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An Assessment of the Need for an Adult Protective Services Program

(Conducted Pursuant to HR 590)

September 2003

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Summary and Recommendations

House Resolution 590 requires the LB&FC to conduct a study to examine the need for a protective services program for physically and cognitively impaired adults between 18 and 59 years of age. (See Appendix A.) (Children to age 18 are protected under the Child Protective Services Law, and adults 60 and older are protected under the Older Adults Protective Services Act.) This report discusses the extent and types of protective services that may be needed and the possible administrative structure for such a program. It also presents information on anticipated costs and suggests concepts and principles for legislation to implement an adult protective services (APS) program in Pennsylvania.

Protective services are those services provided to people who, due to age or impairment, are in danger of being mistreated or neglected, are unable to protect themselves, and have no one to assist them. Protective service workers are often the first responders to reports of abuse, neglect, and exploitation of vulnerable people. Protective services typically include a 24 hours/7 days a week intake capacity, mandated reporting, investigations and risk assessments, case management plans, service monitoring, and evaluation. Protective services can also include short-term services such as emergency shelter, counseling, and clothing, among others.

Existing Services in Pennsylvania

Pennsylvania is among the relatively few states that do not have a statutorily authorized protective services program for adults between the ages of 18 and 59. We did not conduct a 50-state survey, but various reports indicate that Pennsylvania is one of 8 to 10 states that does not have a statutory provision requiring protective services for 18 to 59 year olds. Although Pennsylvania does not have a statewide protective services program for the 18-59 year old population, many of the Commonwealth's existing social services programs do provide at least some level of safeguards for clients within their programs. As noted below, however, there are significant gaps in who is covered under these programs and the level of services available. The programs we reviewed include:

Mental Retardation Programs. Adults with mental retardation represent a major segment of the potential client base for an APS program. The Department of Public Welfare's (DPW) Office of Mental Retardation estimates that about 120,000 Pennsylvanians have mental retardation, 63,000 of whom are registered in the Commonwealth's mental retardation system.

For those who are registered in the system, significant protections exist through Department bulletins and regulations. In particular, in 2002 the Department implemented an extensive MR Incident Management System

which requires incidents to be investigated by the provider, county, or state, depending on the seriousness of the incident. However, because the system was implemented through a DPW bulletin rather than regulation, providers are not required to use the system, and we are aware of at least two providers who have chosen not to participate in the Incident Management System. All providers are, however, required to meet the incident reporting standards established in regulation which, although not as rigorous as the Incident Management System, require reporting and investigation of certain incidents, including client abuse.

DPW's MR Incident Management System does not cover the approximately 57,000 persons with mental retardation who are not registered in a state or county MR program. Additionally, although a provider is to report incidents they observe, or become aware of, when providing services in a private home, neither the provider nor the county or state has the authority to conduct an investigation or require corrective action in the client's private home, even if that person is a registered client.

Mental Health Programs. DPW's Office of Mental Health and Substance Abuse Services (OMHSAS) is in the process of developing an incident management bulletin for providers of MH services similar to that developed for the mental retardation system. Currently, however, OMHSAS has no specific reporting and investigating requirements beyond those in its licensing regulations. Its regulations identify clients' rights and require providers to have policies to report, investigate, and take action to address violations.

Personal Care Homes. Often persons who need assistance with daily living reside in a licensed personal care (boarding) home (PCH). As of October 2002, DPW licensed 1,786 PCHs housing approximately 53,000 residents. When the Department receives a complaint regarding a PCH, it can investigate to determine whether the home is meeting its regulatory and contractual obligations to provide a safe home for its residents. The focus of the investigation, however, is not on the treatment or situation of a particular individual, but on the facility itself.

To address this need for older Pennsylvanians, in 1997, DPW entered into a Memorandum of Understanding with the Department of Aging to coordinate investigative activities pertaining to individuals aged 60 and older living in PCHs. In FY 2001-02, about 5 percent of abuse reports received by the Area Agencies on Aging (AAAs) pertained to these residents. The AAAs do not, however, investigate cases involving persons under age 60.

Long Term Care Facilities. The Department of Health maintains a complaint and investigation system for long term care facilities. Complaints can be received 24 hours a day, and investigations are to be initiated within two days of receipt. As with personal care homes, however, the investigations are focused on whether the facility is meeting licensing standards, more so than on advocating on behalf of a particular individual. DOH investigators are not, for example, authorized to remove a resident from the facility or order the facility to take specific actions regarding treatment of a patient or resident.

To address the needs and concerns of individuals, the Commonwealth created the Office of State Long Term Care Ombudsman for persons 60 and older. Area Agencies on Aging are the local providers of ombudsman service. In instances where a complaint alleges abuse, neglect, or financial exploitation and the resident is 60 or older, the ombudsmen may refer the complaint to the local Older Adult Protective Services Unit. Ombudsmen do not have direct authority to require action by a long-term care facility.

Home Health Agencies. Home health agencies that provide medical care are regulated by the Department of Health. In 1998, the Department implemented a policy requiring that an investigation be initiated within 24 hours of a complaint where someone is in immediate jeopardy, with an on-site investigation to be conducted within two days. Non-emergency investigations have longer time frames. The Department of Health typically receives between 40 to 80 complaints per year pertaining to home health agencies. The Department reviews the provider's investigation to assure that appropriate action was taken and that, if the client was over 60, a referral was made to the county's AAA.

Domiciliary Care Facilities. Domiciliary care homes, which provide supervised living arrangements in a home-like environment for adults aged 18 and older, are licensed by the Department of Aging. Domiciliary care homes are required under certification regulations and the Older Adults Protective Services Act to report any suspected abuse, including for 18-59 year olds, to the AAA that serves their county. The AAA then investigates under the authority provided by OAPSA for persons aged 60 and older and under its certification regulations for persons under age 60. Under these regulations, a AAA can remove a resident from the facility if they deem it necessary.

State and County-Funded APS Programs. Although the Commonwealth does not have a statute establishing an adult protective services program for 18 to 59 year olds, several counties do provide limited APS services either through the county AAA or another county human service office. Often these programs are funded by a combination of state Human Services Development

Fund (HSDF) monies (through the Department of Public Welfare) and local county funds.

The seven counties that reported using HSDF funds to support an APS program for 18 to 59 year olds in FY 2001-02 are Butler, Centre, Erie, Lehigh, Northumberland, Philadelphia, and Westmoreland. Together, these counties reported using $380,637 in HSDF funds to provide protective services to 591 clients. This figure excludes protective service-type activities and services provided through other human service systems. These programs also vary considerably in the services they provide. We did not survey every county, but are aware that at least several other counties (e.g., Beaver, Cumberland, and Lehigh) also provide APS services for persons aged 18-59 using county or other non-HSDF funds.

Because Pennsylvania does not have a state statute authorizing protective services for persons aged 18-59, county staff are not able to enter a home or provide services to an adult under age 60 without permission. While counties report they can often avoid such direct confrontations, they can and do happen on occasion. In contrast, persons aged 60 or older can be removed from their home or compelled to accept services upon a court order according to the provisions of the Older Adults Protective Services Act.

Pennsylvania Protection and Advocacy. In addition to these state and county efforts, the federal government funds independent, nonprofit agencies to investigate abuse, neglect, and rights violations for people with physical and cognitive disabilities. In Pennsylvania, this agency is Pennsylvania Protection and Advocacy, Inc. PP&A, however, is not authorized to remove an individual from a home or institution. PP&A also noted that due to staff limitations (35 statewide), they primarily rely on working through the systems already in place by referring most complaints to the state licensing and county program offices and that their goal is to affect systemic improvements, not focus on individual cases.

Guardianship. Pennsylvania law authorizes a court to appoint a guardian to protect and promote the well-being of persons whose mental incapacity prevents them from making their own decisions. A guardian, in effect, can make decisions for the incapacitated person necessary for daily living, including consenting to protective services for the individual. Numerous county agencies that we met with reported, however, that it is difficult to establish guardianships due to a lack of individuals willing to serve in this capacity and the costs involved in initially establishing the guardianship.

Crimes Code. Under the Pennsylvania Crimes Code, it is a crime for a paid caregiver to neglect a care-dependent person for whom he/she is responsible to provide care. Depending on the violation, caregivers can be charged with

either a misdemeanor or felony. Since 1998, 127 cases have been prosecuted under this section of the Crimes Code. Additionally, individuals can obtain protection from abuse orders regarding potential abuse or injury that may occur in their home by family or household members, sexual or intimate partners, or persons who share biological parenthood.

Need for a State Adult Protective Services Program

In assessing the need for an adult protective services in Pennsylvania, we considered:

Gaps in Current Protective Services Efforts. As discussed above, various protections exist for people receiving public services or living in a state-licensed facility. However, often these protections are limited, particularly if the alleged abuse occurs at the client's private residence, and they are typically focused at resolving systemic issues pertaining to facility licensing requirements, not the immediate needs of a particular individual. Moreover, very few protections exist for people with physical or cognitive disabilities aged 18 to 59 who are not receiving services in a state-licensed facility or through a publicly funded program.

Reports to the Department of Aging. In FY 2001-02, the Department of Aging received 716 reports of possible abuse concerning persons under age 60. This represents only 5 percent of all reports received by the Department from the AAAs. However, under the Department's current guidelines, reports of abuse for persons aged 18-59 are often neither investigated nor referred to another agency, which undoubtedly discourages such reports from being filed.

Caseloads in Counties That Provide APS Programs for Persons Aged 18-59. Philadelphia appears to have one of the more comprehensive APS programs for persons aged 18-59. In FY 2001-02, Philadelphia reported providing APS services to nearly 1,000 adults aged 18 to 59, but officials noted that the city's emergency shelter program also provides protective services as part of its activities. Lehigh County assigns two staff to investigate reports of abuse involving adults under the age of 60, and in FY 2001-02, provided APS for 62 adults under age 60. Several counties reported that they typically see relatively few cases per year, but even some of these counties expressed concern about the lack of an APS program for this age group.

Caseloads in States That Provide APS Programs for Persons Aged 18-59. The National Association of Adult Protective Services Administrators reported that in 2000, 396,187 elder/adult abuse reports were investigated nationwide. Of these reports, 166,012 (42 percent) were substantiated. For the 21 states that provided a breakout of their substantiated reports by age, 30 percent involved adults under age

60. Similarly, Maryland, which has a comprehensive APS program, reported that 27 percent of its adult/elderly APS clients were between the ages of 18 and 59.

Provider and Advocacy Groups. Most, but not all, of the provider and advocacy groups we contacted offered at least qualified support for a state-mandated APS program. Listed below are brief summaries of the positions of three organizations that developed written comments regarding HR 590.

> *Arc of Pennsylvania*, an advocacy organization for persons with mental retardation, supports a new protective services statute, provided the statute contains provisions to ensure civil rights are honored and that the law mandates the least restrictive intervention.
>
> *The Coalition for Personal Care Home Reform*, an organization comprised of representatives from various nonprofit organizations throughout Pennsylvania who advocate on behalf of personal care home residents, supports the implementation of an adult protective services program to address caretaker abuse, neglect, and exploitation, provided sufficient safeguards are included to ensure individual rights are protected.
>
> The *Pennsylvania Association of Resources for People with Mental Retardation (PAR)*, a statewide association of providers of mental retardation services, believes there are sufficient measures in place regarding abuse and neglect reporting, investigation, and resolution through existing law and that additional requirements may promote confusion, delay, and unnecessary cost.

Although not providing a unified written position, many *Area Agencies on Aging* officials also told us they believe the Commonwealth needs a protective services program for the 18-59 year-old population. Among the AAA Executive Policy Committee, there was also near unanimous agreement on the need for a statutory APS program for this age group.

Case Studies. To supplement these statistics and commentaries, the report includes several brief "case studies" of individuals who may benefit from an adult protective services program. The case studies were submitted by county AAAs and various other social service entities and organizations that interact with persons with physical and cognitive impairments.

Pending Legislation. House Bill 1925, introduced in August 2003, cites the need for protective services for adults with developmental disabilities and establishes a protective services program to be administered by the Department of Public Welfare. Many of the provisions in the bill are similar to those in OAPSA.

Cost and Administrative Placement

Cost. We estimate that an adult protective services program for physically and cognitively impaired adults aged 18-59 would cost approximately $5 million annually. This estimate assumes:

About 30 Percent of All Reports of Adult Abuse and Neglect Will Involve Individuals Aged 18 to 59. In states that provide protective services for all adults, on average 30 percent of the substantiated reports of abuse involved adults aged 18-59, with the remaining 70 percent involving adults aged 60 and older. Several of the county AAAs we contacted thought it reasonable to assume that, if the Commonwealth were to enact an APS program, between one-fourth and one-third of the caseload would involve adults aged 18-59. This would translate to roughly 4,000 reports a year, of which we estimate about 1,200 (30 percent) would be substantiated. Because Pennsylvania has a well-developed Incident Management System for persons registered in state-funded mental retardation programs, it is conceivable that the 30 percent estimate is somewhat high. We used the 30 percent figure, however, to reduce the risk of underestimating potential costs.

The APS Program Will Include Only Activities Such as Receiving and Investigating Reports and Providing Short-Term Case Management and Emergency Services. An adult protective services program typically provides for a 24 hours/7 days a week intake capacity, mandated reporting provisions, an investigation and risk assessment process, and developing and implementing short-term case management plans. Protective services can also include short-term services such as emergency shelter, counseling, and clothing. We did not include longer-term services, such as providing meals-on-wheels, permanent housing, substance abuse treatment, transportation, or personal care, in our cost estimate of an APS program. AAAs, providers, and advocates all expressed concern that these longer-term services may not be available after APS services are terminated. While we share these concerns, we agree with those contacted during this study who indicated that the potential lack of long-term services should not be used as a reason for not establishing an APS program.

APS Program Costs Will Be Similar for the 18-59 Population as for Those Over Age 60. In FY 2001-02, the Department of Aging and AAAs report spending $9.4 million to provide adult protective services to persons over the age of 60, which they informed us may be somewhat underreported. Of this amount, $5.6 million was for intake and investigation, $3.5 million for temporary and emergency services, and $240,000 for training and Department of Aging administrative costs. While the long-term cost of providing services to the under age 60 population could be substantially higher than for the over age 60 population, the intake, investigation, and short-term service costs are likely to be similar. Assuming that the relationship of 18-59 year olds needing protective services is 3 to every 7 60+ year old protective

services clients (i.e., 30 percent of total APS cases), the estimated cost to provide protective services to those aged 18-59 is $4.0 million annually. Given that new programs inevitably require certain additional training and start up costs, we believe an estimate of approximately $5 million annually to be realistic for the first several years of operation.

Administrative Placement. We concluded the two most feasible administrative homes for an APS program are: (1) the Department of Aging, as an extension of the Older Adults Protective Services Program or (2) the Department of Public Welfare's Office of Social Programs, the office which currently administers the Human Services Development Fund.

Department of Aging. The Department of Aging, together with the Area Agencies on Aging, provided over $358 million in services to older Pennsylvanians in FY 2001-02, including over $9 million in protective services. As such, these agencies have the experience and administrative structure to provide similar protective services to younger adults. We also note that several AAAs currently operate limited protective services programs for this population. Potential difficulties of using the Department of Aging/AAAs to administer an 18-59 year old APS system include:

Many of The Long-Term Social Services That Will Be Necessary Are Administered Through the Department of Public Welfare. DPW administers the Commonwealth's programs for the mentally retarded, mentally ill, substance abuse, homeless assistance, attendant care, and various other services that would eventually need to be accessed by many people served by an adult protective services program. It is reasonable to assume that better coordination with these programs would exist if the APS system were operated through the Department of Public Welfare rather than the Department of Aging. Others argue, however, that an APS program should be housed in an agency that is independent from the DPW service system.

Some AAAs May Be Reluctant to Expand Their Mission Beyond Providing Services to the Elderly. Several AAAs reported that their governing boards may be reluctant to take on additional responsibilities for adults under age 60. They suggested that AAAs be allowed the option to decline these responsibilities. This could be a particular concern for some private, nonprofit AAAs.

AAAs May Not Be as Sensitive to the Concerns of the Independent Living Movement. As discussed above, many advocates for the physically and cognitively impaired strongly believe that individuals who may be in need of protective services should be allowed to assert their rights to make their own choices and to take their own risks. These advocates are concerned that AAA personnel, who work almost exclusively with the elderly, may not be sufficiently attuned to this philosophy.

Department of Public Welfare. The Department of Public Welfare's Office of Social Programs (OSP) administers the Human Services Development Fund, the only state funds that counties can use for an 18-59 year old APS program. OSP also oversees several social service programs that provide services to physically and cognitively impaired adults. For these reasons, we consider the Office of Social Programs to be a feasible administrative location for an APS program. Potential difficulties of using the Department of Public Welfare to administer an 18-59 year old APS system include:

Lack of Independence. Several advocates state that an adult protective services program should be located in an independent cabinet-level agency. They cite the inherent conflict of interest that exists when a department that is responsible to provide funding to service providers is also responsible to provide protective services to the individuals receiving these services. While some may question whether the Department of Aging should be considered fully independent, it is clearly far less involved in providing services to 18 to 59 year olds than is the Department of Public Welfare.

Placing the APS Program in the Office of Social Programs Would Create a Third Protective Service System. Pennsylvania currently has two protective service systems: the Child Protective Services System in the Department of Public Welfare's Office of Children, Youth and Families and the Older Adults Protective Service System in the Department of Aging. Placing the APS program in the Office of Social Programs would create a third system that, in addition to cost inefficiencies, likely would be confusing to the public.

DPW's Regulatory "Culture." Although difficult to quantify, the Department of Public Welfare tends to have more of a regulatory enforcement culture compared to the Department of Aging which, by statute, is charged to advocate for the individual. While both have certain advantages, we found a general consensus among those we interviewed that APS workers should serve primarily as advocates for the client.

Other Options. Other options we considered but judged to be infeasible are listed below:

(1) *an independent state-level agency.* This would create a third protective service system and a new administrative apparatus for a program that we estimate will cost only $5 million annually.
(2) *combining the APS system with Child Protective Services.* Virtually everyone we spoke to discouraged this approach, citing the significant legal and developmental differences between children and adults and the burdens already placed on the county Child Protective Services system.

(3) *county district attorneys.* There is no statewide administrative structure for county District Attorneys, and few in the advocacy community supported the legalistic/law enforcement overtones that would accompany an APS program operated out of a county district attorneys office.
(4) establishing *a new, combined protective service agency* for children, adults, and the elderly. We did not think the relatively modest APS program we are proposing could justify such a sweeping change.

Recommendations

We believe this report provides sufficient evidence of the need for adult protective services for persons aged 18 to 59 with physical or cognitive impairments, and we recommend the General Assembly enact such a statute.

We recommend such a statute:

1. **Create statutory authority for an APS program by amending OAPSA.** It would be relatively straight-forward to amend the Older Adults Protective Services Act to include all adults aged 18 and older (see Appendix B). OAPSA is generally viewed as a sound piece of legislation, and its provisions are familiar to the legal and social service community. A new act pertaining only to persons aged 18-59 years old would be another option, but we saw little advantage to this approach, assuming the program is administered through the Department of Aging. If the APS program were placed in another department, such as the Department of Public Welfare, a separate statute may be more appropriate.

2. **Cover persons aged 18-59 with a physical or cognitive impairments.** House Resolution 590 refers to the need for protective services for persons aged 18 to 59 with physical or cognitive impairments. Although the Child Protective Services Law and the Older Adults Protective Services Act cover everyone under age 18 and age 60 and older, respectively, we believe it appropriate that the General Assembly limit the 18-59 year old APS program to persons who, due to a physical or cognitive impairment, are unable to provide for their own care and protection. We further recommend that the department with administrative responsibility for the program define "physical or cognitive impairment" in terms of functional limitations similar to the definitions in OAPSA regulations regarding incapacitated persons.

3. **Place the program in the Department of Aging.** While placing an 18-59 year old APS program in the Department of Public Welfare is feasible, we recommend that, if the General Assembly creates such a program, it be housed in the Department of Aging. Using the existing PDA structure

avoids the duplication and confusion that would result by creating a new protective services program in the Department of Public Welfare. Establishing the program in the Department of Aging also provides a degree of independence from the Department of Public Welfare which administers or funds many of the social services APS clients may be receiving.

4. **Allow county discretion for local administrative placement.** Some counties (e.g., Philadelphia and Lehigh) already operate an APS program through an entity other than the local AAA, and some AAAs may be unwilling to take on these additional responsibilities. As the program would ultimately be a county responsibility, we recommend the General Assembly allow the county commissioners to make the final decision regarding the administrative placement of the program at the county level. We think this is important given the different county human service structures and system cultures that exist throughout the Commonwealth. Nonetheless, the Department of Aging, as the state administering agency, would need to maintain efficient monitoring and reporting systems.

5. **Retain existing mandated reporting provisions.** We recommend the General Assembly consider retaining the same mandatory reporting entities for an 18-59 year old APS program as for the 60 and older program: domiciliary care homes, home health care agencies, long-term care nursing facilities, and personal care homes. The General Assembly recently amended the mandatory reporting requirements of OAPSA (through Act 2002-171) to exempt facilities providing services to individuals with mental retardation and licensed by DPW or funded through a county mental retardation program from the mandatory reporting requirement for reports concerning individuals under age 60. Given the Office of Mental Retardation's new reporting and investigation procedures and that the General Assembly recently exempted OMR providers, we recommend this exemption also apply to an 18-59 year old APS program. (All other provisions of the act would remain for this population; the exception only applies to the mandated reporting provisions.) We further recommend that the Departments of Public Welfare and Health establish procedures within their licensing and investigation programs to require providers and program employees to report situations in which they believe abuse or neglect might be occurring but do not have authority to investigate (e.g., where the provider or county employee cannot obtain permission to enter the home) to the APS program.

