Aging Care Consultation Services
Karin Taifour, MA LMHC GMHS

Agenda

- Elder abuse, aging process, systems issues
- Forms of mistreatment
- If You See Red Flags: Ask, Report, Act
- What happens once you report

You're a mandatory reporter, right??

- RCW 74.34 requires professionals to report if they have **"suspicion"** or **"reason to believe"** that abuse, neglect, abandonment, or financial exploitation of a vulnerable adult has occurred.
  - You do not need to have proof or evidence.
  - Investigating the situation is not your job!
- *If you fail to report, it is a misdemeanor offense.*
- *You can be found liable for damages and can lose your license!*

Knowledge around elder abuse issues

- About three decades behind the knowledge around child abuse.
- About one decade behind the knowledge around domestic violence. (ONPEA)

Three main causes of elder abuse

- Dependency
  - The abused is often dependent on the abuser for physical care and help with activities of daily living.
  - The abuser is often dependent on the abused for financial support.
- Isolation
  - Controls the victim and keeps the abuse/exploitation hidden
- Interpersonal power and control
  - All abusive relationships, regardless of age, are about power and control, and most involve threats, intimidation or coercion.
  - The more vulnerable someone is, the more likely they are to be taken advantage of in some way.

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To understand elder abuse, first…

- You have to understand the aging process
- Aging = susceptibility to abuse/neglect
- Especially functional changes: difficulty defending self, dependent on others for help, fear of losing independence = more vulnerable to threats
- People providing care = people in your personal space, can be dehumanizing, infantilizing, demeaning
- Biggest fear = loss if independence: "I'm an American dammit"

Physical changes that occur with aging

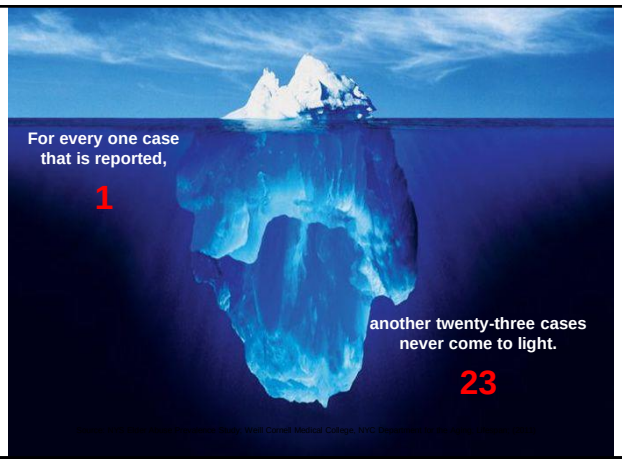
- Our average physical peak at age 20, we all have lots of extra capacity, as we age we have less marginal capacity
- As we age we lose bone density, cardiac function, skin thickness, capillary strength, reaction time, memory
- As age increases, so do chronic Illnesses, medications, depression, and dementia; but there is a decrease in the quantity and quality of social support.

Increased vulnerability

- Physical changes increase vulnerability to abuse/neglect
- Makes people more dependent on others for assistance, increasing the opportunity for abuse, neglect and exploitation to occur
- AND makes it harder for them to recognize it, and to accurately report it
- AND makes it challenging for it to be diagnosed, substantiated
- AND makes it more difficult to recover from it.

Prevalence

- Estimated frequency ranges from 2% to 10%
- Between 1 and 2 million Americans age 65+ have been mistreated by someone on whom they depended for care or protection
- 84% of elder abuse is committed by a relative, most often the victim's adult child



Why don't victims report it?

- Dependence: reliance on the abuser/exploiter, that they may be abandoned
- Fear of retaliation: it will get worse if they say anything
- Lack of knowledge: what is actually abuse, what help there might be, where/how to get help

Why don't others report it?

