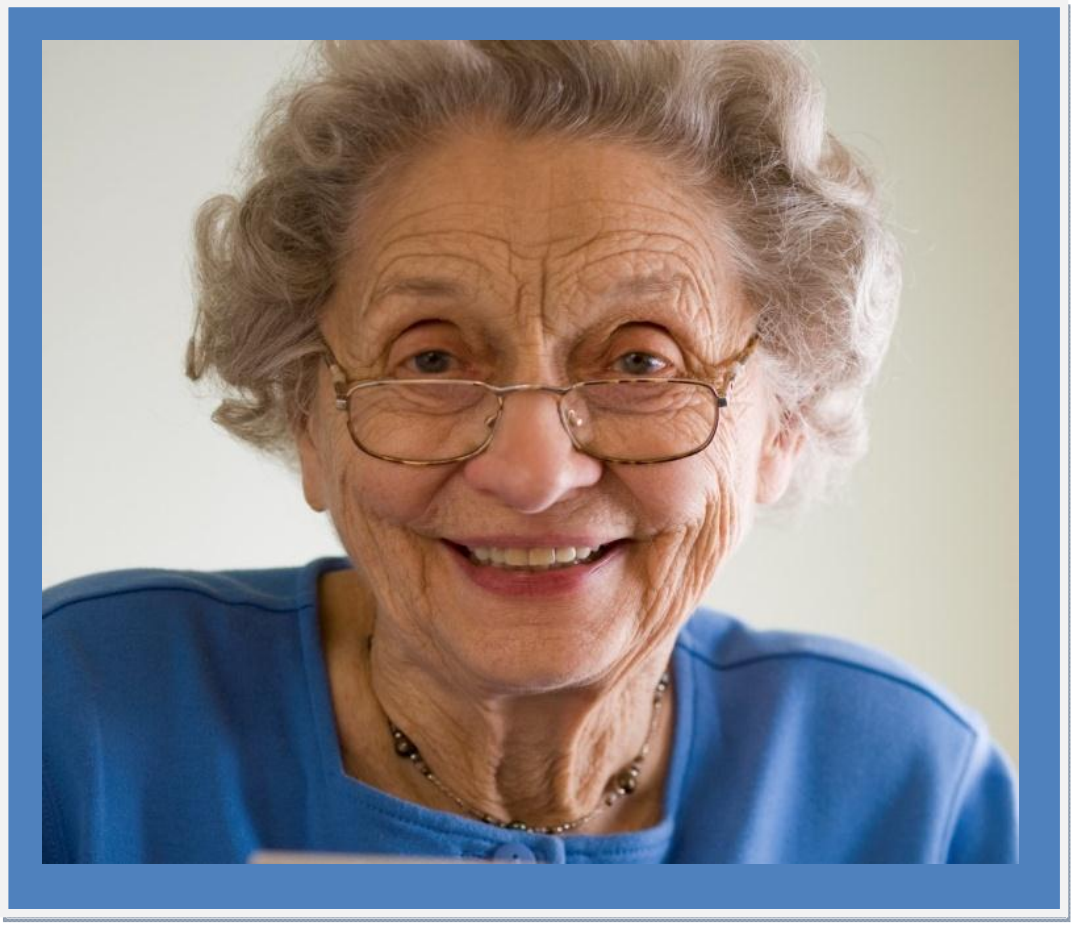
ADVANCED SERIES ON SELF NEGLECT: Legal, Ethical and Practice Issues



PARTICIPANT MANUAL

MODULE 3

PARTICIPANT MANUAL

ADVANCED SERIES ON SELF NEGLECT

Legal, Ethical and Best Practice Issues ©

This training was developed by the Academy for Professional Excellence, which is funded by a generous grant from the Archstone Foundation.

Curriculum Developer

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INTRODUCTION

THE ACADEMY FOR PROFESSIONAL EXCELLENCE

We are pleased to welcome you to the Advanced Series on Self Neglect, developed by Project MASTER, a program of the Academy for Professional Excellence.

The Academy for Professional Excellence was established in 1996 and provides training, technical assistance, organizational development, research, and evaluation to public and private health and human service agencies and professionals.

The Academy is a project of San Diego State University School of Social Work (founded in 1963), which offers both a bachelorôs and masterôs degree in Social Work. The School of Social Work at San Diego State University was founded in 1963 and has been continuously accredited by the Council of Social Work Education since 1966.

The Academy has extensive experience in providing specialized services, including:

- multi-disciplinary competency-based trainings
- curriculum development
- needs assessment
- research
- evaluation
- meeting facilitation
- organizational development consultation services

MASTER is an Archstone Foundation funded program of the Academy for Professional Excellence which has the overarching goal is to develop standardized core curricula for new and experienced APS social workers and to share these trainings on a national scale. Professional training opportunities are a critical step toward ensuring APS social workers have the appropriate tools to serve their victims. MASTER has worked extensively with state and national partner agencies in the development of this curriculum.

Our partners include:

- National Adult Protective Services Association Education Committee (NAPSA)
- The Statewide APS Training Project of the Bay Area Training Academy
- California Department of Social Services, Adult Services Branch
- California State University Sacramento IHSS Training Project
- Protective Services Operations Committee of the California Welfare Director's Association (PSOC)
- California Social Work Education Center Aging Initiative (CalSWEC)

ACKNOWLEDGMENTS

This training is the result of a collaborative effort between Adult Protective Services administrators, supervisors, staff development officers and workers across the state and the nation; professional educators; and the Academy for Professional Excellence staff members. Project MASTER would like to thank the following individuals and agencies:

Agencies

Bay Area Academy, Statewide APS Training Project
California Department of Social Services, Adult Services Branch
California Social Work Education Center Aging Initiative
Imperial County Department of Social Services
Orange County Social Services Agency
Riverside County Department of Public Social Services
San Bernardino County Department of Aging and Adult Services
San Diego County Aging and Independence Services

Regional Curriculum Advisory Committee

Carol Mitchel, APS Manager and PSOC Representative, Orange County
Beverly Johnson, LCSW, Staff Development Officer, Riverside County
Brenda Pebley, APS Manger, Imperial County
Carol Castillon, APS Supervisor, San Bernardino County
Carol Kubota, LCSW, Staff Development Officer, Orange County
LaTanya Baylis, Staff Development Officer, San Bernardino County
Zachery Roman, Staff Development Officer, Los Angeles County

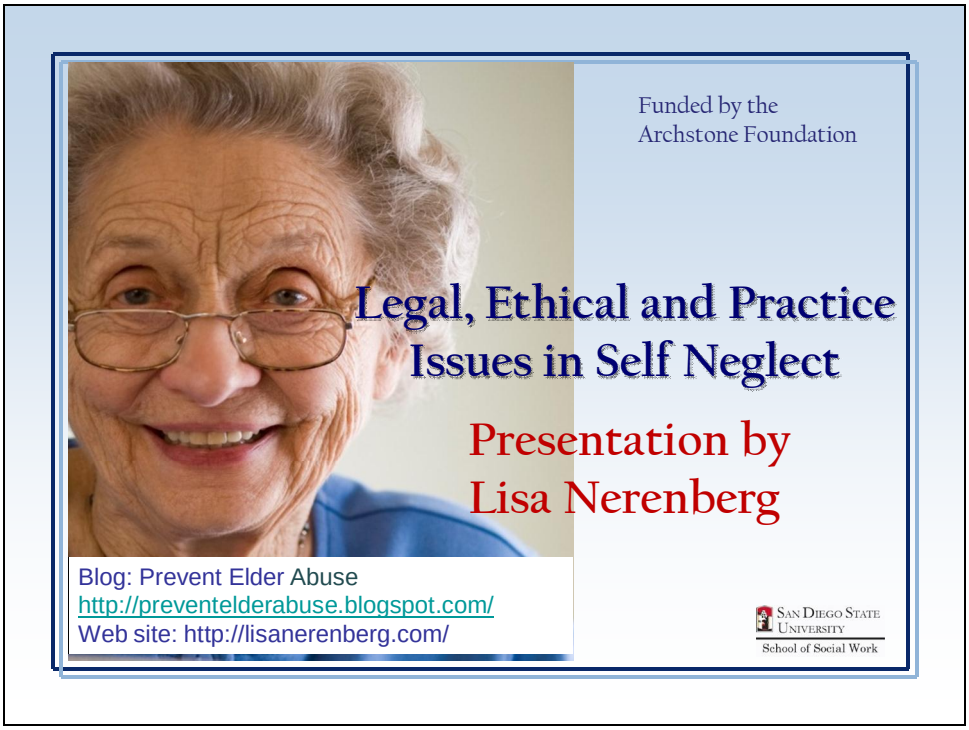
Committees

Project MASTER Steering Committee
APS Core Curriculum Committee
Protective Services Operations Committee of the California Welfare Directors Association

