Bourbon	46	24	52%	
Boyd	141	77	55%	
Boyle	88	68	77%	
Bracken	46	43	93%	Above
Breathitt	65	59	91%	Above
Breckinridge	30	25	83%	
Bullitt	38	5	13%	Below
Butler	13	12	92%	
Caldwell	18	14	78%	
Calloway	45	40	89%	Above
Campbell	37	35	95%	Above
Carlisle	14	13	93%	
Carroll	69	62	90%	Above
Carter	74	58	78%	
Casey	102	15	15%	Below
Christian	207	120	58%	
Clark	29	26	90%	Above
Clay	115	109	95%	Above
Clinton	195	44	23%	Below
Crittenden	20	17	85%	
Cumberland	12	7	58%	
Daviess	1,008	472	47%	Below
Edmonson	7	5	71%	
Elliott	16	14	88%	
Estill	35	24	69%	
Fayette	1,533	947	62%	
Fleming	70	69	99%	Above
Floyd	582	270	46%	Below
Franklin	180	153	85%	Above
Fulton	33	31	94%	Above
Gallatin	3	2	67%	
Garrard	26	22	85%	
Grant	344	67	19%	Below

Worker's DCBS Region/ County	Number of Incidents Referred	Number of Incidents Investigated	% of Incidents Investigated	Different from Rest of State
Graves	128	115	90%	Above
Grayson	29	25	86%	
Green	29	28	97%	Above
Greenup	171	152	89%	Above
Hancock	27	21	78%	
Hardin	1,137	261	23%	Below
Harlan	206	96	47%	Below
Harrison	18	11	61%	
Hart	60	48	80%	
Henderson	180	132	73%	
Henry	31	28	90%	Above
Hickman	21	20	95%	Above
Hopkins	328	287	88%	Above
Jackson	13	11	85%	
Jefferson	4,462	4,042	91%	Above
Jessamine	112	87	78%	Above
Johnson	236	204	86%	Above
Kenton	651	581	89%	Above
Knott	175	152	87%	Above
Knox	39	27	69%	
LaRue	20	9	45%	
Laurel	472	170	36%	Below
Lawrence	94	41	44%	Below
Lee	100	37	37%	Below
Leslie	29	25	86%	
Letcher	306	132	43%	Below
Lewis	23	21	91%	Above
Lincoln	126	108	86%	Above
Livingston	58	13	22%	Below
Logan	65	7	11%	Below
Lyon	24	15	63%	
Madison	172	112	65%	
Magoffin	147	116	79%	Above
Marion	50	35	70%	
Marshall	51	30	59%	
Martin	120	96	80%	Above
Mason	20	19	95%	Above
McCracken	200	187	94%	Above
McCreary	38	30	79%	
McLean	16	15	94%	
Meade	46	22	48%	

Worker's DCBS Region/ County	Number of Incidents Referred	Number of Incidents Investigated	% of Incidents Investigated	Different from Rest of State
Menifee	17	15	88%	
Mercer	55	47	85%	Above
Metcalfe	41	36	88%	Above
Monroe	26	23	88%	Above
Montgomery	65	62	95%	Above
Morgan	31	30	97%	Above
Muhlenberg	140	93	66%	
Nelson	144	69	48%	Below
Nicholas	36	20	56%	
Ohio	154	56	36%	Below
Oldham	30	24	80%	
Owen	58	52	90%	Above
Owsley	66	28	42%	Below
Pendleton	51	35	69%	
Perry	232	214	92%	Above
Pike	765	214	28%	Below
Powell	51	22	43%	Below
Pulaski	504	288	57%	Below
Robertson	0	0	0%	
Rockcastle	13	10	77%	
Rowan	100	90	90%	Above
Russell	61	32	52%	
Scott	74	52	70%	
Shelby	59	33	56%	
Simpson	39	29	74%	
Spencer	17	10	59%	
Taylor	41	33	80%	
Todd	57	13	23%	Below
Trigg	34	27	79%	
Trimble	19	11	58%	
Union	117	111	95%	Above
Warren	1,016	423	42%	Below
Washington	16	12	75%	
Wayne	53	42	79%	
Webster	18	17	94%	Above
Whitley	41	18	44%	Below
Wolfe	32	24	75%	
Woodford	257	24	9%	Below
State:	**20,515**	**13,181**	**64%**	

