Colorado Adult Protective Services (APS)

Annual Report – Fiscal Year 2020-21

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August 2021

COLORADO
Adult Protective Services
Division of Aging & Adult Services

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Colorado Adult Protective Services (APS) Program Overview

The Colorado Adult Protective Services (APS) program was established in statute in 1983 to provide protective services for vulnerable persons age 65 and older. The program was expanded in 1991 to the current statute, which establishes protective services for at-risk adults[1] age 18 and older (Title 26, Article 3.1 of the Colorado Revised Statutes). The APS program is located within the Colorado Department of Human Services. The APS program is located within the Colorado Department of Human Services. The purpose of the APS program is to intervene on behalf of at-risk adults to correct or alleviate situations in which actual or imminent danger of abuse[2], caretaker neglect[3], exploitation[4], or harmful act[5] (all of which are grouped in the term "mistreatment"), or self-neglect[6] exist. APS does not have statutory authority to investigate allegations of verbal or emotional abuse, in the absence of other mistreatment categories or self-neglect. APS is charged in statute (Title 26, Article 3.1, C.R.S.) with accepting reports of mistreatment and self-neglect of at-risk adults, investigating the allegations[7], assessing the client for other health and safety needs, and working with the client to implement protective services when

[1] **At-Risk Adult** means an individual eighteen years of age or older who is susceptible to mistreatment or self-neglect because the individual is unable to perform or obtain services necessary for his or her health, safety, or welfare, or lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his or her person or affairs. (Section 26-3.1-101, C.R.S.)

[2] **Abuse,** pursuant to Section 26-3.1-101(1), C.R.S., means any of the following acts or omissions committed against an at-risk adult:

A. The non-accidental infliction of physical pain or injury, as demonstrated by, but not limited to, substantial or multiple skin bruising, bleeding, malnutrition, dehydration, burns, bone fractures, poisoning, subdural hematoma, soft tissue swelling, or suffocation;

B. Confinement or restraint that is unreasonable under generally accepted caretaking standards; or,

C. Unlawful sexual behavior as defined in Section 16-22-102(9), C.R.S.

[3] **Caretaker Neglect**, pursuant to Section 26-3.1-101(2.3)(a), C.R.S., means neglect that occurs when adequate food, clothing, shelter, psychological care, physical care, medical care, habilitation, supervision, or other treatment necessary for the health, safety, or welfare of the at-risk adult is not secured for an at-risk adult or is not provided by a caretaker in a timely manner and with the degree of care that a reasonable person in the same situation would exercise, or when a caretaker knowingly uses harassment, undue influence, or intimidation to create a hostile or fearful environment for an at-risk adult. However, the withholding, withdrawing, or refusing of any medication, any medical procedure or device, or any treatment, including but not limited to resuscitation, cardiac pacing, mechanical ventilation, dialysis, artificial nutrition and hydration, any medication or medical procedure or device, in accordance with any valid medical directive or order, or as described in a palliative plan of care, is not deemed caretaker neglect. In addition to those exceptions identified above, access to Medical Aid in Dying, pursuant to Title 25, Article 48, C.R.S., shall not be considered caretaker neglect.

[4] **Exploitation** means an act or omission that:

A. Uses deception, harassment, intimidation, or undue influence to permanently or temporarily deprive an at-risk adult of the use, benefit, or possession of anything of value; or,

B. Employs the services of a third party for the profit or advantage of the person or another person to the detriment of the at-risk adult; or,

C. Forces, compels, coerces, or entices an at-risk adult to perform services for the profit or advantage of the person or another person against the will of the at-risk adult; or,

D. Misuses the property of an at-risk adult in a manner that adversely affects the at-risk adult's ability to receive health care or health care benefits or to pay bills for basic needs or obligations.

[5] **Harmful act** means an act committed against an at-risk adult by a person with a relationship to the at-risk adult when such act is not defined as abuse, caretaker neglect, or exploitation but causes harm to the health, safety, or welfare of an at-risk adult.

[6] **Self-Neglect**, pursuant to Section 26-3.1-101(10), C.R.S., means an act or failure to act whereby an at-risk adult substantially endangers his or her health, safety, welfare, or life by not seeking or obtaining services necessary to meet the adult's essential human needs. Choice of lifestyle or living arrangements shall not, by itself, be evidence of self-neglect. Refusal of medical treatment, medications, devices, or procedures by an adult or on behalf of an adult by a duly authorized surrogate medical decision maker or in accordance with a valid medical directive or order, or as described in a palliative plan of care, shall not be deemed self-neglect. Refusal of food and water in the context of a life-limiting illness shall not, by itself, be evidence of self-neglect. "medical directive or order" includes, but is not limited to, a Medical Durable Power of Attorney, a Declaration as to Medical Treatment executed pursuant to Section 15-18-104, C.R.S., a Medical Orders for Scope of Treatment Form executed pursuant to Article 18.7 of Title 15, C.R.S., and a CPR Directive executed pursuant to Article 18.6 of Title 15, C.R.S. In addition to those exceptions identified above, access to Medical Aid in Dying, pursuant to Title 25, Article 48, C.R.S., shall not be considered self-neglect.

[7] **Allegation** means a statement asserting an act or suspicion of mistreatment or self-neglect involving an at-risk adult.

appropriate. The APS program collaborates with law enforcement and/or the district attorney for criminal investigation and possible prosecution.

APS receives reports from professionals who work with at-risk adults, such as health care professionals and community non-profit agencies; from other government agencies, such as local health departments; from law enforcement, and concerned friends, neighbors, and family members. When the investigation of the allegations and the assessment of the at-risk adult's strengths and needs determines that the adult is being mistreated or is self-neglecting, the APS program offers protective services to the adult to prevent, reduce, or eliminate risk and improve safety.

APS County and State Roles

The Colorado APS program is state-supervised and county administered. Specifically, as stated in Section 26-1-111(1), C.R.S., the Department is charged with the administration or supervision of all the public assistance and welfare activities of the State, including the APS program. And, by statute, County Departments of Human Services (County Departments) are responsible for implementing the APS program. (Section 26-3.1-101, C.R.S., et seq.)

County Department APS programs receive reports of at-risk adult mistreatment and self-neglect, evaluate the report to determine whether the alleged victim is or may be an at-risk adult and mistreatment or self-neglect may be occurring, i.e., meets criteria for APS intervention. The County Department APS program then conducts investigations into those reports meeting criteria for an investigation. County Departments provide protective services by offering casework services; arranging, coordinating, delivering, and monitoring services to protect adults from mistreatment and self-neglect; assisting with applications for public benefits; providing referrals to community service providers; and initiating probate proceedings, when appropriate. County Department APS programs exchange information and collaborate with local law enforcement, district attorneys, and other agencies authorized to investigate mistreatment and self-neglect. However, the role of APS is limited by the fact that once the investigation is complete, the client has the choice as to whether or not to accept services that may reduce or eliminate mistreatment or self-neglect from continuing to occur. For example, if an at-risk adult, who appears to be competent to make decisions, refuses services, he or she cannot be forced to accept services.

The State APS program, located within the Department, establishes statewide program policy (in consultation with counties and through the legislative and rule making processes), provides technical assistance and consultation to counties (especially regarding the interpretation of state regulations and best practices), monitors statutory compliance and program operations, develops methods for inter-program coordination through the development and implementation of protocols and interagency agreements, develops and provides training to counties, provides management and oversight of the Colorado APS data system (CAPS), and handles consumer inquiries regarding APS.

Currently, there is no federal APS program or regulations for state APS programs. As a result, the population served, the mistreatment accepted for investigation, and program rules for implementation of the APS program vary from state to state. For example, some states only serve persons aged 60 and

older and do not provide protective services to younger adults who may also be vulnerable to mistreatment. The U.S. Department of Health and Human Services, Administration for Community Living (ACL) has developed guidelines for state APS programs. These guidelines, while voluntary, are the first step in establishing a model for APS programs with the long-term goal of standardizing APS practice across all states and U.S. territories. The Federal guidelines can be found at ColoradoAPS.com.

APS Priorities

Adults have inherent rights to make their own choices and decisions, including the right to make decisions that other people would consider unsafe or unwise. When working with at-risk adults, APS works to reduce risk and improve safety for the adults while respecting their right to live as they want to live. APS will work to ensure that protective services are provided within the key priorities, outlined below.

Confidentiality: By statute and rule (Section 26-3.1-102(7), C.R.S., and 12 CCR 2518-1, 30.250), all APS report and case information (written or electronic) is confidential and cannot be released without a court order except in very limited circumstances. For example, limited information can be shared with another agency, such as law enforcement, when conducting a joint investigation with that agency, or when necessary to set up services needed to improve safety such as with a home care provider. The Administration for Community Living's (ACL, 2020) Voluntary Consensus Guidelines for State Adult Protective Services Systems also identifies the need to delineate confidentiality of APS reports and cases.

Self-Determination & Consent: Adults have the right to make decisions for themselves without interference from others. Therefore, unless the adult is breaking the law or municipal code or does not have the cognitive capacity to make responsible decisions or understand the consequences of the decisions, the adult has the right to refuse APS services. Clients may choose to accept some services but not all services that the APS caseworker determined necessary for their health and/or safety. The client may even choose to continue living in an unsafe situation or with the perpetrator of the mistreatment (Section 26-3.1-104, C.R.S. and 12 CCR 2518-1, 30.240). The Administration for Community Living's (ACL, 2020) Voluntary Consensus Guidelines for State Adult Protective Services Systems identifies person-centered service, another way to describe self-determination, as a recommended ethical principle.

Least Restrictive Intervention: APS will acquire or provide services, including protective services, for the shortest duration and to the minimum extent necessary to remedy or prevent mistreatment and/or self-neglect. For example, APS will attempt to implement services that keep clients in their homes, if it is safe to do so. Placement in an assisted living or other long-term care facility would only be considered if the client's needs were too great to remain safely in his/her home or if the client was choosing to move. Additionally, APS does not keep cases open for longer than is necessary to complete the investigation and implement services. As a result, the vast majority of Colorado's APS cases are open for less than three months (Section 26-3.1-104, C.R.S. and 12 CCR 2518-1, 30.240; see the Case Closure section for more details). The priority for least restrictive

intervention is also included in the Administration for Community Living's (ACL, 2020) Voluntary Consensus Guidelines for State Adult Protective Services Systems.

Mandatory Reporting

There are mandatory reporting laws in almost all states (49), for professionals who have consistent contact with at-risk and older adults (National Adult Protective Services Resource Center [NAPSRC] & National Association of States United for Aging and Disabilities [NASUAD], 2012). The Colorado Legislature passed Senate Bill 13-111, which modified the criminal statute, making it mandatory for certain occupational groups to report physical and sexual abuse, caretaker neglect, and financial exploitation of at-risk elders (persons age 70 and older) to law enforcement within 24 hours, beginning July 1, 2014 (Section 18-6.5-108, C.R.S.). The Legislature passed Senate Bill 15-109, which expanded the criminal mandatory reporting law to include at-risk adults with an intellectual and developmental disability (IDD) who are age 18 or older and expanded the list of professionals named as mandatory reporters. These changes took effect July 1, 2016. The same list of mandated professionals and some additional professional groups are named as "urged" reporters under the APS statute, for reporting the possible mistreatment or self-neglect of an at-risk adult age 18 and older (Section 26-3.1-102, C.R.S.).

While mandatory reporting is in place in Colorado for the two sub-sets of vulnerable adults (at-risk elders and at-risk adults with IDD), the mandatory reporting laws do not cover about 27% of the populations served by the APS program, for example adults under age 70 who have dementia, a brain injury, or an advanced neurological disease. Once reports have been made, law enforcement is required by statute to share the reports with APS and APS has a similar statutory requirement to share their reports with law enforcement. Law enforcement is responsible for investigating criminal activity while APS focuses on identifying risk factors for the client, including investigating who may be mistreating the client, and alleviating any safety issues.

APS Funding

In the 2011 report, The U.S. Government Accounting Office (GAO) stated that the increase in demand for APS services has not been met with an equivalent amount of resources to effectively respond. In fact, a lack of financial resources was rated as the largest hindrance met by APS programs. States do not receive any single source of funding for their adult protective services programs, which results in those programs turning to multiple funding sources (NAPSRC & NASUAD, 2012). The Colorado Adult Protective Services program is funded through the APS Line Items in the Long Bill. In Fiscal Year (FY) 2020-21[8] the Colorado APS program was appropriated approximately $20.4 million, of which approximately $14 million was from State General Funds, $3.7 million was from local matching funds, $2.1 million was from federal funds, and $397,000 was from cash funds. It is important to note that there are no dedicated sources of federal funding for APS programs in states. However, the Colorado General Assembly allocates approximately $2.1 million of Colorado's federal Social Services Block Grant (SSBG), known as Title XX, to the Adult Protective Services program, and in FY 2020-21, the APS program was allocated $300,000 from the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020. County

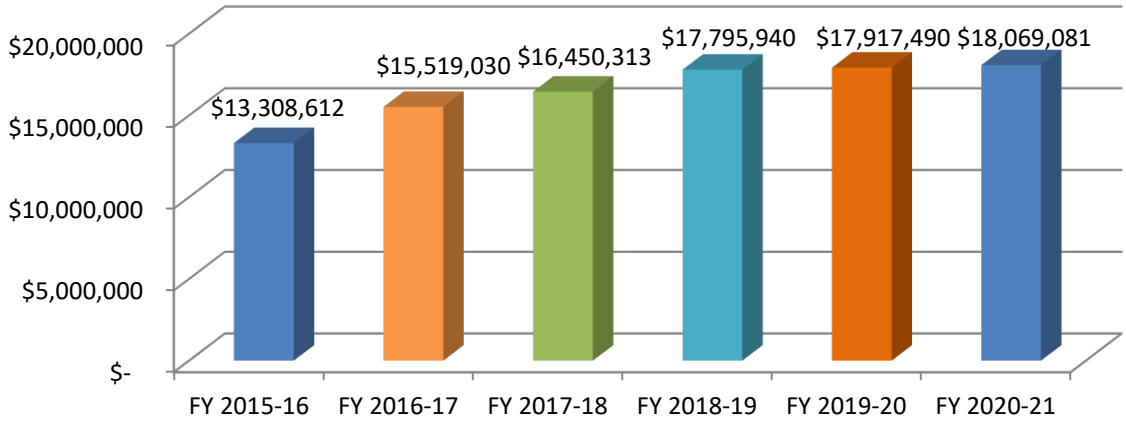
[8] The state fiscal year (FY) runs from July 1 through June 30 (i.e., FY 2020-21 was 7/1/2020 through 6/30/2021).

Departments must provide 20% matching funds to receive State General Fund. County Departments may also use additional local monies outside of the APS administration allocation, depending on County Department needs and priorities. The $20.3 million for the APS program in FY 2020-21 was appropriated as follows:

- Approximately $1,000,000 for State Department staff salary, benefits, operating, travel, and to provide training to County Department APS staff and the community
- Approximately $261,000 for the Colorado Adult Protective Services data system (CAPS)
- Approximately $18 million for County Departments' APS program administration costs
- $531,000 for Client Services. The Client Services allocation is used to purchase emergency, short term, and one-time goods and services that are unavailable through other programs and are necessary for APS clients' health and/or safety
- Approximately $439,000 for costs associated with conducting CAPS check pre-employment screening and the provision of due process for substantiated perpetrators

The chart below details County Department APS administration expenditures since FY 2015-16.

APS County Administration Expenditure FY 2015-16 through FY 2020-21



**Note: these expenditures do not include State administration expenditures or client service funds.*

In 2008, the federal Elder Justice Act (EJA) was passed in Congress. The EJA authorized Congress to appropriate funding for state APS programs but until recently, Congress had never appropriated the authorized funds. The EJA has been funded through two COVID-19 relief bills, the Coronavirus Response and Relief Supplemental Appropriations Act of 2020 and the American Rescue Plan Act of 2021. These two Acts provide one-time funding for APS programs. Colorado will receive approximately $5.2 million to use roughly between April 2021 and September 2024 to improve and enhance its APS program.

The Aging Population

With the aging Baby Boomer generation (people born between 1946 and 1964) and longer life expectancies, the number of people over the age of 65 is going to grow exponentially, particularly in Colorado. In fact, Colorado's growth in this age group between 2010 and 2015 was the third fastest in the U.S. (Colorado State Demography Office, 2016). Looking forward, the Colorado State Demography

Office (2019) projects that the number of people 65 years and over will increase by 57% between 2010 and 2020 and Colorado will see an additional 86% increase in the 65+ population between 2020 and 2050. During the same 2020 to 2050 time frame, growth in the 18-64 population is projected to increase 33%. While not every adult will be an "at-risk" adult or experience mistreatment, with this explosion of the elderly population and continued growth in population in the 18-64 population, the need for APS programs will become even more important in the years to come.