6. **Provide for coordination of investigative and program activities.** Currently, Pennsylvania's protective services statute for persons who are at least 60 years old (OAPSA) includes provisions for consultation between the Department of Aging and the licensing agency in carrying out

program activities. Department of Aging regulations further defines such coordination so as to avoid duplication of effort and to foster jointly developed remedies. We recommend that the Department of Aging develop memoranda of understanding with the Departments of Public Welfare and Health to encourage such efficiency and maximize coordination in any 18-59 year old APS program.

7. **Provide for a dedicated source of funding.** We estimate the cost of an 18-59 year old APS program to be about $5 million annually. Many of the counties we spoke with voiced concerns that the program not be an unfunded mandate on the counties. Normally, such programs would be funded through a General Fund appropriation. Given that we are recommending the program be administered through the Department of Aging, it may also be feasible for the General Assembly to consider funding the program through the Lottery Fund, which currently funds the protective services program for persons aged 60 and older. While generally reserved for programs for the elderly, the Lottery Fund is used to support the Commonwealth's Homeowners and Renters Assistance Program, which is available to persons under age 60 with permanent disabilities.

I. Introduction

House Resolution 590, passed in June 2002, requires the LB&FC to conduct a study to examine the need for a protective services program for physically and cognitively impaired adults between 18 and 59 years of age. We began initial work on this project in late fall 2002 and conducted most of the field work and analysis in the spring and summer of 2003.

Audit Objectives

This examination addresses and makes proposals regarding:

1. What types of services may be needed?
2. What is the most appropriate administrative structure for such a program and what are the anticipated costs?
3. What is the necessary legislative language to implement an adult protective services program?
4. What are other relevant factors to inform the General Assembly on how best to meet the needs of these citizens?

Methodology

To determine what protections already exist for physically and cognitively impaired persons between the ages of 18 and 59, we reviewed state statutes and regulations of human and social services programs. We also reviewed pertinent federal statutes and regulations. To identify legislative concerns, we sent letters to each member of the House Aging and Older Adult Services Committee, the Senate Aging and Youth Committee, the House Health and Human Services Committee, and the Senate Public Health and Welfare Committee. We also met with legislators and staff who expressed an interest in the study and otherwise communicated with legislative staff on pertinent topics.

To determine the level of need for an adult protective services program we visited 13 AAAs and interviewed the directors of an additional 17 by telephone. We also met with staff of ten county mental health and mental retardation agencies. We discussed the existing protective services programs they administered, whether they felt the program was benefiting the population, and whether they felt there was a need to expand the program or create a new program that would specifically try to prevent abuse of younger adults.

We obtained reports on adult protective services programs in other states and developed a survey asking selected other states to describe their programs. We reviewed a 2003 National Association of Adult Protective Services Administrators report comparing how states administered their adult protective services programs. Among other areas, the report focused on the age of the population served by the program, where the program was administratively located, and the cost to manage the program.

We also had contacts with a variety of associations and advocacy groups interested in protecting Pennsylvania's vulnerable population. We held extensive meetings with officials in the Department of Aging (PDA), the Department of Public Welfare (DPW), and the Department of Health (DOH) to gain an understanding of existing programs, how such programs ensure that the clients they serve are protected, and to implement issues related to an 18-59 year old protective services program.

We obtained cost information from PDA to determine the cost of its existing adult protective services program. We also acquired information on dollars spent, particularly in programs administered by DPW, on investigative activities related to complaints of abuse or on activities related to the alleviation of existing abusive situations.

It should be noted that the primary purpose of this report was to determine the need for an adult protective services (APS) program. To achieve this end, we examined other like programs in Pennsylvania. Although we do provide descriptive information and data about these programs, we did not audit each of them separately, therefore, we have described how they are supposed to be implemented, not if they indeed are implemented according to statutes and regulations. For example, we did not do extensive work to determine if protective services investigations are completed within proscribed time frames. Also, while the report provides information on guardianship issues and programs in the context of their impact on adult protective services, a full review of Pennsylvania guardianship plans was outside the scope of this audit, and we made no recommendations in this area.

Acknowledgements

We wish to thank the Secretaries of Aging, Public Welfare, and Health and their staffs for the excellent cooperation and assistance afforded us during this review. Additionally, we would like to acknowledge the assistance provided by the many Area Agencies on Aging, and county human service, mental health, and mental retardation offices we either visited or contacted. Finally, the numerous providers and advocacy organizations, and other interested persons that worked with us to identify key issues and concerns and provided data for this study were of great help.

Important Note

This report was developed by Legislative Budget and Finance Committee staff. The release of this report should not be construed as an indication that the Committee or its individual members necessarily concur with the report's findings and recommendations.

Any questions or comments regarding the contents of this report should be directed to Philip R. Durgin, Executive Director, Legislative Budget and Finance Committee, P.O. Box 8737, Harrisburg, Pennsylvania 17105-8737.

II. Pennsylvania's Protective Services Efforts Only Partially Address the Needs of 18-59 Year Olds

Adult protective services (APS) are those services provided to certain people who, due to age or impairment, are in danger of being mistreated or neglected, are unable to protect themselves, and have no one to assist them.[1] Protective services programs are often the first responders to reports of abuse, neglect, and exploitation of vulnerable people.

Abuse is the infliction of physical harm, pain, or mental anguish; the willful deprivation by a caretaker of goods or services that are necessary to maintain physical or mental health; sexual harassment; or rape. Neglect is the failure of the individual or the caretaker to provide goods and services essential to avoid a clear and serious threat to physical or mental health. Environmental factors beyond the control of the individual or caretaker are not in and of themselves considered abuse or neglect. Exploitation involves use of the individual or individual's resources without informed consent, or consent through coercion, misrepresentation, or threats, and is commonly used for financial gain.

Adult protective services programs generally include, but are not limited to, the following:

- receiving reports of abuse, neglect, or exploitation;
- investigating reports of abuse, neglect, or exploitation;
- assessing risk;
- developing and implementing case plans;
- short-term service monitoring; and
- evaluation.

Protective services can include short-term services such as emergency shelter, counseling, and clothing; they do not, however, include long-term human service delivery. Additionally, APS is a social service and, although law enforcement and criminal issues may be present, engaging police authority is not normally the focus or intent in a protective services program. Instead, the focus is to remove the person from imminent danger and address his/her specific needs.

Protective services statutes usually provide a legal basis for access to the person and records to investigate the alleged abuse, neglect, or exploitation as well as involuntary removal of the person from the environment if it is determined that the person is at imminent risk of death or serious physical harm. The "emergency services" authority is time-limited, making the acceptance of services voluntary in the absence of a court order.

[1]The descriptions and discussions in this section are compiled in large part from PA statute, a 2003 National Center of Elder Abuse report, and a review of other state statutes.

Pennsylvania's Older Adults Protective Services Act (OAPSA), 35 P.S. §§10225.101 et seq., mirrors the general provisions of a protective services program discussed above. In addition, the act mandates reporting of suspected abuse by an employee or administrator of a facility covered by the act.

Existing Protective Service Efforts in Pennsylvania

Pennsylvania has two age-based protective services statutes: OAPSA for adults ages 60 and older and the Child Protective Services Law for children under the age of 18. In addition, other protections are provided for vulnerable adults who are served through state-licensed facilities or providers and by Pennsylvania Protection and Advocacy, Inc. (PP&A), a federally funded agency.

Older Adults Protective Services Act

This act protects Pennsylvanians who are 60 years of age and older against neglect and physical, mental, and financial abuse. The act defines an older adult in need of protective services as, "an incapacitated older adult [60 years of age or older] who is unable to perform or obtain services that are necessary to maintain physical or mental health, for whom there is no responsible caretaker and who is at imminent risk of danger to his person or property." PDA regulations, 6 Pa. Code §15.2, further define incapacitated older adult as an older adult who due to one or more functional limitations needs assistance to perform or obtain services to maintain physical or mental health.

Each Area Agency on Aging (AAA) is required to receive reports on older adults 24 hours a day, seven days a week. An investigation must be initiated within 72 hours. If a report is substantiated, a client assessment resulting in recommended action is conducted. The AAA arranges for or provides the necessary services and monitors the ongoing need for services.

The act authorizes the AAA investigators to obtain access to the person and records necessary to conduct the investigation. Although acceptance of services is generally voluntary, the act authorizes involuntary intervention by emergency court order where there is clear and convincing evidence that if protective services are not provided, the person to be protected would be at imminent risk of death or serious physical injury. The initial order may not exceed 72 hours, although an additional order may be sought.

The act also mandates reporting of suspected abuse by an employee or administrator of a facility covered by the act. Facilities include:

- domiciliary care home;
- home health care agency (includes hospice);
- long-term care nursing facility;
- older adult daily living facility; and
- personal care homes.

An employee or administrator of these facilities, in addition to reporting to the AAA, is required to contact law enforcement officials when there is a reasonable suspicion that the client is a victim of sexual abuse, serious physical injury or serious bodily injury or that a death is suspicious. In the case of a death where there is reasonable cause to believe the death was the result of abuse, the AAA is required to forward a report to the coroner.

In 2002, the act was amended to exempt providers from the mandatory reporting provisions of the act for individuals with mental retardation in residences licensed by the Department of Public Welfare (DPW) or funded through a county mental retardation program to adults age 60 and older. Reports for individuals under age 60 are now made directly to the licensing entity (DPW). Prior to this amendment, OAPSA mandatory reporting requirements pertaining to home health agencies were interpreted to apply to individuals under age 60 receiving MR services, resulting in the reports being made to the AAA and forwarded to the licensing entity. This change was made in part because the AAAs have no authority under OAPSA to investigate allegations of abuse, neglect, or exploitation involving an adult under age 60.

Department of Aging Reporting Process. Persons or agencies wanting to report possible abuse, or agencies mandated by Act 1997-13,[2] generally call either the statewide elder abuse number or the local AAA. Although reporters are not required to identify themselves, in most instances the AAAs are able to document the source. Reports are received from health care agencies, family members, the general public, social service agencies, nursing homes, and the victim, among others.

In FY 2001-02, approximately 22 percent of the reports were initiated by nursing homes; 17 percent by family members; 17 percent by the general public; and 15 percent by health care agencies. Reports from victims themselves represented 3 percent of all reports received, while 4 percent of the reports were made anonymously.

Classification and Investigation Process. Once a report of possible abuse is received, AAA staff classify the risk into one of five categories. Each category has a timetable by which investigations are to begin. Exhibit 1 describes the five categories and the requirements for the timely initiation of an investigation. Over the last three fiscal years (FYs 1999-00, 2000-01, and 2001-02), approximately 43 percent of all reports were classified as non-priority; 31 percent were classified as priority; 8 percent were classified as emergency; 16 percent were classified as no need for services; and 1 percent was referred to another AAA.

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[2]This act amended OAPSA to mandate reporting of suspected abuse by employees or administrators of covered facilities, investigation of those reports and established penalties for failure to comply with these requirements. Additionally, employees and administrators are required to report suspected sexual abuse, serious physical injury, serious bodily injury, or suspicious death to law enforcement. Deaths where abuse is suspected must also be reported to the coroner within 24 hours.

Every report involving an older person must be investigated by qualified adult protective services workers to determine if APS services are needed. Department of Aging regulations require that protective services supervisors and caseworkers undergo criminal background checks and receive comprehensive APS training in investigative practices and protective services casework procedures before they are allowed to investigate abuse reports. They must also undergo annual in-service training in protective services. The curriculum includes interviewing techniques, completing report forms, case status assessment, referral of reports to protective services staff, and emergency procedures. As part of this review, we observed a portion of this mandatory training.

Exhibit 1

Five Possible Classifications That Reports of Abuse Are Placed in and How Quickly Such Reports Must Be Investigated

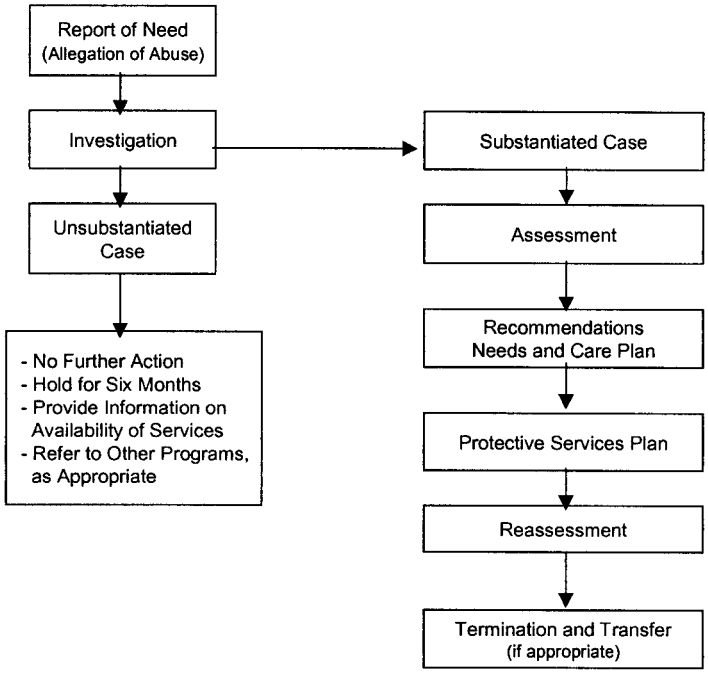
Classification	Required Response Time to Begin Investigation
Emergency	Immediately referred to a protective services caseworker. The caseworker is to make every attempt to secure the immediate safety of the older adult.
Priority	Immediately referred to a protective services caseworker. The investigation is initiated as soon as possible. Reasonable attempts are made to initiate the investigation and visit the older adult within 24 hours.
Non-Priority	Referred to a protective services caseworker within the normal hours of the agency's current or next day of business. An investigation is to be initiated within 72 hours. Every attempt is made to visit the older adult face-to-face.
Another Planning and Service Area	The older adult possibly needing protective services is located in another AAA's area of responsibility. A referral is made to the appropriate AAA if the report meets the criteria for placement in the emergency, priority, or non-priority category.
No Need for Protective Services...	A case in which the person reported to need protective services is under age 60; or able to maintain physical/ mental health; or has a responsible caretaker; or has no imminent risk to their person or property.

Source: Pennsylvania Department of Aging, FY 2001-02 Older Adults Protective Services Report.

If the investigation shows that protective services are warranted, a written client needs assessment must be prepared and protective services offered. Services are provided after the client has given informed consent. The client has the right to refuse services. However, under OAPSA, services may be provided without such consent if the client is: unable to consent; the court orders services; the client's court-appointed guardian requests services; or if provided as part of a court-ordered emergency involuntary intervention. Exhibit 2 is a flowchart of the adult protective services investigative process.

Exhibit 2

Older Adult Protective Services
Case Management Flow Chart



Source: Developed by LB&FC staff from a similar exhibit in the FY 2001-02 Older Adults Protective Services Report.

60+ APS Data. Between FY 1999-00 and FY 2001-02, the number of APS reports received by AAAs increased by 1,431, while the number of substantiated reports increased by 98. In FY 2001-02, substantiated cases that qualified for APS services were approximately 23 percent of total reports received. Over the past three years, abuse investigations have substantiated approximately 24 percent of all reports of abuse. Please see Table 1 for more information. Increased public awareness of the program as a result of information campaigns that AAAs are required to undertake has undoubtedly also led to more abuse being identified and reported.

According to the Department of Aging's 2001-02 annual report, "the age group most often found to need protective services (73 percent) is over age 75. Since those over age 75 comprise 39 percent of Pennsylvania's age 60+ population, they are being abused at a rate nearly twice as high as their proportion of the general aging population."[3] According to the U.S. Census Bureau, Pennsylvania's population between the ages of 75 to 84 grew 21.3 percent between 1990 and 2000. Pennsylvania's elderly population ages 84 and over grew 38.3 percent over the same ten years.

[3] *2001-02 Older Adults Protective Services Report,* Pennsylvania Department of Aging, p. 10.

Table 1

Number of Older Adult Protective Services Reports Which Substantiated the Need for Protective Services*

FY	APS Reports Received	Need for Protective Services Substantiated	Percent of Total Reports Substantiated
1999-00.....	10,991	2,703	25%
2000-01.....	11,451	2,626	23
2001-02.....	12,422	2,801	23

*APS reports received and need for protective services substantiated data only include adults 60 and over.

Source: Pennsylvania Department of Aging, adult protective services data.

Child Protective Services Law

The Child Protective Services Law (CPSL) establishes procedures for reporting and investigating alleged child abuse. Certain types of suspected child abuse must be reported to law enforcement officials for investigation of criminal offenses. The CPSL defines child abuse as any of the following when committed upon a child under 18 years of age by a parent, household member, person responsible for a child's welfare, or the significant other of a parent:

- Any recent act or failure to act which causes a nonaccidental serious physical injury.
- Any act or failure to act that causes nonaccidental serious mental injury, sexual abuse, or sexual exploitation.
- Any recent act or failure to act or series of such acts or failures to act that creates imminent risk of serious physical injury to or sexual abuse or sexual exploitation.
- Serious physical neglect that endangers a child's life or development or impairs the child's functioning.

Reports of suspected abuse are received by the DPW's ChildLine and Abuse Registry, which is the central registry for all investigated reports of abuse. Individuals who come into contact with children in the course of practicing their profession are required to report when they have reasonable cause to suspect that a child has been abused. However, any person may report suspected abuse.

Counties are responsible for investigating child abuse reports and delivering services to those children accepted for service. Counties must provide 24 hour/ 7 days per-week coverage; in cases of reported abuse, an investigation must begin within 24 hours or immediately if circumstances warrant. The investigation is to include: notification to ChildLine, interviews of appropriate individuals, written records of investigation, color photograph of injury, and medical evidence if possible.

Once a case is accepted for service, a Family Service Plan (FSP) is developed which includes:

- identifying information for the child and family members;
- description of circumstances under which the case was accepted;
- service objectives;
- services to be provided;
- actions to be taken by children, family, agencies, and dates for the completion of those actions;
- placement amendments, as needed; and
- results of FSP reviews.

FSPs are to be reviewed at least every six months, with the review results recorded in the plan. The CPSL also requires counties to provide general protection services to address less severe circumstances that do not fall within the law's definition of abuse. County children and youth agencies are required to provide services intended to keep children in their homes, whenever possible. As with child protective services cases, counties are to develop an FSP and ensure that needed services are provided to the family.

Table 2 below shows the total number of reports made to children and youth offices and the number of reports that were substantiated. It shows that while reports have increased by 3 percent from CY 1999 to CY 2001, substantiated reports have decreased by almost 6 percent within the same time frame.

Table 2

C&Y, Total Reports and Substantiated Reports

Calendar Year	Total Reports	Substantiated Reports
1999	22,397	5,076
2000	22,809	5,002
2001	23,099	4,784

Source: DPW Annual Reports on Child Abuse.

Protections Through Other Social Service Programs

Statutory and regulatory mechanisms are in place to provide certain protections to vulnerable adults receiving social services who are served through licensed providers or are in licensed facilities. Agencies serving these populations have responsibilities under federal and state requirements to assure the health and safety of individuals receiving certain services. Appendix C provides overview information on protective service regulatory requirements for selected types of licensed providers of services to vulnerable adults in Pennsylvania. For example, most licensed facilities must report incidents or accidents involving clients which can include abuse and neglect. In the case of an incident or accident in a nursing home, the facility's medical director has the responsibility to review the incident or accident and

address the health and safety hazards at the facility. The requirements, however, vary from program to program.

In all cases, licensed providers and facilities are required to meet certain licensing standards and are subject to inspection by the licensing agency. Failure to comply with the requirements may result in provisional licensing or license revocation. The following provides an overview and analysis of the extent of protective service authorizations and activities within several pertinent human service and licensure systems.[4]

Programs Administered by the Department of Public Welfare

The Mental Health and Mental Retardation Act of 1966, 50 P.S. §4101 et seq., requires counties to establish mental health and mental retardation programs to provide "diagnosis, care, treatment, rehabilitation and detention of the mentally disabled" through nine mandatory services, including emergency services and interim care for individuals who have been removed from their homes and are awaiting admission to a state-operated facility. The act provides for commitment to a facility on application by a relative, guardian, friend, or someone standing in loco parentis to the individual and civil court commitment. Commitment, however, is based on the determination that the person is mentally disabled and in need of care or treatment due to the mental disability. The act does not provide specific protective services to address abuse or neglect, although it does provide the statutory basis for much of the mental health (MH) and mental retardation (MR) systems in Pennsylvania.

In addition to its mental retardation and mental health programs, the Department also regulates personal care homes, attendant care programs, family living homes, adult training facilities, vocational facilities, intermediate care facilities for persons with MR, community homes, foster home care, community residential rehabilitation services for the mentally ill, and long-term structured residences.

DPW's Office of Mental Retardation. Pennsylvania has an estimated population of 120,000 people with mental retardation; of these, about 63,000 are registered in the state's MR system. In addition to its licensing regulations, in 2002, DPW's Office of Mental Retardation (OMR) implemented an incident management policy "to establish processes that will protect the health and safety, enhance the dignity, and protect the rights of individuals receiving supports and services."

The policy, OMR Bulletin 00-01-05-Incident Management and OMR Bulletin 00-02-14-Incident Management Interpretive Guideline, applies to individuals who

[4]This review highlights certain licensing requirements but does not provide an exhaustive list of all requirements, types of facilities or services. We focused on those requirements that address abuse and neglect and, therefore, we did not include "generic" safety requirements, e.g., fire protection, required for these facilities.

receive MR supports and services authorized by a county MH/MR Program and/or from licensed MR facilities. Anyone who receives funds from the MR system to provide or secure supports or services for these individuals and employees licensed by OMR are to report incidents as defined in the bulletins. The procedures are applicable to licensed facilities and county-funded mental retardation programs. Persons not registered with OMR and/or not receiving state funded services are not covered under the bulletin or licensing regulations. Exhibit 3 compares several key provisions of OAPSA and the bulletin.