Appendix E

Types of Adult Protective Services Incidents Investigated by DCBS Region and County January 1, 2002, to September 30, 2003

(Excluding Domestic Violence and Self-Neglect)

In TWIST an incident could have multiple alleged victims and perpetrators. An incident was counted once for each alleged victim and type of allegation (abuse, neglect, exploitation), regardless of how many alleged perpetrators were involved. Investigations do not include incidents in which the victim could not be located or those for which "Accepted for Investigation" was the only outcome. Incidents were assigned to a county based on the referral county. This may differ from the DCBS office that worked the incident. See report text for details. Regions or counties are shown as "Below" or "Above" the rest of the state only when the difference is statistically significant ($p<0.01$ using two-sided Fisher's Exact Test). Localities with the same percentage may not have the same level of statistical significance.

Worker's DCBS Region/County	Total Incidents Investi-gated	Abuse Incidents	% of Total: Abuse	Different from Rest of State	Care-taker Neglect Incidents	% of Total: Neglect	Exploi-tation Incidents	% of Total: Exploi-tation
Barren River	634	275	43%	Above	285	45%	74	12%
Big Sandy	900	291	32%	Below	511	57%	98	11%
Bluegrass Fayette	947	304	32%	Below	431	46%	212	22%
Bluegrass Rural	849	337	40%		417	49%	95	11%
Cumberland Valley	568	228	40%		279	49%	61	11%
FIVCO	342	171	50%	Above	137	40%	34	10%
Gateway/ Buffalo Trace	383	175	46%	Above	162	42%	46	12%
Green River	824	450	55%	Above	324	39%	50	6%
Kentucky River	671	204	30%	Below	420	63%	47	7%
KIPDA Jefferson	4,042	1,511	37%		1,764	44%	767	19%
KIPDA Rural	111	52	47%		40	36%	19	17%
Lake Cumberland	554	216	39%		288	52%	50	9%
Lincoln Trail	458	175	38%		240	52%	43	9%
Northern Kentucky	852	322	38%		385	45%	145	17%
Pennyrile	599	217	36%		327	55%	55	9%
Purchase	447	129	29%	Below	274	61%	44	10%

Worker's DCBS Region/County	Total Incidents Investi-gated	Abuse Incidents	% of Total: Abuse	Different from Rest of State	Care-taker Neglect Incidents	% of Total: Neglect	Exploi-tation Incidents	% of Total: Exploi-tation
Adair	35	12	34%		16	46%	7	20%
Allen	28	7	25%		13	46%	8	29%
Anderson	49	43	88%	Above	6	12%	0	0%
Ballard	11	1	9%		8	73%	2	18%
Barren	23	18	78%	Above	4	17%	1	4%
Bath	34	16	47%		13	38%	5	15%
Bell	127	49	39%		72	57%	6	5%
Boone	18	7	39%		7	39%	4	22%
Bourbon	24	16	67%	Above	7	29%	1	4%
Boyd	77	27	35%		46	60%	4	5%
Boyle	68	20	29%		42	62%	6	9%
Bracken	43	25	58%		13	30%	5	12%
Breathitt	59	21	36%		32	54%	6	10%
Breckinridge	25	9	36%		9	36%	7	28%
Bullitt	5	3	60%		2	40%	0	0%
Butler	12	4	33%		8	67%	0	0%
Caldwell	14	7	50%		7	50%	0	0%
Calloway	40	9	23%		27	68%	4	10%
Campbell	35	16	46%		14	40%	5	14%
Carlisle	13	3	23%		6	46%	4	31%
Carroll	62	13	21%	Below	42	68%	7	11%
Carter	58	18	31%		26	45%	14	24%
Casey	15	6	40%		7	47%	2	13%
Christian	120	60	50%		54	45%	6	5%
Clark	26	7	27%		15	58%	4	15%
Clay	109	27	25%	Below	60	55%	22	20%
Clinton	44	32	73%	Above	10	23%	2	5%
Crittenden	17	10	59%		7	41%	0	0%
Cumberland	7	4	57%		3	43%	0	0%
Daviess	472	282	60%	Above	164	35%	26	6%
Edmonson	5	1	20%		3	60%	1	20%
Elliott	14	5	36%		6	43%	3	21%
Estill	24	9	38%		13	54%	2	8%
Fayette	947	304	32%	Below	431	46%	212	22%
Fleming	69	40	58%	Above	28	41%	1	1%
Floyd	270	56	21%	Below	197	73%	17	6%
Franklin	153	41	27%	Below	90	59%	22	14%
Fulton	31	8	26%		17	55%	6	19%
Gallatin	2	1	50%		0	0%	1	50%
Garrard	22	7	32%		14	64%	1	5%
Grant	67	25	37%		33	49%	9	13%
Graves	115	43	37%		62	54%	10	9%
Grayson	25	14	56%		8	32%	3	12%
Green	28	5	18%		22	79%	1	4%
Greenup	152	93	61%	Above	47	31%	12	8%