- Families – family conflict, dysfunctional factors, fear of getting in trouble themselves, thinking it might make things worse, don't know who to call
- Friends/neighbors – don't know who to call, reluctance to get involved, "not my business"
- Professionals – uneducated around signs of it, lack of knowledge about the requirement to report even suspected issues

Cultural factors in abuse reports

- A person's culture of origin influences their family dynamics and what is acceptable behavior and treatment of others
- Culture can also impact whether a person feels able to ask for help outside the family or community
- Cultural factors and prior experience can also affect how the person trusts or feels comfortable with health care providers or other professionals
- LGBTQ seniors are particularly impacted by abuse and exploitation

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Cultural considerations

- Always consider personal attitudes and biases
- Each situation is unique: differences between law, ethics, and moral responsibility
- Involvement of other parties means another set of views:
  - Various disciplines, agencies, and organizations each have their own protocols and priorities.
  - Conflict may occur between different values and philosophies, e.g. protectionism vs self determination.

Risk Factors

- Dementia puts elders at high risk of abuse:
  - Nearly 50% experience some kind of abuse
  - 47% experience mistreatment by caregivers
- Mental illnesses and/or substance disorders often affect perpetrators and/or victims

Dementia ≠ capacity loss

- Early to moderate stages: typically less able to understand, appreciate options in making decisions.
- Moderate to later stages: many can still reason, express choices.
- Dementia care partners are not reliable proxies!
  - People with dementia are consistent in their choices and preferences as they progress through the disease.
  - Caregiver partners often inaccurately estimate what the person with dementia wants.

Red flags

- Dr Laura Mosqueda talked about not liking the term “red flags” as it can make people jump to conclusions:
  - “what we want is for these things to prompt us to ask more questions – if the answer is “I don’t know” or it’s unclear or inconsistent, that’s not good enough.”
- Before we make unfair assumptions, we have to get more info, ask a lot of questions.
- There is no magic line – lots of gray areas. We know what great care is, and we know what terrible care is, but in between…
- Your mindset should be “If I have suspicion, I have to report”

A sudden change is a medical problem

- All of these point to the importance of documenting what is reported at the time of visit
  - Unexplained injuries, implausible or vague explanations, or changing stories
  - Delay in seeking care
  - Recently healed injuries that were never treated
- "A sudden change in behavior is a medical problem until proven otherwise" – Laura Mosqueda
- Differential diagnosis – need to have elder abuse on our list and be sure to rule it out so that we don't miss it.

Issues around systems

- Often there are conflicts between the caregiver's job description or care plan requirements vs person-centered care
  - e.g. family expectations vs professional's approach
  - resistance to care vs prescribed treatments
- Need to look at systemic issues and whole situation – not accusing, but asking questions
  - E.g. if people won't go in to see their doctor – use visiting nurses etc., some way to get eyes on the person and see what's actually going on.

Forms of mistreatment

- Abuse
  - Physical abuse
  - Sexual abuse
  - Verbal, emotional and psychological abuse
- Neglect
  - Self Neglect
- Abandonment
- Financial Exploitation
- Undue Influence

RED FLAGS: Physical Abuse

- Fractures, sprains, strains
- Bruises, welts, cuts, sores, burns
- Injuries in unusual locations, shapes
- Multiple injuries in various healing stages
- Suspicious explanation
- Delay seeking care

Physical abuse can be

- Impacting someone with your hands: pushing, shoving, hitting, slapping, poking, pinching, pulling hair
- Impacting someone with an object: doing any of the above using an item such as a cane, ruler, stick, brush, etc.
- Impacting someone orally: biting them or spitting on or at them
- Confining or restraining a person inappropriately
  - Restraining them to a bed or chair
  - Locking them in a room or barriers to prevent movement
  - Criteria for the use of restraints are very specific and must be for the safety of the older adult – never used as a form of punishment or for the convenience of staff.
  - Use of restraints must be reviewed regularly.

Medical forms of physical abuse

- Over-medicating or under-medicating the person, not giving medication as prescribed
- Not treating or under-treating pain
- Unnecessary therapies or procedures
- Antipsychotics or sedatives for people with dementia ,when environmental changes and supports may better address anxiety, agitation or behaviors.

Key issues with some signs

- E.g. bruises, fractures, burns, pressure sores
- Location, old injuries, history consistent with exam, context – why did it happen
- Consider "abuse until proven otherwise"
  - sometimes it's obvious, e.g. non-ambulatory person gets large burn on their hands.