Rates of Mistreatment

It is hard to produce estimates of mistreatment of at-risk adults nationwide for many reasons. Mistreatment is defined differently in different programs and states. Additionally, many incidents of mistreatment go unreported (Aravanis et al., 1993; Choi & Mayer, 2000; Cooper & Livingston, 2016; Applied Research & Consulting, LLC, 2015; GAO, 2011; National Center on Elder Abuse & Westat Inc., 1998; Tamutiene et al., 2013) due to the fact that the victims are resistant to report on the alleged perpetrators for fear of losing their social support or experiencing retaliation, or because they are embarrassed/ashamed, overwhelmed, uncomfortable about the topic, in denial of the problem, feel that the experience was not "serious" enough, do not think that reporting will help, or are simply not able to report due to various deficits (i.e., dementia, non-verbal, etc.; Acierno , 2018; Applied Research & Consulting, LLC, 2015; Aravanis et al., 1993; Bennett, Levin, & Straka, 2002; Quinn, 2002; Tamutiene et al., 2013). Furthermore, instances of financial fraud can often go unreported because the individuals blame themselves (DeLiema, Fletcher, Kieffer, Mottola, Pessanha, & Trumpower, 2019; Applied Research & Consulting, LLC, 2015).

Additionally, people seem to be less likely to report incidents of mistreatment if the perpetrator is a family member or friend (Acierno, 2018; MetLife Mature Market Institute [MMI], 2011). Even with underreporting, estimates for the rates of mistreatment experienced by adults range from about 2% to 11% (Acierno et al., 2010; Cooper, Selwood, & Livingston, 2008; Lachs, Williams, O'Brien, Hurst, & Horwitz, 1997; Lifespan of Greater Rochester, Inc., Weill Cornell Medical Center of Cornell University, & New York City Department for the Aging, 2011; Pillemer et al., 2011). Moreover, with the rapid growth of the elderly population, an increase in the number of mistreatment cases can be expected in the future (Aravanis et al., 1993). National estimates display that the number of APS reports is increasing (National Adult Maltreatment Reporting System (NAMRS), 2018; Teaster et al., 2006).

The Impact of Mistreatment and Self-Neglect

At-risk adult mistreatment and elder abuse have been recognized as a public health and human rights problem (ACL, 2020; Dong, 2015) and each year millions of older adults experience abuse (Lifespan of Greater Rochester et al., 2011; Acierno et al., 2010). Mistreatment and self-neglect impact vulnerable adults in a number of ways. Many negative physical and psychological/emotional impacts such as health issues, distress, perceived self-efficacy, feelings of powerlessness, depression, anxiety, and even PTSD, are associated with individuals who have experienced mistreatment (Acierno, 2018; Comijs, Penninx, Knipscheer, & van Tilburg, 1999; Applied Research & Consulting, LLC, 2015; Tamutiene et al., 2013; U.S. Department of Justice, Department of Health and Human Services, Connolly, Brandl, & Breckman, 2014). Researchers estimate that elders who have experienced abuse are at a 300% higher risk of death compared to those who did not experience abuse (Dong et al., 2009; Taylor & Mulford, 2015). After a

13-year follow-up, elders who had experienced mistreatment, compared to elders who experienced self-neglect, had a poorer survival rate (Lachs, Williams, O'Brien, Pillemer, & Charlson, 1998). Elders who experience abuse are three times as likely to be admitted to a hospital (Dong & Simon, 2013; Taylor & Mulford, 2015) and four times as likely to be admitted to a nursing home (Taylor & Mulford, 2015). Hospitalizations of elders due to abuse are at least partially accountable for rising healthcare costs (Dong & Simon, 2013).

Mistreatment impacts more than just the victims of the abuse given that many elders and at-risk adults rely on government programs for resources, such as Medicaid to pay for long-term care. This can be particularly apparent in cases of financial exploitation. If the adult was not already dependent on government resources, sometimes exploitation can cause the adult to rely on these programs (e.g., Medicaid; Gunther, 2011; U.S. Department of Justice et al., 2014). Complicating the situation further, sometimes these adults do not qualify for Medicaid because the Medicaid rules consider five-year "look back" for finances and prior to the recent exploitation, the adult would not have qualified. In Gunther's (2011) report on the cost of exploitation in Utah, it was estimated that the direct and indirect costs of exploitation of seniors in the state amounted to $52 million in 2009. MetLife MII (2011) estimated a $2.9 billion loss on behalf of elder financial abuse victims nationwide in 2010. The ACL (2016) pointed out that those losses are even higher, given that the MetLife MMI review did not include adults aged 18-64. Other government entities estimate that the shared costs of elder abuse are well into the billions of dollars (U.S. Department of Justice et al., 2014). Beyond the negative health and financial impacts, adult mistreatment can endanger a person's autonomy (ACL, 2016; GAO, 2011, Navigant, 2016).

In addition to putting a strain on government assistance, when adults do not have enough resources to cover their essential needs, often times the burden to cover the gaps can fall on family and friends. There are significant financial, physical, and emotional tolls that family and other informal caregivers experience as a result of providing care (Feinberg, Reinhard, Houser, & Choula, 2011; Hoffman & Mendez-Luck, 2011; VandeWeeerd, Paveza, Walsh, & Corvin, 2013). In fact, VandeWeeerd et al. (2013) found in their study that 84.4% of caregivers reported feeling burdened by providing the care and only 17.4% of caregivers reported having no level of depression (versus mild, moderate, and severe). Many informal caregivers do not receive pay for those duties, have fulltime positions outside of the caregiving role, do not have adequate training to perform the required tasks, and have to use their own money to cover various care costs (Feinberg et al., 2011; Hoffman & Mendez-Luck, 2011). Feinberg et al. (2011), point out these caregivers' own financial situations become more dubious, not just due to the money spent on care, but also on the income lost from missing work and borrowing from their savings and retirement. Moreover, they estimated that the value of this unpaid caregiving work (from 2009) would be approximately $450 billion. Hoffman and Mendez-Luck (2011) state that the number of these types of informal caregivers is likely to explode due to the U.S. Census' projected growth of individuals aged 65 and older in the next 30 years (more than doubling).

Individual Characteristics Associated with Higher Rates of Mistreatment

One of the most widely recognized characteristics associated with mistreatment is low social support (Acierno et al., 2010; Cooper & Livingston, 2016; Lachs et al., 1997; Pillemer et al., 2011). Furthermore,

older adults are more likely to be experiencing social exclusion/isolation (De Donder, De Witte, Brosens, Dierckx, & Verté, 2014). In their survey of victims of scams, DeLiema, et al. (2019) found that the individuals who engaged and/or lost money in a scam reported significantly higher states of loneliness. Further, the individuals who lost money were more likely to not have another individual with whom they could discuss the "offer" (read scam). Other research indicates that social support helped account for the decreased levels of depression and anxiety that individuals of mistreatment experienced later in life (Acierno, 2018). Similarly, Comijs et al. (1999) found that social support had a positive effect on psychological distress levels for victims of mistreatment, whereas this same association was not present for individuals who did not experience mistreatment. This indicates that social support is more advantageous to elders who experience mistreatment than to those who do not experience mistreatment.

Individuals with physical impairments (i.e., needing assistance with activities of daily living [ADLs]) and/or having poor physical health are associated with higher risk of being mistreated (Acierno et al., 2010; Bureau of Justice Statistics, 2011; GAO, 2011; Lachs et al., 1997; Lachs & Pillemer, 2015; Peterson, et al., 2014). Perpetrators who do not know their targets often look for visible vulnerabilities, such as physical impairments (MetLife MMI, 2011). Similarly, individuals with intellectual or developmental disabilities, dementia, or cognitive impairments are also at a higher risk of being abused, violently assaulted, and exploited (Cooper et al., 2009; Bureau of Justice Statistics, 2011; Gunther, 2011; Lachs et al., 1997; Lachs & Pillemer, 2015; Petersilia, 2001; Pillemer et al., 2011; Wood et al., 2014). Agarwal , Driscoll, Finke, Howe, and Huston (2009) note that approximately half of adults in their 80s have dementia or another form of a cognitive impairment. Elders with high levels of functional impairment were found to be twice as likely to be physically abused by their caregivers compared to elders without those same deficits (VandeWeerd et al., 2013). Mental illness is also correlated with higher rates of mistreatment (GAO, 2011; Teaster, Stansbury, Nerenberg, & Stanis, 2009). Finally, past traumatic events are associated with higher rates of mistreatment (Acierno et al., 2010).

Specifically related to exploitation, certain risk factors become more predictive. Elders may be more susceptible to undue influence given that cognitive, physical, and health issues start arising with increased age; not to mention that they are more desirable targets for exploitation with the financial assets and savings that they have acquired over their lifetimes (Quinn, 2002). Undue influence involves the exertion of one person's will over another's. It often utilizes threats, deception, or fraud and is frequently present in instances of mistreatment, particularly, financial exploitation (Quinn, 2002). Castle et al. (2012) found that older adults may be more vulnerable to exploitation due to their decreased perception of untrustworthiness in other individuals. In their survey, Applied Research & Consulting, LLC (2015) found that a majority of financial exploitation victims blamed themselves for being too trusting of the perpetrator. Additionally, studies have found that financial literacy of older adults declines with age (Agarwal et al., 2009; Gamble, Boyle, Yu, & Bennett, 2015; Hibbard , Slovic, Peters, Finucane, & Tusler, 2001), but confidence in managing personal finances and financial decision making does not drop with age (Finke, Howe, & Huston, 2011; Gamble et al., 2015). This indicates that although the capacity to make these decisions may diminish with age, many older adults are not aware of the decline.

Adults who need help managing their finances are much more likely to be exploited (Choi & Mayer, 2000; Gunther, 2011). Perpetrators are also taking larger amounts of money from older adults with dementia or cognitive impairments compared to those older adults without these impairments (Gunther, 2011). Gunther (2011) points out that when older adults need help with their finances, they are more likely to be taken advantage of by a family member, but that often times, it is a family member or close friend who *catches* the exploitation. Being exploited by a family member can lead to increased risk of depression and anxiety (Acierno, 2018). MetLife MII (2011) found that there were three major reasons for the occurrence of elder financial abuse: (1) the older adult happened to be a barrier to what the perpetrator desired, (2) the perpetrator was desperate for money (often the perpetrator is dependent on the older adult for financial needs), (3) or the perpetrator formed a relationship with the adult solely for the purpose of exploitation. Furthermore, for elder financial abuse, a majority of victims were living alone and required assistance with their healthcare or home maintenance (MetLife MMI; 2011).

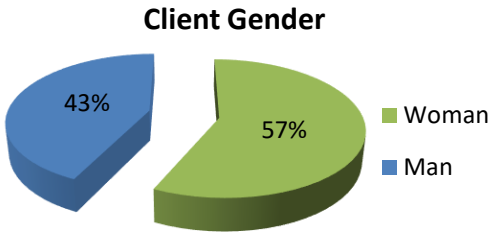
APS Client Demographics

According to APS statute (Section 26-3.1-101, C.R.S.), at-risk adults are defined as individuals age 18 or older who are susceptible to mistreatment or self-neglect because they are unable to perform or obtain services necessary for their health, safety, or welfare, or lack sufficient understanding or capacity to make or communicate responsible decisions. Examples of conditions that increase risk include: dementia, physical or medical frailty, developmental disabilities, brain injury, neurological disorders, and major mental illness. Persons are not considered "at-risk" solely because of age and/or disability.

The following sections identify demographic information about APS clients served in Colorado in FY 2020-21.

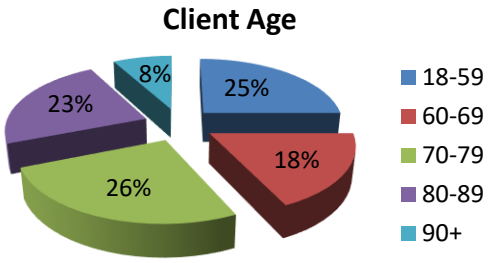
Client Gender

A majority of APS clients in FY 2020-21 were women (57%), which is consistent with statistics that show that women tend to experience greater instances of abuse in comparison to men (Laumann, Leitsch, & Waite, 2008) and estimates from nationally pooled state APS program data (NAMRS, 2018). The proportion of women grows even larger when looking at clients with a substantiated allegation of sexual abuse (81%). Less than 1% of APS clients in FY 2020-21 were transgender or non-binary.



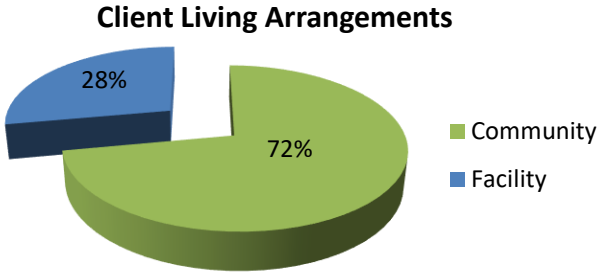
Client Age

Most APS clients were aged 70 or older (57%). Three quarters (75)% of APS clients were aged 60 or older, which is in line with what was reported in the NAMRS (2018) report (approximately 70%). Similar to what was reported in the NAMRS (2018) review, clients with a substantiated physical or sexual abuse allegation tended to be younger and clients with a substantiated exploitation allegation tended to be older when compared to the age of all clients with at least one substantiated allegation.



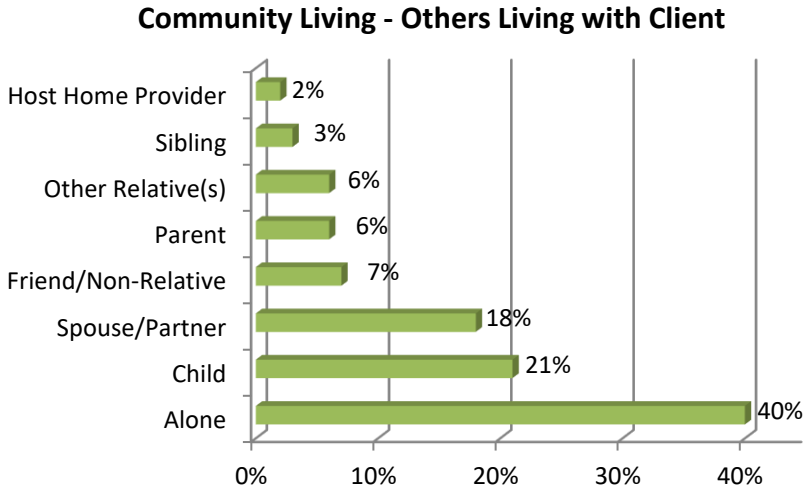
Client Living Arrangements

In FY 2020-21, about 72% of APS clients lived in a community setting, such as their own home or the home of a family member, while 28% lived in a facility, such as a skilled nursing facility or a group home. The ratio of clients living in the community vs facility shrinks



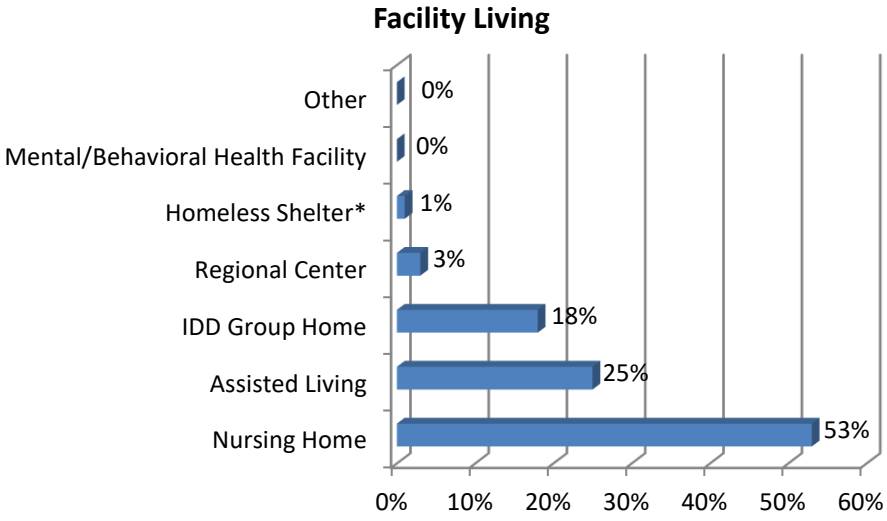
when limiting the population to those clients with at least one substantiated allegation (66% in the community, 34% in a facility). This is likely at least partially due to the inherent fact that facility settings have a larger number of people in contact with the residents who could mistreat someone (i.e., other residents, staff, etc.) and facilities have large numbers of mandatory reporters. Conversely, when looking at substantiated allegations of self-neglect specifically, those clients are more likely living in a community setting.