Evaluation Consultants

James Coloma, Evaluation Consultant
Jane Birdie, Evaluation Consultant
Cynthia Parry, Evaluation Consultant

TRAINING GOALS AND OBJECTIVES

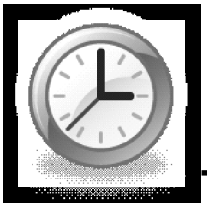


By the end of this training, participants will be able to:

- Explain APSôauthority to intervene in self neglect cases
- Identify state laws that apply to self neglect
- Describe basic principles of legal capacity
- Discuss ethical principles that apply in self neglect cases
- Describe ñdue diligenceòand its application to APS practice in self neglect cases
- Work effectively with community partners
- Describe promising practices for handling self neglect cases

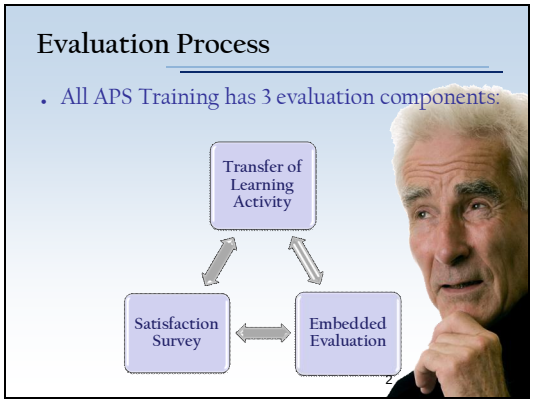
PRESENTATION

WELCOME AND INTRODUCTIONS



TIME ALLOTTED: 15 minutes

Slide # 2



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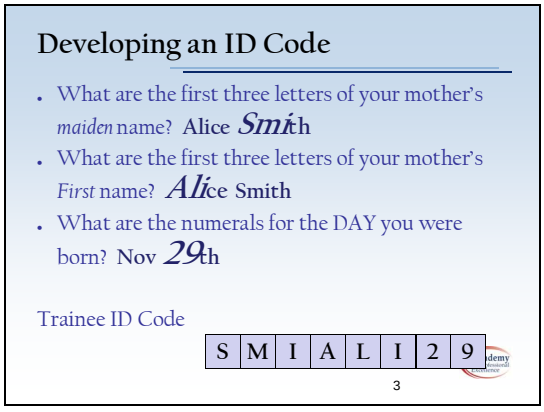

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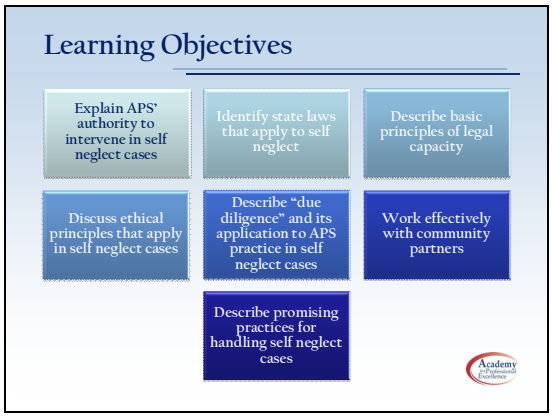
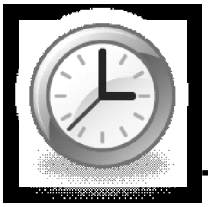
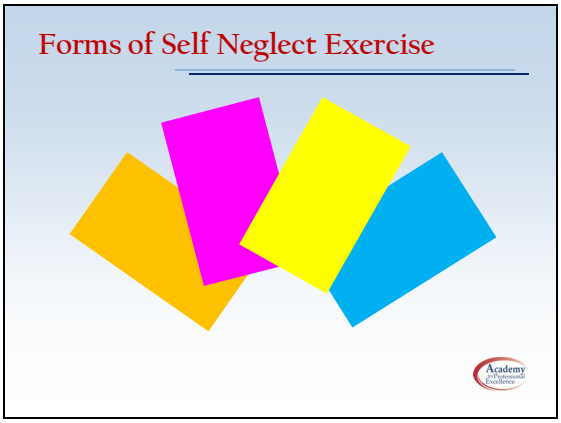

Learning Objectives
Explain APS' authority to intervene in self neglect cases
Identify state laws that apply to self neglect
Describe basic principles of legal capacity
Discuss ethical principles that apply in self neglect cases
Describe "due diligence" and its application to APS practice in self neglect cases
Work effectively with community partners
Describe promising practices for handling self neglect cases

FORMS OF SELF NEGLECT



TIME ALLOTTED: 45 minutes

Slide # 5



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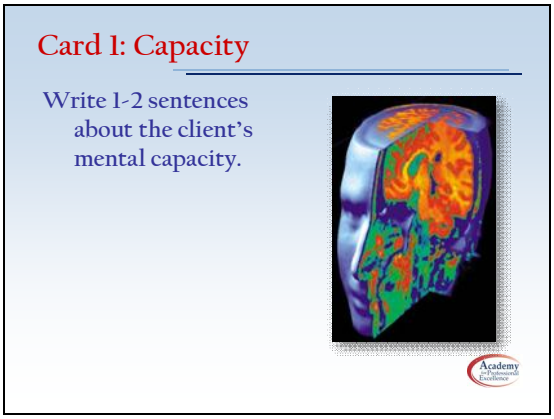
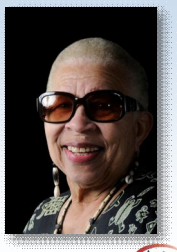


Slide # 7

Card 2: What's at Risk

Write 1-2 sentences about what is at risk:

- To the client
- To family, neighbors, or other third parties
- To you or your agency

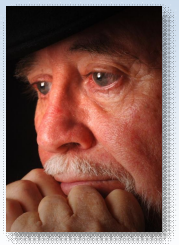


Slide # 8

Card 3: Legal / Ethical Concerns

Write 1-2 sentences about :

- Legal issues the case raises
- Ethical issues the case raises (to you or others)



Slide # 9

Card 4: Outcomes

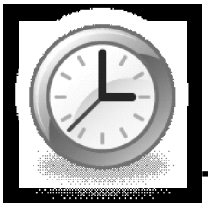
Write 1-2 sentences about what you would like to happen.

Slide # 10

Small Group Assignment

Step 1	Step 2	Step 3	Step 4
Assign a "scribe" to take notes.	Assign a "reporter."	Read through the cards.	Discuss cases, looking for common themes and variations

AUTHORITY TO INTERVENE IN SELF NEGLECT CASE



TIME ALLOTTED: 20 minutes

Slide # 11

Title XX Definition of Self Neglect

To receive Title XX Social Services Block Grant funds, states are "encouraged," but not required, to spend the funds to establish services to meet national goals, which include advocacy and services to adults who, "as a result of physical or mental limitations, are unable to act in their own behalf; are seriously limited in the management of their affairs; are neglected or exploited; or are living in unsafe or hazardous conditions.

Slide # 12

California's Welfare and Institutions Code

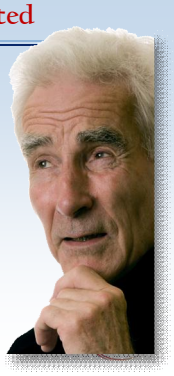
Definition of Self Neglect

The failure of the elder or dependent adult to exercise a reasonable degree of care in providing for his/her own needs in such areas as personal hygiene, food, clothing, shelter, medical and mental health care, or avoiding health and safety hazards, malnutrition or dehydration.

Slide # 13

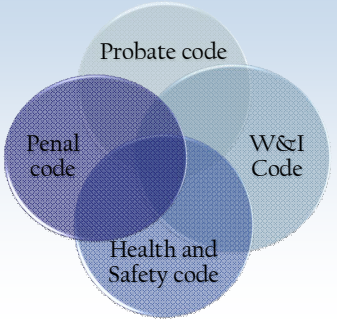
Unbefriended & Unrepresented

People with diminished capacity who have not executed advance directives; who lack family, friends and others to serve as surrogates; and who need medical care or treatment that require consent (Karp & Wood, 2003).



Slide # 14

Laws Pertaining to Self Neglect



Slide # 15

Probate Code §1801. Conservatorship

Conservatorship: A mechanism by which courts appoint people to handle the affairs of individuals who are unable to protect themselves as the result of disability.