Mosqueda's bruising study

- 90% of accidental bruises are on extremities.
- 75% don't remember how they got them.
- Color of bruise did not correlate to age.
- People taking meds like warfarin got more bruises but they did not last longer.
- People who were abused had more bruises, on different parts of the body, they were bigger bruises, no one asked about them – but when asked, most people did say that someone hurt them.
- Pay attention to the location, size, and story. ASK how they got it. ASK SPECIFICALLY did anyone hurt you.

Things to consider

- Victim vulnerabilities, functional status
- Caregiver abilities, issues
- Pattern/history of healthcare use – e.g. son says they refuse to go see the doctor, but did they go to the doctor before the son moved in?

Medical workup needed

- Blood tests – helpful to see if malnourished, dehydrated, meds not taken, tox screen
- Care plans, documentation – e.g. with multiple falls, what actions did they take to try to address the issue?
- Asking doctor for labs – may have to educate them that there are concerns about ruling out if abuse or neglect has occurred, this will help us to identify or exclude some issues.

RED FLAGS: Sexual Abuse

- Fear of being touched
- Bruising on breasts, inner thighs, around arms
- Unexplained infections, STDs
- Bleeding in genital areas or mouth
- Difficulty walking or sitting
- Torn, stained, and/or bloody clothing, underwear, bedding
- Inappropriate (enmeshed) relationships between older adult and abuser

Sexual abuse can be

- Any sexual behavior directed toward an older adult without that person's full knowledge and consent; it includes coercing and older person through force, trickery, threats, or other means into unwanted sexual activity. (ONPEA)
- Covers unwanted sexual contact with elder who are unable to consent, as well as between care providers and their elderly clients.
- Gerontophilia – age-discordant sexual preference. Based on analysis of offenders' motivations, researchers have been studying whether this is a separate type of paraphilia

Sexual abuse can be

- Contact offenses:
  - oral, anal, and vaginal rape,
  - unwanted touching, sexualized kissing, fondling
  - Forcing a person to touch another person sexually or to perform a sexual act
- Non-contact offenses:
  - sexual harassment and threats,
  - forced pornography viewing,
  - exhibitionism, and
  - Coerced nudity as a form of humiliation or for explicit photographing

Sexual abuse as "care"

- Unnecessary, obsessive or painful touching of the genital area that is not part of a prescribed nursing care plan – e.g. inserting spoons or fingers into an older adult's rectum, cleansing inner and outer vaginal areas with alcohol wipes.
- Typically, perpetrators claim that these behaviors are necessary for the victim's health or hygiene, despite medical warnings (Chihowski & Hughes, 2008; Ramsey-Klawsnik,1996).
- Sexual homicides of older people also occur (Jeary, 2005; Safarik, Jarvis, & Nussbaum, 2002)

RED FLAGS: Verbal, emotional, psychological

- Elder appears depressed and/or anxious
  - sleep/appetite disturbance
  - decreased social contact
  - loss of interest in self
  - apathy
  - suicidal ideation
- Caregiver (and/or elder) is evasive, anxious, or even hostile

Verbal, emotional, psychological abuse

- Words or actions that put a person down, are hurtful, make the person feel unworthy
- Not considering a person's wishes
- Not respecting a person's belongings or pets
- Denying access to friends or family
- Threats, e.g. to put them "in a home"
- Treating an older adult like a child

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Most harmful

- The World Health Organization found that many older adults report psychological/emotional abuse to be the most harmful. (WHO, 2002)
- Many reported that physical scars could heal but emotional scars were the most difficult to deal with.

RED FLAGS: Neglect

Some things are more obvious:

- Malnutrition
- Dehydration
- Inadequate, dirty, or inappropriate clothing
- Odor, lack of basic hygiene
- Untreated or improperly treated wounds

RED FLAGS: Neglect

Some are less obvious:

- Home cluttered, filthy, in disrepair, fire/safety hazards, or lacking adequate facilities (stove, refrigerator, heat, plumbing, electricity)
- Misuse, disregard, and/or absence of medicines, medical care, assistive devices (eyeglasses, dentures, hearing aids)
- Person with dementia left unsupervised
- Bed-bound person left without care

Neglect: active vs passive

- Difference of motivation:
- Active neglect: deliberate withholding of care and basic necessities of life
  - caregiver is aware that their actions are not in the best interest of the older person.
- Passive neglect: failure to provide proper care due to lack of knowledge, experience, or ability
  - Caregivers may be doing the best they can, may not have the knowledge, skills, or resources to provide adequate care
  - May be misguided by inaccurate or outdated information, e.g. restraints keep the older person safe.