For example, facilities covered include:

- Adult Training Facilities,
- Vocational Facilities,
- Community Homes for Individuals with Mental Retardation,
- Family Living Homes, and
- Intermediate Care Facilities for Persons with Mental Retardation.

To the extent the bulletin exceeds the applicable regulations, its requirements are optional until adopted as regulation. The bulletin exceeds the regulations, for example, in areas such as requiring certified investigators to investigate incidents, expanding the number of reportable incidents, and establishing an electronic web-based reporting system. The regulations only generally require incident investigations without, in all cases, detailing how the investigation is to be conducted. The bulletin is optional, and two large providers have opted not to use it; they are, however, still bound by other applicable regulations.

The policy establishes the following:

- Mandatory reporting of incidents by anyone who receives funds to provide or secure supports or services for individuals authorized to receive services from the county MH/MR program and employees, subcontractors, and volunteers of facilities licensed by DPW's OMR; providers in the home are required to report incidents that occur when they are present in the home.
- Reportable incidents include abuse (to include neglect, physical abuse, psychological abuse, sexual abuse, and verbal abuse), accident or injury requiring treatment beyond first aid, death, emergency closure, emergency room visit, hospitalization, law enforcement activity, medication error, missing person, misuse of funds, psychiatric hospitalization, use of restraints, rights violation, and suicide attempt.
- Investigation by the provider, county, or OMR depending on the incident. For example, an allegation of abuse is investigated by the provider whereas the death of an individual residing in a provider-operated facility is investigated by the provider and DPW's OMR and/or the Department of Health.
- Use of certified investigators. (Investigators may be employees of the provider.)
- Data and information analysis.

Exhibit 3

Comparison of OAPSA and OMR Protection

OAPSA Statute and Regulations	OMR Bulletin
Definition of Protective Services:	**Services Provided:**
Statute - Protective services are those activities, resources and supports provided to older adults to detect, prevent, reduce or eliminate abuse, neglect, exploitation and abandonment.	The primary goal of an incident management system is to assure that when an incident occurs the response will be adequate to protect the health, safety and rights of the individual. The standardization of reporting, the time frames for reporting, investigation and follow-up are key to conducting individual, provider, countywide and statewide analysis of incidents.
Regulations define protective services as: activities, resources and supports provided to older adults under the act after the initiation of an investigation to prevent, reduce or eliminate abuse, neglect, exploitation and abandonment. Protective services activities include the following: (1) Administering protective services plans. (2) Receiving and maintaining records of reports of abuse. (3) Conducting investigations of reported abuse. (4) Conducting assessments and developing service plans. (5) Petitioning the court. (6) Providing emergency involuntary intervention. (7) Arranging for available services needed to fulfill service plans, which may include, as appropriate, arranging for services for other household members to reduce, correct or eliminate abuse, neglect, exploitation or abandonment of an older adult. A partial listing of the services that may be made available to reduce, correct or eliminate abuse, neglect, exploitation or abandonment of an older adult is found in §15.93(c) (relating to service plan). (8) Purchasing, on a temporary basis, as provided under §15.112 (relating to uses of funding authorized by the act), services determined by a service plan to be necessary to reduce, correct or eliminate abuse, neglect, exploitation or abandonment of an older adult when the services are not available within the existing resources of the agency or other appropriate provider.	Providers are to promote the health, safety, rights and dignity of individuals receiving services; develop provider-specific policy/procedures for incident management; assure when incidents occur that affect a person's health, safety or rights, that the people who are present: (1) Take prompt action to protect the person's health, safety and rights. This includes separation of the target when the individual's health and/or safety is jeopardized. This separation shall continue until an investigation is completed. In addition, the target shall not be permitted to work directly with any other service recipient during the investigation process. When the target is another individual receiving supports or services, and complete separation is not possible, the provider shall institute additional protections. (2) Notify the responsible person, designated in provider policy.
Investigation Timeline for Mandated Reporters	**Investigation Timeline for Mandated Reporters**
An employee or administrator with reasonable cause to suspect that a recipient is a victim of abuse shall immediately make an oral report to the licensing agency. Written report must follow within 48 hours. Within 48 hours of making the oral report, the employee or administrator shall make a written report to the agency. The agency shall notify the administrator that a report of abuse has been made with the agency.	All reportable incidents are to be submitted electronically to OMR via a web-based system. An initial report is due within 24 hours of the incident or within 24 hours of when the provider learns of the incident. An incident report is due within five days of the incident or of the date when the provider learns of the incident. A final report is due when the incident is finalized by the provider with an outside limit of 30 days.

Source: Developed by LB&FC staff from statute and DPW/Aging documents.

Reportable incidents include incidents that occur when the provider is in the home of the individual, or suspected or alleged abuse of which the provider becomes aware regardless of whether they are providing services at the time the alleged abuse occurred. Providers are also required to report the death of any individual to whom they are providing services. The provider, however, does not have the authority to investigate incidents occurring in the home, at another provider agency, or at a community establishment, e.g., a hospital. In these cases, the county is to take all available action to protect the individual's health and safety.[5] The bulletin does not specifically require that law enforcement be contacted in designated cases.

Incident management reporters include any provider receiving funds from the MR system, either directly or indirectly, employees, subcontractors, and volunteers of facilities licensed by DPW and individuals or families who are their own providers. Even if an individual is receiving only case management services, all reporting requirements still apply.

Investigations. As noted above, investigations may be conducted by the provider, the county, OMR, or jointly. Only certain incidents require that the investigation involve both the provider and the county, i.e., injury resulting from restraint requiring hospitalization or emergency room treatment or treatment beyond first aid and an allegation of abuse involving use of restraint, or both the provider and OMR and/or the Department of Health (DOH) (with county participation as requested by OMR), i.e., deaths of provider residents. Reportable incidents in which the CEO or Board of Directors of an organization is the target of the investigation also require the county or OMR to investigate.

OMR has established a protocol for investigations that address conflicts of interest, establishing the purpose of the investigation, interviewing, gathering evidence, weighing credibility, and reporting findings and conclusions. The investigation record is to include the incident report, evidence, witness statements, and the certified investigator's report and is to be kept separately from the individual's record.[6]

Because providers are allowed to investigate incidents of abuse, neglect, and exploitation allegedly perpetrated by their own employees, some persons have contended that a conflict of interest is inherent in OMR's incident management system. Several officials and persons we spoke to, however, did not think this was a significant problem as DPW and/or the county have the option to conduct the

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[5]Available action includes, for example, the case of a child, MH/MR contacting Child Protective Services. The county does not, however, have any additional authority for adults between the ages of 18 and 59.

[6]Investigations are to be undertaken by certified investigators. Requirements for certified investigators include graduation from high school, being at least 21 years of age, meeting criminal background requirements, and completing OMR's required investigation training which includes the course "Conducting Serious Incident Investigation." Those who pass the training course are certified for three years, at which time a refresher course is required to be recertified.

investigation. Since an oversight mechanism is in place, they believe internal investigations are appropriate and have certain advantages in terms of promptness and familiarity with agency personnel and procedures. Some MH/MR offices we spoke with expressed similar points.

Number of Reported Incidents. Between January 2002 and the end of January 2003 (13 months), there were 37,000 incidents reported.[7] Of these incidents, about 2,600 were the result of abuse, neglect, or exploitation, with the remainder being instances of injury, accident, medication error, or other. Table 3 below shows the number of confirmed abuse incidents reported to OMR across Pennsylvania. In October 2002, a new abuse category–Individual to Individual–was added to the system. This occurs when an incident is between two people receiving services, for example, an altercation between two residents of a facility. The regular abuse category includes both abuse and neglect.

Table 3

MR Incident Management System
Confirmed Incidents, Statewide

	Abuse/Neglect	Misuse of Funds	Individual to Individual Abuse
Ages 18-59.....	2,297	127	81
Ages 60 and over.....	309	21	35

Source: Department of Public Welfare.

The MR Bulletin and protective services do not necessarily apply to all licensed facilities serving MR clients. Personal care homes serve MR clients but may not receive MR funds. Many of these clients receive funds through SSI or income maintenance funds rather than county MR funds.

Other Non-Covered Persons. We also note that in order to receive services under the MR system, an individual must be deemed mentally retarded by the age of 22. A person who becomes impaired after age 22, for example through Alzheimer's disease or a traumatic brain injury, would not be eligible for MR services.

DPW's Office of Mental Health & Substance Abuse Services. As of August 2003, DPW's Office of Mental Health and Substance Abuse Services (OMHSAS) was in the process of developing an incident management bulletin for providers of MH services similar to that developed for OMR (expected to be implemented in early 2004). Currently, OMHSAS has no specific reporting and investigating requirements beyond those in its licensing regulations. For example, community residential rehabilitation licensing regulations require providers to have a written policy prohibiting neglect, abuse, exploitation, or maltreatment by employees or other

[7]The 37,000 incidents represent incidents that are required to be reported under the bulletins. Some providers report more incidents than required, thus the actual number of reports is higher.

clients. This policy is to include procedures for investigating, reporting, and taking action on alleged violations of client rights. The results of these investigations are to be reported to the county MH/MR office. In general, OMHSAS licensees must comply with a patients' bill of rights, which includes not being subject to harsh or unusual treatment. However, no specific investigation and reporting processes are required by the regulations.

OMHSAS officials reported that there is some need for an APS within their client population, but not a great need. They anticipate that their new bulletin will be sufficient for clients of state-funded programs. OMHSAS reports developing this system not because there have been a high number of incidents, but because OMHSAS recognizes a gap in its services and is moving to close it. OMHSAS' system will cover all licensed providers, including intensive case management.

DPW's Personal Care Home Regulatory Program. Personal care homes (PCHs), sometimes called boarding homes or assisted living facilities, offer room and board and assistance with the activities of daily living (such as bathing, grooming, and meal preparation) for people who are aged, blind, disabled, or need assistance in order to live in the community. If four or more persons who are not relatives of the operator live at the PCH, it must be licensed by DPW. A PCH provides residents with assistance, as needed, with personal care services, including personal hygiene, activities of daily living, storing and offering medications at prescribed times, and personal finance. Residents must be 18 years of age or older. Both mobile and immobile residents may live at a PCH.

As of October 2002, DPW reported that there were 1,786 licensed PCHs, with a capacity of approximately 80,000 beds. Approximately 1,400 homes are operated for-profit, with the remainder operated as nonprofit. There are approximately 53,000 residents living in these PCHs.[8]

DPW's Personal Care Home officials report that they do investigate charges of abuse against individual PCH residents. However, since they do not have the authority to institute individual intervention or case management, they refer to the appropriate agency any resident who is in need of these services. DPW's role is to determine if a PCH is operating according to its licensing regulations (55 Pa. Code Ch. 2620). When DPW responds to a complaint, it investigates whether the PCH is meeting its regulatory and contractual requirements to provide a safe home for the residents, not as an advocate for a specific resident. A resident might remain at risk even though a formal complaint has been received and an investigation of the PCH begun because the Department is not authorized to invoke a separate intervention or protective services for the resident.

The PCH license is a business license which requires the operator to provide a safe, healthy and humane environment for its residents. While protective services

[8]Pennsylvania Bulletin, Vol. 32, No. 40, October 5, 2002, p. 4940.

or case management authority is not written into the regulations governing licensure, there is the legal base of the Public Welfare Code that mandates licensure as the standards of health, safety and welfare of PCH residents. In the case of a complaint concerning a resident who is a client of another social service agency, such as a county MH agency, who happens to live at a PCH, DPW will refer the complaint allegations to that agency prior to or during the investigation. That agency decides whether to undertake any remedial action, including investigating the report itself. If the client is over age 60, the Department of Aging (PDA) receives the report and conducts an investigation under OAPSA. Department (PCH) officials acknowledge there is no similar process for individual resident intervention and providing crisis case management services to adults under the age of 60.[9]

DPW does not maintain complaint data specific to age of the complainant. As noted, the complaint system in place is focused on determining whether the PCH is in violation of DPW's regulations focused on facility business practices. In CY 2001, DPW received 743 complaints from residents or their families regarding PCHs. In CY 2002, 792 complaints were received. In 1997, DPW and PDA jointly signed a Memorandum of Understanding to coordinate services and information sharing regarding personal care home residents who are at least 60 years of age. The agreement requires the staff of the two departments, as well as regional staff and AAAs, to coordinate investigative activities when there has been a complaint made against the operator or staff of the PCH to avoid duplication and to develop joint remedies. In FY 2000-01, approximately 6 percent of all APS abuse reports received by AAAs pertained to residents of PCHs; in FY 2001-02 this dropped to 5 percent.

Under PCH regulations, unusual incidents, defined to include among others, death, serious injury requiring hospitalization, complaint of resident abuse, and outbreak of contagious disease, are required to be reported to DPW's licensing field office. Written notice is required to follow within five days. The regulation does not require any action to be taken by the facility or the department. Amendments to these regulations are pending.[10]

DPW's Attendant Care Program. The purpose of the attendant care program is to enable adults ages 18-59 who are mentally alert and have physical disabilities to perform activities of daily living. These services allow eligible persons to remain in their homes and communities rather than in an institutionalized setting.

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[9]The Pennsylvania Health Law Project released a *Report on Pennsylvania's Personal Care Homes and Assisted Living Residences* publicly in October 2002. The report concludes that existing statutes and regulations are inadequate to guarantee that only facilities providing good, quality care are licensed and allowed to operate in the state. Additionally, the report concluded that DPW did not respond promptly to protect residents when violations were apparent. The report recommended substantial reform.

[10]Proposed regulations were published on October 5, 2002, 32 Pa.B. 4939. These proposed regulations are replacing the current personal care home regulations found at 55 Pa. Code Ch. 2620. These regulations are expected to be published as final in February 2004. The new regulations are intended to strengthen health and safety requirements for personal care homes by, for example, adding to the incidents that must be reported, expanding the regulatory rights of the residents by listing 28 specific residents' rights and mandating greater training and competency requirements for direct care staff.

Attendant care services include: in-home personal assistance services such as assistance with bathing, dressing, meal preparation, and housekeeping. These services differ from traditional homemaker and chore services in that they recognize the consumer's right to make decisions regarding the level and intensity of care.

Services are provided under Act 1986-150 and the Attendant Care Medicaid Waiver Program (ACMWP). If an individual is Medicaid eligible and meets all program criteria, they are serviced in the ACMWP. Individuals who are not Medicaid eligible or who do not meet the ACMWP criteria, but who meet all other need considerations, are served in the Act 150 Program. Although attendant care providers are not licensed, DPW monitors these agencies and has a toll-free line for complaints. If the Department receives a complaint, it requires the provider to review the situation.

Programs Administered by the Department of Health

DOH also licenses and regulates human service programs for vulnerable populations. The programs include home health care, long-term care, and drug and alcohol services.

Home Health Care Agency Licensure. A home health care agency is staffed and equipped to provide nursing and at least one therapeutic service to disabled, aged, injured, or sick persons in their residence. The agency may also provide other health-related services to protect and maintain persons in their own homes. According to the Pennsylvania Home Care Association, in CY 2000 these agencies served almost 353,000 patients. There are two types of home health care agencies:

- 280 *licensed agencies,* which are Medicare certified. Licensed facilities can be paid by Medicare and include skilled medical care and therapy of some type.
- 400 *unlicensed agencies.* They provide non-medical assistance, including activities of daily living (e.g., bathing, cooking.).[11]

Licensed home health care agencies provide and coordinate services for those consumers who need nursing and other health care services in the home as ordered/prescribed by the consumer's physician. These services, such as skilled nursing and skilled therapies, are provided by registered nurses and licensed health care aides who, in addition to personal care and daily living services, provide home health care services.

Licensed home health care agencies are regulated by the Department of Health. In 1998, the Department implemented a formal complaint response policy with 24 hour coverage. When a complaint is made and someone is in immediate

[11]House Bill 518 expands the types of agencies that would require licensing by the Department of Health. As of September 2003, the bill was under consideration in the Senate Aging and Youth Committee.

jeopardy or the agency's actions may be placing other patients in a situation constituting immediate jeopardy, an investigation is initiated within 24 hours, and an onsite investigation is to be conducted within two days. For a non-jeopardy situation, an investigation is to be initiated within two days; if warranted, an onsite investigation is to be conducted within eight weeks. If abuse by an agency employee is founded, DOH can investigate and take action against the agency. The Department reviews the provider's investigation to assure that appropriate action was taken and that, if the client was over 60, the incident was reported to the county AAA for protective services consideration.

DOH receives between 40-80 complaints per year pertaining to home health care agencies. Table 4 below shows the number and types of incidents and complaints received in CY 2002 related to protective services.[12] These are reported incidents only.

Table 4

Home Health Care Agencies
Type and Number of Reported Incidents
(Protective CY 2002 Services Related)

Type of Incident	Number of Incidents
Resident Abuse/Neglect	3
Care or Services	52
Death	1
Complaint of Patient Abuse	7
Misappropriation of Resident Property	1
Other	17
Total	81[a]

[a]Please note that CY 2002 represents higher than average complaint activity.

Source: Department of Health.

If an incident occurs and involves the home health care agency personnel, it is a relatively simple matter to remove the perpetrator from the home. The DOH can require that the person is no longer allowed in patients' homes. If the issue is a more systemic one, the DOH requires a plan of correction to address the deficiencies. Failure to correct the deficiencies could lead to license revocation. According to a DOH official, provisional licenses have only been issued two or three times in the past three years.

Auditor General's Report. In October 1999, the Auditor General released a performance audit of Home Health Care in Pennsylvania. The audit recommended that, although DOH generally ensured that minimum standards were met, the

[12]In years past, DOH received fewer complaints than in 2002, i.e., it received a total 60, 44, and 62 in CYs 1997, 1998, and 1999 respectively. DOH officials reported that recently implemented improved reporting systems account for the 2002 increase.

Department should go beyond those minimum standards to ensure better care and safety for home health patients. In addition, the report found that, when DOH did find deficiencies, it did not follow up on-site, but rather accepted self-certified compliance. The Auditor General found that DOH did not impose sanctions on home health care agencies for deficiencies.

In its response to this report, DOH stated it would develop a strategy to more effectively use the full range of sanctions consistent with the Health Care Facilities Act. According to a DOH official, two or three provisional licenses have been issued in recent years, and only these facilities have received monetary fines. The Department has also referred some home health care agencies with federal certification to the federal government, wherein termination of federal certification was recommended. It also reports an increase in site visits resulting from comments made in the Auditor General's report.

Long-Term Care Facilities. These facilities provide skilled and/or intermediate nursing care to two or more patients who are unrelated to the licensee for a period exceeding 24 hours.[13] Long-term nursing care facilities are licensed by DOH and governed by the long-term care facilities licensure regulations.

DOH has a complaint investigation process for these facilities, wherein all investigations must be initiated within two days of receipt so that the investigator is assured that residents are not in immediate danger and that an acceptable resolution is being formulated. Complaints can be received in a variety of ways--by telephone, written, from central office, or from the Auditor General. There is twenty-four hour coverage for receiving complaints. Complaint investigations can be augmented by other agencies, such as the Department of Aging.

According to the DOH's written policy, all complaints are to be answered promptly, evaluated for immediate jeopardy to residents and investigated in a timely and appropriate manner. The Department collects complaint data for trending purposes. Increased monitoring of a particular facility is initiated if the facility received 10 complaints within a 15-month period. The Department also monitors the complainants' satisfaction with the investigation, promptness of response, and notification of the outcome.

Table 5 shows the number of citations that long-term care facilities have received in recent years. The list is not comprehensive of all citations, however, because we have included only those that would have relevance to protective services. The data indicates that significant numbers of citations are issued to long-term care facilities.

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[13]Intermediate care facilities exclusively for the mentally retarded, commonly called ICF/MR, are not considered long-term care nursing facilities under this definition and are licensed by DPW.

Table 5

Selected Department of Health Citations to Long-Term Care Facilities

Type of Citation	Number of Citations[a]
Quality of Care	
Highest Practicable Well-Being	366
Supervision & Assistance to Prevent Accidents	361
Pressure Sores	151
Environment Accident Hazard Free	137
Long-Acting Drugs	106
Unable to Carry Out Acts of Daily Living Receives Services	71
Maintenance of Body Weight & Protein Levels	59
Incontinence Receives Treatment	58
Treatment and Services to Increase Range of Motion	51
Maintenance of Proper Hydration	43
Treatment & Services to Maintain/Improve Abilities	39
Special Needs	37
Medication Errors	35
Treatment & Services to Prevent Naso-Gastric Problems	30
Staff Treatment of Residents	
Report Allegations	216
Mistreatment, Neglect, Misappropriation	27
Resident Assessment	
Comprehensive Care Plans	187
Infection Control	
Est. and Maintain Control Program	101
Quality of Life	
Dignity	79
Accommodation of Need	52
Self-Determination & Participation	27
Physical Restraints	67

[a]Numbers of citations represent an average of two years, April 2001 to March 2003.

Source: Pennsylvania Department of Health.

After a citation is issued, the cited facility must issue a plan of correction. The time the facility has to comply depends on the type of citation and the severity of the incident. The facility is to be revisited by licensure inspectors and, if it remains noncompliant, sanctions can be issued, including fines, provisional licenses, and, in rare cases, closure. According to a DOH official, at any given time, about 35 to 40 of the approximately 750 nursing homes are on provisional licenses.