- **Conservatorship of person** is for the handling of personal needs through the provision of medical care, food, clothing and shelter
- **Conservatorship of estate** is for the management of financial resources and assets

Slide # 16

Why Conservatorship?

Probate Courts appoint conservators when the following criteria are met:

- The proposed conservatee lacks sufficient mental capacity to manage his/her affairs
- The person is at risk

AND

- Conservatorship can reduce risk

Slide # 17

Conservatorship may be needed when:

- Severely impaired victims are unable to grasp the severity of their situation and refuse needed services
- Family members are quarreling over custody or assets
- Adult children want to claim inheritances prematurely or influence their older family members to make new wills
- Less restrictive legal devices, such as durable powers of attorney or trusts, have been misused.

Slide # 18

Other California laws relating to self-neglect

Probate code

- 1801: Conservatorship
- 2250: Temporary conservatorship
- 3200: Medical treatment for incapacitated persons
- 2950: Authorizes public guardians to freeze or seize assets when intending to file for conservatorship
- 2952: Authorizes specially trained peace officers to initiate process to take control of property)

Welfare and Institutions code

- 5150: Emergency, temporary basis to assess their need for psychiatric treatment or hospitalization
- 5350: Hospitalization in a psychiatric facility
- 15703-15705.40: "Protective custody" **Health and Safety code**
- 1418.8 (authorizes skilled nursing or intermediate care facilities to make medical decisions for incapacitated residents)

Penal code

- 597: Cruelty to animals

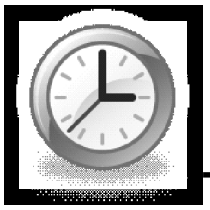
California Laws that May Apply in Self Neglect Cases.

Situation	*Statutes*
An adult appears to be a danger to him or her self or others, or gravely disabled as a result of mental illness.	**Welfare and Institutions code §5150** permits police or mental health workers to remove individuals from their homes on an emergency, temporary basis to assess their need for psychiatric treatment or hospitalization. May lead to LPS conservatorship (**Welfare and Institutions code §5350)** if the person has a serious mental disorder or is impaired by chronic alcoholism and requires hospitalization in a psychiatric facility
An adult is incapable of managing his or her financial and/or personal affairs and is at risk of abuse, neglect, exploitation or undue influence	**Probate code §1801** provides for ñprobate conservatorship,òa process in which courts appoint individuals (conservators) to act on behalf of incapacitated persons (conservatees). After filing petitions for appointment, prospective conservators can file petitions for temporary conservatorship (Probate code **§**2250) which enables them to provide conservatees with immediate care for a limited time, pending the determination of the main petition.
An adult is unable to consent to needed medical treatment	**Probate code Section §3200** allows for health and medical care providers, neighbors, friends and others to petition the court to order medical treatment and to select and discharge health care providers and institutions on behalf of the incapacitated person. **Health and Safety code Section §1418.8** authorizes skilled nursing or intermediate care facilities to conduct interdisciplinary team reviews to make medical decisions for incapacitated residents who lack surrogates when physicians prescribe medical interventions that require informed consent.

An adultôs assets are in imminent jeopardy and the adult is believed to be incapable of protecting them	**Probate code §2950** authorizes public guardians to freeze or seize the assets of persons who are incapacitated when the assets are believed to be in jeopardy and the PG intends to file for conservatorship. **§2952**[1] authorizes specially trained peace officers to issue declarations stating that there is probable cause to believe that a crime is being committed against an incapacitated person and that the person is in danger of losing his or her property. The declaration must be co-signed by local APS supervisors and sent to public guardians who may then take possession or control of the property.
A personôs home or residence is hazardous	**State and local fire, building, housing, and health codes** address blight and safety hazards.
A person is a nuisance to others	**Penal code §370** addresses acts or situations that are injurious, indecent, offensive or obstructive to neighborhoods, communities or others.
Pets are not being cared for properly	**Penal code §597** addresses cruelty to animals. Failure to provide adequately for pets can result in the removal of animals. People convicted of cruelty to animals can be ordered into counseling.

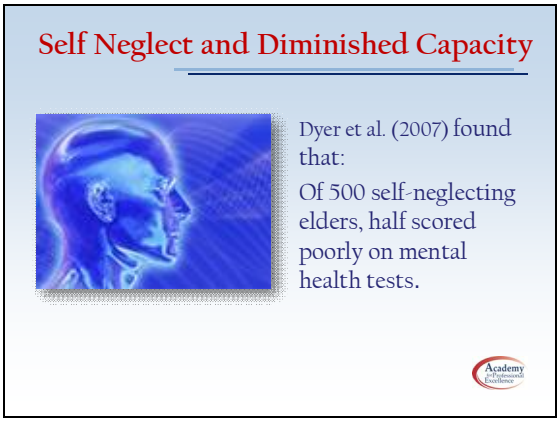
[1] This statute is being used in some California counties and not others.

Decision-Making Capacity and Consent



TIME ALLOTTED: 25 minutes

Slide # 19



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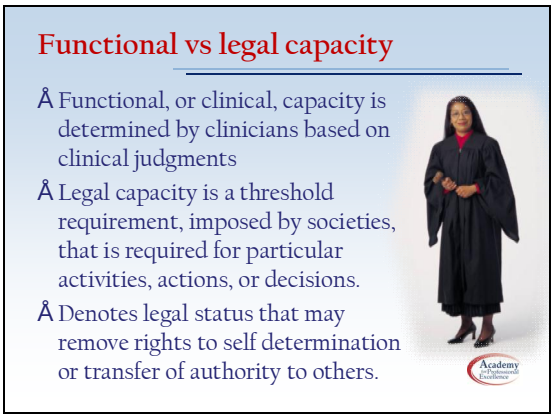

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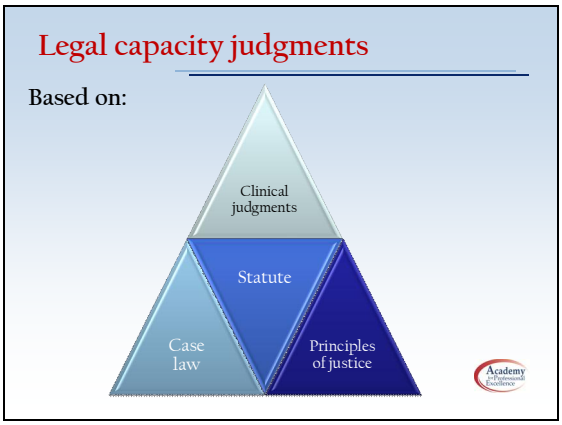

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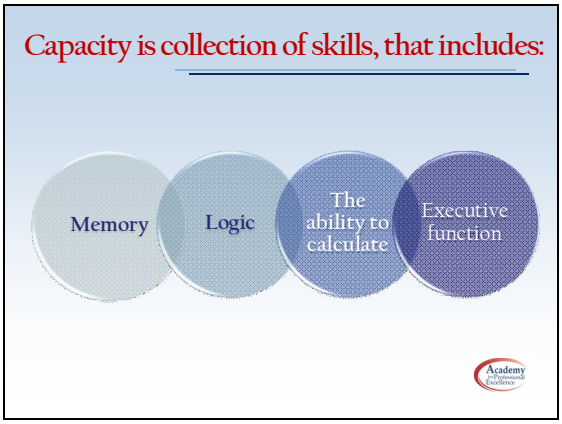

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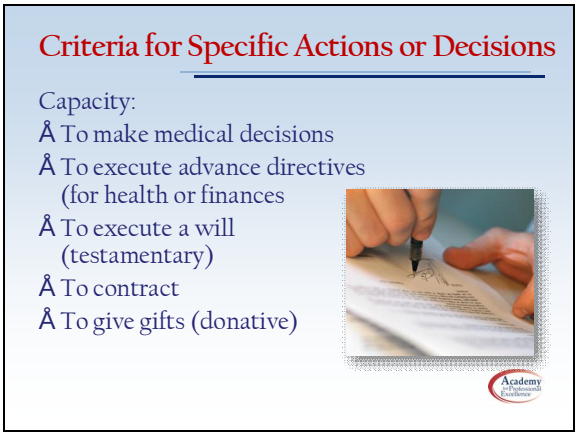
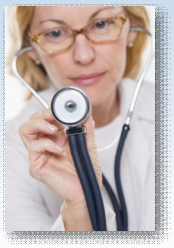


Slide # 24

Capacity Declarations for conservatorship

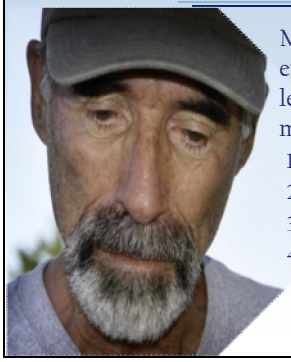
Form GC-335

- May be filed as an attachment to the Petition for Appointment of Conservator
- Must be completed by
  - Psychiatrist
  - Psychologist
  - Geriatric physician
  - Palliative medicine physician
  - Family doctor



Slide # 25

Deficits in Mental Functioning



Must be supported by evidence of deficits in at least one of the following mental functions

1. Alertness and attention
2. Information processing
3. Thought processes
4. Ability to modulate mood and affect

Slide # 26

Filling out Capacity Declarations

- Problems
- Failure to fill out

Capacity Declaration: GC335

GC-335

ATTORNEY OR PARTY WITHOUT ATTORNEY *(Name, State Bar number, and address)*:

TELEPHONE NO.: FAX NO. *(Optional)*:
E-MAIL ADDRESS *(Optional)*:
ATTORNEY FOR *(Name)*:

Name and Address

To keep other people from seeing what you entered on your form, please press the Clear This Form button at the end of the form when finished.