Neglect can be

- Withholding care or medical attention
- Leaving a person in an unsafe place
- Over- or under-medicating
- Not providing food, liquids
- Not providing proper clothing, hygiene, or toileting assistance
- Untreated injuries or wounds, including bedsores

Limiting freedom

- Denying a person privacy in their home environment
- Withholding information the person is entitled to know or receive
- Denying a person visitors or phone calls or mail
- Restricting a person's liberty, not letting them go out or socialize
- A newer issue in WA state: law passed to prevent guardians from limiting access to a person

RED FLAGS: Self-Neglect

Same signs as those for neglect – also:

- Eccentric or idiosyncratic behaviors
- Self-imposed isolation
- Marked indifference to self
- Refusal of help in general, including health care services

Self-neglect

- Many people do not consider self-neglect a form of elder abuse
  - Older person is causing harm to themselves, vs being harmed by another person
  - Variation in states as to whether Adult Protective Services cover it
- In Washington State, self-neglect IS investigated by APS
- Should not rule out the possibility of other forms of elder abuse also being present or having occurred

RED FLAGS: Abandonment

- Abandonment is leaving a senior who is unable to care for him or herself in some way alone and without any way to get help:
  - Person could be left at home alone when they need 24/7 care,
  - Person could be taken to the ER and left there alone, or
  - Person could be left alone in a public place.
- Often it is just the senior's own report that a caregiver has left them without any other assistance.
- Need to look into other types of neglect, abuse, exploitation as well.

RED FLAGS: Financial Exploitation

Changes in will, Power of Attorney or property title documents:

- Sudden or unexplained changes
- Elder is unaware of or unable to comprehend transaction or impact on finances
- Done using new attorney unknown to elder
- Done without involvement of existing or already-named POA or executor

RED FLAGS: Financial Exploitation

Missing funds or decrease in assets:

- Funds wired out of country for mysterious reasons
- On-line transfers though elder doesn't use computer
- Lottery, mail fraud, internet scams

RED FLAGS: Financial Exploitation

Changes in long-time banking or investment patterns:

- Suspect is added to older adult's accounts as joint account holder
- Financial products or services unsuitable for an older adult's circumstances, such as long-term annuities
- Fraudulent investments (Ponzi or pyramid schemes)

RED FLAGS: Financial Exploitation

Inappropriate spending:

- Significant gifting to suspect, inconsistent with elder's gifting history
- Caregiver receiving additional reimbursement for care and companionship beyond contracted amount
- Elder purchasing items that they otherwise wouldn't
  - e.g. luxury items

RED FLAGS: Financial Exploitation

Changes in appearance, health status, habits, living standards:

- Inability or failure to meet basic needs, purchase medicines or medical assistive devices, or to seek medical care (can't afford it)
- Disparity between assets/income vs. appearance/condition
- Missing personal property, cash, valuables, mail
- Unpaid bills

RED FLAGS: Financial Exploitation

Behavior of Exploiter:

- Cashing older adult's check or using credit/debit card without authorization, or forging signature
- Controlling elder's money but failing to provide for elder's needs – "living off" elder
- Isolating and controlling elder:
  - Accompanying to bank to make significant withdrawals
  - Controlling credit/ATM cards, checks, and/or communication

RED FLAGS: Undue Influence

- Array of tactics by perpetrator to take over elder's free will and obtain their "consent" to transfer of assets
- Method to commit Theft
- Pattern of manipulative behaviors: "Process not an event"

RED FLAGS: Undue Influence

Perpetrator behaviors

- Isolate from other people and information, keep unaware
- Intermittent acts of kindness
- Prey on vulnerabilities
- Create dependency, lack of confidence in own abilities
- Create fear, induce shame and secrecy