Office of State Long-Term Care Ombudsman. The Office of the State Long-Term Care Ombudsman is mandated by federal and state legislation. It is responsible for designing, implementing, and managing a statewide reporting and investigative system for complaints made by or on behalf of older consumers (it does not, however, have authority to investigate complaints of persons under age 60) of long-term care services. The Office establishes policies and procedures, ensures compliance with federal and state requirements, and analyzes and monitors federal and state legislation. Area Agencies on Aging (AAA) are designated by the

state legislation. Area Agencies on Aging (AAA) are designated by the Department of Aging to be the local providers of ombudsman services. The Office of the State Long-Term Care Ombudsman coordinates the efforts and functions of all Area Agencies on Aging to help ensure an effective complaint process at the local level. Responsibilities of AAAs include collecting and maintaining adequate complaint and case data; informing consumers; and ensuring that a minimum of one on-site visit is conducted per contract year to each licensed or certified long-term care facility. In FY 2001-02, ombudsmen made 15,798 on-site visits to such facilities.

The greatest numbers of adults with access to ombudsman services are older residents of 4,300 long-term care facilities with approximately 253,000 beds. In FY 2000-01, ombudsmen statewide responded to 6,252 complaints involving residents of long-term care facilities. In FY 2001-02 the number of complaints dropped to 5,723. Of all complaints received, 44 percent were made by a relative or friend, 23 percent by the resident themselves, and 11 percent by facility staff.

The majority of complaints (62 percent) involved residents in long-term care facilities. Residents of personal and domiciliary care homes were involved in 37 percent of all complaints. In classifying complaints, 37 percent involved residents' rights, 27 percent were complaints about quality of care, and 19 percent were complaints about residents' quality of life. Table 6 presents data on the total number of complaints received and verified in FY 2001-02.

Table 6

Complaints Received and Investigated by Ombudsmen Statewide
(FY 2001-02)

Facility Where Resident Lives	Total Number of Complaints	Total Number of Complaints Verified	Percent of Complaints Verified
Nursing Facility	3,531	1,697	48%
Personal Care/Dom Care Home	2,130	978	46
Other Residential Settings	62	32	52

Source: Pennsylvania's Long-Term Care Ombudsman Program, Annual Report FY 2001-02.

In instances where a complaint alleges abuse, neglect, or financial exploitation, the ombudsmen may refer the complaint to the appropriate office, such as the local Older Adult Protective Services Unit, e.g., a county AAA. Ombudsmen do not have direct authority to require action by a facility of long-term care services. The ombudsmen must work with the appropriate licensing agency to ensure effective enforcement. In FY 2001-02, less than 1 percent of complaints investigated by ombudsmen were referred to the APS program for investigation.

Auditor General Reports. The Auditor General has issued several reports relative to long-term care facilities. *A Performance Audit of the PA Department of*

Health's Complaint System For Nursing Home Residents and Their Families was issued in 1998 and found that DOH was late investigating complaints and would not assure families that it was providing the oversight necessary to ensure nursing home residents were receiving the quality care and services to which they were entitled. The report also found that DOH should strengthen its complaint prioritization process and that monitoring of complaints was not effective or consistent.

A 2000 report, *A Follow-up Performance Audit of Nursing Home Oversight,* found the complaint system much improved with twenty-four hour operations, increased initial investigation time, and went beyond the requirements of its complaint policy by conducting most investigations on-site. However, the report also found that DOH had failed to impose sanctions in cases of egregious violations and that, when imposed, sanctions were applied inconsistently.

According to a Department official, the Auditor General's reports have been the impetus for changes in their systems and, in response to this report, a better system for reviewing long-term care facilities has been developed, with an additional supervisory layer of field managers being added. This helped to provide better oversite and to help reviewers with decision making in the field. In addition, DOH purchased new technology to better track complaints and for better follow-up to the complainant.

Department of Aging Domiciliary Care Home Certification

Domiciliary care is a supervised living arrangement in a home-like environment for adults 18 and over (no more than three adult residents are permitted) who are unable to live alone because of demonstrated difficulties: (1) in accomplishing activities of daily living; (2) in social or personal adjustment; or (3) resulting from disabilities. Local Area Agencies on Aging are responsible for assessment and placement of residents in domiciliary care homes. They also certify domiciliary care homes.

Residents are eligible for a state-funded domiciliary care supplement payment if they are eligible for Supplemental Security Income (SSI) or have an income less than the combined federal/state payment for domiciliary care and are not related to the provider. People who are not eligible for the supplement may reside in domiciliary care homes as private pay residents. Domiciliary care homes are mandated by OAPSA to report any suspected abuse of residents, regardless of age, to the AAA that serves their county. However, they can only conduct investigations and provide services under OAPSA to residents aged 60 and older. For individuals under age 60, the AAA conducts investigations under its domiciliary care regulations. The AAA care manager can relocate the resident as one response to a report of abuse, and PDA officials pointed out that domiciliary care residents typically are clients of other human services which provides them at least some additional

protections. Fewer than one-half of one percent of APS abuse reports forwarded to AAAs originated from domiciliary care homes in FY 2000-01 and in FY 2001-02. Abuse reports substantiated involving domiciliary care residents were 0.7 percent in FY 2001-02, for a total of approximately 90 cases.

Other Protective Service Programs and Activities

In addition to the regulatory requirements of specific social service programs, several counties operate limited protective service programs for persons aged 18-59, and some protections are afforded through Pennsylvania Protection and Advocacy and the Pennsylvania Crimes Code.

Protective Services Through the Human Services Development Fund[14]

The Human Services Development Fund (HSDF) was established by Act 1994-78 and is administered through DPW's Office of Social Programs. It provides flexibility to accommodate local needs and priorities within and between seven categorical human services programs: Adult Services, Aging, Children and Youth, Drug and Alcohol, Homeless Assistance, and the Community Mental Health and Mental Retardation Programs. DPW allocates appropriations among the counties by formula to serve multiple purposes and client populations, unlike categorical funding which is focused on only one client population. Decisions on which programs to fund with HSDF dollars are made at the county level.

Many HSDF-funded services are available through county adult services programs, including: adult day care, adult placement, counseling, home-delivered meals, housing, life skills education, and transportation. Some counties have used their HSDF funds to establish an adult protective services program. Table 7 shows the total clients served and total expenditures for adult services for the past several years.

[14]During this review the FY 2003-04 budget reduced HSDF state funding levels by 90.5 percent, from $36.8 million to $3.5 million. Restoration of at least some of these funds is under consideration by the Governor's Office and the General Assembly, as of early September 2003.

Table 7

Adult Services Provided With HSDF Funds

	Adult Services		Adult Protective Services	
	Clients Served	Expenditures	Clients Served	Expenditures
FY 1998-1999.....	79,188	$10,532,622	638	$391,774
FY 1999-2000[a].....	92,719	10,902,187	598	368,956
FY 2000-2001[a].....	90,426	11,074,708	536	364,896
FY 2001-2002[a].....	105,655	11,701,300	591	380,637

[a]These figures were provided by DPW in draft form.

Source: Department of Public Welfare, Office of Social Programs.

According to DPW, as of FY 2001-02, seven counties have chosen to use some of their HSDF funding to provide protective services to adults, aged 18-59. These counties are Butler, Centre, Erie, Lehigh, Northumberland, Philadelphia, and Westmoreland. Table 8 shows the number of clients served and associated expenditures for the past three fiscal years. Please note these are solely HSDF expenditures and that counties may also use additional local monies to supplement state funds.

Table 8

County Adult Protective Services – Clients Served and HSDF Expenditures

	FY 1999-2000		FY 2000-2001		FY 2001-2002	
County	Clients	Expenditure	Clients	Expenditure	Clients	Expenditure
Butler.....	68	$ 31,258	65	$ 27,686	65	$ 30,190
Centre	15	2,791	9	1,839	4	1,332
Dauphin.....	2	3,280	1	1,040	0	0
Erie.....	42	25,482	32	25,482	52	25,992
Lehigh	67	82,985	45	98,152	62	80,982
Northumberland	105	42,788	119	43,488	112	48,341
Philadelphia.....	291	141,621	257	124,699	288	150,205
Westmoreland.....	8	38,751	8	42,570	8	43,595
TOTAL.....	598	$368,956	536	$364,896	591	$380,637

Source: Office of Social Programs, Department of Public Welfare

The figures above, however, are somewhat misleading because the counties vary widely in the services they provide. Some use these funds for representative payee programs or to provide meals to incapacitated people between the ages of 18 and 59.[15] Additionally, in almost all counties we spoke to, if a call comes into a AAA regarding an individual under 60, the caseworkers and intake people refer the

[15]A representative payee is a person authorized to provide financial management for social security and SSI payments for beneficiaries who are incapable of managing their payments.

person to other human service agencies and services to obtain help. Counties using HSDF for protective services include:

Butler County. Butler County serves individuals through HSDF as a representative payee, with about 100 people in its program. The county estimates that aiding people in paying their bills and enabling them to keep their homes saves other human services costs that these people will likely not need. Butler also has an informal guardianship program for those who are 18-59.

Centre County. Centre County uses some of its HSDF funds for certain adult services and has an Adult Services Office. Centre County reports that the majority of adult services clients have mental or physical disabilities requiring services such as homemaker services or housing assistance. The Adult Services Office undertakes home assessments for adults and refers them to appropriate social services agencies.

Erie County. Persons served under the HSDF protective services category receive shelter and transitional housing. Domestic violence victims are generally the population served. Erie County served 52 clients with these services in FY 2001-02, up from 32 the year before.

Lehigh County. The county's Aging and Adult Services Office provides both protective and guardianship services to any adult regardless of age. Two staff members are assigned to investigate APS reports for the adult population under age 60. In FY 2001-02, Lehigh used approximately $81,000 in HSDF funds to provide protective services for 62 adults under age 60. The protective services provided to 18-59 year old adults and adults over age 60 is the same; however, there is a limit on the amount of services provided to younger adults because of funding constraints. Investigations of reports of abuse are undertaken in both homes and facilities; however county officials return to a facility once investigated to assure that substantiated problems have been rectified.

The Aging and Adult Services Office is also the guardian for adults when no other individual or agency is available. In April 2003, they were guardians for 58 adults, five under the age of 60. They were also representative payee for 125 adults, of which one-third were under age 60.

Northumberland County. In Northumberland County, HSDF expenditures are used mostly for at-home meals for people between the ages of 18 and 59. In addition, at times, the Adult Services Office receives calls from people with little or no income who are in desperate need for a particular medication. The Office reported that it often agrees to pay for such a prescription.

Philadelphia County. Philadelphia provides adult protective services through its Office of Emergency Shelter and Services. APS in Philadelphia includes field investigations of all reports of abuse, neglect, abandonment, or exploitation of adults, ages 18-59; social casework, case management and coordination with other providers and agencies; representative payee services; assistance with filing protection from abuse orders; and filing of involuntary medical and psychiatric commitments or other court ordered interventions. During FY 2001-02, the APS unit reports having served an average of 74 clients per month. Protective services plans are developed for each client and are reviewed every six months, if necessary. A part of these plans is to

transfer clients to other city agencies and services. When an adult is stabilized, the APS unit continues with case management services until a permanent placement is made or independent living is achieved.

Philadelphia reports spending approximately $450,000 on APS. Of this, about $350,000 is expended on salaries and benefits and $100,000 in residential costs related to APS. One county official estimates that $450,000 is low because it does not capture the operating costs for many of the other services provided to APS clients. Philadelphia received about $150,000 in HSDF funds for FY 2001-02.

Westmoreland County. With HSDF funds, the Westmoreland County AAA has provided limited protective and guardianship services to adults aged 18-59. During FY 2001-02, the AAA received 53 referrals under age 60; the guardianship unit managed between seven and ten cases. The county reports that the program is patterned after the one mandated under OAPSA, to the extent that it can be without legislation and funding.

As in other counties, due to lack of statutory authority, the county has no standing to obtain a court order to enter a home as they do for the over 60 population. If a report comes in from an MR registrant residing in a facility who is under 60, the AAA turns the case over to the MH/MR office. But if the report is in regard to a home-based person, it would be assigned to an aging counselor for investigation. Guardianship services, provided in Westmoreland County since 1984 for those under age 60, are provided by the AAA. Since 1995, 20 people have received guardianship services.

Although we did not survey each county, we found that several other counties are providing some protective services, but not using HSDF funds to do so. In Allegheny County, protective services for the 18-59 age group are provided through Allegheny Crisis and Emergency Services. This is funded through Community Care Behavioral Health Organization and is based on a managed-care model. Example activities include emergency in-home evaluations, placements, referrals for services, facilities and programs, and plan development.

In Beaver County, some adult protective services are provided to mentally retarded persons, aged 18-59, through the county's Arc, and, similar to Allegheny County, HSDF funds are not used. Arc provides advocacy services, attempts to obtain MR services if not previously received, tries to safely place an individual who is in danger, and sometimes obtains power of attorney for clients. The Beaver Arc is the county's contractor for protective services under OAPSA as well.

Pennsylvania Protection and Advocacy, Inc. (PP&A)

PP&A, Inc. is an independent, nonprofit agency mandated by federal law (i.e., Developmental Disabilities Assistance and Bill of Rights of 2000, Protection for Individuals with Mental Illness Act and Protection and Advocacy for Individual Rights) to investigate abuse, neglect, and rights violations. The laws require the agency to be independent from any agency that provides treatment or services and

to have the authority to take necessary steps to address issues related to abuse, neglect, and rights violations.

The PP&A is federally funded and is authorized to have access to the individual, the facilities providing care to the individual, and the individual's records. According to PP&A staff, however, they do not have authority to remove an individual from the home or facility. The individual, a relative, or a case manager of the individual (if the individual is in service) must authorize access to the home. Due to staffing limitations (approximately 35 staff statewide), the PP&A conducts limited investigations. Instead, the staff works through the systems already in place by referring the issue to the licensing agency, assisting clients in filing complaints, and following up on investigations conducted by other agencies.

Throughout our review, various persons and organizations emphasized the authority and potential impact of the activities and services provided by the Protection and Advocacy network. Some suggested that because of the network, additional protections through a separate authorized program are probably not needed. Our conversations with PP&A staff and related groups, however, indicated significant limitations to PP&A's authority and work, in part due to staffing constraints. Additionally, PP&A staff pointed out that their focus is essentially to evolve systemic change and additional protections—not to focus on advocating for an individual case situation.

Criminal Justice System

The Pennsylvania Crimes Code, at 18 Pa.C.S.A. §2713, defines the offense of neglect of a care dependent person. Since 1998, 127 cases have been prosecuted under this section of the Crimes Code (a case may have multiple counts of the same charge). A care-dependent person is defined as any adult who, due to physical or cognitive disability or impairment, requires assistance to meet his needs for food, shelter, clothing, personal care, or health care.

A caretaker is guilty of neglect of a care-dependent person if he:

- Intentionally, knowingly, or recklessly causes bodily injury or serious bodily injury by failing to provide treatment, care, goods or services necessary to preserve the health, safety or welfare of a care-dependent person for whom he is responsible to provide care.
- Intentionally or knowingly uses a physical restraint or chemical restraint or medication on a care-dependent person, or isolates a care dependent person contrary to law or regulation, such that bodily injury or serious bodily injury results.

A violation of the first subsection constitutes a misdemeanor of the first-degree if the individual suffers bodily injury and a felony of the first-degree if the individual suffers serious bodily injury. A violation of the second subsection

constitutes a misdemeanor of the first-degree if the victim suffers bodily injury and a felony of the first-degree if the victim suffers seriously bodily injury.

A caretaker is defined as any person who:

- is an owner, operator, manager or employee of nursing home, personal care home, domiciliary care home, community residential facility, intermediate care facility for the mentally retarded, adult daily living center, home health agency or home health service provider whether licensed or unlicensed;
- provides care to a care-dependent person in the settings described in paragraph (1); or
- has an obligation to care for a care-dependent person for monetary consideration in the settings described in paragraph (1) or in the care-dependent person's home.

The Departments of Aging, Health, and Public Welfare are required to report immediately to local law enforcement or the Office of Attorney General if, in the course of conducting a regulatory or investigative responsibility, they have reason to believe that a care-dependent person or persons residing in a facility have suffered bodily injury or have been unlawfully restrained. District attorneys, as well as the Attorney General, have the authority to investigate and institute criminal proceedings.

The act provides affirmative defenses for the caretaker; for example, lawful compliance with a care-dependent person's advance directive for health care. Although the act applies to all care-dependent persons regardless of age, it does not apply to persons other than paid caretakers. Therefore, family member abuse or neglect may not be prosecuted under this section. Family members may, however, be prosecuted for other criminal offenses, e.g., assault.

In addition, the Protection From Abuse Act, 23 Pa.C.S.A. §6101 et seq., applies to all people regarding potential abuse or injury that may occur in their homes, and allows courts to issue protection orders to victims of abuse against family or household members, sexual or intimate partners or biological parents. Proceedings under the act may be initiated by an adult or emancipated minor for that person or by any parent, adult household member or guardian ad litem for a minor child, or by the guardian of an adult who has been declared incompetent. The order may include directing the defendant to refrain from abusing the plaintiff, awarding temporary custody of children or removing the defendant from the household, among others. Law enforcement officers are required to provide the abused person with oral and written notice of the availability of safe shelter and of domestic violence services in the community including the hotline number for domestic violence services. Violations of the orders can result in arrest, contempt of court, private criminal complaints, and civil contempt.

This act, however, does not provide protection from abuse by caregivers, certain relatives, or unrelated individuals who do not reside in the household or have an intimate relationship with the victim. Senate Bill 158 seeks to amend this act to include abuse by a caretaker of a care-dependent person defined as an "adult 60 years of age or older who, due to physical or cognitive disability or impairment, requires assistance in meeting needs for food, shelter, clothing, personal care or health care."

Programs, such as those against domestic violence, provide a degree of protection to vulnerable adults. Rape crisis and domestic violence services are made available to residents of all of Pennsylvania's counties through grants with the Department and the Pennsylvania Coalitions Against Rape and Domestic Violence. The coalitions maintain a county-by-county breakdown of services they provide.

III. Additional Evidence of the Need for a Protective Services Program for Persons 18-59 Years Old

As described in Chapter II, significant gaps exist in the protections currently available for persons between the ages of 18 and 59 with physical and cognitive impairments. Among the most significant gaps are (1) people who are not receiving services though a state-licensed or state-funded program and therefore do not have the protections built into these programs; (2) situations in which the abuse or neglect occurs at the client's private home and the homeowner refuses to allow investigators into the house; and (3) clients living in state-licensed facilities where the licensing agency may cite the facility for not providing appropriate care, but the agency does not have authority to deliver protective services to the affected client.

In addition to identifying these gaps, we also sought to assess the need for an adult protective services (APS) program by reviewing statistics on reports of neglect and abuse received by the Department of Aging and other states that offer protective services to 18-59 year olds, obtaining comments from state and county officials and other advocates and stakeholders, and identifying case studies of individuals who could benefit from an adult protective services system.

Possible APS Cases Reported to the Department of Aging

During FY 2001-02, the Department of Aging received 716 reports of possible neglect or abuse of adults under age 60. Although this represents only 5 percent of all reports of need for protective services received by the Area Agencies on Aging (AAA), Department staff acknowledges that there could be many others that were never reported by the AAAs. For example, if the AAA is able to resolve the complaint by referring the caller to another agency for help, it might not forward the report to the Department. In addition, several AAA directors told us that the police and other agencies know that the AAAs have no programs for persons under age 60 and therefore do not refer such cases to them.

In some cases, the Department of Aging refers reports it receives to other state agencies. But often reports remain in the Department with no further action being taken. The Department also does not require that AAAs report where they referred such cases. In meetings and telephone calls with individual AAAs, we found that once a referral is made to another agency, the AAA is not responsible to ensure that services are provided. Some AAAs we spoke with said they informally follow-up with a telephone call to the agency to try to ensure that some type of service was provided.

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APS Cases Reported in Other States

In a report released in April 2003, the National Association of Adult Protective Services Administrators (NAAPSA) reported that in 2000, 396,187 elder/adult abuse reports were investigated nationwide. Investigations resulted in a total of 166,012 reports being substantiated, for an overall substantiation rate of 42 percent. Only 29 states provided a breakout of their substantiated reports by age. For the 21 states that reported for 18 to 59 year old programs, a total of 38,725 (30 percent) involved adults from the ages of 18 to 59, and 88,453 (70 percent) involved adults age 60 and over. For the forty states reporting (and including persons over age 60), self-neglect (42 percent), physical abuse (20 percent), and caregiver neglect (13 percent) were the most common occurring substantiated allegations of abuse.[1]

Comments From Stakeholders

We met with a variety of stakeholders during this review. In general, the persons we interviewed believe there is a need for some type of APS program for physically or cognitively impaired individuals. While the need may not be overwhelming in terms of numbers of people who would require APS services, for those who need these protections the need can be great.

As discussed below, several organizations expressed concern that any APS program the Commonwealth would establish should have strong civil rights protections. One organization was opposed to an APS program that would cover persons registered in a state-funded mental retardation program, citing the several levels of protections that already exist in this system. In addition to state and county officials, included among the organizations we contacted and who provided us with comments were:

- Area Agencies on Aging
- Center for Independent Living of Central Pennsylvania
- Coalition for Personal Care Home Reform
- Developmental Disabilities Council
- Mental Health Association of SE PA
- MH/MR Administrators Association
- National Citizen's Coalition for Nursing Home Reform
- PA Association of Resources for People with MR (PAR)
- PA Community Providers Association
- PA Council on Independent Living
- PA Health Law Project
- PA Homecare Association
- PA Protection and Advocacy
- United Cerebral Palsy of Central PA (UCP)

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[1] *A Response to the Abuse of Vulnerable Adults: The 2000 Survey of State Adult Protective Services,* The National Association of Adult Protective Services Administrators, April 2003. The reporting year differs from state to state. States provided data for the most recent reporting year that data was available. For purposes of our report, we make the assumption that any data that we report or comment upon reflects conditions as they were in the year 2000.