SUPERIOR COURT OF CALIFORNIA, COUNTY OF

STREET ADDRESS:
MAILING ADDRESS:
CITY AND ZIP CODE:
BRANCH NAME:

CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF *(Name)*:

☐ CONSERVATEE ☐ PROPOSED CONSERVATEE

CAPACITY DECLARATION—CONSERVATORSHIP

CASE NUMBER

TO PHYSICIAN, PSYCHOLOGIST, OR RELIGIOUS HEALING PRACTITIONER

The purpose of this form is to enable the court to determine whether the (proposed) conservatee *(check all that apply)*:

Must mark A,B, or C

A. ☐ is able to attend a court hearing to determine whether a conservator should be appointed to care for him or her. The court hearing is set for *(date)*: _____. *(Complete item 5, sign, and file page 1 of this form.)*

B. ☐ has the capacity to give informed consent to medical treatment. *(Complete items 6 through 8, sign page 3, and file pages 1 through 3 of this form.)*

C. ☐ has dementia and, if so, (1) whether he or she needs to be placed in a secured-perimeter residential care facility for the elderly, and (2) whether he or she needs or would benefit from dementia medications. *(Complete items 6 and 8 of this form and form GC-335A; sign and attach form GC-335A. File pages 1 through 3 of this form and form GC-335A.)*

(If more than one item is checked above, sign the last applicable page of this form or form GC-335A if item C is checked. File page 1 through the last applicable page of this form; also file form GC-335A if item C is checked.)

COMPLETE ITEMS 1–4 OF THIS FORM IN ALL CASES.

GENERAL INFORMATION

1. *(Name)*:
2. *(Office address and telephone number)*:
3. I am
   a. ☐ a California licensed ☐ physician ☐ psychologist acting within the scope of my licensure ☐ with at least two years' experience in diagnosing dementia.
   b. ☐ an accredited practitioner of a religion whose tenets and practices call for reliance on prayer alone for healing, which religion is adhered to by the (proposed) conservatee. The (proposed) conservatee is under my treatment. *(Religious practitioner may make the determination under item 5 ONLY.)*
4. (Proposed) conservatee *(name)*:
   a. I last saw the (proposed) conservatee on *(date)*:
   b. The (proposed) conservatee ☐ is ☐ is NOT a patient under my continuing treatment.

Must be dated

ABILITY TO ATTEND COURT HEARING

5. A court hearing on the petition for appointment of a conservator is set for the date indicated in item A above. *(Complete a c*
   a. ☐ The proposed conservatee is able to attend the court hearing.
   b. ☐ Because of medical inability, the proposed conservatee is NOT able to attend the court hearing *(check all items below that apply)*
      (1) ☐ on the date set *(see date in box in item A above)*.
      (2) ☐ for the foreseeable future.
      (3) ☐ until *(date)*:
      (4) **Supporting facts** *(State facts in the space below or check this box* ☐ *and state the facts in Attachment 5)*.

If B. must check boxes

Signature!

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.
Date:

(TYPE OR PRINT NAME) (SIGNATURE OF DECLARANT)

Include # of pages

Page 1 of ___

Form Adopted for Mandatory Use
Judicial Council of California
GC-335 [Rev. January 1, 2004]

CAPACITY DECLARATION—CONSERVATORSHIP

Probate Code, §§ 811, 813, 1801, 1825, 1881, 1910, 2356.5

American LegalNet, Inc.
www.USCourtForms.com

Name!

CONSERVATORSHIP OF THE ☐ PERSON ☐ CONSERVATEE ☐	ESTATE OF *(Name)*: ☐ PROPOSED CONSERVATEE	CASE NUMBER:

6. **EVALUATION OF (PROPOSED) CONSERVATEE'S MENTAL FUNCTIONS**

Note to practitioner: This form is ***not*** a rating scale. It is intended to assist you in recording your *impressions* of the (proposed) conservatee's mental abilities. Where appropriate, you may refer to scores on standardized rating instruments.
(Instructions for items 6A–6C): *Check the appropriate designation as follows:* ***a*** *= no apparent impairment;* ***b*** *= moderate impairment;* ***c*** *= major impairment;* ***d*** *= so impaired as to be incapable of being assessed;* ***e*** *= I have no opinion.)*

A. **Alertness and attention**

(1) Levels of arousal (lethargic, responds only to vigorous and persistent stimulation, stupor)
a ☐ b ☐ c ☐ d ☐ e ☐

(2) Orientation (types of orientation impaired)
a ☐ b ☐ c ☐ d ☐ e ☐ Person
a ☐ b ☐ c ☐ d ☐ e ☐ Time (day, date, month, season, year)
a ☐ b ☐ c ☐ d ☐ e ☐ Place (address, town, state)
a ☐ b ☐ c ☐ d ☐ e ☐ Situation ("Why am I here?")

(3) Ability to attend and concentrate (give detailed answers from memory, mental ability required to thread a needle)
a ☐ b ☐ c ☐ d ☐ e ☐

B. **Information processing.** Ability to:

(1) Remember (ability to remember a question before answering; to recall names, relatives, past presidents, and events of the past 24 hours)
i. Short-term memory a ☐ b ☐ c ☐ d ☐ e ☐
ii Long-term memory a ☐ b ☐ c ☐ d ☐ e ☐
iii Immediate recall a ☐ b ☐ c ☐ d ☐ e ☐

(2) Understand and communicate either verbally or otherwise (deficits reflected by inability to comprehend questions, follow instructions, use words correctly, or name objects; use of nonsense words)
a ☐ b ☐ c ☐ d ☐ e ☐

(3) Recognize familiar objects and persons (deficits reflected by inability to recognize familiar faces, objects, etc.)
a ☐ b ☐ c ☐ d ☐ e ☐

(4) Understand and appreciate quantities (deficits reflected by inability to perform simple calculations)
a ☐ b ☐ c ☐ d ☐ e ☐

(5) Reason using abstract concepts. (deficits reflected by inability to grasp abstract aspects of his or her situation or to interpret idiomatic expressions or proverbs)
a ☐ b ☐ c ☐ d ☐ e ☐

(6) Plan, organize, and carry out actions (assuming physical ability) in one's own rational self-interest (deficits reflected by inability to break complex tasks down into simple steps and carry them out)
a ☐ b ☐ c ☐ d ☐ e ☐

(7) Reason logically.
a ☐ b ☐ c ☐ d ☐ e ☐

C. **Thought disorders**

(1) Severely disorganized thinking (rambling thoughts; nonsensical, incoherent, or nonlinear thinking)
a ☐ b ☐ c ☐ d ☐ e ☐

(2) Hallucinations (auditory, visual, olfactory)
a ☐ b ☐ c ☐ d ☐ e ☐

(3) Delusions (demonstrably false belief maintained without or against reason or evidence)
a ☐ b ☐ c ☐ d ☐ e ☐

(4) Uncontrollable or intrusive thoughts (unwanted compulsive thoughts, compulsive behavior).
a ☐ b ☐ c ☐ d ☐ e ☐

Mark ALL questions

Must not be all a's and e's are to be avoided

(Continued on next page)

CONSERVATORSHIP OF THE ☐ PERSON ☐ ESTATE OF *(Name)*: | CASE NUMBER:

☐ CONSERVATEE ☐ PROPOSED CONSERVATEE

Name

6. *(continued)*

D. **Ability to modulate mood and affect.** The (proposed) conservatee ☐ has ☐ does NOT have a pervasive and persistent or recurrent emotional state that appears inappropriate in degree to his or her circumstances. *(If so, complete remainder of item 6D.)* ☐ I have no opinion.