RED FLAGS: Caregivers

- Verbally aggressive or controlling
- Demeaning, insulting, uncaring
- Overly concerned about spending money (vs. meeting elder's needs)
- Appears to lack concern/interest
- Infantilizes, dismisses, or speaks for the elder
- Provides answers/info different than info provided by the elder
- Overly protective and closely monitors interactions
- Isolating the elder
  - Doesn't let anyone into the home
  - Doesn't let others speak to the elder
  - Doesn't give the elder privacy

RED FLAGS: Chart Notes

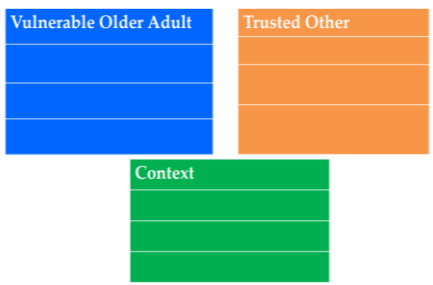
- Impaired patient presenting alone
- ER visits for injuries or unexpected worsening of chronic illness/condition
- "accident prone"
- "non-compliant with medications"
- "resistant to medical care"
- "anxiety disorder"
- "help-rejecting behaviors"

If You See Red Flags…

- Ask about abuse
- Support safety
- Report

How to think about what you see

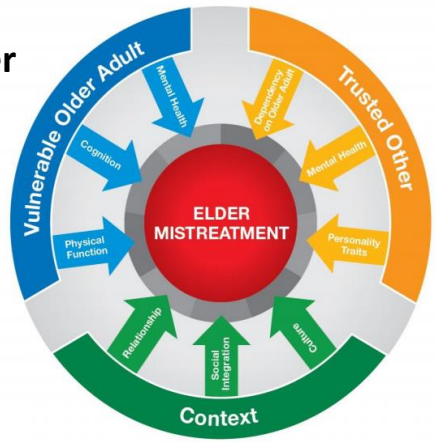
- Dr Laura Mosqueda's Abuse Intervention/Prevention Model (AIM)



From Mosqueda L, Burnight K, Gironda MW, Moore AA, Robinson J, Olsen B. (2016). The Abuse Intervention Model (AIM): A pragmatic approach to intervention for elder mistreatment. *J Am Geriatr Soc*.

And put it together

- Which of these might we influence?



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Tips to screen for elder abuse

- Make it a routine part of your clinical / professional practice to ask every client questions about abuse – and to rule out the possibility of abuse.
- Assure that all discussions are private.
- The primary focus is on patient safety.

Older adults usually will not volunteer information about experiencing abuse or neglect unless specifically asked.

Before you ask

- Attend to the environment
  - Choose a setting where the older adult is comfortable and at ease
  - Do everything possible to ensure that the conversation will not be overheard or interrupted.
- Connect with the person
  - Be mindful of hearing difficulties, language barriers, cultural and religious values.
  - Be attentive, sit facing the person, make eye contact.
  - Use clear and simple language.
  - Establish rapport.
  - Make sure they know this is a safe environment.

Before you ask

- Statement of fact to "normalize" it can be helpful before direct questioning
  - "I don't know if this is a problem for you, but because so many people I see are dealing with abusive relationships, I have started asking about it routinely."
  - "Because there is help available for anyone being abused or exploited, I now ask all the people I meet with about the possibility if it is occurring to them."

As you ask…

- Watch what you say and how you say it:
  - Maintain a relaxed, non-judgmental, supportive demeanor.
  - Talk less and listen more:
    - Allow them to talk at their own pace.
    - Take time to allow them to respond.
  - Avoid comments that may seem like putting down the alleged or suspected abuser.
  - Offer support and discuss options but do not give advice.

Questions to ask the older person

- Has anyone at home ever hurt you?
- Has anyone ever made you do things you did not want to do?
- Has anyone taken something that belongs to you without asking?
- Does anyone scold or threaten you, recently or in the last few years?
- Have you ever signed documents you do not understand?
- Are you afraid of anyone that lives with or cares for you?
- Are you alone often?
- Has anyone ever failed to assist you when you needed help?