Comments From State and Local Officials

Department of Aging. Various Department of Aging officials see a need for an 18-59 year old adult protective services program, citing their lack of authority to investigate serious abuse/neglect situations for persons under age 60. At a minimum, they believe the Department should have the authority to follow up on those cases it refers to other agencies. (See also Department of Aging comments as regards administrative placement of such a program in Chapter IV.)

Department of Public Welfare. Officials in the Department of Public Welfare (DPW) indicated a need for improvement and better coordination within and among the various human services programs the Department licenses and regulates. While recognizing that gaps in protective services still exist, they point to the significance of the recent Incident Management System in the Office of Mental Retardation. The Department plans (as discussed in Chapter II) to make similar improvements in other human services systems, such as mental health and personal care homes. They see a need to maintain responsibility for their human service clients to the extent possible, while recognizing the need to assure independence in APS investigations and actions.

While the DPW officials we spoke to believe there is a need for a more formalized protective services system, they cautioned against a redundant and overly bureaucratic program. They would like to see such any APS program the Commonwealth might enact coordinate closely with their Department's existing regulatory and licensing systems.

County MH/MR Offices. Most county MH/MR officials we spoke to agree that the MR population is vulnerable to neglect and abuse and would benefit from an APS program. In certain cases of 18-59 year olds who are being abused or neglected, MH/MR offices have no authority for a legal intervention and can be refused access to individuals who are living at home, even if they have been receiving services. One county tries to obtain guardianships for the most vulnerable of this population, even though it may not necessarily be the least restrictive option, because they have no other way to ensure that abuse and neglect will be stopped. Two MH/MR offices, however, did not see a need for a protective services system. In one of the offices, they estimate that only about 10 people per year might need the service. Another county official expressed concern that, if an APS were implemented, abuse might increase as a way to quickly enter the publicly funded human services system.[2]

Most of the MH/MR offices we spoke to have waiting lists for their services; the Pennsylvania Association of Resources for People With Mental Retardation

[2]As happens in other human services systems, such as drug and alcohol services, sometimes people who are desperate to obtain services will cause deliberate harm to themselves or others to receive such services.

(PAR) estimates that there are 20,000 people on waiting lists statewide who are not receiving any services. PAR believes that additional services are needed for those on waiting lists and that these needs should be addressed before any other services, i.e., a new protective services program, are implemented. However, according to one county official, the MR waiting list is designed so that individuals in crisis situations are bumped to the top of the list and that if a person is in need of protective services, one could generally conclude that he or she is in crisis and would, therefore, soon receive services.

Area Agencies on Aging Adult Protective Services Personnel. In early 2003, we interviewed key staff responsible for administering APS at the county level. We made visits to 13 AAAs to gain an understanding of how their programs function and whether they saw a need to expand the APS program to adults under age 60. We made telephone calls to an additional 17 AAAs to obtain comments about the possibility of establishing a similar program for adults under age 60. Key findings from these interviews include the following: (See also Exhibit 4 for further information.)

- Only 2 of the 30 AAAs we contacted reported providing protective services to adults under age 60. Because funding from the Department of Aging is restricted to adults 60 and over, AAAs providing such services use Human Services Development Fund (HSDF) monies and other money raised locally. The services that can be provided are limited, however, because funding is low.
- 19 of the 30 AAAs see a difference between the needs of adults under age 60 and those 60 and over. Six AAAs believe that the differences are minimal and five AAAs gave no response to this question. They generally agreed that younger adults have more issues with drugs and alcohol than older adults. Older adults tend to be frailer, which makes it easier to work with that age group, as they are not as mobile. There are also more financial management issues with adults under age 60 because they tend to be less frugal than older adults. Disabled persons who are being abused may also be hesitant to report such abuse for fear of losing their independence.

Emphasis on Coordination Among Human Service Agencies. As noted in Chapter II, the Departments of Health and Public Welfare have inspection and investigation requirements related to the facilities and providers they license, and they are concerned that any APS system not duplicate functions within and among their agencies. OAPSA addresses this issue in part by requiring reports involving state-licensed facilities to be investigated under procedures developed by the Department of Aging in consultation with the licensing agency.

Department of Aging regulations require that OAPSA investigations be coordinated with the licensing agency, including notification of the investigation and ongoing contact to assure the agency is fully informed of the activities, findings, and

Exhibit 4

Selected Comments of Area Agency on Aging Directors and Staff

- Of all existing agencies that could potentially take on investigations of the 18-59 age group, the AAAs are probably the best equipped to do so. If they had sufficient budgets, taking on this responsibility should be no problem. The mental health system generally does not respond as fast to reports of abuse, and because their caseloads are so high, it is often difficult for them to undertake timely and sufficient investigations.
- Another thing to remember in developing a program is that staff would likely have to be on call 24 hours per day. Not only do you need someone answering the phone, but someone to provide the ancillary services as well. This is also an issue because AAAs that hire from within the state civil service system are having trouble finding qualified and decent employees. We never get anyone good from the lists and you definitely need people with some PS experience.
- The Aging and Adult Service Office is really the only agency providing APS for anyone in the county. We have seven hospitals in our county, one of which is a rehab hospital, which draws people for services. Once they come, many decide to stay. We therefore have a significant population of adults under age 60 who have service needs and at times need APS.
- We are frustrated that we do not have the same type and level of authority when investigating under 60 allegations of abuse that we do with the 60 plus APS program. There should be legislation enacted that would give us the same level of clout that is allowed under OAPSA. Another frustration is that adults under age 60 often do not meet the need for services from established social service agencies, but still need assistance. For example, persons with brain injury generally do not meet the minimum criteria for service, but still could benefit from care management, meals, and other services that would be available if they were 60 or older.
- I have a big concern for the under 60 population, especially those 50 years old to 59 years old. There are a number of people in this age group that are in need of services in general. Often people in this age group experience abuse from others or self-neglect and need immediate intervention that would be available through APS if they were age 60. At the same time the AAA is stretched to the maximum already just to provide services to the 60 and over population. Even apart from a discussion of whether or not it is appropriate for them to take on additional APS responsibilities for a younger population, the question of adequate funding would have to be discussed.
- We are not guardian for anyone under age 60. We have been asked about it but have always said "no." The main reason is that the people in the community are the tougher cases, and that is where the majority of younger adults are, even those who would qualify for guardianship. Often it is the family that is the real problem to deal with. Their APS numbers are low because they do everything they can to keep a person from having to need APS in the first place. They receive approximately 50 to 60 reports a year and after investigations, determine that about half are justified and need APS or some regular services from the AAA. For those they are able to keep off APS, they treat as case management cases. They might receive services from the AAA, but they would not be considered APS services.
- The AAA would be the most logical place to put an 18 to 59 APS program. However, there would still be a need for quality service checks of whoever provides the service locally, especially if the county decides to contract it out. I would have a problem with the Human Services Office taking on APS, as well as MR as they do not provide quality services already to their existing clientele.
- We do not provide APS for adults under the age of 60. There is no real need for such a program in their rural area, regardless of where it would be placed administratively.

Exhibit 4 (Continued)

- With 18-59 year olds, there is no standing to obtain a court order to enter the home, which is the major difference between the two age groups. There is a need for a formal APS program. The needs of the 18-59 year old population are more complex. The level of services and the intensity of services are greater than the over 60 population.
- The 18 to 59 populations tend to have significant drug and alcohol issues. Additionally, there are recurrence issues, unlike the aging system; and they may not be able to "solve" the problem.
- Can be very frustrating for the under 60 population. No one wants to be responsible for them and no one has the authority to intervene with them if they refuse help.
- The disabled are especially vulnerable when it comes to sexual assault. They are often afraid to report it and therefore have nowhere to go. The reality is that many disabled are abused but do not want intervention because they are afraid they will lose their independence. When it comes to the mentally retarded, there are often cases of family not taking the person to doctor's visits or to the hospital when they should.
- The most prevalent APS services needed are respite care, home health aides and adult day care. Often abuse by family members occurs because they are simply exhausted with dealing with the client's physical and mental problems on a daily basis. Getting alternative services often stops the abuse. Financial exploitation is becoming more and more of a problem. Physical abuse is second to financial abuse. It can take months to investigate these cases.
- Lack of an APS program for adults under age 60 is a real concern. Even if it's only one to two people per year, the need is there. It is long overdue.
- There is a significant need for an 18 to 59 APS program. However, it would involve a whole different level of service modality. Younger adults are more active and mobile; there are more drug and alcohol issues, some move from friend to friend in a transient lifestyle. Certainly there have been cases where family and acquaintances have taken advantage of these people.
- There is a real need for services for adults under age 60. We receive telephone calls consistently requesting crisis intervention for people under 60, and there is no entity to provide those services. If MH and MR can not or will not provide service there is nowhere else to go. If we could at least provide case management to younger adults, that would be an improvement. At least a case manager could coordinate services for a client and is more aware of other service options that might be available.
- These people, adults under age 60, fall through the cracks unless they are MH/MR eligible or experiencing domestic violence that might make them eligible for help from the victim assistance office. However, who is going to pay for the on-going services if such a program is mandated?
- Guardianship court orders are the immediate need. There are many people who need protective services help who are in their 50s. Since January 2003, we have received reports of four or five adults in their 50s that could have been helped if they were 60.

Source: Questionnaire responses and in-person staff and telephone interviews with AAAs.

results of the investigation. This process is "to avoid duplication of effort and to foster jointly developed remedies to situations requiring protective service interventions." According to both Aging and DPW officials, this coordination of activities is, in fact, not frequently undertaken, but officials suggested that they would like to reduce redundancy and improve coordination in the future. The Departments of Health and Public Welfare support a similar process to help ensure investigations are coordinated, perhaps through a Memorandum of Understanding between the APS agency and each of the licensing agencies.

Advocacy and Provider Groups

Virtually all the advocacy groups with whom we spoke agreed that there is a need for an APS program for 18-59 year olds, provided that the APS systems not infringe on an individual's right to make independent decisions. One major provider association, the Pennsylvania Association of Resources for People with Mental Retardation, believes sufficient protections already exist within the MR system and that another protective services program could be counterproductive.

Coalition for Personal Care Home Reform. The Coalition is comprised of representatives from 13 nonprofit organizations[3] who represent/advocate for residents of personal care homes. The Coalition strongly agrees with and supports the implementation of an APS program, specific to abuse, neglect, and exploitation by caretakers, noting that its members have provided legal services to many vulnerable individuals between the ages of 18 and 59, particularly residents of personal care homes, who need such a program. The Coalition believes "one of the most fundamental rights of an adult protective services program must be the person's right to refuse some or all protective services." The coalition believes such a program should be administered by an independent state-level office and that any funding dedicated to implementing an adult protective services program should not replace money or other resources available for other services the individual may be entitled to receive.

Arc of Pennsylvania. Arc, an advocacy organization for the mentally retarded, also strongly supports establishing a protective services program in Pennsylvania and cites certain elements to be included to ensure an effective program. These include:

- the capacity to consent, in that courts should be allowed to order emergency protective services, but with a time limit, and that adequate legal counsel be appointed;

[3]Coalition members include: The Advocacy Alliance, The Arc of PA, Center for Advocacy for the Rights and Interest of the Elderly, Elderly Law Project of Community Legal Services, the Homeless Advocacy Project, Mental Health Association of Fayette Co., Mental Health Association of SE PA, Nami PA Montgomery Co., PA Health Law Project, PA Mental Health Consumers Association, PA Protection and Advocacy, and PA VA Medical Center – Behavioral Health.

- that education and training should be provided to abuse investigators, families and people with disabilities, service providers and supports coordinators, and criminal justice personnel;
- that the least restrictive intervention be mandated by an APS statute and that institutionalization must not be an option;
- that the APS agency have certain responsibilities; and
- that an APS program be administered by an independent state-level office, because of the conflict of interest inherent in a program whereby funding is provided by the same entities that are providing services.

PA Council on Independent Living. A representative from the Council on Independent Living said that, while they can see the need for a protective services program for younger adults, physically disabled persons typically are able to make more decisions about their needs and, therefore, have less of a need for external protections. They believe any APS program that would include the physically disabled population would need to have clear and strong provisions to protect individual rights and individual choice. There is also a concern that an APS program would take away funding from what are more necessary programs, such as Attendant Care Program.

PA Association of Resources for People With Mental Retardation (PAR). Although PAR supports the goals of HR 590 "because all people in the Commonwealth should be free from imminent risk of death or injury due to a physical or cognitive impairment, neglect or abuse," it does not support the creation of a new program that would offer protective services to adults. PAR believes sufficient protections currently exist, especially through the MR Incident Management Bulletin and other pertinent state and federal laws and regulations. PAR's positions include that:

- additional services are needed now for people with MR on waiting lists and the General Assembly should take action to fund services for those with identified needs;
- the most appropriate administrative structure for abuse and neglect reporting for people with MR is the Office of Mental Retardation; and
- any statute mandating an APS program should exempt people with MR who are eligible for or are receiving services through the mental retardation system.

Additionally, PAR is concerned that ". . . additional requirements may promote the type of confusion, delay and unnecessary costs that prompted passage of Act 171 . . . to exempt facilities that are licensed or funded by the Department of Public Welfare from the duplicative abuse reporting requirements of the Older Adults Protective Services Act for people with mental retardation who are under age 60."

Case Studies

Through our fieldwork, interested persons provided us with examples of case studies of impaired persons who they believe could have benefited from an adult protective service program. These persons have a variety of impairments that prevent them from living independently, including mental retardation, physical problems, mental health problems, and traumatic brain injury. Several of these individuals have multiple diagnoses. Exhibit 5 provides brief descriptions of some of these cases.

Pending Legislation

House Bill 1925, introduced in August 2003, establishes protective services for adults with developmental disabilities to be administered by DPW.[4], [5] Although many of its provisions are substantially similar to OAPSA, e.g., reporting, investigating and access authority, it differs in several ways. HB 1925 does not:

- include the criminal history check for employees of facilities; and
- exempt facilities providing services to individuals with mental retardation in residences licensed by DPW or funded through a county mental retardation program from mandatory reporting requirements.

The bill also does not specifically cover persons with physical disabilities or who have mental health service needs. DPW officials expressed general agreement with the provisions of the bill but informed us that they expect the recommendations pursuant to HR 590 may affect the final approach to protective services. They suggested that an APS program probably should also cover a broader range of persons.

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[4]Developmental disabilities are defined in the bill as a severe, chronic disability of an individual that: (1) is attributable to a mental or physical impairment or combination of mental and physical impairments; (2) is manifested before the individual attains the age of 22; (3) is likely to continue indefinitely; (4) results in substantial functional limitations in three or more of the following areas of major life activity: (i) self-care; (ii) receptive and expressive language; (iii) learning; (iv) mobility; (v) self-direction; (vi) capacity for independent living; and (vii) economic self-sufficiency; and (5) reflects the individual's need for a combination and sequence of special, interdisciplinary or generic services, individualized supports or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

[5]"Care-dependent individual" is defined as an adult who has a developmental disability that is attributable to a mental impairment that begins before age 22 and that results in substantial functional limitation in three or more areas of major life activity.

Exhibit 5

Selected Case Studies
Individuals Who Are in Need of Adult Protective Services[a]

Female, Age 19.

- Went from foster placement and was adopted (natural parents deceased); diagnosis of mental retardation, with an IQ of 42 and a mental age of seven and a half. Referred to by her family as the mortgage child, since her benefits went toward the house payment, rather than her care.
- Was restricted to a basement with only a cot-type bed and portable toilet and forced to shower outside. She was sexually, physically, and financially abused by her stepsister's boyfriend, forcing sexual activity and injecting her veins with beer. There was no interaction with schoolmates, neighbors, etc.
- Originally lived in one county and was placed in another. CYS in the first county was not helpful and the second county's CYS had no knowledge of her. Monitoring was non-existent.
- GAP: This person was not registered in the MH/MR system.

Three Young Adults

- All three have severe/profound mental retardation and live with their family in substandard housing, infested with rodents and bugs. They are in ragged clothing, while the son without MR wears expensive clothing.
- Their mother was arrested for cashing her deceased husband's SS checks. One of the young adults got a severe burn on a weekend and received no medical attention until staff returned to the home.
- Their caseworker reported these incidents, and the MH/MR office told the provider that these individuals were its responsibility. Mother does not like being reported and has discontinued services, with the result being that no service system has access.
- GAP: No service system has access to these people because family discontinued services.

Female, Age 52

- This woman is a timid individual who is soft-spoken and is limited intellectually. A friend who was concerned about financial exploitation referred her to APS.
- She had unknowingly taken a tenant into her home who was seriously mentally ill and who had a criminal record, including a conviction for child molestation. The tenant did meet the rent; however, the tenant caused significant damage to the house. The tenant intimidated her into putting his name on the deed.
- The tenant convinced the woman to take an $87,000 loan against her property, the proceeds of which he reportedly intended to use for himself.
- Through PS, the woman was temporarily removed from her home. She was able to file a landlord tenant complaint to get the tenant removed from the home and to help her obtain estimates and arrange for her home to be repaired.
- GAP: This county has a PS system. In most other counties, there is no service system in place to help this woman, who does not have MR.

Male, Age 32, resident of a skilled nursing facility

- Individual, while mentally capacitated, is diagnosed with cerebral palsy and lives in a skilled nursing facility where each resident receives $30 per month in personal funds. Person was persuaded by his mother to 'loan' her the money, which is never paid back.
- Individual had returned from a visit to the mother's house with scratches on his face, presumably from crawling up the stairs to use the bathroom.
- GAP: No PS program in place.

Male, Age 23

- This individual's father is deceased and he lives with his mother and her boyfriend. He has a diagnosis of metal retardation. He was a Special Ed graduate, has been steadily employed and enjoys various activities and has good peer interactions.

Exhibit 5 (Continued)

- He received a considerable settlement from an accident, which his mother has used to buy a house and for her own expenses. Leftover funds are in her name. The individual resides on the top floor of the house with a leaky roof. He works full-time and his mother only allows him $10 of his wages per week; neither she nor her boyfriend are employed.
- He would like to leave home and be on his own but is afraid that his mother will die if he leaves and is fearful of any action that she might take. He wants assistance, but each time it is offered, he refuses and wants everything kept secret from his mother.
- GAP: No legal authority for emergency intervention.

Female, Age 18

- This woman, diagnosed with MR, was living at home with her mother. Her case manager determined that conditions were unhealthy and unsafe – bed sheets smeared with feces and blood, a roach in her feeding tube. In addition, her mother forced her to wear diapers, even though she did not need them.
- The county asked if she wanted to move out and indeed she did. She was placed in a Family Living Provider (FLP) where she was doing well. Her mother, unhappy with the move, made accusations that her daughter was being abused at the facility. They were investigated and were unfounded. The individual moved to another FLP when her mother continued her accusations. The young woman was moved to a respite provider following a substantiated allegation of abuse and her mother demanded that she move back home.
- She moved back home rather than deal with her mother's repeated verbal abuse toward her and her providers. She is now 20 and is back home wearing diapers and living in less than ideal conditions. Her case manager has only been able to speak to her once since her move back home.
- GAP: No legal authority for emergency intervention.

Female, Age unknown

- This woman has bi-lateral amputations, diabetes and mental health/mental retardation diagnoses. She was receiving care from a friend and her boyfriend; she paid her friend for care and they all lived together. The friend and boyfriend coerced the woman to sign over her SSDI checks to them.
- The friend got a job at a hotel, with one of the benefits being that free board was provided. They all moved to the hotel. When the couple wanted privacy, they took her out of her wheelchair and placed her in the bathtub, where they left her for days in urine and feces; she developed bedsores and became seriously ill.
- The boyfriend picked up a hitchhiker one day and brought him to the motel room. He heard someone yelling for help, proceeded to call the police and the woman was found. She was taken to the hospital and treated and is now in a nursing home.
- GAP: Woman not in a service system.

Male, Age 19

- This young man has severe mental retardation, a seizure disorder and cerebral palsy; he is non-verbal and is dependent on caregivers for all his needs. He was living at home with his mother, where living expenses were paid for with his SSI. His mother was unemployed and made no attempts to find employment.
- The house, rented to the family with assistance, had only one bedroom and was in very bad condition. The house was inspected by the zoning administrator and found to be unfit for habitation. The young man and his mother were no longer eligible for public housing because they owed court costs.
- One day, the mother called her daughter to say that she and her son might be dead by that evening. The father and the police were called and the young man went to live with his father, who is now pursuing guardianship of his son to legally prevent him from returning to his mother.
- GAP: Services provided, but no authority for emergency intervention; eventually resolved within the family.

Exhibit 5 (Continued)

Female, Age unknown

- A woman with moderate mental retardation was repeatedly raped by her mother's live-in boyfriend and became pregnant. She would not agree to leave her mother. As a result, the MR system could do nothing to protect her.
- The police and the district attorney attempted to protect this woman but were not able to have the boyfriend arrested or have the young woman taken out of the home.
- GAP: No legal authority for emergency intervention.

Female, Age 34

- A woman with mental retardation was living with her mother and attended a community based skill enhancement program where she began to develop skills and self-expression. This newfound self-expression proved troublesome to her mother, who withdrew the woman from the program. Provider staff made numerous visits to the home and were refused admittance.
- The mother worked full-time and left her daughter unattended at home, tied either to her bed or to a chair, left in one position for eight to nine hours a day. Pressure wounds developed and became infected.
- The mother finally took the daughter to the hospital in a snowsuit and said that she had a cold. The doctor could smell deteriorating flesh and wanted to do a full exam but the mother refused. The doctor called social services, and only because this county has a voluntary guardianship agency was the woman able to get the physical care she needed and received placement in a supervised apartment setting in the community.
- GAP: Without the guardianship program, no other assistance would have been available.