Worker's DCBS Region/County	Total Incidents Investi-gated	Abuse Incidents	% of Total: Abuse	Different from Rest of State	Care-taker Neglect Incidents	% of Total: Neglect	Exploi-tation Incidents	% of Total: Exploi-tation
Hancock	21	8	38%		13	62%	0	0%
Hardin	261	95	36%		143	55%	23	9%
Harlan	96	54	56%	Above	33	34%	9	9%
Harrison	11	6	55%		4	36%	1	9%
Hart	48	16	33%		25	52%	7	15%
Henderson	132	43	33%		72	55%	17	13%
Henry	28	14	50%		7	25%	7	25%
Hickman	20	1	5%	Below	19	95%	0	0%
Hopkins	287	90	31%		160	56%	37	13%
Jackson	11	3	27%		8	73%	0	0%
Jefferson	4,042	1,511	37%		1,764	44%	767	19%
Jessamine	87	45	52%		32	37%	10	11%
Johnson	204	92	45%		98	48%	14	7%
Kenton	581	226	39%		244	42%	111	19%
Knott	152	12	8%	Below	134	88%	6	4%
Knox	27	14	52%		12	44%	1	4%
LaRue	9	4	44%		3	33%	2	22%
Laurel	170	69	41%		80	47%	21	12%
Lawrence	41	28	68%	Above	12	29%	1	2%
Lee	37	21	57%		12	32%	4	11%
Leslie	25	11	44%		7	28%	7	28%
Letcher	132	40	30%		84	64%	8	6%
Lewis	21	8	38%		11	52%	2	10%
Lincoln	108	37	34%		59	55%	12	11%
Livingston	13	10	77%	Above	2	15%	1	8%
Logan	7	0	0%		7	100%	0	0%
Lyon	15	3	20%		11	73%	1	7%
Madison	112	41	37%		52	46%	19	17%
Magoffin	116	35	30%		67	58%	14	12%
Marion	35	17	49%		18	51%	0	0%
Marshall	30	12	40%		17	57%	1	3%
Martin	96	50	52%	Above	33	34%	13	14%
Mason	19	5	26%		13	68%	1	5%
McCracken	187	52	28%	Below	118	63%	17	9%
McCreary	30	12	40%		16	53%	2	7%
McLean	15	5	33%		8	53%	2	13%
Meade	22	3	14%		16	73%	3	14%
Menifee	15	6	40%		3	20%	6	40%
Mercer	47	17	36%		28	60%	2	4%
Metcalfe	36	17	47%		15	42%	4	11%
Monroe	23	15	65%		6	26%	2	9%
Montgomery	62	15	24%		34	55%	13	21%
Morgan	30	9	30%		16	53%	5	17%
Muhlenberg	93	19	20%	Below	64	69%	10	11%
Nelson	69	29	42%		36	52%	4	6%