Must mark has/does not

***(Instructions for item 6D:** Check the degree of impairment of each inappropriate mood state (if any) as follows: **a** = mildly inappropriate; **b** = moderately inappropriate; **c** = severely inappropriate.)*

Anger	a ☐	b ☐	c ☐	Euphoria	a ☐	b ☐	c ☐	Helplessness	a ☐	b ☐	c ☐
Anxiety	a ☐	b ☐	c ☐	Depression	a ☐	b ☐	c ☐	Apathy	a ☐	b ☐	c ☐
Fear	a ☐	b ☐	c ☐	Hopelessness	a ☐	b ☐	c ☐	Indifference	a ☐	b ☐	c ☐
Panic	a ☐	b ☐	c ☐	Despair	a ☐	b ☐	c ☐				

If D is marked "has", must complete E

E. The (proposed) conservatee's periods of impairment from the deficits indicated in items 6A–6D

(1) ☐ do NOT vary substantially in frequency, severity, or duration.

(2) ☐ do vary substantially in frequency, severity, or duration *(explain; continue on Attachment 6E if necessary):*

F. ☐ *(Optional)* Other information regarding my evaluation of the (proposed) conservatee's mental function (e.g., diagnosis, symptomatology, and other impressions) is ☐ stated below ☐ stated in Attachment 6F.

This is the opportunity to indicate any environmental or social factors that compound the mental capacity issues.

Must complete

ABILITY TO CONSENT TO MEDICAL TREATMENT

7. Based on the information above, it is my opinion that the (proposed) conservatee

a. ☐ has the capacity to give informed consent to any form of medical treatment. This opinion is limited to medical consent capacity.

b. ☐ lacks the capacity to give informed consent to any form of medical treatment because he or she is ***either*** (1) unable to respond knowingly and intelligently regarding medical treatment ***or*** (2) unable to participate in a treatment decision by means of a rational thought process, ***or both***. The deficits in the mental functions described in item 6 above significantly impair the (proposed) conservatee's ability to understand and appreciate the consequences of medical decisions. This opinion is limited to medical consent capacity.

Must complete

(Declarant must initial here if item 7b applies: _____***.)***

Number of pages attached: _____

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

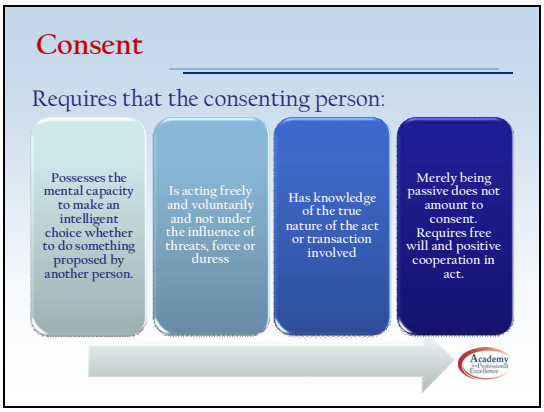
Date:

2nd signature!

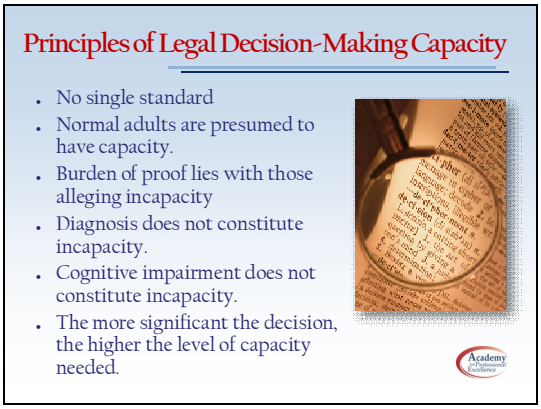
(TYPE OR PRINT NAME) (SIGNATURE OF DECLARANT)

GC-335 [Rev. January 1, 2004] **CAPACITY DECLARATION—CONSERVATORSHIP** Page 3 of 3

Slide # 27



Slide # 28

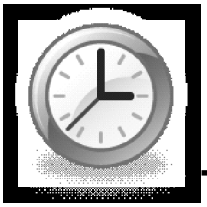


Criteria for Specific Actions or Decisions

Decision or Action	Criteria
Capacity to make medical decisions or execute advance health care directives	The patient must have the ability to: • Understand the medical problem • Understand the proposed treatment • Understand alternatives to the proposed treatment • Understand and appreciate the foreseeable benefits and risks of the treatment and of postponing or refusing it. • Communicate decisions
Capacity to execute a will (testamentary)	The person must: • Have the ability to describe what a will is • Have the ability to describe a basic plan for distributing their assets to heirs • Know the nature and extent of his or her bounty • Be able to identify or recognize potential heirs and beneficiaries
Capacity to contract	The person must be able to understand the nature and consequences of the transaction.
Capacity to give gifts (donative)	The person must have ñan intelligent perception and understanding of the dispositions made of property and the person and objects one desires shall be the recipients of oneôs bountyò
Capacity to create or revoke a power of attorney	Traditionally based on the capacity to contract although some courts have held that the standard is similar to that for making a will.APA-ABA
Triggers for taking protective action [2]	• The existence of diminished capacity • A risk of substantial harm • An inability to act adequately in oneôs own interest (includes that ability to withstand undue influence)
Probate conservatorship	California courts use ñcapacity declarations,òwhich can be filled out by doctors, psychologists and religious healing practitioner address the following elements of ñexecutive functionò • Alertness and attention • Information processing. • Thought disorders • Ability to modulate mood and affect.

[2] Recommended for lawyers under the American Bar Associationôs Model Rules of Professional Conduct.

ETHICAL AND CULTURAL ISSUES



TIME ALLOTTED: 10 minutes

Slide # 29

Ethical Principles

Autonomy.	The right of individuals to make decisions for themselves that are voluntary and intentional and not the results of coercion, duress or undue influence.
Least restrictive alternatives.	Options that are least restrictive of incapacitated persons' autonomy, independence, and freedom of choice.
Beneficence.	"Doing good for others" or promoting their welfare. When clients cannot make decisions for themselves, workers may need to act in their best interest.
Justice.	The fair and equitable distribution of benefits and burdens. Workers must balance the needs of self neglecting clients against those of other clients.
Nonmaleficence.	"Do no harm."
Privacy.	People's right to control information about themselves.

NATIONAL ADULT PROTECTIVE SERVICES ASSOCIATION

NATIONAL ADULT PROTECTIVE SERVICES ASSOCIATION

Code of Ethics

Adult Protective Services Ethical Principles and Best Practice Guidelines

Dedicated to the memory of Rosalie Wolf

Adult Protective Services are those services provided to older people and people with disabilities who are, or are in danger of being mistreated or neglected, are unable to protect themselves, and have no one to assist them.

Interventions provided by Adult Protective Services include, but are not limited to, receiving reports of adult abuse, exploitation or neglect, investigating these reports, case planning, monitoring and evaluation. In addition to casework services, Adult Protection may provide or arrange for the provision of medical, social, economic, legal, housing, law enforcement or other protective, emergency or supportive services.

Values

***Guiding Value*:** Every action taken by Adult Protective Services must balance the duty to protect the safety of the vulnerable adult with the adultôs right to self-determination.

***Secondary Value*:** Older people and people with disabilities who are victims of abuse, exploitation or neglect should be treated with honesty, caring and respect.

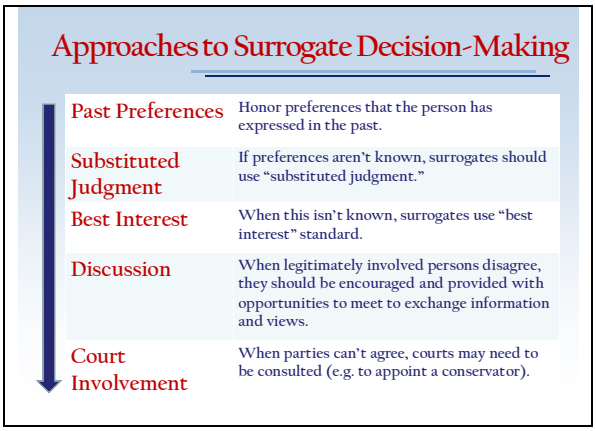
Principles

- Adults have the right to be safe.
- Adults retain all their civil and constitutional rights unless some of these rights have been restricted by court action.
- Adults have the right to make decisions that do not conform with societal norms as long as these decisions do not harm others.
- Adults are presumed to have decision-making capacity unless a court adjudicates otherwise.
- Adults have the right to accept or refuse services.