Most clients in FY 2020-21 living in the community lived alone (41%), with a child (21%), or with a spouse/partner (18%).



Note that these percentages do not add up to 100 because clients may fall into multiple categories.

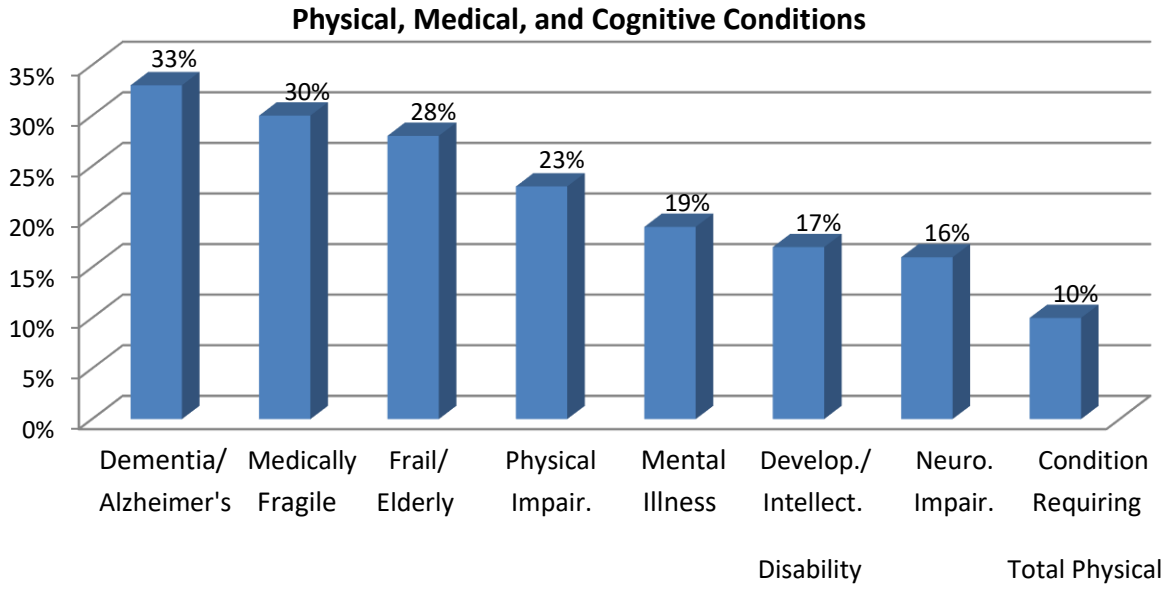
Clients who lived in a residential facility most often lived in a nursing home (53%), an assisted living facility (25%), or a group home for persons with an Intellectual and Developmental disability (18%).



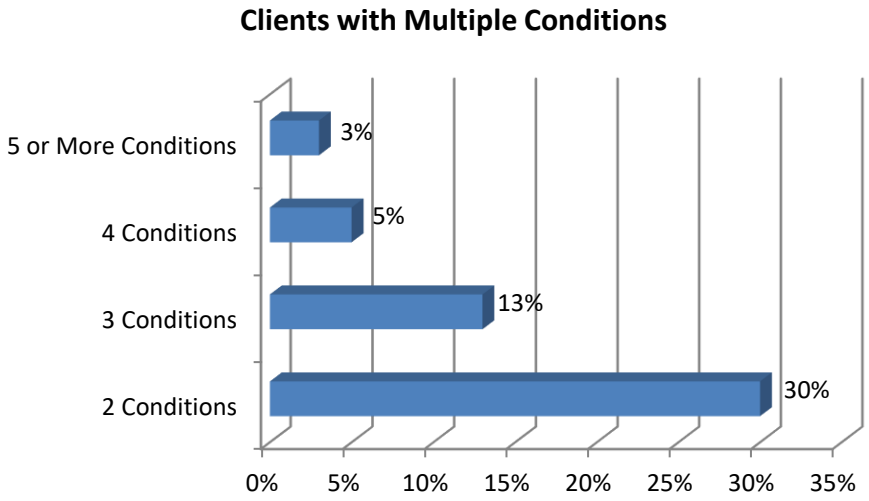
**Only includes clients living in a homeless shelter facility. If all clients who were homeless were included the percentage would increase to 9%.*

Client Risk Factors

There are many physical, medical, and cognitive conditions that may make an adult "at-risk" for mistreatment or self-neglect depending on the severity of the condition and how that condition impacts the adult's ability to provide for their health and safety or impacts their ability to make or communicate responsible decisions. In FY 2020-21, the most common condition impacting APS clients was "Dementia/Alzheimer's" (33%). Other common conditions were "Medically Fragile" (30%), "Frail Elderly" (28%), "Physical Impairment" (23%), Major Mental Illness/Emotional Disorder (19%), "Developmental/Intellectual Disability" (IDD, 17%), "Neurological Impairment (16%), and "Condition Requiring Total Physical Care" (10%). The most common conditions impacting APS clients with at least one substantiated allegation fell into the IDD category (19%). Similarly, IDD conditions were the most common type of condition for clients with a substantiated allegation of sexual abuse (29%). For clients with a substantiated allegation of physical abuse, the most common conditions fell into the IDD or the dementia/Alzheimer's categories (18% each). The number of APS clients with a developmental or intellectual disability has grown over the years. For example, in FY 2015-16, approximately 8% of clients had a developmental or intellectual disability, compared to 17% in FY 2020-21. It is likely that this major change is due to the implementation of Senate Bill 15-109 which became effective July 1, 2016, and the increased number of reports made involving individuals with an intellectual and/or a developmental disability.



Furthermore, 51% of APS clients had two or more of these conditions, adding complexity to resolving the health and safety issues for the client. This jumps to 58% of APS clients when looking at clients with at least one substantiated allegation, which is in line with what was reported in NAMRS (2018).

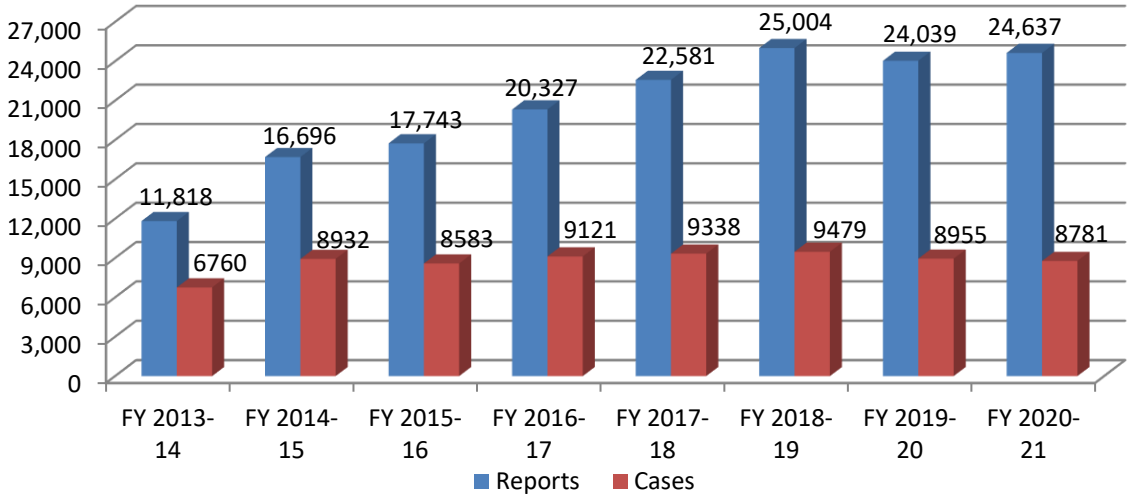


The APS Case Process

Reports and Cases

Colorado APS has experienced significant increases in the number of reports received since the Mandatory Reporting laws were passed and became effective on July 1, 2014 and July 1, 2016. As a result, the number of cases open for investigation and provision of protective services has continued to rise as well. There was a 2% increase in the number of reports APS received in FY 2020-21 compared to FY 2019-20. There was also an 1% increase in the number of cases opened for investigation in FY 2020-21 than in FY 2019-20. The only exception to this general trend of growth is the drop in the number of reports (and resulting cases) seen in FY 2019-20, which the program is still catching up to. This drop in reports and cases can be partially explained by the decrease in reports received in the final quarter of FY 2019-20 (i.e., during the COVID-19 pandemic). Overall, there has been a 108% increase in the number of reports over the past seven years. Colorado APS has an experienced a 30% increase in open cases since the implementation of mandatory reporting.

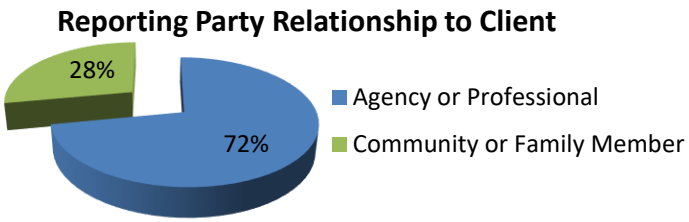
APS Reports and Cases FY 2013-14 through FY 2020-21

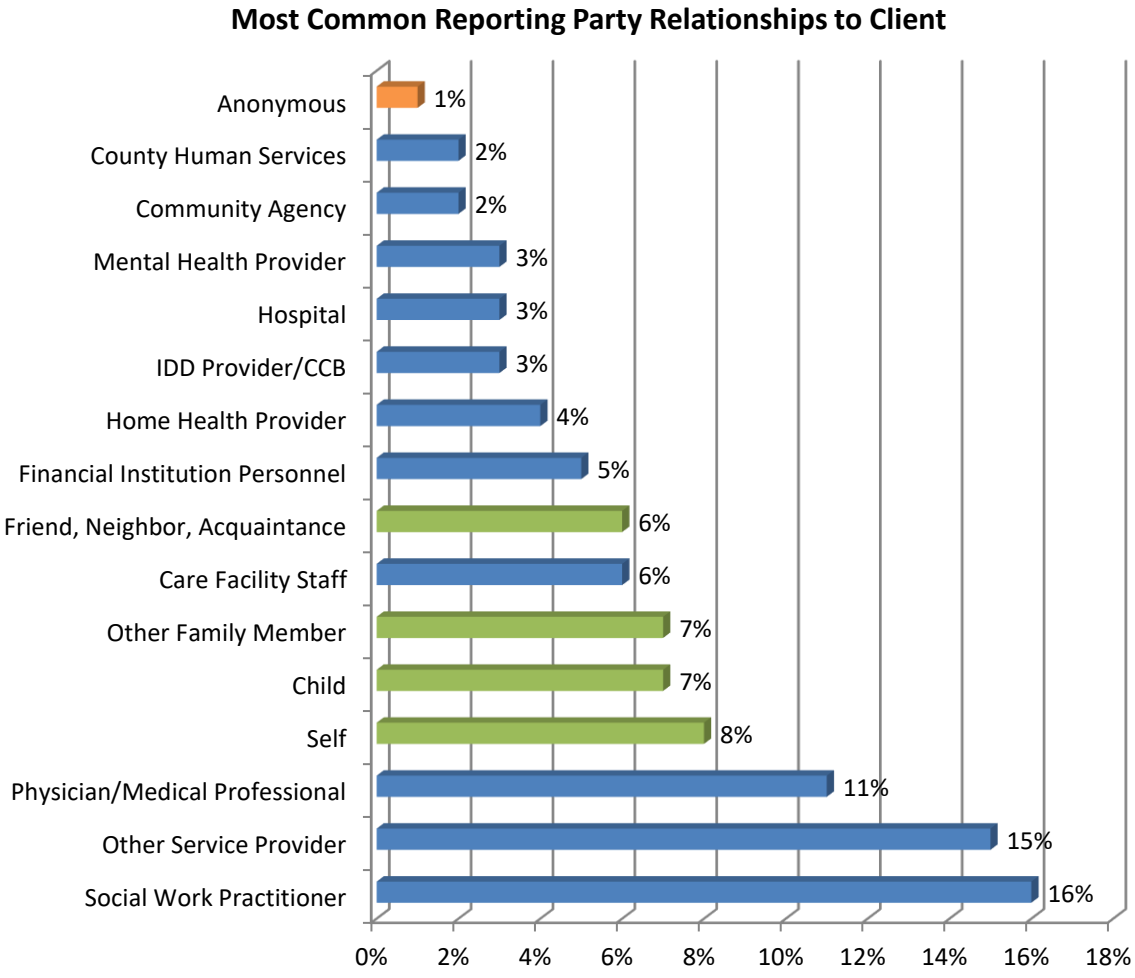


As this table shows, not all reports become a case. Approximately 29% of APS reports received in FY 2020-21 were opened as a case compared to FY 2019-20 when approximately 29% were opened as a case. Some reasons that not all reports become a case are: the report was made as a precaution due to mandatory reporting but did not meet APS criteria, the report did not include an allegation of mistreatment or self-neglect as defined in APS statute, the client in the report did not meet the APS definition of an at-risk adult (or did not appear to meet that definition at the time of the report), etc. As noted in the Mandatory Reporting section, being an “at-risk elder” or an “at-risk adult with IDD” under the mandatory reporting statute does not mean the person is an “at-risk adult” per the APS statute. APS cannot provide protective services to “at-risk elders” or “at-risk adults with IDD” as defined by the mandatory reporting statute, unless they also meet the definition of “at-risk adults” under the APS statute.

Reporting Party Relationship to Client

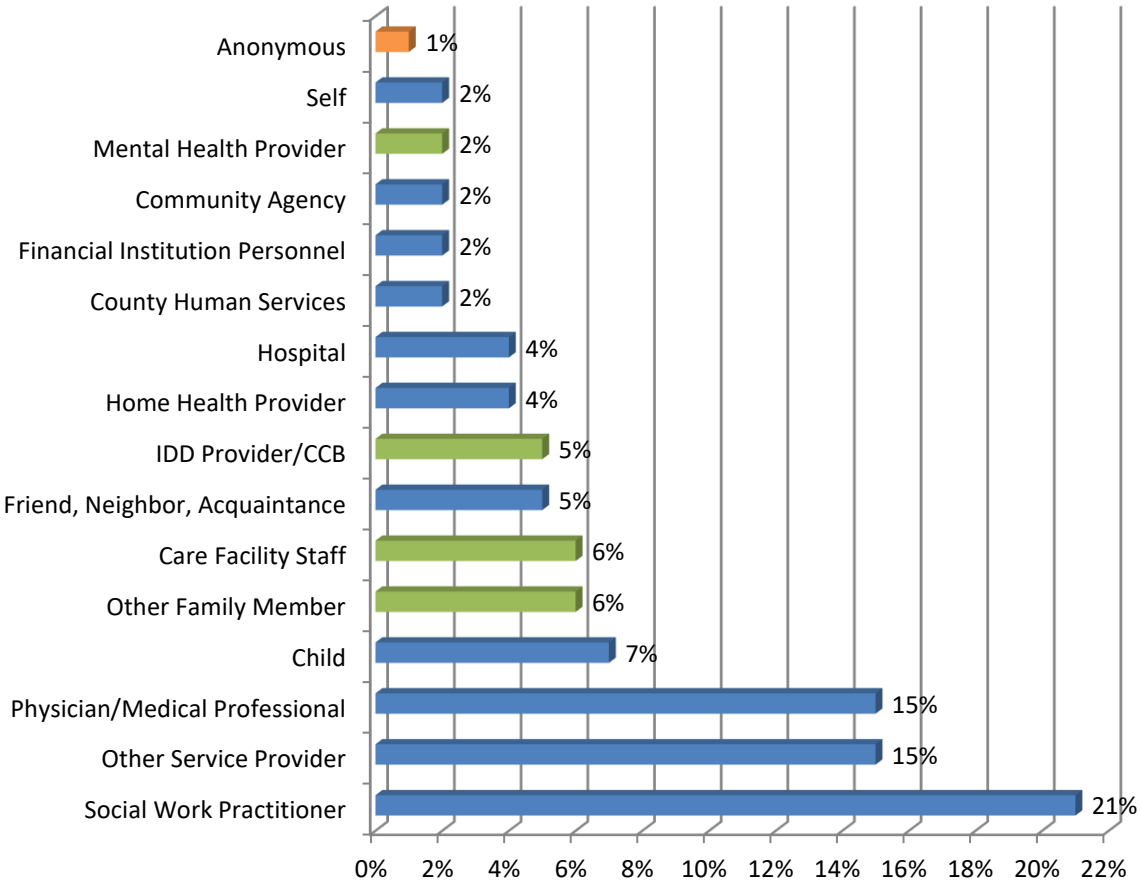
Reports are made to APS by a variety of professionals who work with at-risk adults, family, friends, neighbors, and sometimes by the adult themselves. If the reporter chooses, he or she may remain anonymous when making a report to APS. In FY 2020-21, a majority of reporting parties were professionals who work with at-risk adults (72%). In national APS data (NAMRS, 2018), it was found that a majority of reporting parties were professionals as well. This is likely influenced by mandatory reporting laws throughout the states. The most common reporting party group was social work practitioners (16%), which is in line with what Teaster et al. (2006) reported in their national survey on elder abuse (~11%).