Worker's DCBS Region/County	Total Incidents Investi-gated	Abuse Incidents	% of Total: Abuse	Different from Rest of State	Care-taker Neglect Incidents	% of Total: Neglect	Exploi-tation Incidents	% of Total: Exploi-tation
Nicholas	20	15	75%	Above	4	20%	1	5%
Ohio	56	35	63%	Above	18	32%	3	5%
Oldham	24	11	46%		11	46%	2	8%
Owen	52	19	37%		29	56%	4	8%
Owsley	28	14	50%		13	46%	1	4%
Pendleton	35	15	43%		16	46%	4	11%
Perry	214	73	34%		131	61%	10	5%
Pike	214	58	27%	Below	116	54%	40	19%
Powell	22	10	45%		10	45%	2	9%
Pulaski	288	103	36%		158	55%	27	9%
Robertson	0	0	0%		0	0%	0	0%
Rockcastle	10	3	30%		5	50%	2	20%
Rowan	90	51	57%	Above	31	34%	8	9%
Russell	32	5	16%		21	66%	6	19%
Scott	52	14	27%		27	52%	11	21%
Shelby	33	20	61%		10	30%	3	9%
Simpson	29	6	21%		16	55%	7	24%
Spencer	10	3	30%		5	50%	2	20%
Taylor	33	18	55%		12	36%	3	9%
Todd	13	6	46%		7	54%	0	0%
Trigg	27	12	44%		15	56%	0	0%
Trimble	11	1	9%		5	45%	5	45%
Union	111	69	62%	Above	41	37%	1	1%
Warren	423	191	45%	Above	188	44%	44	10%
Washington	12	4	33%		7	58%	1	8%
Wayne	42	19	45%		23	55%	0	0%
Webster	17	8	47%		8	47%	1	6%
Whitley	18	9	50%		9	50%	0	0%
Wolfe	24	12	50%		7	29%	5	21%
Woodford	24	9	38%		14	58%	1	4%
State:	**13,181**	**5,057**	**38%**		**6,284**	**48%**	**1,840**	**14%**

Appendix F

Outcomes of Adult Protective Services Incident Investigations by DCBS Region and County January 1, 2002, to September 30, 2003

(Excluding Domestic Violence and Self-Neglect)

In TWIST an incident could have multiple alleged victims and perpetrators. An incident was counted once for each alleged victim and type of allegation (abuse, neglect, exploitation), regardless of how many alleged perpetrators were involved. Investigations do not include incidents in which the victim could not be located or those for which "Accepted for Investigation" was the only outcome. Incidents were assigned to a county based on the referral county. This may differ from the DCBS office that worked the incident. See report text for details. Regions or counties are shown as "Below" or "Above" the rest of the state only when the difference is statistically significant ($p<0.01$ using two-sided Fisher's Exact Test). Localities with the same percentage may not have the same level of statistical significance.

Worker's DCBS Region/County	Total Incidents Investi-gated	Substan-tiated	% of Total: Substan-tiated	Different from Rest of State	Some Indica-tion	% of Total: Some Indication	Unsubstan-tiated	% of Total: Unsub-stantiated
Barren River	634	166	26%	Above	66	10%	402	63%
Big Sandy	900	156	17%		85	9%	659	73%
Bluegrass Fayette	947	230	24%	Above	156	16%	561	59%
Bluegrass Rural	849	209	25%	Above	59	7%	581	68%
Cumberland Valley	568	151	27%	Above	45	8%	372	65%
FIVCO	342	45	13%	Below	57	17%	240	70%
Gateway/ Buffalo Trace	383	102	27%	Above	54	14%	227	59%
Green River	824	204	25%	Above	179	22%	441	54%
Kentucky River	671	102	15%	Below	69	10%	500	75%
KIPDA Jefferson	4,042	669	17%	Below	530	13%	2,843	70%
KIPDA Rural	111	33	30%		8	7%	70	63%
Lake Cumberland	554	128	23%		49	9%	377	68%
Lincoln Trail	458	65	14%	Below	43	9%	350	76%
Northern Kentucky	852	149	17%		146	17%	557	65%
Pennyrile	599	133	22%		76	13%	390	65%
Purchase	447	91	20%		66	15%	290	65%