Practice Guidelines

- Recognize that the interests of the adult are the first concern of any intervention.
- Avoid imposing personal values on others.
- Seek informed consent from the adult before providing services.
- Respect the adultôs right to keep personal information confidential.
- Recognize individual differences such as cultural, historical and personal values.
- Honor the right of adults to receive information about their choices and options in a form or manner that they can understand.
- To the best of your ability, involve the adult as much as possible in developing the service plan.
- Focus on case planning that maximizes the vulnerable adultôs independence and choice to the extent possible based on the adultôs capacity.
- Use the least restrictive services firstô community based services rather than institutionally based services whenever possible.
- Use family and informal support systems first as long as this is in the best interest of the adult.
- Maintain clear and appropriate professional boundaries.
- In the absence of an adultôs expressed wishes, support casework actions that are in the adultôs best interest.
- Use substituted judgment in case planning when historical knowledge of the adultôs values is available.
- Do no harm. Inadequate or inappropriate intervention may be worse than no intervention.

Slide # 30



Hierarchy of Approaches to Surrogate Decision-Making.

Even when people cannot express preferences, their autonomy should be respected to the extent possible. The following hierarchy of approaches applies:

- Honor preferences that the person has expressed in the past. These can be determined by consulting clientsô records and people who know them. It should be noted, however, that past preferences may need to be re-considered. For example, it may no longer be advisable for a client who consumed alcohol in moderation in the past to continue in do so in light of illnesses, medications, etc.
- If preferences are not known, surrogates should use ñsubstituted judgment.ò This means that decisions should be based on what the person would have wanted or preferred. This approach requires substantial information about clientsô views and wishes.
- When there is insufficient information on which to base substituted judgment, surrogates must decide based on their judgment about what would be in the ñbest interestò of the patient. Estimates of best interest are based on what a rational, normal person would prefer, not just on what the surrogate prefers.
- In cases in which physicians, surrogates, other family members, service providers, or other legitimately involved persons disagree about what is in the personô best interest, parties should be encouraged and provided with opportunities to meet to exchange information and views.
- In cases where agreement can't be reached, interested parties should consult ethics committees if available. Other options include multidisciplinary elder abuse teams or other problem-solving groups.
- When a surrogate or physician is acting against the expressed preferences or best interest of the patient and consultation with an institutional ethics committee fails to bring a resolution of the disagreement, the courts can be consulted to order treatment or appoint a conservator.

Slide # 31

Cultural Variables

Do all cultural groups share the same values?

Slide # 32

Small Group Assignment

Step 1	Step 2	Step 3	Step 4
Assign a "scribe" to take notes.	Assign a "reporter."	Read through the case.	Answer the questions

Case 1: Mrs Alvarez

Mrs. Alvarez is 92 years old and lives alone in an apartment. She has 10 cats and her home is filthy and infested with fleas, lice, cockroaches and flies. Neighbors have called the police to complain about the odor. On several occasions, neighbors and the facility's manager have made reports to APS. Each time APS has investigated, they have found Mrs. Alvarez to be marginally capable of making decisions. Recently, the management sent her an eviction notice stating that if she does not clean up the apartment immediately and get rid of the cats, she will be evicted. She wants to stay in the apartment.

Questions for small group

- What interventions should be considered? What are the benefits, risks and limitations of each?
- What interventions should be tried first and why?
- How would you evaluate Mrs. Alvarez' decision-making capacity and ability to consent to services?
- What ethical issues does the case raise?
- What is APS' role in this case?

Case 2 Mr. Smith

Mr. Smith suffers from severe diabetes. After his wife died four years ago, he stopped following the regimen for diabetics his doctor prescribed. He eats mostly snack foods, is overweight, and refuses to monitor or have others monitor his blood sugar level. He has repeatedly been referred to APS but refuses services and has been assessed as marginally able to make decisions. APS has kept his case open and continued to check in with him occasionally. Those working with him are unsure of whether his lack of self-care is due to apathy, depression or because he doesn't understand what needs to be done.

As a result of the uncontrolled diabetes, Mr. Smith developed edema and lesions in his left leg. He was recently admitted to the hospital with a gangrenous foot and his doctors are recommending amputation. Mr. Smith is refusing to give consent and his physician does not believe he understand the risks.

Questions for group

- What interventions should be considered? What are the benefits and drawbacks of each?
- What interventions should be tried first and why?
- What factors and criteria should be considered in determining whether Mr. Smith has legal decision-making capacity?
- What ethical issues do the case raise?

Case 3: Mrs. Wells

Mrs. Wells is 78 years old. At 76 she began losing her vision as a result of glaucoma. She is now totally blind in one eye and almost blind in the other. She has become increasingly depressed and started drinking heavily. She is unable or unwilling to take medication that her doctor prescribed for the glaucoma and has refused assistance from a home health agency to assist with the administration of the medication. She has also refused training to help her adapt to her blindness and offers of assistance from the Department for the Visually Handicapped. As a result, She has not learned how to manage her finances. Six months ago, she agreed to have a personal care attendant several times a week to shop for her. The attendant fills out the checks and has Mrs. Wells sign them.

The attendant recently came to the bank and attempted to close out the account, which contained $15,000. The bank employee refused, stating that the attendant had no authority to do so. The attendant claimed that she had Mrs. Well's permission and asked the bank employee for a power of attorney form, stating that would return with Mrs. Well's signature. The employee contacted APS and a worker went out to investigate. Mrs. Wells did not seem to understand how much money she had or that she was at risk of being exploited. When asked what Mrs. Wells wanted to do about the situation, she stated "Let's just wait and see."

Questions for small group

- What interventions should be considered? What are the benefits and drawbacks of each?
- What interventions should be tried first and why?
- What factors and criteria should be considered in determining whether Mrs. Wells has legal decision-making capacity?
- What is APS' role in this case?

Case 4. Mr. Chambers

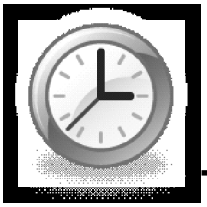
Mr. Chambers, who is 92 years old, is frail and emaciated. He lives alone and has managed marginally for several years. He pays bills sporadically but is occasionally without electricity and food. He has two children who live out of state from whom he is estranged.

He recently suffered a stroke and was brought to the emergency room and hospitalized for approximately a week. He wants to go home but the hospital discharge team feels that he is unsafe at home and can no longer live independently. They have recommended nursing home placement but the county's nursing home refused to accept him because he has no "responsible party." The hospital is claiming that that the costs of the unnecessary hospitalization will impact other patients. The public guardian has refused to take the case because Mr. Chambers is not at imminent risk.

Questions for small group

- What interventions should be considered? What are the benefits and drawbacks of each?
- What interventions should be tried first and why?
- What factors and criteria should be considered in determining whether Mr. Smith has legal decision-making capacity?
- What ethical issues do the case raise?
- What is APS' role in this case?

CAREGIVING SYSTEMS



TIME ALLOTTED: 25 minutes

Slide # 33

Mr. Nobody (40 minutes)

- Interventions
- Examples of due diligence

Slide # 34

Caregiving systems

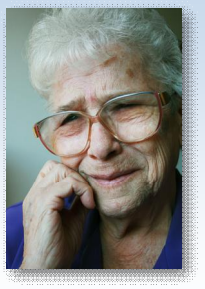
Neglect and Self-Neglect as the Absence or Breakdown of Caregiving Systems *

(From Dubin, T., Garcia, R., Lelong, J., & Mowesian, R. (1986). *Family neglect and self-neglect of the elderly: Normative characteristics and a design for intervention*. Austin, TX: Hogg Foundation for Mental Health, Family Eldercare, Inc.)

Slide # 35

Absent or "broken" caregiving systems

1. Overwhelmed Caregiving Systems
2. The Dysfunctional Caregiving System
3. The Self Interested Caregiver
4. The Elder Alone
5. Elders who Refuse Care



Neglect and Self-Neglect as the Absence or Breakdown of Caregiving Systems*

Types of Neglect and Self-Neglect

A. Overwhelmed Caregiving Systems

1. Definition: The older person has family, friends, or paid caregivers who are actively involved in providing care but are not doing everything that's necessary.
2. Examples:
   a) The caregiving system was adequate at one time - but then there were changes, a gradual deterioration or an abrupt incident - a stroke for example - which rendered the care inadequate.
   b) The caregiver is trying to balance caregiving with a job or other responsibilities.
   c) the elder really should be in nursing home - they need extensive care - but they're refusing to go
   d) The family cannot afford nursing home care or support services
3. Prognosis: highest rates of success because there is a system in place, the senior is willing to accept help, and people are willing to provide care.
4. Promising Approaches: Because caregivers are exhausted, they are unwilling to agree to interventions that require them to do more. If caregivers are offered help that takes burden off, the situations can be improved.