The concentration of different reporting party relationships changes when the pool is limited to cases that result in a substantiated allegation. For instance, when looking at all reports, social work practitioners account for 16% of reporting parties versus 21% when limited to cases with substantiated allegations. Conversely, 8% of all reports that APS receives come from the client (self-reporting), but when restricted to cases with substantiated allegations, the number drops to 2%.

Most Common Reporting Party Relationships to Client with Substantiated Allegations

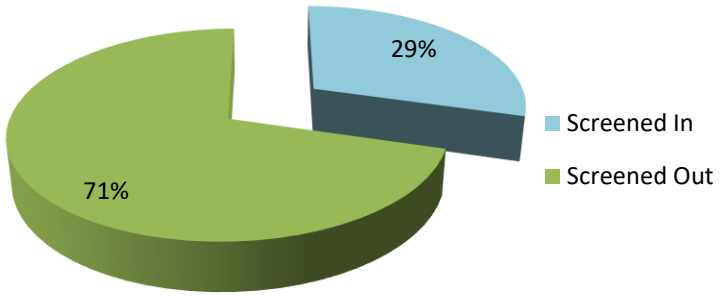


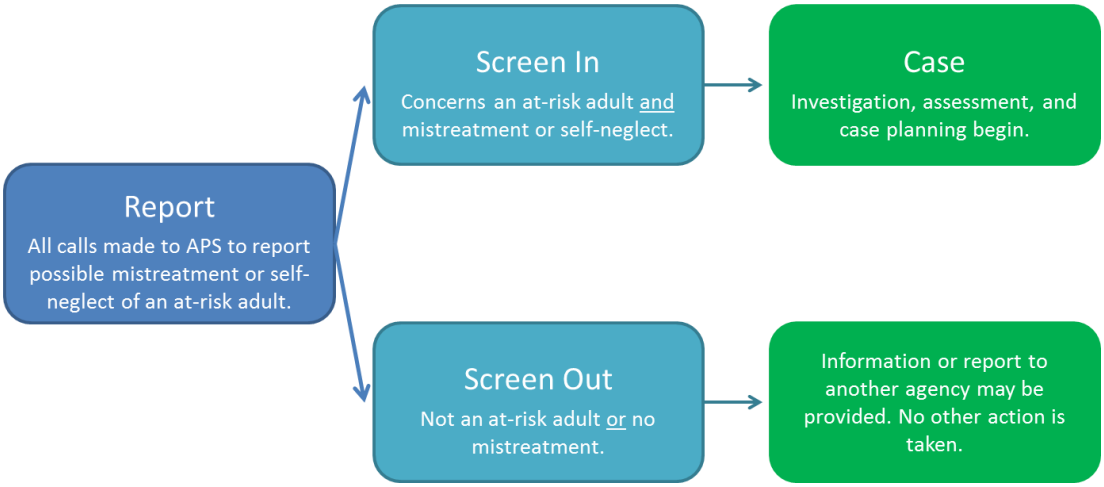
Report Screening

When a report is made to APS, County Department APS personnel evaluate the report to determine whether it meets eligibility criteria for investigation, which is twofold: (1) it involves an at-risk adult as defined in the APS statute and (2) there is alleged or suspected mistreatment and/or self-neglect. Reports that do not meet criteria are screened out and are not investigated further. Regardless of whether the report meets criteria for APS intervention, the report will be shared with law enforcement within 24 hours so that law enforcement can review the report for potential criminal activity. APS does not have access to all of Colorado's law enforcement records and so is not able to provide information on the number of these reports that were criminally investigated by law enforcement or prosecuted by

district attorneys. However, as a result of the project with Judicial District 18, limited information on criminal investigations can be found on pages 35. The most common reason a report was screened out in FY 2020-21 was that there was no reported mistreatment (46%; i.e., what was being reported did not meet Colorado APS' definitions of mistreatment or self-neglect). The second most common reason was that the client involved did not meet Colorado APS' criteria of an at-risk adult (40%). Reports can also be screened out if there is a current open case (9%; in such an instance the worker would add the new allegations to the existing case and investigate), if the alleged incidence (same occurrence, not just the same type of allegation) was investigated in a prior case and no new information is available (2%), if there is not enough information to investigate (1%; i.e., the report does not have enough information to contact the client, reporting party, witnesses, or other collaterals and there is no other information to indicate where contact information can be found), or if the adult has a history of refusing services (1%, when the client has been recently assessed by APS and is able to make decisions and the only allegation is self-neglect).The final reason that a report can be screened out is if the adult does not reside in Colorado.

Once a report is determined to meet criteria for intervention by APS, the report is screened in, meaning it will be assigned to a caseworker who will begin an investigation, and it is now considered a case. In FY 2020-21, 29% of reports were screened in and became an APS case. In general, cases require a thorough investigation of the allegations and an overall assessment of the client's strengths and needs. A vast majority of all APS cases that are screened in result in an investigation, but some cases do not require an investigation. For example, if the adult is not "at-risk" by Colorado's definition of an at-risk adult, the case will be closed without completing the investigation.

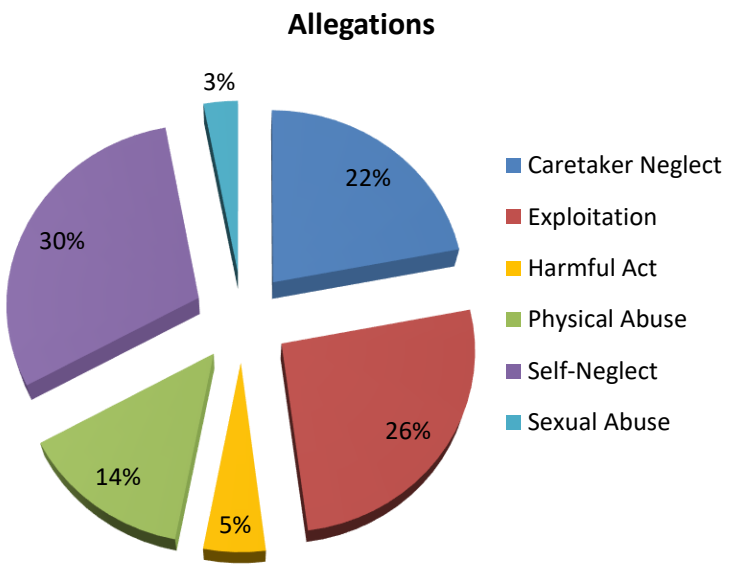




Investigation

Investigations and assessments are usually completed simultaneously. Investigations involve interviews with witnesses and other persons who have knowledge of the client and/or allegation. Caseworkers collect evidence to review such as photographs of bruising, medical records, and/or bank statements. A review of the evidence is then completed to determine if the allegations are substantiated, unsubstantiated, or inconclusive. A substantiated finding means that the investigation established by a preponderance of evidence that mistreatment (or self-neglect) has occurred and the substantiated perpetrator was responsible. In their 2018 report, the National Adult Maltreatment Reporting System (NAMRS, 2018) identified that 62.7% of State APS programs utilized preponderance of evidence as their standard of evidence in investigations. An unsubstantiated finding means the investigation did not establish any evidence that mistreatment or self-neglect has occurred. An inconclusive finding means that some evidence of mistreatment or self-neglect may be present but the investigation could not confirm the evidence to a level necessary to substantiate the allegation. There are cases in which a finding is not made, either because an investigation was not required, for example, upon assessment the adult is determined not to be "at-risk" or because APS was unable to complete an investigation, for example, APS was unable to locate the adult and there were no other leads to follow for an investigation.

In FY 2020-21, 30% of allegations were for self-neglect, that is, it was alleged that the client was not providing for their basic needs. Self-neglect was the most common allegation made. This is in line with what Teaster et al. (2006) found in their national survey on elder abuse (approximately 27%). The most common form of *mistreatment* reported was exploitation at 26%. These figures changed somewhat from prior fiscal years due to the addition of the harmful act allegation (definition provided here) that was added during the fiscal year. These numbers could change even more next fiscal year when the harmful act allegation is available for the full year. It is important to note that there may be multiple allegations occurring in any given case. Clients often experience multiple forms of mistreatment and self-neglect at the same time (Aravanis et al., 1993). For example, a client may be self-neglecting and exploited by a family member; or a client may be physically and sexually abused. The average number of allegations per case in FY 2020-21 was 1.5.

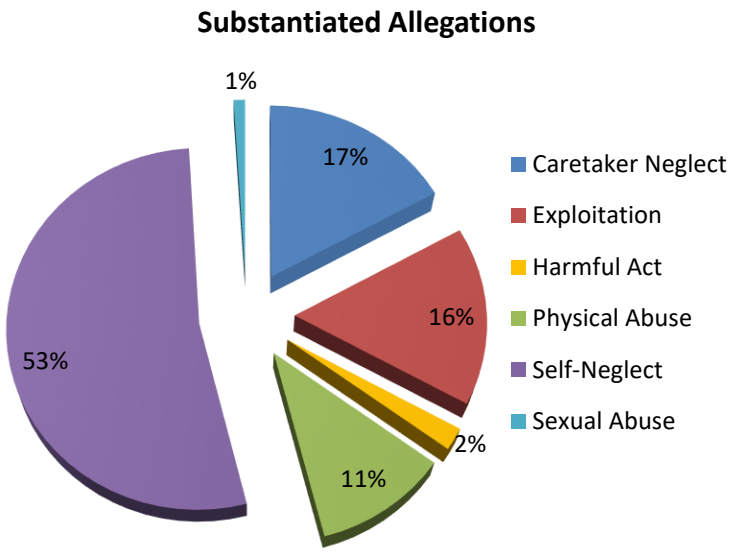


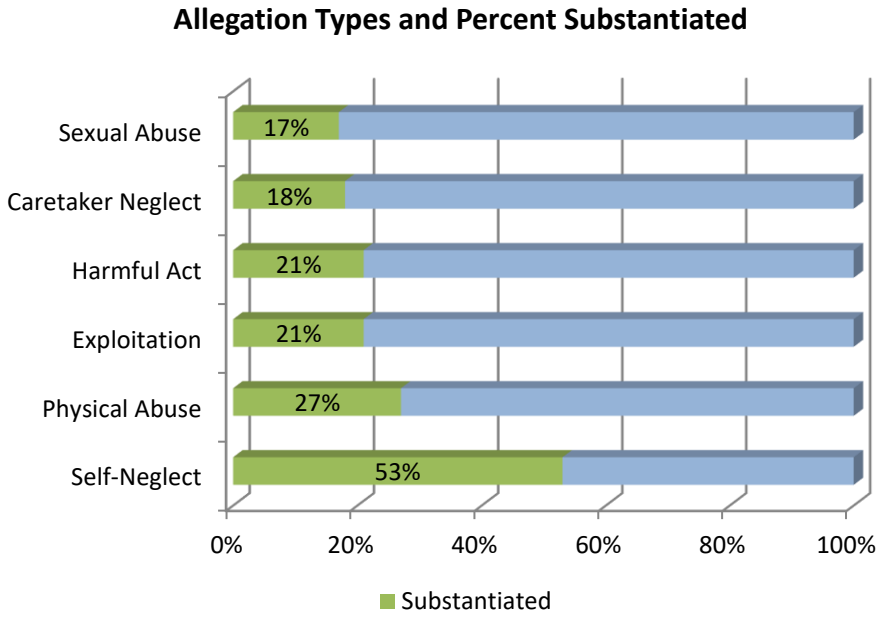
When reviewing the percentage of each type of allegation received before mandatory reporting and now, there are some major changes. For example, in FY 2013-14 (the fiscal year before mandatory reporting) physical abuse accounted for 8% of all allegations received, compared to 14% in FY 2020-21. The percentage of exploitation allegations has also grown in that time, from 23% to 26%. This is in line with research findings that amounts elder financial abuse are higher than previously reported (Acierno et al., 2010). Alternatively, self-neglect went from 46% to 30%. However, even with the reduction of self-neglect allegations over the years, it remains the most common allegation made, which is in line with other state's rates of allegations (National Adult Protective Services Association [NAPSA] & NAPSRC, 2016). The percentage of allegations received for caretaker neglect and sexual abuse have remained relatively stable between FY 2013-14 and FY 2020-21.

The reported loss of money and property to clients who were exploited (the allegation was substantiated) in FY 2020-21 was approximately $13.5 million. Since Colorado began tracking losses due to exploitation in FY 2014-15 and the end of FY 2020-21, at-risk adults in Colorado have lost approximately $144.6 million. This approximate loss of assets does not include the loss that the State experienced as a result of these clients being exploited, which may have increased the need for public services and benefits, such as Medicaid, food assistance, or Old Age Pension. And, as noted previously in this report, this cost can be high. Unfortunately, DeLiema et al. (2019) found that households with lower income were more strongly correlated with likelihood of engaging with, and losing money in, a scam.

Due to the explosion of the elderly population (i.e., the aging baby boomer generation), financial exploitation of the elderly is likely to increase at a similar pace. Financial exploitation is recognized as one of the fastest growing areas in APS nationally (NAPSRC & NASUAD, 2012). The most common forms of financial exploitation range from scams, misuse of power of attorney, credit cards (misuse or identity theft), bank account withdrawals, prepaid cards, wire transfers, identity theft, and changes in house ownership (either though deeding property or through deception; Federal Trade Commission, 2017; Gunther, 2011; Gunther, 2012; Wood et al., 2014). DeLiema, et al. (2019) reported that the highest victimization rates came from scams online or for tech support and for fraudulent check/money orders. In the same survey, it was found that the method that the perpetrator utilized was associated with whether the elder engaged with the scam and ultimately lost money. For example, although phone and email scams were the most common method reported, social media scams were the most detrimental (with higher rates of engagement and funds lost). Scams that are disguised to seem like the requests are coming from official organizations, that use time pressure, or that invoke higher levels of emotional arousal can be more effective at getting prospective victims to engage or acquiring the perpetrators' desired outcomes (DeLiema et al., 2019; Kircanski et al., 2018). Furthermore, many perpetrators use more than one method of exploitation (Gunther, 2011; Gunther, 2012; Thomas, 2014).

Approximately 30% of the total number of allegations made in FY 2020-21 were substantiated, 22% were inconclusive, 35% were unsubstantiated, and for 13% of the allegations, a finding was not made, as described above on page 20. The largest proportion of substantiated allegations belonged to self-neglect (53%), which is in line with the finding in NAMRS (2017) national report and Teaster et al.'s (2006) national survey that self-neglect represented the majority of substantiated allegations. The other proportions in the NAMRS report were similar as well (all forms of exploitation was 19%, caretaker neglect was 19%, physical abuse was 10%, sexual abuse was 0.8%). The Teaster et al. (2006) survey found similar proportions of caregiver neglect (~20%) and exploitation (~15%, it should be noted that this was financial exploitation, specifically). It is important to note that these numbers are likely to differ some because the NAMRS report included mistreatment categories that Colorado APS defines differently.