Just ASK

- It is acceptable to simply ask,

"Have you been abused or mistreated?"

- Notice inconsistencies and discrepancies. Ask clarifying questions.

Supporting Safety

- Validate person's experiences
- Name it as abuse: No one has the right to abuse you.
- Identify abuse as a problem:
  - The abuser is at fault and was wrong.
  - You did not deserve this or cause it.

Supporting Safety

- Provide information
- Educate about the dynamics of abuse:
  It's not temporary, and it will get worse.
- Affirm person's right to safety/care
- Identify and refer to resources: There are safe options and help.

Supporting Safety

- Establish follow-up process
- Respect autonomy, confidentiality (to the extent possible)
- Plan for safety/emergencies
- Report as required by law

Safety planning

- Process of the protector/helper and the victim jointly creating a plan to minimize victim risk
- Can include:
  - Prevention strategies – relocating to a shelter or moving, restraining or protective orders, hiding
  - Protection strategies – escape routes, shelters, locking in oneself
  - Notification strategies – cell phones, easily accessible emergency numbers, alarm pendants, security systems, code words, faith and community organizations

Questions to ask possible abusers

- All of us have the potential to "take out" our frustration on the folks we care for …
  - Yelling/Belittling
  - Getting physical
- It doesn't mean you're a bad person… it usually means that you're overwhelmed.
- It's ok to acknowledge when you are overwhelmed and accept help.
- Here's what we can do…

Case Studies

Tools and tests

- Tools should not be used as a checklist.
- Screening and assessment tools are not diagnostic tools.
- Providers using tools must be appropriately trained.
- The use of tools requires sensitivity and therapeutic communication skills
- More than one tool may be required to identify different types of abuse and neglect.
- Be mindful of cultural aspects and the unique needs of subpopulations of older adults during the screening process.
- Few tools have been validated for languages other than English.
- Consider what follow-up support will be offered if abuse or neglect is identified.

Adapted from http://rnao.ca/sites/rnao-ca/files/Preventing_Abuse_and_Neglect_of_Older_Adults_final_July31.pdf_)

Screening for elder abuse

- Currently there is no gold standard for elder abuse screening.
- Many screening tools exist, with the majority designed for use by health care providers.
- The American Medical Association recommends that all geriatric patients receive elder abuse screening (Burnett et al., 2014) but the U.S. Preventive Services Task Force said evidence is insufficient (U.S. Preventive Task Force, 2013).
- A positive screen for elder abuse does not ubiquitously mean that elder abuse is occurring, but does indicate that further information should be gathered.

Caution on screening tools

- First make sure there is nothing medical going on! (workup list)
- Be sure to thoroughly familiarize yourself with any tool – watch online training videos to see how it is used in different circumstances
- Practice it with a peer or supervisor before using it with a client/patient
- Stay within your scope of practice!

Tools and tests, with dementia

- Issues in assessment of people with dementia:
  - People are more than the sum of their cognitive abilities: **context** and **psychological vulnerability** are key aspects too.
  - Traditional approaches overemphasize deficits and under-emphasize strengths, while hypothetical vignettes over-emphasize deficits.
  - The subjective experience of the person with dementia remains important: analyzing the actual decision is critical.

Adapted from Mast BT (2011). Whole person dementia assessment. Baltimore, MD: Health Professions Press.

Tools and tests – financial capacity

- Financial capacity differs from other types of capacity in several respects:
  - Focus – broader range of activities and tasks
    - Handling money, making cash transactions, paying bills, banking/checking account usage
    - Ongoing management of resources so needs are met, and avoiding scams
  - Duration – extended time frames
  - Settings – in home, in community, at bank, by phone, online
  - Cognitive components are numerous and multidimensional
    - Mental and written calculations, registering and recalling information
    - Proecedural learning and memory (e.g. how to use a checkbook or ATM)
    - Executive abilities (e.g. organizing and keeping documents or tax records)
    - Varieties of judgment skills