B. The Dysfunctional Caregiving System

1. Definition: A caregiving system is in place but the dynamics between caregivers, or between caregivers and older person are characterized by dysfunction.
2. Examples:
   a) The older person is difficult and alienates others - choreworkers quit or the older person fires them
   b) Family members are estranged
   c) Feuding families. You may have sibling feuding with each other or with the older person.
   d) Alcoholic families
3. Prognosis: Not good unless "tolerant outsiders" (people who are not involved in the conflict) can be found.
4. Promising Approaches: The likelihood of success improves if feuding family members are kept involved (so that they won't sabotage treatment plans), but are not in control. Guardianship can be very helpful to shift responsibility away from people who are enmeshed in the conflict.

C. The Self Interested Caregiver

1. Definition: Someone has responsibility for providing but the care is inadequate because the caregiver is really just in it for the money.
2. Examples:
   a) Caregiver is being paid or stands to inherit.
   b) But they're really just concerned or preoccupation with their own interests.
   c) Accounted for the fewest number of cases
3. Prognosis: Interventions are relatively simple if caregivers were removed as responsible parties.
4. Promising Approaches: Guardianship. Money management.

D. The Elder Alone

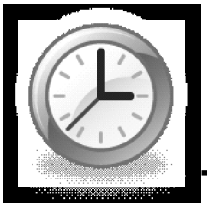
1. Definition: Elders who have no one to provide care. Since the neglect in these situations can not be attributed to anyone other than the elders themselves, these cases are often referred to as self neglect.
2. Examples:
   a) Elder recently lost close friends or relatives, or spouses who were providing care and alternative arrangements haven't been made.
   b) Elders who have chosen to be alone or to live with animals.
   c) Debilitated couples where neither member is capable of providing care to the other.
3. Prognosis: Depends on the reason that the older person or couple is alone. Many older people and their families don't know about services. Some may agree to services when they hear about them.
4. Promising Approaches: Educate seniors and their families about services.

E. Elders who Refuse Care

1. Definition: Same as above but senior has refused help.
2. Examples:
   a) Senior is depressed. May be close to die and wants to die
   b) Senior doesn't want to have their affairs scrutinized
   c) Senior is committing slow form of suicide.
3. Prognosis: Poor but depends on reasons that clients are refusing help. If they really want to die, there may be little that can be done.
4. Promising approaches: If judgment is shaded by depression, it may be treatable. Bringing services in to home. Crisis may precipitate change.

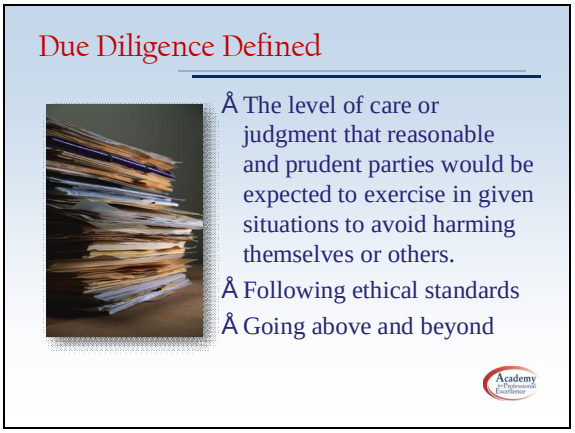
* Dubin, T., Garcia, R., Lelong, J., & Mowesian, R. (1986). *Family neglect and self-neglect of the elderly: Normative characteristics and a design for intervention*. Austin, TX: Hogg Foundation for Mental Health, Family Eldercare, Inc.

DUE DILIGENCE DEFINED



TIME ALLOTTED: 30 minutes

Slide # 36



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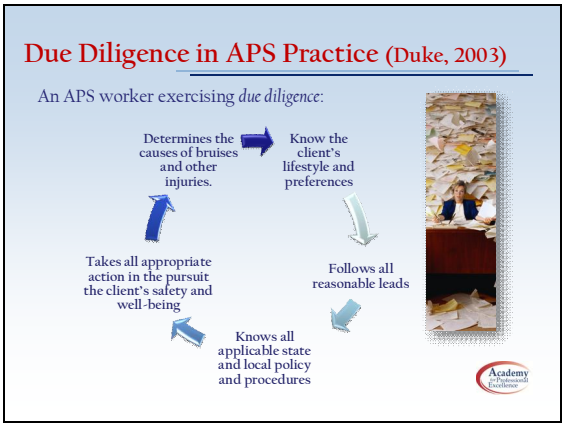
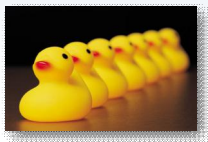


Slide # 38

Following Policies and Procedures

Workers must follow:

- Legal mandates and applicable laws
- Agency policies and procedures, including:
  - Chains of command
  - Eligibility criteria (with respect to self neglect cases)
  - Appeals process (e.g. if they disagree with supervisors)
  - Confidentiality
  - Record keeping



Slide # 39

Complying with Accepted Community Standards

- Present cases at community problem-solving forums, such as multidisciplinary teams, geriatric mental health teams, and ethics committees
- Stay apprised of current literature on self neglect
- Stay apprised of community resources and training opportunities

Slide # 40

Documentation

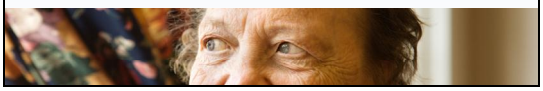
In Legal Proceedings:

- Demonstrate the need for conservatorship
- Keep an abusive or otherwise inappropriate relative from being appointed as conservator or guardian
- Provide the basis for protective orders
- May be used as evidence in criminal cases
- May be requested when workers or their agencies are being sued
- When workers' conduct is questioned by licensing boards or professional associations

Slide # 41

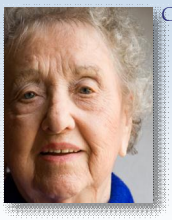
What to Document: Capacity and Consent

- Client's judgment is impaired
- Statements that indicate that clients do not realize how dangerous or serious their situations are Changes over time. Has there been a gradual or rapid decline? What services were offered and refused?
- Were services offered and refused? Be specific about the type of services offered and when they were offered.
- Clients' stated reasons for refusing services.
- How well is the clients "tracking," or following what is being said
- Clients' memory is impaired.



Slide # 42

Preferences, Values, and Lifestyles



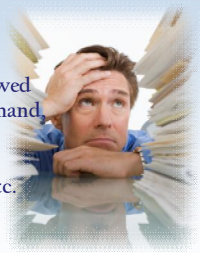
Client's (or others') statements about:

- Treatment and service preferences
- Indicators of clients' wishes and preferences (e.g. advance directives or statements to others like "I never want to live like a vegetable)
- Values
- Life-style

Slide # 43

What to Document: Workers' Actions

- Actions taken by workers
- Reasons for actions not taken
- Indicators that workers followed their agencies' chains of command, such as consulting with supervisors, following rules concerning documentation, etc.



Documentation

While good documentation is an essential part of APS practice, it is especially critical in self neglect cases for the following reasons:

- APS may be involved with clients continuously or repeatedly over long periods. Good documentation can ensure continuity of care by providing a record of developments and agencies' involvement in cases, which can be accessed by substitute or newly-assigned workers, supervisors and others.
- Documentation collected over time provides a "baseline," which can alert workers to changes in clients' health, cognitive status, conditions or circumstances over time.
- There is a tendency for workers to document what they do, not what they don't do. It is particularly important in self neglect cases for them to documents actions they did not take (options that were proposed and refused)
- Documentation of self neglect is likely to be used in legal proceedings.