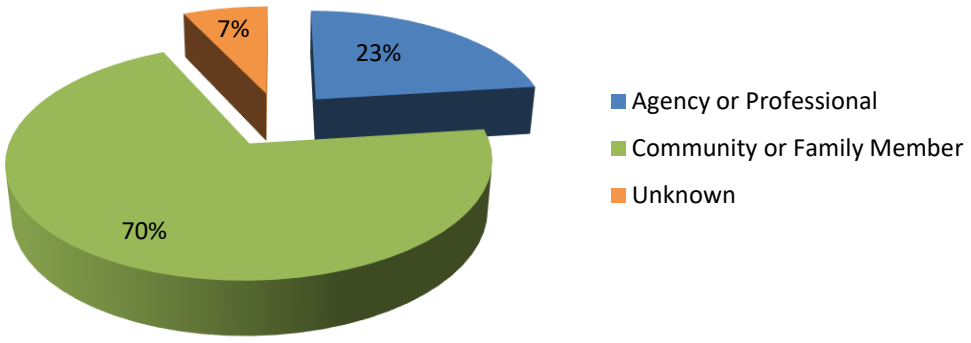




Perpetrator Relationship to Client

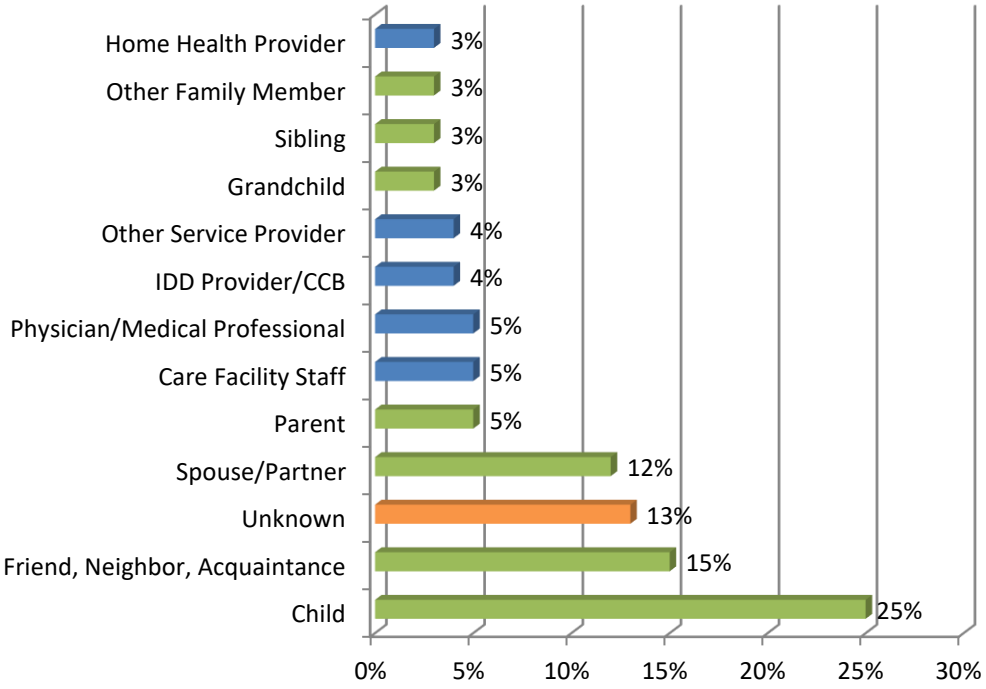
The majority of substantiated perpetrators identified in reports to APS programs across the state in FY 2020-21 (70%), were either a family member or person the victim knows, such as a neighbor, friend, or acquaintance. This estimate is in line with others found in research (Choi & Mayer, 2000; Gunther, 2011; Gunther, 2012; Lachs & Pillemer, 2015; Lachs et al., 1997; Peterson et al., 2014). About 23% of substantiated perpetrators were professionals who provide services to the client, such as home care or nursing care staff, and about 7% of perpetrators were unknown at the time of the report.

Substantiated Perpetrator Relationship to Client



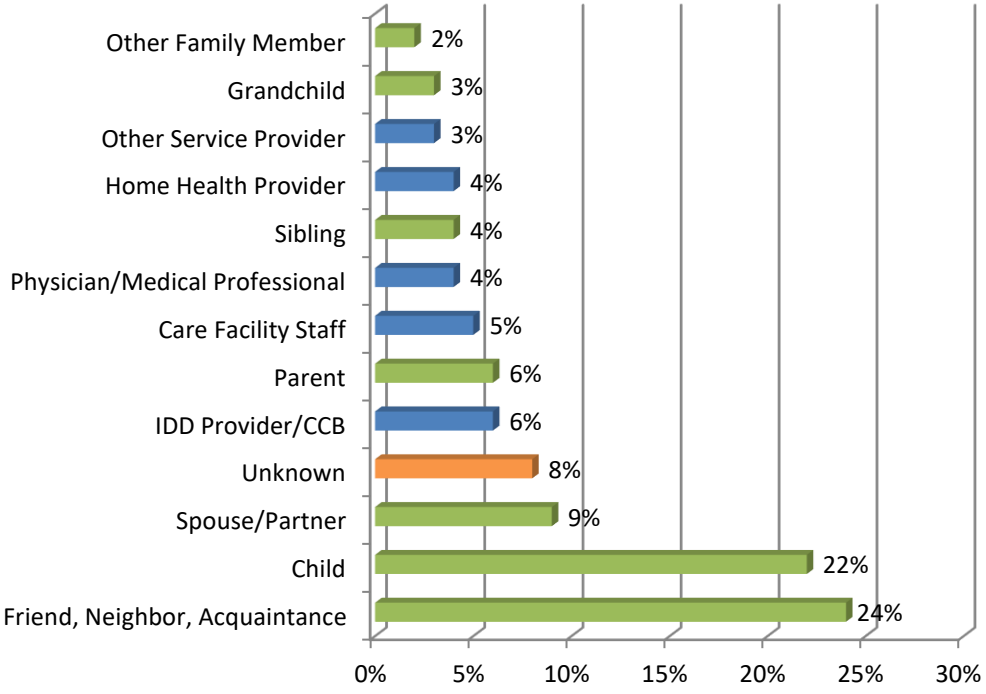
In FY 2020-21, the most common relationships for *alleged* perpetrators of mistreatment were the adult's children (25%), a friend/neighbor/acquaintance (15%), unknown (13%), and spouse/partner (12%).

Most Common Alleged Perpetrator Relationships to Client



When we look at this same chart but limit the pool to perpetrators who had a substantiated finding of mistreatment we see some minor changes. For instance, the "Parent" relationship group goes up 1% (from 5% to 6%) while the "Unknown" relationship group percentage goes down 5% (from 13% to 8%, which is partially due to caseworkers identifying and updating the "Unknown" perpetrator relationship identified at the time of the report). However, "Child" remains one of the most common relationships, which is in line with Teaster et al.'s (2006) and Peterson et al.'s (2014) large-scale survey results.

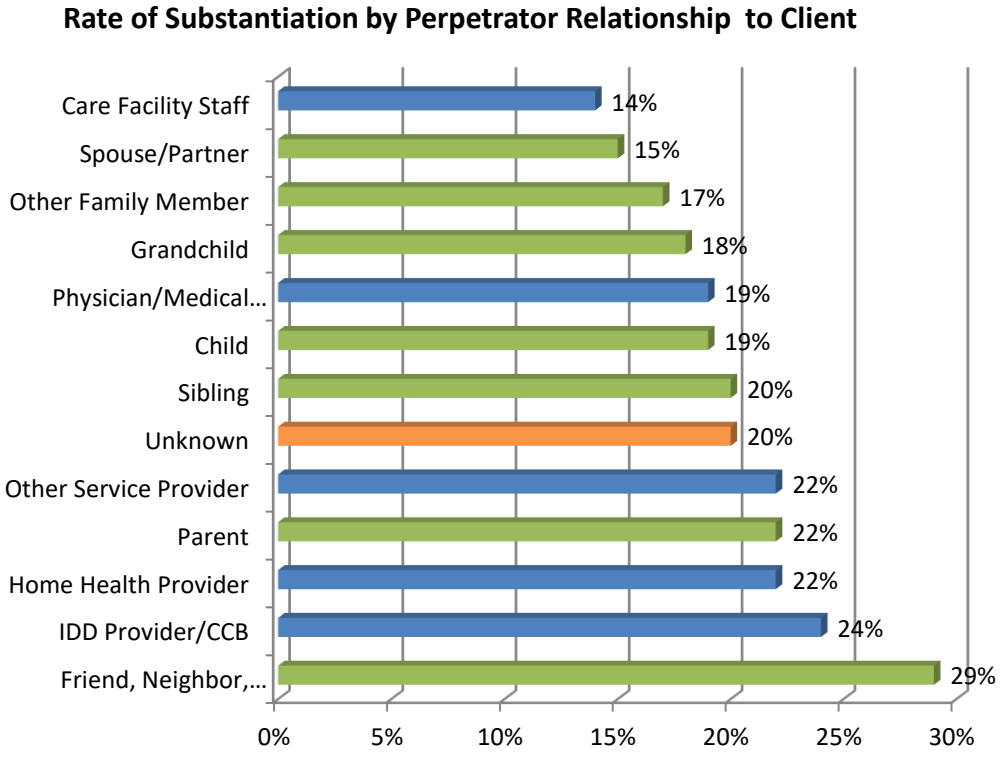
Most Common Substantiated Perpetrator Relationships to Client



When looking at the relationship between substantiated perpetrators and clients within allegation types, there are some trends that appear. For example, the "Friend, Neighbor, Acquaintance" relationship group accounts for 24% of all substantiated findings of mistreatment, but when looking at substantiated caretaker neglect allegations, that number drops to 4% (most often perpetrated by family members or professional staff). Conversely, that 24% of all substantiated allegations of mistreatment jumps to 58% for physical abuse and 53% for sexual abuse substantiations. Family members are responsible for approximately 46% of all substantiated mistreatment allegations but that increases to 55% for caretaker neglect substantiations. The "Unknown" relationship group accounts for 8% of all substantiated allegations of mistreatment, but that increases to 22% for substantiated exploitation. Finally, the "Child" relationship group accounts for 22% of all mistreatment substantiations, but it declines to 8% of physical abuse and 2% of sexual abuse substantiations.

Overall, approximately 20% of all allegations made against alleged perpetrators in FY 2020-21 were substantiated, 26% were inconclusive, 42% were unsubstantiated, and 12% could not be determined. Below is a chart with the percentage of substantiated allegations per relationship category for FY 2020-

21. For example, 29% of all the allegations made against the "Friend, Neighbor, Acquaintance" group were substantiated.



Joint Investigations

Investigations may be conducted jointly with a partnering agency that has statutory authority to investigate mistreatment (i.e., a collaborative investigation). Typical agencies that conduct joint investigations with APS include:

- Law enforcement
- District attorneys
- Medicaid fraud investigators
- Community Centered Boards
- Colorado Department of Public Health and Environment Health Facilities Division
- Long-term care ombudsmen
- County Department of human services fraud investigation and child welfare units

In FY 2020-21, most APS cases did not involve a joint investigation. However, of those cases that did include a joint investigation, a vast majority were investigated jointly with law enforcement.

County Department APS programs, law enforcement agencies, district attorneys, and other agencies responsible by law to investigate the mistreatment of at-risk adults are required by statute (Section 26-

3.1-103(3), C.R.S.) to develop and implement cooperative agreements to coordinate these joint investigative duties to ensure the best protection for at-risk adults. Those agencies include:

- Local law enforcement
- District attorney (DA)
- Long-term care ombudsman - advocates for residents of nursing homes, assisted living residences, and similar licensed adult long-term care facilities.
- Community Centered Boards (CCBs) – organizations that provide services to adults with intellectual and developmental disabilities, such as eligibility determination, coordination and arrangement of services, and oversight of direct care providers.

Assessment

Colorado APS has developed a systematic assessment tool that underwent a validation process. The validation process is critical to ensuring the reliability and validity of the data, which is why validated assessment tools are recommended (ACL, 2020; De Donder et al., 2014). The assessment involves an evaluation of the client's strengths and needs to determine risk[9] and safety[10]. Caseworkers create a holistic evaluation of risk to identify areas that place the client at risk and areas that are strengths for the client.

Colorado's assessment tool looks at risk factors in the status areas of: 1)activities of daily living and instrumental activities of daily living (often revolving around the client's physical capabilities), 2) cognition, 3) behavioral concerns, 4) medical concerns, 5) home/residence, 6) finances, and, 7) mistreatment. Examples of specific risk factors that are evaluated include the client's ability to communicate, whether the plumbing is working, whether the client's awareness of personal financial needs, whether the client is experiencing delusions, the client's orientation to time/place, whether the client has an acute/unmet medical issue, and so on.

Caseworkers also record whether any services have already been implemented prior to APS involvement that help mitigate the risk of these factors and increase the client's safety. If a client has a risk in a certain area and there is no adequate service or support already in place, the APS caseworker will identify a possible solution in the case plan and work with the client to implement the needed service or intervention. For example, if clients are no longer able to prepare meals, do their laundry, or clean their home, the APS caseworker, with the client's input and consent, would work to get a homemaker to come into the client's home to assist with these daily chores. As such, the assessment is used to help identify possible interventions (e.g., services) for the case plan.

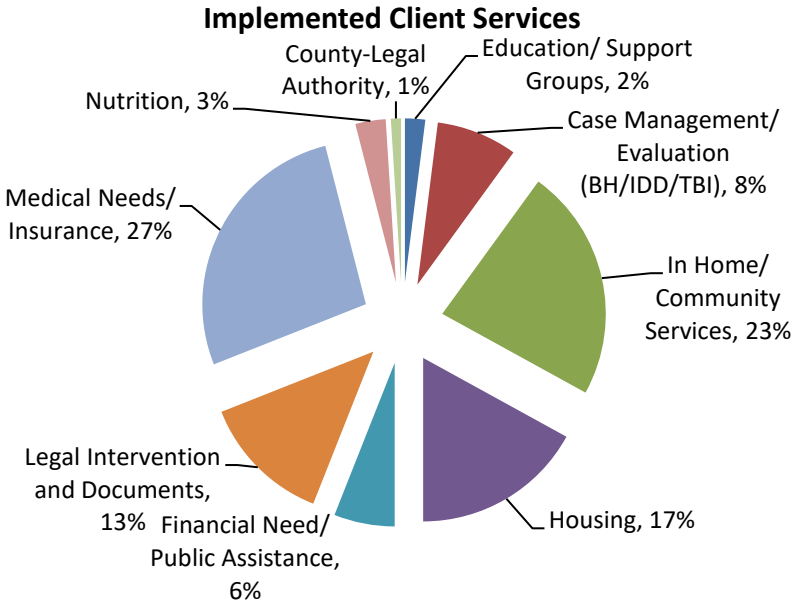
[9] **Risk** means conditions and/or behaviors that create increased difficulty or impairment to the client's ability to ensure health, safety, and welfare.

[10] **Safety** means the extent to which a client is free from harm or danger or to which harm or danger is lessened.

Case Planning

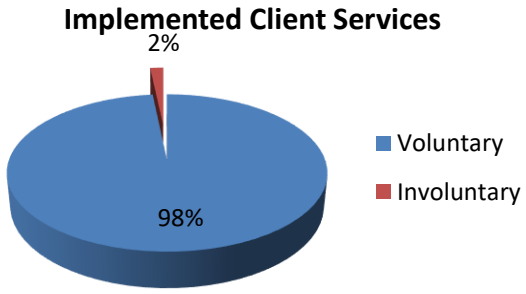
Case planning refers to the process of using the information obtained from the investigation and assessment to identify, arrange, and coordinate protective services in order to reduce the client's risk and improve safety. Unless it has been determined that the client does not have a sufficient understanding or capacity to make responsible decisions, services may only be implemented with the client's consent (see the Involuntary Case Planning and Alternative Decision Makers section below for more details when the client does not have sufficient understanding or capacity). APS caseworkers strive to involve clients in the case planning whenever possible, in keeping with the APS principals of consent, self-determination, and least restrictive intervention. The ACL (2020) also recommends involving the client when case planning, utilizing a person-centered approach (self-determination). APS will attempt to identify and implement services that will allow clients to remain safely in their home, if that is their wish. However, a move to a family member's home, an assisted living residence, or a nursing home may be the best option if the client's level of care is so great that safety cannot be maintained by in-home services. But, unless the client has been determined to lack capacity by the Court, the client may refuse some or all services. As a result, APS caseworkers will attempt to identify additional alternative services that the client may be more open to implementing.

The most common types of services implemented were medical needs/insurance (27%), in-home/community services (23%), housing (17%), and legal services (13%). Medical needs/insurance services include things like doctor visits, dental care, medications, and insurance applications. In-home/community services include items such as home health care, homemaker services, and transportation. Housing services are comprised of subsidized housing applications, rent counseling, and assisting clients in moving to appropriate housing (e.g., assisted living), etc. Legal services involve resources like attorney consultations, requests for legal documents (i.e., ID, birth certificates, etc.), and legal authority designation. Common financial services include application for public assistance programs, financial counseling, and setting up auto-pay for bills.