Worker's DCBS Region/County	Total Incidents Investi-gated	Substan-tiated	% of Total: Substan-tiated	Different from Rest of State	Some Indica-tion	% of Total: Some Indication	Unsubstan-tiated	% of Total: Unsub-stantiated
Adair	35	6	17%		3	9%	26	74%
Allen	28	4	14%		3	11%	21	75%
Anderson	49	20	41%	Above	5	10%	24	49%
Ballard	11	2	18%		1	9%	8	73%
Barren	23	4	17%		6	26%	13	57%
Bath	34	15	44%	Above	4	12%	15	44%
Bell	127	26	20%		21	17%	80	63%
Boone	18	2	11%		7	39%	9	50%
Bourbon	24	7	29%		0	0%	17	71%
Boyd	77	12	16%		10	13%	55	71%
Boyle	68	14	21%		8	12%	46	68%
Bracken	43	8	19%		17	40%	18	42%
Breathitt	59	6	10%		0	0%	53	90%
Breckinridge	25	4	16%		1	4%	20	80%
Bullitt	5	4	80%	Above	1	20%	0	0%
Butler	12	3	25%		1	8%	8	67%
Caldwell	14	2	14%		5	36%	7	50%
Calloway	40	2	5%		1	3%	37	93%
Campbell	35	3	9%		5	14%	27	77%
Carlisle	13	2	15%		3	23%	8	62%
Carroll	62	3	5%	Below	6	10%	53	85%
Carter	58	10	17%		4	7%	44	76%
Casey	15	2	13%		2	13%	11	73%
Christian	120	24	20%		10	8%	86	72%
Clark	26	12	46%	Above	1	4%	13	50%
Clay	109	26	24%		8	7%	75	69%
Clinton	44	7	16%		0	0%	37	84%
Crittenden	17	3	18%		1	6%	13	76%
Cumberland	7	2	29%		0	0%	5	71%
Daviess	472	106	22%		120	25%	246	52%
Edmonson	5	0	0%		1	20%	4	80%
Elliott	14	4	29%		3	21%	7	50%
Estill	24	3	13%		0	0%	21	88%
Fayette	947	230	24%	Above	156	16%	561	59%
Fleming	69	26	38%	Above	5	7%	38	55%
Floyd	270	28	10%	Below	16	6%	226	84%
Franklin	153	42	27%		4	3%	107	70%
Fulton	31	6	19%		3	10%	22	71%
Gallatin	2	0	0%		0	0%	2	100%
Garrard	22	3	14%		1	5%	18	82%
Grant	67	8	12%		5	7%	54	81%
Graves	115	29	25%		24	21%	62	54%
Grayson	25	6	24%		0	0%	19	76%
Green	28	6	21%		2	7%	20	71%
Greenup	152	15	10%	Below	36	24%	101	66%