Male, Age 32

- This man, diagnosed with mental retardation and Down's syndrome, lived at home with his elderly mother and received in-home services from an MR provider. He was active in school and community activities until age 16, when his father died. At this point, his mother withdrew him from all programs and socialization activities.
- The county MR office made a home visit and found him to be bedfast, bereft of self-care skills, unable to walk or speak, contracted arms and legs, teeth full of cavities, and incontinent. Also, the home had deteriorated significantly, making it unsafe for both mother and son.
- A recommendation was made for the county to petition the court to have the young man declared incapacitated and to have a guardian appointed so he could move to a more appropriate living situation.
- The problem, however, was finding funds for the court proceedings, attorney, etc., and finding someone to take guardianship. While the county was trying to set legal proceedings in motion, the mother allowed some services for her son.
- GAP: Local MR office has no authority.

Various residents of a skilled nursing facility.

- Several residents are incompetent and incapable of making their own decisions, including about their own medical care. This poses problems when these individuals need acute medical care and the facility cannot make these decisions.
- The facility encourages family members to take guardianship so decisions can be made, but few do. One of the issues is that many residents have elderly parents who themselves are losing decision making capacity. Additionally, after the parents' deaths, it is difficult to find a new guardian. Even if another person is willing to take guardianship, the cost of guardianship is prohibitive. Further, the facility cannot be appointed as guardian for its residents.

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[a]The above cases were presented to us from various organizations and stakeholder groups and represent individuals who organizations believe might be in need of adult protective services. We report these cases as such, but we have made no conclusions as to actual need for adult protective services.

Source: Developed by LB&FC staff from reports provided by several stakeholder groups.

IV. Cost and Administrative Placement

This chapter addresses the potential cost and possible administrative placement of an APS program at the state and county level.

Cost Estimate for an Adult Protective Services Program

To estimate the potential cost of an adult protective services (APS) program for adults ages 18 to 59, we reviewed the cost to provide protective services to older Pennsylvanians (under OAPSA) and the costs incurred in other states that provide protective service programs for persons aged 18-59.

Pennsylvania's 60+ APS Program

In FY 2001-02, the Department of Aging (PDA) spent $358 million, principally through proceeds from the Lottery, providing services to older Pennsylvanians, including protective services. Tables 9 and 10 indicate that annual funding for the protective services program, as well as the number of people receiving such services, is increasing.

Dollars spent by the Department on all services rose approximately 9 percent in the three fiscal years shown in Table 9. The number of people receiving these services in FY 2001-02 was over 352,000. State dollars spent on the APS program to fund county intake and investigation services rose approximately 15 percent. The Department budgeted over $6.3 million in FY 2002-03 toward the continued operation of the intake and investigation portion of the program.

Table 9

Dollars Spent to Provide Services to Older Pennsylvanians and Dollars Provided to AAAs to Administer Local APS Programs

FY	Dollars Spent on All Services	Number of People Served[a]	Dollars Spent Only on APS[b]	Number of APS Persons Served
1999-00.....	$328,165,735	350,515	$5,061,419	9,447
2000-01.....	331,936,392	356,366	5,300,693	10,101
2001-02.....	358,433,358	352,631	5,792,802	10,932

[a]Total represents individuals who received at least one service from the Department of Aging through an Area Agency on Aging. In some cases a person may have received multiple services within a specific service category or within another of the 28 different service categories. However, they are only counted once as receiving a Department of Aging service.

[b]Dollars spent on APS represent 2 percent of all dollars spent in each fiscal year. Total dollars reported for APS are only the costs related to the provision of intake and investigation services by AAAs. They do not include those ancillary costs that AAAs reported as actual APS costs to PDA to ameliorate the abusive or neglectful conditions that were found. Total dollars spent to serve APS clients includes local funds that were provided by some counties to their AAA. See Table 10 for a further description of these fuller APS costs.

Source: Pennsylvania Department of Aging statistics.

Each year, the Department distributes a block grant to the AAAs for the provision of services. Each AAA determines how much is needed to fund their APS programs and submits a budget and a protective services plan to the PDA. The Department approves the budget and the plan but does not mandate a minimum dollar amount that must be spent for APS. In addition to providing financial data on the APS program, Table 10 presents information on the number of adults age 60 and over who were served each fiscal year and the number of "units of service" provided to these adults.

Table 10

Allocations Provided to AAA's to Pay for Adult Protective Service Intake and Investigations and the Number of People Served*
(FY 1999-00 – FY 2002-03)

	FY FY 1999-00	FY FY 2000-01	FY FY 2001-02	FY FY 2002-03[a]	% Change
Total State APS Allocation.....	$4,936,432	$5,140,807	$5,646,359	$6,108,475	24%
Total Local APS Allocation[b]....	124,987	159,886	146,443	223,336	79
Total APS Allocation	$5,061,419	$5,300,693	$5,792,802	$6,331,811	25%
Persons Receiving Service.....	9,447	10,101	10,932	10,980	16%
Cost Per Person.....	$ 536	$ 525	$ 530	$ 624	17%
Units of Service Provided.....	9,137	9,750	10,680	10,813	18%

*Also includes the costs the AAAs budget for APS salary and benefits, some costs related to the physical infrastructure and the cost to maintain a 24 hour, 7 days-a-week protective services telephone service.

[a]Planned level of services and costs in FY 2002-03 based on data provided by the Department of Aging, as well as data included in the Governor's Executive Budget for FY 2003-2004.

[b]Only a few Area Agencies on Aging receive a small amount of funds locally to supplement the dollars received from the state to provide adult protective services. In FY 2001-02 for example, 12 AAAs reported they had received a total of $146,443 in local funds to supplement state funding.

Source: Pennsylvania Department of Aging.

The AAAs report their services and costs for adult protective services separately from the services they provide to non-protective services clients. Table 11 shows expenditures statewide by AAAs to provide protective services after an investigation has determined that services are necessary. Under OAPSA:

> an AAA with a protective services client who needs such services as meals, attendant care and/or transportation, etc., is expected to provide those services through other funding sources such as the aging block grant or local funds. Only if no other source exists can the protective services allocation be used for services other than receiving reports, conducting investigations, completing assessments, and developing service plans.

The Department of Aging staff that oversee the APS program believe that the cost to provide services to APS clients is actually higher than what is being reported

by the AAAs. This is because the AAAs do not always separately record the costs of services, such as meals-on-wheels or homemaker services, provided to APS clients. When not separately identified, the costs for these services are combined with the costs of services provided to non-APS clients. The Department could not, however, provide an estimate of the extent of such under-reporting.

Table 11

Cost of Services Provided by AAAs Related to Adult Protective Services
(FY 2000-01 – FY 2001-02)

Cost Center	FY 2000-01	FY 2001-02	% Change
Protective Services Assessments	$1,018,839	$1,082,079	6%
Home Delivered Meals	59,098	55,700	-6
Congregate Meals	2,558	2,621	2
Passenger Transportation	9,368	11,272	20
Legal Assistance	51,630	86,602	68
Home Health	7,097	10,219	44
Personal Care	234,953	253,444	8
Personal Assistance Service	9,955	2,894	-71
Overnight Shelter & Supervision	46,000	52,626	14
Home Support	36,184	31,914	-12
Adult Day Care	26,413	12,963	-51
Care Management	1,562,883	1,573,861	1
Guardianship	209,028	234,724	12
Other	46,495	71,202	53
Total	$3,320,501	$3,482,121	5%

Source: Pennsylvania Department of Aging. Dollars spent to fund these expenditures would have been taken from the AAAs' aging block grant and funds raised locally.

Through discussions with local AAA staff, we became aware that some AAAs aggressively try to steer clients to services before they deteriorate to the level that they would qualify for APS intervention. When a need for services is recognized, they begin case management to identify needed services so that the client's condition does not deteriorate. Although not reported as an APS intervention, these efforts could be considered as pre-APS intervention. These types of interventions, however, are not separately identified. The case management costs, as well as the services that result from that case management, are charged to the general cost centers.

Table 12 shows the units of service provided statewide by cost center to APS clients over two fiscal years. A unit of service equates to either one hour of service provided or one meal delivered or one trip provided. Personal care services and home delivered meals were the most commonly provided services.

Table 12

Adult Protective Services Units of Service Provided
(FY 2000-01 – FY 2001-02)

Cost Center	FY 2000-01	FY 2001-02	% Change
Protective Services Assessments	2,384	3,115	31%
Home Delivered Meals (Number)	14,234	12,639	-11
Congregate Meals (Number)	589	717	22
Passenger Transportation (Trips)	1,647	1,189	-28
Legal Assistance (Hours)	1,055	1,421	35
Home Health (Hours)	430	652	52
Personal Care (Hours)	14,158	15,319	8
Personal Assistance Service (Hours)	1,442	1,691	17
Overnight Shelter & Supervision (Stays)	3,985	2,582	-35
Home Support (Hours)	1,708	1,297	-24
Adult Day Care (Days)	465	267	-43
Guardianship (Number Managed)	443	1,560	252
Other	288	452	57

Source: Pennsylvania Department of Aging.

Department of Aging Costs to Administer the APS Program. Department of Aging costs to administer APS are mainly the expenses associated with paying staff to provide oversight of the program. Information we requested indicates that on an annual basis approximately $186,000 in salary and benefits are paid to nine staff to work full-time or part-time on the APS program. In addition to these costs, the Department contracts with a private organization to provide basic and advanced APS training to AAA protective services staff. For the two-year period FY 2000-01 and FY 2001-02, approximately $95,000 was budgeted for basic APS training and $8,000 for advanced APS training.

Combined Costs to Provide APS to Residents Age 60 and Over. Table 13 combines the dollars spent by AAAs to receive and investigate reports of abuse, the costs to provide short-term services subsequent to the investigation, and Department of Aging administrative costs. The greatest cost is for intake and investigation. Approximately 60 percent of reported costs were used to pay for these services. The actual provision of services represented approximately 38 percent of costs.

Departmental administrative costs represented 3 percent of all costs in both fiscal years reported. As discussed, however, because of inconsistency and variability in AAA reporting practices, the cost of services provided by some AAAs for a protective services client may be included in other cost centers. If they can identify such cases and begin providing services the individual may never need protective services.

Table 13

Cost to Provide Adult Protective Services: Intake & Investigation and Provision of Services
(FY 2000-01 – FY 2001-02)

Cost Center	FY 2000-01	FY 2001-02	% Change
Intake & Investigation Costs[a]	$5,140,807	$5,646,359	10%
Provide Ancillary Services	3,320,501	3,482,121	5
Department Adm. Costs[b]	233,829	240,305	3
Total	$8,695,137	$9,368,785	8%

[a]Does not include local funds of $159,886 in FY 2000-01 and $146,443 in FY 2001-02 for APS.

[b]Administrative costs include salary and benefits paid to staff with APS responsibilities, as well as APS training costs. The Department provided the annual personnel costs for one year to administer APS. We used that figure for both fiscal years reported. Basic APS training costs were broken out for each fiscal year, so the appropriate dollar figure was assigned to the pertinent fiscal year. Advanced APS training costs were not broken out by fiscal year. We assigned half the cost to each fiscal year reported.

Source: Developed by LB&FC staff from information provided by the Pennsylvania Department of Aging.

Protective Services Costs in Other States

Other States' Cost to Provide APS to Residents. An April 2003 report found that states were spending $7 million annually on average to administer an APS program.[1] An analysis of the data included in this report, however, shows the difficulty of comparing one state to another. Twenty-seven states and the District of Columbia provided expenditure data in response to the survey. While the report did not directly identify the age of the population protected by these expenditures, using data included on other tables in the report, we were able to determine the age of the population that was served by these funds. As shown in Table 14, most of the programs serve both vulnerable younger adults as well as the elderly.

[1]*A Response to the Abuse of Vulnerable Adults: The 2000 Survey of State Adult Protective Services,* The National Association of Adult Protective Services Administrators, April 2003.

Table 14

APS Budget Information as Reported by States*

Age of Population Protected	Number of State Programs That Provided Protection	Average Expenditures, by State Groups to Provide APS to the Eligible Population
Adults 18 and Older	21	$7,361,887
Adults 60 and Over	3	4,574,528[a]
Adults Ages 18 to 65	3	1,037,549

*Caution should be used in drawing conclusions from these average expenditures as the amount of expenditures fluctuated significantly by state. For example, for the 21 states that reported that they protected all adults, expenditures ranged from $30,000 to almost $31 million. For the four states that reported that their expenditures protected adults 60 and over, including Pennsylvania, expenditures ranged from $630,000 to slightly over $41 million.

[a]One state that reported significantly higher expenditures for its program was removed from this category because the overall average was affected far too significantly. If that state is included, the average expenditures for states serving adults 60 and over increased to approximately $13.7 million for four states.

Source: Developed by the LB&FC from *The 2000 Survey of State Adult Protective Services* Report.

Expenditures Identified Through Survey of Selected States. To try to better understand the costs that states incur to provide an APS program, we contacted selected states to obtain additional financial information. We sent a survey requesting information on the administration and cost of their APS program. Eight states responded to our survey. Additional program cost information on these and other states was obtained by accessing the Internet and through telephone calls.

Example survey responses:

- **Indiana** indicated that the budget in FY 2001-02 for APS was $2.4 million to serve all adults over age 18. The average direct cost to investigate a complaint is $185. Data on the average direct cost per substantiated complaint was not available.
- **Maryland** does not track expenditures separately. The total adult protective services budget for FY 2002-03 is $3.3 million. Approximately 23 percent of that is federal SSBG funds, according to department staff. Expenditures for direct services, the average direct cost to investigate a complaint, and the average direct cost per substantiated complaint were not available.
- **Ohio** reported that in state fiscal year 2002 revenue received by the program from the state was approximately $2.3 million to administer an APS program to serve adults age 60 and over. Program staff, however, could not provide information on the level of expenditures to provide direct services to APS clients. They note in their survey response that such expenditures are tracked at the local level. Expenditure information on the average direct cost to investigate a complaint and the average direct cost per substantiated complaint were also unavailable.
- **Wisconsin** in CY 2001 specifically budgeted and spent approximately $2 million in state funds on its 60 and over protective services program. An additional

$95,000 in federal funds was also expended. Funds were used to investigate 3,223 complaints; a total of 1,022 of these complaints (32 percent) were substantiated. Although state statute requires that counties investigate reports of abuse or neglect of the 18 to 59 adult population, there is no statutory requirement that data be provided to the state on the number or outcome of these investigations. Information on the level of expenditures to investigate complaints for this population was not available.

Estimate of Cost to Expand the APS Program to Adults 18-59 Years Old[2]

We estimate that a program to provide protective services to 18-59 year olds with physical or cognitive impairments could initially cost approximately $5 million annually. As shown on Table 15, we derived this estimate by extrapolating the cost of the current Department of Aging/AAA protective services program for the 60 and older population and then applying that figure to an estimated number of substantiated reports for the 18-59 population.

In developing this estimate, we assumed that about one-third of all substantiated reports will involve persons between the ages of 18 and 59. In the 21 states that could break down the age of their adult protective service clients, on average 30 percent of the substantiated reports involved adults aged 18-59, with the remaining 70 percent involving adults aged 60 and over. We also contacted several county AAAs who thought it reasonable to assume that, if the Commonwealth were to enact an APS program, at least one-fourth, and perhaps more than one-third, of the caseload would involve adults aged 18-59. Given all these factors, our estimate is that roughly 4,000 reports would likely be received and approximately 1,200 cases might be substantiated statewide annually.

Because Pennsylvania has a well-developed Incident Management System for persons registered in state-funded mental retardation programs—which represents a significant portion of the potential APS client base—it is conceivable that the 30 percent estimate is somewhat high. It is also likely that it will take several years for the general public to become aware of the APS program, which could result in lower numbers of reported cases in the first few years of the program. We use the 30 percent figure, however, because we did not want to risk understating potential program costs.

Our cost estimate also assumes that the APS program will include only those types of protective services covered for the 60 and older population. This would include a 24 hours/7 days a week intake capacity, an investigation and risk

[2]Please also note that some counties reporting to DPW that they use HSDF funds for APS do not actually have programs and use the reported funds for representative payee programs or to provide meals to the 18-59 year old population. Some counties (see Chapter II), however, use a portion of their HSDF monies for APS programs. The counties may or may not include some of their own funds to supplement state dollars. In FY 2001-02, counties spent $11.7 million (HSDF only) on adult services, with $381,000 (or 3 percent) of those funds spent on protective services.

assessment process, and developing and implementing short-term case management plans.

We did not include the cost of providing longer-term services, such as permanent housing, substance abuse treatment, transportation, or personal care, as part of the cost of an APS program. AAAs, providers, and advocates all expressed concern that these longer-term services may not be available to APS clients after the initial services are terminated. While we understand and share these concerns, we agree with many of those contacted during this study that this should not be used as a reason for not establishing an APS program.

We have added $1 million to our $4 million cost estimate to cover inflation, first year start-up and training costs, and to provide an allowance to adjust for the possible under-reporting of costs the Department of Aging believes is occurring in the protective service program for the 60 and over population.

Table 15

Estimate of Dollars Needed to Pay for APS for Adults 18 to 59*

Age of Adults	Substantiated Reports	Cost	Cost Per Substantiated Report
60 and Over[a]	2,801	$9.4 million (FY 2001-02)	$3,350
18 to 59[b]	1,200 (Est.)	$4 million (Est.)	$3,350 (Est.)

*Please note that these estimates are for protective services only; they do not include the potential costs for long-term services to APS client or potential increased demand.

[a]Data reported for adults 60 and over represent the overall cost to administer the adult protective services program and provide short-term services to clients.

[b]Data shown for adults 18 to 59 is an estimate based on the assumption that roughly 30 percent of all substantiated APS reports will involve persons aged 18-59.

Source: Developed by LB&FC staff from cost figures provided by the Pennsylvania Department of Aging and the 2003 NAAPSA report, *A Response to the Abuse of Vulnerable Adults: The 2000 Survey of State Adult Protective Services.*

Possible Sources of Funds

The county officials we interviewed expressed concern that, should the Commonwealth enact a new APS program, it not become an unfunded mandate for the counties. For this reason, and because it is likely that many persons receiving APS services will also need long-term services (thus, placing additional pressures on existing social service programs), we assumed no significant amount of county funds would be available to support a new APS program.

We also could not identify a likely source of federal funds for such a program. While many states use federal Social Service Block Grant funds to support their

APS programs, we did not believe it feasible to rely on these funds being redirected from their current purposes to a new program area.

If the General Assembly were to create an 18-59 year old APS program, it would presumably be funded through a separate General Fund appropriation.[3] The General Fund typically provides such money to human services programs in the absence of federal or special funds of the Commonwealth. Aside from the General Fund, the only dedicated source of state funds we thought feasible was the Lottery Fund.[4] Although the proceeds from the Lottery are almost exclusively dedicated for programs for the elderly (including the Commonwealth's protective service program for those aged 60 and older), the Senior Citizens Rebate and Assistance Act, funded by the Lottery, does authorize assistance for permanently disabled persons regardless of age.

Administrative Placement of an Adult Protective Services Program to Serve Adults 18 to 59

As discussed in Chapter VI, most states (41) have chosen to place their adult/elderly protective services programs wholely within their Human Services agency (such as the Department of Public Welfare). In many of these states (23), the state Agency on Aging is also housed within the Human Services agency. In six states, including Pennsylvania, the protective service program is administratively located within a separate state Agency on Aging. Texas is unique in that it has a separate state agency dedicated to protective services for all age groups.

We concluded that the two most feasible administrative homes for a 18-59 year old APS program in Pennsylvania are the Department of Aging or the Department of Public Welfare. This section also discusses the administrative placement of the program at the local level as well as various other organizational placement ideas suggested to us during this review.

Pennsylvania Department of Aging

Since 1987, the Department of Aging (PDA) has been responsible for administering the protective services program provided for in the Older Adults Protective Services Act for adults age 60 and over. In FY 2001-02, the Department provided over $358 million in services to elderly Pennsylvanians, including over $9 million for protective services.

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[3]While funds could be provided through the Human Services Development Fund, that would undermine the concept of this Fund, which is to provide a flexible source of funding for noncategorical needs.

[4]In our June 2003 report entitled *Providing Prescription Drug Coverage for Low and Moderate Income Senior Citizens*, we report that the Lottery Fund is projecting a year end balance of $216.5 million for FY 2003-04.

While we did not establish as an objective of this study to assess the protective services provided to the 60 and older population, there appeared to be a general consensus among the groups and individuals we interviewed that the protective services program operated by the Department of Aging and the AAAs has been successful. In particular, the legislation establishing the APS program (the Older Adults Protective Services Act) is widely regarded as a well-written law that gives the Department and AAAs the necessary authority to pursue abuse and neglect cases, whether occurring in an institution or in a private home. The program has also had the benefit of a reliable funding source through the Lottery Fund. As shown in Table 10 of this report, between FY 1999-00 and FY 2002-03 the total state APS allocation increased 24 percent, while the number of persons receiving service increased 16 percent.

The Department of Aging believes it has the experience and administrative apparatus, including reporting and monitoring capacities with local entities, to provide a similar level of protective services to younger adults. They pointed to the need to maintain consistency in such reporting and oversight activities with local administrators should they become the responsible state agency for 18-59 APS programs. They also noted that, since several AAAs currently operate limited protective services programs for this population, placement with the Department would be a good fit.

One concern expressed to us was that AAAs may not be as sensitive as perhaps they could be to the philosophy of the independent living movement. Advocates for the physically and cognitively impaired were concerned that individuals who may be in need of protective services be allowed to assert their rights to make their own choices of how and where they want to live. They believe that AAA personnel, who currently work almost exclusively with the elderly, may not be as sensitive to these issues.