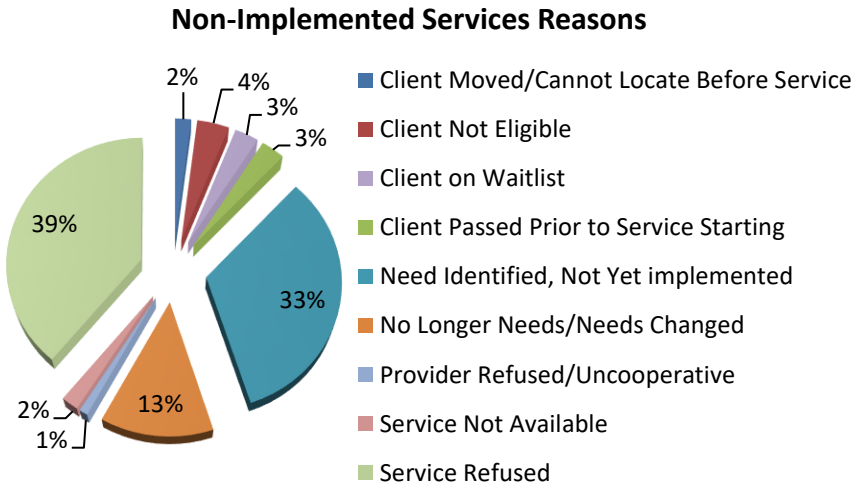
In FY 2020-21 statewide APS utilized approximately $ $379,928 of the APS Client Services funds to purchase goods and services necessary for clients' immediate health and safety. These funds are used only for emergency or short-term services necessary for the client's health or safety when a client is unable to pay for the good/service and there is no other program available to provide the needed goods/services. These funds were used for home modifications (grab bars in showers, wheelchair ramps, etc.), short-term home health services, cleaning services and pest eradication, cognitive capacity evaluations, housing, transportation services, and more.

Approximately 98% of all of the implemented services were arranged with the client's cooperation. The remaining 2% of implemented services were carried out because the client was unable to consent (e.g., client lacks cognitive capacity or is in a coma), the client's legal guardian consented to the service, and/or the client was violating a municipal code (see the Involuntary Case Planning and Alternative Decision Makers section below for more details).



Client services can end for many reasons. The most common reason in FY 2020-21 for a service to end was simply that the service was complete (93%). The next most common reason was a client decision to end the service (e.g., revoked consent or resistant to service delivery, (3%). Services can end because they are ineffective (2%), the provider may have safety concerns (1%), or because the client moved out of the state or the client cannot be located after the service began (1%).

There are services that are identified by APS caseworkers as needed to improve safety and reduce risk for their client that were not implemented. There are several reasons why a service may not be implemented. Clients with cognitive capacity have the right to refuse any or all suggested services, services may be unavailable in certain areas of the state, the client may not meet eligibility criteria for the service, the client may be on the waitlist to receive the service, the client may have moved out of the state prior to the implementation of the service, the caseworker may be unable to locate the client after the service was identified, or it may be that the caseworker is still in the process of coordinating the service. When analyzing services that were not available, three trends stood out: 31% fell into the In



Home/Community Services, 20% fell into the Housing group, and 19% fell into the Legal grouping. The most common services within those groups were guardianship, facility living (assisted living, nursing home, Medicaid long-term care), home health, and homemaker services. These shortages were present most frequently in the larger metro areas but were identified as unmet needs across the state. In their multi-country research, Bennett et al. (2002) noted the lack of available quality services for older adults was a common challenge faced.

Involuntary Case Planning and Alternative Decision Makers.

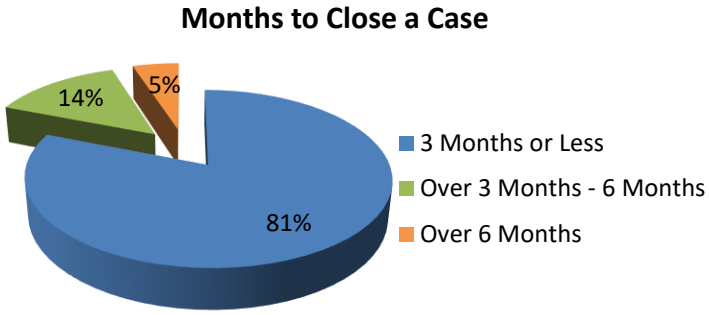
As noted previously in this report, approximately 2% of services that APS implemented on behalf of clients in FY 2020-21 were implemented involuntarily. APS may need to implement services without a client's consent when there are circumstances that prevent a client from being able to provide consent, when a client is at imminent risk of serious injury or death, or when a law is being violated. For example, for emergency medical or behavioral health treatment, or when the client may be in violation of a law or municipal code, such as hoarding or vermin clean up requirements. This is in line with the ACL's (2020) voluntary guidelines that policies need to be established for involuntary case planning and the decision to implement those services should not be taken lightly.

Occasionally, the client may have cognitive deficits that are so great that they are unable to consent to or refuse protective services. In these cases, the only option to ensuring the client's health and safety might be to petition the court to have a guardian appointed, as outlined in Section 15-14-301, C.R.S., to assist with decision making for the client. Only the court can declare a person to be incapacitated. A client who is unable to manage his/her finances because of cognitive limitations may need a conservator, as outlined in Section 15-14-401, C.R.S. Representative payees may be a less restrictive option for some APS clients who need assistance with managing finances but who otherwise are not incapacitated. However, a representative payee is only an option for clients who receive Social Security benefits (including SSI or SSDI) or who are receiving a pension from another company that offers a representative payee option. APS would work with their county attorney whenever a legal intervention, such as guardianship or rep payeeship is necessary.

The APS program works to identify an appropriate family member or friend who can take on fiduciary responsibility for the client or, if a client has enough financial resources, a paid guardian, conservator, or representative payee could be appointed. Some counties have a Public Administrator who can be appointed the conservator for some clients. If the APS client is living in or moving to a long-term care facility, that facility might be named by the Social Security Administration (or other pension plan administrator) as the client's representative payee. Per statute and rule, County Departments may assume guardianship, conservatorship, and/or representative payeeship for clients who have no other appropriate option, but are not required to do so. In keeping with the priority of ensuring the least restrictive intervention, less than 1% of new cases in FY 2020-21 could only be resolved by the County Department APS program becoming the client's legal representative. Cases in which the County Department APS program is appointed as guardian, conservator, or representative payee remain open for as long as that legal authority is needed for the safety of the client.

Case Closure

As the NAPSRC and NASUAD (2012) pointed out in their review of APS programs, due to the complexity of cases, 40% of APS programs across the country do not have a specific timeframe for closing cases. Colorado is one of these states. The states that did report they had a specific timeframe also stated that there are many exceptions and extensions to those policies. For Colorado APS, even though there is no specified timeframe by which a case must be closed, with the exception of cases in which APS holds legal authority for the client (guardianship, conservatorship, or representative payeeship) or the case is exceptionally complex, APS services (i.e., cases) are short-term. NAMRS (2018) found that nationally in FFY 2018[11], 51.3% of all APS cases were closed between 15-60 days. In FY 2020-21, Colorado APS closed 55.4% of cases between 15-60 days. About 81% of all cases are closed within three months and 95% are closed within six months. Less than 2% of cases are open longer than one year, which are primarily those cases in which APS holds legal authority for the client.

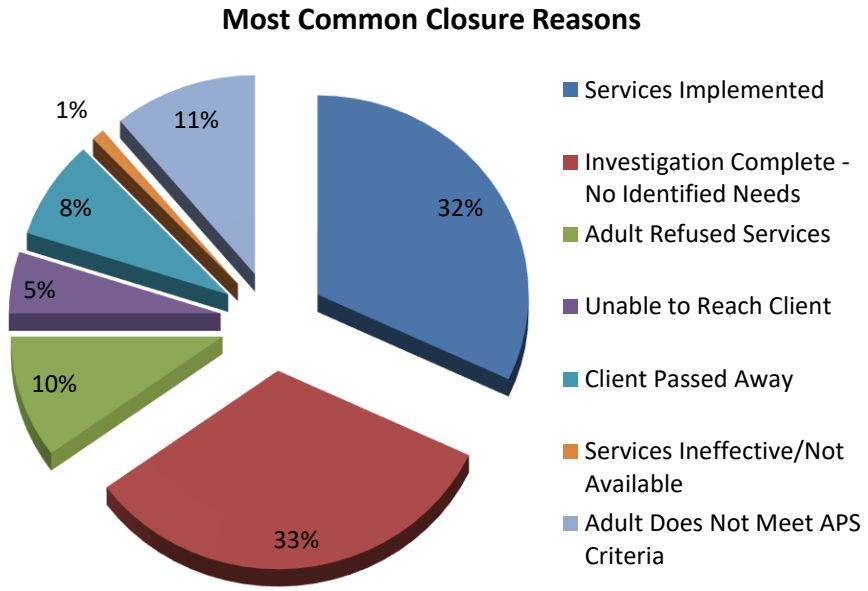


A majority of cases indicate that the individuals who were alleged to have committed mistreatment are still involved with the client at case closure. However, when limited to those with a substantiated allegation of mistreatment, that number of cases that indicate that the perpetrator is no longer involved, increase significantly (approximately 17%). When compared to cases with any substantiated allegation of mistreatment, there is a lower percentage of perpetrator involvement at closure for cases with a substantiated allegation of exploitation (11%) and sexual abuse (20%). This could be expected given that 22% of substantiated exploitation allegations are from the "Unknown" relationship group (i.e., someone who is not habitually involved with the client) and 53% of substantiated sexual abuse allegations are perpetrated by individuals in the "Friend, Neighbor, Acquaintance" relationship group (i.e., it's possibly easier to remove access to the client for that relationship group than to remove access for a family member). Conversely, substantiated allegations of harmful act see an increase (16%) in the percentage perpetrator involvement at closure. A majority of perpetrators of harmful act are family members (56%). As previously noted, numbers related to harmful act should be taken cautiously given that this allegation type was added during the fiscal year, thus figures may not represent what would appear if an entire years' data was included.

Cases are closed once APS has completed its investigation and intervention (or there is no further need of intervention, or all options for intervention have been exhausted). In 32% of cases, APS is able to implement services, sometimes with assistance from other agencies or family members, to improve the

[11] NAMRS utilizes the Federal Fiscal Year (FFY) which for FFY 2018 was October 1, 2017 through September 30, 2018.

health and safety for the client. This is close to the national estimate that almost a third of cases were closed after the implementation of services in the FFY 2018 (NAMRS, 2018). In about 33% of cases, the case is closed immediately following the investigation and assessment because the client had no health or safety needs. In another 10% of cases, APS identified needs but the client was competent and refused any services or assistance from APS. In other cases, the APS caseworker is unable to locate the client so the case is closed once the investigation is completed to the best of the caseworker's abilities. Cases are closed when the APS client passes away or when the caseworker has exhausted all attempts to locate the client (in both instances, an investigation is completed prior to closure). For about 1% of cases, the service(s) needed to improve safety for the client is not available in the community (or not available anywhere in Colorado), the only provider for the service cannot safely provide the ser vice because of the client's aggressive or violent behaviors, or the service(s) is ineffective. In these situations, the case is closed after the investigation is completed and the APS caseworker has exhausted all options for the client. Finally, APS cases are closed immediately if after assessing the client, the caseworker determines that the client does not meet the criteria of an at-risk adult.



Progress and Future Developments

APS Staff Training

Every new Colorado APS caseworker and supervisor must attend a nine-day intensive Training Academy; other APS staff, such as case aides or administrators may attend Training Academy but are not required to do so. This in-depth training on the APS program includes the rules and regulations, casework practice, client populations, client strength and needs assessment, and investigation certification. ACL (2020) recommends providing this type of "orientation to the job" training focused on ensuring that new workers can gain the job knowledge and acquire the relevant abilities required for them to successfully fulfill their duties. Training Academy was offered quarterly in FY 2020-21. There were 76 new workers that attended one of the Training Academy events in FY 2020-21. Of those attendees, 87% were caseworkers, 4% were supervisors, and 9% were other positions (managers/administrators, case aides, etc.).

Quarterly Training Meetings (QTM) in prior years were typically provided in-person at various locations across the state and through webinar for those APS staff not living in the immediate area. However, due to COVID-19, the QTMs this fiscal year were only provided via webinar. All QTMs are recorded so that APS workers who are unable to attend live can listen to the training at their convenience. QTMs cover topics such case plans, investigations, confidentiality, screening decisions, findings, assessments, legal authority, updated rules/statutes, and other casework related topics. There were approximately 1200 total attendees in the four QTMs in FY 2020-21. Along with the QTMs, APS typically delivers targeted full-day training sessions about different casework topics that are developed and delivered by experts in their field. These targeted training sessions in FY 2020-21 focused on person-centered assessment and were recorded so that all APS workers could take the training at their convenience. There were over 70 attendees.

Colorado APS also facilitates ten to twelve 90 minute webinar training opportunities, called Tuesday Topics, each fiscal year. These training sessions are offered to APS workers live via webinar and are recorded so that workers who are unable to attend live can listen to the training at their convenience. There were over 860 total attendances for Tuesday Topic opportunities in FY 2020-21, increasing APS staff knowledge on a variety of casework topics, such as capacity to consent to sex, COVID-19 response for older Coloradans, Colorado Cross-Disability Coalition, consumer-directed options in Colorado, regional center operations, domestic violence, brain injuries, secondary trauma, dementia, and Colorado's Veteran Community Living. The Tuesday Topics, QTMs, and targeted training events provide the core competency and advanced/specialized training that the ACL (2020) recommends be provided to workers on a regular basis.

Finally, two to four times per year APS provides a three-day Advanced Investigations training opportunity for all caseworkers and supervisors who wish to fine-tune their investigation and interviewing skills above what they learned in Training Academy. There were 22 caseworkers and supervisors who attended the two sessions of this training that were offered in FY 2020-21.

Continuing Education Requirements

Nationally among state APS programs, about 66% of states require training for their workers through state policy but less than half have the requirement in their statutes (NAPSRC & NASUAD, 2012). The ACL (2020) recommends requiring training for workers as it has been associated with worker retention and satisfaction, not to mention enhanced skills and competency (Zlotnick, DePanfilis, Daining, & Lane, 2005). Colorado APS has provided standardized training for new workers since 2007 and formalized its training and continuing education requirements for its workers in rule in 2012 (12 CCR 2518-1). In 2017, the Colorado General Assembly passed legislation that formalized training requirements in statute (HB17-1284). During in FY 2020-21, 100% of all new workers completed required training for new APS staff and 100% of experienced APS supervisors, caseworkers, and case aides met the annual continuing education training requirements set by Colorado APS rules (12 CCR 2518-1). APS County Department staff (those required to complete training and others) completed approximately 8,500 hours of continuing education.

Adult Protection (AP) Teams and Community Education

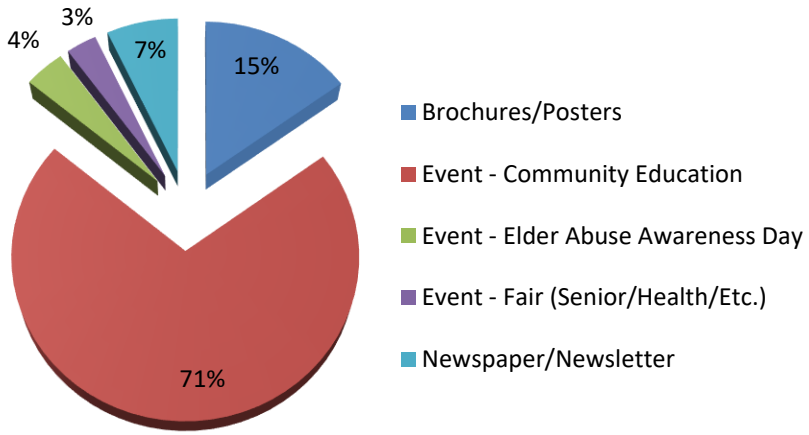
The Colorado Adult Protective Services (APS) rules require counties that had 10 or more screened-in reports (cases) in the previous fiscal year to convene a multi-disciplinary Adult Protection (AP) Team. The AP Team is an advisory group that can review the processes used to report and investigate alleged mistreatment and self-neglect, review the provision of protective services, facilitate coordination of services, and provide community education on the APS program and the mistreatment and self-neglect of at-risk adults. AP Teams are a fairly common practice within APS programs (NAPSRC & NASUAD, 2012). Multidisciplinary teams are commonly recommended for addressing adult mistreatment and have been noted to be effective method for inter-agency coordination, data-sharing, coordinating care plans, etc. (ACL, 2020; Aravanis et al., 1993; Navigant, 2016; Rizzo, Burnes, & Chalfy, 2015, U.S. Department of Justice et al., 2014). Among many other benefits, multi-disciplinary teams have been associated with increased rates of prosecution (ACL, 2020) and with reducing costs by decreasing long-term care placement (Navigant, 2016). Colorado currently has 48 active AP Teams representing 52 of its 60 counties with an APS program.