Worker's DCBS Region/County	Total Incidents Investi-gated	Substan-tiated	% of Total: Substan-tiated	Different from Rest of State	Some Indica-tion	% of Total: Some Indication	Unsubstan-tiated	% of Total: Unsub-stantiated
Hancock	21	0	0%		3	14%	18	86%
Hardin	261	44	17%		36	14%	181	69%
Harlan	96	28	29%		5	5%	63	66%
Harrison	11	5	45%		1	9%	5	45%
Hart	48	5	10%		9	19%	34	71%
Henderson	132	29	22%		23	17%	80	61%
Henry	28	10	36%		3	11%	15	54%
Hickman	20	12	60%	Above	3	15%	5	25%
Hopkins	287	78	27%	Above	38	13%	171	60%
Jackson	11	4	36%		1	9%	6	55%
Jefferson	4,042	669	17%	Below	530	13%	2,843	70%
Jessamine	87	31	36%	Above	8	9%	48	55%
Johnson	204	48	24%		32	16%	124	61%
Kenton	581	117	20%		109	19%	355	61%
Knott	152	15	10%	Below	0	0%	137	90%
Knox	27	12	44%	Above	1	4%	14	52%
LaRue	9	1	11%		0	0%	8	89%
Laurel	170	48	28%	Above	8	5%	114	67%
Lawrence	41	4	10%		4	10%	33	80%
Lee	37	6	16%		6	16%	25	68%
Leslie	25	4	16%		4	16%	17	68%
Letcher	132	14	11%	Below	32	24%	86	65%
Lewis	21	3	14%		4	19%	14	67%
Lincoln	108	25	23%		7	6%	76	70%
Livingston	13	3	23%		2	15%	8	62%
Logan	7	5	71%	Above	1	14%	1	14%
Lyon	15	2	13%		7	47%	6	40%
Madison	112	22	20%		8	7%	82	73%
Magoffin	116	23	20%		6	5%	87	75%
Marion	35	4	11%		2	6%	29	83%
Marshall	30	8	27%		7	23%	15	50%
Martin	96	27	28%		11	11%	58	60%
Mason	19	3	16%		1	5%	15	79%
McCracken	187	30	16%		24	13%	133	71%
McCreary	30	2	7%		1	3%	27	90%
McLean	15	4	27%		1	7%	10	67%
Meade	22	1	5%		1	5%	20	91%
Menifee	15	1	7%		3	20%	11	73%
Mercer	47	4	9%		3	6%	40	85%
Metcalfe	36	7	19%		0	0%	29	81%
Monroe	23	9	39%		2	9%	12	52%
Montgomery	62	22	35%	Above	6	10%	34	55%
Morgan	30	2	7%		4	13%	24	80%
Muhlenberg	93	11	12%		3	3%	79	85%
Nelson	69	5	7%	Below	2	3%	62	90%

Worker's DCBS Region/County	Total Incidents Investi-gated	Substan-tiated	% of Total: Substan-tiated	Different from Rest of State	Some Indica-tion	% of Total: Some Indication	Unsubstan-tiated	% of Total: Unsub-stantiated
Nicholas	20	1	5%		7	35%	12	60%
Ohio	56	13	23%		14	25%	29	52%
Oldham	24	2	8%		1	4%	21	88%
Owen	52	11	21%		4	8%	37	71%
Owsley	28	8	29%		4	14%	16	57%
Pendleton	35	5	14%		10	29%	20	57%
Perry	214	49	23%		22	10%	143	67%
Pike	214	30	14%		20	9%	164	77%
Powell	22	2	9%		2	9%	18	82%
Pulaski	288	83	29%	Above	34	12%	171	59%
Robertson	0	0	0%		0	0%	0	0%
Rockcastle	10	0	0%		0	0%	10	100%
Rowan	90	22	24%		10	11%	58	64%
Russell	32	5	16%		0	0%	27	84%
Scott	52	11	21%		1	2%	40	77%
Shelby	33	16	48%	Above	1	3%	16	48%
Simpson	29	8	28%		4	14%	17	59%
Spencer	10	1	10%		1	10%	8	80%
Taylor	33	8	24%		1	3%	24	73%
Todd	13	3	23%		1	8%	9	69%
Trigg	27	7	26%		9	33%	11	41%
Trimble	11	0	0%		1	9%	10	91%
Union	111	47	42%	Above	16	14%	48	43%
Warren	423	121	29%	Above	39	9%	263	62%
Washington	12	0	0%		1	8%	11	92%
Wayne	42	7	17%		6	14%	29	69%
Webster	17	5	29%		2	12%	10	59%
Whitley	18	7	39%		1	6%	10	56%
Wolfe	24	0	0%	Below	1	4%	23	96%
Woodford	24	7	29%		3	13%	14	58%
State:	**13,181**	**2,633**	**20%**		**1,688**	**13%**	**8,860**	**67%**