Financial capacity: unique

- Typically decisional capacity concerns are verbal in nature and cognitive testing of verbal conceptual knowledge and short term verbal memory are good predictors of capacity there.
- "Financial capacity comprises a broad range of conceptual, pragmatic, and judgment abilities, used across a range of everyday settings, that are critical to the independent functioning of adults in our society." *(Marson, 2001)*

Financial capacity and dementia

- Financial capacity is one of the first abilities to go as cognition declines.
- Financial performance – e.g., credit cards, home equity loans, mortgages and car loans – peaks in middle age. The decision-making "sweet spot" is age 53.3. (Agarwal, et al, 2009)
- Research found a rapid decline in financial skills over one year in people with mild Alzheimer's. (Martin et al, 2008)
- People with mild cognitive impairment make four times the amount of financial errors. (Roush, 2014)
- Declines in money management skills occur early in clinical disease process, may precede diagnosis of Alzheimer's disease. (Triebel et al, 2009; Griffith et al, 2003)
- Diagnosis of Mild Cognitive Impairment or mild AD should raise red flags about probable financial capacity impairment.

Financial capacity warning signs

- Memory lapses – forgetting to pay bills, or multiple payments.
- Disorganization – difficulty staying on top of finances.
- Math mistakes.
- Confusion – trouble understanding basic financial terms.
- Impaired judgment – e.g. investments that don't make sense.

Assessing financial capacity

- Assessments can be either direct or indirect.
  - Direct: based on a sample of the individual's self-report or actual performance, in an office setting (i.e., interviews, observations, assessment instruments) or a real-life setting (observations).
  - Indirect: based on information from records or third parties (e.g., record review, interviews with individuals knowledgeable about the person's financial performance).

More financial assessment tools

- Some tools designed to assess functional abilities include tasks that relate to financial capabilities, such as identifying and counting currency, writing a check, and balancing a checkbook.
- However, if financial competence is only measured in the test environment, the tests can't capture real-world functional ability.

Documentation tips

- Capture details and specifics – these may be evidence later:
  - assessment findings – risk factors and signs of abuse and neglect;
  - statements (direct quotes) or behavior by the older adult or others;
  - involvement of substitute decision makers;
  - protective factors (e.g., strengths, capacities and effective coping techniques);
  - priorities, needs and preferences of the older adult with regard to lifestyle and care decisions;
  - plan of care/interventions that reflect the older adults' priorities and needs;
  - collaborations with team members and referrals to specialists;
  - applicable legal documents being relied on; and
  - evaluation of plan/interventions.

Mandated reporters in WA

- See Handout

What happens once you report

- Law Enforcement
  - Patrol officer is dispatched to interview reporter, collect evidence
  - If case appears to be criminal, it is assigned to a detective
    - Detective may or may not have specialized training
  - Detective investigates

What happens once you report

- Detective investigates
  - Interviews victim, witnesses
  - May videotape interview of victim
  - Often obtains victim's medical and care records
  - May obtain capacity evaluation of victim
  - Interviews suspect

What happens once you report

- If detective finds sufficient evidence, refers case to
  - County prosecutor if felony, or
  - Municipal or District Court prosecutor if misdemeanor
- Prosecutor:
  - Files charges
  - Declines to file
  - Asks for additional investigation

What happens once you report

- Adult Protective Services / DSHS
  - Contacts reporter, takes down information
  - If case meets criteria set out in 74.34, assigns to investigator
- Investigator:
  - Interviews victims and others, gathers information
  - Obtains financial and medical records
  - Makes finding of substantiated, unsubstantiated, inconclusive
    - Fair hearing, appeals process

If you want to know what happened…

- Law enforcement: Call the assigned detective or sergeant of the involved agency
- Charges were filed: call the relevant prosecutor's office
- APS: Call the assigned investigator and/or supervisor

Remember . . .

- **You must immediately report to authorities**
- **You do not need to have proof or evidence**
- ***Investigating the situation is not your job!***

Remember . . .

You must immediately report any information that leads you to "have reason to believe" that mistreatment has occurred.

If you're not sure if you should report, you probably should.

If you're still not sure what to do, call me and ask!

Aging Care Consultation Services

Helping you solve your puzzle so all the pieces fit into place

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