AP Teams consist of representatives from collaborating service agencies in a variety of professional groups which includes attorneys, law enforcement, mental health professionals, hospital/facility staff, social workers, long-term care ombudsman, Community Center Board (CCB) staff, agencies that provide services to at-risk adults, and other professionals who have experience with at-risk adults. Some strengths of these types of collaborations included enhanced communication, improved relationships among the collaborating agencies, better coordination of services, and an increased number of services provided to at-risk adults (Teaster et al., 2009). Furthermore, this coordination helps agencies gather an understanding of program limitations, their differing roles in serving this at-risk adult population, offers an opportunity for cross-training, can help reduce duplication of efforts, and can offer interventions that no one agency could provide individually (Lachs & Pillemer, 2015; Malks, Schmidt, & Austin, 2002; Taylor & Mulford, 2015; Teaster et al., 2009),

As mandated by rule (12 CCR 2518-1, 30.830), community education about at-risk adult mistreatment and self-neglect is a central function of AP Teams. During FY 2020-21, AP Teams provided 187 community educational opportunities to an estimated 30,491 professionals and community members in their respective counties. Colorado APS is still seeing a decrease in the total number of AP Team training events offered when compared to FY 2018-19 (the fiscal year prior to the COVID-19 pandemic).

The most common form of education opportunity in FY 2020-21 was a community education event (71%).

AP Team Community Education Events



Colorado APS provides an online training about mandatory reporting which is available to mandatory reporters and other members of the public at ColoradoAPS.com. This training was accessed 5,317 times in FY 2020-21.

Strategies for Improving Future Outcomes

Colorado APS Data System (CAPS)

In 2014, Colorado APS designed and implemented the Colorado APS Data System (CAPS) and CAPS has been a very effective data system. CAPS has enabled the State APS program to better identify client and program needs and track the progress of cases. CAPS allows for every part of the case to be documented electronically, thus the entirety of the case can be viewed at once without referencing paper files. As a result, CAPS has facilitated a more efficient method of evaluating the quality of casework and any areas of improvement identified during quality assurance analyses can be addressed. Colorado's APS program continues to make improvements to CAPS to create efficiencies and other improvements for users, improve data collection, and ensure CAPS continues to meet stringent security guidelines.

Judicial District 18 (JD18) and CAPS

Both the mandatory reporting statute (§18-6.5-108(2)(b), C.R.S.) and the APS statute (§26-3.1-102(3), C.R.S.) require the sharing of new reports between the law enforcement agency (LEA), APS, and the district attorney's office (DA) within 24 hours of receiving the report. APS is required to share all new reports with the appropriate LEA, who in turn must share those reports with the DA. When the LEA takes the new report, they must share the report with APS and the DA. Sharing of reports in a timely manner between these three agencies is important and may be critical in ensuring the safety of the at-risk adult. In practice, sharing reports is a manual process and APS and LEAs have limited resources that sometimes cause delays in the sharing of those reports.

In an effort to create a more efficient and timely process for sharing reports, the state APS program collaborated with Judicial District 18 (JD18), which serves Arapahoe, Douglas, Elbert, and Lincoln (and part of Adams) counties, the County Department APS programs in those counties, and the 21 LEAs serving those communities to develop a common data system for Judicial District 18 (JD18) and the 21 LEAs within JD18.

The project was completed in October 2018. The project consisted of building a data system for JD18 and its law enforcement agencies called Colorado At-Risk & Elder System (CARES). LEAs take reports they receive from mandatory reporters and enter those reports into CARES. The DA has access to this system so LEAs no longer need to manually share the reports with the DA. An interface between CAPS and CARES was created so that as soon as a new report is created by APS in CAPS or by LEAs in CARES, the report is sent automatically, eliminating the need to manually share the reports. This also ensures that LEAs and APS are notified within minutes rather than the full 24 hours allowed in statute. Now, each agency can respond more quickly to reports of mistreatment. This project could be expanded to other Judicial Districts across Colorado that have an interest in automating report sharing and utilizing a data system that provides an efficient method for tracking reports, investigations, and investigation outcomes.

According to information provided to the State APS office by the 18th Judicial District Office (C. Nevill, personal communication, June 22, 2021), this project has been very successful in tracking, investigating, and prosecuting crimes associated with the mistreatment of at-risk elders (aged 70 and above) and at-risk adults age 18 and older with intellectual and developmental disabilities. CARES has provided a centralized location for taking these reports and tracking investigation outcomes in an efficient and effective data system. Specifically, between calendar year 2017 (prior to implementation of CARES) and 2020, JD18 saw a 68% increase in the number of reports it received for at-risk elders and at-risk adults with IDD. Additionally, during this same time, JD18 saw a 7% increase in cases that resulted in criminal charges against the perpetrator. In the previous two fiscal years, there were a greater number of criminal charges, so it is likely that the 7% referenced above would be even greater if not for the COVID-19 pandemic.

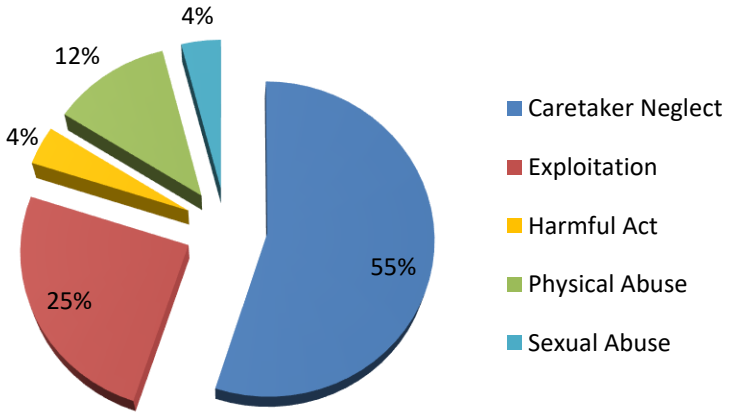
CAPS Background Checks and Appeals (House Bill 17-1284)

In 2017, the Colorado General Assembly passed House Bill 17-1284, which required certain employers effective January 1, 2019 to request a check of the Adult Protective Services data system (CAPS) to determine whether a prospective employee has been substantiated of causing or committing mistreatment (physical or sexual abuse, caretaker neglect, or exploitation) of an at-risk adult. Employers who are required to request a CAPS check for new employees include health facilities, adult day care facilities, nursing homes, regional centers for persons with intellectual and developmental disabilities, home care agencies, service provider agencies for persons with IDD, and other service and care providers who work with at-risk adults. Beginning in January 2022, courts will be required to request a CAPS check for any person who may be appointed as a guardian or conservator of an at-risk adult to determine whether the potential employee has been substantiated of mistreatment. Also beginning January 2022, the Colorado State APS program will share information with the Department of Regulatory Agencies (DORA) when a licensed healthcare professional is substantiated of mistreatment of an at-risk adult while performing their professional duties. Colorado joins many other states in creating a process for employers to check APS records prior to hiring a new employee. In 2018, NAPSA reported that there are about 25 other states (26 total) with similar “registries”, as they are often referred to in other states.

In FY 2020-21, the CAPS Check Unit (CCU) received 112,863 requests for CAPS checks on potential employees. Of those, the CCU identified 445 hits or matches (meaning that of the CAPS check requests from authorized employers, these were confirmed to have been substantiated as a perpetrator of mistreatment against an at-risk adult in CAPS). CAPS checks are “flagged”, i.e., each week CAPS check staff cross-check potential employee requests for CAPS checks against newly substantiated perpetrators from the week before. If there is a “match” the employer will be notified of the new substantiation. Of the 445 hits, 296 were flagged hits. When there is a match the employer is provided information on the date of the investigation, the county department that conducted the investigation, the mistreatment type (physical abuse, sexual abuse, caretaker neglect, or exploitation), and the severity level (impact) of the mistreatment on the client.

House Bill 17-1284 also established due process for people substantiated in an APS case of mistreatment against an at-risk adult, which became effective on July 1, 2018. All the states with a similar process require that substantiated perpetrators be notified of their placement on the registry (NAPSA, 2018). Appeal requests are handled by the Child and Adult Mistreatment Dispute Review Section (CAMDRS), which is located in the Administrative Review Division of the Department. Per rule (12 CCR 2518-1), an appeal can only be made if there was not a preponderance of evidence or if what was substantiated as mistreatment does not meet the statutory or regulatory definition of mistreatment.

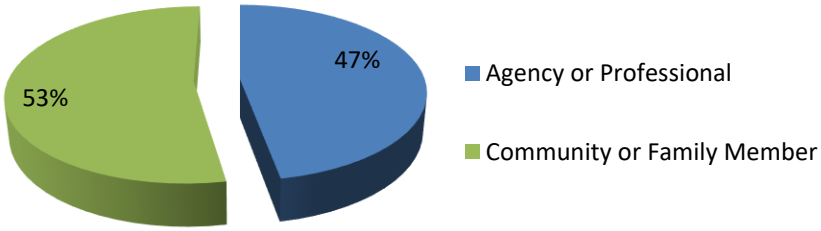
Appeals Received in Fiscal Year 2020-21 by Mistreatment Type

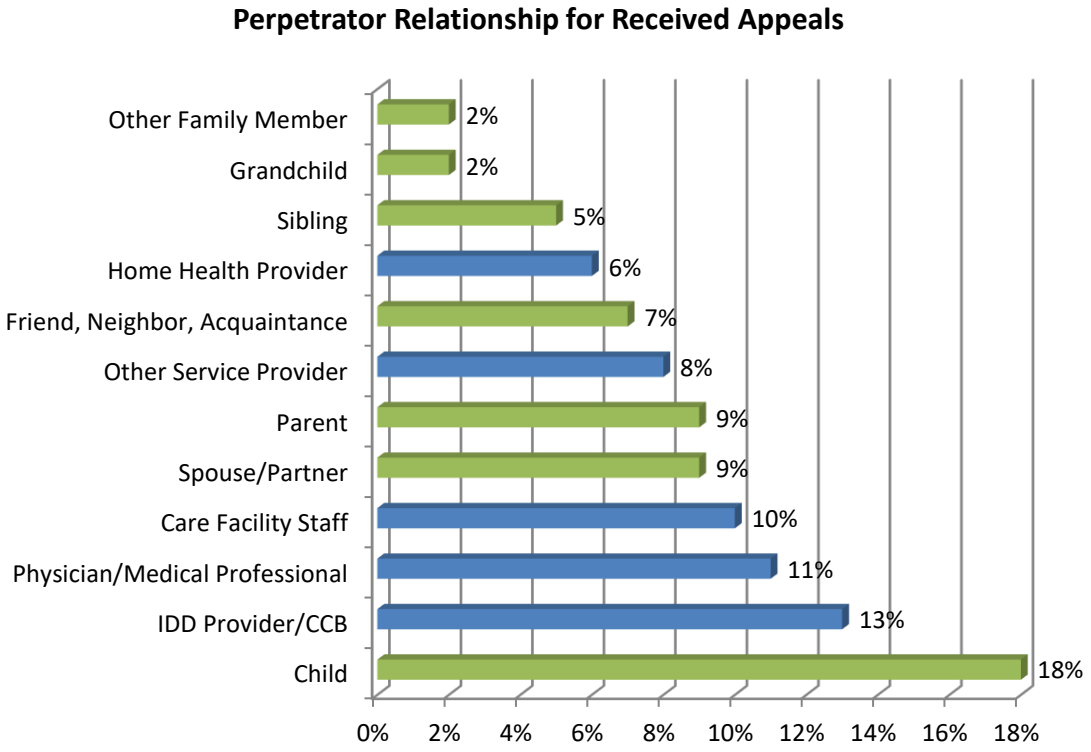


There were 252 appeals requested for FY 2020-21 cases. The majority of appeals (55%) were related to substantiated caretaker neglect findings.

More than half of the substantiated perpetrators who filed an appeal were community or family members (53%). In looking at more specific relationships, the largest relationship groups filing appeals were children of the client (18%), service providers for people with intellectual and developmental disabilities (13%), and physicians and other medical professionals (11%).

Perpetrator Relationship Type for Received Appeals





Investigations Training

Colorado's APS caseworkers and supervisors are required to attend specialized investigations training and become certified investigators as a requirement of House Bill17-1284. The Department contracts with a company that specializes in training related to mistreatment investigations to deliver a three-day basic investigations curriculum for all new Colorado APS staff. This three-day training is incorporated into Training Academy that is provided for all new workers (mentioned above here). This same company teaches a three-day Advanced Investigations curriculum and delivered it twice during FY 2020-21 (mentioned above here). The advanced investigations training is available to caseworkers and supervisors who wish to continue to improve their investigation and interviewing skills.

Quality Assurance

Formal and informal reviews of individual cases and other statutory and regulatory program requirements are conducted annually on the APS program. In addition, County Department APS Supervisors are required by rule (12 CCR 2518-1, 30.340) to perform case reviews on 15% or more of each caseworker's caseload each month. Supervisor's also have the choice to provide reviews of cases at specific junctions (e.g., assessment, case plan, etc.) on each case instead of completing case reviews on 15% or more of each caseworker's caseload each month. Additionally, every finding made by a caseworker must be reviewed and approved by the county department's APS supervisor. A monthly

review of specific casework measures (e.g., timeliness monthly contacts) is also conducted as part of the Department's C-Stat process to create a clearer picture of how County Department APS programs are performing over time across various measures of performance. Finally, each year a statewide review of specific program requirements is conducted.

During the 2017 Legislative Session, the General Assembly provided funding for the Department to establish an APS Quality Assurance (QA) unit to conduct formal reviews of casework performed by County Department APS programs. This APS QA unit is located in the Administrative Review Division of the Department to ensure independence. In FY 2020-21, ARD conducted reviews for 54 counties. The reviews by ARD identify areas for improvement and need for continued education and guidance by the Department. Additionally, ARD completed their first review of screened out reports during FY 2020-21. The Department will continue to provide training and guidance to county departments.

State Audit

During FY 2019-20 the Colorado Office of the State Auditor (OSA) conducted their first audit of the APS program since it was enacted in 1983 (see report here). The Department implemented the audit recommendations in FY 2020-21, and those changes will help the APS program, due-process and appeals, and CAPS checks, which ultimately will improve protections for at-risk adults experiencing mistreatment or self-neglect. The OSA identified gaps in the APS statute that it felt should be addressed and presented those policy recommendations to the Legislative Audit Committee (LAC). The LAC agreed and sponsored HB21-1123 to address two of the OSA's recommendations. As mentioned above, beginning in January 2022, courts will be required to request a CAPS check for any person who may be appointed as a guardian or conservator of an at-risk adult to determine whether the potential employee has been substantiated of mistreatment and Colorado State APS will share information with the Department of Regulatory Agencies (DORA) when a licensed healthcare professional is substantiated of mistreatment of an at-risk adult while performing their professional duties.

Elder Justice Act (EJA) Funding Priorities

As noted previously, the Elder Justice Act was funded for the first time through the Coronavirus Response and Relief Supplemental Appropriations Act (CRRSAA). and the American Rescue Plan Act of 2021 (ARPA). These two Acts provide one-time funding for APS programs. Colorado will receive approximately $5.2 million to use roughly between May 2021 and September 2024 to improve and enhance its APS program. Approximately $1.3 million will be used by county APS program to help offset the increased costs of providing APS services during the COVID-19 pandemic. The APS program will use a portion of the funds to develop a long-range, three-to-five-year plan for improving and enhancing the APS program. The remaining funds will be used to begin implementation of the Plan and to provide targeted grants to county department APS programs to improve services in their county or region.