Appendix G

An Overview of ElderServe

ElderServe was incorporated as Senior House in 1962 by the Community Chest (now Metro United Way). Initial funding for the agency came from the National Council of Jewish Women and the Junior League of Louisville. Now the various programs in ElderServe are funded through the United Way and federal grants. In July 1990, the name of Senior House was changed to ElderServe to signify the expansion of social services provided by the agency. Currently, ElderServe serves approximately 8,000 of Louisville's seniors. ElderServe operates at two sites, one in downtown Louisville and the other in west Louisville.

ElderServe operates several programs to fulfill its mission:

- *Senior Companion:* This program pairs individuals aged 60 and older with seniors and other people who have difficulty with daily living tasks. Through their assistance and friendship, Senior Companions help others live independently in their own homes rather than in an institutional setting. Senior Companions volunteer for 20 hours a week and become part of a team of caregivers. In return, they receive a modest stipend plus meal and transportation reimbursement.

- *TeleCare:* This program is a personal reassurance program for those who need to stay in touch. On a daily basis, TeleCare volunteers call elderly and homebound people. Volunteers call every morning, Monday through Friday, to check on the well-being of those in the program. If someone does not answer, follow-up calls are made, and, if necessary, the volunteer alerts neighbors, family, police and/or medical officials. The requirements to be a client are that 1) clients must want to be called, 2) clients must be available/responsive to receive a phone call between 8:30 and 11:00 a.m., 3) clients need a "contact" person who keeps in touch on a regular basis, and 4) clients contact the home office when they know they will not be available for their morning safety check.

- *Individual Client Services:* This program is designed for individuals in targeted areas of Louisville who have special circumstances in their lives and need temporary social service. Assistance is provided in finding the individual various resources ranging from post-hospital planning to housing, transportation, government benefits, and family relationships.

- *Group Client Services:* Programs are designed for people aged 50 and older and include creative arts, educational and self-help opportunities, and travel and trips.

- *CustomCare Home Service:* This service provides "assistance-in-living" care. Flexible, customized plans for individuals include personal care (bathing, grooming, dressing), home management (light housekeeping, laundry, grocery shopping, light meal preparation), wake-up services (bath, breakfast, medication reminder), chore services (window washing, carpet shampooing, general cleaning). These services are provided at a cost to the individual.

- *Crime Victims Assistance:* In existence since 1996 and funded through the Victims of Crime Act, this program provides assistance to seniors who have been the victims of violent crimes or personal or financial abuse. Victims receive a comprehensive array of services from the beginning of the incident through the court process and beyond, all designed specifically for the elderly. Services include help with filing police reports, finding emergency shelter, replacing identification, obtaining emergency protective orders, working with police, and obtaining crisis intervention and counseling.

- *Adult Day Care:* This program provides adult day care services to high-need, homebound elderly who can utilize a medically supervised setting during the day to allow them to remain in the community and delay institutional or nursing home placement. The facility is licensed and accepts those who qualify for Medicaid and KIPDA subsidies.

- *SeniorLink Corporate Consultation Service:* ElderServe is part of a national network offering assistance to employees of large corporations. Trained, professional staff offer customized consultations to employees who may need assistance in dealing with problems related to services for elderly family members.

- *Grandparenting Program:* Many seniors, because of family circumstances, are in the position of raising their grandchildren. This program provides support services to these seniors and their families.

- *Supporting Independence Initiative (SIT-UP)*: This program is one of six nationally funded projects that enables the elderly and nonelderly residents of public housing to live independently and to prevent premature or unnecessary institutionalization.

- *Nutrition Program:* Lunches are provided Monday through Friday for more than 250 seniors.

- *Dependent Care Solutions (DCS):* This program is a collaboration between ElderServe and Community Coordinated Child Care. DCS is an employer-sponsored service seeking to help employees who are in need of care for their children, elderly parents, or both.