One potential drawback of using the Department of Aging to administer an 18-59 APS system is that many of the long-term social services that younger APS clients may need are funded by the Department of Public Welfare. Among these are programs for the mentally retarded, the mentally ill, substance abuse treatment, homeless assistance, domestic violence, and attendant care programs. Placing the APS program in the Department of Aging rather than DPW may hinder access to DPW program experts and may make access to these programs more difficult for APS clients. Several advocacy groups, however, stressed that the APS program should be placed in an independent state agency, or at least one that is independent from the DPW social service system.

Of the 30 AAAs that we contacted, 22 indicated that if an APS program for 18-59 year old adults is statutorily required by the legislature, it should be placed administratively in the Pennsylvania Department of Aging. Two AAAs indicated

that the Department of Health should be chiefly responsible for such a program, and two AAAs thought that the Department of Public Welfare should be responsible. Four AAAs were unsure where to place such a program at the state level. The main reason AAAs presented for placing the program in the Department of Aging was that the Department already has experience administering an APS program and is thus best qualified to take on the task, especially given that the Department has an "advocacy" mission which emanates from its statutory charge.

Pennsylvania Department of Public Welfare

The chief argument for placing the 18-59 year old APS program in the Department of Public Welfare is that many of the long-term social services used by the younger adult population are administered in that Department, including programs for the mentally retarded, mentally ill, substance abuse, homeless assistance, and attendant care. It is reasonable to assume that better coordination with these programs would exist if the APS system were operated through DPW rather than the Department of Aging.

Additionally, DPW's Office of Social Programs administers the Human Services Development Fund, the only state funds that counties can currently use to provide protective services for adults between the age of 18 and 59. Several counties, including Philadelphia, Lehigh, Erie, and Northumberland, use HSDF funds to provide APS services to younger adults. The Office also oversees several of the social service programs that provide services to impaired adults, including programs for the homeless, attendant care, and the Community Services Program for Persons with Physical Disabilities. For these reasons, we also consider the Office of Social Programs to be a feasible administrative location for an APS program. We note, however, that the Office of Social Programs does not currently have the level of infrastructure regarding reporting, monitoring, and liaisoning with local agencies that exists in other DPW deputates or in the Department of Aging.

Perhaps the greatest drawback to placing the APS program in the Office of Social Programs is that it would create a third protective system in the Commonwealth. The two existing systems are the Child Protective Services System in the Department of Public Welfare's Office of Children, Youth and Families and the Older Adults Protective Service System in the Department of Aging.[5] In addition to the cost inefficiencies a third system would create, having three different systems depending on the age of the client would also be confusing to the public.

[5]We did not consider it feasible to expand the Child Protective Services system to include persons over age 18. The CPS system has its own complex legal and funding requirements and constraints, there are significant legal and developmental differences between children and adults, and many county Child Protective Services programs are already operating under heavy caseloads.

Another factor, although difficult to quantify, is that the Department of Public Welfare tends to have a licensing and regulatory enforcement "culture" which focuses primarily on monitoring providers and facilities. In contrast, the Department of Aging, in part due to its statutory charge, tends to have more of an advocacy culture which focuses on the needs of the individual. While both approaches have certain advantages, we found, as did the Wisconsin Adult Protective Services Modernization Project, a general consensus that APS workers should serve primarily as advocates for the client.

Department of Public Welfare officials reported that their Office of Social Programs is a viable option for administering an 18-59 year old APS program. They pointed out that they could provide oversight and facilitate coordination with the various human service agencies such APS clients likely would be needing. Further, they indicate that placing the APS Program in DPW would help minimize the overlap and duplication that might occur with their licensing and regulatory enforcement programs. They also stated that they did not foresee significant problems coordinating and collaborating with the Department of Aging if it were the state administrator.

Other Potential Organizational Placements

Other suggestions for possible organizational placements for an APS program include:

Independent State-Level Agency. Several advocates believe an adult protective services program should be located in an independent state-level agency. They cite the inherent conflict of interest that exists when a department that is responsible to provide funding to service providers is also responsible for providing protective services to the individuals receiving the service.

We are aware of only one state—Texas—that administers its protective services through an independent state-level agency, the Texas Department of Protective and Regulatory Services. As noted above, however, in some respects the Department of Aging could be considered an independent agency in that most state-funded services to persons with physical or mental impairments are funded through the Department of Public Welfare.

Pennsylvania County District Attorney's Offices. At least one state, Indiana, has opted to allow its county district attorneys to administer its APS program for 18-59 year olds. One group we interviewed during this study made a similar recommendation for Pennsylvania, citing the need for more active participation by the law enforcement community in cases of neglect and abuse. We found, however, that there is no state-wide administrative structure for county district attorneys,

and we found little support in the advocacy community for a strong law enforcement or prosecutorial presence as part of an APS reporting and investigation process.

APS Placement at the Local Level

The counties that currently operate an adult protective services program for adults aged 18 to 59 have placed these programs within their Area Agencies on Aging or within a county-administered human service office, such as the county Department of Human Services. Virtually all county officials we contacted, including county commissioners, MH/MR directors, county human service directors, and AAA directors, suggested that the counties be given discretion as to which agency they might use to administer an 18-59 year old APS program. They pointed to differing human service structures and systems and local provider and advocacy cultures as important factors counties need to consider in placing such a program.

Area Agencies on Aging. In our survey of 30 AAAs, 22 indicated that it would be best to place an adult protective service program with the AAAs. They pointed out AAAs already have trained staff with APS experience. The staff are familiar with investigating abuse and self-neglect cases and assessing the appropriate level of services needed. (Two counties responded that the county Mental Health and Mental Retardation Office or their Behavioral Health Commission would be the best agency to take on such a program, and six indicated they were unsure where such a program should be placed at the county level.) As noted above, several AAAs commented that the county commissioners should have the option to decide where such a program should be placed.

One potential difficulty with placing an APS program under the auspices of the AAAs is that some AAAs may be reluctant to expand their mission beyond providing services to the elderly, especially if the funding for these additional responsibilities is uncertain. They suggested that the AAAs be allowed the option to decline administrative responsibility for an 18-59 APS program. This could particularly be an issue in counties where the AAA is a private nonprofit agency and that agency might decline these additional responsibilities, despite the county wanting the agency to administer the program.

County Human Service Office. Several counties have established adult protective service programs within their county human service structure but not as part of its AAA. Philadelphia, for example, provides protective services to persons aged 18-59 through their Office of Emergency Shelter and Services within their Department of Human Services. Lehigh County operates its protective services program for 18-59 year olds through its Office of Adult Services.

V. Guardianship Issues Pertaining to a Protective Services System

Many persons who may need protective services are able to make decisions concerning many or all of their life activities. Situations arise, however, where it becomes apparent that the individual in need of services is not capable of making those decisions, including the decision to accept protective services, due to mental incapacity.

In cases where the individual needs protective services but does not agree to accept them, any interested party may seek a determination of incapacity under the guardianship law. This can be time-consuming and costly and requires someone to serve as guardian. Most persons we contacted during the course of this study indicated that finding an interested person to serve as guardian can be difficult as in many cases there are no family members who are willing or able to serve as guardian. Without such guardians, it can be difficult to place persons identified through a protective services program in a safe, permanent living arrangement. For this reason, many of the people we spoke to during this study believe that improved guardian procedures be integral to the long-term services of any adult protection services program.

Purpose of Guardianship

Guardianship is designed to protect and promote the well-being of those whose functional limitations prevent them from making their own decisions. It establishes a legal relationship between a competent adult and a person over the age of 18 whose disability causes incapacity. The disability may be caused by mental illness, developmental disability, age, accident, or other causes. Developmental disability or mental illness is not by itself sufficient reason to declare someone incapacitated. Pennsylvania's guardianship statute, 20 Pa.C.S.A. §§5501-5555, specifically states that, "no presumption of incapacity shall be raised from the alleged incapacitated person's institutionalization."

Guardianship law in Pennsylvania seeks to balance the needs of the incapacitated person with his/her ability to participate as fully as possible in all decisions which affect him/her; therefore, Pennsylvania law adopts the principle of and a preference for limited guardianship. This means the court can find a person "partially incapacitated" and appoint a "limited guardian" of a person or an estate to manage only specific affairs deemed necessary by the court.

Establishment of Guardianship

Guardianship is established by the court after an interested party files a petition for the appointment of a guardian for a person or person's estate. The court determines after a hearing whether the person is incapacitated. Under Pennsylvania law, an incapacitated person is:

> . . . an adult whose ability to receive and evaluate information effectively and communicate decisions in any way is impaired to such a significant extent that he is partially or totally unable to manage his financial resources or to meet essential requirements for his physical health and safety.

Any qualified individual, corporate fiduciary, non-profit corporation, guardianship support agency as defined in the act or county agency may serve as guardian, although the court is to give preference to a person suggested by the incapacitated person.[1] The petitioner seeking guardianship must establish by clear and convincing evidence that the respondent is incapacitated. In determining that, the court must consider and make specific findings of fact concerning:

- the nature of any condition or disability, which impairs the individual's capacity to make and communicate decisions;
- the extent of the individual's capacity to make and communicate decisions;
- the need for guardianship services, if any, in light of such factors as the availability of family, friends, and other supports to assist the individual in making decisions and in light of the existence, if any, of advance directives such as durable powers of attorney or trust;
- the type of guardian, limited or plenary, of the person or estate needed based on the nature of any condition or disability and the capacity to make and communicate decisions; and
- the duration of the guardianship.

The law additionally provides for an emergency guardianship for persons who need the immediate appointment of a guardian. In these cases, the court must find by clear and convincing evidence that the respondent is incapacitated, the respondent needs a guardian, and failure to appoint a guardian would result an irreparable harm to the respondent, the respondent's person or estate. The court must specify the powers, duties, and liabilities of that guardian in its order. An emergency guardianship is in effect for no longer than 72 hours although that order may be extended for 20 days from the date of the expiration of the initial emergency order. Full guardianship proceedings are required past the expiration of the extension. Additionally, an emergency guardianship of the estate may not exceed 30 days, and at that time a full guardianship must be instituted.

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[1]A guardianship support agency is available to serve as guardian when no other person is willing or qualified to become guardian. The agency itself may be appointed guardian with no individual named by the court.

In general, guardians have the authority to make the decisions for the incapacitated person necessary for their daily life, including designating the person's residence, maintaining their financial matters, and providing required consents or approvals on behalf of the incapacitated person. Guardians are required to file at least annually reports concerning the person for whom they serve as guardian. These reports are to include the current address and type of placement of the incapacitated person, any major medical or mental problems experienced by the incapacitated person, as well as a brief description of the incapacitated person's living arrangements and the social, medical, psychological, and other support services he/she is receiving.

Need for Guardianship Services

Although Pennsylvania law allows any qualified individual, corporate fiduciary, non-profit corporation, guardianship support agency, or a county agency to serve as guardian, numerous county agencies have indicated that there is a lack of individuals willing to serve in this capacity. Additionally, counties cite the cost of pursuing guardianship as affecting their ability to find willing guardians, particularly when no public funds are available to offset these costs.

Some counties do, however, have some form of a guardianship program in place. For example, in Beaver County, a non-profit corporation, PA Guardianship Services,[2] serves as the guardian for individuals who are incapacitated. This organization has been guardian for an estimated 500 people since its inception and is currently guardian for about 30 people, 6 or 7 of whom are between the ages of 18 and 60.

Westmoreland County has a more formalized guardianship program, which was implemented in 1984. Guardianships are requested of the court for a number of individuals who do not receive services under OAPSA because they have not reached the age of 60. In these cases, guardianship has been pursued, either by the agency or an outside referral source, because it was determined that there was no less restrictive alternative. The AAA provides both guardianship and guardianship-type services. As of spring 2003, they had 80 wards, eight of whom are between the ages of 18 and 59.

Lehigh County's AAA also has a formalized guardianship program, for which the AAA is the guardian of record. The program has five wards between the ages of 18 and 60. Five staff are dedicated to providing intensive case management and guardianship services. Included in both Lehigh's and Westmoreland's programs are those wards who are over 60; they constitute, in fact, the majority of guardianships.

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[2]PA Guardianship Services is part of an umbrella organization called Achieva. Achieva is a coalition of the Beaver County Arc, Allegheny County Arc, Compro (early intervention/residential services), RAMS (mail services and tech center), and Family Trust (estate planning for those with disabilities).

Those under 60 include those with mental retardation, chronic mental illness, head injury, trauma, and early onset Alzheimer's.

Other counties, such as Lancaster and Centre, do not have formal guardianship programs, but do make some efforts on behalf of their clients. In Lancaster, Neighborhood Services serves as public guardian.[3] There are 35 wards total, which is the maximum number that Neighborhood Services can handle. In 2002, the AAA began a pilot project of taking guardianship of those with lesser problems, i.e., there are no estates involved and wards are MA eligible and are already in facilities. In Centre County, the AAA is not involved in guardianship beyond trying to find a family member and, if necessary, work with a local attorney to take on these responsibilities.

State Guardianship Office

Legislation has been introduced in prior sessions of the Pennsylvania General Assembly to create a Commonwealth Guardianship Office to serve as guardian for certain incapacitated persons (House Bill 1647, Session of 2001, and House Bill 2267, Session of 2000). In general, these bills would have established a Commonwealth Guardianship Office as an independent agency to manage guardianship services for incapacitated persons. The office would be charged with continually monitoring the care and progress of the incapacitated person for whom they have been appointed guardian and receive reports from public and private agencies providing services to the incapacitated person. These bills provided for reimbursements from the estate of the incapacitated person to help offset court costs, as well as guardian fees as currently provided in law.

[3]A newer organization, Pennsylvania Guardianship, has been established and currently has about three or four wards.

VI. Adult Protective Services Programs in Other States

There is no federal agency responsible for collecting data from states on the number of abuse reports received and investigated. Consequently, there is no national database that can be accessed to compare different state programs. Additionally, most programs have limited data management system capabilities. This makes it difficult to collect any but the most basic information on the level of abuse and the corresponding need for adult protective services (APS) protections. Finally, because there is no national authority providing consistent definitions of elder/adult abuse, exploitation, and neglect, states define these areas differently, which makes it difficult to develop standard outcome measures that can be used to compare the performance of individual programs.[1]

Adults Protected by APS Program

Because there are no federal statutes or categorical funding related to the delivery of APS for adults under age 60, each state has developed its own system for service delivery. Our review found that the majority of states (41) have enacted statutes for protective services for adults, regardless of age. Six state programs serve only older persons, and four programs serve only disabled adults aged 18-65. Exhibit 6 presents information on these programs.

Although the definitions for covered populations vary among the states, in general the definitions cite a physical or mental impairment that affects the ability of the adult to provide for his own care or protection. At least one state, Indiana, more specifically defines this population to include individuals with dementia, habitual drunkenness, excessive use of drugs, or other physical or mental incapacity.

[1] *State Adult Protective Services Data Management Systems 2001,* a survey report of the National Association of Adult Protective Services Administrators, December 2001.

Exhibit 6

Populations Served Under Elder/Adult Protective Statutes

Population Protected	States
Adults Age 60 and Over.....	Connecticut; Massachusetts; Nevada; Ohio; Pennsylvania; Rhode Island
Vulnerable/Disabled/Impaired Adults, 18-65.....	District of Columbia; Idaho; Mississippi; North Dakota
Vulnerable/Disabled/Impaired Adults, All Ages.....	Alaska; Alabama; Arkansas; Arizona; California; Colorado; Delaware; Florida; Georgia; Hawaii; Illinois; Indiana; Iowa; Kansas; Kentucky; Louisiana; Maryland; Maine; Michigan; Minnesota; Missouri; Montana; Nebraska; New Hampshire; New Jersey; New Mexico; New York; North Carolina; Oklahoma; Oregon; South Carolina; South Dakota; Tennessee; Texas; Utah; Vermont; Virginia; Washington; West Virginia; Wisconsin; Wyoming

Source: Developed by LB&FC staff from four principal sources. The first source was information reported by The National Center for Elder Abuse in April 2003. The NCEA obtained their data from a survey that was sent to each state and the District of Columbia in March 2000. A second source of information was a review of selected states' adult protective services web sites. A third source of information was a review of selected states' statutory provisions for adult protective services. Finally, telephone calls were made to adult protective services staff in selected states to clarify or verify data. Based on this data, in some cases we moved a state from the category of serving a specifically defined population based on age to the more generable category of serving vulnerable, disabled, or impaired adults of all ages. Some states divide adult protective services responsibilities between two agencies depending on age and/or disability and have separate defined statutes giving different state agencies the responsibility of providing protective services.

How States Have Administratively Placed Their APS Program

The survey undertaken in 2000 by the National Center for Elder Abuse (NCEA) asked state APS offices to identify the state administrative agency responsible for administering their program. We used this information as a starting point, but changed some states to another category based on additional information and conversations with selected state officials. The results of the survey (see Exhibit 7) illustrate how each state has taken its own approach in developing and administering an APS program.

Forty-one states have placed their APS programs in a human service agency such as our DPW. In many of these states, the state unit of aging, which may or may not be responsible for the APS program, is also located within the human service agency. Pennsylvania is one of six states in which the APS function is within an independent state agency on aging.

Exhibit 7

Administrative Placement of the State Agency Responsible for Elder/Adult Protective Services

APS in Human Service Agency, State Agency on Aging Is Separate Agency	APS in the State Agency on Aging, Which Is in Human Service Agency	APS in the State Agency on Aging, Which Is a Separate Agency	APS in Human Service Agency, State Agency on Aging in Same Agency, but not Responsible for APS	APS Is in Other Agency[a]
Alabama	Arizona	Alaska	District of Columbia	Indiana
California	Colorado	Idaho	Kentucky	Kansas
Florida	Connecticut	Illinois	Minnesota	Michigan
Georgia	Delaware	Louisiana[b]	Montana	Texas
Hawaii	Maine	Pennsylvania	Nebraska	
Iowa	Massachusetts	Rhode Island	New Hampshire	
Louisiana[a]	Missouri		New Jersey	
Maryland	Nevada		Oregon[b]	
Mississippi	North Dakota			
New Mexico	Oklahoma			
New York	South Dakota			
North Carolina	Utah			
Ohio	Vermont			
South Carolina	Wisconsin			
Tennessee				
Virginia				
Washington				
West Virginia				
Wyoming				

[a]Indiana's APS program is within the Family and Social Services Administration but operates through the county prosecutor's offices. Kansas has located its APS office in the state public welfare agency. Michigan has its APS program in the Family Independence Agency, and Texas APS program is in the Department of Protective and Regulatory Services.

[b]Both Louisiana and Oregon have two separate protective services offices, one for protective services to vulnerable disabled adults and one for elder abuse victims.

Source: Developed by LB&FC staff from The National Association of Adult Protective Services Administrators, *2000 Survey of Adult Protective Services*, as well as a review of individual APS state web sites and from information obtained by telephone. In some instances, our placement of a particular APS program differs from The National Center for Elder Abuse survey because of these additional contacts.

How States Investigate Reports of Abuse

All survey respondents indicated that they could investigate reports of abuse in domestic settings, including private homes. Only 34 states indicated they could investigate reports of abuse in institutional settings, such as nursing homes. For states that did not give their APS program the authority to investigate reports of abuse at institutions, such investigations were handled by the state regulating authority for that institution or the state ombudsman. Pennsylvania's elderly protective services program investigates reports of abuse in both settings.

We reviewed selected states' statutes to determine how they compared in seven areas. Exhibit 8 presents the results of this review for 19 different state APS programs. The majority of the states have passed legislation mandating reporting when health care workers, social service agencies, or staff becomes aware of possible abuse.

APS Features of Selected States

APS programs nationwide have developed diverse approaches to meeting the needs of their vulnerable population. We found wide variation across states with regard to services offered, oversight, population covered, and response procedures. While most states serve vulnerable adults of all ages, some, such as Pennsylvania, serve only the elderly. In some states, counties have considerable autonomy in administering APS programs, leading to disparities even within states; e.g., in Ohio.

Indiana. In 1985, the Indiana legislature enacted legislation to protect adults from abuse, neglect, and exploitation by creating an APS program. A unique feature of the program is that the Indiana Prosecuting Attorney's Council was asked to assume functional control. Indiana is the only state in which the APS program is a criminal justice function. Full-time investigators are employed and operate in the offices of 18 prosecutors. Advantages in this arrangement include immediate access to the prosecutor, law enforcement, and the courts. This in turn permits the active pursuit of sanctions against the perpetrators.

Indiana's program serves adults who are 18 years or older and who are incapable by reason of mental illness, mental retardation, dementia, habitual drunkenness, excessive use of drugs, or other physical or mental capacity of managing or directing the management of their property or providing or directing the provision of self-care, who have been harmed or threatened with harm as a result of neglect, battery, or the exploitation of the individual's personal services or property.

Exhibit 8

Selected Provisions in Other States' Adult Protective Services Statutes

State	Applicable Population	Reporting Requirement[a]	Investigation Requirement	Access to Records/People	Guardianship[b]	Court Orders Available	Client to Pay for Services[c]
Alabama	18 & Older	X	X		X	X	X
Arizona	18 & Older	X	X	X	X	X	
Colorado	18 & Older	X	X	X	X	X	
Delaware	18 & Older	X	X	X	X	X	X
Florida	18 & Older	X	X	X	X	X	
Illinois	18 to 59[d]	X	X	X	X	X	
Indiana	18 & Older	X	X	X		X	
Maryland	18 & Older[e]	X	X		X	X	X
Michigan	18 & Older	X	X	X	X		
New Jersey	18 & Older	X	X	X	X	X	X
New York	18 & Older	X	X	X	X	X	
Ohio	60 & Older	X	X	X		X	X
Oklahoma	18 & Older	X	X	X		X	X
Oregon	18 & Older	X	X	X	X		
Pennsylvania	**60 & Older**	**X**	**X**	**X**		**X**	
Texas	18 & Older	X	X	X	X	X	X
Utah	18 & Older	X	X	X	X	X	X
Virginia	18 & Older	X	X	X	X	X	X
West Virginia	18 & Older	X	X	X	X	X	
Wisconsin	18 & Older	X	X	X	X	X	X

[a]Refers to requirement where facilities, doctors, social service workers, or others must report incidences where they expect a person has been abused or neglected, or where there is a possibility of self-neglect to the appropriate APS office. Not every state mandates reporting by the same categories of people.