APS Caseload Ratios

Caseload average represents the average number of open cases assigned to each caseworker FTE (full time equivalent). The goal is to maintain a caseload average of 20:1 or less. The caseload average calculation reflects new cases opened during the fiscal year and those cases still open from the prior fiscal year; represented as [(New Cases/12) + Cases Carried Over from Prior FY] / FTE. The APS program caseload average for FY 2020-21 was 15:1 statewide (while the ten largest County Department APS programs had a 17:1 caseload average). However, it is important to note that the caseload average for many counties was significantly higher than these figures at many points during the fiscal year because counties had numerous caseworkers out on leave due to COVID-19. As mentioned in the funding section, high caseloads and lack of resources to fund APS program needs, such as training, new staff, etc., were noted in the Government Accountability Office (GAO, 2011) survey as major challenges experienced in state APS programs across the country.

APS Contacts

For more information visit the APS website (cdhs.colorado.gov/aps).

If you have questions concerning the APS program, please email us (cdhs_aps_questions@state.co.us). Do not email a report of mistreatment or self-neglect of an at-risk adult.

If you are a mandatory reporter and need to make a report of abuse, caretaker neglect, or exploitation of an at-risk elder (aged 70 years or older) or at-risk adult with an intellectual and developmental disability (aged 18 and older), please notify law enforcement where the mistreatment occurred.
If you want to make a report of abuse, caretaker neglect, self-neglect, or exploitation of an at-risk adult, please contact the County Department's APS intake line in which the at-risk adult resides. County Department phone numbers are listed on the APS website or you can access them directly by clicking on the link here.
Training on mandatory reporting to law enforcement and reporting to APS is available online. For more information visit the APS website (cdhs.colorado.gov/aps).

References

Acierno, R. (2018). National elder mistreatment survey: 5 year follow-up of victims and matched non-victims. *National Institute of Justice (NIJ)*. Retrieved from https://www.ncjrs.gov/pdffiles1/nij/grants/252029.pdf.

Acierno, R., Hernandez, M. A., Amstadter, A. B., Resnick, H. S., Steve, K., Muzzy, W., & Kilpatrick, D. G. (2010). Prevalence and correlates of emotional, physical, sexual and financial abuse and potential neglect in the United States: The national elder mistreatment study. *American Journal of Public Health, 100*, 292–297.

Administration for Community Living (2016). Final national voluntary consensus guidelines for state adult protective services systems. Retrieved from https://acl.gov/programs/elder-justice/final-voluntary-consensus-guidelines-state-aps-systems.

Administration for Community Living (2020). National voluntary consensus guidelines for state adult protective services systems. Retrieved https://acl.gov/sites/default/files/programs/2020-05/ACL-Guidelines-2020.pdf

Agarwal, S., Driscoll, J.C., Gabaix, X., and Laibson, D. (2009). The age of reason: Financial decisions over the life-cycle with implications for regulation. *Brookings Papers on Economic Activity, 40*, 51-117. Retrieved from https://dash.harvard.edu/bitstream/handle/1/4554335/laibson_ageofreason.pdf?sequence=2.

Applied Research & Consulting, LLC for the FINRA Investor Education Foundation (2015). Non-traditional costs of financial fraud: A report of survey findings. FINRA Foundation. Retrieved from https://www.finrafoundation.org/ sites/default/files/nontraditional-costs-financial-fraud_0_0_0.pdf.

Aravanis, S.C., Adelman, R.D., Breckman, R., Fulmer, T.T., Holder, E., Lachs, M., O'Brien, J.G., & Sanders, A.B. (1993). Diagnostic and treatment guidelines on elder abuse and neglect. *Archives of Family Medicine, 2*(4), 371-88.

Bennett G., Levin, S.P., & Straka, S. (2002). Missing voices. Views of older persons on elder abuse. *Geneva: World Health Organization*. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/67371/WHO_NMH_VIP_02.1.pdf;jsessionid=A09A53BD2367BB5A767777FE12AD89DE?sequence=1.

Bureau of Justice Statistics. (2011). Crime against persons with disabilities, 2008-2010 – Statistical tables. Retrieved from www.bjs.gov/index.cfm?ty=pbdetail&lid=2238

Castle, E., Eisenberger, N. I., Seeman, T. E., Moons, W. G., Boggero, I. A., Grinblatt, M. S., & Taylor, S. E. (2012). Neural and behavioral bases of age differences in perceptions of trust. *Proceedings of*

the National Academy of Sciences of the United States of America, 109(51), 20848–20852. DOI:10.1073/pnas.1218518109

Choi, N.G., & Mayer, J. (2000). Elder abuse, neglect, and exploitation. *Journal of Gerontological Social Work, 33*(2), 5-25.

Colorado State Demography Office, Department of Local Affairs. (2016). Aging in Colorado part 2: What does it mean for our state? Retrieved from https://demography.dola.colorado.gov/crosstabs/aging-part-2/.

Colorado State Demography Office, Department of Local Affairs. (2019). Population by single year of age – Region. Retrieved from https://demography.dola.colorado.gov/population/data/sya-regions/.

Comijs, H.C., Penninx, B.W.J.H., Knipscheer, K.P.M., and van Tilburg, W. (1999). Psychological distress in victims of elder mistreatment: The effects of social support and coping. Journal of Gerontology, *54B*(4), 240-245. Retrieved from https://pdfs.semanticscholar.org/74e7/84f60b7144697b6e6769f0d3b5e9154c8f38.pdf

Cooper, C., & Livingston, G. (2016). Intervening to reduce elder abuse: Challenges for research. *Age and Aging, 45,* 184-185. DOI: 10.1093/ageing/afw007.

Cooper, C., Selwood, A., Blanchard, A., Walker, Z., Blizard, R., Livingston, G. (2009). Abuse of people with dementia by family carers: Representative cross sectional survey. *BMJ, 338*, Retrieved from https://www.bmj.com/content/bmj/338/bmj.b155.full.pdf.

Cooper, C., Selwood, A., & Livingston, G. (2008). The prevalence of elder abuse and neglect: A systematic review. *Age and Ageing, 37*, 151-160.

De Donder, L., De Witte, N., Brosens, D., Dierckx, E., & Verté, D. (2014). Learning to detect and prevent elder abuse The need for a valid risk assessment instrument. *Procedia - Social and Behavioral Sciences, 191,* 1483-1488. Retrieved from http://www.sciencedirect.com/science/article/pii/S1877042815028438.

DeLiema, M., Fletcher, E., Kieffer, C.N., Mottola, G.R., Pessanha, R., & Trumpower, M. (2019). Exposed to scams: What separates victims from non-victims?. *FINRA Foundation.* Retrieved from https://www.finrafoundation.org/sites/finrafoundation/files /exposed-to-scams-what-separates-victims-from-non-victims_0_0.pdf.

Dong, X. (2015). Elder abuse: A systematic review and implications for practice. *The American Geriatrics Society, 63*, 1214-1238.

Dong, X., & Simon, M. (2013) Elder abuse as a risk factor for hospitalization in older persons. *JAMA Intern Med, 173*(10), 911-917.

Dong, X, Simon, M., Mendes de Leon, C., Fulmer, T., Beck, T., & Hebert, L. (2009). Elder self-neglect and abuse and mortality risk in a community-dwelling population. *Journal of the American Medical Association, 302*(5), 517–526. DOI: 10.1001/jama.2009.1109.

Federal Trade Comission (2017). Consumer Sentinel Network Data Book for January – December 2016. Commission and Staff Reports. Retrieved from https://www.ftc.gov/system/files/documents/reports/consumer-sentinel-network-data-book-january-december-2016/csn_cy-2016_data_book.pdf.

Feinberg, L., Reinhard, S.C., Houser, A., Choula, R. (2011). Valuing the invaluable: 2011 update –The growing contributions and costs of family caregiving. *AARP Public Policy Institute*. Retrieved from https://assets.aarp.org/rgcenter/ppi/ltc/i51-caregiving.pdf

Finke, M., Howe, J.S., Huston, S. (2011). Old age and the decline in financial literacy. *Forthcoming in Management Science 63*(1), 213-230. Retrieved from https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1948627.

Gamble, K., Boyle, P., Yu, L., & Bennett, D. (2015). Aging and financial decision making. *Management Science, 61*(11), 2603–2610. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4662381/pdf/nihms658302.pdf.

Gunther, J. (2011). The Utah cost of financial exploitation. Utah Division of Aging and Adult Services. Retrieved from http://digitallibrary.utah.gov/awweb/awarchive?type=file&item=43025.

Gunther, J. (2012). The 2011 Utah economic cost of elder financial exploitation. Utah Division of Aging and Adult Services. Retrieved from http://victimsofcrime.org/docs/default-source/financial-fraud/2011-economic-cost-of-financial-exploitation.pdf?sfvrsn=2.

Hibbard, J.H., Slovic, P., Peters, E., Finucane, M.L., Tusler, M. (2001). Is the informed-choice policy approach appropriate for Medicare beneficiaries? *Health Affairs, 20*(3), 199-203.

Hoffman, G. & Mendez-Luck, C. (2011). Stressed and strapped: Caregivers in California. Policy brief (UCLA Center for Health Policy Research). 1-8.

Kircanski, K., Notthoff, N., DeLiema, M., Samanez-Larkin, G. R., Shadel, D., Mottola, G., and Gotlib, I. H. (2018). Emotional arousal may increase susceptibility to fraud in older and younger adults. *Psychology and Aging, 33*(2), 325–337.

Lachs, M., & Pillemer, K. (2015). Elder abuse. *New England Journal of Medicine, 373*, 1947–56. DOI: 10.1056/NEJMra1404688.

Lachs, M. S.,Williams, C., O'Brien, S., Hurst, L., & Horwitz, R. (1997). Risk factors for reported elder abuse and neglect: A nine-year observational cohort study. *The Gerontologist, 37,* 469-474.

Lachs, M. S., Williams, C., O'Brien, S., Pillemer, K. A., & Charlson, M. E. (1998). The mortality of elder mistreatment. *Journal of the American Medical Association, 280*, 428-432.

Laumann, E., Leitsch, S., & Waite, L. (2008). Elder mistreatment in the United States: Prevalence estimates from a nationally representative study. *The Journals of Gerontology Series B, Psychological Sciences and Social Sciences*, *63*(4), S248–S254.

Lifespan of Greater Rochester, Inc., Weill Cornell Medical Center of Cornell University, & New York City Department for the Aging (2011). Under the radar: New York state elder abuse prevalence study. Retrieved from https://ocfs.ny.gov/main/reports/Under%20the%20Radar%2005%2012%2011%20final%20report.pdf.

Malks, B., Schmidt, C.M., & Austin, M.J. (2002). Elder abuse prevention. *Journal of Gerontological Social Work, 39*(3), 23-40.

MetLife Mature Market Institute (MMI; 2011). The MetLife study of elder financial abuse: Crimes of occasion, desperation, and predation against America's elders. Retrieved from https://ltcombudsman.org/uploads/files/issues/mmi-elder-financial-abuse.pdf

National Adult Maltreatment Reporting System (2017). FFY2016 Data report – Release 1. Retrieved from https://acl.gov/sites/default/files/programs/2017-08/NAMRS2017_Report_Release-1.pdf.

National Adult Maltreatment Reporting System (2018). Adult maltreatment. Retrieved from https://namrs.acl.gov/getattachment/Learning-Resources/Adult-Maltreatment-Reports/2018AdultMaltreatmentReport2.pdf.aspx?lang=en-US.

National Adult Protective Services Association (2018). National adult protective services association abuse registry national report. Retrieved from http://www.napsa-now.org/wp-content/uploads/2018/05/APS-Abuse-Registry-Report.pdf.

National Adult Protective Services Association & National Adult Protective Services Resource Center (2016). Lessons learned from research and practice: An APS technical assistance report – Part II: Innovative practices from the field. Retrieved from http://www.napsa-now.org/wp-content/uploads/2016/02/Lessons-Learned-from-Research-Practice-Part-II.pdf.

National Adult Protective Services Resource Center & National Association of States United for Aging and Disabilities (2012). Adult protective services in 2012: Increasingly vulnerable. Retrieved from http://www.napsa-now.org/wp-content/uploads/2012/06/BaselineSurveyFinal.pdf.

National Center on Elder Abuse & Westat Inc. (1998). The national elder abuse incidence study. Washington, D.C. Retrieved from https://www.acl.gov/sites/default/files/programs/2016-09/ABuseReport_Full.pdf.

Navigant (2016). State promotion of adult protective service program efficiencies. Retrieved from https://guidehouse.com/-/media/www/site/insights/healthcare/2016/state-promotion-of-aps-program-efficiencies.pdf.

Petersilia, J.R. (2001). Crime victims with developmental disabilities: A review essay. *Criminal Justice & Behavior, 28*(6), 655-94.

Peterson, J., Burnes, D., Caccamise, P., Mason, A., Henderson, C., Wells, M., & Lachs, M. (2014). Financial exploitation of older adults: A population-based prevalence study. *Journal of General Internal Medicine, 29*(12), 1615–23. DOI: 10.1007/s11606-014-2946-2.

Pillemer, K., Breckman, R., Sweeney, C.D., Brownell, P., Fulmer, T., Berman, J.,… Lachs, M.S. (2011). Practitioners' views on elder mistreatment research priorities: Recommendations from a research to practice consensus conference. *Journal of Elder Abuse & Neglect, 23*(2), 115-126.

Quinn, M. J. (2002). Undue influence and elder abuse: Recognition and intervention strategies. *Geriatric Nursing, 23*(1).

Rizzo, V. M., Burnes, D., & Chalfy, A. (2015). A systematic evaluation of a multidisciplinary social work: Lawyer elder mistreatment intervention model. *Journal of Elder Abuse & Neglect, 27*(1), 1-18. Retrieved from https://orb.binghamton.edu/cgi/viewcontent.cgi?article=1005&context=social_work_fac

Tamutiene, I., De Donder, L., Penhale, B., Lang, G., Ferreira-Alvest, J., & Luoma, M.L. (2013). Help seeking behaviour of abused older women (cases of Austria, Belgium, Finland, Lithuania and Portugal). *Filosofija – Sociologija, 24*(4), 217-225. Retrieved from https://www.researchgate.net/publication/261986700_Help_seeking_behaviour_of_abused_older_women_Cases_of_Austria_Belgium_Finland_Lithuania_and_Portugal/download

Taylor & Mulford, (2015). Evaluating the Los Angeles County elder abuse forensic center. *National Institute of Justice, 276*, 32-37.

Teaster, P.B., Dugar, T., Mendiondo, M., Abner, E.L., Cecil, K.A., Otto, J.M. (2006). The 2004 survey of adult protective services: Abuse of adults 60 years of age and older. The National Center on Elder Abuse. Retrieved from http://www.napsa-now.org/wp-content/uploads/2012/09/2-14-06-FINAL-60+REPORT.pdf.

Teaster, P.B., Stansbury, K.L., Nerenberg, L., & Stanis, P. (2009) An adult protective services' view of collaboration with mental health services. *Journal of Elder Abuse & Neglect, 21*(4), 289-306.

Thomas, D.E. (2014). The Wyoming cost of financial exploitation 2011, 2012, and 2013. Utah Adult Protection Services. Retrieved from http://www.nasuad.org/sites/nasuad/files/Wyoming%20Cost%20of%20Financial%20Exploitation%20FINAL%202011-13.pdf.

U.S. Department of Justice, Department of Health and Human Services, Connolly, M.T., Brandl, B., & Breckman, R. (2014). The Elder Justice Roadmap: A stakeholder initiative to respond to an emerging health, justice, financial and social crisis. Retrieved from https://www.justice.gov/file/852856/download.

U.S. Government Accounting Office (GAO). 2011. Elder justice: Stronger federal leadership could enhance national response to elder abuse. *GAO-11-208*. Washington, DC: GAO.

VandeWeerd, C., Paveza, G.J., Walsh, M., & Corvin, J. (2013). Physical mistreatment in persons with Alzheimer's disease. Journal of Aging Research. 2013;2013:920324. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3613078/pdf/JAR2013-920324.pdf

Wood, S., Rakela, B., Navarro, A., Bernatz, S., Wilbur, K. H., Allen, R., & Homier, D. (2014). Neuropsychological profiles of victims of financial elder exploitation at the Los Angeles County Elder Abuse Forensic Center. *Journal of Elder Abuse & Neglect, 26,* 4, 414-423. Retrieved from https://pdfs.semanticscholar.org/f551/fd6c9b42fc528e1f90f2ada250810c3e3d20.pdf

Zlotnick, J., DePanfilis, D., Daining, C., & Lane, M. M. (2005). Professional education for child welfare practice: Improving retention in public child welfare agencies [Institute for the Advancement of Social Work Research research brief]. Child Welfare Workforce Series. Retrieved from http://www.socialworkpolicy.org/wp-content/uploads/2007/06/7-CW-SRR-Brief2.pdf