Documentation may be needed in self neglect cases to:

- Demonstrate the need for conservatorship
- Keep an abusive or otherwise inappropriate relative from being appointed as conservator or guardian
- Provide the basis for protective orders
- May be used as evidence in criminal cases
- May be requested when workers or their agencies are being sued
- When workers' conduct is questioned by licensing boards or professional associations

The following should be documented:

Physical signs and symptoms

The following physical signs and symptoms of self neglect can be documented using photographs, descriptions, and body maps, which are drawings of the front, sides, and back of a human figure:

- Bruises and other injuries (photographs, descriptions and body maps, which are drawings of the front, sides, and back of a human figure, can be used to describe injuries)
- Pressure ulcers
- Weight loss
- Dental problems
- Deteriorated or dilapidated living conditions, filth, pest infestations
- Signs of hoarding and cluttering
- Adequacy of facilities. Are there hazards or dangers, adequate heating, etc.
- Evidence of medication mismanagement, non compliance, etc.
- Adequate clothing and assistance devices
- Evidence of alcohol or substance abuse

Behavioral Signs and Symptoms

- Lethargy
- Depression
- Signs of post traumatic stress disorder (PTSD) including withdrawal, hyper-vigilance and fear
- Patient's demeanor (the patient is crying, shaking, angry, agitated, upset, calm, or happy.
- Sexual "acting out" (may be a sign of sexual assault).
- Fearfulness, distrust
- Hallucinations
- Alertness
- Flat affect
- Agitation and anxiety

Indicators of capacity and consent, including:

- Changes over time. Has there been a gradual or rapid decline?
- Statements that indicate that clients do not realize how dangerous or serious their situations are
- Client's judgment is impaired
- What services were offered and refused?
- Number of times offered and refused
- Clients' stated reasons for refusing services
- How well is the clients "tracking," or following what is being said
- Memory

Indicators of Clients' Preferences, Values and Lifestyles

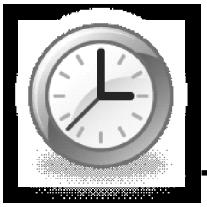
Indicators of preferences, values and lifestyles can be documented by recording clients' (or others') statements about:

- Their treatment and service preferences
- Their wishes and preferences as told to others or as indicated in advance directives
- Values
- Life-style

Workers' Actions

- Actions taken by workers
- Reasons for actions not taken
- Indicators that workers followed agency chain of command, such as consulting with supervisors, following rules concerning documentation, etc.

PARTNERING



TIME ALLOTTED: 15 minutes

Slide # 44

Slide # 45

Slide # 46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The Academy for Professional Excellence

Legal, Ethical and Practice Issues in Self Neglect

Best Practices and Resources

Lisa Nerenberg

October 4, 2009

Best Practices in Self Neglect

- The Santa Clara County (California) Medical Association, working with a multidisciplinary team, developed a protocol entitled, "Medical Decision Making for the Unbefriended," which has been distributed to all acute care hospitals in the county. They have also developed protocols for "do not resuscitate (DNR)" orders and the delivery of futile medical care.
- To encourage family members to serve as conservators, Contra Costa County has a conservatorship workshop where family members who want to serve or who are currently serving as conservators can get help.
- Santa Clara County has a medical ethics committee that routinely reviews cases involving elders with diminished mental capacity who need medical treatment and lack surrogates. The group was, in one case, granted Probate Code §3200 powers to make medical decisions for an "unbefriended" elder.
- San Francisco APS has developed a referral panel of private professional conservators. To be included on the panel, conservators must agree to provide occasional pro bono services.
- Several courts in California have started self-help conservatorship clinics, which permit families and friends of incapacitated elders to file for conservatorship without the assistance of lawyers.
- San Francisco's Code Enforcement Task Force responds to reports of homes that are hazardous to occupants and neighbors as a result of deterioration, garbage piling up, multiple animals, pest infestations, drug activity, etc. Members represent city attorneys; police, fire, and health departments, building inspectors, and planning departments. Although their primary goal is to make owners take responsibility for upkeep, team members also work with APS and other social service providers to address the needs of occupants, which often include self neglecting elders. The team may exert pressure or provide leverage to get self neglecting elders to improve their residences to avoid eviction or lawsuits or to comply with court orders. Upon receiving reports, members inspect the premises, record code violations, inform owners, suggest corrections, and set a deadline for making repairs.
- In Los Angeles County, the Departments of Aging, Housing, Animal Services, and Mental Health work together to address the needs of residents who hoard. The county

organized the Hoarding Task Force, a multidisciplinary team that meets monthly to discuss cases and sponsors an annual conference, which teaches supportive counseling techniques for working with elderly hoarders and informs participants of available resources. A needs assessment is currently being conducted.

- Humboldt County uses a team approach that pairs APS workers and public health nurses (PHN). The PHNs are funded by SPMP (Skilled Professional Medical Personnel), TCM (Targeted Case Management) and APS allocation. They have observed that PHN's are often better able than APS workers to gain access in self neglect situations. The nurses make safety and medical assessments, encourage clients to seek medical care, and provide liaison with hospitals and physicians' staff. They are further integrating a mental health clinician into the team.
- Geriatric Evaluation Networks Encompassing Services, Information and Support (GENESIS) is a partnership between Los Angeles' Department of Mental Health and the Department of Community and Senior Services/Adult Protective to provide mobile health and mental health support for frail homebound elders. The agencies coordinate their activities through interagency agreements, use of shared assessment protocols, clinical case conferences, joint planning, and disposition. The program has been particularly effective in helping victims of elder abuse who have mental health problems. GENESIS' mobile, "trans/multidisciplinary" teams are each composed of a licensed clinical social worker and registered nurse who conduct joint in-home visits to provide mental health assessments, crisis stabilization, short-term treatment, and linkage to needed services. In addition, GENESIS has on staff a geriatric internist, nurse practitioner, and gerontologist. In 1999, GENESIS signed a formal memorandum of understanding (MOU) with Adult Protective Services to provide assessment to older adults, who APS believes may have a mental health issue that puts them at risk.

Resources

- Bibliography on Self-neglect. The Clearinghouse on Abuse and Neglect of the Elderly (CANE), maintains a collection of publications and elder abuse and neglect for the National Center on Elder Abuse. CANE has produced an annotated bibliography on self neglect, which is available on-line: http://www.elderabusecenter.org/default.cfm?p=cane_neglect.cfm
- A Day in the Life of Adult Protective Services. This in-depth report produced by the California Welfare Directors' Association describes calls made to Adult Protective Services in one 24 hour period. Synopsis of the calls, data, and recommendations and recommendation. The original report and updates are available online at http://www.cwda.org/publications/adult.php
- A compendium of California laws pertaining to animals, "The California Animal Laws Handbook" is published annually by the State Humane Association of California. It is available at www.statehumane.org.

- Animal Hoarding: Structuring Interdisciplinary Responses to Help People, Animals and Communities at Risk. This publication was produced in 2006 by the Hoarding of Animals Research Consortium (HARC), which is affiliated with Tufts University Veterinary School and the Massachusetts chapter of the Society for the Prevention of Cruelty to Animals. It is available on-line at: www.tufts.edu/vet/cfal/hoarding.
- "Animal Hoarding: A Community Task Force Solution," Video produced by the Humane Society of the United States. For information, visit HSUS website: http://www.hsus.org/video_clips/page.jsp?itemID=27260574

Websites

California Attorney General's Office	http://caag.state.ca.us/
California Courts Self Help Center	http://www.courtinfo.ca.gov/selfhelp/
California Department of Aging	http://www.aging.state.ca.us/
Consortium for Research in Elder Self-Neglect (CREST) led by Baylor College of Medicine	http://www.bcm.edu/crest/?PMID=4131
County Welfare Directors Association	http://www.cwda.org/
National Adult Protective Services Association	http://www.apsnetwork.org
National Association of Social Workers	http://www.socialworkers.org/
National Center on Elder Abuse	http://www.elderabusecenter.org/

Research

The Consortium for Research in Self-Neglect of Texas (CREST) is an interdisciplinary collaboration led by the Texas Elder Mistreatment Institute, Baylor College of Medicine, that is attempting to establish a case definition for self-neglect and strategies for prevention and intervention. They are looking at relationships among self-neglect and executive dysfunction, alcohol abuse, hoarding behavior, and nutrition and are attempting to develop risk and severity assessment tools for self-neglect. The team has developed a instrument, the KELS Test, for Substantiating self neglect. See www.bcm.edu/crest/?PMID=4143 and www.bcm.edu/crest/?PMID=0.

The Leonard Schanfield Research Institute, Council for Jewish Elderly; in collaboration with the University of Illinois-Chicago, is refining and testing a client assessment instrument for detecting risk or signs of self-neglect in community-dwelling elders. Specific objectives of the project, which is funded by the Retirement Research Foundation, are to identify and rank key risk indicators for self neglect. Ten clusters of risk factors have emerged: mental health assessment; hoarding; infection control; medical health issues; level of cooperation (compliance/adherence); emotional assessment; social/cultural issues; and financial issues.

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