[b]Indicates that guardianship provisions are specifically referenced in the APS statute. Guardianship may otherwise be provided for elsewhere in state statutes.

[c]If the client has the resources.

[d]Illinois provides protective services for persons 60 and over under a separate statute.

[e]For persons who are 65 and older, protective services must be coordinated with the Department of Aging or the local office on aging.

Sources: Developed from a review of other states' statutes. The exhibit does not include information from regulations, policies, or actual programs that a particular state may have promulgated or established.

In FY 2001-02, a total of 12,894 complaints were investigated, of which 9,038 (70 percent) were substantiated. Although the number of substantiated complaints that pertained to adults under age 60 was not provided, the state official answering our survey indicated that approximately 34 percent of substantiated complaints involved adults under age 60. Using this percent as a guide, 3,073 of all substantiated complaints affected adults under the age of 60. According to an official with Indiana's APS program, providers, witnesses, and perpetrators provide more in-depth information to a criminal justice investigator than could have been obtained by an investigator with a social service agency. Investigators are able to concentrate on the crime and enlist other entities to provide any direct services that are necessary.

Maryland. Maryland has a state-supervised, county-administered system for adults 18 and over. The program is housed in the Maryland Department of Human Resources (MDHR). Local departments of social services conduct all APS investigations and file all petitions for guardianship for clients living at home or in assisted living facilities. The Department of Aging Ombudsman investigates complaints in nursing homes. Investigations are conducted in response to every reported incident of suspected abuse, neglect, self-neglect, or exploitation of a vulnerable adult.

A separate program within MDHR, the Adult Public Guardianship program, provides services to vulnerable adults between the ages of 18 and 64 who have been certified medically incompetent to make decisions relevant to their self-sufficiency. Local offices are the guardians of last resort for this population. The guardian handles all concerns except financial matters. The Maryland Department of Aging and Area Agencies on Aging serve as the guardians of last resort for adults 65 and over. A third program, the Representative Payee program, designates a trained volunteer to act as the representative payee for disabled adults. According to a Maryland official, the advantages to its program are that expertise is located in one agency, coordination with law enforcement is simpler, and there is consistency across the state. Disadvantages, however, are that local staff do not always have access to the resources needed for the mentally ill, developmentally disabled, or substance abusing customer.

In FY 2001-02, Maryland APS staff investigated 3,625 complaints involving adults 60 and over. Of those complaints, 1,683 (46 percent) were confirmed or indicated. An additional 1,488 complaints involving adults between the ages of 18 and 59 were investigated. A total of 619 (42 percent) of these complaints were confirmed or indicated (28 percent of all confirmed reports).[2] Within this age group, 59 percent of complaints involved adults 49 years old and younger. The data tracking system MDHR uses does not allow them to track complaints by type of referral, setting of referral, or type of disability.

Ohio. Ohio is a state-supervised, county-administered system which primarily serves persons who are at least 60 years old. County staff investigate abuse, neglect, and exploitation reports. State staff investigate complaints made by constituents regarding the way cases are handled. There are 88 County Departments of Job and Family Services (CDJFS) which are responsible for receiving and investigating all reports of abuse, neglect, and exploitation of the elderly population 60 years and older. Data on complaints made about adults under age 60 are not collected by the

[2]There were an additional 213 complaints received where the age of the victim was unknown.

state. The Ohio Revised Code requires the program to be made available to persons 60 years of age or older; the law does not reference persons 18 to 59 years of age in its definition. However, 49 out of 88 Ohio county agencies voluntarily serve the 18 years of age and older population as part of their APS program.

According to information provided by state staff, in state fiscal year 2002, there were 10,262 complaints received about adults 60 and over and 1,089 complaints received about adults 18 to 59. Unlike Pennsylvania, the state APS Office does not have data on the number or percent of those complaints substantiated. It also does not collect mistreatment information, client profile information, settings where abuse occurred, and disposition of substantiated cases.

Wisconsin. In August 2000, the state began examining its existing 18 year old plus APS program with the intent of strengthening it so that more vulnerable adults were protected, regardless of where they live. State officials chose to undertake a review of their program, in part because the existing program had gaps that did not provide the necessary safeguards for all vulnerable adults. An Adult Protective Services Modernization Workgroup examined current adult protective services practices and state law to support these practices. As of August 2003 the review was essentially finished and a committee of the state legislature was evaluating the recommendations. The workgroup affirmed the historic role of APS as social workers "brokering needed services for competent adults and pursuing legal authority where the imposition of involuntary services is warranted." The workgroup also recommended the need to develop a better criminal justice response in situations of abuse by others, including the expectation that law enforcement take the lead in APS assessments and investigations in certain situations, specifically crimes involving domestic violence, sexual assault, caregiver abuse, and financial exploitation.

Oregon. Adult protective services (APS) investigative responsibilities are divided between two offices within the Oregon Department of Human Services. One office investigates reports of abuse involving elderly and disabled adults, 18 years of age and over, living in the community. The second office investigates reports of abuse involving the developmentally disabled living in facilities licensed by the state. In CY 2000, these two offices collectively investigated 11,479 reports of abuse or neglect. A total of 4,723 (41 percent) were substantiated. Oregon APS spends approximately $422 per case on its investigations. To encourage better response to allegations of abuse and to better ensure that all necessary steps are taken to protect vulnerable adults, many counties in Oregon have created multi-disciplinary teams. These teams review cases and provide interventions for elderly adults at risk of self-neglect or abuse that have a combination of social, mental health, health, and alcohol/drug problems. Intervention is also provided to the disabled adult having complex care needs and/or multiple diagnoses. If necessary, discussions are held with law enforcement agencies to determine if possible legal action is warranted, and, reportedly, these efforts have increased the number of prosecutions throughout the state. State law, however, only mandates that child abuse reports be referred to law enforcement agencies. A June 2002 evaluation of the program found that the limited ability of APS investigators to access financial and medical records hampers investigations and prosecution of APS cases.

Texas. Three program areas serve APS clients. In-home investigations are the largest and oldest program. Adults age 64 and older who live in their home or in

unlicensed room-and-board homes are protected by this program. In addition, adults with disabilities and adults living in nursing homes who may have been financially exploited are also afforded protection. If abuse or neglect is substantiated, investigators arrange for the necessary services to alleviate the problem. According to the Texas Department of Protective and Regulatory Services, in 2002 a total of 56,906 in-home investigations were completed, of which 41,154 (72 percent) were substantiated. A second program is responsible for undertaking APS investigations in MH/MR facilities and related programs, such as state schools, state hospitals, state mental health/mental retardations centers, and facility and community center contractors for disabled individuals 18 years of age and older. During 2001, APS investigators completed 7,942 investigations, of which 1,061 cases were substantiated. Half of the cases involved neglect. A third APS program protects elderly and disabled adults where maltreatment is confirmed through the process of taking on guardianship responsibilities when there is no one else to do so. APS guardianship may be provided directly by state staff or through contracts with local entities. In 2002, APS directly provided guardianships for 513 adults and contracted for an additional 178. Caseworkers are required to notify law enforcement of abuse or neglect cases that have been substantiated that constitute a criminal offense under the law.

VII. Appendices

APPENDIX A

PRINTER'S NO. 3924

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE RESOLUTION

No. 590 Session of 2002

INTRODUCED BY SATHER, SCHULER, GRUCELA, M. BAKER, CAPPELLI, PICKETT, B. SMITH, PISTELLA, BLAUM, BROOKS, CALTAGIRONE, COY, CREIGHTON, CRUZ, DALEY, DALLY, DeWEESE, FAIRCHILD, GABIG, GEIST, GEORGE, HENNESSEY, HERMAN, HESS, HORSEY, HUTCHINSON, JAMES, KENNEY, LAUGHLIN, LESCOVITZ, MELIO, R. MILLER, S. MILLER, ROBINSON, ROEBUCK, ROSS, SANTONI, SAYLOR, SEMMEL, SHANER, SOLOBAY, STABACK, STERN, E. Z. TAYLOR, TIGUE, VANCE, WALKO, WANSACZ, WASHINGTON, G. WRIGHT AND YOUNGBLOOD, JUNE 3, 2002

REFERRED TO COMMITTEE ON RULES, JUNE 3, 2002

A RESOLUTION

Directing the Legislative Budget and Finance Committee to conduct a study on the need for the development of a protective services program within this Commonwealth for physically and cognitively impaired adults between 18 and 59 years of age.

WHEREAS, Citizens of this Commonwealth from 18 to 59 years of age who are at imminent risk of injury or death due to a physical or cognitive impairment, neglect, abuse or other incapacitating condition currently have no program of protective services available to them; and

WHEREAS, Those citizens are entitled to the same legislatively mandated protective services as children and older adults in this Commonwealth; and

WHEREAS, The statutory establishment of the child protective services system and the older adult protective services system has resulted in substantial increases in the general public's

awareness of the problems of abuse and neglect of those vulnerable populations and has led to substantial increases in the number of reports received by children and youth agencies and area agencies on aging; and

WHEREAS, Pennsylvania is one of only nine jurisdictions in the nation that does not have a protective services program for adults who are between 18 and 59 years of age; and

WHEREAS, A survey conducted in 40 states by the National Association of Adult Protective Services Administrators found that during the 1999-2000 reporting period, 40,156 substantiated cases occurred, prompting the need for protective services for adults under 60 years of age; therefore be it

RESOLVED, That the House of Representatives direct the Legislative Budget and Finance Committee, in consultation with experts and specialists in the field of adult protective services, to conduct a study to examine the need for protective services for adults between 18 and 59 years of age, the types of services needed, the most appropriate administrative structure for an adult protective services program, the necessary legislative language to implement an adult protective services program and other relevant factors which would inform the General Assembly in determining how best to meet the needs of these citizens; and be it further

RESOLVED, That the committee make a report, with recommendations as appropriate, which shall be submitted to the Speaker of the House of Representatives and to members of the Health and Human Services Committee within one year of the adoption of this resolution.

APPENDIX B

One Approach and Suggested Statutory Language to Amend Pennsylvania's Older Adults Protective Services Act (OAPSA)

Section 101. **Short title**.

This act shall be known and may be cited as the Adult Protective Services Act.

Section 102. **Legislative Policy**.

Amend to *include adults between the ages of 18 and 59 with physical or cognitive impairments.*

Section 103. **Definitions**.

Add "Adult" and define as *Person within the jurisdiction of the Commonwealth who is between 18 and 59 years of age.*

Add "Adult in need of protective services" and define as *An adult with a physical or cognitive impairment who is unable to perform or obtain services that are necessary to maintain physical or mental health, for whom there is no responsible caretaker and who is at imminent risk of danger to his person or property.*

Add "Adult with physical or cognitive impairments" to definitions for Abandonment, Abuse, Caretaker, Exploitation, Intimidation, Protective services, and Protective setting.

Amend definition of "Agency" to read *The local provider of protective services which for older adults is the area agency on aging or the agency designated by the area agency on aging, and for adults is the agency designated by the County to provide these services.*

Add "Physical or cognitive impairment" and define as *A mental, physical or developmental disability that results in one or more functional limitations and impairs the person's ability to provide for the person's care and protection.*

Chapter 3. **Administration**.

Add "Adult with physical or cognitive impairments" to various sections that reference "older adult."

Chapter 5. **Criminal History for Employees**.

No changes.

Section 705. **Confidentiality of and access to confidential reports**.

Add the State Long-term Care Ombudsman to section (b) exceptions.

New Section. **Exception to Mandated Reporting Requirements of Chapter 7**.

The requirements of Chapter 7 shall not apply to adults with a physical or cognitive impairment receiving services from facilities that provide services to individuals with mental retardation in residences licensed by DPW or funded through a county mental retardation program.

Funding. Designate funding as appropriate.

Source: Developed by LB&FC staff.

APPENDIX C

PA Requirements for Addressing Unusual Incidents in Selected Licensed Facilities or Services*

Personal Care Boarding Home:[1]

Mandated Reporting. The licensee or administrator must immediately report by telephone unusual incidents involving the health, safety, and well-being of residents to the PCH licensing field office. If a weekend or holiday incident, notification must be the next working day. Written notification of incidents must be sent to the PCH licensing field office within five working days of the occurrence.

Required Investigation. Not specifically provided for in regulation.

Required Monitoring. Not specifically provided for in regulation.

Access to Records/People. The home administrator and staff must provide immediate access to the home, residents, and records to DPW staff, Department of Aging OAPSA staff, and Long-Term Care Ombudsman program staff.

Nursing Home:[2]

Mandated Reporting. Health Care Facilities Act regulations require that if a health care facility is aware of information about noncompliance with regulatory requirements or is aware of a situation or event that would seriously compromise quality assurance of patient safety, the facility must immediately notify DOH in writing.

Required Investigation. The facility's medical director has the responsibility to review incidents and accidents that occur and to address the health and safety hazards at the facility.

Required Monitoring. Not specifically provided for in regulation.

Access to Records/People. Not specifically provided for in regulation.

Foster Home Care:[3]

Mandated Reporting. The foster home care provider must notify the administering agency (private agency from which DPW is purchasing services) immediately in the event of an unusual incident or accident involving a client, a serous illness, or the client's death or impending death. The administering agency must promptly notify the client's family or significant other in the event of an unusual incident or accident involving the client, a serious illness, or the client's death or impending death. The administering agency must also submit a written report to DPW within three days concerning an unusual incident involving a client, a serious injury to or accidental death of, or suicide of a client.

Required Investigation. Reports of poor care, mistreatment or exploitation of clients by a foster care provider shall be thoroughly investigated by representatives of the administering agency. Investigations must include a home visit and must be completed in three days. A copy of the investigation report must be maintained by the administering agency and one provided to DPW.

*This appendix does not include all licensed facilities. Other facilities include, for example, adult day care, family living homes, and intermediate care facilities.

Appendix C (Continued)

Required Monitoring. The administering agency is responsible for evaluating foster home care providers on an annual basis, and more often if necessary.

Access to Records/People. Not specifically provided for in regulation.

Home Health Agency:[4]

Mandated Reporting. Health Care Facilities Act regulations require that if a health care facility is aware of information about noncompliance with regulatory requirements or is aware of a situation or event that would seriously compromise quality assurance of patient safety, the facility must immediately notify DOH in writing.

Required Investigation. Whenever DOH, upon inspection, investigation, or complaint, finds a violation, it must give written notice to the health care provider.

Required Monitoring. A home health care agency is subject to inspection at any time by DOH representatives. Agency must have a plan of correction if deficiencies are found. DOH will ascertain agency compliance with plan.

Access to Records/People. A facility or agency must provide DOH/agents with full access to the facility, its records, staff, and clients.

Domiciliary Care Home:[5]

Mandated Reporting. The provider must immediately notify the AAA regarding unusual incidents. The AAA must immediately notify the client's family or designate, if available, in the event of an unusual incident involving the client. Reports of neglect, mistreatment, abuse or client death shall be made by the AAA to the Department of Aging within 72 hours of a documented incident. Reports which are related to protective services cases and are made by the AAA under the Older Adults Protective Services Act satisfy this requirement.

Required Investigation. A report of an unusual incident shall be thoroughly investigated by representatives of the AAA. The investigation shall include a home visit, which shall take place within 72 hours of the date the report was received by the AAA. Investigations performed by the AAA as part of a protective services intervention under the Older Adults Protective Services Act satisfy this requirement.

Required Monitoring. The AAA is to conduct follow-up interviews, inspections, and emergency visits as appropriate.

Access to Records/People. A provider must provide AAA representatives and Department of Aging staff with full access to the facility, its records, staff, and clients.

Adult Training Facilities:[6]

Mandated Reporting. The individual's family and the residential service provider must be notified immediately in the event of an unusual incident. The facility shall orally notify, within 24 hours after abuse or suspected abuse of an individual occurs: (1) the county mental health and mental retardation program if the individual involved in the unusual incident has mental illness or mental retardation; (2) the funding agency; and (3) the appropriate regional office of mental retardation. In the event of a client death, a death report form must be completed and

submitted within 24 hours to: (1) the county mental health and mental retardation program if the individual had mental illness or mental retardation; (2) the funding agency; and (3) the regional office of mental retardation.

Required Investigation. The facility shall initiate an investigation of the unusual incident and complete an unusual incident report within 72 hours after an unusual incident occurs to: (1) the county mental health and mental retardation program if the individual involved in the unusual incident has mental illness or mental retardation; (2) the funding agency; and (3) the appropriate regional office of mental retardation. In the event of a client death, the facility must investigate within 24 hours.

Required Monitoring. At the conclusion of the investigation the facility shall send a copy of the final unusual incident report to: (1) the county mental health and mental retardation program if the individual involved in the unusual incident has mental illness or mental retardation; (2) the funding agency; and (3) the appropriate regional office of mental retardation.

Access to Records/People. Not specifically provided for in regulation.

Older Adult Daily Living Centers:[7]

Mandated Reporting. The facility must have written policies and procedures on preventing, recording, reporting, investigating and managing unusual incidents that occur at the center. The client's responsible party, the client's family, if appropriate, and the residential services provider, if applicable, must be immediately notified in the event of an unusual incident relating to a client. In cases of abuse or suspected abuse, within 24 hours after an unusual incident occurs but not later than the next working day, the center operator must orally notify the Aging Department, the funding agency, and the county MH/MR program if the client has mental illness or mental retardation. If the unusual incident involves a client's death, the center operator must report in writing within 24 hours of the death.

Required Investigation. Within three working days after an unusual incident occurs, the center operator must conduct an investigation and complete a report and send copies to the DOA, the funding agency, and the county MH/MR program if applicable.

Required Monitoring. The center is subject to announced and unannounced onsite inspections.

Access to Records/People. The center must provide to Department of Aging agents full access to the center and its records, to staff and to clients.

APPENDIX D

Joint Response of the Departments of Aging and Public Welfare to This Report

COMMONWEALTH OF PENNSYLVANIA

September 26, 2003

Philip R. Durgin
Executive Director
Legislative Budget and Finance Committee
Room 400
Finance Building
Harrisburg, PA 17105-8737

Dear Mr. Durgin:

Thank you for your September 5, 2003 letter in which you transmitted the draft report from the Legislative Budget and Finance Committee (LB&FC) entitled "An Assessment of the Need for an Adult Protective Services Program." We found it to be a comprehensive and thorough review of an issue long needing Commonwealth attention. In general, we concur with the recommendations in the report, with the exception of number four, and number seven regarding the funding source for the program. More specifically, our comments regarding each recommendation as numbered, are as follows:

1. We support the amendment of the Older Adults Protective Services Act (OAPSA) to create the statutory authority necessary for extending protective services to adults age 18 and older. We would suggest, however, that the name of the Act and related services be changed to perhaps the "Adult Safety Assurance Act" to reflect attention to the preferences of the disability community.

2. We agree that a protective services program should cover persons with physical and/or cognitive impairments age 18-59. As legislation is developed to implement a new Safety Assurance program, we will need to be mindful of the differences within the population of individuals who are cognitively and physically disabled. These differences translate into different needs and desires, which should be taken into account when we define who we are protecting and how the system protects them.

3. We agree that the program should be placed in the Department of Aging's Protective Services unit, with coordination of investigative and program activities with appropriate units at the Department of Welfare and respective local agencies. The Department of Aging has the experience and administrative infrastructure at the local and state level to provide 24-hour a day-seven day a week response ability. It is not fiscally prudent to establish a duplicate infrastructure through the Department of Public Welfare or a new agency. The Departments of Aging and Welfare are committed to working very closely together to coordinate investigations and provision of services. Legislation should address coordination to ensure the appropriate systems are established.

4. We disagree that counties should be given the discretion for local administrative placement. It is important to maintain statewide uniformity on protective services investigation and program operations. Having various agencies in different counties designated as the reporting contact will result in confusion by both professionals and consumers/families. The Department of Aging's network of Area Agencies on Aging has the infrastructure and expertise to provide the added local administration. It currently conducts assessments for the provision of services to persons with disabilities under the age of 60, staffed by social workers and nurses, many of whom have human service backgrounds.

5. We concur that existing mandated reporting entities should be included for 18-59 year olds. However, the legislature should revisit the issue of whether facilities licensed by DPW, or funded through county mental retardation programs to provide services to individuals with mental retardation, should be exempt from mandatory reporting.

6. Coordination of investigative and program activities is critical. Upon passage of an act extending protective services to this age group, memoranda of understanding will be developed by the relevant Departments to coordinate activities. These memoranda should address issues of post-investigation coordination to ensure appropriate service agencies have the information necessary to direct consumers' care.

7. While we concur that a dedicated source of funding should be provided, we disagree that Lottery Funding should be considered. We believe a new funding source must be identified for the program expansion, reserving Lottery funds for the anticipated growing demand for services for persons aged 60 and older as the "Baby Boomer" age cohort qualify for Lottery-funded services.

In addition, we believe future legislation should address the issue of short and long-term intervention and service planning following investigations. Additional funding must also be identified for enhanced planning and service delivery.

Thank you for the opportunity to comment on the draft report. If you have any questions or should need any further assistance, please do not hesitate to contact us.

Sincerely,

Nora Dowd Eisenhower
Secretary
Department of Aging

Estelle B. Richman
Secretary
Department of Public Welfare